

OPTN/UNOS Committee • 6 days ago

The OPTN/UNOS Thoracic Committee (Committee) commends the OPO Committee's efforts to develop a framework for expedited organ placement. Such a policy should be useful to OPO's and hopefully will facilitate placement of organs at risk of being discarded. The concept paper mentioned potential significant delay in organ procurement to allow for allocation of organs turned down by procurement teams in the operating room. Any delay may adversely impact the thoracic organs because: 1) donor organ function may deteriorate under these conditions, and 2) the recipient operation will very frequently have already started resulting in unacceptably prolonged delays after induction of anesthesia and after incision and proceeding with the recipient surgical procedure; this include prolonging cardiopulmonary bypass time. This needs to be taken into account if extra time is spent on allocation of the turned down organs. The Committee pointed out it may be challenging to define an "aggressive" center and achieve consensus around the actual triggers that would be used to move to expedited placement. A majority of members disagreed with using DonorNet data to identify centers that would be eligible to receive expedited offers, and there was some concern around what evidence would be utilized to determine what a center would or would not accept (i.e. modeling would not be applicable). However, a few members supported a system-driven mechanism to determine eligibility, versus leaving it to the OPO's discretion.

There was consensus that an allocation system should include an expedited placement trigger based on an event like an organ declined in the OR that would allow an OPO to expedite organ placement, could allow an OPO to move to an expedited list after a well-defined point in the process and that transplant centers should be allowed to choose whether or not they want to have their candidates on an expedited list. There was less agreement amongst committee members in their responses to the other questions posed by the OPO Committee.

ASTS • 6 days ago

The American Society of Transplant Surgeons (ASTS) appreciates the opportunity to comment on the concept document on expedited placement for hard-to-place allografts. The ASTS strongly supports the desire to improve the efficiency of organ placement, reduce organ discard, and increase the number of transplants performed. As time to placement increases, ischemic time and the risk of discard increase. We strongly endorse rigorous tracking of acceptance behavior to avoid offering organs to centers that never use organs with certain risk factors.

Eventually this data will inform allocation of organs and streamline placement. We support the development of pilot projects to achieve expedited placement among interested centers. These might include automatic expedited placement using data-derived filters, center-based allocation, or inversion of the waiting list, as proposed by Dr. Ratner, 'dealing from the bottom of the deck.'

We recognize the concern that some centers might 'lose out' on offers based on their own past behavior and a system should be developed to increase offers to those centers based on expectations of increased acceptance using defined filters.

Ultimately the system will encourage and support centers that wish to expand their filters and increase utilization.

1. Should an allocation system include an expedited placement trigger based on defined donor characteristics that would allow an OPO to expedite the placement of an organ?

The development of a decision tool which identifies hard-to-place organs and triggers an alternative placement methodology is logical. This requires pre-recovery allocation to prevent late reallocation, which must become the exception and trigger quality review. This trigger may also be used to adjust the number of different centers that are offered the organ simultaneously to increase placement. As more centers gain experience with these organs, centers will be given the opportunity to change their

acceptance practices and regain access to donors with risk criteria.

2. Should an allocation system include an expedited placement trigger based on an event like an organ declined in the OR that would allow an OPO to expedite the placement of an organ?

We support the use of intraoperative turndowns as a trigger for expedited placement of donor organs as intraoperative turndowns dramatically increase the risk of discard. Additional triggers including the need for expedited recovery due to hemodynamic instability could also be considered. All intraoperative turndowns should be subject to QAPI activities at the level of the center and the OPO. Each time an organ is declined, the center should be asked to explain what data was available at recovery but not prior to that time (e.g., liver biopsy, abnormal anatomy) that led to this decision. Decline for quality after cross clamp dramatically increases the risk of organ discard. Centers which repeatedly engage in this practice should be encouraged to participate in process improvement activities.

3. Should the allocation system allow an OPO to move to an expedited list after a well-defined point in the allocation process (e.g., after offers to x candidates, after offers to x hospitals, within x hours of the scheduled OR time)?

We support other triggers to move to an expedited placement as appropriate. Once the donor is in the room, expedited placement is appropriate in the case of intraoperative turndown or expedited recovery for hemodynamic instability. In this case, cross clamp should be delayed pending final allocation of all extra renal organs if possible.

