

**OPTN Organ Procurement Organization (OPO) Committee
Cross Organ Rules Workgroup
Meeting Summary
February 14, 2020
Conference Call**

Diane Brockmeier, Workgroup Chair

Introduction

The Cross Organ Rules Workgroup (the Workgroup) met via Citrix GoToMeeting teleconference on 2/14/2020 to discuss the following agenda items:

1. Workgroup History and Charge
2. Approach
3. Challenges
4. Thoracic Notification Limits

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

1. Workgroup History and Charge

UNOS Information Technology (IT) staff provided an overview of history and charge for this workgroup.

Summary of discussion:

- Workgroup formed to support decision-making around released organ rules for kidney and pancreas allocation. The released organ proposal is currently out for public comment.
- Workgroup will continue to support the released organs programming effort by periodically providing input on design.
- Workgroup has evolved into a decision-making body for cross organ rules that support allocation efficiencies for all organ types.

The Workgroup will determine what cross-organ rule tenets the OPTN should be operating under, and use these standards to develop one consistent, streamlined approach across all organs and match types for definitions around notification limits (NL), contact management (CM), and donor acceptance criteria (AC).

2. Approach

- Understand current state rules around notification limits, contact management, and donor acceptance criteria as it relates to allocation.
- Establish a temporary, immediate fix for thoracic distance-based allocations (heart and heart-lung) for notification limits only.
- Define necessary rules for kidney, pancreas, and kidney/pancreas and discuss a potential, cross organ rules fix in preparation for a December implementation of distance-based allocation policies. There could also be a short-term solution identified.
- Establish more permanent "tenets" for cross organ rules related to NL, CM, and AC.
- Establish a pattern, based on these tenets, to develop more permanent, long-term fixes for cross organ rules.

- Determine if the patterned developed should be accompanied by UNetsm system changes.
- Determine if the patterned developed could be appropriate for continuous distribution.

3. Challenges

- There are many layers to this problem. For example, the definitions for import vs local, some in distance-based allocation, others in none-distance allocation
- Align across organ types to the extent possible
- Import vs released
- OPO and transplant center operational needs
- Future state vs current state
- Third party vendors

Notification Limits

- Overview of current rules, local and non-local system enforced limits.

A member asked why the limits were changed from the original 5/10 when electronic offers were first implemented in 2007. UNOS IT staff noted that following implementation member feedback noted that too many offers were going out so the number was adjusted to the current 3/5.

Contact Management

- The overview of current contact management rules garnered no questions or comments.

Donor Acceptance Criteria

- The overview of local and import features across all organ types garnered no questions or comments.

Workgroup members commented on how helpful the video and other documentation that was distributed prior to the call was and suggested continuing this practice whenever possible.

4. Thoracic Notification Limits

UNOS IT staff presented the current state:

- Local Centers = Host OPO may set their own limits for locals centers inside their donation service area (DSA) for pre and post recovery.
- Non-local Centers = Non-local offers get sent to 3 programs pre-recovery and 5 programs post-recovery.

The problem with the current limits and recent allocation changes is that “non-local centers” can be mixed in with local centers on the match runs, which can affect the number of offers that can be sent out. For example, if an OPO sets their local limit at 20 and the non-local programs are mixed in with the local programs, there is the potential for the “non-local” system enforced limit of 3 to be reached early on and prevent additional notifications. Another example is when the first three candidates on the match run are “non-local” and the notification limit is reached before offers can be sent to any local programs.

In October 2019, Thoracic Committee leadership made the decision not to make changes to the tools based on the experience from the changes to lung allocation. UNOS IT staff noted that there are fewer lung programs, which could explain why no concerns have been raised about the limits. There has recently been some feedback from OPOs about the efficiency of placement due to the notification limits, specifically around the placement of hearts. IT staff is evaluating the feasibility of a temporary fix

that could be put in place. The Workgroup will be given the opportunity to provide feedback on this fix once more details and options are available.

UNOS IT staff noted recent notification limit changes that were implemented with the new liver allocation system. The rules for the original and import liver match runs include:

- Local Centers = Includes centers within the host OPO's DSA, those in the 150 nautical mile classifications, and Status 1A/1B up to 500 nautical miles.
- Non-local Centers = Non-local offers go to 3 programs pre-recovery and 5 programs post-recovery.

The Workgroup will be asked to consider something similar for thoracic allocation that will serve as a temporary fix until the development of standard tenets across all organ types. For thoracic allocation, there are four distance-based allocation units (250 NM, 500 NM, 1000 NM, and national), urgency statuses 1-6, as well as primary and secondary blood type. UNOS IT staff provided an example from the heart allocation table that showed the impact of each of these factors.

One member noted that it might be less important to delineate local vs non-local as the OPTN moves toward distance-based allocation systems. The key is to follow the match run and be efficient with organ placement. He noted that there are situations where early local notification is important or sending offers to centers most likely to accept the organ. Examples provided include:

- The accelerated kidney allocation project where there is a focused offer to centers.
- Allocation of livers and liver-intestines from DCD donors or donors at least 70 years old – this was recently implemented with the liver acuity circles.

These are good examples of ways to improve efficient organ placement.

UNOS IT staff asked if using some sort of grouping would be beneficial. For example, if an OPO typically goes through a certain classification to place an organ from a certain type of donor, it could help inform the workgroup's decision based on data. This approach might make more sense than using local and non-local. A member noted that when discussing local and import, local is really referring to those hospitals in an OPO's area for which we provide services.

UNOS IT staff noted that redefining the definitions could be part of the discussion around the tenets and longer-term solutions. The rules could be such that they include all candidates within 250 NM or candidates within 250 NM and a higher status that could align with what was done for liver allocation. One member noted that how far an OPO needs to go down the match run classifications is dependent on how many candidates are within each of those classifications.

The Workgroup agreed to request data to evaluate how far down the list it takes to get an organ placed. UNOS IT staff noted that there is data that looked at the 75th and 90th percentile. However, this data was based on historical information and not recently implemented distance-based allocation.

One member asked if it was possible to propose sending offer to a certain number of classifications or programs and then allow the OPOs to use discretion on how many offers go out based on their experience and the type of donor. Another member noted that it would be nice to have some predictive analytics for this. Members discussed the example of how many local kidney centers receive offers and the challenges to respond to individual notifications if the primary contact does not respond for all candidates on their transplant center list. One member also noted that when liver allocation was implemented, his center received approximately 30 offers for their Status 1 candidate. He noted that this shows the need to create a balance between getting offers out without creating a burden on

transplant centers. Finally, a member noted that the number of offers that go out at noon is different from 2:00 am. That can be part of our standards –who receives the offers and how, the time of day, etc.

Data request

The Workgroup would like to better understand the efficiency of adult heart allocation since the January 2020 implementation. This will include reviewing pre and post implementation allocation data to assess whether heart allocations are taking longer and if there are changes to the acceptance sequence numbers.

Next Steps:

- UNOS Research staff will draft a data request. Additional members from the following committees will be added prior to the next conference call: Thoracic, Transplant Coordinators, and Liver and Intestine.

Upcoming Meeting

- March 11, 2020 (Teleconference)