OPTN Expeditious Task Force
Meeting Summary
January 28 and 29, 2024
Detroit, MI

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Introduction

The Expeditious Task Force met in-person in Detroit, Michigan, and virtually on January 28-29, 2024, to participate in a collaborative workshop. The Task Force engaged in activities, presentations, and discussions around the following topics:

1. Mapping the Transplant Journey
2. Communication Strategy
3. Community Forum Planning
4. Fireside Chats with Brandi Krushelniski & Michael Goldstein
5. Rescue Pathway Variance Protocols
6. Organ Non-Use Study
7. Policy Review
8. MPSC Allocations Review

In addition to the appointed Task Force members, Task Force advisors and guests, representatives from the Health Resources and Services Administration (HRSA), the Centers for Medicare & Medicaid Services CMS), the Scientific Registry of Transplant Recipients (SRTR) contractor, and the Organ Procurement and Transplantation Network (OPTN) contractor that attended were invited to participate in the activities and discussions. The following is a summary of those activities.

1. Mapping the Transplant Journey

During the opening hour of the workshop, Task Force members reviewed and provided feedback on the journey map created by the OPTN contractor and support staff. The journey map displayed the step-by-step process of organ transplant from four lenses: patient, donor family, organ procurement organization (OPO), and transplant center. While the version of the journey map hung on the workshop's walls was based on prior user experience research, fine tuning is always necessary. Task Force members could rearrange steps of the transplant process, add new steps, elaborate on existing steps, or provide general feedback.

Next Steps

The team will update the journey map based on the feedback collected, pinpoint where the Task Force's solutions fall in the transplant journey and transform it into an interactive prototype to share with the wider community.

2. Communication Strategy

The OPTN contractor invited Envoy, a consulting firm with expertise in strategic communications, to share ways to create effective messaging around the Expeditious Task Force's purpose and mission. At the start of the workshop, the firm's lead mediator presented a preliminary communications deck to the

Task Force for review, and then solicited feedback from the audience on areas for improvement. At the end of the workshop, the mediator presented a revised version of the communications deck based on the initial round of feedback.

3. Community Forum Planning

The Expeditious Task Force has the opportunity to engage the broader transplant community in its work through community forums. These forums will enable the Task Force to collaborate with more stakeholders and devote the necessary amount of time to addressing areas of opportunity within the OPTN. On the first day of the workshop, Task Force members met in small groups to brainstorm on the aspects of organ utilization and efficiency which they believe could best be addressed through a community forum. Below are the topics the Task Force submitted:

1. C-Suite engagement, buy-in, and commitment-making
2. Creating a formal definition of "successful" transplantation
3. Defining and preventing "late declines"
4. Increasing transplant center capacity and academic health care delivery systems to create sustainable, quality growth
5. Developing an ethical, alternate pathway for hard-to-place organs (separate forum for each organ)
6. Increasing organ utilization through greater patient readiness at time of offer
7. Reducing variation in donor management practices
8. Standardization of allocation practices between OPOs, between transplant centers, and between surgeons
9. Creating transparency around cost reimbursement

4. Fireside Chats

Brandi Krushelniski, MBA, RN, BSN

On Sunday evening, the Expeditious Task Force had the pleasure of learning from Brandi Krushelniski, Vice President of the Norton Thoracic Institute of St. Joseph's Hospital & Medical Center in Phoenix, Arizona. Brandi gave a brief presentation on her program and its mission, explaining how the Norton Thoracic Institute grew to become one of the nation's top lung transplant programs in less than ten years. The program boasts high transplant volumes and short waitlist times, while maintaining above average survival rates. Brandi also participated in a guided discussion with Task Force leadership, with the key takeaways noted below:

- **Involve the C-Suite:** Brandi noted the importance of involving the hospital's C-Suite in major transplant program decisions and events; continuous exposure and participation in the transplant program's operations increases support and buy-in. In the past, she has invited C-Suite members to speak to new physicians at welcome events and includes C-Suite members in their transplant council.
- **The power of the patient:** Brandi emphasized how influential it can be to invite stakeholders to meet the patients whose lives will be impacted by the decisions they make. Whether it is the hospital's C-Suite or the finance department, Brandi has found she makes the most compelling case when she focuses on the patient.
- **Establish personal relationships with OPOs:** Brandi explained, from the lens of a transplant program, the importance of building and nurturing person-to-person relationships with OPOs. Brandi's thoracic program conducts many outreach initiatives with various OPOs, has new team members tour the OPO and histocompatibility labs, forms relationships with the pulmonologists

and other staff members, and welcomes OPO staff to call in at any hour of the night. Brandi also noted the importance of repeating this philosophy of personal relationship-building with other stakeholders in the transplant community, including finance departments and transportation partners.

