SRC – AMS Meeting Minutes

Analytical Methods Subcommittee Teleconference

April 23, 2025; 10:00 AM – 12:30 PM CDT

Voting Members:
William Parker, MD, MSCP, PhD (co-chair) ('26)
Joel Adler, MD, MPH ('26)
Syed Ali Husain, MD, MPH, MA, FASN ('26)
Jonathan (JD) Daw, PhD ('27)
Erika Helgeson, PhD ('25)
William (Bill) Irish, PhD ('25)
Yong-Fang Kuo, PhD ('27)

Not in attendance:
Megan Neely, PhD ('25)

Ex-Officio:
Grace Lyden, PhD (SRTR staff co-chair)

Not in attendance:
Adriana Alvarez, MS (HRSA)
Brianna Doby, MPH (HRSA)
Shannon Dunne, JD (HRSA)
Sarah Laskey, PhD (HRSA)

SRTR Staff:
Avery Cook, MPH, MSW
Tonya Eberhard
Amy Ketterer
Maria Masotti, PhD
Jon Miller, PhD
Sydney Kletter Sharma
Jon Snyder, PhD, MS
Nicholas Wood, PhD
David Zaun, MS

Not in attendance:
Allyson Hart, MD, MS
Ryutaro Hirose, MD
Larry Hunsicker, MD, PhD
Roslyn Mannon, MD, FASN
Mona Shater, MA

Welcome and introductions

Co-chairs Dr. Grace Lyden and Dr. William Parker called the Analytical Methods Subcommittee (AMS) meeting to order and confirmed quorum had been met. Dr. JD Daw introduced himself as a new member; he shared his background as a sociologist, demographer, and associate professor at Penn State. The other committee members introduced themselves as well and provided brief backgrounds regarding their roles and connections to the AMS, while noting the high engagement, collegiality, and diverse perspectives of the current committee. Dr. Lyden reviewed the agenda and reminded members to keep their conflict-of-interest forms updated with any changes.

Nominating committee updates

Dr. Lyden discussed the upcoming departure of Dr. Erika Helgeson, Dr. Bill Irish, and Dr. Megan Neely, whose terms will run through December 2025, and thanked them for their service. She reviewed the nomination process to recruit replacements, with the nomination cycle beginning on May 1, 2025, and applications being accepted through July 2025. She shared that she and Dr. Parker would review submissions and make nominations to the Scientific Registry of Transplant Recipients (SRTR) Review Committee (SRC) Nominating Committee by September 2025, with final approval of new members in October 2025. New appointees would begin their terms in January 2026. Dr. Lyden stressed the importance of current AMS members helping to identify qualified candidates and encouraging applications from professionals who could contribute fresh perspectives and expertise.

Death after delisting

Dr. Maria Masotti provided follow-up to a discussion topic from the January meeting, in which she presented findings regarding unusually high survival rates among heart, liver, and lung candidates who had been delisted without receiving a transplant. These trends began around 2015 and were not explained by changes in candidate characteristics. After extensive internal analysis, SRTR hypothesizes there is a systemic issue with data quality, specifically with the completeness of delisting mortality data. SRTR has requested permission from the Health Resources and Services Administration (HRSA) to link SRTR data with the Centers for Disease Control and Prevention's (CDC's) National Death Index (NDI) to validate death records. Dr. Masotti also noted ongoing efforts to replicate these findings with the Organ Procurement and Transplantation Network (OPTN) through a formal data request and to submit results in a peer-reviewed manuscript. Dr. Daw discussed known issues with the Social Security Death Master File and how changes in federal data sharing policies may have affected death record completeness. Suggestions were made to explore the linkage with other datasets, such as the End-Stage Renal Disease (ESRD) Network for kidney patients and multiorgan transplant combinations, to further evaluate patterns. The committee agreed the issue was significant and warranted further investigation.

