OPTN ORGAN PROCUREMENT AND TRANSPLANTATION NETWORK

OPTN Liver and Intestinal Organ Transplantation Committee
Acuity Circles Work Group
Meeting Minutes
May 7, 2019
Conference Call

Julie Heimbach, MD, Chair
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Introduction

The Acuity Circles Work Group (the Work Group) met via teleconference on 05/07/2019 to discuss the following agenda items:

1. Discuss Committee Feedback on One-Hour Time Limit to Acceptance
2. Review Draft Basic Recovery Standards
3. Review Draft Survey Regarding Perceived Barrier to Local Teams Recovering
4. Review Draft List of Data to Request Related to Costs
5. Discuss Requirement for Recovery of Other Abdominal Organs

The following is a summary of the Work Group's discussions.

1. Discuss Committee Feedback on One-Hour Time Limit to Acceptance

During their last meeting, the Work Group discussed creating a one-hour time limit for transplant programs to submit a final acceptance as a way to decrease discards and the time it takes to place an organ. The Liver and Intestinal Organ Transplantation Committee (the Committee) then discussed the idea during their in-person meeting and gave the Work Group feedback.

Summary of discussion:

The issue that this proposal intends to address is when a program accepts two livers for the same patient, goes to the operating room (OR) and recovers the first liver, and then brings the liver back to their center before releasing the second liver. A similar problem is when some programs bring a liver back to their center and then decline the liver for "size" just so that they can then attempt to allocate the organ to a different candidate listed at their center. The proposed solution was to create a rule where the liver must be accepted with the intent to transplant within one hour of cross clamp. The Committee discussed the problem and proposed solution during their in-person meeting and provided the following concerns and recommendations:

Concerns:

- Concern that this would disadvantage programs willing to accept marginal organs and highly urgent candidates
- Proposed solution could cause more livers to be allocated through expedited placement
- Proposed solution could delay cross-clamp
- Some programs rely on local recovery so they need to bring the liver back to their center before final acceptance

Recommendations:

- Exempt Status 1 Candidates (programs more willing to accept marginal livers for highly urgent candidates)
- Exempt livers accepted through waivers

- Once procurement team leaves the OR, then all other offers are released for reallocation
- Have OPOs monitor late reallocations as a way to reduce behavior

A Work Group member noted that implementing the proposed solution for organs not from a donation after cardiac death (DCD) donor would be beneficial for organ procurement organizations (OPOs). The Chair asked if there should be a time limit for DCD donors. The Work Group member stated that this would depend on how long the donor took to pass away and that the time limit should be up to the transplant centers. It is more difficult to make an acceptance decision on a DCD donor, so there should be more time allowed.

A Work Group member stated that the problem was programs bringing livers back to their center before declining them. The Work Group member felt that there is no reason to leave the donor hospital without a final acceptance.

The Chair asked if they should include a provision to allow programs to make a mistake and miss the deadline once before they are referred to the Membership and Professional Standards Committee (MPSC). The Work Group supported this idea.

The Chair noted that at the in-person Committee meeting, a concern was raised about the proposal's impact on highly-urgent pediatric candidates. The concern was that programs may accept marginal livers or livers from older donors for these candidates but may receive a better offer while they are in the process of procuring the first liver. Some Committee members wanted to preserve the ability of transplant programs to accept better livers for highly-urgent candidates.

The Chair felt that if these candidates were listed as Status 1A or 1B, then it would not be worth the extra time to go get the second liver. Another Work Group member agreed that it would not make sense to have a Status 1A wait an additional 12 or more hours to get the second liver. The Work Group member did not think that Status 1A or 1B candidates should be exempt from the proposal.

Another Work Group member noted that OPOs will also need to be held accountable to make sure that organs are allocated according to the match run. The Work Group agreed that the Committee will need to discuss the proposal with the OPO Committee.

The Work Group also agreed to not include open offers in the proposal.

Next Steps:

The Work Group will continue to refine the proposal before bringing it back to the Committee for discussion.

2. Review Draft Basic Recovery Standards

The Work Group previously discussed creating a list of minimum requirements for organ recovery. The goal was to have more standardized recovery practices so that programs are more willing to utilize local recovery. A Work Group member was tasked with starting to develop the list of standard practices.

Summary of Discussion:

The Work Group member tasked with developing the draft presented some common clinical standards for liver procurement. The Work Group agreed with many of the guidelines and noted that programs will be able to deviate from the standard as needed. The Work Group is also working on a survey to address barriers to local recovery. The Chair suggested including questions about clinical recovery practices in the survey to validate some of the Work Groups suggestions. The Work Group agreed with including these questions in the survey.

