



Administrative Efforts to Encourage Centers to Use Marginal Organs

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CUTTING EDGE OF
TRANSPLANTATION

AST | AMERICAN SOCIETY OF
TRANSPLANTATION

RESOLVING THE ORGAN SHORTAGE



PRACTICE |



POLICY |



POLITICS

FEBRUARY 25-27, 2016 • PHOENIX, ARIZONA

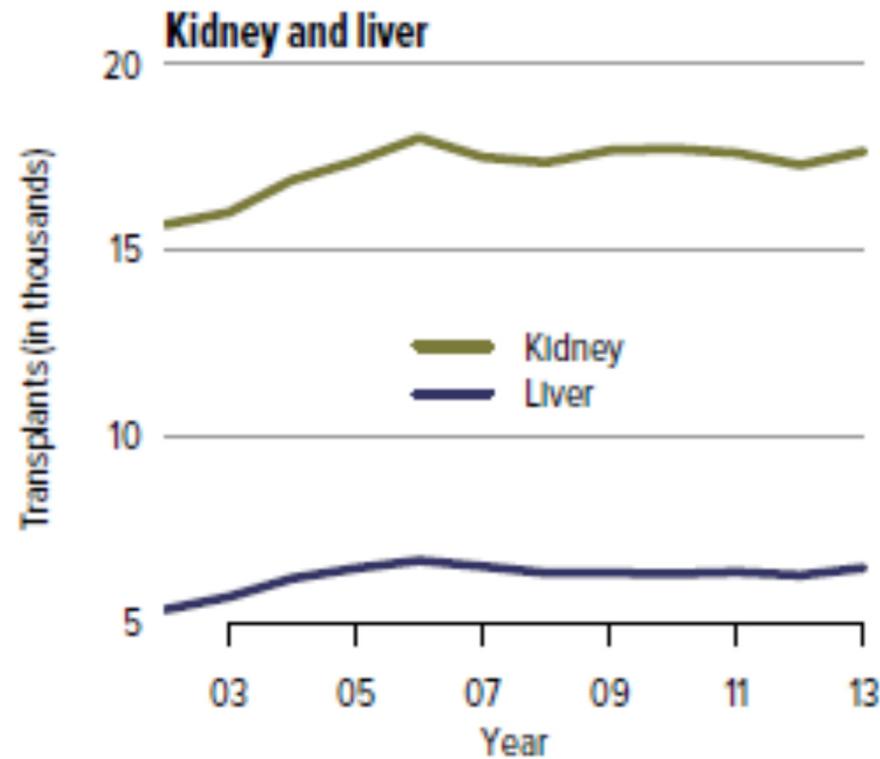
Conflict of Interest Disclosure

- I have no relevant financial relationships to disclose.
- The opinions expressed are solely those of the speaker and do not reflect official OPTN/UNOS policy

