

OPTN/UNOS Transplant Coordinators Committee (TCC)
Meeting Summary
September, 23, 2015
Chicago, IL

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Discussions of the full committee on September 23, 2015 are summarized below and will be reflected in the committee's next report to the OPTN/UNOS Board of Directors. Meeting summaries and reports to the Board are available at <http://optn.transplant.hrsa.gov/>.

Committee Projects

1. None

Committee Projects Pending Implementation

2. None

Implemented Committee Projects

3. None

Review of Public Comment Proposals

4. **Reduce Documentation Shipped with Organs (Organ Procurement Organization Committee)**

The Transplant Coordinators Committee reviewed and supported this proposal. Some committee members had the following questions/comments:

- How will transplant centers receive last minute documentation from the OPO when organ offers have been accepted and recovered (i.e. anatomy, biopsy results)? The accepting center needs information to verify donor organ information, just prior to transplant and in cases where the recipient procedure starts prior to the organ's arrival.
- Did the OPO Committee consider putting in the PHS record in the box as a safety net?
- This change will require a lot of education for internal staff on how to access the information in DonorNet, particularly for OR staff.
- For the occasional case of pre-serology organ recovery, documentation that indicates pending infectious disease testing should be included.
- Serologies and infectious disease reports, sent with the organ should include NAT, if results are available.

5. **Revise KPD Priority Points (OPTN Kidney Paired Donation Pilot Program (OPTN KPD))**

The Transplant Coordinators Committee reviewed and supported this proposal. Some committee members had the following questions/comments:

- What are some examples of informed consent of “remedies”?
- With the increase in points with the highly sensitized patient, will virtual crossmatches be done immediately after the match run to decrease the potential of broken chains or swaps before the center starts investing time in calling their surgeons and patients?
- Can you clarify how many points will be allocated to pediatric recipients, given there is more weight given to patients who are highly sensitized?

6. Simultaneous Liver Kidney Allocation (SLK) (Kidney Transplantation Committee)

The Transplant Coordinators Committee reviewed and supported this proposal. Some committee members had the following questions/comments:

- If a patient receives a SLK, and a kidney fails on day 95 and they are relisted for kidney, are they considered in the safety net?
- Please clarify why a center would provide a kidney transplant to a patient with only a moderate GFR and then for the safety net, the patient has to have a GFR of 20. If you look at the CRD breakdown for GFRs, it does not make sense that it would be modified.
- Most patients would not receive a kidney with a GFR of 30, why allow it with an SLK
- Has the new KAS and Liver Share 35 changed some of this? Are you seeing sicker Liver patients with worsening renal function showing up on these lists?
- Once a patient has a liver transplant, does the patient become more sensitized and have a harder chance at getting a kidney?
- This seems to greatly affect the kidney-only candidates. We have already been affected by the KAS. Have you done models looking at kidney only candidates?
- If we are going down the liver match, we would be mandated to offer the kidney if it was available, but the OPO would still have the choice which multi-visceral it chooses? It was one committee member’s understanding that if an OPO offers for an SLK locally, then the Share 35 must be offered regionally as well, but it was not said that they had to allocate an SLK at all. If chosen to allocate to a local SLK, then we must also allocate to a regional SLK.
- One concern is that the policy always references a “transplant nephrologist”. Not all transplant centers have a designated transplant nephrologist. Should that reference be removed or changed? Will it cause problems for transplant centers as currently worded? Also, is it the designated nephrologist that has to follow the patient and document the results or can the transplant team manage the patient and get confirmation from the designated nephrologist of the results meeting criteria?
- A concern for some regions that have kidney only programs, transplant centers are seeing a decline in local kidney transplants because a large number of kidneys are being exported out of the local area. One of the issues is the effect of hepatic-renal syndrome and where the line is. If a liver is transplanted, and there is some return of kidney function, should the liver center return the kidney? If function does not return then do they go into the safety net?

Other Significant Items

7. Policy Oversight Committee (POC) Update

The Committee Vice-Chair reviewed POC activities and approved committee project list with updates and how the TCC will become involved in selected projects.

