

# Driving Progress in Organ Donation and Transplantation Through Strategic Measurement and Continuous Quality Improvement

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June 2026



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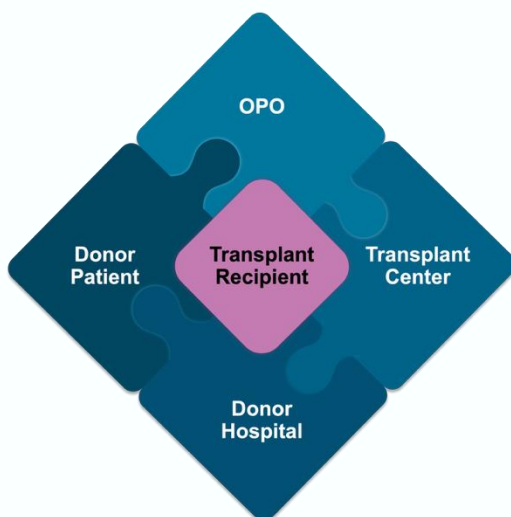
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## Purpose of This Plan

This plan, *Driving Progress in Organ Donation and Transplantation Through Strategic Measurement and Continuous Quality Improvement*, is intended to provide an overview of the strategic measurement framework for Organ Procurement Organizations (OPOs), explain how it was developed, and explain how the initial set of measures can enable OPOs to continue to pursue quality and performance to grow organ donation.

While this plan focuses primarily on the activities of OPOs, the measurement framework was developed with the idea of a single system for organ donation and transplantation (Exhibit 1). Additionally, the framework and implementation approach is intended to offer a way of approaching collaboration with donor hospitals, donor families and patients, transplant centers, and transplant recipients and their providers.

**Exhibit 1. Components of the Donation and Transplant System**



OPOs already carry out continuous quality improvement (QI) initiatives and have for decades. Along with using standard practices in healthcare organizations for quality and performance, all OPOs are required by the Centers for Medicare & Medicaid Services (CMS) to maintain Quality Assessment and Performance Improvement (QAPI) programs under 42 CFR § 486.348. Some OPOs have also chosen to pursue the Baldrige Performance Excellence Program™ or use a Balanced Scorecard™ approach to promote excellence in their organizations.

This plan first summarizes the ecosystem in which OPOs work and the complex and careful series of activities OPOs undertake to enable a donor's organs to be available for transplant recipients. Understanding the work of OPOs and where their responsibilities begin and end within the larger transplant system is critical to measuring their performance accurately and to identifying opportunities for developing or sharing best practices.

Next, the plan offers a framework for action and the associated measures developed by and for OPOs. There are many potential areas of measurement, and through the measure development process, key areas were identified for initial focus. Measures for future development were also identified, including opportunities for shared measures with donor hospitals and transplant centers. Over time, additional measures that provide independent, verifiable performance metrics for the system can and should be developed.

Finally, the plan describes how the measurement framework can be implemented so the framework and measures are used to promote action and collaboration among stakeholders. The plan begins with two measures that are critical drivers of donation: Referral Rate (the identification of potential donors) and Approach Rate (the initiation of the donation conversation with families). These two areas were selected based on input from OPOs as well as for their potential to immediately impact organ donation and transplantation overall and save more lives.

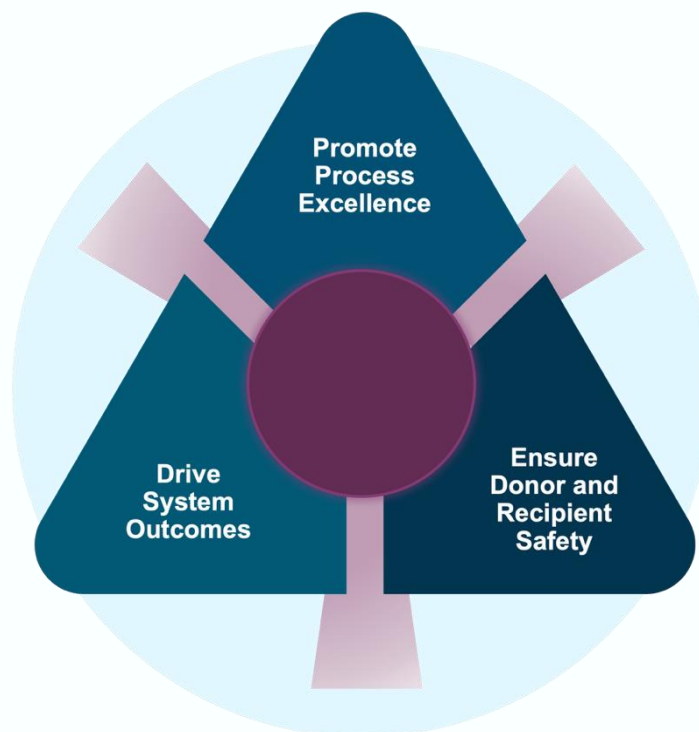
The plan and measurement framework provide a unified and overarching vision for the measurement of OPOs that will enable them to work together with partners such as federal, state, and local governments, community organizations within their Designated Service Area (DSA), donor hospitals, and transplant centers, as well as with other key stakeholders, such as transportation providers, to better honor donors and their families and serve individuals on the transplant waiting list. While there are many ways to measure OPO performance, a shared and collaborative approach creates the best opportunity for impact.

## Understanding Organ Procurement Organizations

In order to understand the measurement framework and initial set of measures and why they were developed, it is necessary to understand OPOs and the landscape for organ donation and transplantation. That landscape is complex, but at its core, it is centered around the donor, the recipient, and their families.

OPOs are the federally designated, not-for-profit entities that work with donor hospitals to identify potential organ donors, coordinate the recovery of organs for transplantation, and support donor families through the donation process - including authorization and bereavement support. OPOs work within this system by collaborating with many other organizations to make the generous gift of life possible through organ donation. To carry out this important work, OPOs focus on three primary aims: (1) promoting process excellence, (2) ensuring donor and transplant recipient safety, and (3) driving donation and transplant outcomes (see Exhibit 2).

Exhibit 2. Three Primary Aims of OPOs



Operational and process excellence is critical due to the time-sensitive nature of the organ donation process. OPOs work with donor hospitals and families to ensure donors are identified, appropriate options for donation are provided using best practices, including discretion and sensitivity, and organ recovery happens safely, in a timely manner, and with respect for the donor and their family. OPOs are also responsible for ensuring recovered organs are transported to a transplant center for a recipient. Throughout this process, OPOs collect data to help improve safety, donor care, and lifesaving outcomes.