Organ shortage drives challenging transplant issues

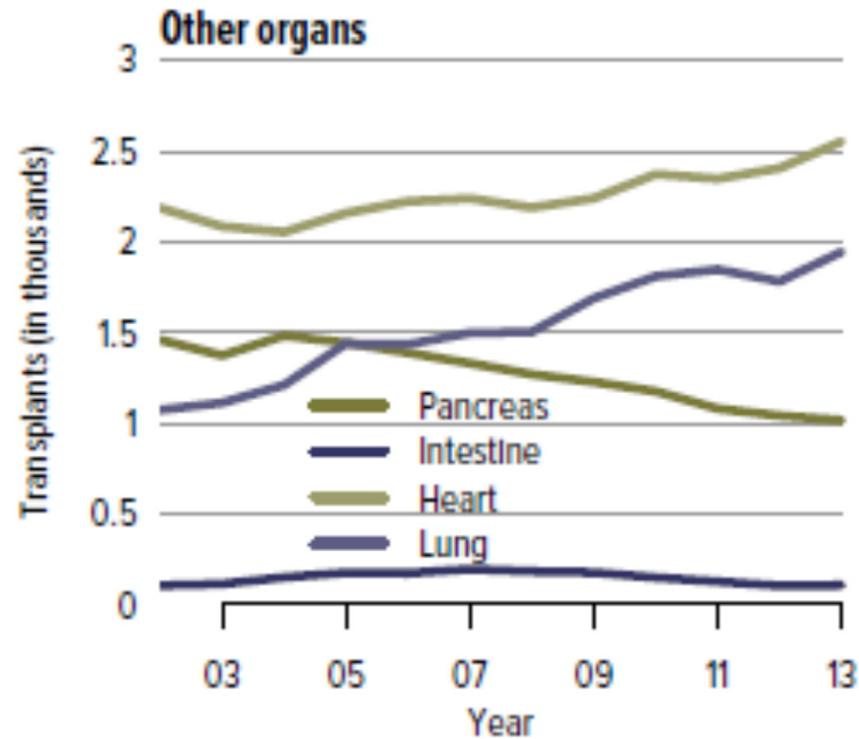
And frankly is depressing

Total annual transplants



SRTR Annual Report 2013

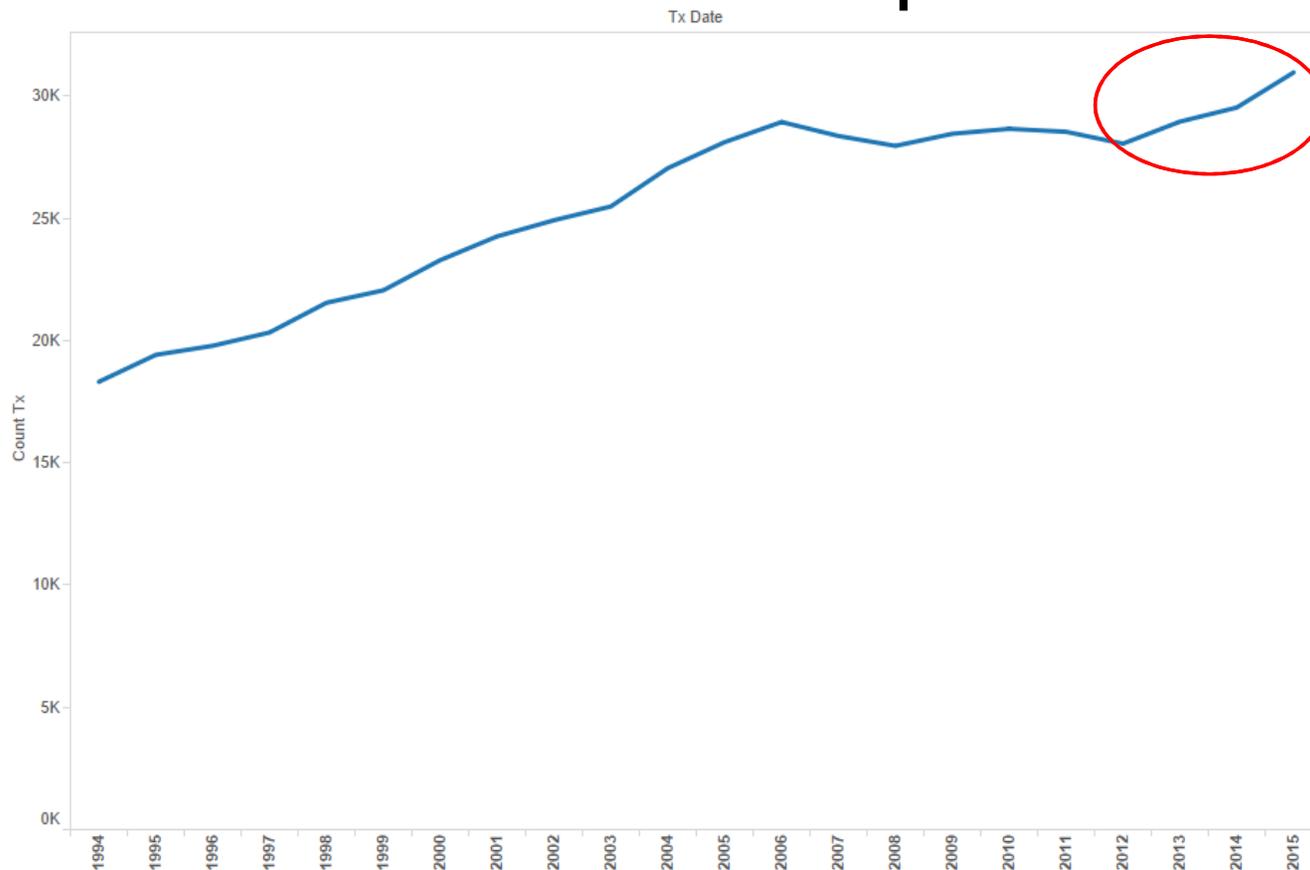
Total annual transplants



SRTR Annual Report 2013

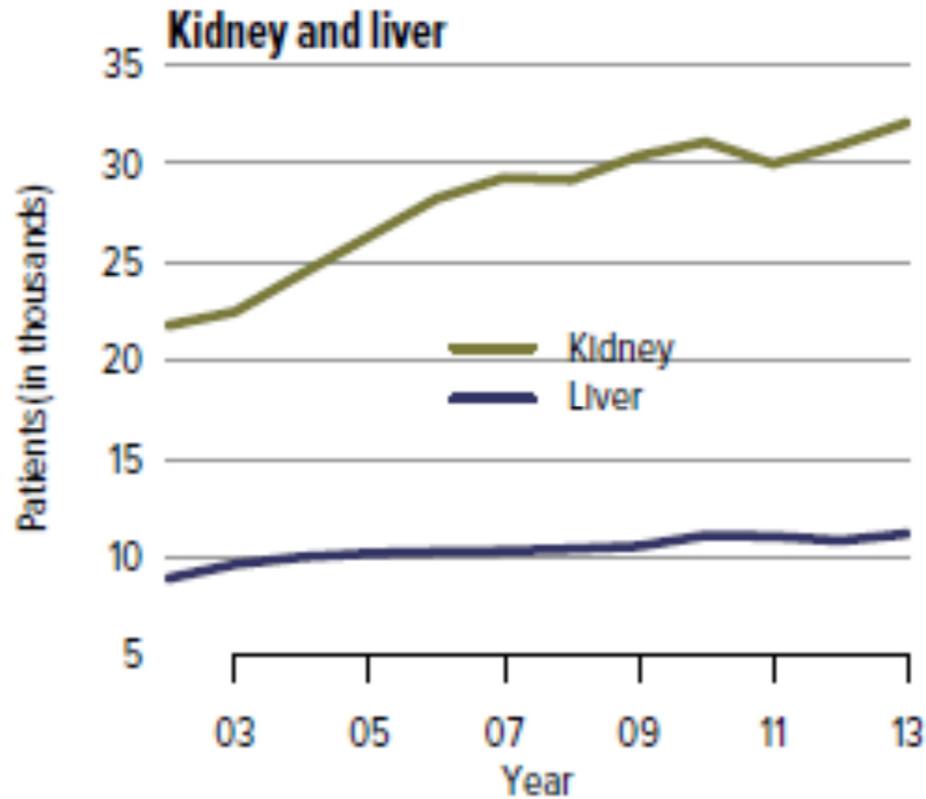
Sheet 1

Number of transplants



UNOS Spring Regional Meeting 2016

Annual waitlist additions: Much unmet need



SRTR Annual Report 2013

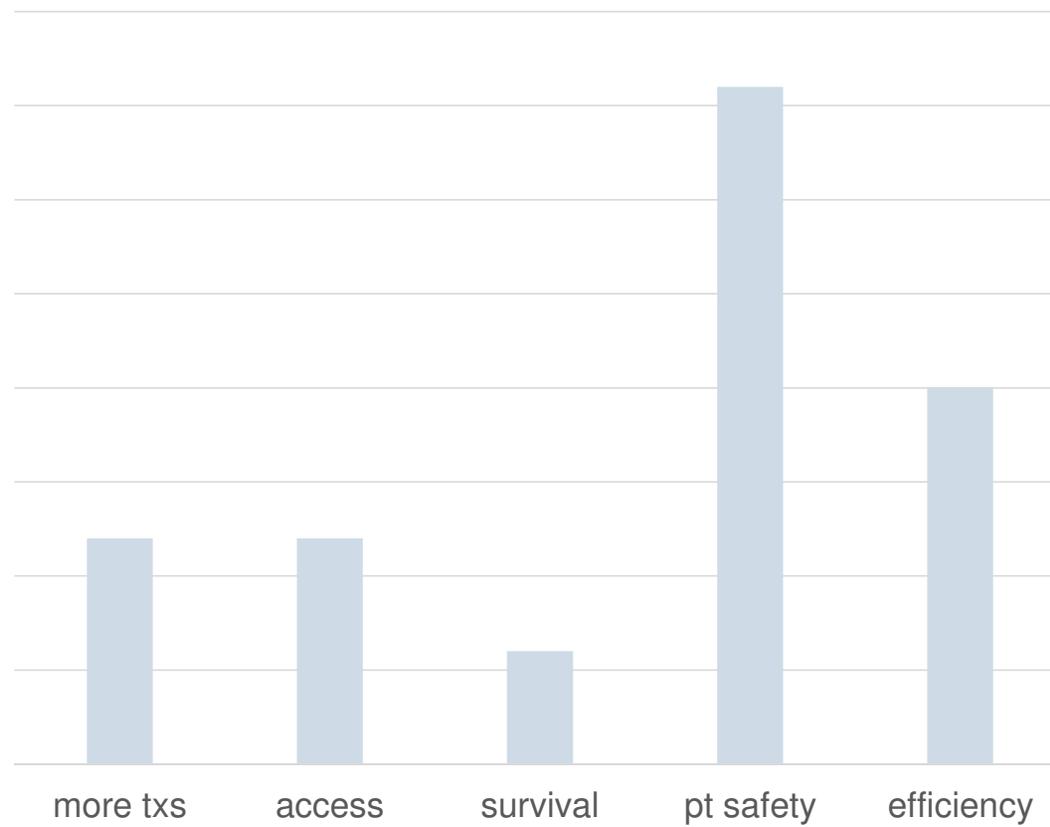
What can we do to alter the
balance of **supply** and demand?

