

# Committee Update

*Ryutaro Hirose, MD*

*Liver and Intestinal Organ Transplantation Committee*

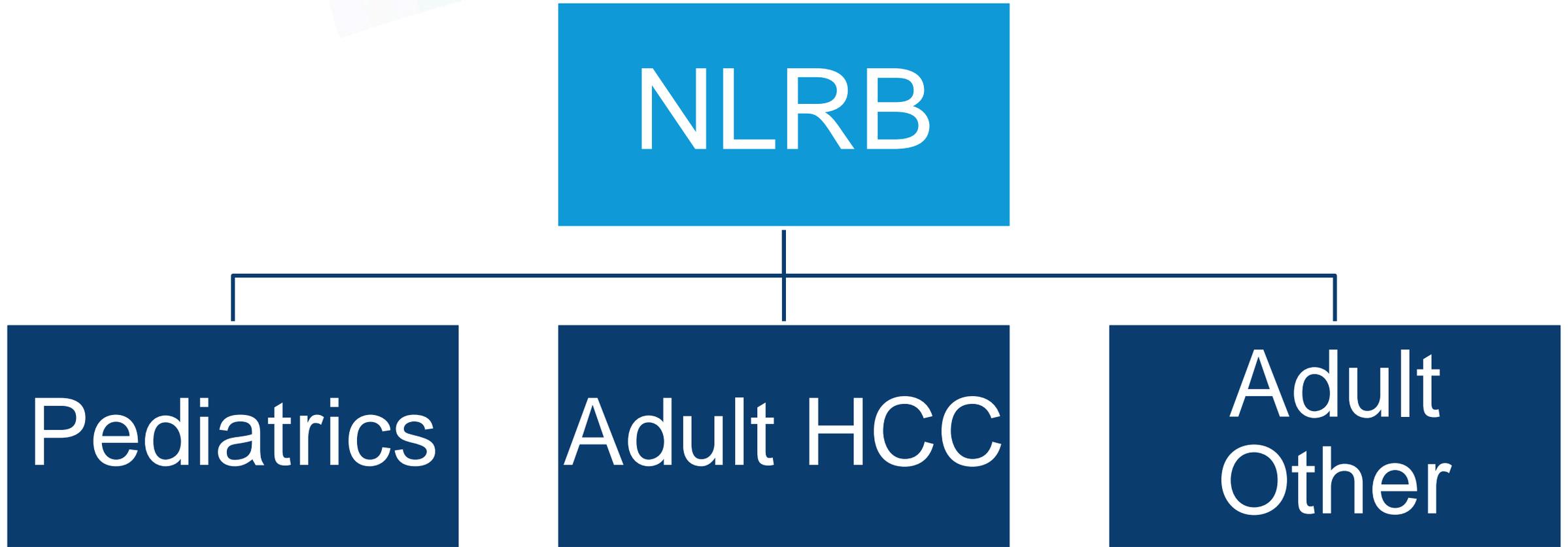
*Board of Directors Meeting*

*December 1-2 2015*

# Priority Projects

- National Liver Review Board (NLRB)
- Redistricting

# Proposed Structure



# Increase Consistency and Equity

- Every active program can be represented
- Term is one year with option to extend
- Cases are randomly assigned and require supermajority for approval
- Required yearly training for all members
- Committee develops guidelines for most common types of non-standard exceptions and pediatrics

# Increase Efficiency

- Automate six standard MELD exceptions
- Allow the NLRB to return a candidate who meets standard exception criteria but misses an extension deadline to auto-approval

# Continued Development

- Revise the initial MELD score and three-month elevator for standard exceptions
- Revise HCC policy: (new project pending approval)
  1. Not eligible for exception points:
    - Single tumor, 2-3 cm, completely ablated, unless evidence of recurrence (no need for transplant)
    - AFP >1,000, unless reduced to below 500 (high risk for recurrence)
  2. Expand standard criteria to include candidates that meet specific downstaging criteria
    - To match practice, evidence for equivalent results

# Redistricting

# Requests

- Based on feedback received at June 2015 Forum
- **October 2015:** Additional analysis to determine impact of MELD/PELD exceptions on previously modeled scenarios
- **Spring 2016:** Model 500-mile concentric circle distribution based on donor hospital location
  - Proximity points for local candidates at radii of 150 and 250 miles

# Optimization

Based on 3 things:

1. Number of donors recovered in each DSA (actual data)
2. Number and match MELD of candidates in each DSA (actual data)
3. Constraints determined by the Committee

When the Committee chooses another disparity metric, the maps do not change.

