

**OPTN Membership and Professional Standards Committee
Organ Procurement Organization (OPO) Performance Monitoring Enhancement Workgroup
Meeting Summary
February 6, 2025
Conference Call**

Rick Hasz, Chair

Introduction

The MPSC OPO Performance Monitoring Enhancement Workgroup met in open session virtually via Webex on February 6, 2025, to discuss the following agenda items:

1. Welcome
2. Potential OPO Performance Metrics
3. Next Steps

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

1. Welcome

The Chair welcomed the workgroup members. He explained that MPSC Leadership had requested that the Scientific Registry of Transplant Recipients (SRTR) provide information on the OPO performance metrics they had been working on. The OPTN should consider these metrics for OPO performance monitoring until data collected on the proposed Ventilated Patient Form is available for metric development.

2. Potential OPO Performance Metrics

SRTR staff provided an overview of work performed on risk-adjusted OPO performance metrics based on recommendations from its National Transplant Metrics Consensus Conference held in 2022. This conference was held pursuant to Task 5 of the SRTR's contract with the Health Resources and Services Administration (HRSA).

Based on one of the consensus conference recommendations, the SRTR has already stopped using the imminent and eligible donor potential definitions. A second consensus conference recommendation was to "develop a new donor potential definition and metric, leverage existing OPO data captured within OPO electronic medical records, present metrics at OPO and donor hospital levels, and include risk adjustment." In response to this recommendation, the SRTR produced risk-adjusted donation rate and transplant rate measures. The data sources used by the SRTR include the SRTR Standard Analysis File for data on donors and the Centers for Disease Control (CDC) Multiple Cause of Death (MCO) data for potential donors.

SRTR staff provided details on the construction of a potential donor definition (denominator) that:

- Includes inpatient deaths of patients under the age of 76 whose primary cause of death falls within certain ICD-10 codes that are compatible with donation.
- Excludes ICD-10 codes that are based on potential donor exclusions in OPTN Policy 1 and some additional ICD-10 codes for conditions that would preclude donation based on Federal Regulation.

For the donation rate, the numerator is donors defined as an individual from whom at least one organ is recovered for the purpose of transplantation after declaration of death. Data was provided for the number of potential donors (denominator) using the exclusion and inclusion criteria described above for the years 2018 through 2022.

SRTR staff explained that risk adjustment is performed to remove factors that vary from organization to organization and are outside the control of the organization, OPOs in this instance, such as age of decedents in the Donation Service Area (DSA). Because the SRTR is not able to link patients between the CDC MCOB data and the donors in the SRTR Standard Analysis File, the SRTR is only able to risk adjust for three variables, age, sex, and race/ethnicity, to produce an expected donation rate. As with other performance measures produced by the SRTR, they applied a Bayesian hazard ratio to account for differences in size between DSAs. SRTR staff provided plots that compare an unadjusted to an adjusted donation rate which showed that there is a pretty high correlation between the unadjusted and adjusted donation rate but not a perfect correlation, so adjusting for population characteristics may lead to notably different performance evaluations for some OPOs as compared to others. There are OPOs that, using an adjusted donation rate, are substantially outperforming or underperforming their unadjusted donation rate. Additionally, SRTR staff provided examples of the reports developed for potential inclusion in the OPO Specific Reports (OSRs).

SRTR staff briefly described the organ recovery and transplant rates, noting that there are similarities in how these are produced and the results. One significant difference is that the recovery and transplant rates include the OPTN Policy 1 organ-specific exclusions in the organ-specific denominators. Plots that compare organ-specific unadjusted and adjusted organ recovery and organ transplant rate ratios have similar results to the donation rate. The organ recovery rate ratio measures organs recovered for purposes of transplant and the organ transplant rate ratio measures organs transplanted. The SRTR Director noted that a point of discussion is whether to utilize a recovery rate rather than a transplant rate since OPOs do not have significant control over whether an organ is transplanted.