- **Cost barriers:** When asked about the biggest challenges her program is currently facing, Brandi explained how new technologies are constantly being developed that could drastically improve transplant outcomes, but no roadmap has been created yet for financing that technology. Until a reimbursement model is established for purchasing and maintaining such technology, it is cost prohibitive.

Michael Goldstein, MD

On Monday morning, the Expeditious Task Force hosted a second guest speaker: Dr Michael Goldstein, the director of abdominal organ transplantation at Hackensack University Medical Center in Hackensack, New Jersey. Dr. Goldstein presented to the Task Force about his program's journey of growth and success. In 2023, Hackensack University Medical Center realized a 35% growth in transplant volume, the largest increase among transplant centers nationwide. Additionally, it was the #1 center in New Jersey for shortest waitlist time to transplant and for 1-year kidney graft survival. Hackensack's "secret sauce" is a team culture of total buy-in, collaboration, and patient focus. This, coupled with an aggressive clinical, surgical, and medical style, has led to high organ acceptance rates that minimize waiting times and increase patient access to transplantation. Dr. Goldstein also participated in a guided discussion with Task Force leadership and answered questions from the broader Task Force audience attending the meeting. Below are the key takeaways from his presentation.

- **Stay patient-centric:** Dr. Goldstein explained that patient needs should be the main drivers of changes to metrics. He noted the importance of understanding patient needs and shaping hospital policies accordingly.
- **Build rapport with the C-Suite:** Dr. Goldstein emphasized the importance of constant communication with the C-Suite. If the C-Suite is not aware of the desired outcomes, for example, then they cannot be held accountable if the transplant program does not achieve those outcomes. Dr. Goldstein organizes quarterly meetings with his C-Suite to review outcomes, SRTR data, rankings, etc. His perspective is that, ultimately, it is the C-Suite's program; the transplant coordinator is just the driver.
- **Promoting early transplant:** Dr. Goldstein explained his kidney program's mindset that minimizing time on the waitlist is more important than waiting for a low KDPI kidney. When a new patient registers at Hackensack, his program shows them a PowerPoint presentation on the benefits of accepting a high KDPI kidney sooner, and the consequences of electing to stay on dialysis longer. Additionally, Hackensack does not decline high KDPI kidneys before evaluating them. Instead, the center works with the patient on an offer-by-offer basis and educates them on how they would benefit from accepting the organ.
- **In-house services:** Dr. Goldstein's team has in-house perfusion services which has limited the dependency on outside resources they need to utilize more organs. Hackensack pumps approximately 90% of all kidneys using their own kidney perfusion pumps, which has resulted in better outcomes for patients and lower operating costs.
- **Know where you stand:** Dr. Goldstein noted the importance of understanding that the world does not revolve around transplant, and as such, it is important to be realistic when asking for resources.
- **Creating a dynamic match run:** Dr. Goldstein explained how the current match run is not utility-based, and we are losing utility at the expense of equity. Dr. Goldstein suggested creating a

dynamic match run that updates as the risk of the organ increases (e.g., due to increasing cold ischemic time) and more information about the organ is entered.

- **Waitlist management program:** Hackensack University Medical Center created its own waitlist management program, where they have patients eligible for transplant based on the donor risk criteria. Not only does this reduce staff burnout, but it enables the center to always have a patient ready for any organ offer they receive.

5. Rescue Pathway Variance Protocols

Plenary Session

The Task Force presented on a recently submitted proposal to revise OPTN Policy 1.3 requirements to permit variance protocols focused on short, rapid tests of change for expedited placement, or "rescue pathways." The proposal also called for the creation of OPTN Policy 5.4.G Open Variance for Expedited Placement, which outlines the criteria and expectations for the rescue pathway variance protocols. While the proposed policy is in effect, community and committee members can submit rescue pathway protocols, and one or more of these protocols could be approved by the Executive Committee based on the Task Force's recommendations. Members who opt into the variance for expedited placement can use the approved protocols, and those protocols will eventually be publicized.

