OPTN Organ Procurement Organization Committee
Deceased Donor Registration (DDR) Review Workgroup
Meeting Summary
October 8, 2020
Conference Call

Jeff Trageser, Workgroup Chair

Introduction

The OPTN DDR Review Workgroup (the Workgroup) met via Citrix GoToMeeting teleconference on 10/08/2020 to discuss the following agenda items:

1. Organ Dispositions Discussion
2. Review of Previous Discussions

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

1. Organ Dispositions Review Discussion

Summary of discussion:

Recovery Team #

The workgroup discussed the rationale for using the 6-digit Medicare provider number and questioned how this data is being used. One member noted that with broader distribution, more local recovery surgeons are being utilized and they might work for a local transplant hospital or an OPO. SRTR staff noted that this is important information to help monitor the logistical impact of broader distribution. For example, being able to determine if the recovery team was from the transplant center that would ultimately transplant the organ.

UNOS staff inquired if this data is used for membership purposes. UNOS Research staff noted that if it is collected at the individual level it could be used for that purpose, but

The workgroup members discussed using the UNOS 4-digit center code instead of the Medicare provider number. Workgroup members supported this as a way to improve the quality of the data. Additionally, the workgroup recommended clarifying the definition – if an individual working for an OPO procures the organ then the OPO would enter their organization's 4-digit code.

Initial and Back Table Flush Solution

Workgroup members agreed that the solution lists are acceptable and includes an "other" option. Members did question why the volume of the initial and back table flush was required and only collected for the liver and pancreas. Workgroup members discussed whether the flush solutions should actually be collected. One member noted that it could be important if there is a recall for a particular solution so that OPOs and transplant centers could identify those donors and recipients. Another member noted that it could be used if there is an unknown cluster of primary graft dysfunction.

The workgroup recommended removing the requirement to report the initial and back table flush solution for liver and pancreas dispositions.

Final flush and storage solution

Workgroup members noted that data is collected in the donor feedback and cascades to the DDR. Therefore, the workgroup did not recommend any changes to this data element.

2. Review of Previous Discussions

Summary of Discussion

Donor Management

The workgroup discussed how the list of medications do not provide much useful information. These are collected as yes, no, or unknown responses and do not provide dosages or identify how long these medications were given to the donor. There is also an issue of reliability because of the varying interpretation of what should be entered. For example, what type of diuretics (loop vs. osmotic) were given to the donor.

One member noted that heparin is included in the patient outcome models but there is still uncertainty about how and when the heparin is administered. For example, if a donor is not on a heparin drip, the OPO staff might enter "no" if they are following the flow sheet. Members agreed that any clarification would be helpful for anyone entering or using this data.

A member noted that his OPO uses the "other" field to enter antibiotics. Another member reviewed the SRTR models and noted that several of the medications in this section are included in the models. There was discussion about the possibility of pulling the data from the donor charts because it would have more information than just yes, no, or unknown. SRTR staff noted that they do look at all the fields and keep the ones that are predictive in the models. These usually remain in the models for three years before being re-evaluating the entire list. A member noted that if OPOs are not entering the heparin information consistently it could affect the models (since all donors receive heparin prior to cross-clamp).

UNOS staff agreed to help identify the medications that are important and determine if they are collected elsewhere, such as in DonorNet. One challenge with relying on DonorNet for data collection is some fields are not required to run a match. Therefore, the frequency of them being populated is an OPO-specific practice.

One member suggested that we remove all of the medications if the SRTR was willing to get the data from another source. SRTR staff noted that the benefit of getting data from the DDR is that its OMB approved form and a standardized way of collecting the data.

Inotropic Medications at Time of Cross Clamp

The workgroup agreed that this is important information but questioned how this could be applied to DCD donors. The workgroup agreed to update the language to include "or at time of withdrawal of life-sustaining medical support" in order to capture DCD donors.

Number of Transfusions

Workgroup members acknowledged that the current data element needs to be revised because there is a significant difference between one and five transfusions. Additionally, the "unit" for transfusions can be significantly different for a small pediatric donor than an adult donor.

A workgroup member suggested that actual volume in milliliters (ml) would be a more accurate measure. SRTR staff supported either capturing a more accurate count of transfusions or actual volume. A member inquired about the use of this data and if a larger number of transfusions is indicative of organ quality or recipient outcomes. SRTR staff noted that they do look at this across all organs to determine if it is predictive and questioned if data that are more granular might be even more

predictive. They also noted that the current effect in the liver model is not large but it was selected as one of the predictors. Finally, they noted that zero is the lowest risk, so anything other than zero is a higher risk in the models.

The workgroup discussed the timing of the transfusions. For example, a donor might receive a significant amount of blood products when first admitted to the hospital and then a week or so later the OPO initiates donor management and does not perform any transfusions. A member inquired if the workgroup decides to collect the volume, should there be a shorter timeframe. Currently, terminal hospitalization is very broad. Another member commented that if someone has received a number of transfusion, even if it is over a number of weeks, there are so many impacts on that patient and the viability of those organs. She also appreciated the concept of timing but consideration should be given to other factors that could affect outcomes.

A workgroup member suggested the following:

- Transfusions – yes or no
- If yes, total volume
- Timeframe

Upcoming Meetings

- October 22, 2020

Attendance

- **Workgroup Members**
  - Jeff Trageser
  - Meg Rogers
  - Deb Cooper
  - Sue McClung
  - Kristine Browning
- **HRSA Representatives**
  - Marilyn Levi
  - Adriana Martinez
  - Raelene Skerda
  - Jim Bowman
- **SRTR Staff**
  - Bert Kasiske
  - Jon Snyder
  - Andrew Wey
- **UNOS Staff**
  - Robert Hunter
  - Rebecca Brookman
  - Darby Harris
  - Peter Sokol
  - Sarah Taranto
  - Alice Toll
  - Kimberly Uccellini
  - Nicole Benjamin
  - Grace Acda
- **Other Attendees**
  - Diane Brockmeier
  - Kurt Shutterly