CATEGORY 4
STRATEGY/MARKETING/LEADERSHIP

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UNOS TRANSPLANT MANAGEMENT FORUM

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Organization:
Hackensack University Medical Center

Award Category:
Strategy/Marketing/Leadership

Title:
With the New Allocation Change, Should Transplant Centers Start Pumping Kidneys?

Primary Author/Credentials/Organization/City/State:
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Problem/Situation: The new UNOS kidney allocation changes effective December 2020 will be removing the geographic limits of donation service areas (DSA) and UNOS regions favoring a zone of 250 nautical miles (NM) from the donor hospital for kidney allocation. Transplant centers with low median waiting times will have access to fewer deceased donor kidneys (DDK) compared to transplant centers in neighboring DSAs with longer waiting times. In our case, instead of sharing the local organ donor pool with 3 local centers, a 250 NM radius will include over 25 centers from different regions with larger and more mature waiting lists. This change will dramatically reduce locally allocated organs and broaden the sharing distance of lifesaving DDKs for our patients. In order to mitigate the risk of prolonged cold ischemic time (CIT) and to increase utilization of nationally shared kidneys, our transplant center developed a hospital-based machine preservation center utilizing hypothermic machine perfusion (HMP) in January of 2020. Implementation of HMP allowed improved evaluation of organs with higher KDPI and increased acceptance of kidneys with longer CIT. It is likely that organ procurement organizations (OPO) might be less inclined to provide HMP with broader sharing of kidneys, making hospital access to HMP more vital. To our knowledge, only five centers in the nation utilize hospital-based HMP.

Methods/Practices/Interventions: A retrospective study compared characteristics and immediate outcomes of two groups of DDKs transplanted between January through October 2020: 1) DDKs preserved with cold storage technique (CST) **(**N=32) and 2) DDKs preserved using HMP (N=66). After organ evaluation on HMP, due to the higher machine-measured renal resistance and biopsy results, 12 (18.18%) of HMP preserved kidneys were discarded and excluded from the study leaving this cohort with 54 kidneys.

Findings/Solutions/Conclusions: Despite having a higher non-local share, a higher mean donor age, a higher median cold ischemic time (CIT), and a higher DCD rate), patients that received HMP kidneys have a significantly lower delayed graft function (DGF) and shorter median length of stay (LOS) (4 vs. 5 days) compared to patients that received DDKs preserved with CST ($p<0.01$). No kidney in either cohort had primary non-function.

Implications/Relevance: HMP allowed us to get better access to non-local DDKs as it expanded our ability to evaluate nationally allocated kidneys that were locally declined, improved organ flush characteristics, alleviated risk of prolonged CIT while optimizing kidney function, and improved organ utilization. Other benefits included reduced hospital costs due to reduced LOS and DGF as well as transplanting patients faster and thus decreasing waitlist mortality and disease progression. Our current discard rate of kidneys evaluated through HMP is at 18.18% (12/66) suggesting we have the potential to be even more aggressively evaluating DDKs.

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References:

1. I. Jochmans et al. The Prognostic Value of Renal Resistance During Hypothermic Machine Perfusion of Deceased Donor Kidneys. American Journal of Transplantation 2011; 11: 2214–2220
2.Y. Yushkov et al. Identifying risk factors in renal allografts before transplant: machine-measured renal resistance and posttransplant allograft survival. Progress in Transplantation, Vol 22, No. 2, June 2012

Figures/Charts/Tables:

Figure 1:DDK Characteristics CST vs. HMP

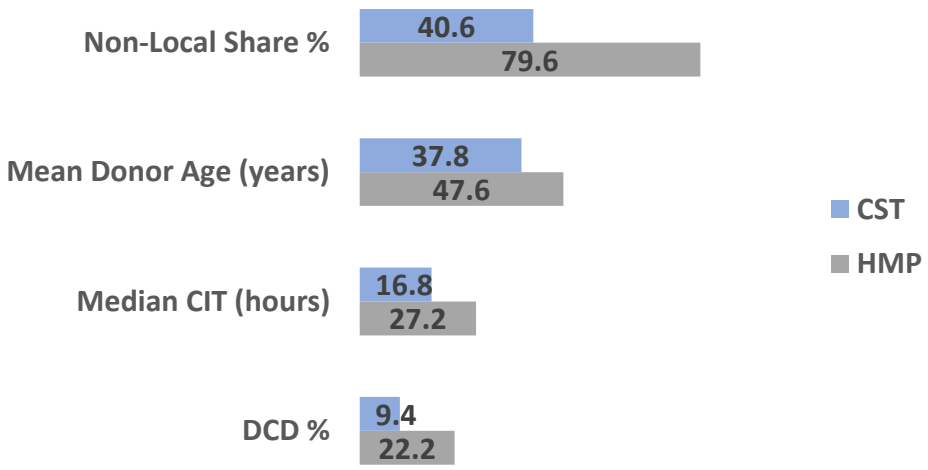
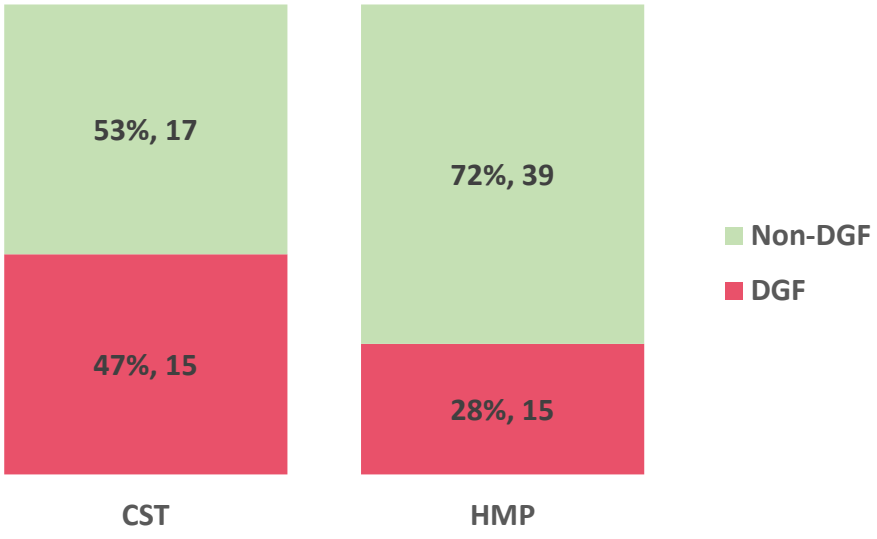


Figure 2: DGF rate (Percent, Number of Cases) CST vs. HMP



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Title:
Have You Been Leveraging the Power Of Your ESRD Network?

Primary Author/Credentials/Organization/City/State:
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Problem/Situation: What does the End State Renal Disease (ESRD) Network do? How can the ESRD Network help with kidney transplant program needs? If you are unsure of these two questions, this presentation will showcase one transplant program's fruitful collaboration with its regional ESRD network. There are 18 ESRD Networks in the United States, each overseeing its own state(s) and territories to work toward improving the quality of care provided to patients with renal disease. While one key role of the networks is to help CMS understand the needs of dialysis patients, they also collaborate with dialysis and transplant centers to optimize care.

Methods/Practices/Interventions: At our center we routinely send the ESRD network monthly transplant data and a yearly summary report. In recent years, this one-way reporting structure transformed into a more collaborative partnership. We started using our network to disseminate information regarding bi-annual symposium to regional dialysis centers. In addition, virtual Grand Rounds invitations are shared with dialysis center personal within the ESRD network. The goal is to increase knowledge on kidney and pancreas transplant in the dialysis community and emphasize the ways patients can benefit from this type of treatment option. We also circulate patient centered videos to social workers within the network and encourage that these are shared with patients. Together we created customized monthly reports with maps to better understand dialysis center patient potential. Our last joint project was the automation of 2728 forms required for pre-emptive patients to obtain Medicare benefits post-transplant.

