**OPTN/UNOS Liver and Intestinal Organ Transplantation Committee**
**Meeting Minutes**
**November 8, 2017**
**Conference Call**

**Julie Heimbach, MD, Chair**
**James Trotter, MD, Vice Chair**

## Introduction

The OPTN/UNOS Liver and Intestinal Organ Transplantation Committee met by conference call on 11/8/2017 to discuss the following agenda items:

1. Review of Current Policy Language – Enhancing Liver Distribution Proposal
2. Variances

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

## 1. Review of Current Policy Language

The Committee discussed the current policy language for the *Enhancing Liver Distribution* proposal and voted.

Summary of Discussion:

During the Committee's call on 11/2/2017, there was not a quorum of the Committee required to vote on the final policy language for the Committee's proposal.

The Committee quickly reviewed the clarifications to final policy language that were discussed during the November 2nd conference call. One of those items was policy related to blood type compatibility for Status 1A/1B or MELD >30 candidates. The Committee previously discussed that policy would emphasize that the MELD >30 threshold would not include proximity points. A committee member asked for clarification that the policy would remain the same, and not include proximity points.

The Committee voted 17-Support, 1-Oppose, and 1-Abstention on the final policy language for the proposal.

## 2. Variances

The Committee discussed the currently programmed liver variances and their relation to the current proposal.

Summary of Discussion

During the Committee's call on 11/2/2017, there was not a quorum of the Committee required to vote on a recommendation to the Board of Directors for the current liver variances. There are 5 current variances to liver allocation. The split liver variance is not being addressed as part of the Committee's current review of liver variances.

Regions 1 and 10 share for Status 1 patients on a common regional list. Pediatric donor livers are offered first to Status 1 patients within Region 1 and 10. Current policy has separate classifications for the DSA and Region with regards to allocation to Status 1A candidates for this subset of donor livers. The current proposal allocates regionally for Status 1A candidates for pediatric donors, therefore this variance is encompassed in the current proposal.

The Hawaii DSA in Region 6 uses the standard distribution and allocation system with the following exception. Liver candidates with compatible blood types are included with identical

blood types for blood type O donors. A committee member asked for clarification about the details of the Hawaii variance. It was clarified that this variance applies only to candidates and the OPO in Hawaii regarding the allocation of blood type O donor livers simultaneously to liver candidates within the DSA with compatible blood types in addition to identical blood types.

The Committee voted 19-Support, 0-Oppose, and 0-Abstentions to support extending the Hawaii DSA variance and terminating the Regions 1 and 10 variances pending board approval and implementation of the new proposal.

Region 9 utilizes the standard distribution and allocation system for allocating livers with the following exception. As New York composes most of Region 9, the BOD approved an alternative local unit where “Statewide” classifications replace the DSA and Regional classifications. New York essentially shares all livers throughout Region 9. The Committee was presented an option to amend the Region 9 variance. This option involves replacing all references to “DSA” with “region” throughout Policy 9.8: Liver Allocation, Classifications, and Rankings. Within the allocation classifications, instances of a liver recovered in New York being allocated to the “DSA” would be replaced with regional allocation. Additionally, this variance would provide proximity points to any candidate in Region 9 for a liver recovered in Region 9. This is different from the proposed national policy that would provide proximity points to candidates in the Circle or DSA. For a liver recovered in Region 9, this would effectively become “Circle or Region”.

A committee member asked how the liver program outside of New York City (Rochester) would be disadvantaged if the current variance was eliminated. A committee member replied that the Rochester center would not receive proximity points with the new proposal for a liver recovered in New York City. Currently the Rochester center receives a significant percentage of their donor livers from the NYRT (New York City) DSA. Candidates at the Rochester Center could be perceived as having a disadvantage compared to candidates in the NYRT DSA for a liver recovered in the NYRT DSA. Currently, this potential does not exist due to the region-wide sharing variance. A committee member stated that the SRTR modeling did not include the existence of the variance. Another committee member stated that the high percentage transplants in Rochester resulting from donors from NYRT suggests that this variance is working for that program, in that the broadened sharing within Region 9 results in more transplants occurring in a DSA outside of the DSA the liver was recovered in.

A committee member stated that prioritizing the candidates in Rochester for a liver recovered in NYRT, would disadvantage candidates at centers outside of Region 9 but within the 150 nautical mile radius circle in Regions 1 and 2. A committee member replied that this variance could also lower the MELD at transplant for candidates in Region 9, which would provide candidates within the 150 mile circle, but outside of region 9 “less competition” because they would have similar MELD scores to candidates within Region 9. A committee member stated the modeling doesn’t represent this variance and that this causes an issue. Another committee member stated that this could open the door for other areas wanting to establish a separate variance that benefits their regions. A committee member replied that this was a possibility but any variances that were brought forth would require consideration by the Committee and ultimately approval by the Board of Directors.

A committee member stated that the center in upstate New York is an isolated area that provides access to a specific population, and that this variance appears to support this program without causing much effect on other programs outside of Region 9. A committee member replied that they think the variance will indeed “hurt” candidates in Region 1 and 2. A committee member stated that the disadvantage of not having the variance for this specific small program

is likely greater, than any potential disadvantage on the larger centers outside of Region 9 but within the circle of a liver recovered in Region 9.

The Committee voted 12-Support, 3-Oppose, and 4-Abstentions to recommend to the Board of Directors that the Region 9 variance is amended as described and extended pending board approval and implementation of the current proposal.

**Upcoming Meetings**

- November 8th, 2017 – Conference Call
- December 21st, 2017 – Conference Call