Donor and transplant safety is a continuous focus for OPOs. Staff at OPOs include highly skilled and trained healthcare professionals who work directly with organ donors, donor families, and hospitals to ensure donation is appropriate and to guide the safe recovery, allocation and transport of donated organs. The OPO team also includes laboratory professionals to provide test results that might rule out donation, medical device companies to safely handle and maintain the organs, research partners, and tissue recovery partners, all working together in support of donation and transplantation.

To maintain safety, OPOs follow rules established by regulators such as CMS, the Organ Procurement and Transplantation Network (OPTN), the Health Resources and Services Administration (HRSA), the Food and Drug Administration (FDA), and state, local, and Tribal regulators. OPOs also work through their laboratory providers to get special input from the Centers for Disease Control and Prevention (CDC) or state health departments in the event donor testing reveals certain infectious diseases.

OPOs work with other partners to drive toward state and national donation and transplant goals. OPOs also work with donor registries that allow people to make a personal decision to sign up as a potential organ, eye, and tissue donor. Many states operate such registries so people can register as a donor when applying for a driver's, hunting, fishing, or other state identification card or license. In addition to state registries, Donate Life America (DLA) hosts a national donor registry to help promote organ donation registration across the United States. People can sign up as an organ, eye, and tissue donor on DLA's national registry at [registerme.org](https://registerme.org).

Donor hospitals and OPOs share a critical partnership as hospitals are where patient care, family support, and the opportunity for donation come together. Donor hospitals include key staff in emergency departments, intensive care units (ICUs), and operating rooms, as well as hospitalists, physicians and other hospital providers who declare death, social workers, family support services, administrators, ethics committees, and lawyers.

Due to the complexity and many moving parts of the organ donation process, transportation providers are also essential partners for OPOs. Transportation entities involved with organ donation include commercial providers like couriers or airlines, emergency medical services, the Transportation Security Administration (TSA), private ground transportation, transportation technology companies, and charter air companies. Transportation providers play multiple roles in the donation process, transferring potential donors to donor care units or hospitals, transporting recovered organs to transplant centers, and enabling OPO staff to travel to hospitals across often geographically large DSAs.

After an OPO identifies a potential donor, the transplant centers—another key collaborator in the donation and transplant ecosystem—assess each organ, determine medical suitability, and accept organs for their matched patients. Working closely with OPO teams, they coordinate timing, share clinical information, and ensure organs are transplanted safely and efficiently. OPOs and transplant centers form a united network that honors donor gifts and helps save lives.

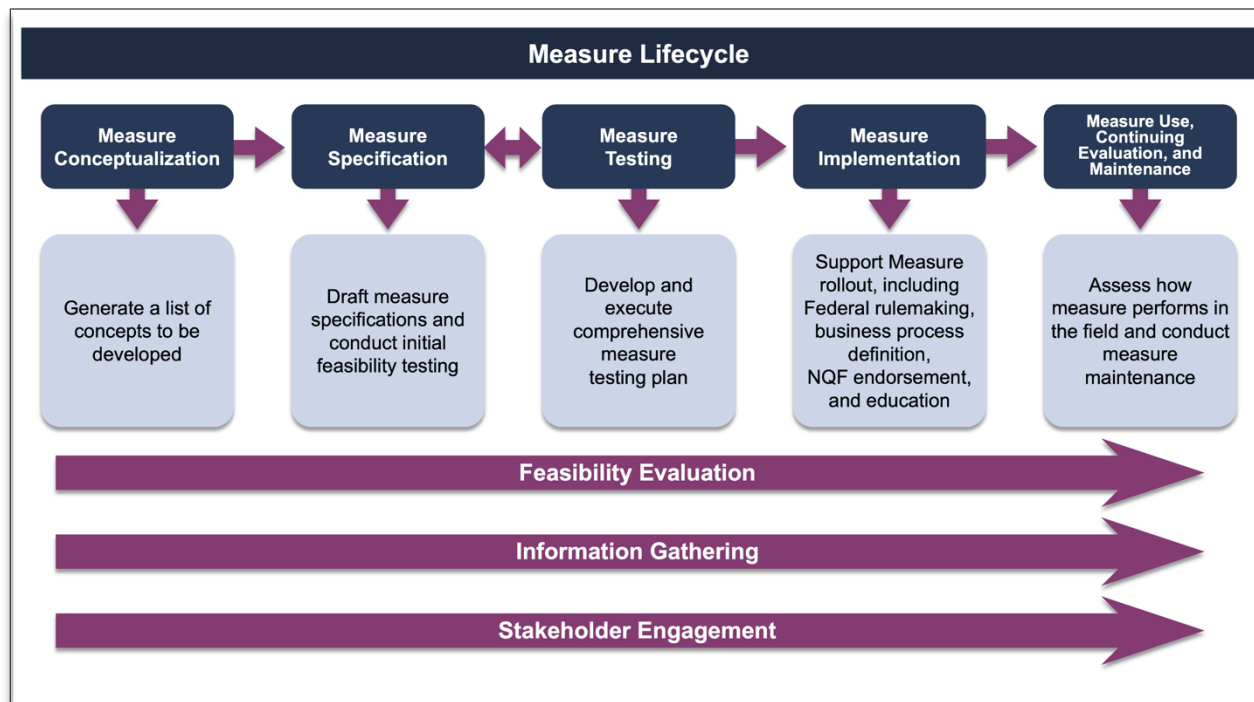
The ecosystem in which OPOs do their work is incredibly complex, but its purpose is to honor donor heroes, support families, and save lives. Every part of this system depends on collaboration, trust, and a shared commitment to success.

## Developing Validated OPO Quality and Performance Measures

Using scientifically valid measures of the quality and efficiency of healthcare services, including organ donation and transplantation, enables policymakers, healthcare leaders, and clinical leaders to track and improve systems of care.

The CMS Blueprint Measure Lifecycle<sup>1</sup> (Exhibit 3) was used as a guide by AOPO and its partner, Econometrica, Inc., to develop healthcare quality and performance measures.