4. Once an expedited placement trigger has been met, should the OPO use their own discretion to get the organ placed for transplantation?

The ASTS supports the use of structured, policy-driven allocation decisions, that will incentivize OPO's to maximize placement of organs. The use of OPO discretion to bypass potential candidates to offer the organ to known aggressive centers reflects a failure of the current system that should be improved. The expedited organ placement system should include an opt-in feature (similar to high KDPI organ acceptance). However, if centers choose to opt in to the system and then repeatedly decline offers that are accepted by other candidates, they will be excluded from the expedited offer program until they demonstrate a plan to change their practice.

5. Once the expedited placement trigger has been met, should the list of potential candidates be limited to those at transplant hospitals with a recent history of transplanting organs from similar donors?

The organ allocation process must be fair and transparent. The use of extended criteria organ is contingent on having appropriate candidates on the list and institutional capabilities to care for similar transplant recipient/donor selection. The expedited organ placement system should include an opt-in feature (similar to high KDPI organ acceptance). Transplant programs should have the option to opt into the expedited placement system. Centers must look objectively at the benefits for their patients. In addition, patients who indicate a willingness to accept higher risk organs should be informed about the center's use of higher donor risk organs. Patients should also be provided with data on transplant rate and outcomes which will allow them to make an informed choice about accepting high risk donor organs.

6. Should transplant hospitals be allowed to choose whether or not they want to have their candidates on an expedited list?

Transplant programs should have the option to opt into the expedited placement system.

7. Should the allocation system give higher priority to candidates more likely to accept an organ that has a higher likelihood of discard based on statistical models?

As acceptance data improves, allocation will be informed by past behavior as in many other system algorithms. Patients should be included in the alternative allocation system on an opt-in basis and ordered using standard allocation parameters. Models that identify hard-to-place organs might be used to determine the number of initial offers that are made and should be used to initiate the expedited system.

8. Should DonorNet® set a transplant hospital's acceptance criteria based on the hospital's past acceptance practices?

Yes. However, centers should have the opportunity to set their own DonorNet® criteria and receive feedback about their acceptance practices. If centers repeatedly decline organs which are accepted by other centers and for which a willing listed patient exists, they should be engaged in a process improvement intervention such as the COIIN project. Centers that continue to decline appropriate offers should be subject to additional review by the OPTN and MPSC.

OPTN/UNOS Committee • 6 days ago

Region 3 Vote: 25 support, 1 oppose, 0 abstentions

The region supports the concept of developing a process for expedited placement. However, members cautioned the committee about developing policy that may only benefit a few centers or those centers with large waiting lists. There was concern about using past acceptance behavior as the criteria to limit which centers receive offers through an expedited pathway. There was a suggestion to allow a portion of the waitlist to be eligible to receive expedited offers at each center. For livers, members believe that there are ways to augment MELD to predict which livers would work well and believe that developing a COIIN project for liver could also be beneficial.

ASHI • 6 days ago

"The American Society of Histocompatibility and Immunogenetics generally supports the proposal. ASHI feels that additional study and clarification is required in cases where HLA laboratories may be under an expectation of expedited results. In regard to specific questions, they will be listed in order below: 1. ASHI generally supports an expedited system which may be of benefit to certain patients; but, such a system must balance utility and justice. 2. ASHI generally supports an expedited trigger in an attempt to limit organs being discarded. 3. ASHI generally supports an expedited system after a defined period of time in an attempt to limit organs being discarded. 4. ASHI generally supports an OPO using its own discretion to get the organ placed for transplantation, if in an expedited scenario. 5. ASHI generally supports an OPO using a list of potential candidates limited to those at transplant hospitals with a recent history of transplanting organs from similar donors. However, as stated above, such a system must balance utility and justice. 6. ASHI generally supports hospitals having the choice of whether or not they want to have their candidates on an expedited list. 7. ASHI generally supports any allocation system that attempts to limit organs being discarded. However, without seeing the data from modeling the statistical models, ASHI cannot offer further comment. 8. ASHI generally supports DonorNet® being utilized to bring efficiency to allocation in ways that minimize organ wastage and provides maximum possible benefit to patients. "

AOPO • 6 days ago

The Association of Organ Procurement Organizations strongly supports the development of a mechanism for expedited placement for deceased donor livers that are at risk of discard. The development of an expedited placement policy with specific guidelines will provide more transparency for the placement of these organs and reduce liver discards. The expedited placement system developed should have multiple triggers for expedited placement of a liver.