The Work Group then discussed creating a standard list of images for OPOs to share with transplant programs. A Work Group member suggested that the images should include a surgeon's view in situ, a close-up in situ, and a post-flush in the basin. The Work Group felt that having these three images in UNet^{SM} would allow transplant programs to make better, quicker decisions. A Work Group member also noted that there is now technology to share biopsy images. The Work Group agreed that sharing these images would be ideal. The Work Group noted that it will become even more important to share information earlier in the process and more frequently with broader distribution. The Work Group agreed that they will need to work with the OPO Committee to operationalize these ideas.

Next Steps:

The Work Group member who presented the draft standards will write them up and share with the Work Group.

3. Review Draft Survey Regarding Perceived Barrier to Local Teams Recovering

The Work Group previously discussed creating a survey to help identify barriers to local recovery. The Chair created a draft survey and sent it to the Work Group prior to the meeting.

Summary of Discussion:

A Work Group member stated that two of the reasons why programs do not utilize local recovery are size issues and quality issues when transplanting highly urgent patients. The Work Group member also stated that sometimes it is faster to fly and recover the organ. Occasionally, the OPO will wait to put the organ on a plane until the procurement is complete, whereas if the transplanting program recovers it themselves, they will leave as soon as the organ is procured. Although it may not be captured in the survey, the Work Group member felt that timing, quality, and size are all important factors in utilizing local recovery.

The Work Group discussed the use of University of Wisconsin (UW) solution versus histidine-tryptophan-ketoglutarate (HTK) in procurements. Work Group members had varied preferences. They also discussed the cost associated with different procurement techniques.

Next Steps:

Work Group members will review the draft survey and send feedback to the group. The Chair will investigate any cost differences between the use of UW and HTK.

4. Review Draft List of Data to Request Related to Costs

The Work Group previously discussed how they will measure any changes in costs related to the implementation of the Acuity Circles policy.

Summary of Discussion:

The Chair noted that the definition of an organ acquisition charge may change because they were previously based on where the organ was recovered. The Chair also noted that it should be possible to measure costs related to flying because transplant programs receive invoices.

The Chair stated that they should come up with a more robust list of data points to track in order to see how the Acuity Circles policy impacts costs. The Chair noted that it would be best if they could have the data on these metrics from the year prior to implementation of Acuity Circles so that they can compare to the data from after implementation.

A Work Group member noted that some OPOs do not import livers so the data on these livers would need to come from the transplant center that imports the liver. A Work Group member noted that the organ acquisition fees are set by OPOs.

Another Work Group member noted that Acuity Circles could increase flying, which would cause organ acquisition costs to go up. The Chair noted that many transplant programs pay for their own flights so an increase in costs would not be reflected in the organ acquisition fee.

A Work Group member asked if the OPTN was tracking changes in costs after the implementation of the new lung allocation policy. If so, the Work Group member suggested using a similar methodology to measure costs. The Work Group member also suggested changing the definition of "local" to some fixed distance from the transplant program for cost measurement.

UNOS staff will reach out to their research team to see if there has been any analysis of cost data related to the new lung allocation policy.

The Chair stated that it is important to figure out some way to track this data in a reliable way. Even if they cannot capture everything and it is not perfect, it is better to have some good data than nothing.

A Work Group member commented that OPOs flying donors to their procurement centers makes cost analysis more complex. These flights must be included in any cost calculation. Another Work Group member noted that one OPO stated that it is actually cost-effective to fly donors to procurement centers because then they can manage the donor better. Another Work Group member agreed that this practice has proven to be cost effective.

Next Steps:

The Work Group will continue to discuss ways to track cost changes associated with the Acuity Circles policy.

5. Discuss Requirement for Recovery of other Abdominal Organs

The Work Group previously discussed a proposal to require the liver team to recover other abdominal organs if there is no local or pancreas/bowel team present. The proposal was suggested because some liver teams have been unwilling to recover other abdominal organs. The full Committee discussed the proposal and supported moving forward with it as a policy proposal but requested more definition on what the liver team would be responsible for doing.

Summary of Discussion:

The Chair stated that the Committee broadly supported moving forward with this as a policy proposal. This practice is currently an expectation, but it is not always followed so it should become policy. If it becomes policy, programs will be referred to the MPSC if they violate the requirement. A Work Group member stated that if the liver team recovers the other organs, then they should be provided transportation in a timely manner. The Chair also stated that the liver team should not be required to put kidneys on pumps.

Next Steps:

The Work Group supported moving forward with the policy proposal.

Upcoming Meeting

- To be scheduled