Update on multiorgan candidates in PSR pretransplant metrics

Dr. Lyden presented an update regarding the reporting of kidney-pancreas transplant candidates in SRTR program-specific reports (PSRs). Historically, kidney-pancreas candidates were included only in a stand-alone kidney-pancreas report and not in the corresponding kidney or pancreas program reports. This exclusion led to a lack of visibility in the metrics reviewed by the OPTN's Membership and Professional Standards Committee (MPSC), which uses kidney and pancreas reports for performance evaluation. Unlike with other multiorgan transplants such as heart-lung, which are counted in multiple organ-specific reports, kidney-pancreas candidates were omitted from single-organ pretransplant metrics, leading to inconsistency in reporting and oversight.

In response to recommendations from the AMS and the MPSC, SRTR has implemented a policy change that will now include kidney-pancreas candidates in both kidney and pancreas program reports. Starting with the spring 2025 reporting cycle, kidney-pancreas candidate data will be factored into pretransplant mortality and transplant rate metrics within the corresponding organ-specific reports at each transplant center. This harmonizes kidney-pancreas reporting with the approach used for other multiorgan transplants and ensures that all patient cohorts are reflected in evaluations that inform regulatory decisions and program monitoring. Dr. Lyden emphasized that this change resolves a gap in the system where pretransplant deaths among kidney-pancreas candidates were previously invisible to the MPSC's review processes.

Data analysis presented at the meeting demonstrated that this change will have minimal impact on kidney program metrics due to the large volume of kidney-alone candidates, but the change will significantly affect pancreas program metrics, where kidney-pancreas cases form a larger share of the candidate pool. Specifically, the inclusion of kidney-pancreas data introduces greater variability in tier assignments for pancreas programs, reflecting the increased sample size. While some pancreas programs may see shifts in rate ratios, the effect is not systematically positive or negative, and the change is seen as a step forward in data transparency and fairness. Committee members supported this approach; they affirmed that it enhances consistency across transplant reporting and improves public and regulatory confidence in SRTR metrics.

1-year posttransplant evaluations for programs with only 6 months of follow-up

Dr. Jon Miller led a discussion on the appropriateness of publishing 1-year posttransplant outcome metrics for new transplant programs that have not yet accrued a full year of follow-up data. He explained that under current SRTR method, programs with only 6 months of follow-up still receive a 1-year outcomes page in their PSR, which may be misleading. This occurs because patients who received transplant in the last 6 months of the cohort are censored at 182 days, as complete 1-year follow-up data from OPTN forms are not yet available. As a result, the 1-year survival estimate presented is not truly based on 1-year data but rather on limited follow-up, thus potentially misrepresenting program performance.

To address this, Dr. Miller proposed redacting the 1-year outcomes page from reports when a program has only 6 months of posttransplant data. These programs would still receive 1-month and 90-day outcomes and continue to contribute to national benchmarks. The redaction would apply both to new programs and to cases where pediatric or donor-type subsets (e.g., living vs. deceased) have limited data due to rare activity. Dr. Joel Adler discussed the implications of this change, especially for Centers for Medicare & Medicaid Services (CMS) certification processes, which rely on SRTR reports. There was general consensus that publishing extrapolated or incomplete 1-year metrics could be misleading for regulators and the public.

The committee acknowledged that although this situation affects a small number of reports (17 out of approximately 1,200 in the current cycle), this proposal improves accuracy and transparency. Members emphasized that this approach avoids misinterpretation of performance in early-stage programs and aligns more closely with statistical best practices. Dr. Adler reviewed CMS requirements and reinforced the importance of having a full year of follow-up for legitimate 1-year evaluations. A vote was proposed to the committee regarding their support of SRTR's proposal for redacting 1-year outcome tables and figures for centers that only have a maximum of 6 months of follow-up for the transplants they performed. Dr. Parker motioned for a vote, which was seconded by Dr. Syed Ali Husain. The vote was unanimously supported, with Dr. Yong-Fang Kuo being the only abstention. The redaction will take effect with the spring 2025 reporting cycle, and SRTR will ensure clear communication about redacted sections in affected reports.

