OPTN

EXPEDITIOUS

TASK FORCE

Organ Usage through Placement Efficiency

Our focus in Detroit

*Delve deeper into specific Task Force projects and gather the right input and feedback to further their **launch**.*

69 workshop participants

INCLUDING

Patient and donor family advocates

Transplant hospital professionals

Administrative professionals

OPO professionals

OPTN contractor & SRTR staff

HRSA representatives

Participants

Patient & Donor Family Advocates

- Kenny Laferriere
- Jennifer Lau
- Pat Ledbetter
- Jeff Lucas
- Marcus Simon
- George Surratt

TxP Professionals

- Marie Budev
- Alden Doyle
- Dean Kim
- Catherine Kling
- Michael Kwan
- Deborah Levine
- Matthew Levine
- Silas Norman
- Lloyd Ratner
- Jason Rolls
- Marc Schecter
- Nicole Turgeon

Administrators

- Laura Butler
- Donna Dickt
- Dianne LaPointe Rudow
- Jennifer Milton
- James Pittman
- Jesse Schold
- Dennis Wagner
- Sena Wilson-Sheehan

OPO Professionals

- Woodlhey Ambroise
- J. Kevin Cmunt
- Christopher Curran
- Kyle Herber
- Kevin Lee
- David Marshman
- Barry Massa
- Ginny McBride
- Colleen McCarthy
- Christine Radolovic
- Marty Sellers
- Lisa Stocks
- Matthew Wadsworth

OPTN Contractor

- James Alcorn
- Keighly Bradbrook
- Kate Breitbeil
- Jadia Bruckner
- Aileen Corrigan-Nunez
- Rebecca Goff
- Bonnie Felice
- Darby Harris
- Bridgette Huff
- Ann-Marie Leary
- Rebecca Fitz Marino
- Carlos Martinez
- Joel Newman
- Beth Overacre
- Rob Patterson
- Laura Petrosky
- Tina Rhoades
- Kristen Sisaithong
- Dale Smith
- Kaitlin Swanner
- Kayla Temple
- Alison Wilhelm
- Carson Yost

CMS

- Katie McDonald
- Jean Moody-Williams
- Amanda Michael

Invited Guests

- Michael Goldstein
- Brandi Krushelniski

Facilitators

- Jacob Filon
- Leelah Holmes
- Chloe Keller
- Esther Kim
- Kylee Talwar
- Chris Zinner

SRTR

- Ryo Hirose
- Jon Snyder
- Nick Wood

HRSA

- Chris McLaughlin

HLA Representatives

- John Lunz

Agenda – Day 1

4:00 pm	**Welcome** Goals, Agreements, and Icebreaker
4:45 pm	**Communication**
5:45 pm	**Community Forum Planning**
6:15 pm	**Dinner**
6:45 pm	**Fireside Chat**
7:30 pm	**Wrap Up**
8:00 pm	**Goodnight!**

Agenda – Day 2

The Morning

8:00 am	Welcome
8:15 am	Warm-up
8:30 am	Fireside Chat
9:15 am	Expedited Placement
10:00 am	Break
10:15 am	Non-Use Study
10:45 am	Breakouts Non-Use Study Expedited Placement Securing Commitments

The Afternoon

12:15 pm	Lunch
12:45pm	Breakout Share
1:15 pm	Policy Review
1:55 pm	Break
2:10 pm	Communication Plan
2:40 pm	Wrap Up
3:00 pm	Goodbye!