SRTR staff noted that it is possible to reasonably evaluate OPOs using these metrics but there are important limitations:

- The CDC MCOB data are released with a 2-year lag.
- There are a limited number of variables that are available for risk adjustment.
- It is not possible to track individual deaths from being a potential donor to an actual donor, creating the risk of misclassification.
- Patient ventilator status is not yet collected in a way that can be used to estimate potential donors.

The SRTR Director noted that HRSA is not currently supportive of the SRTR continuing work on these metrics, but HRSA did agree to the SRTR presenting the metrics to the Workgroup for consideration by the MPSC.

Summary of Discussion:

Decision: The Workgroup recommended that the MPSC request data from the SRTR on the results of potential thresholds for the SRTR metrics presented.

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Workgroup members discussed the exclusion of patients that are HIV positive from the potential donor definition. Transplant programs do transplant HIV positive donor organs, and the Hope Act has been updated to remove the requirement for IRB approved research in order to accept HIV positive donor organs for kidney and liver transplantation. The SRTR has considered removing HIV positive status but noted that the OPTN has not yet updated policy. A Workgroup member noted that it may be premature to remove this exclusion as currently there are often no candidates on the match run for and/or no placement of HIV positive donor organs.

Variability in what is reported by states on death certificates was another area of discussion. SRTR staff noted that they concluded that if there is clear evidence of an exclusionary condition as a secondary cause of death, that variability should not be ignored even if there is state variability in reporting. The SRTR does not exclude variables from other measures if there is data missing. The one difference is that transplant programs have a lot more control over their missing data than missing data on death certificates for OPO measures.

In the context of a discussion of risk adjustment, the Workgroup examined its goal for reviewing and considering these measures for use in OPTN OPO performance evaluation. This work is intended to be complimentary to the CMS metrics and to aid OPOs in identifying opportunities for improvement and sharing of effective practices between OPOs. Without risk adjustment, it would be hard to accurately identify those OPOs in need of improvement and high performing OPOs that could provide information on effective practices.

The Workgroup discussed the two-year lag in the CDC data and the SRTR prediction models that are included in the SRTR data analysis report. SRTR staff confirmed that the CDC MCOD data is released on a two-year lag as opposed to the deceased donor registration data which has a lag of a few months. The CDC MCOD data could have an even longer lag if the metric is being produced later in the year. The SRTR has been pursuing a number of ways to account for the lag. One of the possibilities is to use the data to create a statistical model to predict the number of potential donors in a Donation Service Area (DSA) based on the time trend and a number of other characteristics that are reported by the OPO. One of the downsides to the predictive model is that the data that is used to predict the number of potential donors is reported by the OPOs. At the national level, the model is a fairly good predictor of the number of potential donors but at the individual DSA level there is a pretty broad confidence interval. The SRTR concluded that the model is reasonable for an aggregated measure to predict an OPO's number of potential donors in the absence of real data but because of the broad confidence interval, it would not be recommended for use to predict which tier an OPO will fall into under the CMS metrics. The predictive model would give an OPO a sense of trends but not be useful for OPO evaluation. SRTR staff mentioned another avenue that SRTR staff are aware of to recreate potential donor numbers with more recent data. Some groups are using the CDC's WONDER dataset, which is real time data that appears to be extremely close to what is ultimately reported in the CDC MCOD dataset. The drawback is that the data in the CDC's WONDER dataset is only available at the county level, and it is censored for counties with less than ten potential donors. These groups are using the CDC WONDER data for counties for which the data is available and then using an adjustment factor based on modeling for counties for which data is not available to get closer to the number of potential donors.

The Workgroup Chair asked if these metrics, or an alternative predictive metric, would be available on the same 6-month cadence as current OSRs. SRTR staff stated that if they were to add these to the OSRs, the data would be the same for each 6-month report in a single year since the CDC MCOD data is released once a year. With regard to using predictive models, currently the SRTR and SRTR Review Committee discussions have concluded that it is better to use the more reliable CDC MCOD data rather than modeling the outcome and making some assumptions about counties that are too small, but this is

still under discussion. There is concern that using predictive donor potential has a risk for misinterpretation.

