OPTN Transplant Coordinators Committee
Meeting Summary
April 20, 2023
Conference Call

Stacy McKean, RN, Chair
Natalie Santiago-Blackwell, RN, MSN, Vice Chair

Introduction

The OPTN Transplant Coordinators Committee (the Committee) met via Citrix GoToMeeting teleconference on 04/20/2023 to discuss the following agenda items:

1. Welcome
2. Organ Offer Acceptance Limits Project: Request for Feedback
3. Patient/Volunteer Education: Request for Feedback
4. Reminders

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

1. Welcome

Committee leadership and staff welcomed the Committee members.

Summary of discussion:

The Committee members had no questions or comments.

2. Organ Offer Acceptance Limits Project: Request for Feedback

The Committee received a presentation from the OPTN OPO Committee on their aim to modify *OPTN Policy 5.6.C: Organ Offer Acceptance Limit* to only allow a transplant hospital to have one organ offer acceptance for each organ type for any one candidate. This would eliminate the scenario where a transplant program can be primary for offers from two different donors and wait to determine which organ to accept for their candidate.

The presenter concluded that concurrent acceptance events most frequently occur for liver; the majority of candidates that concurrently accept organs are highly medically urgent; lungs concurrently accepted are most frequently transplanted with the acceptor; the majority of livers concurrently accepted are transplanted with another candidate and, for lungs and livers declined by concurrent acceptors, the most frequently occurring refusal reason is "Candidate transplanted or pending transplant."

Data Summary:

Multiple acceptance events between March 15, 2021 and September 15, 2022 occurred 811 times for liver, 62 times for lung, and 4 times for heart. Concurrent acceptors for lungs tended to have relatively high lung allocation scores (65.52% had a LAS of 50 or greater).

The outcomes for livers that were concurrently accepted were 50.74% (823) "transplanted with another candidate," 35.02% (568) "transplanted with acceptor," 8.08% (131) "organ not recovered," 4.93% (80) "recovered for transplant but not transplanted," and 1.23% (20) "recovered not for transplant." The

most common refusal reason for recovered livers concurrently accepted then declined was “candidate transplanted or pending transplant” (49.5% - 450), followed by “candidate ill, unavailable, refused, or temporarily unsuitable” (15.84% - 144).

The outcomes for lungs that were concurrently accepted were 34.68% (43) “transplanted with acceptor,” 33.87% (42) “organ not recovered,” 25.81% (32) “transplanted with another candidate,” 3.23% (4) “recovered for transplant but not transplanted,” and 2.42% (3) “recovered not for transplant.” The most common refusal code for recovered lungs concurrently accepted and then declined was, “candidate transplanted or pending transplant” (38.89%), followed by “organ size” (13.89%).

The presenter noted that on average, lungs are declined around 5 hours before cross clamp and 12 hours before for those transplanted to another candidate. On average, livers are declined around 1.5 hours before cross clamp and 2 hours before for those transplanted to another candidate.

Out of sequence bypass codes are utilized 16% of the time for livers concurrently accepted then declined; almost double the national rate for all accepted livers. There was only 1 lung placed out of sequence. The cold ischemic time for transplanted livers that were declined by the concurrent acceptor was slightly longer than those that were transplanted with the concurrent acceptor (6 vs. 5.72 hours); for lung the cold ischemic time was similar for transplant lungs concurrently accepted then declined versus those accepted and transplanted with the acceptor (5.4 hours and 5.3 hours respectively).

Summary of discussion:

The presenter asked which of the following options the Committee prefers:

- Modify *OPTN Policy 5.6.C: Organ Offer Acceptance Limit* to only allow a transplant hospital to have one organ offer acceptance (primary offer).
- Add timeframe prior to scheduled donor organ recovery to make a decision if there is more than one offer for a candidate.
- Exceptions to the one organ offer acceptance based on medical urgency status.
- Organ specific requirements.
- Exception for DCD donors.

A member asked about preventing an unlimited number of offers. The OPO Committee representative noted that previous policy language was silent on the number of offers that a transplant hospital could accept for one candidate. He added that the implementation of two acceptances was a product of other policy language changes several years ago.

A member commented that late turndowns can be inconvenient not just for OPOs but also transplant hospitals. She added that her transplant hospital is willing to accept late offers, however it does create some logistical challenges. She also added that an exception should be considered for donation after circulatory death (DCD) donors, especially as perfusion technology and other forms of recovery are developed. The OPO Committee representative noted the data shows that only 4.5% of livers with concurrent offers were from DCD donors.

A member acknowledged that if exceptions are given to higher status liver candidates there would not be a significant decrease in the number of concurrent acceptances.

A member asked about how the timeframe option would work. The OPO Committee representative noted that adding a timeframe would be the most complicated option to consider because donor recovery times can change numerous times. Additionally, the timeframes might need to be different for each organ type, particularly thoracic versus abdominal organs.

There was no further discussion.

Next Steps

Committee staff will provide this feedback to the OPO Committee.

3. Patient/Volunteer Education: Request for Feedback

UNOS staff provided an overview of a project to develop an educational resource for OPTN patient and donor family volunteers who serve on Committees as well as the Board of Directors. Staff noted that while the current focus is to provide information to inform and empower patient and donor family volunteers, this education could have a broader impact. The education aims to provide an overview of the full process involved in a transplant – from patient referral and listing for transplant. Education will also include processes from donor referral to recovery, placement, and transplant.