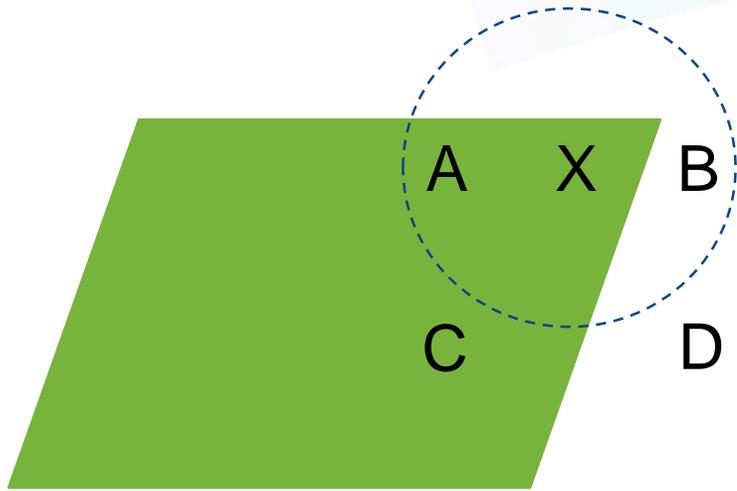
# Constraints

No new optimization performed, same constraints:

- Contiguous-DSA districts
- Between 4 and 8 districts
- Minimum of 6 transplant centers in any district
- Waitlist deaths cannot increase
- Maximum average travel time of 5 hours

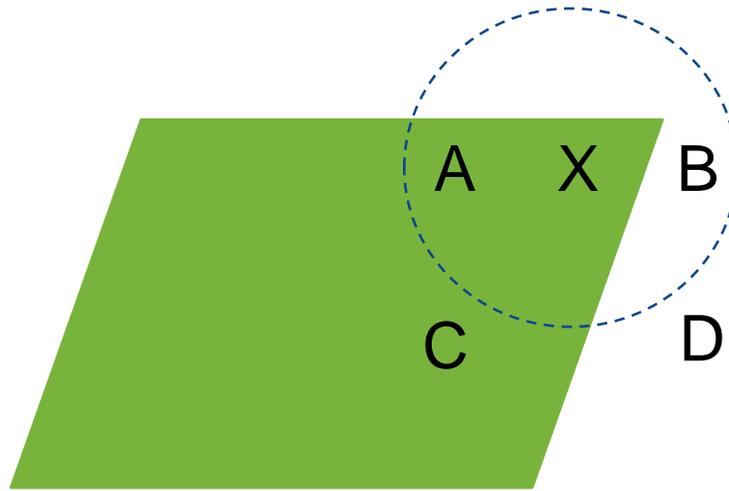
# In District vs. Out District Scenarios

In District



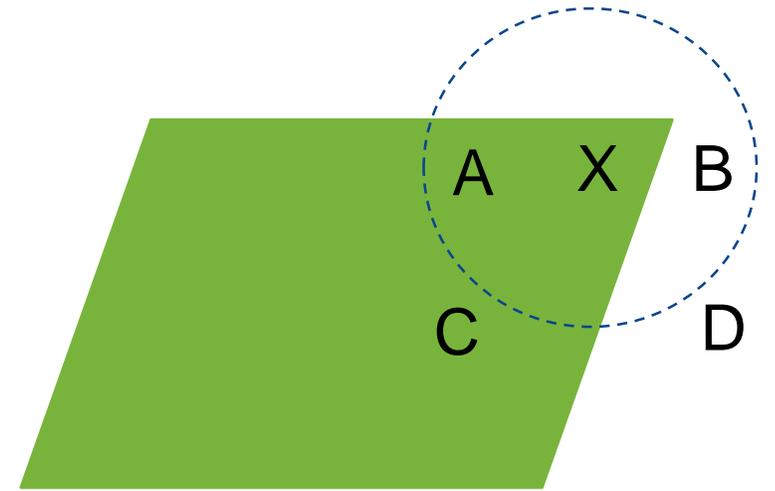
Rectangle: District  
Circle: Proximity Radius  
X: Donor Center  
A-D: Transplant Centers