Approaches to increase number of transplants

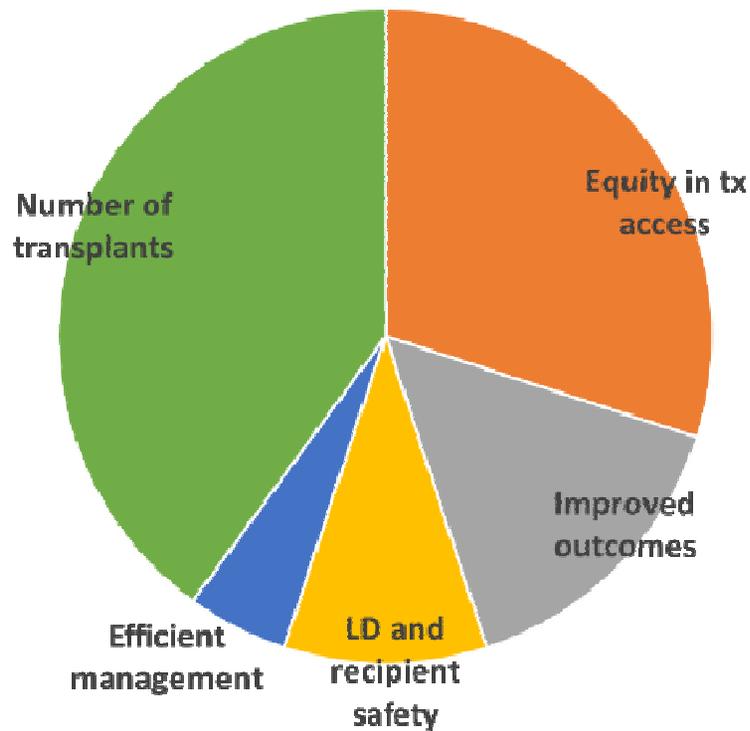
- Increase living donors
- Identify increased number of deceased donors
- Condition organs to enhance transplantability
- Utilize organs that are currently turned down
 - Diminish putative administrative barriers to use of such organs