Findings/Solutions/Conclusions: In our state there are currently 204 active dialysis units. Through the information provided by our network we were able to identify new opportunities for referrals from dialysis centers, adapt our outreach strategy, and increase the number of dialysis centers where we have gotten referrals from by 18% in 2020 despite COVID-19. In addition, we were able to improve our 2728 pre-emptive signup compliance to 100% and ensuring all our patients receive Medicare benefits post-transplant. Our ESRD network also customized their reports to include dialysis center medical director contact information which we use for letting them know once we transplanted their patients to improve awareness and collaboration as well as to ensure sustainability of recurring referrals and joint treatment plans.

Implications/Relevance: Collaboration with your ESRD network cannot only help your transplant center, but also improve your relationships with dialysis centers and ultimately provide better transplant access to your community. Network collaboration should not be limited to state borders and we found working with ESRD networks in neighboring states increased our reach and allowed us to help more patients with kidney disease.

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Award Category:
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Title:
TRANSPLANT OPPORTUNITIES ON A LARGER SCALE: OFFERING HOPE TO PATIENTS WITH A HIGH BODY MASS INDEX

Primary Author/Credentials/Organization/City/State:
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Problem/Situation:

Patients who otherwise would be good candidates for transplant are often denied transplant evaluation due to body mass index (BMI) selection criteria standards. Our program identified a need in our market to re-evaluate our selection criteria in order to provide hope for patients who find themselves over the BMI threshold of 36. We collaborated with a bariatric surgery team to provide an opportunity for these patients to potentially be evaluated, listed and ultimately receive a lifesaving kidney transplant.

Methods/Practices/Interventions:

In 2017, the transplant team made the decision to welcome patients with a BMI of 36 and higher into our program in order to have their weight and stature assessed. This was done with the goal of collaborating with these patients to assist them in becoming acceptable transplant candidates. High BMI patients were first scheduled for consults with the transplant surgeon and registered dietitian (RD) to evaluate the patient's weight distribution, abdominal circumference, and weight history. The surgeon, RD and patient then agreed on a plan to address patient's weight status that would best fit their lifestyle and provide the opportunity to progress through our program. In order to achieve this goal, one of 3 paths would be followed: 1) the patient's weight was not prohibitive and they could immediately move forward with transplant evaluation 2) an achievable weight loss goal was set or 3) the patient was given a referral to the bariatric team. During this visit, the transplant team also provided education for the patient on the importance of weight management and decreasing BMI prior to transplantation and for post-transplant success. This process allowed patients to have an achievable path to transplant when they otherwise would likely not have been considered for evaluation.

Findings/Solutions/Conclusions:

A review of the transplant program's data during 2017-2019 allowed 392 patients with a BMI greater than 36 to be surgically evaluated. Of the 392 patients, 36 (9.1%) patient applications were ultimately closed due to high BMI/weight status and 117 (29.84%) patient applications were closed due to reasons not related to their BMI. Currently, we have 160 (40.8%) high BMI candidates being evaluated for kidney transplant listing and 48 (12.2%) high BMI patients were waitlisted. Of the 48 patients waitlisted, 12 had bariatric surgery, 11 lost weight on their own and 25 patients did not have a weight that was prohibitive for transplant. Our transplant team transplanted 31 (7.9%) patients: 6 of which received bariatric surgery, 8 patients lost weight on their own, and 17 patients had a weight that was not prohibitive for transplant. Furthermore, our outcomes with the high BMI patients have been excellent. Out of the 31 patients transplanted with a BMI of 36 or higher, we experienced only 2 1-year graft failures and there were no graft failures in the patients with a BMI of 40 or greater.