Exhibit 3. CMS Blueprint Measure Lifecycle<sup>2</sup>



In the *conceptualization* phase of the measure development process, Econometrica conducted a full environmental scan, which included site visits to seven OPOs, a literature review, interviews with stakeholders, conversations with patients and families, and a public comment period. Additionally, an OPO Stakeholder Group and a Technical Expert Panel (TEP) were assembled, and each met a total of five times. Econometrica also developed an inventory of existing measures related to OPOs and their work as identified in peer-reviewed literature, government materials, and OPO

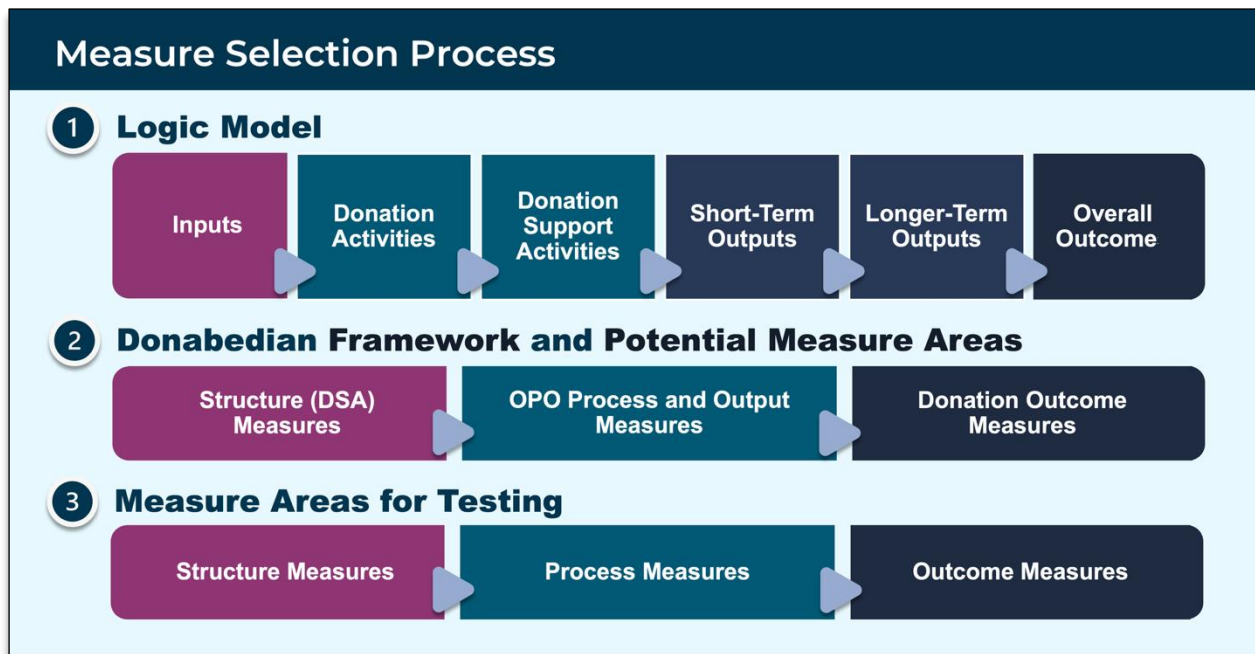
<sup>1</sup>Centers for Medicare & Medicaid Services. (2026, February). Blueprint Measure Lifecycle Overview. <https://mmshub.cms.gov/blueprint-measure-lifecycle-overview>

<sup>2</sup>Centers for Medicare & Medicaid Services. (2021, September). Quality measures: How they are developed, used, and maintained. <https://www.cms.gov/sites/default/files/2021-09/Quality-Measures-How-They-Are-Developed-Used-Maintained.pdf>

documents. Econometrica then developed a logic model (Appendix A) of OPO activities that was iteratively reviewed by the OPO Stakeholder Group and TEP. The logic model describing OPO activities and their relationships with partner organizations was developed and used to inform and guide consensus-building around measure selection.

Econometrica applied the Donabedian model<sup>3</sup> to the logic model to work with the OPO Stakeholder Group and TEP to identify areas for measurement. The Donabedian model is widely used in healthcare measurement and categorizes measures as structural, process, or outcome measures. The Donabedian model is widely used in healthcare measurement and categorizes measures as structural, process, or outcome measures. The Donabedian model emphasizes the interrelationship of the structural aspects of the healthcare ecosystem, the processes involved in delivering quality care, and the effectiveness or outcome of that care. Econometrica worked iteratively with the OPO Stakeholder Group and the TEP to develop measure criteria and select areas for potential measurement. From this collaboration, Econometrica drew several structural, process, and outcome measures for consideration and explored these with the OPO Stakeholder Group and the TEP to identify final areas for measure specification (Exhibit 4).

Exhibit 4. Measure Selection Process



<sup>3</sup>Donabedian, A. (2005). Evaluating the Quality of Medical Care. The Milbank Quarterly, 83: 691-729.  
<https://doi.org/10.1111/j.1468-0009.2005.00397.x>

In the *measure specification* and *testing* phases, Econometrica further defined measure terms with OPO engagement and narrowed the potential measure list by prioritizing measures in domains deemed closely within OPO control, essential to OPO activities across the nation, and indicative of high OPO performance. Additional evaluation of potential measures included formative alpha testing to assess the feasibility of the measures based on data availability and the ability to calculate the measures using technical specifications. Econometrica identified four measures for testing in spring 2026 and four measures for further development and testing in fall 2026.

### Exhibit 5. Proposed OPO Measures

| Timeline    | Abbreviated Title                                     | Full Measure Title                                                                                                                                                                                                                                                |
|-------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Spring 2026 | Referral Rate                                         | Rate of hospital referrals of potential organ donors made to the Organ Procurement Organization (OPO) from within the OPO's donation service area (DSA) in a calendar year.                                                                                       |
|             | Approach Rate                                         | Rate of referred patients that are approached for an organ donation in the Organ Procurement Organization's (OPO's) donation service area (DSA) in a calendar year.                                                                                               |
|             | Authorization Rate                                    | Rate for organ donation among approached, referred potential organ donors in the Organ Procurement Organization's (OPO's) donation service area (DSA) in a calendar year.                                                                                         |
|             | Donation Rate                                         | Rate of deceased organ donors to potential donors in an Organ Procurement Organization's (OPO's) donation service area (DSA) in a calendar year.                                                                                                                  |
| Fall 2026   | Donor Management Goals (DMG) Bundle                   | Percentage of potential organ donors for which the Organ Procurement Organization (OPO) achieved at least 7 of 9 donor management metrics in the OPO's donation service area (DSA) in a calendar year.                                                            |
|             | Organ Yield Rate or Organs Recovered Per Donor (ORPD) | Number of organs recovered for transplant per donor by the Organ Procurement Organization (OPO) within the OPO's donation service area (DSA) in a calendar year regardless of whether the organs are transplanted.                                                |
|             | Organ Utilization Rate                                | Rate of the number of organs transplanted to the total number of available organs from donors with at least one organ recovered for the purpose of transplant within the Organ Procurement Organization's (OPO's) donation service area (DSA) in a calendar year. |
|             | Patient Safety Measure                                | Rate of adverse events related to potential organ donor management and patient safety identified by the Organ Procurement Organization (OPO) within the OPO's donation service area (DSA) in a calendar year.                                                     |