8. Kidney Allocation System (KAS) Update

The vice chair of the Kidney Transplantation Committee provided a brief background, overview, and update on the six month data collection. Trends in the kidney waiting list, distribution of transplants since KAS implementation, longevity matching, geographic distribution of kidney transplants, and other findings were presented. In summary, for the first six months, KAS has been meeting key goals and increased transplant volume by 1%. However, there are several effects that deserve further attention and the Kidney Committee will continue to monitor. TCC members posed the following questions/comments after the presentation:

- There was thought that KAS would decrease the inactive wait list. It was noted that 40% of the kidney list is still inactive and has not changed.
- Has there been any effect on HCV kidneys or kidney discards?
- For SLK kidneys, when they are in the safety net, do they model where most patients fall in the system?

9. Liver and Intestine Organ Committee Update

The chair of the Liver and Intestine Committee provided an update on redesigning liver distribution. Despite improvements in liver allocation and distribution, waitlist mortality remains high for patients with higher MELD scores. Significant disparity exists between OPOs and regions with regard to mean MELD at transplant and waitlist mortality. There were two public forums on this topic where new concepts and next steps were discussed. No policy proposal is immediately forthcoming from this project but the Committee plans to continue to work towards the development of an appropriate proposal. Some questions raised by the TCC included:

- Will liver redistricting polarize transplant centers across the country and begin to eliminate smaller programs?
- Is there uniformity in recipient criteria for qualifying for liver transplants?
- Since the implementation of KAS, there has been an increase in transplanting patients that we feel will have a better long-term outcome, is there a way to incorporate that into the liver population?
- Do you anticipate another public forum before a proposal is distributed for public comment?

10. TransNet Update

A progress update for TransNet training for OPOs and transplant centers was provided. A few questions were asked by committee members regarding how the system works if you have an incompatible match, what to do if vessels are used weeks later but before the vessels expire, and when is this expected to go live.

11. Committee Feedback

Operations and Safety Committee (OSC) Infectious Disease Verification Project

An update on the OSC's Infectious Disease Verification project was provided to the full committee. The Membership and Professional Standards Committee (MPSC) asked the

OSC to consider developing policy for infectious disease verification following several cases of near miss and actual disease transmission when positive results were available but overlooked in living donor cases. A proposal is planned for January 2016 public comment period.

Members of the TCC were asked to provide feedback regarding how many members currently conduct infectious disease verification. Of those that do, who does the verification, at what point in the process and for what results. One member responded that the center does some kind of verification in the recipient operating room but there is no documentation. Another member commented that an ABO and serology verification was recently implemented at her center but it is very cumbersome and the transplant coordinator and surgeon are verifying over the phone. It was suggested that there be a standard form for ABO and infectious disease to simplify the process for centers.

Ad-Hoc Disease Transmission Committee (DTAC) Modify How Results Received Post Procurement Are Communicated

The Committee received a project update on this project's progress to improve communication regarding new information critical to recipient care, enhance recipient safety, and help to prevent or quickly react to potential donor-derived disease transmission. The current patient safety contact requirement must also be considered, as it is not functioning as smoothly in some institutions as others, and has presented challenges in communicating important information in some cases. The DTAC requested a volunteer from the TCC to participate on a working group to identify, develop, and disseminate effective practices for transplant centers.

12. UNOS Research Orientation

UNOS Research staff provided an overview of the Research Department's current and future functions.

13. NATCO Updates

A brief overview of NATCO's upcoming events was provided.

14. Committee Project Brainstorming Session

The Committee dedicated time during the meeting to brainstorming project ideas that meet the OPTN strategic goals. While the goal to increase the number of transplants was the focus of the session, ideas for the other goals were also collected. The top two ideas for increasing the number of transplants were DonorNet Enhancements and Best Practices and Standardizing Reporting of DCD Data.

The DonorNet enhancement and best practices idea incorporates several specific topics that are related to making improvements to DonorNet and making resources available to assist members when using DonorNet. The main problem identified was the amount of time it takes to complete the organ allocation and acceptance process in DonorNet. The extended amount of time it takes to complete the process can lead to organ wastage. Identifying the barriers in place for organ allocation and placement can facilitate the process and increase the number of organs placed; therefore, ideally resulting in more organs transplanted.

The idea to develop a standardized form for DCD data was discussed as DCD data collection is different for each OPO. Time is wasted by the transplant center when staff has to search for information and missing data. There needs to be a standardized form with key data points that the transplant center can use to determine acceptance. A

standard form can expedite placement of organs when pertinent information is consistently documented and available.

Upcoming Meeting

- November 2015 (conference call)