The system should include specific donor profile characteristics identified as early as possible in the donor allocation process which are predictive that expedited placement should be utilized for a specific liver based on these donor factors and other significant time constraints for transplant viability as exist or may arise during a case. In these circumstances, consideration should be given to a reduction in the time allotted for evaluation by each liver center. These expedited cases should also allow multiple

centers to be simultaneously contacted for liver evaluation offers.

Pre-procurement triggers for expedited placement in cases where the marginal liver donor becomes hemodynamically unstable, or is within a defined number of hours prior to organ recovery should be developed.

Another defined trigger should be when the liver is declined in the operating room. When the liver is declined during recovery in the operating room, this should trigger an expedited placement algorithm that considers liver transplant programs center acceptance criteria and historical acceptance behavior. AOPO understands the reluctance of some liver transplant centers to be defined by historical acceptance patterns, but the successful transplantation of these livers requires that centers be experienced and prepared to transplant these organs rapidly. Consideration should be given to developing a dynamic system that can continually assess actual acceptance practices (such as the existing SRTR liver offer acceptance ratios published in the program specific reports) and provide programs the opportunity to be considered for expedited placement if their programs acceptance practices change overtime.

As future policy is developed, AOPO encourages consideration of an expedited placement pathway for organs at statistical risk of discard from the beginning of the process (if defined triggers are known and present prior to allocation) rather than later in the process as a rescue when accumulating time compounds risk of discard or compromised outcome. Evaluation of the effectiveness of an expedited placement policy on a number of factors including total time by stage of placement, distance, utilization rates and patient/graft survival outcomes will be critical. Any data collection required to support that analysis should be included in policy development.

OPTN/UNOS Committee • 7 days ago

The Operations and Safety Committee supports the overall idea of developing expedited organ placement. The OPO Committee has initiated the discussion of this notion with their Concept Paper on Expedited Organ Placement.

The Committee believes that this paper is very timely and is important to discuss in the context of issues outlined in the Ethics Committee paper, "Manipulation of the Waitlist Priority of the Organ Allocation System through the Escalation of Medical Therapies". Several members requested that the OPO Committee take into account effective practices that might differ between local and national allocations. The Committee asks that the Committee also consider distance to delivery as they develop the concept. Committee members agree that the allocation system should include an expedited placement trigger that would allow OPO to expedite organ placement. They also agree that the allocation system should include an expedited placement trigger based on an event like an organ declined in the OR or after a well-defined point in the process. The Committee believes that the allocation system should give higher priority to candidates more likely to accept an organ that has a higher likelihood of discard based on models.

They believe that hospitals should be allowed to choose whether or not they want to have their candidates on an expedited list.

Committee members have varying opinions on whether once an expedited trigger has been met, the OPO should use their own discretion to get the organ placed for transplantation. They do not have a consensus opinion on whether once an expedited trigger has been met, the list of potential candidates should be limited to those at hospitals with a recent past history of transplanting similar donors.

The Committee has mixed opinions on whether DonorNet should set a transplant hospital's acceptance criteria based on the hospital's past acceptance practices. The Committee would not support this principle unless there was a well-defined way to change when there was a change the logic for individual patient circumstances or when there was a staff or philosophy change at a transplant program.

OPTN/UNOS Committee

Region 7 Vote: 13 support, 1 oppose, 1 abstention

The region supports the concept of developing a process for expedited placement. Members of the region offered the following comments for the Committee's consideration as they develop policy language:

Expedited Placement Criteria:

- Members were opposed to allowing past behavior to be used as the criteria to limit which centers receive offers through an expedited pathway. A historical look at acceptances without expedited placement would be very different than acceptances under expedited placement.
- There was a suggestion to create an acceptance threshold to determine which centers qualify for expedited placement. This threshold would likely need to be adjusted over time. Centers would need to continue to meet this threshold in order to qualify for expedited placement offers.
- Members suggest that the committee define the criteria for intraoperative turndowns first and then pursue pre-OR criteria rather than trying to address both at the same time.
- Members suggest defining marginal livers and stratifying this criteria by severity.