Publication of tiers for programs with no recent transplants

Dr. Lyden introduced a discussion on inconsistencies in how SRTR displays tier ratings for transplant programs with extremely limited data, particularly in cases where no transplants were performed during the most recent year. She said the issue came to light through a complaint from Lurie Children's Hospital of Chicago, which noted that the University of Chicago, a center without a pediatric heart transplant program, was still being ranked and shown with tier ratings on SRTR's public search page. Although the University of Chicago had no recent pediatric heart transplants, they had one candidate who contributed minimally to the metrics, which resulted in tier assignments being shown on the search results page. However, the SRTR website is inconsistent; when a user clicks through to the detailed program page for the University of Chicago and selects pediatrics, the page says "no pediatric heart transplants performed" and tier assignments are not shown. Lurie Children's Hospital was concerned this could create confusion for patients.

Dr. Lyden walked the committee through how tier ratings are currently displayed on different SRTR pages and illustrated that inconsistency arises because the search page shows tiers for programs with any evaluable data, even if the volume is minimal, while the detailed program page suppresses tier scores when no transplants have been performed in the most recent year. In the University of Chicago example, the pretransplant tier rating was derived from just 3 days of candidate person-time and one transplant event, which resulted in a tier placement on the search page (Tier 3) despite the limited underlying data.

The AMS agreed that tier ratings based on such minimal data should not be publicly displayed, as they lack meaningful interpretability. Drs. Husain, Adler, and Irish supported a proposal to suppress tier visibility for programs when data volume falls below a meaningful threshold, such as when there are zero transplants or minimal candidate time. Members agreed the SRTR should standardize tier display behavior across the SRTR website. The committee proposed gathering input from the Patient and Family Affairs Subcommittee (PFAS) as a next step.

Historical priors for Bayesian program evaluations

Dr. Lyden revisited a presentation from the January meeting regarding the potential use of historical priors in Bayesian program evaluation, which would allow a transplant program's past performance to influence its current evaluation. The idea stems from the Bayesian framework that SRTR already uses to estimate program metrics like transplant rate and pretransplant mortality, where rate ratios are "shrunk" toward national expectations. Dr. Lyden reiterated the question as to whether a program's most recent nonoverlapping evaluation should serve as the "prior" distribution for the next cycle, rather than relying solely on the national average.

The committee engaged in a thoughtful discussion about the implications of such an approach. Dr. Lyden shared simulations for programs that were improving, worsening, or performing consistently over time, for both small and large programs. Dr. Wood pointed out that under the current methodology, small programs tend to fall in the middle, neither Tier 1 nor Tier 5. Dr. Parker raised the benefit that incorporating a program's own historical performance might improve identification of underperforming small programs and allow small programs that are doing well to jump into higher tiers. Dr. Parker also recommended consulting the MPSC to determine their preferences in the trade-off between reviewing too many programs unnecessarily versus failing to flag a poor-performing program. Dr. Daw and Dr. Adler agreed with this sentiment. Dr. Daw highlighted the perspective that one poor-performing year for an otherwise high-performing program could be regression to the mean or could be due to meaningful factors like practices, leadership, physicians, surgeons or staff, and he likewise cautioned against making this decision based on methodology alone. Dr. Daw also raised questions about how far back the historical data should go, whether a decaying weight with time would be appropriate, and what happens when a program changes in size substantially over time.

While no formal vote was taken on this conceptual topic, the members found it to be a compelling direction for future methodological exploration. The conversation closed with agreement that the thoughtful incorporation of historical information remains a topic worth revisiting in future AMS discussions.

Closing business

Drs. Lyden and Parker thanked members for their thoughtful discussion and voting participation. With no other business being heard, the meeting concluded. The next AMS meeting is scheduled for July 22, 2025, 10:00 AM–12:30 PM CDT.