As a group, the Task Force ideated potential rescue pathway variables. The group brainstormed the following:

- Geographically isolated OPOs
- Cold ischemic time
- Organ risk score creation
- Time factor
- Sequence number
- Geographic equity
- Logistical feasibility (i.e., transportation)
- Patient access, including equity & safety
- Transplant program and OPO networking
- Define "hard/difficult to place"

Breakout Session

A group of Task Force members gathered during the breakout session of the workshop to draft rescue pathway protocols to test. The breakout session aimed to have facilitated discussion around donor characteristics and criteria, conditions for use of expedited placement, and candidate criteria.

To kick off the breakout session, the group participated in a tennis ball activity where they formed teams and passed the ball to each person in the team in the shortest amount of time and fewest number of drops possible. This was done four times, and each round the team strategized to improve performance. The purpose of this activity was to demonstrate what occurs during the process of change and improving performance.

The next activity of the breakout was "reporting from the field," which focused on sharing best practices and priorities across OPOs, transplant centers, patients, and donor families when it comes to placing organs in an effective, efficient, and scalable process. Everyone was asked, depending on their role, the following question:

- To OPOs: What does your organization do that helps place organs and is effective, efficient, and scalable?

    - Key takeaways: OPOs have pre-existing, unique processes and protocols for expedited placement. Some OPOs have even developed their own allocation algorithms for out of sequence scenarios.
- To transplant centers: What have you seen work that helps place organs and is effective, efficient, and scalable?
    - Key takeaways: Direct communication and transparent acceptance pathways between OPOs and transplant centers can help place hard-to-place organs. OPOs may directly contact transplant centers that have historically accepted those organs, and they may also contact backup centers in advance.
- To patients and donor families: What is important to patients & donor families as we are designing, launching, and communicating Plan-Do-Study-Act (PDSA) cycles for organ rescue pathways?
    - Key takeaways: Patients and donor families desire patient-friendly wording in communications and in their delivery. They prioritize transplanting organs in patients as quickly and safely as possible to reduce non-use and non-utilization.

Lastly, the "break it down" activity evolved into an open room discussion regarding which donor and candidate criteria should be eligible for rescue pathways and the conditions for use of those pathways (e.g. hard-to-place, late turn down, reallocation); cold ischemic time was frequently highlighted as an important factor for rescue pathways. Although a consensus was not reached on donor and candidate criteria and the conditions for use of rescue pathways, the group agreed on the need for further discussions by creating OPO and transplant center subgroups, examining the SRTR tool and defining donor characteristics for expedited placement, and studying current rescue pathway protocols.

6. Organ Non-Use Study

Plenary Session

Several members of the Expeditious Task Force have suggested conducting a research study to better understand the current state of organ non-use and non-utilization throughout the OPTN. The Task Force would like to quantify the number of organs that go unused but *could* have been used and categorize the clinical characteristics that lead to non-use or non-utilization.

Based on prior input from various Task Force members, four potential "pillars" of the non-use/non-utilization study were presented to the broader group during the plenary session:

1. **Donor/Organ Clinical Characteristics Analysi**s: Use data analytics to find key clinical predictors of non-use
2. **Aggregated Offer Acceptance Patterns**: Leverage the existing UNOS default offer filters model to understand key combinations of factors leading to declines
3. **Expert Panel Evaluation Simulation**: Enlist a diverse panel of transplant professionals to review approximately 500 organ non-use cases and determine whether those organs *could* have been used
4. **Qualitative/Attitudinal Research**: Conduct interviews to understand the stories behind non-use cases as they occur in near real time

Task Force members provided feedback on the four pillars above via a Menti poll in the form of "I like...", "I wish...", "What if..." prompts. Some emergent themes from that feedback were:

- **I like:** How all the pillars work together, the leveraging of existing data, how the qualitative approach uncovers new insights, the data driven approach to non-use, and how we're pulling data that is not currently captured in the system

- **I wish:** We could identify the "acceptable" level of non-use, uncover which organs are not transplantable, quantify the multi-factorial reasons for non-use, communicate this initiative successfully to the community, and capture results from different geographic areas
- **What if:** This could help transplant centers to better understand their own decline patterns and improve their own growth, this leads to a playbook of effective practices from high growth centers, this leads to better OPO and transplant center relationships, we expand this study in the future to understand patient declines