Other:

- The committee needs to consider a mechanism that will relieve transplant centers of their financial liability when accepting expedited organ offers without full waivers when the organ is "not as advertised."
- The community considers expedited placement based on allocation to a transplant center rather than patients. Patients may be willing to take organs that the transplant center would not accept. Will patients know that they are being bypassed because of the acceptance practices of the transplant center they are listed at? How will they be informed?

OPTN/UNOS Committee • 7 days ago

Region 11 vote: 18 support, 0 oppose, 0 abstentions

Comments: Region 11 views favorably the concept of expedited organ placement and believes that too many organs are discarded due to inefficiencies in the current system. Many members wish that this proposal included a component to define what a provisional yes is and thereby require centers to evaluate offers in real time; this is believed to be the most abused component of the current system. From an OPO perspective, members of Region 11 will be glad to have an expedited placement plan on paper. OPOs are often put in positions where they are forced to choose between expediting placement (which is not currently addressed by policy), or discarding an organ. The Region 11 OPOs welcome direction from the OPO Committee.

Members from transplant centers in Region 11 are concerned about the prospect of any pre-OR trigger to expedited placement and instead prefer in-OR triggers. There is much information that can be gleaned only in the OR that would be valuable to a center's decline or acceptance of an organ, such as anatomy and biopsy results. To expedite placement based only on pre-OR information would be premature and would not take into account certain crucial factors.

Members from transplant centers also strongly believe that past acceptance should not play a role in screening centers from expedited placement. Many programs evolve their acceptance behaviors, change their personnel, or take on patients with unique needs, and it is impossible to guarantee that centers who have not previously entertained certain organ offers would not utilize such organs in the

future. While Region 11 members feel that past acceptance behaviors should not be a consideration, they believe that if it is a component of a future proposal, then there should be a pathway by which centers can be re-considered for expedited placement organs.

Finally, some members in Region 11 noted that organs should be directed to centers – rather than patients – in cases of expedited placement. If an organ is deemed appropriate for expedited placement, then all measures must be taken to ensure its utilization. The best way to accomplish this is to direct offers of such an organ to centers who are good fits, and allow the centers to select the most suitable candidate on a case-by-case basis.

NATCO • 7 days ago

NATCO supports the concept of developing a process for expedited placement with the goal of reducing non-productive time and increasing organs transplanted. NATCO agrees with establishing triggers both pre-O.R. and intraoperatively based on donor characteristics in an effort to maximize consistency and decrease organ discards. Establishing a pre-OR trigger is important, but may be more difficult to define than an intraoperative trigger. However, initiating an expedited process within 3-4 hours prior to a set O.R. time may be a good trigger point because this would allow non-local transplant centers time to coordinate flying in for the recovery. Allowing OPOs to use their own discretion to get organs placed lacks transparency and is the reason why establishing guidelines is imperative to demonstrate equity in access to organs. Limiting expedited organs to those at transplant centers with a recent history of transplanting organs from marginal donors is risky when promoting equity in access; however, when data proves only a few centers are taking these organs, those centers should have some priority to limit potential discards. Centers accepting these expedited organs would need to be reviewed frequently such as every 6 months to determine if other transplant centers have changed their acceptance patterns related to these types of organs. It is difficult to predict future behavior based on past behavior because of staff and surgeon turnover as well as new data and research in the field of transplantation.

OPTN/UNOS Committee • 8 days ago

The MPSC thanks the OPO Committee for presenting its concept paper on expedited organ placement and for its work so far in trying to create consistent processes for members to follow. The MPSC hopes that these processes will not only reduce the number of expedited placement cases that it reviews, but will in turn reduce members' burden in responding to inquiries and providing additional information that is currently needed for these reviews.

MPSC members agreed that separate triggers for pre-O.R. expedited placement and in-O.R. expedited placement are reasonable. One MPSC member stated that in general, cold ischemic time is the factor that ultimately decides whether an organ is used or discarded, so it would be an important variable to consider. If an offer is made post-cross-clamp, a hospital's geographic proximity to the donor will likely help determine whether or not the offer is accepted. Another MPSC member recommended that a trigger based on offers made to a certain number of candidates may be easier to implement than a trigger based on offers made to a certain number of hospitals because the number of hospitals in a certain geographic area is inconsistent, as is the number of candidates on any hospital's waiting list. Some MPSC members were concerned about basing eligibility for expedited offers on past program organ acceptance behavior because behavior can change over time, not only due to a program's decision to change its behavior, but also due to staffing changes and recently implemented or pending allocation changes that may impact the number and types of organs available to a program. Other MPSC members stated that limiting the number of programs receiving expedited offers would be necessary in order to increase the chance that an organ is placed instead of discarded. Additional suggestions included:

- Developing criteria for programs to meet that would let them demonstrate changed behavior if they

are initially excluded from receiving expedited offers

- Using modeling to determine the right balance between the number of programs receiving expedited offers and the desired decrease in discarded organs
- Moving towards the OPO committee's additional concept of incorporating the probabilities of discard and acceptance into the allocation algorithm as the ultimate solution for decreasing the number of discarded organs

The MPSC believes that transparency and accountability are both crucial in the development of the expedited placement processes, and committee members offered the following feedback:

- The types of organs that would be eligible for expedited placement, as well as the eligibility criteria to receive expedited offers, should be precisely described and explained to the community.
- The triggers for expedited placement should be written in policy, and it should be clear in the computer systems when a threshold for expedited placement has been met. The MPSC supports automating the expedited placement process as much as possible, with the hope that they would only need to review expedited placement cases that do not follow policy.
- If the expedited placement processes start to move allocation of certain types of organs to program-specific offers instead of candidate-specific offers, then the proposal should be transparent in discussing this idea.
- Transparency in hospitals' acceptance practices is also important because patients may not know that their hospital is passing on certain types of organs.
- The OPTN previously studied hospital organ acceptance practices, and the results showed that many hospitals' stated acceptance criteria were broader than the hospitals' actual acceptance practices. The results were communicated to the hospitals, but few changes in behavior were observed. Until members are held accountable for their acceptance practices, the proposed process improvements may not be effective.
- After the expedited placement processes are implemented, the OPO Committee should be sure to do a "big picture" review of the effects of expedited placement to make sure that increased efficiency in placing organs hasn't resulted in certain parts of the community being underserved.

Maryjane Farr • 8 days ago

Overall this is a reasonable proposal. I do think this proposal should be limited to programmed triggers done by UNOS and that ad hoc OPO influence bears little if any role in this initiative.

Christine Brenner • 8 days ago

This is a great concept paper and very much needed. I feel that it is important to make the 'last minute' organ allocation so that no organs go in the trash!

Jamie Bucio • 8 days ago

I would support expedited placement based on extended criteria donors/ create organ specific criteria and Placement within a 'X' amount of offers of a scheduled OR time (would need to watch for abuse of this). No to OPO discretion to use their own discretion to get the organ placed for transplantation- could go back to aggressive center only, open offer days and potentially decrease equity, No to after after a well-defined point in the allocation process (e.g., after offers to x candidates, after offers to x centers- this could also limit access to organs geographically depending on allocation model. Yes to organ declined in donor OR. I do support expedited patient waitlists through donor selection criteria. Would only support forced screening after a certain time period of center behavior from start of implementation (give them a chance to open up their minds and speak with their patients about option/ changes). Offer option for centers to opt out of expedited placement offers to facilitate allocation or set criteria they would accept that drives placement of these organs. Would prefer expedited patient

waitlists over priority points. Are there legal ramifications to setting hospital acceptance criteria. Can limit patient access without potential informed consent.

Anonymous • 8 days ago

I would be concerned having a system in place that would allow the OPO sole discretion on how to place the expedited organ without any type of external monitoring. I also do not think a center's past acceptance criteria should determine future offers.

Barbara Jenkins • 8 days ago

Clear Triggers need to be defined.

Anonymous • 8 days ago

While it is our communities goal to get as many people transplant with all organs we need to ensure that all patients have as much as a fair chance as possible. This is particularly important in a situation where a patients health status can change dramatically as is the case with liver patients. We do not want to disadvantage patients who may be listed at a less aggressive center if that is the only option they have near to them.

Anonymous • 8 days ago

This concept paper is very OPO driven selection process that takes the primary choice from transplant centers. Concerns at regional meeting were that transplant centers would be given a 'score' or whatever process was given and other smaller centers would be excluded despite geography or acuity of patients. Considerations need to be given to how will OPO decisions be monitored or enforced and how would transplant centers be able to dictate their criteria in order to participate. At this time, there is more work to be done. I would support the concept or idea, but would need further discussion before implementation.