Deploy OPTN/AST/ASTS/AOPO/ CMS/HRSA energy/synergy

OPTN 2014 Committee Projects



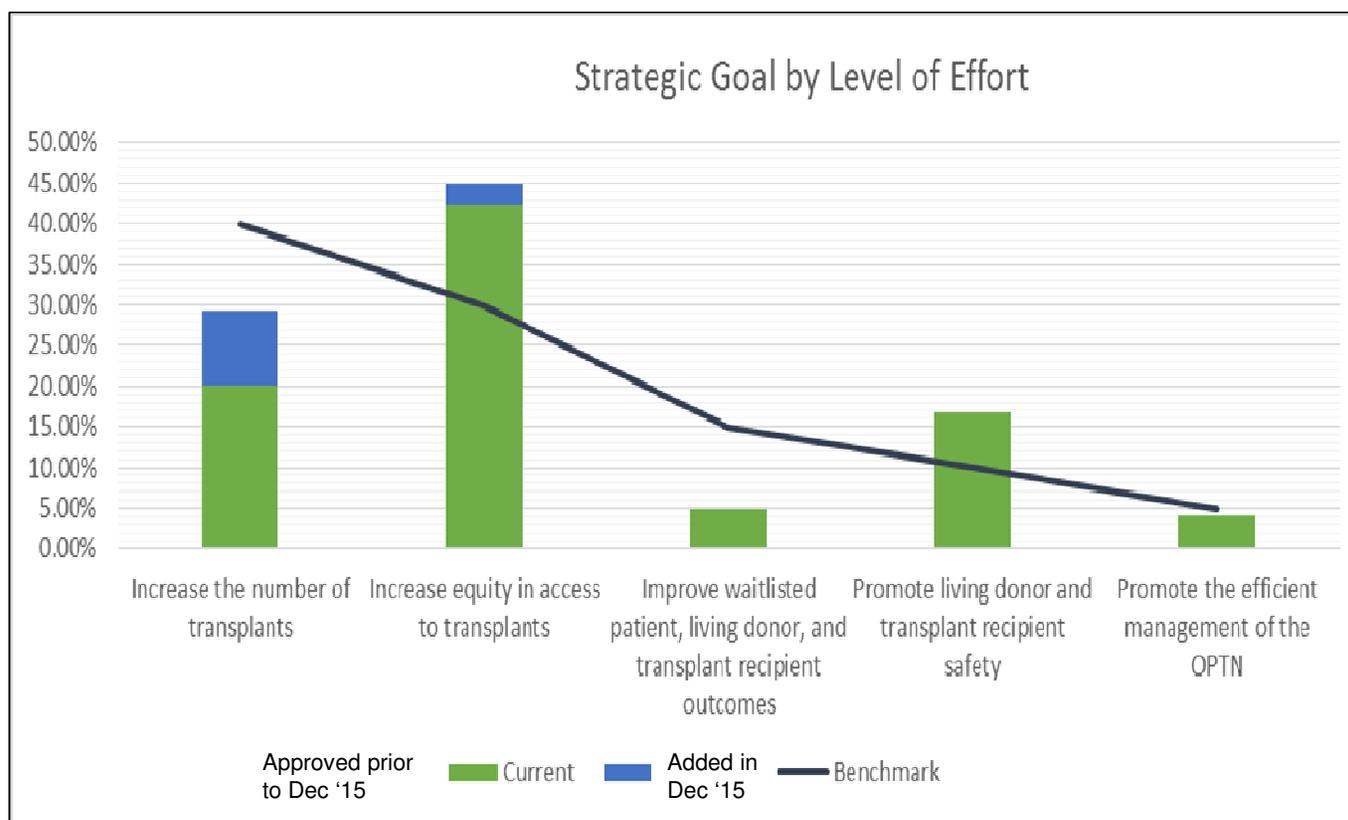
UNOS/OPTN Strategic Plan



2015-2106 Allocation of effort

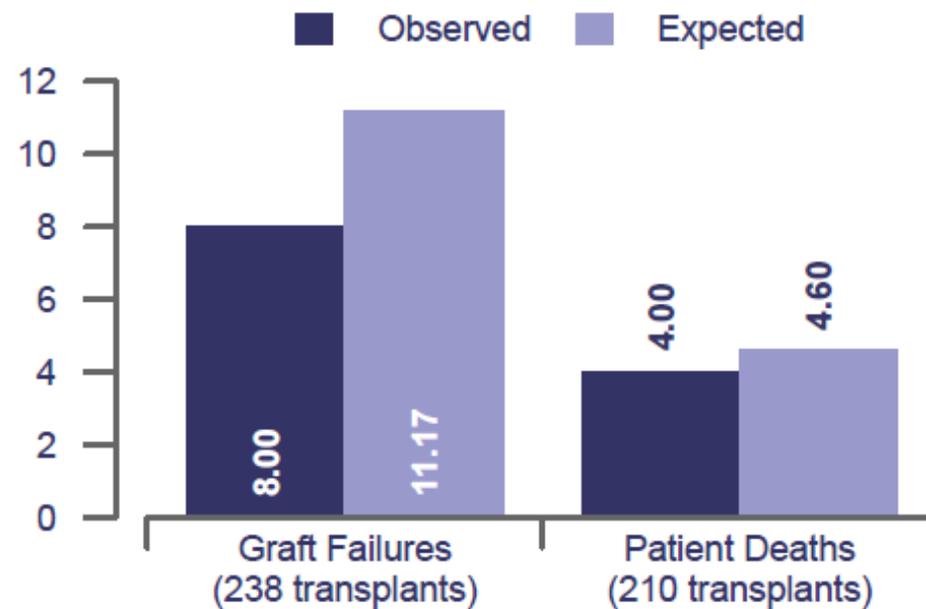
Increase transplants	40%
Provide equity	30%
Improve outcomes	15%
Promote safety	10%
Promote efficiency	5%