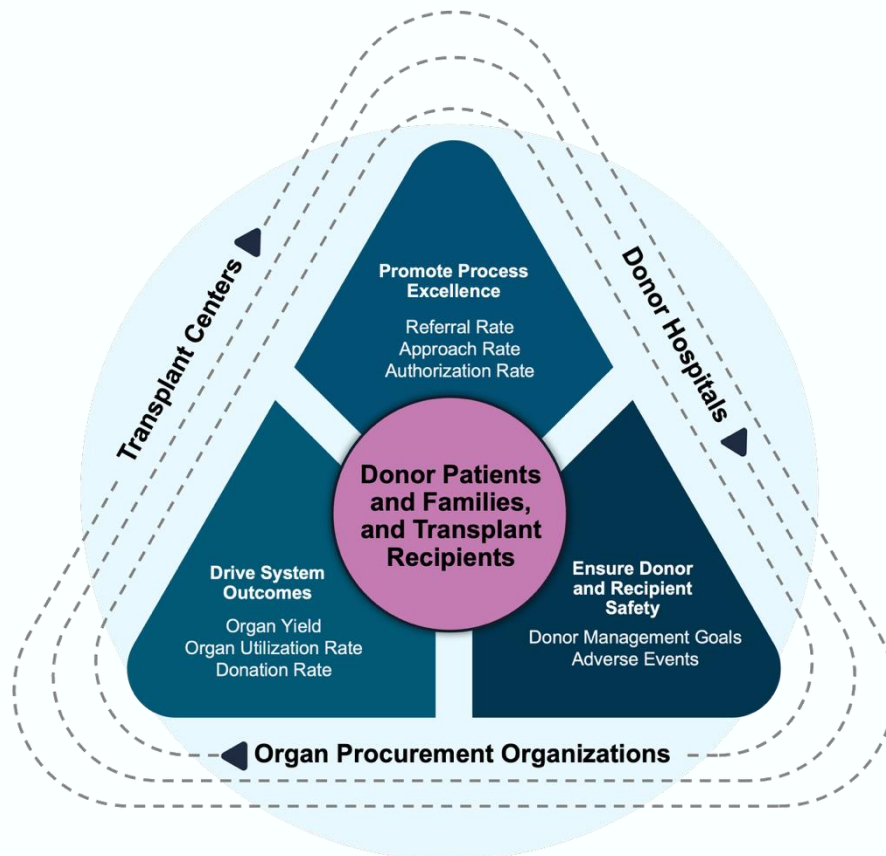
OPOs and the TEP also identified areas for future development and agreed additional structural and shared measures can and should be developed to expand the measured areas in the future.

## Final OPO Measurement Framework

Using the information gathered about OPO activities—including the primary aims of OPOs and the identified measures—and drawing from healthcare quality and performance improvement literature, a measurement framework was developed.

This *Triple Aim of Organ Donation and Transplantation* framework reflects the three main aims of the donation and transplantation system—**(1) promoting process excellence, (2) ensuring donor and transplant recipient safety, and (3) driving system outcomes**—as well as the three primary healthcare partners—**OPOs, donor hospitals, and transplant centers**. Each of the eight proposed measures is aligned to the three aims of the framework. Most importantly, the framework centers donor patients and families and transplant recipients.

Exhibit 6. Triple Aim of Organ Donation and Transplantation for OPOs



This framework mirrors the Institute for Healthcare Improvement's Triple Aim,<sup>4</sup> a widely recognized model for healthcare improvement, while recognizing the differences in donation and transplantation from other areas of healthcare. It promotes a single system model for organ donation and transplantation in which OPOs, transplant centers, and donor hospitals work

together toward the same three aims. This version of the framework highlights the OPOs' areas of measurement. Furthermore, while eight initial measures for OPOs have been included, the framework is flexible and allows for changes to and the addition of measures over time, while continuing to provide a guiding focus. For example, the diagram could be expanded to include donor hospital and transplant center measures.

This single system framework and the relationships depicted between the key actors in the transplantation and donation system also reflect the central values of collaboration and coordination, which Congress cemented into the system in the National Organ Transplant Act (NOTA) of 1984. The framework enables alignment of measures from any stakeholder in the donation and transplantation system to ensure that all aspects of the system are working together.

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<sup>4</sup>Institute for Healthcare Improvement. (n.d.). *Triple Aim*. <https://www.ihl.org/library/topics/triple-aim>

## Implementation of This Plan

OPOs have always prioritized robust performance and QI programs because they serve as the critical link between the lifesaving altruism of donors and the needs of transplant recipients. By implementing a systematic approach to quality and performance improvement, OPOs can identify and mitigate specific bottlenecks in the donation pipeline, ranging from initial referral and family authorization to organ recovery and transportation, thereby increasing the total number of organs successfully transplanted. Beyond clinical outcomes, continuous QI is essential for maintaining regulatory compliance with evolving performance standards, ensuring that high-quality, data-driven metrics guide operational decisions. Ultimately, a commitment to QI fosters improved outcomes by addressing systemic gaps and disparities in the donation process and strengthens public trust in the integrity and efficiency of the national transplant system.

QI is particularly important in the current donation and transplant ecosystem, where government agencies are no longer prioritizing shared national goals, making it essential OPOs and their partners collaborate to strive toward shared aims and outcomes. QI initiatives for OPOs centered around the *Triple Aim of Organ Donation and Transplantation* will enable:

- ▶ **Evidence-Based Scientific Integrity.** QI ensures that the latest clinical research and evidence-based practices are standard across all operations. Whether adopting new preservation technologies or implementing standardized donor management goals (DMGs), a rigorous QI framework ensures clinical decisions are grounded in science rather than habit. This commitment to scientific integrity is vital for maintaining the trust of both donor families and the transplant centers that rely on OPOs to provide high-quality organs.
- ▶ **Data-Driven Performance Monitoring.** Modern QI initiatives move beyond retrospective reviews and toward the use of real-time data analytics. By tracking granular metrics, such as the conversion rate of eligible donors or the "missed opportunity" rate in specific hospital units, OPOs can pinpoint exactly where the system is losing potential lifesaving organs. This data-driven approach allows for targeted interventions, such as adjusting the timing of family conversations or improving the technical protocols during organ perfusion to increase the viability of marginal organs.