Richard Cummings • 8 days ago

I feel strongly that all expedited placement be handled by the Organ Center. There is too much disparity in allocation from local OPO's.

OPTN/UNOS Committee • 10 days ago

The Kidney Committee is supportive of expedited organ placement. The Committee thanks the OPO Committee for the chance to provide feedback early in the concept process. This is a topic that involves the entire transplant community. Specific feedback questions were discussed by the Committee: Should an allocation system include triggers for expedited placement based on defined donor characteristics?

The Committee supports expedited placement triggers. The Committee understands that initially this concept is focused on liver allocation, but the Committee decided to develop policy similar to a trigger with the dual kidney allocation project. Current variability in how OPOs handle expedited placement creates inequity and lack of transparency.

Should an allocation system include triggers for expedited placement based on an event (like organ decline in OR)?

The Committee supports triggers based on process altering events.

Should system allow OPO to move to expedited list after well-defined point in allocation process (after X offers to candidates, X hours of scheduled OR time, etc.)?

The Committee supports expedited placement options after well-defined points in the allocation process. The Committee is interested in further discussions about the details of those well-defined points, as they may change depending on type of organ.

Once trigger met, should OPO use discretion to place organ?

The Committee does not support absolute OPO discretion. There must be defined rules/criteria for transparency. Given each organ, stringent policy review would need to take place to ensure that expedited placement at a given point does not go into violation with current policy, such as highly sensitized allocation in KAS.

Once trigger met, should list of candidates be limited to those at transplant hospitals with recent history of transplanting organs from similar donors?

The Committee strongly objects to limiting candidate list to those at transplant hospitals with recent history or transplanting organs from similar donors. With a process like that in place, the other transplant hospitals would have no chance to receive offers or change behaviors.

Should transplant hospitals be allowed to choose if candidates are on expedited list?

The Committee supports transplant hospitals selecting candidates to be involved in expedited list. The transplant hospitals, and the candidates' physicians and transplant team, are the ones to make that decision – based on urgency and discussions with the candidates.

Should system give priority to candidates more likely to accept an organ that has a higher likelihood of discard based on statistical modeling?

The Committee does not support using statistical modeling to skip candidates and break allocation classifications. The Committee believes that rules/criteria need to be set and the match run should be followed.

Should DonorNet set acceptance criteria based on hospital's past practices?

The Committee does not support acceptance criteria based on a transplant hospitals past practices. Turnover at transplant hospitals happen routinely, and with new surgeons and physicians come new practices and behaviors.
see more

AST • 20 days ago

The American Society of Transplantation supports the proposal in concept and offers the following comments: The AST agrees that policies and guidelines should be developed to guide the expedited placement of donor livers at risk for discard (marginal organs). The expedited allocation system should identify donors as 'potential expedited placement donors' when they possess specific profile characteristics of expedited donors (e.g., age >65, BMI >35, DCD) early in the process and prior to procurement, in order to alert potentially interested centers as well as the local programs that donor acceptance and utilization is under significant time constraints. Once a liver is declined in the OR, the OPO should trigger an expedited placement using a standardized pathway or guidelines that utilizes a list of liver transplant programs profiled to accept organs under these conditions. The list should focus on center acceptance criteria and historical acceptance patterns rather than an 'expedited list' of patients who wish to accept such organs. Furthermore, OPTN should establish clear parameters regarding the placement process and specific timelines for decisions by the primary and backup centers when evaluating marginal organs. Emphasis should be placed on assessment of organ quality and utilization decisions made prior to cross clamp whenever possible. A time limit (e.g., 1 hour from cross clamp) should be implemented on the primary center for a decision to allow for expeditious placement with other vetted centers. Subsequent 'expedited centers' should be contacted in parallel when feasible and limited evaluation time allotted per center. The recommended pre-procurement trigger for expedited placement (within 2-3 hours prior to organ recovery) will have some benefits as well. This process of having a back-up accepting program for expedited placement prior to procurement is likely