Strategic alignment of current OPTN committee projects

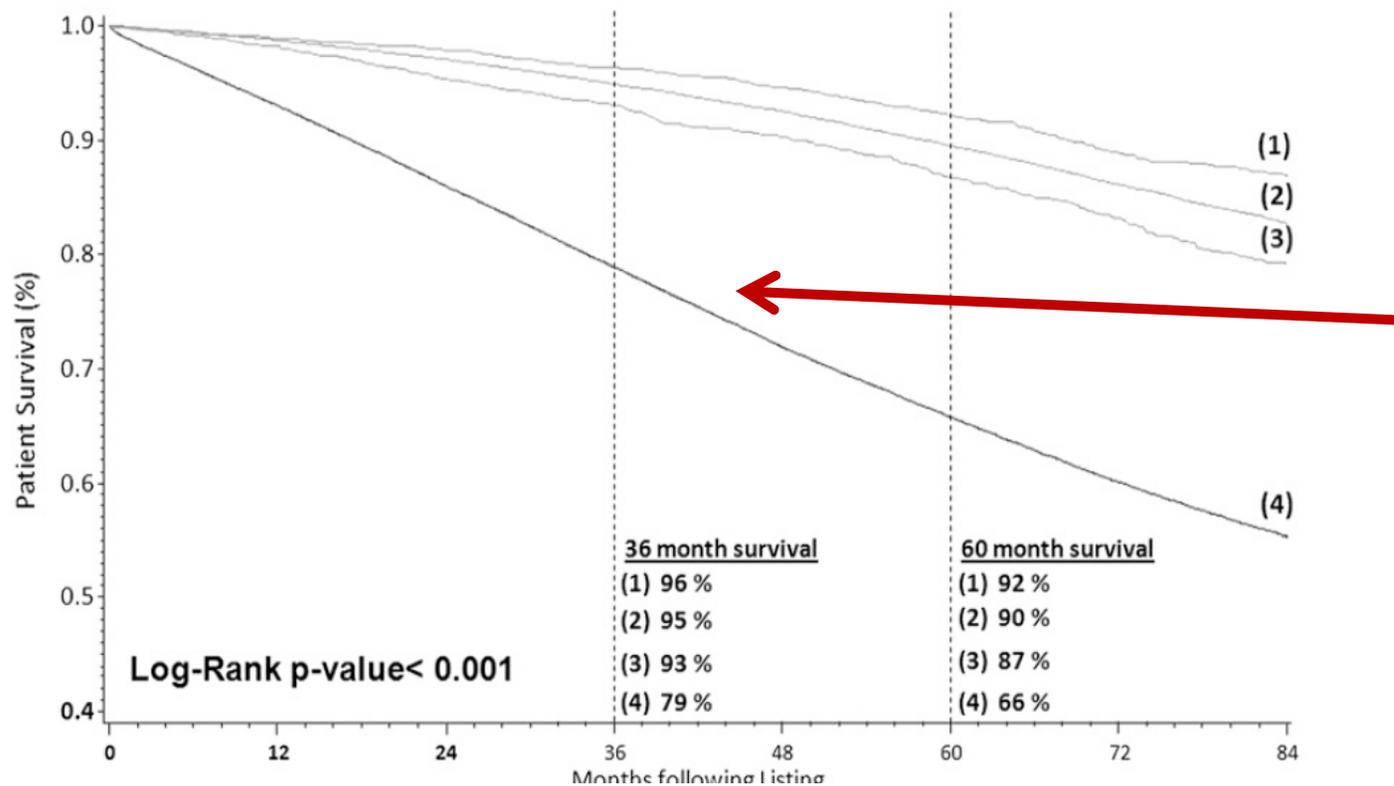


Historical focus on post-tpx outcomes

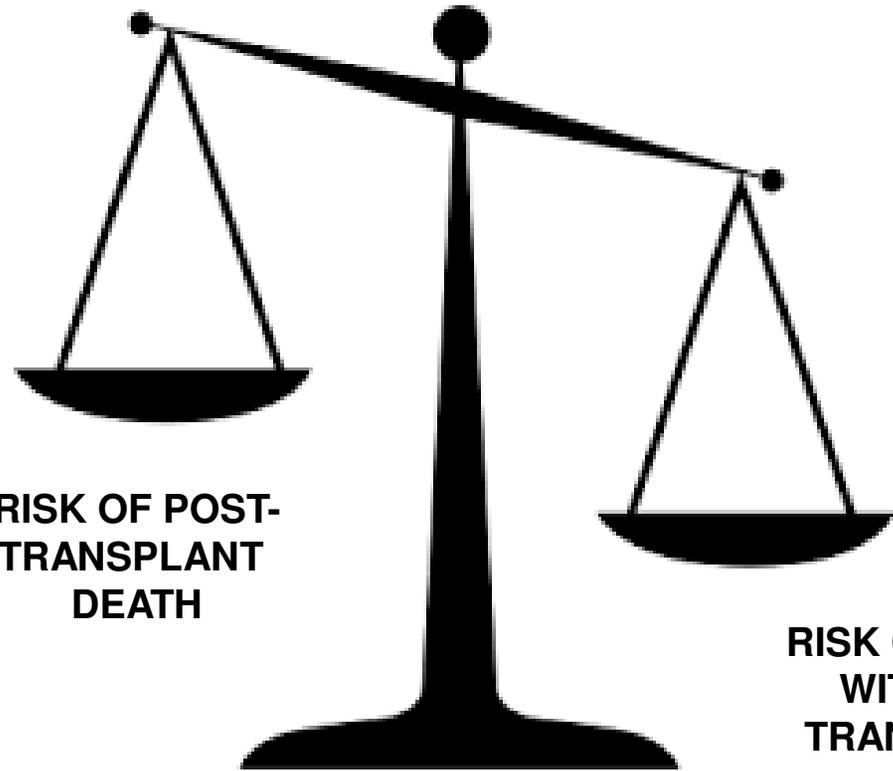
Figure A4. First-year adult graft and patient survival: 07/01/2012 - 12/31/2014



Risk from not getting transplanted at all



Schold JD, et al., CJASN 2014;9:1773-1780

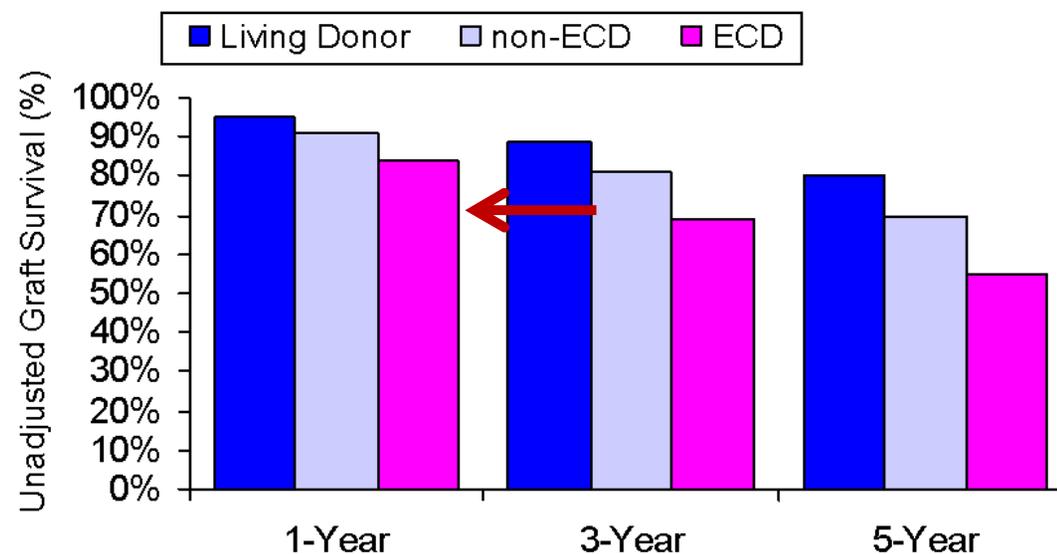


**RISK OF POST-
TRANSPLANT
DEATH**

**RISK OF DEATH
WITHOUT
TRANSPLANT**

What used to be acceptable graft survival is no longer good enough?

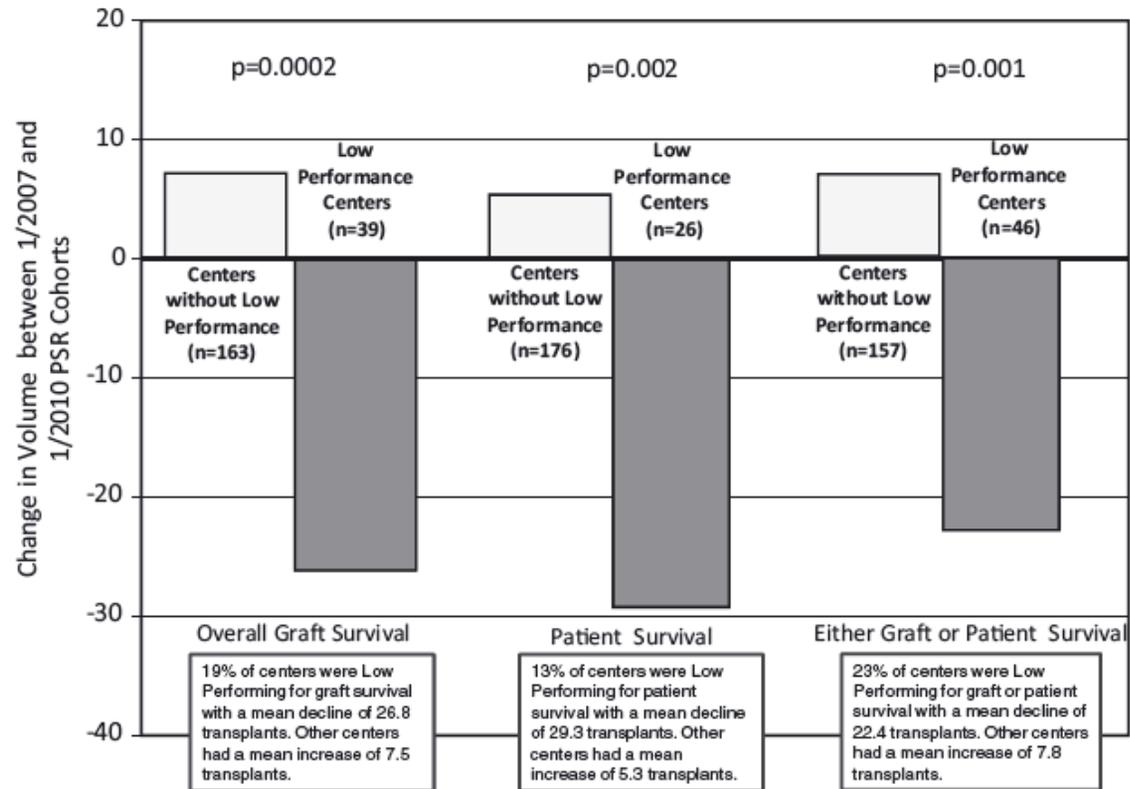
Figure IV-7. Unadjusted 1-Year, 3-Year, and 5-Year Kidney Graft Survival*, by Donor Type: 2000-2005



*Death is included as an event.