In District



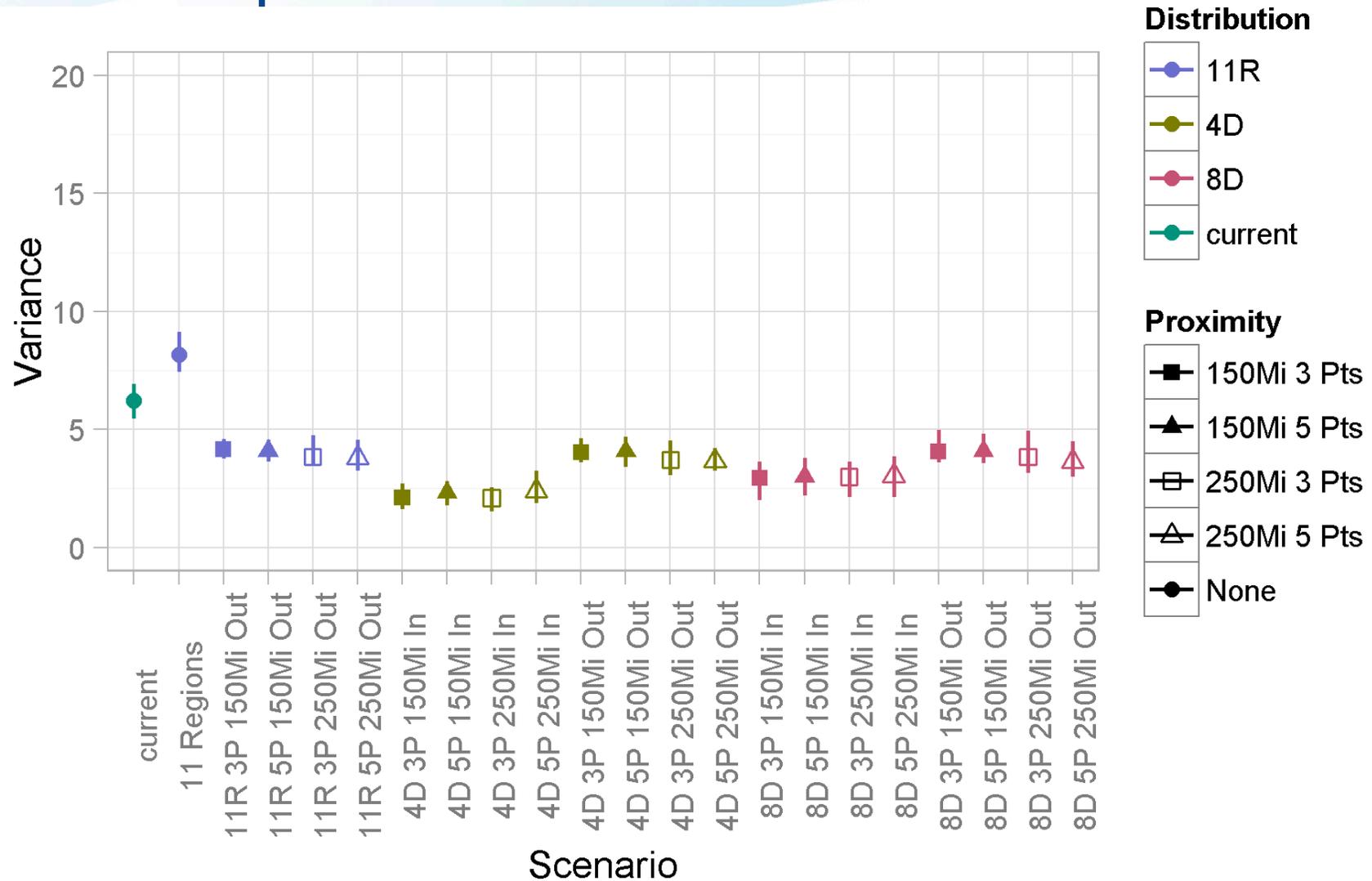
Allocation Groupings:  
1. A+C (A has points)  
2. B+D (B has points)

