OPTN Liver and Intestinal Organ Transplantation Committee
Meeting Summary
September 6, 2024
Conference Call

Scott Biggins, MD, Chair
Shimul Shah, MD, MHCM, Vice Chair

Introduction

The OPTN Liver and Intestinal Organ Transplantation Committee (the Committee) met via WebEx teleconference on 09/06/2024 to discuss the following agenda items:

1. Continuous Distribution: Geographic Equity Attribute Follow-up
2. Continuous Distribution: Exceptions & Median MELD/PELD at Transplant (MMaT & MPaT)

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

1. Continuous Distribution: Geographic Equity Attribute Follow-up

Time was spent discussing this at the last meeting and now a rating scale must be established. Two binary geographic equity scales were analyzed. Two items to discuss are a binary versus decay function and interaction between geographic equity and travel efficiency. The travel efficiency scale is not yet defined. Several candidate profile scenarios (New York, California, Florida) were created to review to highlight how scales would work in different areas of the country. These can be analyzed in different ways for analysis.

Summary of discussion:

One member was concerned how other areas of the country might be impacted compared to large centers. The borders of the circles are the problem. The Chair suggested that maps could be generated around the over 3,000 potential hospitals in the U.S. A declining or decaying curve could be less problematic for competition. One member suggested the linear option is the best and most clear. The Chair suggested a hard boundary at a set distance is antithetical to the goals of continuous distribution. The inflection point in the curve, based on data, seems to be at 20 million (most benefit), and based on variance changes.

One member asked if there is disagreement on linear versus binary function. A member said the linear function is more in the spirit of continuous distribution. Urgency will still be the biggest consideration. When this option is simulated, it will help to clarify whether rural or less populated areas are at a disadvantage.

Next Steps:

A request to simulate at 20 million people with a 100 percent points, with a linear decay at 50 million people.

2. Continuous Distribution: Exceptions & Median MELD/PELD at Transplant (MMaT & MPaT)

Standard exceptions were reviewed at the last meeting. One, Hepatic Artery Thrombosis, is related to medical urgency. Some exceptions can be transferred to priority points. Inequity still exists with MELD exceptions. Urgency is likely more critical over access. Exceptions are the most controversial pieces of the current system for patients. Leaving some familiarity from the current to the new system will help.

A staff member presented how to potentially incorporate standard exceptions into continuous distribution and how the points framework can work. Exceptions can be prospective or retrospective. Options include discreet points, static medical urgency scores, and MMaT and MPaT scores.

Summary of discussion:

A member likes the mapping of median MELD minus 3. This is familiar. MELD/PELD urgency scores should be the driver of continuous distribution, with the other attributes coming next. Exceptions should be in the urgency bucket, and this should be the biggest bucket and there should be mapping to MMaT. High MELD patients should receive priority.

Another member agreed with the above member. The idea of median MELD minus 3 could be translated to a medical urgency percentage. Dynamic changes to these exceptions in future iterations of continuous distribution is more feasible.

The Chair emphasized that the goal is condition-associated priority and reduce true exceptions.

A member commented that median MELD at transplant has been thought of as patient access but can see how it falls into medical urgency. Urgency is already somewhat accounted for.

The Chair commented that the condition associated priority scores would be translated into median MELD minus 3 (or other number). Some geography is already included in miles around the donor hospital.

The consensus seems to be to keep median MELD at transplant. There is extra complexity, but everyone is used to this.

Right now, if a patient is median MELD minus 3, this is still unknown because it depends on donor hospital. Would this change for continuous distribution? The Chair said this would likely still be contingent on the donor hospital.

A member suggested providing a crosswalk or translation to better understand points and MELD scores for patients. This would be good for the future.

Upcoming Meetings

- September 20, 2024, at 2 pm ET (teleconference)
- October 9, 2024, at 8 am ET (in person)

Attendance

- **Committee Members**
  - Aaron Ahearn
  - Allison Kwong
  - James Pomposelli
  - Chris Sonnenday
  - Joseph DiNorcia
  - Neil Shah
  - Shimul Shah
  - Omer Junaidi
  - Scott Biggins
  - Shunji Nagai
  - Vanessa Pucciarelli
  - Cal Matsumoto
  - Kathy Campbell
  - Lloyd Brown
  - Michel Kriss
  - Marina Serper

- **HRSA Representatives**
  - Jim Bowman
- **SRTR Staff**
  - Jack Lake
  - Nick Wood
  - Ryo Hirose
- **UNOS Staff**
  - Benjamin Schumacher
  - Laura Schmitt
  - Meghan McDermott
  - Niyati Updahyay
  - James Alcorn
  - Cole Fox
  - Jesse Howell
  - Susan Tlusty