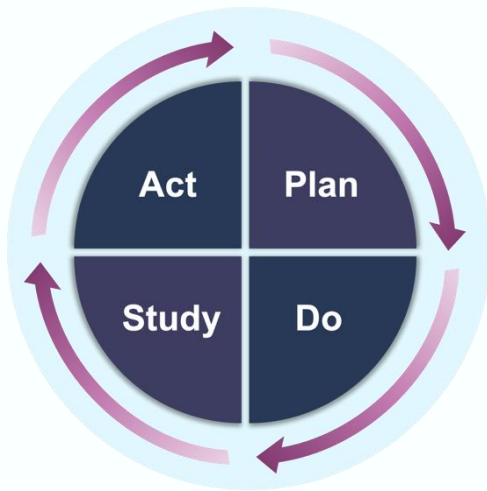
- ▶ **Operational Efficiency and Staff Retention.** QI is not solely about clinical outcomes; it is also about the sustainability of the workforce. The donation process is high-pressure and often involves irregular hours, which can lead to employee turnover and burnout. Systematic QI can streamline workflows, reduce administrative burden, and clarify roles during the organ recovery process. A more efficient operation reduces the burden on OPO and hospital staff, creating a more stable and professional environment that preserves institutional knowledge.
- ▶ **Interorganizational Collaboration.** OPOs do not operate in a vacuum; they are part of a complex ecosystem involving donor hospitals, transplant centers, and regulatory bodies. QI provides a common language for these stakeholders. When an OPO shares its QI data with a donor hospital, it fosters a collaborative relationship based on transparency. This joint accountability helps align the priorities of the ICU staff with the donation team, ensuring that potential donors are identified early and managed optimally.

OPOs are strongly motivated to incorporate best practices into their organizations. They are well-versed in quality assessment and performance improvement activities as required under the CMS Conditions for Coverage (42 CFR §486.348), which state that “the OPO must take actions that result in performance improvements and track performance to ensure that improvements are sustained.” This plan supports, and goes beyond that requirement by promoting proactive excellence. OPOs can refine every stage of the donation process and lead collaboration with donor families, donor hospitals, and transplant centers to support shared goals for reducing wait time and deaths on the transplant list.

## Using the Plan-Do-Study-Act Approach

The Plan-Do-Study-Act (PDSA) cycle is a systematic, iterative process used for the continuous improvement of a product, process, or service (Exhibit 7). Often referred to as the Deming Wheel or the Shewhart Cycle, it is built on the principle of testing small changes, learning from them, and refining them before full-scale implementation. Each step in the cycle represents an opportunity to focus on an OPO's mission and performance.

**Exhibit 7. PDSA Cycle**



The goal of the Plan phase of the PDSA cycle is to define the objective and determine exactly how to measure success. It is important to identify the problem, be specific about what needs to change, and then state the objective to be accomplished (e.g., "Reduce the time from donor referral to first OPO contact by 15%.") After hypothesizing what will happen if the change is implemented, a clear plan should be written for implementation

and ensuring data are collected to track results. The Do phase involves implementing the test of change on a small, controlled scale, often a pilot program or a single department. For example, an OPO might test a referral change with one hospital before expanding to other hospitals. Documentation of observations such as unexpected events, problems, or successes that occur during the test can help determine next steps. Data should also be gathered during the test of change.

The Study phase is the most critical phase for learning why and how a change might impact the outcome. It involves a deep dive into the data to see if the change worked as predicted, including comparing the new data to baseline performance and evaluating against predictions (e.g., "Did the change result in the improvement you expected?"). Summarizing the lessons learned is critical to the next phase in the process. Even if the test "failed," what was learned about the process or the environment that can be identified.

Based on what was learned in the Study phase, the Act phase of the PDSA cycle calls for a decision on the future of the intervention. There are typically three paths: (1) adopt the new process and roll it out more broadly; (2) modify the plan and run a new cycle; (3) discard it and start a new cycle with a different approach.

By using the PDSA approach, OPOs can implement small tests of change and alter authorization strategies for broader implementation. Best practices for PDSA cycles include starting small by testing a change with one staff member on one shift or with one donor hospital before scaling up. Cycles should be run sequentially to test multiple changes to find the right one, and frontline staff should be engaged, as the people who perform the work daily are often the best sources for identifying barriers and predicting how a change will affect workflow. This minimizes risk and allows for rapid adjustments.

## Strategic Areas for OPO Implementation: 2026–2027

To kick off the unified QI process, OPOs will work on two main strategies in 2026 and 2027:

1. Optimize referral rates
2. Optimize approach rates

To work on these strategies, OPOs will use the PDSA cycle to test changes. Examples of these tests of change are outlined in Exhibit 8 and Exhibit 9 below.

### Exhibit 8. Examples of PDSA Tests of Change for Optimizing Referral Rates

| Description of Strategy                                                                                     |
|-------------------------------------------------------------------------------------------------------------|
| Ensuring referral rates are optimized and complete allows for the best use of OPO resources.                |
| Root Cause to Be Addressed.                                                                                 |
| Over- and under-referral of potential donors by donor hospitals.                                            |
| Intended Improvement.                                                                                       |
| Ensure all potential donors are referred on a timely basis and with accurate information needed by the OPO. |

