UNOS Liver Redistricting Concept

Summary

The United Network of Organ Sharing (UNOS) Liver and Intestinal Organ Transplantation Committee recently circulated a concept paper to its members for review and comment. This concept paper suggests the redistribution of livers from a regional basis for status one patients to either a four or eight district model. Under this model, organ procurement organizations would be required to provide donor liver organs to the patient in the (4 or 8 district) area with the highest *MELD/PELD score.

*MELD is the "Model for End-Stage Liver Disease" and PELD is "Pediatric End-Stage Liver Disease." (a numerical scale with a calculated score that predicts who needs a transplant most urgently.) The calculation is based upon various factors such as patient age, test results, etc.

Action

Individuals and institutions are welcome to respond to this concept paper by **July 11, 2014**, via an online survey located at: https://www.surveymonkey.com/s/liverredesign

Position: The UW Health Transplant Program and UW Organ and Tissue Donation are opposed to this concept. Our reasons for opposition are as follows:

1. **Lack of data**:

Addressing geographic disparity in liver distribution has already been attempted under Share 35, which changed liver allocation from a local to regional basis. Share 35 was implemented less than one year ago. It is underdeveloped and there has not been an accumulation and analysis of the data to demonstrate whether the Share 35 policy change has improved any of the following key performance metrics:

1) 1 year patient survival outcomes
2) 1 year graft survival outcomes
3) 3 year patient survival outcomes
4) 3 year graft survival outcomes
5) Pre-transplant mortality on the waitlist

Nationwide implementation of a new liver allocation policy is concerning, given the lack of data that has been assessed on Share 35 and the absence of piloting a new system prior to implementation. There have been significant concerns voiced from the OPO community regarding Share 35. These have been documented at UNOS Regional meetings, AOPO national meetings, Regional conference calls and local emails and phone calls. UNOS has not proactively addressed any of these concerns in the concept document. It is careless to move forward with broader allocation until these issues are addressed and policies are implemented to resolve them.

2. **Potential decrease in overall patient outcomes.**

The models presented in the concept paper are deeply flawed and do not generate substantial improvements to patient care. Table 1, page 10, titled Results of Optimized Redistricting Plans states

that even the most drastic change to allocation, creating 4 districts, and helps 553 patients over 5 years. This is not optimizing patient care or lives saved. It seems unjustifiable to re-allocate livers across the nation for such a marginal change. Increased organ travel distance under the 4 or 8 district model increases cold ischemic time and may have a more negative impact on patient outcomes than anticipated.

In addition, quality of life is not accounted for in the outcomes measured for the new allocation scheme. It is concerning that we look at 1 year survival but do not differentiate along the vast spectrum of what 1 year patient survival looks like. Our stewardship to the community requires us to not only create an equitable system but also create the best possible outcome for the patient. A 1 year patient survival outcome may be that the patient is at home and returned to work or it may be that the patient is in a long term care facility with severe complications after their transplant. It is critical for us to understand the 1 year outcomes and begin measuring the transplant episode not just in length of hospital stay but also in the time for the patient to return home.

3. **Cost:**

The cost data reflected in the concept document is inadequate; only two papers are referenced. One paper was published in October 2009 and used cost data from 2002-2007. The other paper was published in March 2011 and used cost data from 2004-2007. It is irresponsible to draw conclusions from this outdated information. Increased transportation costs are noted in the concept paper, which will increase the cost to hospitals, government payors and patients that have to absorb the additional costs of organ acquisition fees. The transportation cost and safety risk for organ recovery personnel has increased since the implementation of Share 35. Flying teams of personnel, even in the best conditions, bears significant risk and should not be taken lightly. This risk alone should compel us to make local allocation the first option available for each patient.

4. **Organ donation rates**:

If each OPO in the country could yield two more liver donors per year results would exceed the entire redistricting plan. The time, energy and debate that are being spent on the redistricting plan are fundamentally misdirected and distract the community from a more meaningful discussion about increasing organ donation. Indeed, the proposal removes the local accountability for transplant centers to work with their local OPOs on increasing organ donation which weakens our national system. Transplant centers would simply wait for the “system to provide” an organ for their recipient rather than taking a more active role in their local community to educate and engage the public on the need for organ donation.