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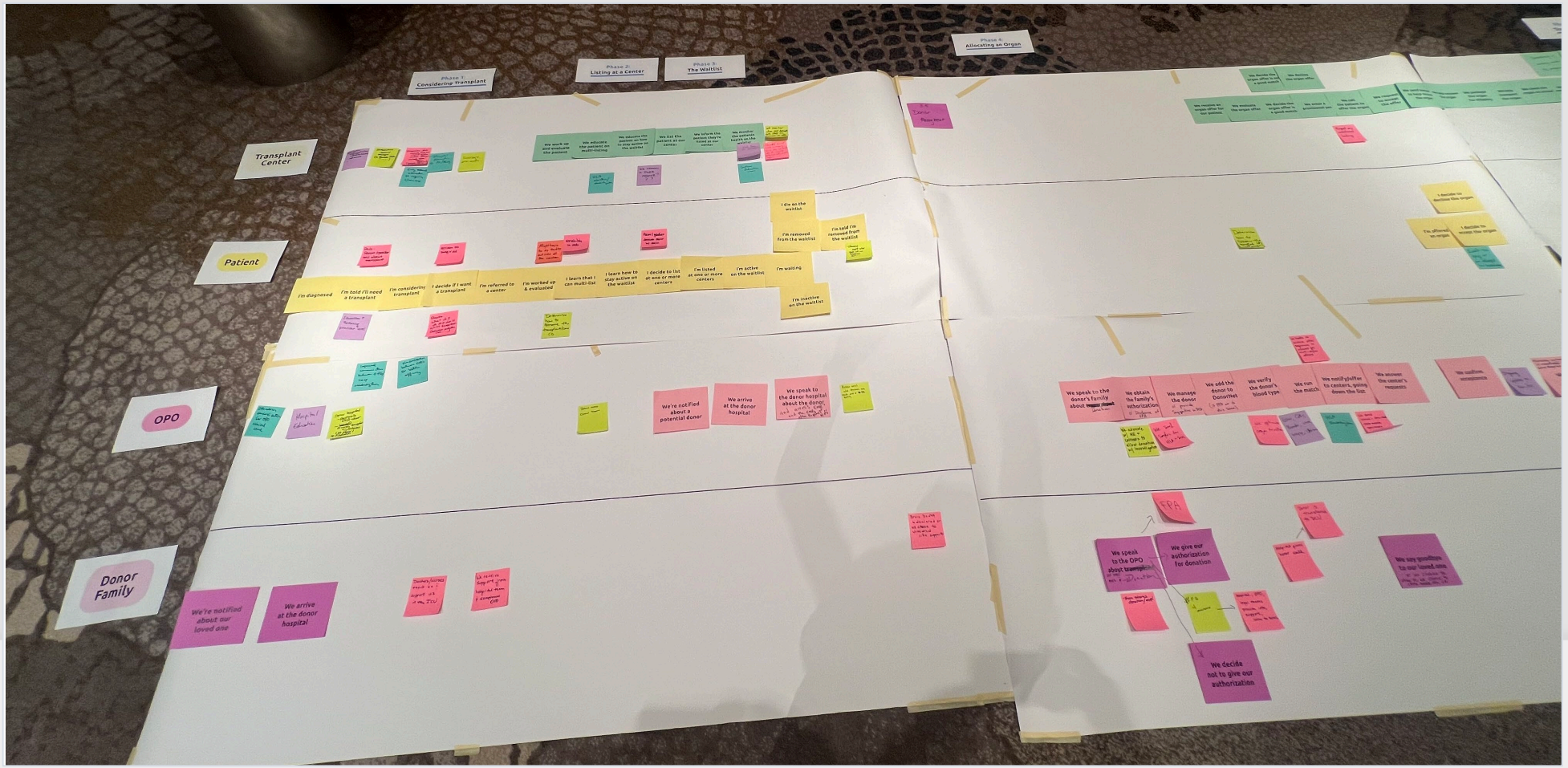
ACTIVITY

Mapping The Transplant Journey

Task Force members reviewed and provided feedback on the journey map created by the OPTN contractor and support staff based off prior user research. The journey map displayed the step-by-step process of organ transplant from four lenses: patient, donor family, OPO, and transplant center. Task Force members rearranged steps of the transplant process, added new steps, elaborated on existing steps, and provided general feedback.



OPTN EXPEDITIOUS TASK FORCE

PRESENTATION & DISCUSSION

Communication Strategy

The OPTN contractor has engaged Envoy, a consulting firm with expertise in strategic communications, to create effective messaging around the Expeditious Task Force's purpose and mission for the broader transplant community and public. At the start of the workshop, a facilitator from the firm presented a preliminary communications deck to the Task Force for review, and then solicited feedback from the audience on areas for improvement. At the end of the workshop, the mediator presented a revised version of the communications deck based on the initial round of feedback.

ACTIVITY

Community Forum Planning

The Expeditious Task Force can engage the broader transplant community in our work through community forums. These forums will enable us to collaborate with more stakeholders and devote the necessary amount of time to addressing areas of opportunity within the OPTN. On Day 1 of the workshop, Task Force members took time to brainstorm in small groups the aspects of organ utilization and efficiency which they believe could best be addressed through a community forum.

Community Forum Plan

WHAT PROBLEM IS THE FORUM ADDRESSING?	WHAT DO WE WANT TO ACHIEVE?

WHAT TOPICS DO WE NEED TO COVER TO ADDRESS THIS PROBLEM? *EX: DATA, STAKEHOLDERS, PROCESSES, TECH*	WHAT INPUT & FEEDBACK DO WE NEED ON THIS TOPIC FROM...			
	PATIENTS, CAREGIVERS, AND DONOR FAMILIES?	*OPOS?*	*TRANSPLANT HOSPITALS?*	*OTHERS?*
1.				
2.				
3.				
4.				
5.				