Out District

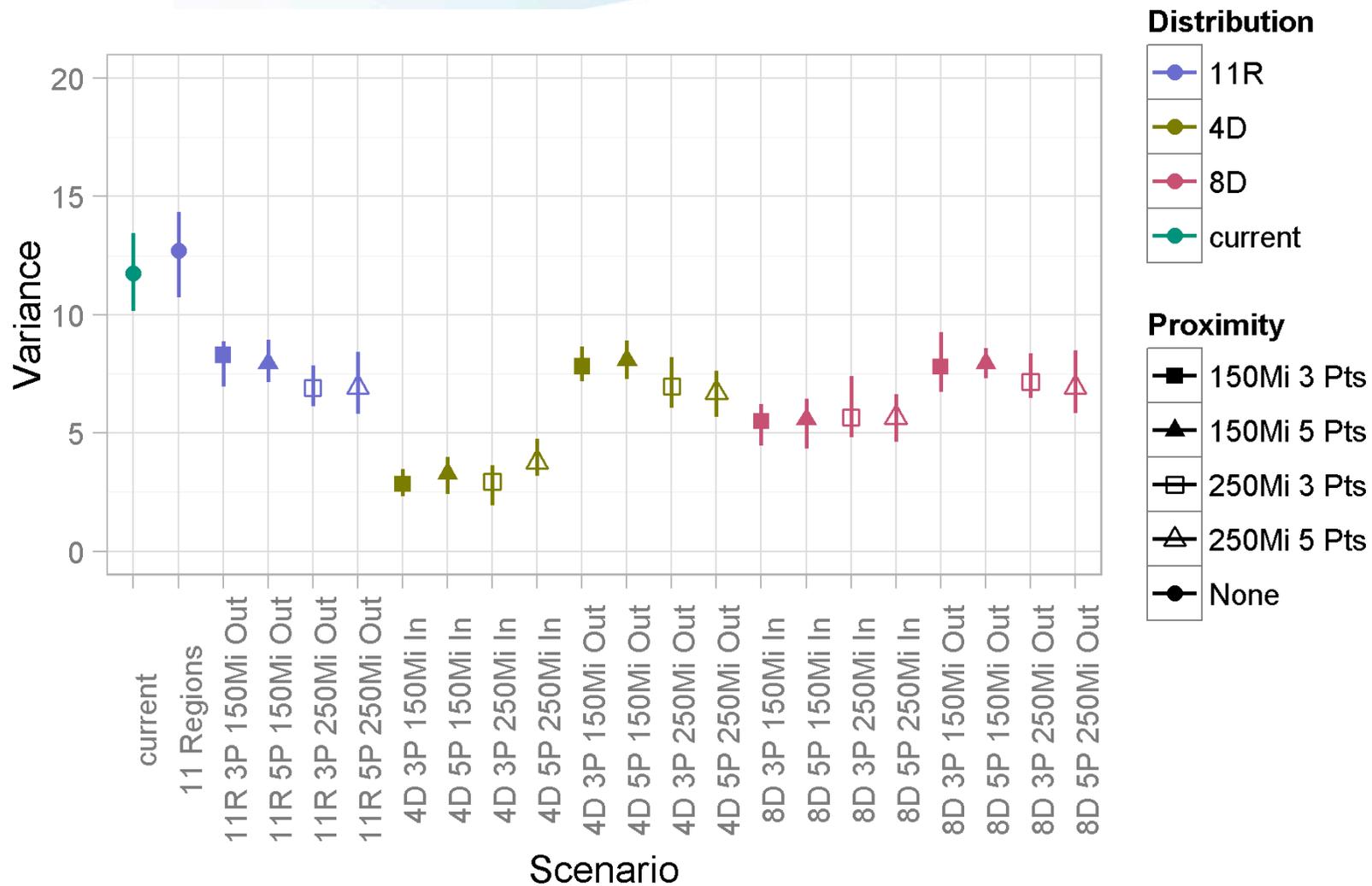


Allocation Groupings:  
1. A+B+C (A, B have points)  
2. D