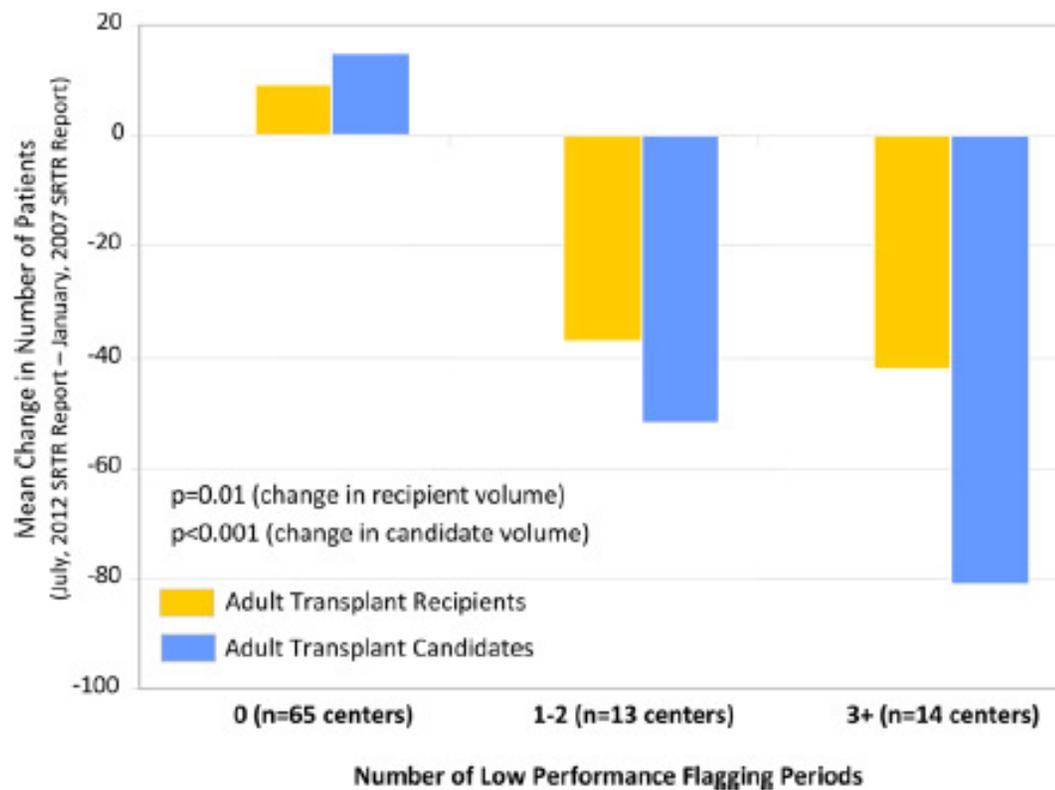
Source: 2007 OPTN/SRTR Annual Report, Tables 5.10a, b, c.

Impact of performance review on kidney txp center volume



Schold JD, et al., Am J Transplant 2013;13:67-75

Impact of performance review on liver txp center volumes



Buccini LD, et al., Am J Transplant 2014;14:2097-2105

Is it time to reset our risk thermostat?



Is it time to reset our risk thermostat?



Is it possible to encourage more use of “marginal organs”?

- Why are they not used at present?
 - Concerns about patient survival
 - Concerns about program survival
 - Distrust of current post-txp outcomes modeling for marginal organs
 - Impact of CMS, MPSC and insurance company oversight
MAGNITUDE UNKNOWN

How do we manage oversight risk as a center?

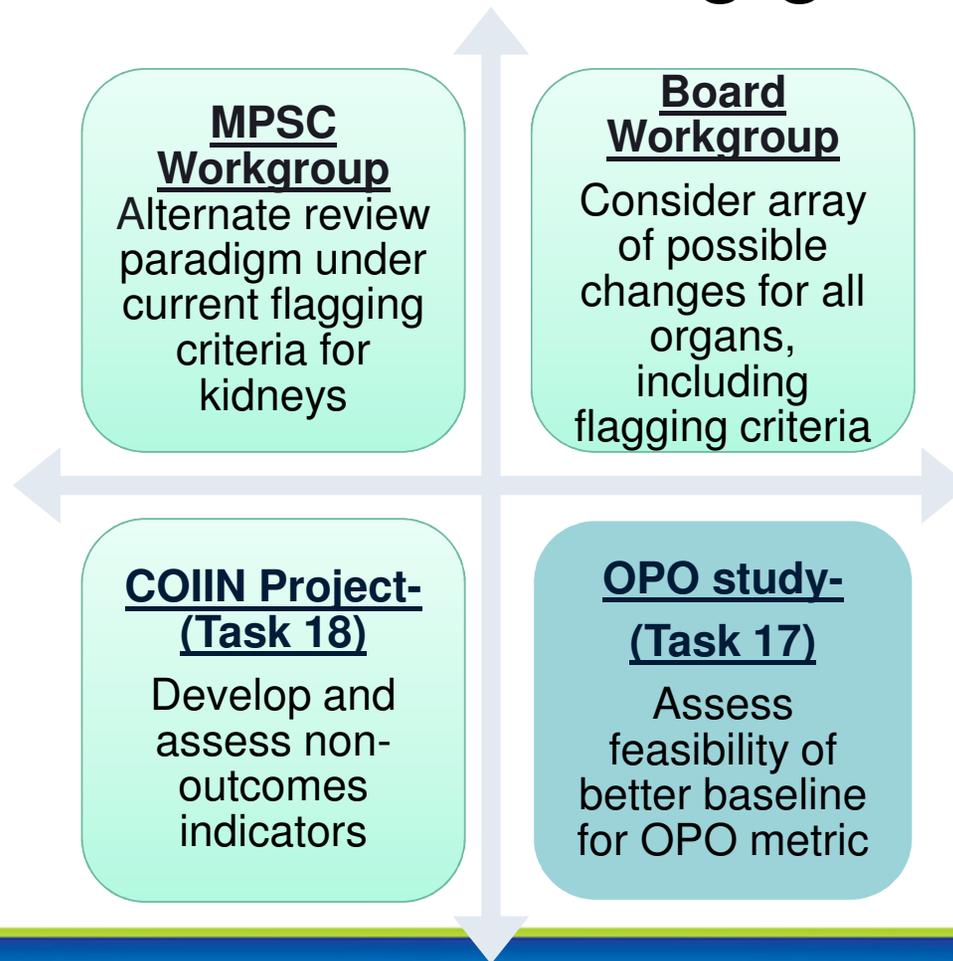


Polling question 1

Concerns about flagging of my program by the MPSC or CMS, related to post-transplant outcomes, impacts my center's use of "marginal organs":

- A. Rarely
- B. Occasionally
- C. Sometimes
- D. Frequently

Current OPTN Working groups



December 2015 OPTN Board Resolution

RESOLVED, that the MPSC is tasked over a period of 6 months to provide the Board with a proposal for an improved program specific reporting system that identifies substantive **CLINICAL** differences in patient and graft outcomes

Board resolution

FURTHER RESOLVED, that the President will appoint a working group consisting of 10 members; 3 from the UNOS/OPTN Board, 3 from the societies of the AAAU, and 3 from the MPSC, and 1 ad hoc member from CMS - this working group will, over a three month period, identify objective measures that define clinically relevant outcome differences - this work group will then submit their findings to the MPSC for approval, and by the June 2016 board meeting, present that proposal to the Board for action.

