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Important facts about organ donation and OPO performance

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To the Editor

We read the editorial by Massie and Roberts with interest but feel it's important to respond to several inaccuracies related to donation and OPO performance.[1] They state, "*… improvement in OPO performance is a worthy goal and tens of millions of dollars and tremendous societal effort has been expended to improve performance…*".[1] The HRSA-sponsored Organ Donor Breakthrough Collaborative, the most successful effort to improve OPO performance, received only $2–4 million dollars/year from 2003–2007. Investment in research to understand and develop better evidence-based approaches to OPO performance has been modest. From 1999–2014, HRSA awarded 96 grants for organ donation research through the Social and Behavioral Interventions to Increase Organ Donation Grant Program, of which only 17 (17.7%) focused on developing interventions to improve organ identification and authorization (https://organdonor.gov/dtcp/behavior.html). These small investments in research, relative to other areas of transplant, may help explain the marked geographic differences in organ donation rates.[2,3]

The authors comment, *"…sowing FUD about relative OPO performance is popular. It is proposed that poor OPO performance is the cause of the geographic disparity…relying on improved OPO performance alone is not reasonable. Opponents warn against 'rewarding poor-performing OPOs.'"*[1] This statement is misleading as it only reflects data from select publications, without citing published data showing that geographic differences in donation are a major contributor to differences in access to transplant. Furthermore, the data referenced by the authors used the performance metric of 'eligible death conversion rates'[4], a metric leaders of the OPO community and UNOS have stated is a poor metric based on an inaccurate measure of the donor potential.[5] To address this question, we evaluated State Inpatient Databases from 45 states (49/58 DSAs) from 2012–2014 using validated methods.[2] We demonstrate that while many DSAs have the potential for considerable improvements in

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donation, those areas with the greatest potential gains with improved organ donation are the largest metropolitan areas (New York, San Francisco, and Los Angeles; Figures 1a and 1b). This reveals that focusing on improving donation rates would increase the number of available livers to a far greater degree for the regions of the country with the greatest potential "need," without harming patients in areas from which livers are removed to supplement these areas.

Lastly, the authors remark, "*But by failing to act, the transplant community punishes not OPOs themselves, but dying patients who have the misfortune to live in the wrong place.*" Redistricting has focused on allocation MELD score, not mortality. Regions 7 and 9 have the greatest increase in transplants under redistricting, yet have lower waitlist mortality rates for patients with a MELD of 25–40, per SRTR data, than Regions 2 and 10. Finally, the responsibility for organ donation rests not just with OPOs, but the entire DSA that includes patients, providers, and the entire community. OPO Boards of Directors include transplant physicians and local community members. To state that focusing on donation is centered solely on OPOs oversimplifies the complex system of donation and minimizes the contributions of those who dedicate their careers to increasing organ donation.

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References

1. Massie AB, Roberts JP. Geographic Disparity in Liver Allocation: Time to Act or Have Others Act for us. Transplantation. 2017 IN PRESS.
2. Goldberg D, Kallan MJ, Fu L, et al. Changing Metrics of Organ Procurement Organization Performance in Order to Increase Organ Donation Rates in the United States. Am J Transplant. 2017; 17(12):3183–3192. [PubMed: 28726327]
3. Goldberg DS, French B, Abt PL, Gilroy RK. Increasing the Number of Organ Transplants in the United States by Optimizing Donor Authorization Rates. Am J Transplant. 2015; 15(8):2117–2125. [PubMed: 26031323]
4. Gentry SE, Chow EK, Massie A, et al. Liver sharing and organ procurement organization performance under redistricted allocation. Liver Transpl. 2015; 21(8):1031–1039. [PubMed: 25990089]
5. Luskin R, Nathan H. Eligible Death Statistic: Not a True Measure of OPO Performance nor the Potential to Increase Transplantation. Am J Transplant. 2015; 15(8):2019–2020. [PubMed: 26031199]

Figure 1a

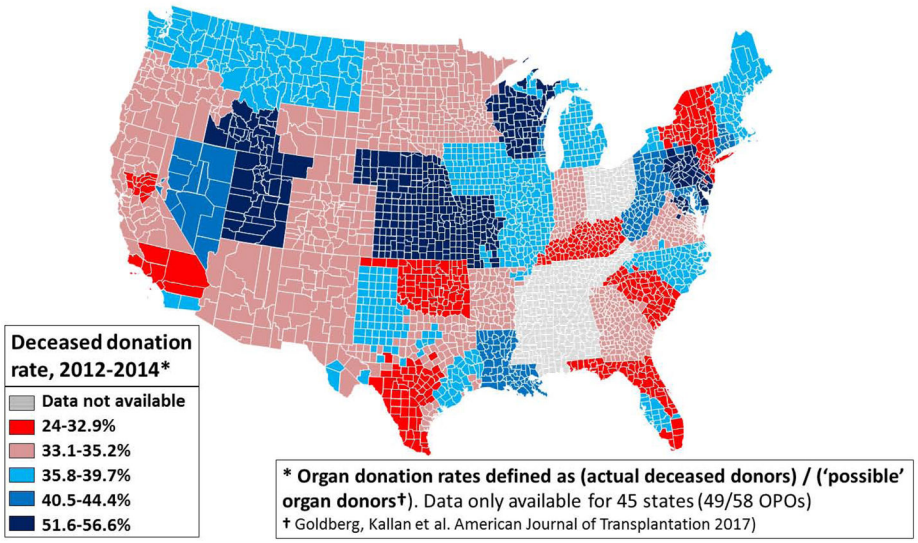

Figure 1b

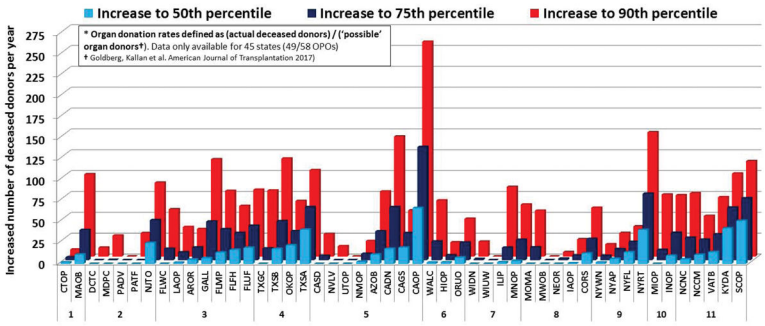

Figure 1.

Figure 1a-Organ donation rates per donor service area using administrative data based on the denominator of 'potential donors'

Figure 1b-Number of potential increased deceased donors per year with maximized DSA-level donation rates