| Potential Tests of Change                                                                                                                                                    | Mechanism                                                                                                                                                                                                | Timeline                              | Evidence                                                                                                                                           | Materials                                                                                                                                                                                  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Audit and standardize "Clinical Triggers" across all partner hospitals (e.g., GCS $\leq$ 5, ventilator dependency, plan to discuss withdrawal of life-sustaining treatment). | Implement electronic medical record (EMR) automated triggers that notify the OPO in real time when a patient meets clinical criteria, bypassing manual notification delays.                              | Phased approach (6–9 months)          | Early referral improves donation outcomes; standardization reduces variability; automation improves timeliness and reliability.                    | Clinical and operational materials (e.g., standard clinical trigger list); EMR technical build specifications; training and change management materials; monitoring and performance tools. |
| Increase the frequency of "rounding" by Hospital Development Specialists.                                                                                                    | Conduct daily "Safety Huddles" in high-volume units to identify potential donors earlier in the clinical progression rather than waiting for imminent death.                                             | Phased approach (4–6 months)          | Early identification improves donation outcomes; proactive rounding reduces missed opportunities; interdisciplinary huddles improve communication. | Clinical and operational materials (e.g., huddle checklist); staffing and workflow tools (e.g., rounding schedules); data and monitoring tools.                                            |
| Implement a Retrospective Death Record Review (DRR) on a monthly cadence.                                                                                                    | Identify every ventilated death that was not referred. Use this data to hold hospital C-suites accountable through Joint Oversight Committee (JOC) meetings.                                             | Phased approach (3–5 months)          | Retrospectives identify missed opportunities; ventilated deaths are a high-yield population; audit and feedback drives behavior change.            | DRR review tools (e.g., Case Review Guide); data and analytics infrastructure; governance and reporting materials.                                                                         |
| Engage with hospital leadership to ensure donation and referral are a priority for the hospital.                                                                             | Stratify hospitals and prioritize high-volume hospitals or hospitals with lower memorandum of understanding (MOU) compliance rates for in-person visits to discuss donation and compliance.              | Monthly or quarterly                  | Leadership relationships can reduce friction and improve problem-solving and engagement.                                                           | Relationships; hospital MOU; senior leadership time.                                                                                                                                       |
| Enable electronic referrals.                                                                                                                                                 | Continue to implement electronic referral connectivity with hospitals, especially high-volume hospitals.                                                                                                 | Long-term                             | Well-designed electronic referrals reduce waste and steps in referral processes.                                                                   | IT staff resources; electronic donor records (EDR) vendor support or engagement; EMR vendor support.                                                                                       |
| Provide job aids for frontline staff on referrals, such as pocket cards or instructional guides in nursing stations.                                                         | Develop job aid materials for critical and intensive care staff and technicians in donor hospitals.                                                                                                      | One month                             | Cognitive testing of materials can yield insights into the types of job aids that are most useful for making timely referrals.                     | Clinical staff engagement; printing or development resources for materials.                                                                                                                |
| Hold listening sessions with acute care and ICU staff regarding their barriers to referral or reasons for over-referral, and then make changes to protocols accordingly.     | Partner with one or more hospitals to hear directly from acute care providers in brief huddles about their perspectives on donations and how barriers to referral could be lowered. Address one barrier. | Phased by hospital or sub-area of DSA | Donor hospital staff initiate the referral process and are key to the donation process.                                                            | Leadership support; time; support for follow-up to address barriers or reasons.                                                                                                            |
| Hold listening sessions with acute care and ICU staff regarding their barriers to referral or reasons for over-referral, and then make changes to protocols accordingly.     | Partner with one or more hospitals to hear directly from acute care providers in brief huddles about their perspectives on donations and how barriers to referral could be lowered. Address one barrier. | Phased by hospital or sub-area of DSA | Donor hospital staff initiate the referral process and are key to the donation process.                                                            | Leadership support; time; support for follow-up to address barriers or reasons.                                                                                                            |

## Exhibit 9. Examples of PDSA Tests of Change for Optimizing Referral Rates

| Description of Strategy                                                                                                                                                                                   |                                                                                                                                                     |                              |                                                                                                                                                                                                                        |                                                                                                                                                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|
| The Approach Rate is highly sensitive to timing and the personnel involved.                                                                                                                               |                                                                                                                                                     |                              |                                                                                                                                                                                                                        |                                                                                                                                                           |
| Root Cause to Be Addressed.                                                                                                                                                                               |                                                                                                                                                     |                              |                                                                                                                                                                                                                        |                                                                                                                                                           |
| Not approaching potential donors or families with appropriate personnel or in a timely way.                                                                                                               |                                                                                                                                                     |                              |                                                                                                                                                                                                                        |                                                                                                                                                           |
| Intended Improvement.                                                                                                                                                                                     |                                                                                                                                                     |                              |                                                                                                                                                                                                                        |                                                                                                                                                           |
| The intended improvement is to ensure all appropriate potential donors are approached in a timely way.                                                                                                    |                                                                                                                                                     |                              |                                                                                                                                                                                                                        |                                                                                                                                                           |
| Potential Action Steps                                                                                                                                                                                    | Mechanism                                                                                                                                           | Timeline                     | Evidence                                                                                                                                                                                                               | Materials                                                                                                                                                 |
| Mandate that all initial approaches are led or co- led by a Designated Requestor (a professional with advanced training in family dynamics and grief counseling).                                         | Establish a "Never-Alone" policy where hospital staff and physicians are trained not to mention donation until the OPO coordinator arrives on-site. | Phased approach (4–6 months) | Designated requestors improve authorization rates; decoupling enhances family decision-making; falls in alignment with national best practices.                                                                        | Policy & protocol materials; training materials; communication tools (e.g., scripts); monitoring and compliance tools (e.g., audit checklist).            |
| Require a formal huddle between the OPO coordinator and the hospital care team prior to engaging the family.                                                                                              | Use a checklist to determine family readiness, cultural/religious considerations, and the most appropriate environment for the conversation.        | Phased approach (3–5 months) | Structured pre-planning improves communication; family readiness influences authorization; cultural competence improves outcomes.                                                                                      | Pre-approach huddle checklist; workflow & protocol documents (e.g., standard operating procedures); training materials; documentation and EMR tools.      |
| Establish a Donation after Circulatory Death (DCD) fast-response team.                                                                                                                                    | Set a goal for DCD donors to maximize authorization rates to represent at least 35%–40% of total donors.                                            | Phased approach (4–6 months) | DCD as a major driver for donor growth; timeliness in DCD success; early identification and rapid activation; operational efficiency drives conversion rates.                                                          | DCD pathway guidelines; staffing and coverage tools; workflow and logistics tools; training and simulation materials.                                     |
| For OPOs in diverse Traumatic Service Areas (TSAs), deploy specialized requestors who match the demographic and linguistic profile of the donor family to reduce "implicit bias" in the approach process. | Implement a "matched requestor model" that aligns family-facing staff with the demographic characteristics of the donor family.                     | Phased approach (5–7 months) | Implicit bias affects communication quality; cultural alignment influences trust and authorization; shared language improves understanding and consent; patient-centered culturally competent care is a best practice. | Workforce and matching tools (e.g., requestor database); training materials; communication resources (e.g., multilingual scripts); operational protocols. |
| Develop a multi-step telephone-based approach protocol for communicating with families about donation when the families are not within the DSA.                                                           | Develop a script and protocol for outreach to potential donor families when their loved one is located in the DSA but the family is not.            | Pilot test in 1–3 months.    | Feedback from donor families or families that declined approach or authorization.                                                                                                                                      | Script; donor family survey or feedback request forms; training materials.                                                                                |

## Additional Considerations for OPOs in Implementation

As OPOs implement PDSA cycles, there are several crosscutting issues that may impact the success of quality improvement initiatives for any measure. These include data-related issues; staff training and culture; building a culture of safety, trust, and learning; enabling ownership of change; and collaboration across OPOs.