Community Forum Topics

- **Unclear definition of "success" in transplantation:** Create a platform to give stakeholders a voice that will allow movement toward a consensus of the definition
- **Limitation of resources:** Help OPOs & TxCs form a business case to secure commitments from their C-Suites to provide the resources to drive quality, sustainable growth and get to 60k transplants by 2026
- **Organ loss due to late declines:** Reduce late declines by creating a formal definition for the term and holding programs accountable in evaluation
- **Inefficient placement of hard-to-place organs:** Reach consensus on activating alternate allocation pathways for each organ type
- **Lack of patient preparedness for offer acceptance & transplant:** Increase utilization through greater patient readiness at time of offer
- **Variation in donor management practices:** Standardize donor management practices to increase efficiency
- **Inconsistent allocation practices:** Achieve consistency in organ offers and acceptances across OPOs and transplant centers, respectively
- **Reimbursement:** Optimize the reimbursement model so that it is aligned with costs; increase transparency

PRESENTATION & DISCUSSION

Fireside Chats

During the Detroit workshop, the Expeditious Task Force had the pleasure of learning from Brandi Krushelniski, Vice President of the Norton Thoracic Institute of St. Joseph's Hospital & Medical Center in Phoenix, AZ and Dr. Michael Goldstein, the director of abdominal organ transplantation at Hackensack University Medical Center in Hackensack, NJ. Both guest speakers gave presentations on the growth and successes of their programs, engaged in conversation with Task Force leadership, and fielded questions from the group.

Key Takeaways from Brandi Krushelniski

Brandi explained how the Norton Thoracic Institute grew to become one of the nation's top lung transplant programs in under 20 years. The following are key takeaways from the discussion:

- **Involve the C-Suite:** Brandi noted the importance of involving the hospital's C-Suite in major transplant program decisions and events to increase support and buy-in. In the past, she has invited C-Suite members to speak to new physicians at welcome events and includes members in the transplant council.
- **The power of the patient:** Brandi emphasized how influential it can be to invite stakeholders to meet the patients whose lives will be impacted by the decisions they make. Whether it is the hospital's C-Suite or the finance department, Brandi has found she makes the most compelling case when she focuses on the patient.
- **Establish personal relationships with OPOs:** Brandi explained, from the lens of a transplant program, the importance of building and nurturing person-to-person relationships with OPOs. Her program conducts outreach initiatives with various OPOs, has new team members tour the OPO and HLA labs, forms relationships with the pulmonologists and other staff members, and welcomes OPO staff to call in at all hours of the night.
- **Cost barriers:** When asked about the biggest challenges her program is currently facing, Brandi explained how new technologies are constantly being developed that could drastically improve transplant outcomes, but no roadmap has been created yet for financing that technology. Until a reimbursement model is established for purchasing and maintaining such technology, it is cost prohibitive.

Key Takeaways from Michael Goldstein MD

Dr. Goldstein spoke about his program's journey of unprecedented growth and success. In 2023, Hackensack University Medical Center saw a 35% growth in transplant volume, the largest increase among transplant centers nationwide. The following are key takeaways from the discussion:

- **Stay patient-centric:** Dr Goldstein explained that patient needs should be the main drivers of changes to our metrics. He noted the importance of understanding patient needs and shaping hospital policies accordingly.
- **Build rapport with the C-Suite:** Dr. Goldstein emphasized the importance of constant communication with the C-Suite. Dr. Goldstein organizes quarterly meetings with his C-Suite to review outcomes, SRTR data, rankings, etc. His perspective is that it is the C-Suite's program; the transplant coordinator is just the driver.
- **Promote early transplant:** Dr. Goldstein explained his kidney program's mindset that minimizing time on the waitlist is more important than waiting for a low KDPI kidney. When a new patient registers at Hackensack, his program shows them a PowerPoint presentation on the benefits of accepting a high KDPI kidney sooner, and the consequences of electing to stay on dialysis longer. Additionally, Hackensack does not decline high KDPI kidneys before evaluating them. Instead, the center works with the patient on an offer-by-offer basis and educates them on how they would benefit from accepting the organ.
- **In-house services:** Dr. Goldstein's team has in-house perfusion services which has limited the dependency on outside resources they need to utilize more organs. Hackensack pumps about 90% of all kidneys using their own kidney perfusion pumps, which has resulted in better outcomes for patients and lower operating costs.
- **Know where you stand:** Dr. Goldstein noted the importance of understanding that the world doesn't revolve around transplant, and as such, it is important to be realistic when asking for resources.
- **Creating a dynamic match run:** Dr. Goldstein explained how the current match run is not utility-based, and we are losing utility at the expense of equity. Equity is important, but in his opinion discarding eight thousand kidneys every year is worse. Dr. Goldstein suggested creating a dynamic match run that updates as the risk of the organ increases (e.g., due to increasing CIT) and more information about the organ is entered.
- **Waitlist management program:** Hackensack University Medical Center created their own waitlist management program, where they have patients eligible for transplant based on the donor risk criteria. Not only does this reduce staff burnout, but it enables the center to always have a patient ready for any organ offer they receive.