Implications/Relevance:

Our transplant program saw an opportunity to increase the number of patients to whom we were able to offer transplant evaluation and in turn, increase referrals to our bariatric partners. By accepting patients with high BMI's, our program accepted almost 400 additional referrals over a 3-year period and 61% of those have either been transplanted or are currently active in the process. Expanding our criteria made us the only program in the area willing to see patients with a high BMI. Despite having a BMI over 36, over 50% of the patients referred had a weight that did not preclude them from evaluation, proving that BMI alone should not be an exclusion criteria. In summary, excluding patients for transplant evaluation based on high BMI limits the transplant center's ability to grow, and excludes a viable patient population.

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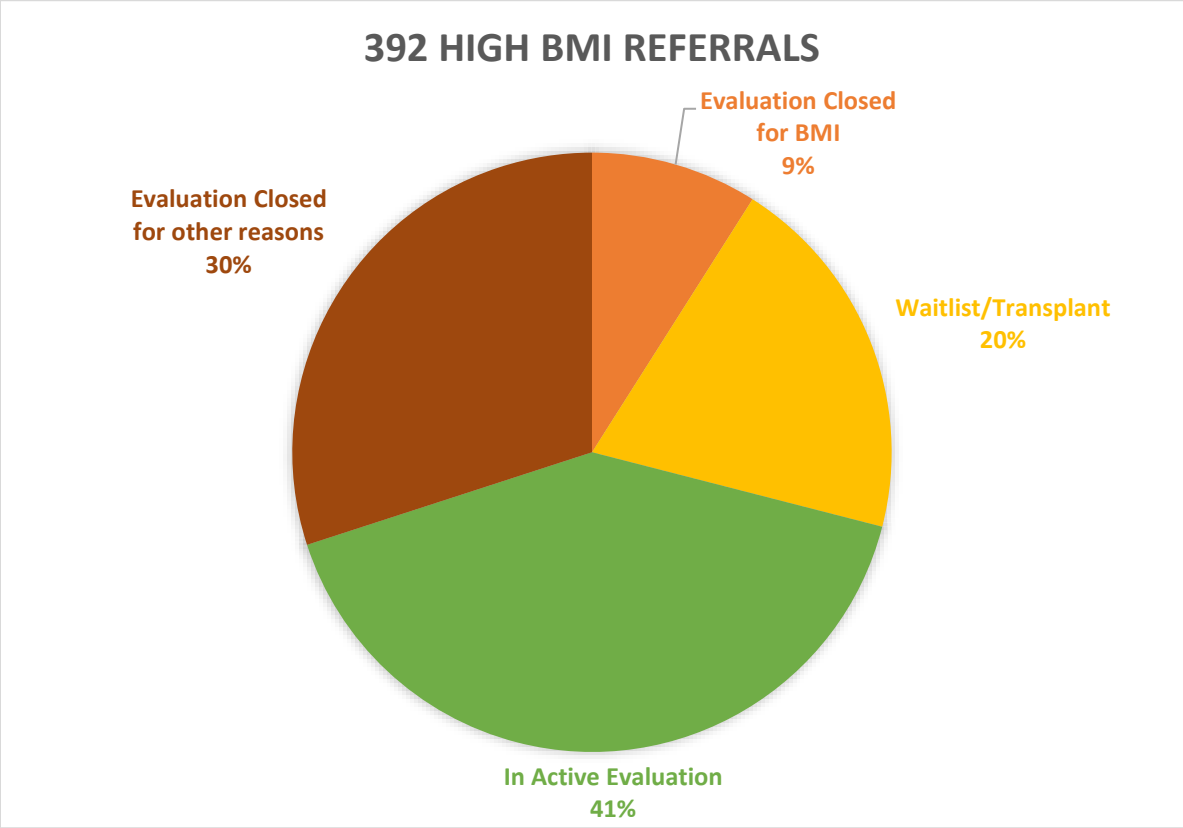
Figures/Charts/Tables:

Figure 1: High BMI Referrals



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Award Category:
Strategy/Marketing/Leadership

Title: Strategic Approach to Increasing Health System Marketing Department Paid Advertising Support for Organ Transplant Center

Primary Author/Credentials/Organization/City/State:
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Problem/Situation: Gain health system marketing department support through comprehensive, formal advertising campaign to increase transplant center brand awareness in key markets, showcasing its living donor, heart, kidney and liver transplant programs. The center had not attained this level of support in several years.

Methods/Practices/Interventions: Transplant center leadership identified opportunity for greater brand and service awareness regionally. A multifaceted strategy was used to engage internal stakeholders to elevate the transplant center, including health system marketing leadership. This approach included:

- Strategic content development
    - Create the content to elevate our center
- Cultivating engagement opportunities
    - Have a seat at the table
- Providing relevant news and updates
    - The right information to drive marketing department decision making

Content Development

The transplant center aimed to produce two feature stories a month to continually showcase the success of our transplant center. This content consisted of written stories, photographs and videos. Most of this content included transplant patient stories, which were shared with internal and external transplant center stakeholders via health system communications channels. These stories were amplified via the transplant center's own communications channels. The language and emotional appeal of the content also helped educate leaders and demystify the world of organ transplantation while showcasing living organ donation and our successes and innovations. This content was crafted and published consistently and strategically to build the necessary "buzz" with these constituencies, among others. This multichannel work was supported by numerous national and local news stories that highlighted the center, patients, and staff.

Engagement Opportunities

Concurrently, the center – through its PR, Marketing and Strategy (PR,M&S) Manager– engaged communications staff and leaders by selecting and attending weekly, biweekly and monthly department meetings in the areas of marketing, public relations and executive communications to provide necessary information. This informed the manager to greater marketing operations and provided forums for the sharing of transplant center updates and information.

Providing Relevant Information

In these settings, the manager worked to strategically engage various teams through newsworthy updates while explaining the process of organ transplantation, procurement and living donation. This process increased interest and engagement of transplantation with the marketing team. Information important to marketers was consistently relayed to help drive decision making, including volume updates, regional and national rankings, access, capacity, new innovations, operational updates, communications needs and need for a brand awareness campaign. The center's PR,M&S manager worked with its leadership to report relevant transplant volume and ranking updates to health system marketing and communications leaders on a routine basis.

Findings/Solutions/Conclusions: These engagement techniques coupled with the success of the center, and aided by their consistency, elevated the transplant center within the health system. This work resulted in the engagement of the health system's advertising agency of record to develop a comprehensive transplant center brand awareness campaign. Published content helped establish the tone and messaging of the campaign, with a concept that relays the center's compassionate care and outstanding outcomes. Education with marketers continued to develop a campaign by organ type and geographic area. The campaign, set to begin in 2021, is anticipated to garner more than 30 million impressions. Advertising breakdown by media spend includes, 24% out of home and 21% broadcast advertising. Other areas include digital advertising. Advertising elements will be leveraged through additional communications channels, such as newsletters, websites and social media following the marketing campaign's launch. The campaign and the development of advertisements is subsidized by the health system marketing department. Additional marketing efforts are ongoing and expected.

Implications/Relevance: Many centers rely on centralized health system marketing departments for campaign development and support. However, these departments often support all centers and service lines in a health system, creating a long list of parties positioning for limited advertising dollars and bandwidth. This submission aims to educate and support other transplant centers in

need of additional marketing support and campaigns. This work not only benefits individual centers, but it also helps raise overall consumer awareness of transplantation and living donation. The authors believe this work represents leadership in the area of marketing and branding through a consistent, strategic approach via advocacy and understanding of health system communications.

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References:

Citations:

Figures/Charts/Tables: Content created

Example of content created