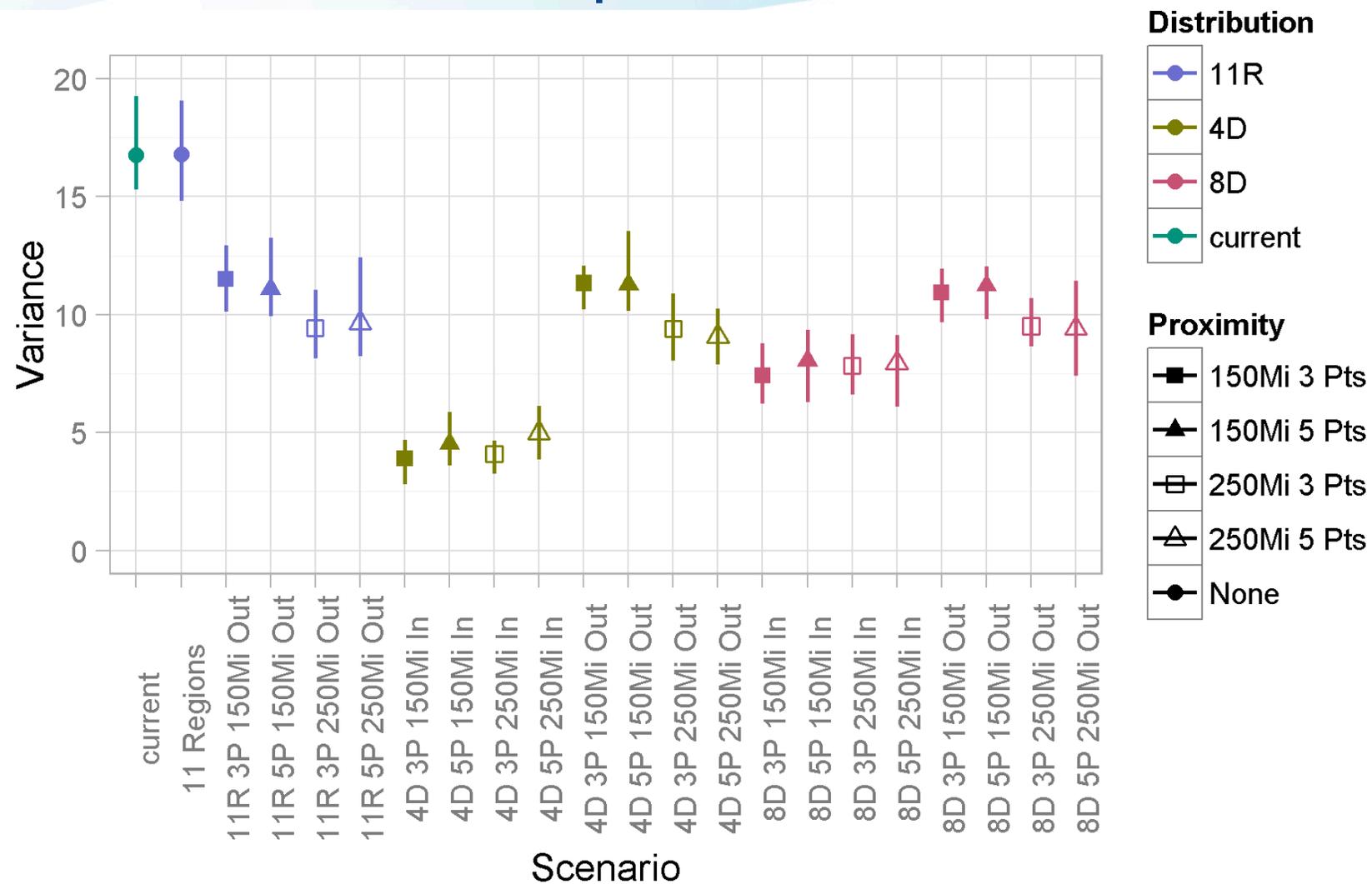
# Variance in Median Allocation MELD/PELD at Transplant by DSA, All Transplants