PRESENTATION

Rescue Pathways Variance Protocols

The Task Force recently submitted a proposal to revise OPTN Policy 1.3 requirements to permit protocols focused on short, rapid tests of change for expedited placement, or “rescue pathways.” In turn, this proposal would create OPTN Policy 5.4.G Open Variance for Expedited Placement. As a group, the Task Force ideated potential rescue pathway variables.

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PRESENTATION & FEEDBACK

Non-Use & Non-Utilization Study

The purpose of the non-use/non-utilization study is to understand the current state of organ non-use and non-utilization throughout the OPTN. Four potential "pillars" of the study were presented, including: Pillar 1 – Donor/Organ Clinical Characteristics Analysis; Pillar 2 – Aggregated Offer Acceptance Patterns; Pillar 3 – Expert Panel Evaluation Simulation; and Pillar 4 – Qualitative/Attitudinal Research.

Designing a Multi-Pronged Study

1 Donor/Organ Clinical Characteristics Analysis

2 Aggregated Offer Acceptance Patterns

How might we apply analytics to existing data in novel ways to learn more about what is driving non-use and offer declines?

3 Expert Panel Evaluation Simulation

How might we engage an independent group of surgeons to look at the complete set of decision data associated with a representative sample of non-used organs to determine which could have been used under what conditions, and which should have legitimately gone unused?

4 Qualitative/ Attitudinal Research

How might we engage a consistent set of interviewers to prospectively look at non-used organs to understand the "story" on why they went unused, and for those never accepted, a random sampling of what made surgeons decline those offers?

Possible Framework for Non-Use Rationales

What are the factors driving whether a donor kidney is transplanted vs. goes unused? How might we categorize them?

Pre-acceptance non-use

(Organ offered -> never accepted -> non-used)

Post-acceptance non-use (a.k.a "Turn Downs")

(Organ offered -> accepted at some point -> still non-used)

Supply Chain

Perceived Availability of Quality Organs

Optimism Bias

Do I believe that this patient will receive a better offer soon, causing me to say no to the current offer?

Donor Organ & Patient Fit

+ other clinical characteristics

What about the donor/organ (pre/post-clamp) made me say no?

Misinformation about the offer

What info was:

- Miscommunicated
- Misunderstood
- Not communicated
- Not seen

…that made me say no?

Match Run

What info about the match run made me say no to this offer?

- Sequence ID
- Assumed Centers ahead of me
- Etc

Transport

What about transport went wrong that made me say no after I initially said yes?

- Flight/courier availability
- Weather/schedule changes
- Mishandled/Lost
- Etc

Transplant Center Environment

What about my situation made me say no after I initially said yes?

- Surgeon availability
- OR availability
- Patient sick
- Patient uncontactable
- Local Biopsy
- Etc…

Donor Specific

Pre-X Clamp

- Donor Age
- Terminal Creatinine
- Avg Urine Output
- DCD Status (Y/N)
- Donor Sex
- Etc

Post-X Clamp

- Biopsy Results
  - Glomeruli sclerosis
  - Interstitial fibrosis
  - Arterial sclerosis
  - Vascular changes
- Pump (Y/N)
- Etc

Non-Donor Related

- Time of Recovery
- Project CIT at Time of Transplant
- Etc

Task Force Feedback

Task Force members provided feedback on the four pillars in the form of “I like...”, “I wish...”, “What if...”. Some emergent themes from that feedback were:

I like:

- How all the pillars work together
- The leveraging of existing data
- How the qualitative approach uncovers new insights
- Data driven approach to non-use
- How we're pulling data we don't collect within the system right now

I wish:

- We could identify the “appropriate” level of non-use
- We could uncover which organs are not transplantable
- We could quantify the multi-factorial reasons for non-use
- We could communicate this initiative successfully to the community
- We could capture results from different geographic areas