### Data Analytics & Performance Monitoring

In the context of high-stakes environments like organ procurement or federal health programs, data analytics isn't just a byproduct of the PDSA cycle, it is the engine. Moving from a general "Plan" to an actionable "Study" phase requires a sophisticated approach to how data is captured, analyzed, and interpreted. Data capture entails gathering data, often via multiple modalities (e.g., surveys, combining existing datasets, interviews). Currently, referrals for potential donors are made to OPO staff while onsite at the donor hospital, by telephone through a call center, or via electronic submission directly into the OPO's EDR systems (e.g., LifeLogics/TrueNorth, iTransplant/InVita Healthcare Technologies). Most but not all EDR systems permit data capture via an application programming interface (API) linked to hospital electronic health records (EHRs)—where available and in coordination with donor hospitals—for the input of patient data, including demographic and clinical data. However, not all OPOs and hospitals have established these connections, which offer a key opportunity to improve data capture.

Many OPOs take advantage of electronic referral tools, while some OPOs rely on manual data entry from phone-based referrals with standardized quality assurance (QA) checks. To address these challenges, OPOs utilize APIs to connect with hospital EHR systems or through repeated outreach to the donor hospitals. In some cases, smaller hospitals do not have the infrastructure, capacity, or resources to integrate an API into their older EHRs or to provide all of the data electronically to the OPO. Maintaining direct connections with staff at these hospitals, or even EHR vendors, is paramount to data availability and eventual integrity.

High-quality data analysis and interpretation both rely on data consistency across OPOs and within variables, such as standardization or uniformity. At a high level, this means that key terminology (e.g., approach) should have standard definitions across OPOs. At a more granular level, this means it is more ideal if data can be consistent across sources, years, surveys, and

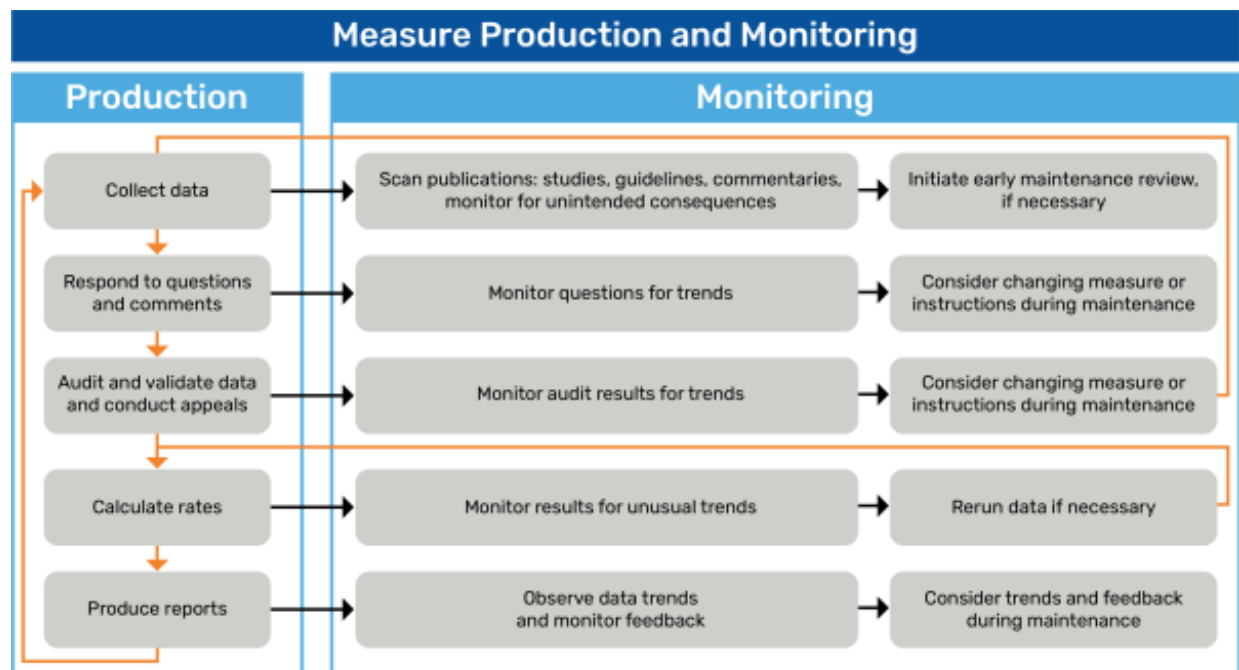
variable details. For example, the way in which data on race or gender is collected can vary across surveys or other data collection methodologies; therefore, measure specifications are useful for this purpose. Each OPO performs standardized QA completeness checks of each donor case file in their EDR; therefore, standards should be consistent across all OPOs.

To further ensure consistency, OPOs must consider the types of updates that might be necessary to:

- ▶ Guarantee the fields in the electronic donor records and other systems match the fields necessary to collect and report on the data.
- ▶ Update electronic donor records systems to allow for rapid reporting or calculation of measures.
- ▶ Audit data quality so the validity and reliability of the data can be determined as needed.

More detail on data capture, current state, and next steps will be available to OPOs through AOPO.

#### Exhibit 10. Measure Production and Monitoring<sup>5</sup>



<sup>5</sup>Centers for Medicare & Medicaid Services. (2025, August). *Measure production & monitoring*. Measures Management System Hub. <https://mmshub.cms.gov/measure-lifecycle/measure-use/production-and-monitoring>

## Staff Training & Culture

Effective QI in an OPO depends not only on technical systems, but also on successfully shaping staff behavior, culture, and engagement. Because OPO work is high-stakes, emotionally taxing, and often occurs in the middle of the night in high-pressure environments, the human side of QI, training and culture, is the primary determinant of whether a program succeeds or quickly loses traction. Below are some considerations OPOs should utilize when thinking about establishing a culture of quality improvement.

Mission-aligned training reframes the focus of QI as mission critical and not just compliance driven. Linking metrics to real-world outcomes, like organ viability and lives saved, helps transform technical measures into meaningful insights that align with the OPO's mission. Meanwhile, focusing on applied training can improve how staff collect data during a recovery without disrupting clinical flow and how they use the data to have more effective conversations with hospital partners. QI initiatives should simplify work rather than add complexity, and training should focus on how to integrate QI into existing workflows that reduce unnecessary burden. Equally, resilience training and acknowledging the weight of OPO work is a healthy part of QI culture. By reducing burden and uncertainty, well-designed systems can help ease burnout and better support staff in carrying out their lifesaving work.

