OPTN Organ Procurement Organization Committee
Organ Offer Acceptance Limit Workgroup
Meeting Summary
November 9, 2022
Conference Call

David Marshman, CPTC, BS, Chair

Introduction

The Organ Offer Acceptance Limit Workgroup ("Workgroup") met via Citrix GoToMeeting teleconference on 11/09/2022 to discuss the following agenda items:

1. Project Purpose
2. Background
3. Data Request

The following is a summary of the Workgroup's discussions.

1. Project Purpose

The Workgroup reviewed the charge of the Workgroup and the desired goal.

Presentation Summary:

Staff explained that OPTN policy 5.6.C: Organ Offer Acceptance Limit allows transplant programs to have up to two acceptances for each organ type for any one candidate. The goal of the Workgroup is to eliminate the scenario where a transplant program can be primary for offers from two different Organ Procurement Organizations (OPOs) and wait to determine which organ(s) to accept for their candidate. This will inform the OPO Committee's proposal *Modify OPTN Policy 5.6.C: Modify Organ Offer Acceptance Limit* in its development.

Summary of discussion:

The Chair reiterated that the core of the project is increasing efficiency; the ability for programs to accept two primary organs for the same recipient frequently results in one of the organs having a "late turndown". This not only affects the efficiency of allocation but also potentially impacts the utilization of the organ.

Next steps:

2. Background

Staff introduced the discussion in the context of the 2017 OPO Committee proposal *Improving the Efficiency of Organ Placement*.

Presentation Summary:

Prior to this project, the 2017 OPO Committee proposal *Improving the Efficiency of Organ Placement*, addressed the following:

- Reduced the time limits for responding to organ offers
- Created new time limits for primary transplant hospitals

- Limited the number of organ offer acceptances
- Required OPOs to manage organ offers in real time

Summary of discussion:

A member suggested that there is difficulty in assessing organ quality using only laboratory values and clinical tests; they supported maintaining options for their patients by accepting two organs and taking the better of the two or the offer that goes to the operating room first. However, they acknowledged that this is an issue and does lead to late turndowns. It was suggested that there could be a timeframe in which a program must turn down one organ prior to the operating room timing (e.g. a program must refuse one organ once the operating room timing is sooner than six hours away).

A second member agreed that, for some recipients, each hour without receiving a transplant is influential. They hypothesized that it could negatively patients whose programs who are forced to choose between two offers and choose the offer that ends up having a later operating room timing. They did, however, also support the proposition to disallow multiple primary offers once an operating room timing has been set.

The Chair summarized the sentiment from the Workgroup, stating that it seemed like members were in favor of preventing multiple acceptances once a program has "skin in the game", or when they have invested resources into the acceptance of the organ. They added that this is why backing up these organs does not work frequently; programs require time to prepare for the acceptance of the organ between assembling organ teams and flight crews, which cannot be done on short notice. They suggested the Workgroup investigate the details of having a "timeout" period in which an organ cannot accept as primary more than one organ – what would trigger the system from disallowing a second primary acceptance or force a transplant program to choose?

A member wondered if the quality of the organ could play a factor, considering that accepting multiple offers with one being a more medically complex organ seemed more acceptable than multiple offers with a low-risk organ. Additionally, for patients that were extremely sick, those patients should have the ability to accept multiple offers because they need a transplant immediately. The programs that are accepting multiple offers for those candidates are likely basing their decision off of which organ has the earlier operating room timing.

Another member suggested that the inefficiency occurs only when the operating room timings are close to each other; if the first organ is accepted by the primary center, the second acceptance will be turned down close to entering the operating room.

Next steps:

The Workgroup will consider what data should be used to develop realistic expectations in policy for transplant programs.

3. Data Request

Research staff presented on a past data request from the Policy Oversight Committee on concurrent acceptances.

Data summary:

Analysis:

- Deceased donor liver offers between 6/13/2018 and 6/12/2019
- 597 candidates accepted two livers concurrently
    - 256 candidates turned down both livers

- Livers had the highest rate of concurrent acceptances, followed by lung, then kidney
    - Lung had the highest rate of non-transplant among concurrent acceptors (39%)
    - Kidney had the lowest rate of non-transplant among concurrent acceptors (2%)

Proposed Data Request:

- The number of current acceptances by organ
- The disposition of organs with concurrent acceptances
- The refusal reasons for organ turndown in concurrent acceptance events
- The refusal reasons for organs turned down in concurrent acceptance events
- The discard reasons for organs discarded with a concurrent acceptance

Summary of discussion:

A member suggested adding the average Model for End-Stage Liver Disease (MELD) score for liver patients, as well as the same urgency scoring for heart, lung, and kidney. They hypothesized that the average MELD would be high, given that those are the patients for whom transplant with any liver is a priority.

Another member suggested adding the time of refusal for the primary acceptor in instances when one or both acceptors refuse the organ.

It was also suggested that the method of recovery (local recovery or procured by the accepting center) should be analyzed. Both Staff and the Chair noted this was data that was not available.

A member considered that the operating room timing of each organ and the time of final acceptance could be analyzed. The Chair stated that the operating room timing was tracked on the donor disposition report (DDR), but may not always be telling of the events that occurred prior to the operating room timing because it could have been updated because of a late turndown.

A member asked if the non-concurrent acceptance practices and concurrent acceptance practices could be evaluated to determine if there is variation in the quality of organs being accepted by programs. A second member added that OPO practice in donor procurement also varies between programs, which can spur variation in transplant program behavior.

The Chair wondered if the usage of the 863 bypass code (expedited placement) could be analyzed alongside the use of the expedited pathway for the placement of organs once a concurrent acceptance refuses the organ. Research staff suggested using all of the “standard” bypass codes used in past analyses which are 861, 862, and 863. The Chair supported this proposition.

A member inquired if there would be an analysis of the responses input into the free text field for “Other, specify” for refusal reasons. Staff replied that if they found a significant number of “Other, specify” responses, that would be a possibility to see if there were trends across it.

Another member asked if the Liver Committee had reviewed the issues stemming from concurrent acceptances. Staff replied that they would ask if the Liver Committee has considered the issues stemming from concurrent acceptances. The member speculated that the liver community would have the most opposition to the proposed changes. The Chair considered that, from an OPO perspective, there was too much open-endedness in the policy in its current state, as it theoretically could enable a program to concurrently accept two of any organ for one recipient; it just happens to have the biggest impact in Liver. Therefore, regardless of the Liver Committee’s sentiment, the policy needs to be addressed holistically.

It was asked, then, whether the problem is not the concurrent acceptance policy, but the transparency from the OPO side on whether or not a primary acceptor had a primary acceptance for a second organ. A member suggested this could be a programmable fix to show OPOs that their primary acceptor had an acceptance in for a second organ. The Chair agreed, but emphasized it needs to be an active alert that notifies an OPO when a program accepts a second organ.

Next steps:

Staff will update the Workgroup on whether the Liver Committee has considered the issue of concurrent acceptances. Research staff will proceed with their data request per the recommendations of the Workgroup.

Upcoming Meeting

- TBD

Attendance

- **Committee Members**
  - David Marshman
  - Errol Bush
  - Gregory Abrahamian
  - Joseph DiNorcia
  - Kevin Daub
  - Kevin Koomalsingh
  - Larry Suplee
  - Pablo Sanchez
  - Jason Rolls
- **HRSA Representatives**
  - Adriana Martinez
  - Vanessa Arriola
- **UNOS Staff**
  - Katrina Gauntt
  - Isaac Hager
  - Robert Hunter
  - Sharon Shepherd