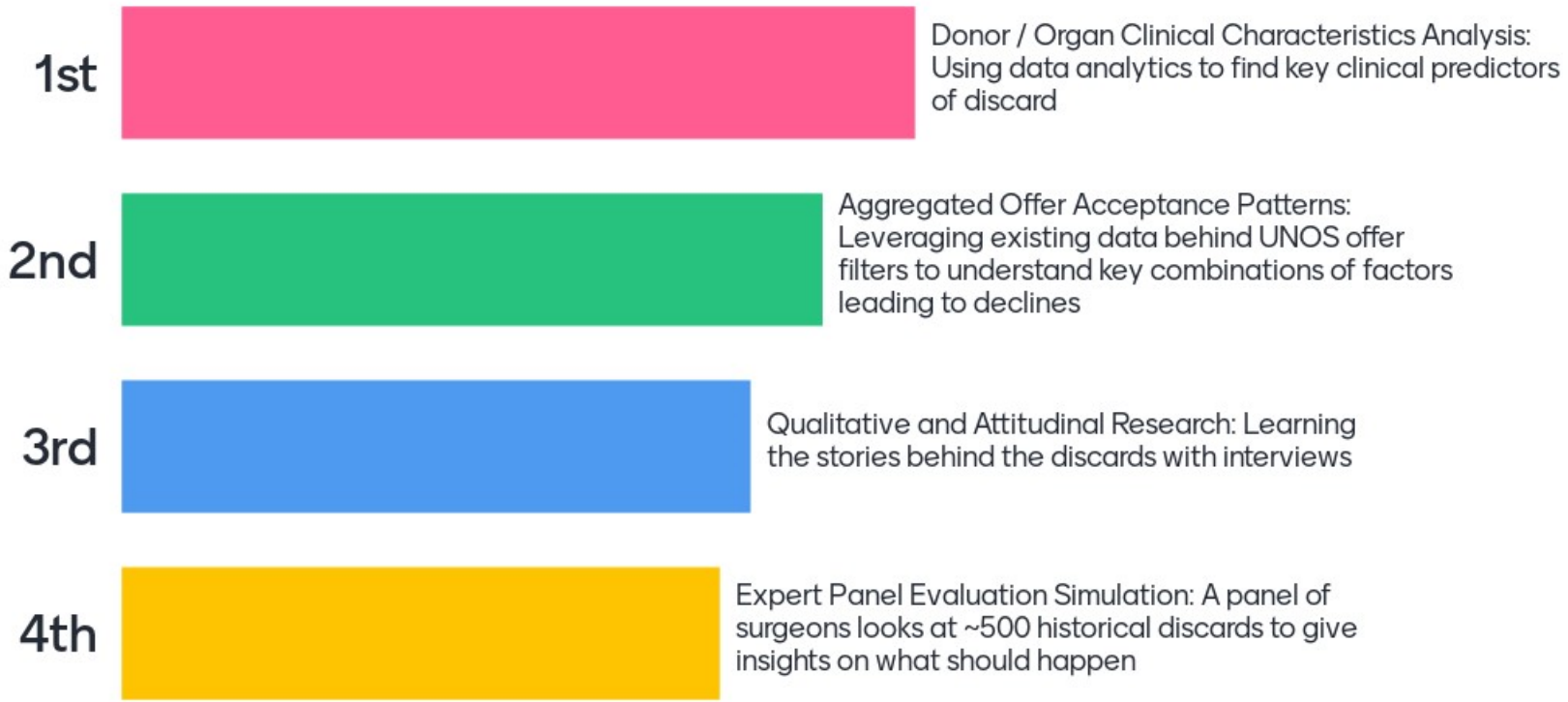
What if:

- This could help transplant centers to better understand their own decline patterns and increase their own growth,
- This leads to a playbook of effective practices from high growth centers,
- This leads to better OPO & transplant center relationships,
- We expand this study in the future to understand patient declines

Pillar Ranking

Expeditious members ranked the four pillars in terms of which they believed could provide the greatest insight. The results were:

1. Pillar 1: Donor/Organ Clinical Characteristics Analysis
2. Pillar 2: Aggregated Offer Acceptance Patterns
3. Pillar 4: Qualitative/Attitudinal Research
4. Pillar 3: Expert Panel Evaluation Simulation


1st
Donor / Organ Clinical Characteristics Analysis: Using data analytics to find key clinical predictors of discard
2nd
Aggregated Offer Acceptance Patterns: Leveraging existing data behind UNOS offer filters to understand key combinations of factors leading to declines
3rd
Qualitative and Attitudinal Research: Learning the stories behind the discards with interviews
4th
Expert Panel Evaluation Simulation: A panel of surgeons looks at ~500 historical discards to give insights on what should happen

PRESENTATION & ACTIVITY

Breakout Groups

Task Force members selected which breakout room they wanted to join that focused on one of the following topics: Non-use & non-utilization, rescue pathway protocols, and securing growth commitments. In these breakout rooms, Task Force members completed activities to facilitate discussion and ideation.