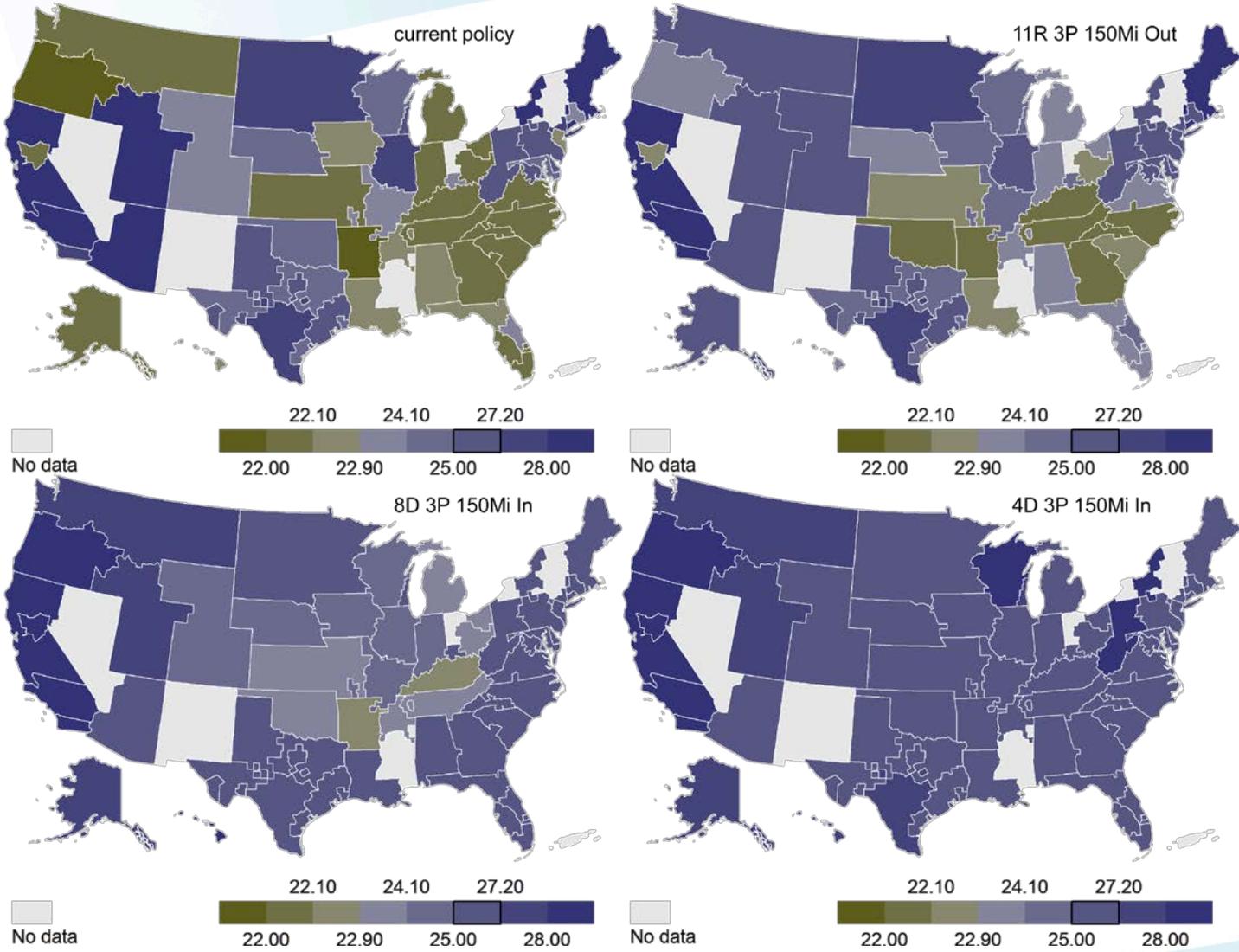
# Variance in Median Allocation MELD/PELD at Transplant by DSA, Recipients with No HCC Exception Points



