

OPTN/UNOS Transplant Administrators Committee (TAC)
Meeting Minutes
January 25, 2017
Conference Call

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Introduction

The Transplant Administrators Committee met via Citrix GoToTraining teleconference on January 25, 2017 to discuss the following agenda items:

1. Policy Review Project
2. Fiscal Impact Advisory Group Update
3. OPTN December Board Meeting Update
4. SRTR's New Website and 5 Tier Outcome Assessment Discussion

The following is a summary of the Committee's discussions.

1. Policy Review Project

The Committee will begin a process of reviewing the OPTN policies for relevance in current practice and provide recommendations to the appropriate OPTN committee. The Committee that receives the TAC's recommendations will then consider if further action is required. This project does not require approval from the Policy Oversight Committee (POC). It will become part of the Committee's regular work.

Summary of discussion:

The proposed scope of this project is to review existing OPTN policies for the following:

- Clarity and accuracy
- Usefulness and relevance
- Usability and findability

A work group will be formed that will be comprised of 5-6 committee members that have a vested interest in reviewing a particular policy. The policies suggested for review are as follows:

- Policy 1: Administrative Rules and Definitions
- Policy 3: Candidate Registrations, Modifications, and Removals
- Policy 5: Organ Offers, Acceptance, and Verification
- Policy 6: Allocation of Hearts and Heart-Lungs
- Policy 7: Allocation of Intestines
- Policy 8: Allocation of Kidneys
- Policy 9: Allocation of Livers and Liver-Intestines
- Policy 10: Allocation of Lungs
- Policy 11: Allocation of Pancreas, Kidney-Pancreas, and Islets
- Policy 13: Kidney Paired Donation (KPD)
- Policy 14: Living Donation
- Policy 15: Identification of Transmissible Diseases
- Policy 16: Organ and Vessel Packaging, Labeling, Shipping, and Storage
- Policy 18: Data Submission Requirements

Review of the OPTN Bylaws will not be included in the scope of this project.

The suggested process is for the Work Group to review a copy of the policy posted on the TCC SharePoint site. Each member of the Work Group will make comments using track changes. Review deadlines will be determined for each policy depending on its length and complexity. This project is estimated to take one year to 18 months to complete.

Next steps:

Committee members were asked to volunteer to participate on the Policy 1 Review Work Group. A conference call will be scheduled in February to develop specific details of the review process for this policy.

2. Fiscal Impact Advisory Group Update

The Fiscal Impact Advisory Group reviews and estimates the financial impact OPTN policies may have on transplant hospitals, OPOs, and histocompatibility labs. At the December OPTN/UNOS Board meeting, eight UNOS and member impact summaries were presented. These summaries were also posted publicly with each proposal on the OPTN public comment website. According to the Board fiscal impact survey results, Board members agreed the new member impact tool helped them gain a better understanding of how the proposed policy changes would impact cost to OPTN/UNOS members.

The 2016-2018 Advisory Group is comprised of histocompatibility labs, transplant hospitals, and OPOs. There are members from small, medium, and large organizations represented. During each public comment cycle, the Group completes a fiscal impact survey for each public comment proposal. There are 15 questions per proposal and solicit responses that are quantitative and qualitative. The general timeline for the Group to review proposals is typically a few days prior to the start of the public comment cycle and continues until a week or two before the Board meeting.

The following changes and improvements will be made for spring 2017:

- increased size of advisory group
- the group will receive presentations on each public comment proposal prior to making estimates
- the survey completed by the Advisory Group will be modified in efforts to obtain better analysis and narrative
- each public comment proposal will request fiscal impact comment
- the fiscal impact statements will be evaluated for accuracy after the proposal has been implemented for one year

Members of the Committee appreciated the efforts of this advisory group. When the Committee reviews public comment proposals, it will provide comments and questions regarding the fiscal impact on transplant hospitals.

3. OPTN December Board Meeting Update

A summary of the outcomes from the December OPTN/UNOS Board meeting was provided. The main discussions were about liver redistricting, system optimization and utilization, and expedited organ placement. A committee member commented that transplant administrators will need to be considered a key stakeholder in above mentioned projects.

Members of the committee were made aware that they can find information on the Board meeting on Transplant Pro at <https://www.transplantpro.org/news/december-2016-board-meeting-actions/>.

Board actions:

- Approved revised adult heart allocation system
- Clarified exception points for liver transplant candidates with hepatocellular carcinoma

Upcoming policy changes:

- Effective March 1, 2017
 - Post-implementation changes to ABO verification policies
 - Primary transplant surgeon requirement changes
 - Primary transplant physician subspecialty requirement changes
 - Remove donor location from required procurement log info
- Pending implementation and notice to members
 - HCC auto approval criteria changes
 - Kidney transplant physician update
 - Update transplant hospital definition
 - Modify adult heart allocation
 - Informed consent changes for potential living donors

4. SRTR's New Website and 5 Tier Outcome Assessment Discussion

The Committee received a presentation on the SRTR's new website and 5 tier outcome assessment rating system. The presentation provided an overview of:

- new website changes
- background of how and why the 5 tier outcome assessment rating system was developed
- how the outcome assessment rating system was intended to be used
- feedback received by public and transplant community
- steps taken thus far in response to feedback received

SRTR addressed the following concerns raised by the transplant community and the TAC:

- Credible intervals are wide and hazard ratios are not "significantly different" from 1.0
- A difference of 1 failure can mean the difference between a 3 and 4 rating, etc.
- Can't be certain that differences between tiers are "meaningful"
- No credible interval/confidence interval on the ratings
- Should show the score so programs can see how close to the tier line they are
- Focuses on the wrong metric, or overemphasizes the post-transplant outcomes
- Risk adjustment is not adequate
- Risk Aversion will be more widespread. All programs will want to avoid risk, not just the bottom programs
- CMS just moved their bar higher and SRTR now made it easier for programs to look bad
- Private payers will use this to be more exclusionary in their determination of centers of excellence
- Centers below 3 on the rating scale will receive centers of excellence designations
- Smaller programs with worse hazard ratios can be rated higher than larger programs with better hazard ratios
- Poor communication of the new system to the transplant community
- SRTR explanations of the tiers is too complex and patients will not be able to understand meanings
- It seems as though the disconnect for most programs is not accounting for the complexity of all the issues. For example, an aggressive program might have a hazard

ratio of 1.5 and transplants patients that might not have been transplanted as compared to a program with a hazard ratio of .4 that cherry picks their offers.

- There is a disconnect between the patient perception of the 5 tier scale and the actual math behind the rating system. It was suggested that case examples with the outcomes data and other case specific information should be presented to patients and ask them how they would rate a center based on the 5 tier scale. SRTR has formed patient focus groups to see how patients are interpreting information and making their decisions on center selection.
- There was concern that people are used to Yelp and hotel ratings and a rating of 3, which means you are performing well, would not be perceived that way. The average lay person would perceive a rating of 3 as average and patients want a center with a rating of a 5, which is the best. A committee member commented there will probably be a fair number of centers that have a rating of 3. Assuming this tool is widely used, those centers with a rating of 3 are going to get passed over when actually they are probably the top performing centers.
- Is the bar symbol conveying the 3 rating means "as expected" or should that symbol be changed?

Upcoming Meeting

- February 22, 2017