Non-Use & Non-Utilization Breakout

MISSION

To closely examine and discuss each of the four potential "pillars" of the non-use/non-utilization study, including the benefits and drawbacks of each, synergies, and proposed improvements.

Non-Use & Non-Utilization Breakout

Discussion Output

Pillar 1: Donor/Organ Clinical Characteristics Analysis

- Analyzing donor and organ data to identify key clinical predictors of non-use can be done in the immediate future
- Identifying clinical characteristics is at the heart of this pillar, while the exploratory dashboard is simply a presentation of that work

Pillar 2: Aggregated Offer Acceptance Patterns

- Understanding key combinations of factors leading to declines based on the existing default offer filter model can be done in the immediate future
- Results from this pillar can be used to identify the centers of interest for Pillar 4
    - E.g., During Pillar 4 research, speak with centers that normally accept the organ based on default offer filters but did not in a specific case

Non-Use & Non-Utilization Breakout

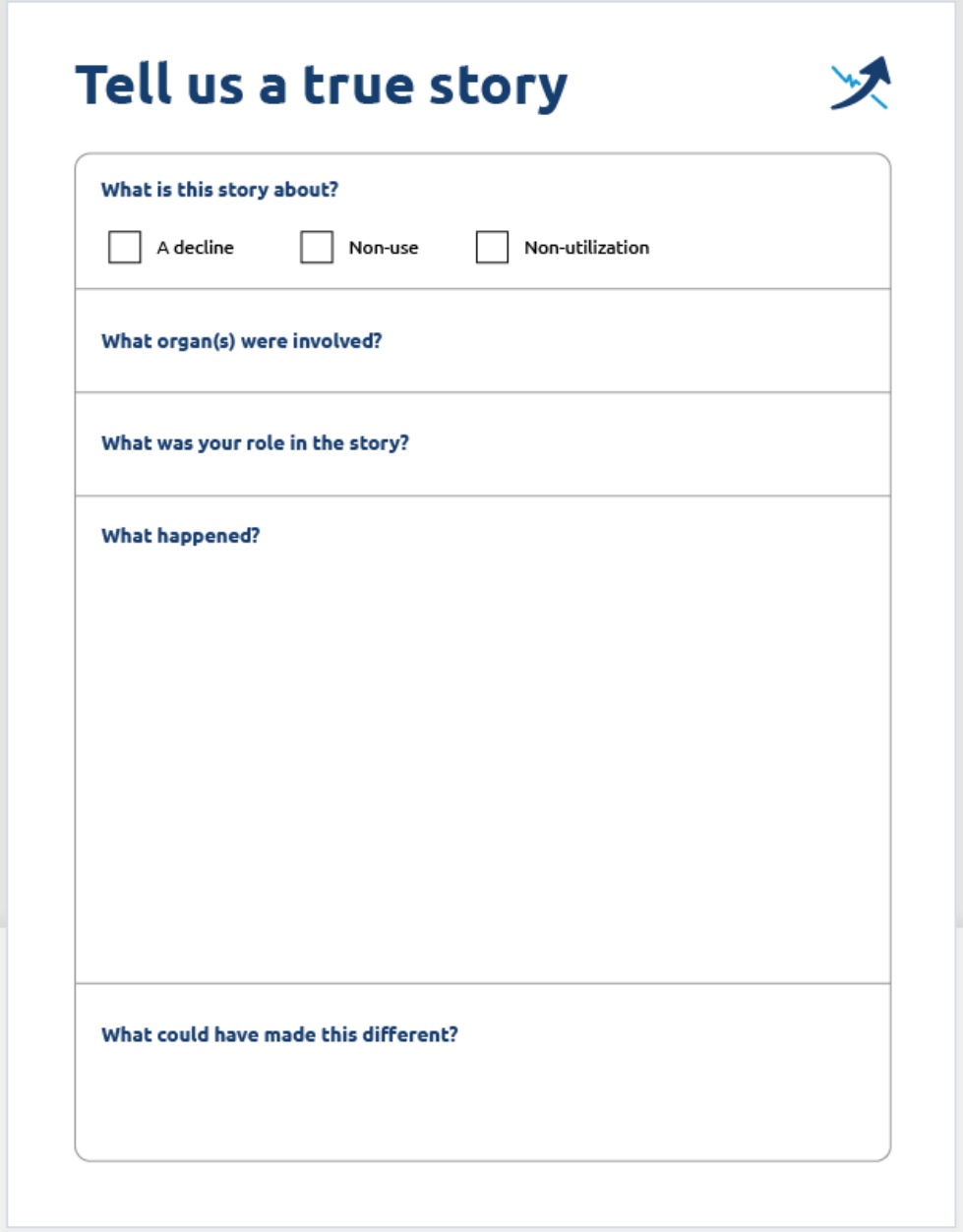
Discussion Output

Pillar 3: Expert Panel Evaluation Simulation

- A panel of transplant professionals to review non-use cases should be introduced as a PDSA before large-scale roll out
- When reviewing non-use cases, consider presenting organs that were transplanted and organs that were not used without indicating which is which
- In addition to transplant surgeons, consider including other panelists who also review organ offers (e.g., nephrologists)

Pillar 4: Qualitative/Attitudinal Research

- Conducting interviews to understand the stories behind real-time, non-use cases should be introduced as a PDSA before large-scale roll out
- Research should leverage both surveys and interviews
- Consider screening which centers to interview by using offer decline codes or leveraging the model-generated default offer filters from Pillar 2



Non-Use & Non-Utilization Study Breakout

See appendix for submitted templates

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How can you help in this effort?

Your name: _____

Non-Use & Non-Utilization Study Breakout

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Rescue Pathway Protocol Breakout

MISSION

To draft a rescue pathway protocol to test and discuss donor criteria, candidate criteria, and conditions that qualify for expedited placement.