Summary of discussion:

Staff requested feedback from the TCC on the following topics that will be included in the educational offering. Staff used an example where a patient goes to their nephrologist to discuss healthcare options and is referred for transplant. Since the education will focus on a kidney transplant, the patient may initially be referred for dialysis prior to being referred to the transplant hospital.

Considering a Transplant

A member commented that if the purpose is to provide a basic orientation, then the proposed language should be sufficient since most kidney patients are referred from dialysis centers. Another member questioned whether there should be a mention of multi-organ transplants since kidney failure could lead to the need for kidney-pancreas or liver-kidney transplant options.

Seeking a Transplant Program

Staff noted this section addresses the transplant center staff patients will be working with as they evaluate transplant programs. The section also addresses how patients can prepare for the evaluation, touching on such topics as insurance coverage and what to expect at the beginning of the process. A member noted it might be important to inform patients of the Medicare benefit for end stage renal disease. He added that even if a patient is not on dialysis, everyone is eligible for the benefit post-transplant.

A member commented that it will be difficult to generalize the process because there is so much variability in how transplant programs evaluate patients. Another member added that patients need to be aware of the testing involved to ensure the patient is a candidate and that there are no risk factors that might impact a transplant. Another member added that while there is testing variability across programs, there are standard test such as radiology and lab tests that could be referenced in the document.

Another member noted the importance of providing a list of options available at a particular program such as living donation and paired exchanges.

A member recommended including information about a psychosocial evaluation that is often required by transplant programs.

A member suggested reviewing the Centers for Medicare and Medicaid Services (CMS) conditions of participation which mandates certain patient education during the initial evaluation for transplant. She

added that some programs wait until they have prior authorization from insurance companies before starting the evaluation.

A member suggested highlighting the fact that transplant programs have different selection criteria and noted that CMS requires that patients be informed about the selection criteria. Another member added that his transplant program also provides the information to their end stage renal disease networks.

A member suggested not including information about the transplant coordinator qualifications. He added that every transplant program is different and could have staff with a variety of education and training (e.g., nurse practitioner, nurse, other clinical certification).

A member also suggested removing the reference to the transplant nephrologist since they might not be involved in the initial evaluation process. A member suggested stating that patients will collaborate with a multi-disciplinary team that will include nurses, social workers, physicians, etc.

Listing

Staff noted that this section will include information about the listing for transplant once the evaluation has been completed. This includes the transplant program listing the patient and registering the candidate on the OPTN Waitlist. Staff noted this section will explain the difference between the Waitlist system and the match run, address program responsibilities such as informed consent, and other options available such as multi-listing and opting in to receive higher KDPI kidneys.

A member suggested including anticipated waiting time and how important it is for the patient to maintain health to stay eligible for a transplant. A member added that periodic re-evaluation and testing might be required as well as keeping up with basic cancer screenings.

A member suggested adding information about the importance for patients to keep transplant programs informed of changes in insurance or other updated medical information such as hospitalizations.

A member noted that some insurance companies require separate authorizations for the evaluation and listing.

Organ Offer and Acceptance

Staff noted that program practice may vary, but many programs opt to have transplant coordinators manage incoming organ offer calls while others will use transplant surgeons or third-party companies for screening offers.

A member commented that it might not be important for patients to know who receives the organ offers, but that the transplant program will be receiving offers and staff will make the determination whether the offer is appropriate for the individual patients. A member suggested emphasizing that someone is available every day and night to receive and evaluate offers and will use pre-established protocols and criteria to make decisions on offers. A member suggested removing any reference to third party screening services.

Staff asked TCC members how they ensure that candidates are ready for transplant when evaluating organ offers. A member responded that most centers contact the candidate about the offer and will direct them to either wait for more information or come into the transplant hospital. She added that pre-transplant admission processes may vary but typically include any pre-admission screening and testing. A member noted that patients need to understand that anything can happen that might lead to the cancellation of the transplant surgery and there is a chance it might take multiple opportunities to receive a transplant.

There was no further discussion.

Next Steps:

Staff will send out the remaining questions to the committee members for review.

4. Reminders

Staff provided a reminder about the next conference call and thanked the committee member for their time.

Upcoming Meeting

- May 18, 2023 (Teleconference)

Attendance

- **Committee Members**
  - Stacy McKeon
  - Angele Lacks
  - Ashley Hamby
  - Ashley Cardenas
  - Brenda Durand
  - Donna Campbell
  - Karl E. Neumann
  - Heather Bastardi
  - Robin Petersen-Webster
  - Jamie Myers
  - Kelsey McCauley
  - Melissa Walker
  - Stacy Sexton
  - Rachel White
  - Valinda Jones – Visiting Board Member
- **HRSA Representatives**
  - Arjun Naik
- **UNOS Staff**
  - Robert Hunter
  - Ross Walton
  - Lauren Mauk
  - Katrina Gauntt
  - Kayla Temple
  - Mel Farley
- **Other Attendees**
  - David Marshman
  - Christine Brenner
  - Anne O'Boye
  - Gertrude Okelezo