

**OPTN Membership and Professional Standards Committee
Performance Monitoring Enhancement Subcommittee
Meeting Summary
February 9, 2021
Conference Call**

Richard Formica, M.D., Chair

Introduction

The Performance Monitoring Enhancement Subcommittee of the Membership and Professionals Standards Committee (MPSC) met via Citrix GoToTraining teleconference on February 9, 2021, to discuss the following agenda items:

1. Welcome and Agenda
2. Progress on Project
3. Threshold Determination
 - SRTR Presentation
 - Subcommittee Discussion
4. Next Steps

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

1. Welcome and Agenda

The Performance Monitoring Enhancement Subcommittee Chair provided an opening statement. The Subcommittee reviewed the agenda and primary objectives for the meeting. Staff reviewed the project plan timeline with the Subcommittee and advised that frequent meetings may be necessary to meet the MPSC's goal of finalizing a public comment proposal by August 2021.

2. Progress on Project

Staff gave a high-level overview of the Performance Monitoring Enhancement Project and highlighted the Subcommittee's previous recommendations for potential scorecard metrics and revisions to the review process. The Subcommittee recommended and the Committee supported inclusion of the following in the public comment proposal:

- Potential Scorecard Metrics
 - Waitlist Management – waitlist mortality, offer acceptance.
 - Post-transplant Outcomes – 90-day survival, 1-year conditional on 90-day survival
- Potential Revisions to Review Process (2-tiered process):
 - Process Improvement Tier (Yellow Zone) – notice with offer of assistance
 - MPSC Intervention Tier (Red Zone) – based on patient safety concerns

3. Threshold Determination

The Performance Monitoring Enhancement Subcommittee Chair introduced staff from the SRTR and provided the Subcommittee with background information regarding the presentation.

SRTR Presentation

The SRTR Director discussed the Subcommittee's recommendations for potential scorecard metrics and revisions to the review process. The Director also noted that the Subcommittee previously recommended the use of a fixed difference from the national average to determine the tier thresholds for the proposed scorecard metrics. The Subcommittee had requested that SRTR provide sample data showing the following differences in the cut-off thresholds:

- Post-transplant outcomes - the number of programs whose standardized survival rates are 3, 5, 7, and 10 percentage points below the national survival rates.
- Pre-transplant metrics - the number of programs whose standardized mortality rate is above and offer acceptance rate is below the national average by more than 1.5, 2.0, 2.5, and 3.0 sample standard deviations (SD) on the logarithmic scale.

The SRTR staff presented the sample data for review by the Subcommittee. The Subcommittee first reviewed the sample data for post-transplant outcomes (90-day and conditional 1-year outcomes) for graft and patient survival metrics for kidney recipients. The example showed the programs that fell above 1 and 3 percentage points above the national survival rate at a 50% probability, 75% probability, and 90% probability that the observed hazard ratio was above the cutoff. The current measurement the MPSC uses is 75% probability. No programs fell above the cutoffs for 5, 7, or 10 percentage points above the national survival rates for kidney graft or patient survival. The Director explained the difference between observed and risk-adjusted outcomes and that the Subcommittee chose to assess programs on risk-adjusted outcomes. In response to questions, the Director showed the Subcommittee where to find the SRTR Risk Adjustment Model Tool on the SRTR website and reviewed the list of predictors for post-transplant outcome metrics. In response to questions from the Subcommittee, the SRTR offered to provide the data for each of the programs that fell above the cutoffs at a future meeting.

The Subcommittee reviewed sample data for pre-transplant metrics (waitlist mortality and offer acceptance ratios) for kidney as an example and referenced that data for other organs when appropriate. The example data showed cut-offs at 1.5, 2.0, 2.5, and 3.0 standard deviation differences and showed the number of programs who were above the thresholds. The final boundaries would need to incorporate the Bayesian probability curves to reflect the certainty of the estimations of the hazard ratios for larger versus smaller programs. In response to questions about the waitlist mortality rate, the Director noted that the question being asked is - on any given day on your transplant list, on a day that a patient is not going to be transplanted, is that patient dying at a rate that is faster or slower than other programs with similar risk patients on their list. When reviewing the offer acceptance data, the Director explained that the metric includes only offers for which the program was primary at some point, and where a program eventually accepted the organ. The Director reviewed the predictors by organ type for the offer acceptance model using the SRTR risk adjustment model tool and noted that the offer acceptance models are the most complex and are able to adjust for both donor and candidate characteristics. In response to a question about the effect of use of the offer filters affects where programs fall on the diagram, the Director noted that the model only looks at offers for which the program was primary for that organ at some point in the match run. If the program screens out offers that the program would not accept using the offer filters, it would decrease the number of offers that the program receives to those the program is more likely to accept and will result in a higher acceptance rate but does not mean the program will be higher than national average. If the program were accepting offers with particular donor and candidate characteristics at the same rate as other programs, the program's adjusted rate would be right around the national average. He also noted that there is

considerable variation in offer acceptance, for example for lung offer acceptance, there are programs of comparable volume accepting less than 1% of offers and other programs accepting over 15 % of offers.