Rescue Pathway Protocol Breakout

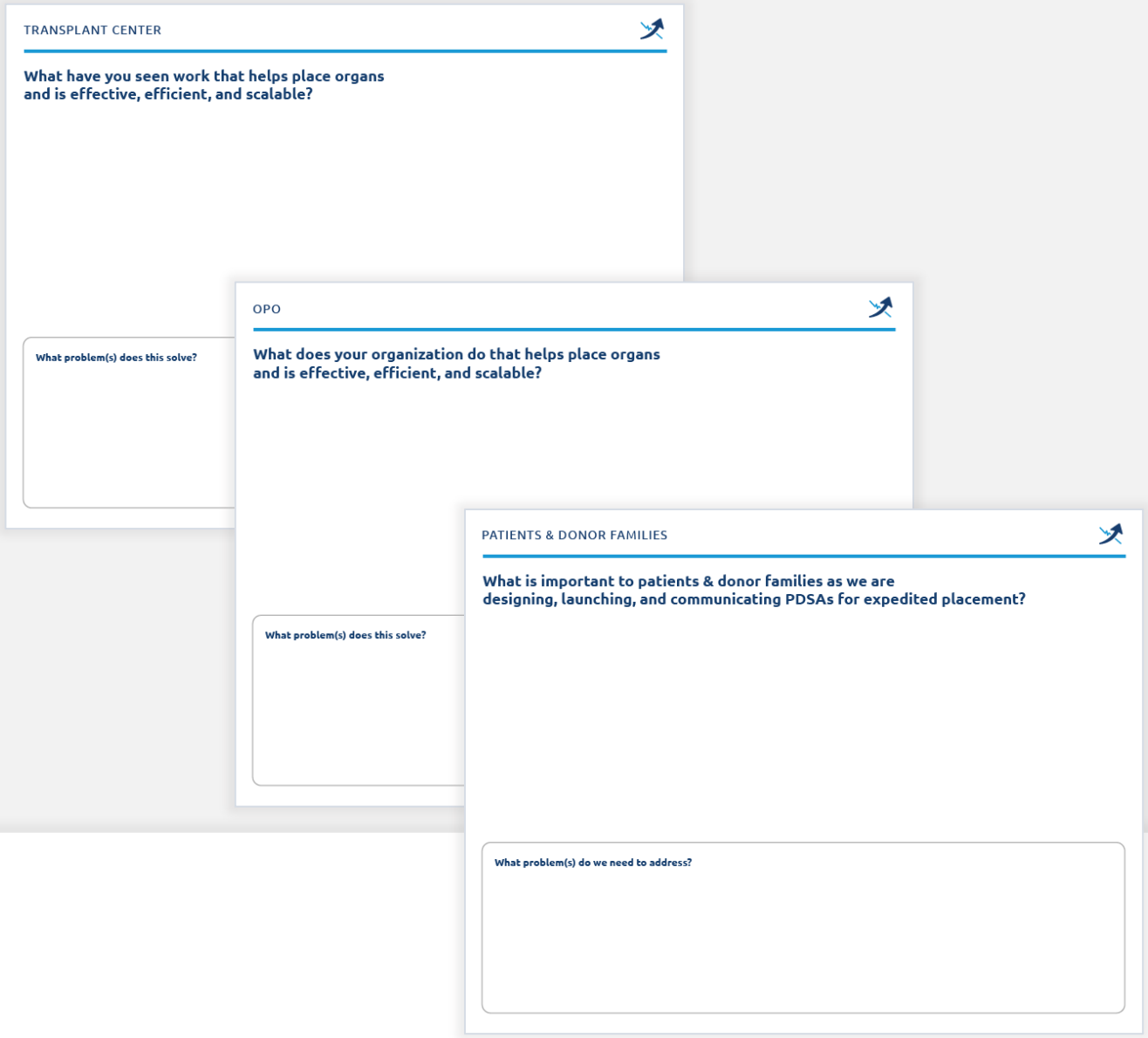
Discussion Output

Kidney Donor Criteria

- Start the rescue pathway at approximately 4-8 hours cold ischemic time (CIT)
- Enter the pathway at multiple points depending on CIT
- OPO should offer to TxC that would result in lowest CIT—open offer (UK reference)
  - Open offer could be inequitable
- Need to flesh out CIT & donor/organ characteristics **OR** hold focus groups with OPOs/TxCs
  - Look at SRTR tool: potentially add donor characteristics to SRTR tool

Rescue Pathway Variables

- Geographically isolated OPOs
- Cold ischemic time
- Organ risk score creation
- Time factor
- Sequence number
- Geographically equitable
- Logistical feasibility (transportation)
- Patient access (equity & safety)
- TxC/OPO networking
- Define "Hard/Difficult to Place"



Rescue Pathway Breakout

See appendix for submitted templates

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Securing Growth Commitments Breakout

MISSION

To discuss how to secure commitments from C-suite leaders to contribute to the 60K transplants by 2026 growth aim

Securing Growth Commitments Breakout

Discussion Output

Key Discussion Topics

- Types of commitments on both the individual and collective Task Force levels
- The requests and offers individuals could present when securing commitments from others in their networks
- Best practices and tips to approach C-suites and secure commitments from them
- Methods and strategies to refine Task Force messaging around growth aims and to increase involvement in spreading the word
- Formats for in-person and virtual events to deliver the message, secure commitments, and celebrate success

Success Factors Identified

- Multiple formats and a combination of those formats to reach all types of stakeholders
- Hosting several smaller, local events
- Direct interaction with patients to secure, celebrate and recognize commitments
- Soliciting public support from national leaders such as the Secretary of Health
- Requiring people to sign letters and publicly announce who is on board
- Messaging and data provided by the Task Force to craft compelling messaging on growth aims
- Focusing efforts on engaging surgeons too