more efficient than offering the organ back to the list if turned down by the accepting program. In addition, the triggers should be in place for high-risk donors who become hemodynamically unstable or donor livers that are considered 'marginal' as described above. Transplant programs with clear past acceptance practices for organs at risk of discard will be included in the eligible programs for expedited placement, and programs without track records may be considered but should be audited regularly to determine their actual participation. Expedited placement requires rapid assessments in short periods of time, and participation of programs in the process that do not put their commitment in practice will simply delay the process and increase the risk of graft dysfunction after transplant. Some metrics regarding center specific behavior should be developed and monitored to determine which centers are more likely to transplant these 'marginal organs'. This strategy will likely decrease the time for organ allocation and increase likelihood of transplant so that the utilization of these potentially discarded organs is optimized. The development of an expedited placement policy with specific guidelines will provide more transparency for the placement of these organs. Importantly, outcomes of the organs placed expeditiously should be monitored along with other logistics as such as time to placement, costs, etc. We recommend instituting a program for both data monitoring and sharing of best practices for marginal liver grafts allocated under an expedited program. The Collaborative Innovation and Improvement Network (COIIN) implemented by the OPTN to evaluate high KDPI kidney utilization provides an excellent model for a similar program.

OPTN/UNOS Committee • 22 days ago

Region 10 Vote: 16 support, 0 oppose, 3 abstentions

The region supports the concept of developing a process for expedited placement. Members of the region offered the following comments for the Committee's consideration as they develop policy language for fall 2018 public comment:

- Members caution the committee with using past behavior as a criterion to limit organ offers through an expedited pathway. The acceptance practices of transplant programs may change for a variety of reasons, including changes in personnel.
- The region is supportive of the two triggers being defined as pre-OR and in-OR.
- The committee needs to take into consideration the opportunity for manipulation and gaming. One example is a single center OPO that has a stake to allocate the organ locally, and could move forward with expedited placement because a centers farther away cannot arrive at the donor hospital as quickly as a local center.
- A member asked that transplant center representatives continue to be included in discussions for developing a proposal for public comment.

OPTN/UNOS Committee • 23 days ago

Region 4 supported the proposal but several members were opposed to allowing past behavior to be used as criteria to limit which center's candidates were on "the list". Those with concerns agreed that behavior can change for a variety of reasons. If the committee does move forward with this trigger, the members feel there needs to be a review of behavior on a regular basis and a defined mechanism for centers to get onto the expedited placement list if their behavior changes. There was also a suggestion that organs transplanted based on expedited placement should be excluded from SRTR performance analysis. Some members support having the committee review programs that put organs "at risk" because of a pattern of late declines. Members agreed that one of the concepts for an allocation system that would give higher priority to candidates more likely to accept an organ that has a higher likelihood of discard based on statistical models, would be difficult to explain or operationalize. Finally, the members were curious about how and when this might roll out to organs other than liver.

Region 4 vote: 27 support, 2 opposed, 1 abstentions

OPTN/UNOS Committee • 23 days ago

The OPTN/UNOS Transplant Administrators Committee (TAC) received a presentation and discussed the Expedited Organ Placement Concept Paper (OPO Committee). The Committee applauds the OPO Committee's work on this issue and agreed something needs to be in place to expedite organ placement and this is a good first step. However, building a model around acceptance practices will be extremely difficult and could have unintended negative consequences when assuming past behavior dictates future behavior. This could negatively impact the system and patients overall. Several members raised the question about how a center could get back into the "expedited system" if they were originally left out. Programs can become conservative after a dip in outcomes or a change in leadership and a center that was previously conservative may find that they look very different under new physician/surgeon leadership and there needs to be a mechanism to allow them to make these changes as their program changes. A member also asked, "As we build a system for expedited placement, how do we make sure it stays expedited?" It was agreed that one way is to reduce time to evaluate from 1 hour to 30 minutes. However, if there are no discerning qualifications essentially it's the same national offer pool and there needs to be some level of filtering or there will be a situation with miss opportunities.

OPTN/UNOS Committee • 24 days ago

Region 8 Vote: 22 support, 0 oppose, 0 abstentions

The region supports the concept of developing a process for expedited placement. Members of the region offered the following comments for the Committee's consideration as they develop policy language for fall 2018 public comment:

- Members were opposed to allowing past behavior to be used as the criteria to limit which centers receive offers through an expedited pathway. With data tools, such as the ROO, transplant centers can analyze their acceptance patterns and change their behaviors. Likewise, aggressive centers may come under review for performance and as a result become less aggressive.
- The committee needs to better define which organs should be "expedited" organs. Members feel that there are "good organs with bad reputations" and not all centers will be willing to take these organs. There was a suggestion that it might be reasonable to create an alternate list of local candidates that would accept these types of organs.
- The factors that trigger expedited placement should be different depending on whether the acceptance is made pre-OR or after visualization in the OR.
- There needs to be a back-up plan for when organs accepted via expedited placement are declined and this plan may need to be broader than just the local list.