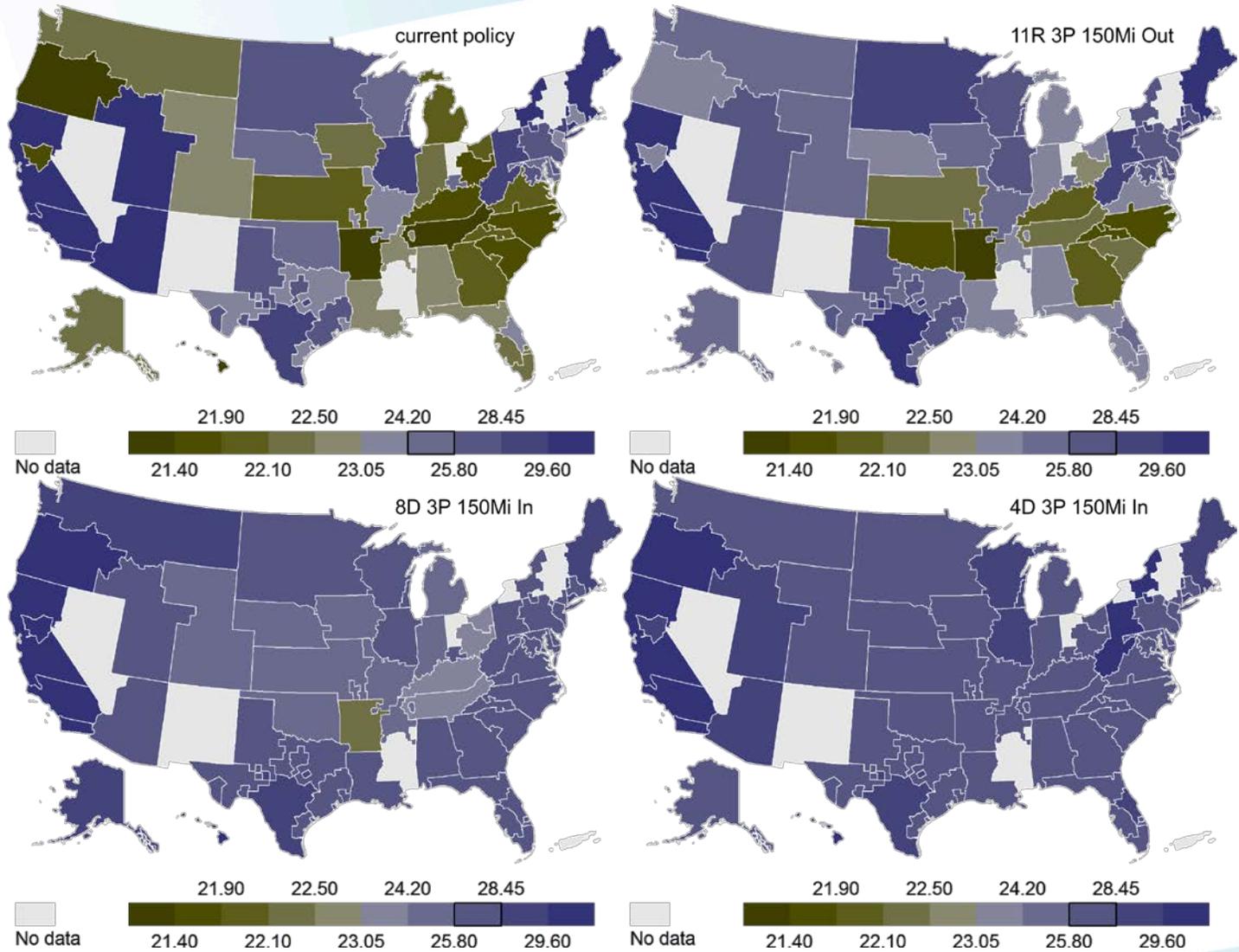
# Variance in Median MELD/PELD at Transplant by DSA, Recipients with No Exception Points