Reducing Disincentives to Transplantation

Board Workgroup

Consider array
of possible
changes for all
organs,
including
flagging criteria

Carl Berg
Kenyon Murphy
Mitch Henry
Jeff Orlowski
David Reich
Jens Goebel
Ken Andreoni
Jesse Schold
Kevin O'Connor

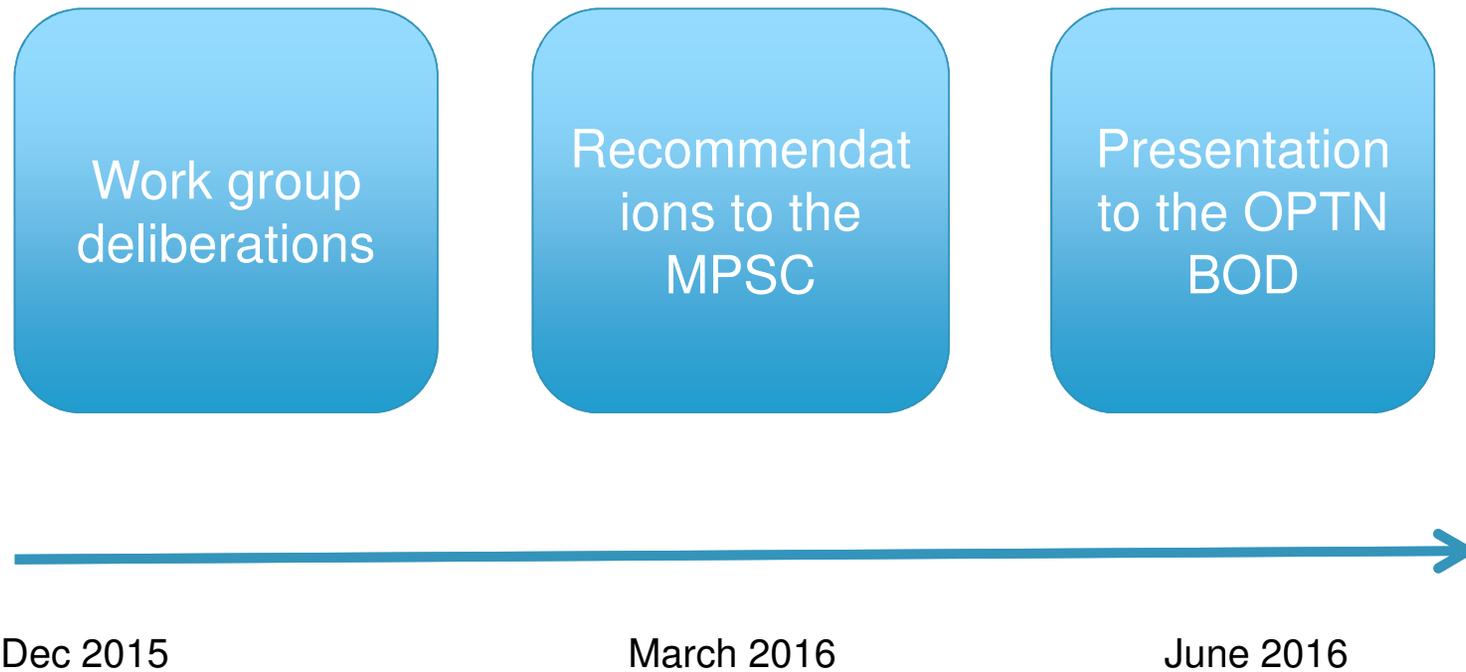
Questions being posed

- Who should be flagged by the MPSC?
- What performance, in a clinical context, merits additional help/attention?
 - How does post-txp variance in outcome compare to waitlist risk?
- Of the MPSC interactions with members, what percentage are “true positives”?

Ultimate question

If we reduce the risk of being flagged by MPSC (in concert with CMS), will programs be willing to utilize organs currently being discarded?

Reducing Disincentives to Transplantation



Polling question 2

I believe that SRTR modeling used in my program specific reports accurately calculates **expected (E)** graft and patient outcomes when my center uses “marginal organs”.