## Build a Culture of Safety, Trust, and Learning

Building a culture of safety, trust, and learning is essential, as it helps create the psychological foundation required for OPOs to engage in the QI work. Psychological safety ensures staff feel comfortable reporting documentation errors or issues with the process and shifts the culture from blaming a single individual to focusing on what needs to be changed in the system. Non-punitive reporting also helps staff understand that QI data is used for process redesign and not to discipline individual performance. This refocuses on the process rather than the individual and where the defect lies in the steps. Closing the feedback loop is another mechanism that helps avoid a “black hole” of data collection and ensures staff see how their input leads to change. This also helps build trust, which is also driven by transparency and regularly sharing the results of the PDSA cycles openly, including successes and failures. Finally, learning can also be collected through staff-generated ideas, where the OPO creates a formal mechanism by which staff can suggest their own PDSA cycles. This formal pathway not only allows staff to propose and test improvements but also builds ownership and engagement.

## Enable Leadership and Frontline Ownership of Change

It is essential that both leaders and frontline staff are enabled to own and drive change. Moving away from top-down mandates empowers other leaders and champions who understand the frontline realities. Peer improvement should be led by respected frontline staff such as senior coordinators; when they model the use of new protocols or data collection tools, their peers are more likely to adopt the change. Ultimately, leadership must be trained in change management. They need to acknowledge the "implementation dip," the period where things might actually feel more difficult or slower as a new process is being learned, and sustain momentum through early challenges. That way, the team feel supported as they move through a short period of uncertainty.

## Promote OPO Cross-Collaboration

Promoting cross-collaboration between OPOs requires intentionally shifting from a competitive mindset to a shared mission of maximizing organ utilization and improving patient outcomes. Establishing formal networks, such as regional working groups or recurring peer forums, creates consistent opportunities to exchange lessons learned, best practices, and innovations. Transparent data sharing and benchmarking, framed around learning rather than ranking, help OPOs understand what drives success and leveraging AOPO support structures, including committees like IMPACT and learning platforms such as AOPOplus, can further facilitate structured collaboration, resource sharing, and dissemination of proven practices. Practical initiatives like staff exchanges, joint trainings, and collaborative pilots also strengthen relationships and accelerate improvement. Ultimately, sustained success depends on strong communication, leadership alignment, and commitment to mutual advancement across the OPO community.

## Looking Ahead

This plan reflects a measurement framework and measures for OPOs. It also provides a mechanism for using traditional quality improvement approaches to improve OPO performance. Over time, the measure set should be expanded and refined to reflect emerging and ongoing areas of focus for OPOs. For example, OPOs specifically recommended that measures be developed in the area of donor family satisfaction. OPOs also recommended ensuring there is an ongoing mechanism for maintaining the measures and ensuring they are connected to initiatives and resources for quality and performance improvement. Based on input from OPOs and other relevant stakeholders, Econometrica proposed the measures in Exhibit 11 to be considered for development through collaboration with donor hospitals and transplant centers given dependencies outside of the direct activities of OPOs. We have suggested development timelines guided by measure complexity, feasibility, and collaboration needs.

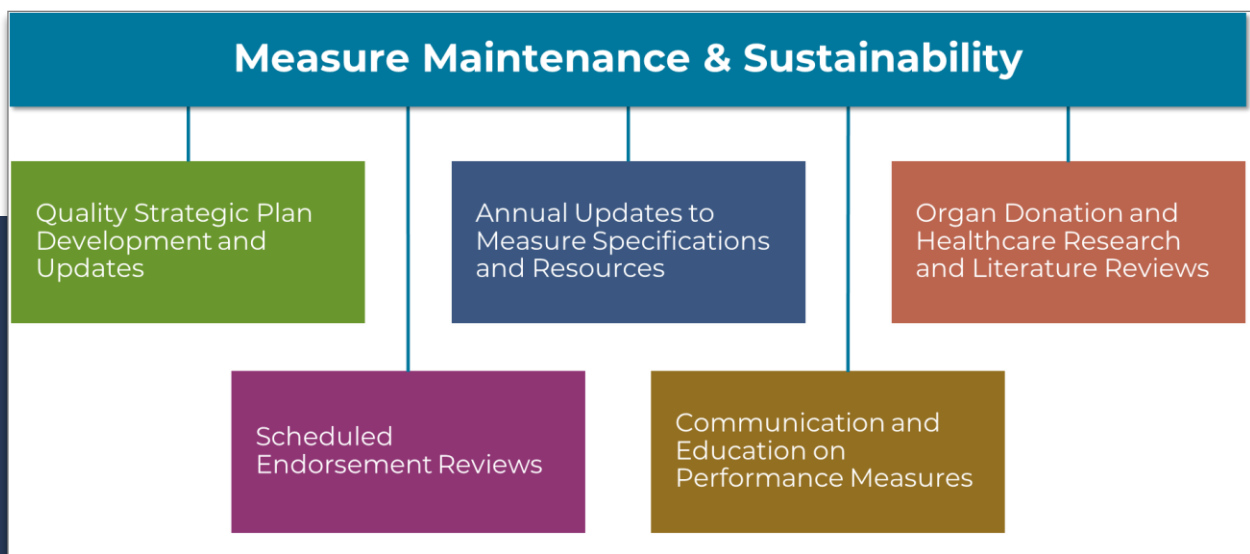
Exhibit 11. Potential Future Measure Topics by Type and Year

| Measure Type      | 2027                       | 2028                                                  | 2029                              | 2030               |
|-------------------|----------------------------|-------------------------------------------------------|-----------------------------------|--------------------|
| <b>Structural</b> | Donor registration systems | Donor hospital capacity<br>Transplant center capacity | Population chronic disease burden | DSA transportation |
| <b>Process</b>    |                            |                                                       | Donor engagement                  | Allocation measure |
| <b>Outcome</b>    | Donor family experience    |                                                       |                                   |                    |

Additionally, while this document is focused on OPOs, it is essential OPOs, donor hospitals, and transplant centers identify areas of shared interest for measurement and joint improvement initiatives. The success of measures that assess performance throughout the organ and transplantation system relies on strong, intentional, and continuous partnership and collaboration among OPOs, donor hospitals, transplant centers, and donor and recipient patients and families.

The Partnership for Quality Measurement (PQM) endorsement process, used to endorse developed measures, requires an intentional maintenance and sustainability plan to ensure measures remain evidence-based, scientifically sound, safe and effective, and aligned with current professional knowledge. Exhibit 12 outlines the main activities for measure maintenance and sustainability.

**Exhibit 12. Measure Maintenance and Sustainability Activities**



Logic Model for OPOs