Subcommittee Discussion

The Subcommittee discussed the sample pre and post-transplant outcomes thresholds. One subcommittee member noted that when reviewing the MPSC workload, it is not just a matter of looking at the number of programs that fall above a threshold in one static report; it is how many programs are in the pipeline since programs will presumably be engaging with the MPSC for a number of cycles. Programs move in and out of the zone. He further stated that the MPSC should set the boundaries liberally for the intervention zone given that programs are battling end-stage organ failure that has abysmal survival rates. The Subcommittee chair noted that the relevant question to consider, as the Subcommittee takes a look at this data prior to the next meeting, is where do we cross over into a clinically relevant need to intervene or in other words, how many events over what would be expected starts to make you worry about something that is going on at that program that needs to be addressed. He suggested that the subcommittee members try to determine where the safety trigger is by considering these questions as they think about reviews that they have done during their time on the MPSC.

Another subcommittee member noted that the MPSC should consider the various other factors involved in waitlist mortality that would make the metric difficult to measure regardless of risk-adjustment, such as the performance of the local OPO, and who is taking care of the patient while on the waiting list. The Subcommittee Chair suggested that even though a program may fall within the MPSC intervention zone, the program would be able to provide the MPSC with mitigating data to address these concerns about factors that might not be accounted for by the risk adjustment. A program that falls within the MPSC intervention zone would not necessarily immediately get a peer visit. The MPSC would inquire and review the response from the program. The SRTR staff mentioned that they are open to having more discussions on risk-adjustment with the MPSC to address each of those factors, particularly as the MPSC may identify factors that are not accounted for in risk adjustment during its review of programs.

The Subcommittee also discussed the offer acceptance metric and agreed that the current offer acceptance process is inefficient. One subcommittee member noted that even at the 1.5 SD, not that many programs are identified. If we really want to affect the inefficiencies in the system and increase transplants, the MPSC may want to consider a boundary that captures more programs initially since this is a metric that has not been previously monitored; and to work with more programs to increase their acceptance rates. The Subcommittee chair noted that system efficiency is a patient safety issue. It may not be as direct as patient or graft survival but overall the more efficient the system is, the safer it is for patients. Another subcommittee member remarked that the MPSC should be careful about penalizing programs for being open to taking more offers and should instead encourage programs, noting that his program recently expanded the offers they were willing to take and did the most transplants ever last year. The Subcommittee Chair agreed that a goal should be to encourage programs to expand the offers it receives by using broader filters if the program is willing to consider accepting an organ within the expanded parameters. On the other hand, a goal should also be to encourage programs to use filters to eliminate offers for organs that they realistically will never accept. These goals will support an efficient system that will get organ offers to programs that are willing to accept them for their patients in a timely manner.

4. Next Steps

The Subcommittee Chair and staff discussed the next steps for the project. SRTR agreed to provide the Subcommittee with outlier data for the next Performance Monitoring Subcommittee meeting to

determine if there is a patient safety issue. The Chair also requested that UNOS staff provide data on the number of cases the MPSC reviewed in any given 12 month cycle for the last couple of years. Staff encouraged the Subcommittee to review the slides before the next MPSC meeting and to expect an availability poll for the next Performance Monitoring Subcommittee Meetings. Staff will upload the SRTR presentation slides into the Subcommittee folder.

Upcoming meeting

- February 23-25, 2021: MPSC Meeting

Attendance

- **Committee Members**
 - Richard N. Formica Jr (Subcommittee Chair)
 - Sanjeev K. Akkina
 - Nicole Berry
 - Errol Busch
 - Adam M. Frank
 - Michael D. Gautreaux
 - John Gutowski
 - Ian R. Jamieson
 - Christy M. Keahey
 - Mary T. Killackey
 - Jon A. Kobashigawa
 - Jules Lin
 - Didier A. Mandelbrot
 - Virginia(Ginny) T. McBride
 - Willscott E. Naugler
 - Matthew J. O'Connor
 - Steve Potter
 - Jennifer K. Prinz
- **HRSA Representatives**
 - Marilyn Levi
 - Chris McLaughlin
 - Arjun U. Naik
 - Raelene Skerda
- **SRTR Staff**
 - Nicholas Salkowski
 - Jon J. Snyder
 - Bryn Thompson
 - Andrew Wey
- **UNOS Staff**
 - Sally Aungier
 - Nicole Benjamin
 - Tameka Bland
 - Robyn DiSalvo
 - Nadine Drumn
 - Amanda Gurin
 - Danielle Hawkins
 - Ann-Marie Leary
 - Jacqui O'Keefe
 - Liz Robbins Callahan
 - Sharon Shepherd
 - Leah Slife
 - Stephon Thelwell

- Gabe Vece
 - Betsy Warnick
- **Other Attendees**
 - None