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

NLRB

- Pediatrics
- Adult HCC
- Adult Other
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

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

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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