The Workgroup discussed the possibility of evaluating variations with regard to Donation after Circulatory Death (DCD) and expiration time and asked if analysis had revealed that organs have been transplanted when the secondary ICD-10 exclusion codes were present. SRTR staff indicated that the currently available data does not allow for these types of analyses as the CDC MCOD and SRTR donor data cannot currently be linked at the level of an individual patient. These types of evaluations could be done following implementation of the HHS data directive once data, containing more detailed data capture on DCD donors, is available.

In response to questions about whether the transplant rate measure would replace the organ-yield measure, SRTR staff opined that the donation and transplant rates discussed today are complimentary to the current organ-yield metric used by the MPSC and so the transplant rate would not necessarily replace the organ-yield metric. One issue noted by the SRTR Director is that any OPO measure that requires that an organ be transplanted gets into a realm where it is both a transplant hospital and OPO performance measure. One of the ideas the SRTR has explored is a recovery rate ratio that would evaluate organs recovered for transplant rather than organs that are transplanted. Workgroup members noted that a recovery rate would need to be adjusted for whether an organ was suitable for transplant, otherwise it may encourage OPOs to recover organs that are not suitable for transplant.

The Workgroup discussed potential MPSC thresholds for these metrics. The SRTR noted it had not yet considered any potential MPSC thresholds for the donation rate or transplant rate that could be used by the MPSC for identifying OPOs for performance review. SRTR staff noted that MPSC thresholds are usually determined through significant discussion with the MPSC. Typically, the SRTR would provide an analysis of the flagging results at various threshold levels. Bayesian flagging criteria similar to what is used for MPSC transplant program metrics could be developed for the risk adjusted donation and transplant rates. As was done during the recent MPSC project adopting new transplant program metrics and thresholds, the SRTR can provide simulated data with false positive and false negative rates to evaluate which flagging algorithms are best able to identify the OPOs that truly have lower rates. The SRTR could do a similar analysis if the MPSC wanted to look at these metrics going forward. The Workgroup supported a recommendation that the MPSC request data from the SRTR on the results of potential thresholds for the SRTR metrics presented. The Workgroup noted it is important for the MPSC to begin evaluating OPO performance based on measures other than just organ yield to support OPO performance improvement soon since sufficient data with sufficient specificity will not be available for metric development in the near future.

3. Next Steps

- At its March 28, 2025, meeting, the MPSC will vote on whether to request data from the SRTR on the results of potential thresholds for the SRTR metrics presented.

Upcoming Meetings

- MPSC Conference Call, February 21, 2025, 1 – 4 pm ET
- MPSC Multi-Day Meeting, March 4 – 6, 2025
- MPSC Conference Call, March 28, 2025, 1 – 4 pm ET

Attendance

- **Work Group Members**
 - Richard Hasz, Workgroup Chair
 - Kristine Browning
 - Chris Curran
 - Micah Davis
 - Chad Ezzell
 - Sander Florman
 - Darla Granger
 - Calvin Henry
 - Kyle Herber
 - Christy Keahey
 - Lori Markham
 - Luis Mayen
 - Debbi McRann
 - Cliff Miles, MPSC Chair
 - Malay Shah
 - Carrie Thiessen
- **HRSA Representatives**
 - None
- **SRTR Staff**
 - Jon Miller
 - Jon Snyder
 - Bryn Thompson
 - David Zaun
- **UNOS Staff**
 - Sally Aungier
 - Matt Belton
 - Marty Crenlon
 - Robyn DiSalvo
 - Katie Favaro
 - Jasmine Gaines
 - Melissa Gilbert
 - Houlder Hudgins
 - Krissy Laurie
 - Amy Minkler
 - Heather Neil
 - Melissa Santos
 - Erin Schnellinger
 - Sharon Shepherd
 - Betsy Warnick
 - Divya Yalgoori
- **Other Attendees**
 - None