- A. True
- B. False
- C. Don't know

MPSC working group

MPSC Workgroup

Alternate review
paradigm under
current flagging
criteria for
kidneys

David Cronin, Chair

David Axelrod

Tim Taber

Rob Kochik

Dennis Martin

Nader Moazami

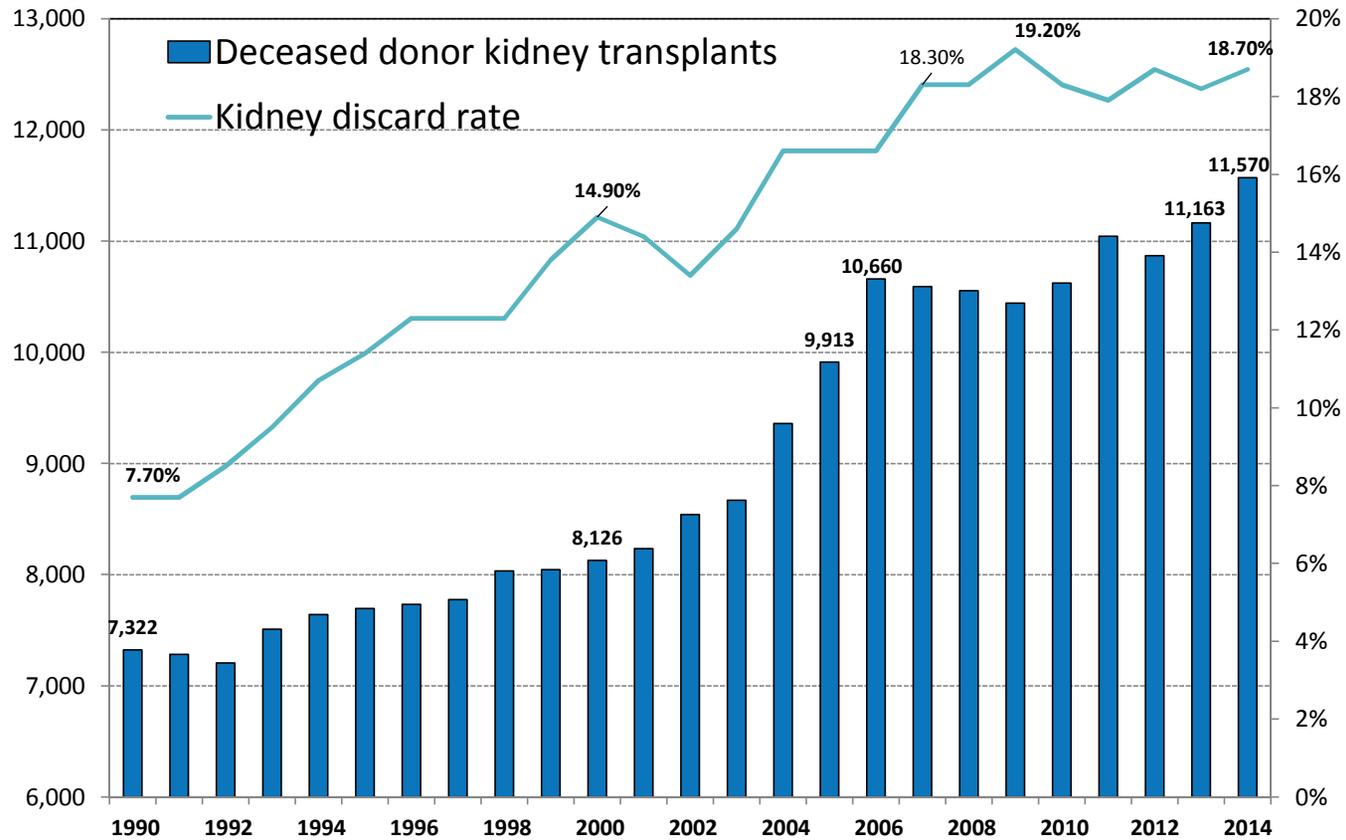
Jeff Orlowski

Chris McLaughlin, Ex Officio

Shannon Dunne, Ex Officio

Raelene Skerda, Ex Officio

Trends in kidney txp

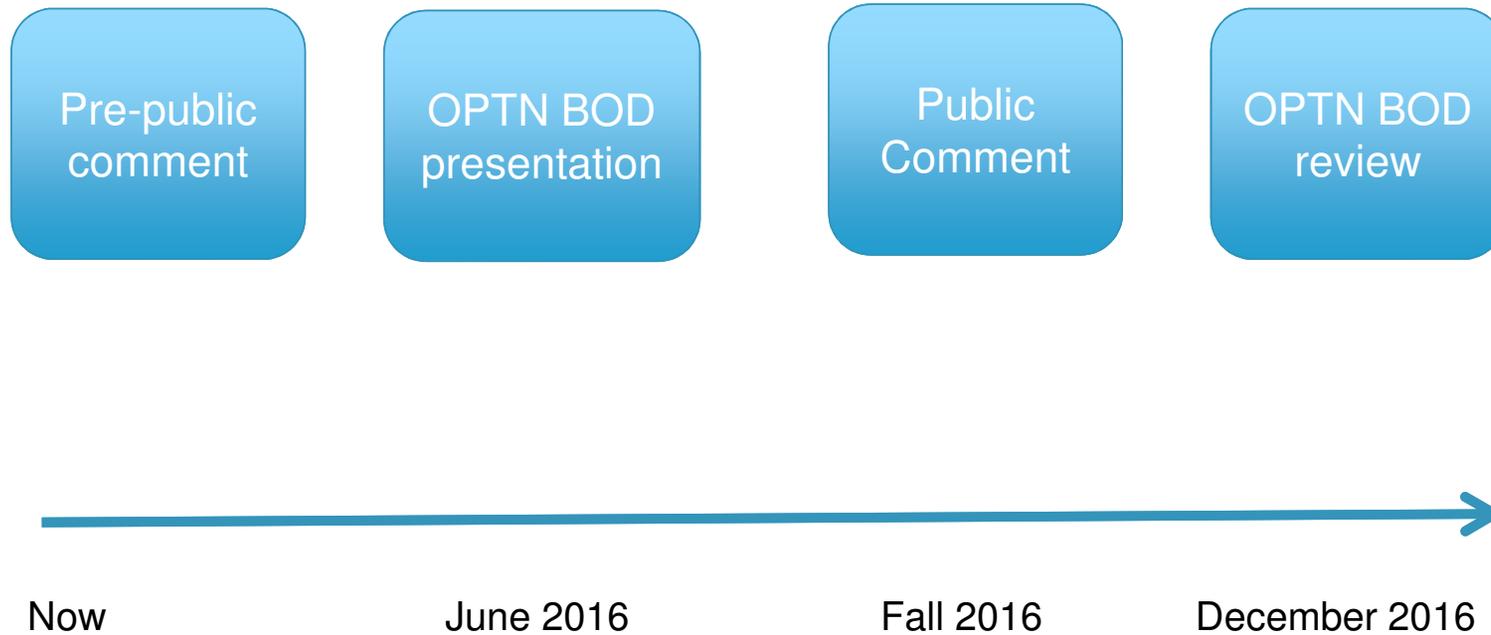


D Stewart; ATC 2013; updated 02APR2015

Approach to encourage use of discarded organs

- MPSC will review kidney programs for lower than expected graft or patient survival if 1 year kidney graft or patient survival meets the established criteria for both
 1. All kidney transplants **AND**
 2. Kidney transplants excluding high risk transplants
- High risk transplants = recipient with an EPTS score >80 using a kidney from a donor with a KDPI \geq 85
- Monitoring of national 1 year graft and patient survival in high risk transplants by MPSC

MPSC working group



Would such an approach achieve its goal?

Depends entirely on impact of concern over impact of higher risk organs use on program behavior

Collaborative Innovation Improvement Network (COIIN)

COIIN Project- (Task 18)

Develop and assess
non-outcomes
indicators

COIN

- Conduct a 3 year pilot project that:
 - reduces the risk-avoidance behaviors that are associated with current monitoring system
 - removes current performance flagging criteria for participating **kidney** transplant programs
 - develops and tests an alternative data-rich quality monitoring framework
 - collaborative approach toward performance improvement and best practices

COIN

- Primary Aim: Increase transplantation by 10% over baseline rate at participating centers
 - Sub Aim 1: Increase utilization rate overall and for moderate and high risk kidneys
 - Sub Aim 2: Increase acceptance rate overall and for moderate and high risk kidneys

COIN

- Develop and deploy real time monitoring tools
- Employ robust QAPI tools to manage performance
- Sharing of best practices from top performing centers using high risk organs
- Collaborative approach
- Freed from usual flagging criteria by MPSC and CMS

COIN: Transplant Center Performance Pilot

- ***Year 1*** – Design and recruitment of centers
- ***Year 2*** – Deployment
- ***Year 3*** – Evaluation

Thank you