Requests and Offers I would like to see the Task Force make to others are:

Request(s) — specify to whom:

1. _____

2. _____

Offer(s) — specify to whom:

1. _____

2. _____

My name: _____

Securing Growth Commitments Breakout

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PRESENTATION & DISCUSSION

Policy Review

Task Force members spent time discussing existing policies that might be barriers to growth, efficiency, and utilization within transplantation. The following slide captures the output of that discussion.

Suggestions for policy change

- Remove the requirement to utilize the Organ Center
- Engage the Organ Center in PDSAs for new allocation algorithms
- Organ Center should have its own established rescue pathway
- Remove the requirement to gain consent before transplanting high KDPI kidneys
- Remove the post-transplant outcomes from the MPSC performance metrics
- Revise the match run based on observed behaviors
- Remove the barriers to having a living donor-only program, especially in rural areas
- Develop a nationally sourced, easily understood set of educational material that explains to patients the benefits of accepting a high KDPI kidney and the drawbacks of opting to stay on dialysis

PRESENTATION

MPSC Update

On January 19th, the Membership and Professional Standards Committee (MPSC) met to discuss current post-transplant outcomes monitoring and allocation reviews. The committee considered removing the threat of post-transplant outcome review monitoring as a potential disincentive to utilization and growth, as well as ways to reduce the burden of reviewing non-compliance of allocations out of sequence cases. After hearing an update on the January 19th meeting, Task Force members shared their opinions on the current post-transplant outcomes, concerns about patient safety and equity, shortcomings of the existing system, and recommendations for change.

LOOKING AHEAD

Next Steps

The next steps of the Expeditious Task Force include:

- Representing the Task Force at regional meetings and national conferences to introduce work and gather feedback on proposed projects
- Sharing Task Force updates among members' individual networks
- Developing a plan for subgroups to continue project work
- A virtual meeting on February 29, 10am-12pm Eastern