Kevin Myer • a month ago

LifeGift, the OPO based out of Houston, Texas supports any effort to remove non-productive time in the allocation and/or distribution processes that contribute to 1) organ loss or 2) increased morbidity in recipients. Past acceptance behaviors/patterns of programs should be considered at some threshold level as past behaviors are indicative of current behaviors when centers continue with same approaches, criteria, etc. When major personnel or program changes occur, these are required to be reported to UNOS, and thus a mechanism exists to allow for changes in auto-screening by the allocation system to help reduce offer time when programs take on a new 'phenotype.' In addition, while this effort is needed and laudable, please consider accelerating the entire system from minute 1 rather than allowing the current system to perhaps languish for a certain number of hours, then transition over to an accelerated process.

Shawn Pelletier • a month ago

Generally agree with the concept and supportive but need more details.

OPTN/UNOS Committee • 2 months ago

Region 2 vote: 21 support, 4 opposed, 2 abstentions

Comments: Region 2 supported the proposal but several members were opposed to allowing past behavior to be used as criteria to limit which centers candidates were included on the expedited list. Those with concerns agreed that it is difficult to predict future behavior based on past behavior and behavior changes for many reasons including new surgeons/physicians, patients severity of illness, availability of surgeons/physicians- to name a few. If the committee does move forward with this trigger, the members feel there needs to be a defined mechanism for centers to get onto the list if their behavior changes and clear guidelines for inclusion on the list. There was also a comment about the "Fast Track" system used by Euro Transplant. Under this system they found that more and more programs started accepting marginal organs and they were not successful in narrowing the list to speed up allocation.

OPTN/UNOS Committee • 2 months ago

Region 5 vote: 24 support, 1 oppose, 0 abstentions

Comments: Region 5 overwhelmingly supports the direction of the OPO Committee to pursue a policy to allow for expedited placement procedures. Members of the region offer the following comments for the Committee's consideration as they develop policy language for fall 2018 public comment:

During the region's OPO breakout session at the regional meeting, the region's OPOs determined a majority of support for "in OR" triggers instead of donor characteristic triggers for initiating expedited placement.

Some members feel that transplant centers must not be permitted to be bypassed in an expedited placement scenario based on history of acceptance of comparable organs. While some centers surely exhibit patterns of acceptance behavior, surgeons come and go and staff who are new to transplant centers and who may have very different philosophies on organ acceptance cannot be excluded because of the patterns of a departed staff. It is also possible that a particular center may not have previously listed the type of patient that would be suitable for an expedited placement organ in the past, but that center may list such a patient in the future and should not be excluded for consideration.

Meanwhile, other members feel that past acceptance behaviors must be accounted for in any expedited placement scenario pursued by the Committee; otherwise, placement of a potentially marginal organ continues to be cumbersome and the purpose of expedited placement is defeated. It is suggested that expedited placement should identify transplant centers who are most likely to accept the organ offer, and to further increase efficiency of placement, each of those centers should then identify the first person that they would consider for such an offer; this would pare down the match and truly promote quick, efficient placement.

A comment was made that the Committee should focus on increasing the granularity of organ screening criteria for transplant centers. For instance, DCD acceptance should be indicated by specific distance instead of simply a local/national breakdown; the current options force centers to open up their criteria to be sure that they miss nothing, and the result is that little to no actual screening takes place.

David McCloskey • 2 months ago

I would suggest that the OPO geographic area should be taken into account in the expedited placement concept. Many of the hospitals in our DSA (ORUO) have a limited potential for successful transportation of an organ to a 'local' transplant center in less than 3 hours. Placement efforts starting after a decline in the OR, transport to an airport and finding a commercial flight as evening approaches leads to long cold

time on kidney and pancreas allocation outside our DSA. It would be great if the OPO could begin aggressively seeking a center before the OR in order to quickly have a primary acceptance and a plan in place.