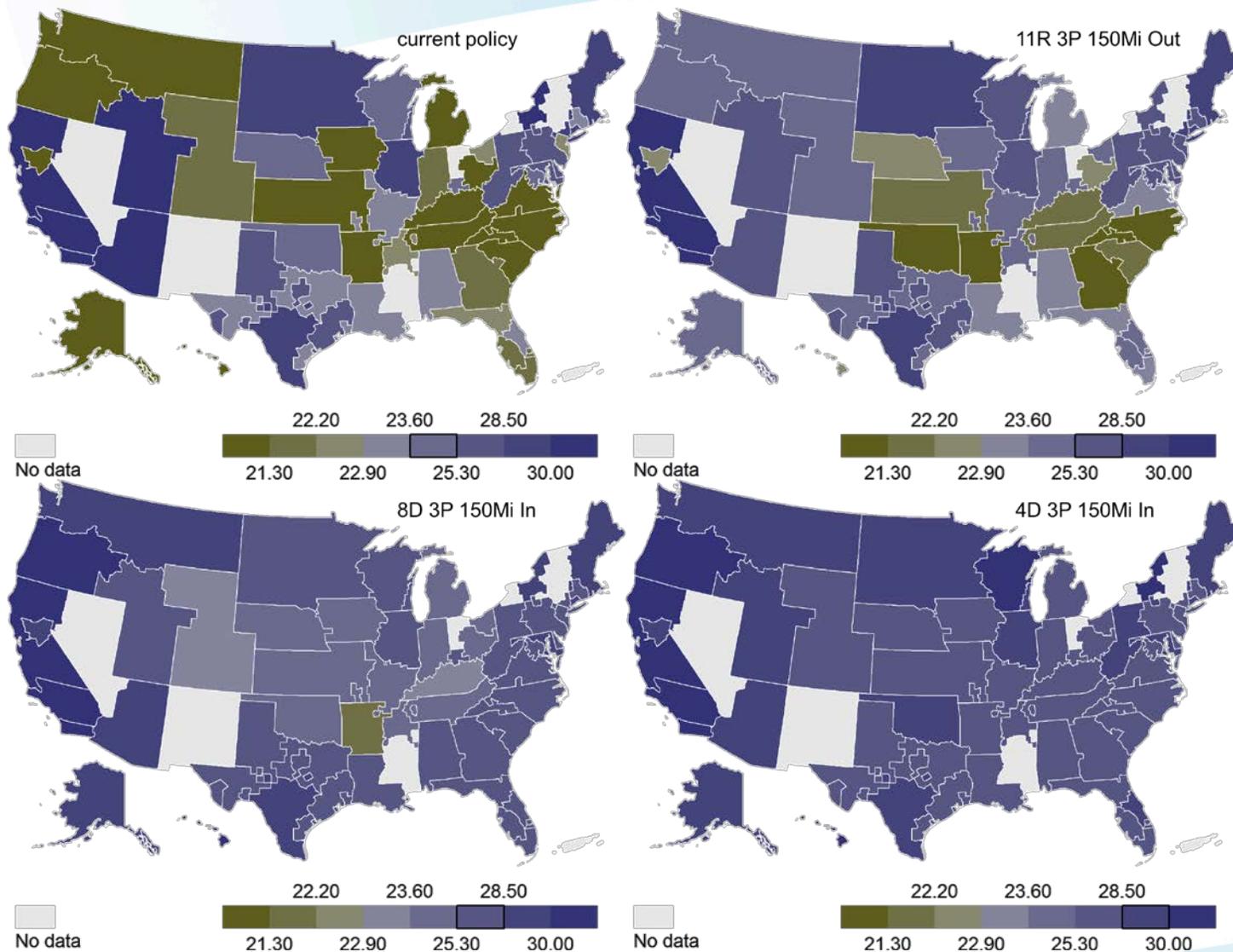
# Geographic Variation in Median Allocation MELD/PELD at Transplant by DSA, All Transplants



# Geographic Variation in Median Allocation MELD/PELD at Transplant by DSA, Recipients with No HCC Exceptions



# Geographic Variation in Median MELD/PELD at Transplant by DSA, Recipients with No Exception Points



# Results

- Distribution becomes more equitable as number of districts decreases
- Recipients without HCC exception points: variation decreases but remains higher for most scenarios
- Recipients with no exception points: variation highest of all, decreases in all scenarios
- 4-district scenarios offer largest reduction in variance, but 8-district also improvement over current policy

# Questions?

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