

OPTN/UNOS Transplant Administrators Committee (TAC)
Meeting Minutes
August 22, 2018
Conference Call

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Introduction

The Transplant Administrators Committee met via teleconference on 08/22/2018 to discuss the following agenda items:

1. Public Comment Proposal Discussion - Frameworks for Organ Distribution (Ad Hoc Geography Committee)

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

Summary of discussion:

The OPTN/UNOS Transplant Administrators Committee received a presentation and discussed the Frameworks for Organ Distribution (Ad Hoc Geography Committee) public comment proposal. One committee member asked about the fixed distance models and how concentric circles that extend past either coast would be considered. He also asked if there is any assessment of socioeconomic makeup of a given region.

The Research Department looked at the impact of having a circle around coastal cities because this was used in thoracic and liver when looking at different distribution models in the past. What was found is that people were concerned about less access to donors due to half the circle being in the ocean. However, it was discovered that the circles around the hospitals on the coasts are more heavily populated than the circles in the middle of the country, and so from that sense have greater access to distribution throughout those circles. In addition, there will be no organs received from ocean areas, but organs would not need to be distributed there as well. It was also felt that cities and localities around national borders and on the coasts might be impacted. However, the Research Department did not see that causing greater disparity in access for candidates.

Regarding socioeconomic status and access, it would be important to look at which of the three frameworks has the most capability for having that conversation. It would be more difficult to have that conversation with the fixed distance from the donor hospital because greater access to some populations versus other would mean having different distances in different places. The second and third frameworks are better suited to giving preference or greater access to disadvantaged populations.

One Committee member asked what was learned from the changes put forth on broader distribution of lungs. This question will be deferred to the thoracic research experts.

Organ-specific committees are currently working on removing the DSA in policy, so it runs the risk of a different framework being chosen by one committee where they would need to go back and make revisions, seemingly creating lost time. The idea of moving towards one unified framework is a long-term goal. Since changes are frequently made to allocation policies, a consistent framework will be reached over time.

In addition, many of the changes recommended by the different committees are complementary. For instance, it is easier to move from framework 1 or 2 into the framework 3. Discussions about

different variables would be required in the first framework, as well as discussions about different metrics that should be optimized for the second framework. Putting those conversations together would lead to the third framework. The distance-based frameworks being discussed right now are really due to expediency, but there will be an eventual transition to the continuous distribution model. The expediency is due to litigation with lung and liver. The Secretary has proclaimed the use of DSAs and regions in allocation policy is not consistent with requirements and must be eliminated. This will happen first with liver and then will happen with the other organs.

Some committees and community members are concerned with the expediency of the changes. The litigation proposes that the transplant community cannot make the allocation policy decisions themselves. Therefore, the crux of this is that the transplant community can indeed build a model that is compliant with the law and do so in a timely manner. If OPTN does not have solutions by next summer, the risk is that legislature will make the decision for the transplant community instead.

None of the proposals require broader distribution or local distribution. None of them address geographic disparity better or worse than another one. It is important to see which framework allows for conversations about all the issues mentioned about access, efficiency, and cost across organs, as well as which framework will allow for policy changes and IT implementation be responsive to the desires of the community.

One committee member felt that the hospital closest to the donor hospital would always come out on top and over time end up with more transplants than other centers that are farther away. Using kidney as an example, two variables would be years of waiting and distance in miles. The question would be how much one would be valued over the other. For example the maximum amount of points for proximity to a donor hospital is equal to 1 year of waiting time. Then waiting time would trump proximity because most have significantly more than 1 year. But in a situation where proximity is more heavily weighted, geographic proximity hospitals would win out. Therefore, the Committee must decide how to weigh each variable.

One concern was how to prevent the weightings from being arbitrary and capricious, as the DSAs are. The overall goal needs to be taken into account and that is where the modeling becomes important. The Final Rule calls for as broad a distribution as feasible. DSAs were not drawn for the purpose of maximizing anything related to organ allocation or distribution. Therefore, the variables could be backed by the overall goals and the different factors can be balanced accordingly. The third model proposed by the SRTR could reverse engineer the problem in that the model could be adjusted to achieve the desired outcome. It still requires a lot of work because those questions have to be answered. Again, the frameworks presented are only proposals at this point.

It was asked if there has been any analysis that the DSA boundaries do or do not work. There has been no analysis to show that the DSA boundaries are uniform from any perspective. This does not change the DSA boundaries from the OPO perspective. But in terms of showing that the boundaries lead to a specific optimization of utilization, placement rates, or placement times, the presenter is not aware of any analyses showing that. There probably is a benefit to OPOs and hospitals that work well together, but the boundaries don't necessarily show that OPOs and hospitals work well together just because they're grouped together by DSA.

The Geography Committee also talked about a model that would make every organ offer national in the Final Rule, but that would not be a valid model for organ transplantation. There are valid reasons under the Final Rule to keeping organs local, including cold time, efficiency, and cost.

Upcoming Meetings

- September 26, 2018 (teleconference)
- October 3, 2018 (Chicago, IL)