

**OPTN/UNOS Operations and Safety Committee
Meeting Minutes
September 27, 2018
Conference Call**

**Michael R. Marvin, M.D., Chair
Christopher Curran, Vice Chair**

Introduction

The Operations and Safety Committee (OSC) met via teleconference on 09/27/2018 to discuss the following agenda items:

1. Introductions and Announcements
2. Frameworks for Organ Distribution - Public Comment Proposal Presentation
3. Air Travel Questionnaire
4. Results to date

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

1. Introduction and Announcements

All meeting attendees were acknowledged.

The next meeting will be the in-person meeting in Chicago. Travel arrangements should be made to attend. Members are invited to attend a pre-meeting dinner.

2. Frameworks for Organ Distribution - Public Comment Proposal Presentation

Every OPTN/UNOS committee is hearing the public comment presentation that the Ad Hoc Geography Committee developed.

Background:

The task is to remove DSA and region from organ allocation policies. A brief overview of the three geographic frameworks was presented.

- *Fixed distance from donor hospital - Concentric circles framework.* The fixed distance from the donor circle essentially uses concentric circles with a radius and circumference around the donor hospital that will be selected by each of the organ-specific committees based on factors such as cold ischemic time, travel, and logistics. Any candidate within the first circle would receive an organ offer before any candidates in the second circle. The Kidney-Pancreas (KP) work group is modeling two versions of this framework with 150/300 nautical miles (NM), followed by national distribution. Another variation is 250/500 NM, followed by national distribution. Advantages are that it is easy to explain and this can extend distribution areas, particularly for medically urgent patients. Disadvantages include the fixed boundaries. If the first circle was 150 NM, a patient with higher medical urgency at 155 NM will not receive that offer until all candidates in the first circle have denied it. Also, given different population densities around the country, and non-contiguous states, regions might be advantaged or disadvantaged in this framework.
- *Mathematically optimized boundaries* - Districts or neighborhoods that are mathematically optimized and could take into account fixed distances or population density and are not drawn with less data-driven and evidence-based practices. Advantages are that it provides consistent results that can be tweaked in real time as it

is being implemented and districts can be changed as needed. Disadvantages include the boundaries may be complex and difficult to explain, and there are still fixed boundaries issues as in the first framework.

- *Continuous distribution* - This assigns points to candidates based on their medical urgency, how good of a match they are, and then assigns variable points for proximity to the donor hospital. Organ-specific Committees will decide how much they value proximity in relation to other variables including medical urgency. Some candidates would be favored over others with similar medical urgency if they are closer to the donor hospital. This comes down to values-based judgments on behalf of the organ-specific committees, but it would remove boundaries from distribution and use proximity as a scale to award more or less points to a candidate based on distance from donor hospital. A disadvantage is the difficulty in explaining how it would work to the community and patients.

A video with animation is also available on the Transplant Pro website that explains the three frameworks. It will be important to gather feedback on each of these frameworks and identify any potential weaknesses.

Summary of discussion:

One comment is that the frameworks seem to be centered on the donor hospital, but sometimes the donors are moved. For example, donors travel to recovery centers, so would it the circle center around where the donor came from or to where they were moved. The Committee Chair understood that the circle would be centered around the original donor hospital. If the distance is related to cold time it would not make sense. UNOS staff confirmed this.

The concern about difficulty educating the public should not be a high priority. UNOS will be more than capable of educating the public about the final framework as they have done with other concepts such as Model for End Stage Liver Disease (MELD). The continuous distribution framework seems to be the most complicated and defensible in terms of organ outcome, fairness and equities. It would be easier to explain a limitation due to cold time, rather than a limitation due to a fixed boundary.

One question concerned heart patients who are still at risk for dying but stable. It was asked how to not disadvantage people on the waitlist who are sick, but maybe not as sick. They wait for so long that they end up dying. With the continuous distribution model, it forces committees to make those value judgments in terms of medical urgency, outcomes, and weighting proximity against those. This will have to come from public input, consensus building and considerations within the committees. It is a valid concern that would be considered in each committee.

One comment was that each of the frameworks will diminish the role of the OPO, as they are based on geography and not on the OPO. It was asked whether the OPO structure and policies will need to be evaluated in the near future. The Chair stated he was not aware of any discussions regarding changing OPOs or DSAs that they serve.

Next steps:

Every member is asked to complete a survey about this proposal. A link to the survey will be emailed out.

3. Air Travel Questionnaire

Summary of discussion:

The Chair thanked everyone for the time they have taken in completing the questionnaire with the OPOs and transplant centers. There are 15 more OPOs that need to be contacted for the air

travel questionnaire. Some of them were reassigned to different members who volunteered. Others are still being worked on or will be completed. Additional contact information can also be found in UNetSM.

One comment was that when making the calls to complete the questionnaire, one response was that the Association of Organ Procurement Organizations (AOPO) is doing a detailed cost survey, trying to come up with increased cost estimates for some of the programs. It might be helpful to come together and share findings with them. OSC leadership is in agreement and has been in touch with them.

4. Results to Date

Summary of discussion:

Yes/no responses are the easiest to analyze and were grouped together in an Excel document that was presented. Answers across each organ are fairly similar with the majority of the answers being no. There is no exact ground mileage cutoff.

If they own or lease or hire their own pilots, the answers are overwhelmingly no. Most do not own their plane. One comment was that percentages of results would also be helpful.

Most have answered that they do not have trouble finding planes or pilots for transporting organs. But for surgeons, the answers are more split. This may be an issue more for programs not in a metropolitan city. Since this is a high-level analysis, this should be evaluated regionally.

Many respondents indicated that they have cases delayed from a lack of planes. Estimates of the percentage of cases delayed from lack of planes range from 0% to 40%.

The farthest driving distance in miles or minutes varies. Some OPOs do not drive more than ten miles and some people will drive up to 960 minutes for a kidney. One comment was that in one state all the donor hospitals are within 10 miles of the OPO, so there is a lot of variation. They would be willing to drive farther, but don't have that opportunity. These data could be broken into region when looking at it in more depth.

The interview covers the percent of organs transplanted by air. Hearts are largely transported by air and only kidneys did not have at least one response with 100% traveling by air. There is a huge range of values that may or may not reveal more information when broken down by area. One comment was that one of the interviewed programs does not do lungs; they recover them and then always transport them.

When asked if OPOs are unable to increase pilots if necessary, the answer was primarily yes. The majority of OPOs responded that they do not use helicopters.

Some of the cost information showed counts to get a grid pattern for what people entered. For the cost of flight, one person said \$900 per hour and four said \$3,500 per hour. No information was provided per mile. Ground costs range from flat fees to no cost because staff drove themselves. There were two different centers that replied it is uncommon for them to have to get two pilots and two planes to bring them there and then if the OR is delayed they have to go back and have another plane and pilot come. That situation made the costs double. The majority of respondents have indicated there is not a charge for planes or pilots on call.

In lung allocation there were some free response questions about the OPOs experience with the recent lung allocation changes. The majority indicated a neutral experience and then a positive experience was the second most common response. One comment was that the neutral/positive answers are encouraging because the initial instinct was that there would be a lot more negative responses.

All the questions were asked generally, not placing any timeframe limits for the answers (for example, whether they got planes within the past 5 years).

Next steps:

Any suggestions on good ways to present data points should be emailed to leadership. Everyone will be involved in looking at the free text data and grouping the answers into themes once all the questionnaires are completed.

Upcoming Meeting

- October 23, 2018, Chicago, IL