Finally, members ranked the four pillars in terms of which they believed could provide the greatest insight. The results were as follows:

1. Pillar 1: Donor/Organ Clinical Characteristics Analysis
2. Pillar 2: Aggregated Offer Acceptance Patterns
3. Pillar 4: Qualitative/Attitudinal Research
4. Pillar 3: Expert Panel Evaluation Simulation

Breakout Session

During the breakout session of the workshop, a subset of Task Force members engaged in a deep dive of the four pillars of the non-use study. Participants discussed the benefits and drawbacks of each pillar, identified synergies between them, and proposed improvements. Overall, the group agreed that all four pillars are valuable, and that we should incorporate multiple organ groups and adult/pediatric into each pillar to the degree possible. Below are the key points from the discussion of each pillar:

1. Donor/Organ Clinical Characteristics Analysis
    a. Can be done in the immediate future
    b. The identification of clinical characteristics is the heart of this pillar; the exploratory dashboard is simply a presentation of the work
2. Aggregated Offer Acceptance Patterns
    a. Can be done in the immediate future
    b. Can use the results of this pillar to identify the centers of interest for Pillar #4 (e.g., for Pillar #4, focus on the centers that normally would have accepted the organ based on the default offer filters but didn't in this specific case)
3. Expert Panel Evaluation Simulation
    a. Should be introduced as a PDSA before large-scale roll out
    b. Consider presenting the panelists with organs that were transplanted and organs that were not used, without indicating which is which
    c. Since the transplant surgeon is not always the one reviewing the organ offer, we should consider adding representatives from other reviewer groups (e.g. nephrologists) to the panel
4. Qualitative/Attitudinal Research
    a. Should be introduced as a PDSA before large-scale roll out
    b. Leverage both surveys and interviews
    c. Consider using offer decline codes to narrow down which centers to interview. Can leverage the model-generated default offer filters from Pillar #2 in the same manner.

Next, participants of the non-use study breakout wrote down and shared personal stories about a time an organ was declined, not used (identified for transplant but never transplanted), or not utilized (never identified for transplant).

At the end of the breakout session, Task Force members offered up personal commitments on how they could help progress the non-use study effort.

7. Securing Commitments

Several Task Force members led a breakout session on securing commitments to contribute to the 60K transplant in 2026 growth aim. In this session, participants discussed:

- **Types of commitments** - the types of commitments individuals could make as well as collective commitments that could come from the Task Force as a whole
- **Requests and offers** - what requests and offers individuals could make when trying to secure commitments from others in their networks
- **Best practices** - tips for how individuals could approach their C-suite to secure commitments
- **Messaging** - how the Task Force could help hone the message regarding growth aims and be involved in sharing information
- **Events** - different formats for in-person and virtual events to deliver the message, secure commitments, and celebrate success

Throughout the session, participants identified several success factors:

- **Multiple formats** - a combination of formats will be required to reach all types of stakeholders (e.g. direct outreach campaigns, in-person and/or virtual events, etc.)
- **Local events** - hosting several smaller, local events may be more impactful than one big national event
- **Patient involvement** - direct interaction with patients can help secure commitments and is a powerful way to recognize/celebrate those commitments
- **National leadership** - soliciting public support from leaders such as the Secretary of Health and Human Services (HHS) would help build a national movement
- **Commitment letters** - requiring people to sign letters is a way to publicly announce who is actively engaged
- **Messaging and data** - the Task Force should provide the tools and support individuals need to successfully secure commitments from others in their networks, such as compelling messaging and data on why growth aims are valuable to different stakeholder groups (e.g. a change package on C-suite enrollment)
- **Reaching surgeons** - efforts should focus on reaching surgeons too, since they are the ones whose risk acceptance mindsets will need to be influenced for real change to occur

At the end of the session, each participant completed a template of the individual commitments, requests, and offers they could make to secure commitments from their network.

8. Policy Review

Task Force members spent time considering existing policies that might be barriers to growth, efficiency, and utilization within transplantation. Should such policies be removed? Do they need to be updated? Listed below are the suggestions offered by the Task Force:

- Remove the requirement to utilize the Organ Center
    - Engage the Organ Center in PDSAs for new allocation algorithms
    - Organ Center should have its own established rescue pathway
- Remove the requirement to gain consent before transplanting high KDPI kidneys
- Remove the post-transplant outcomes from the MPSC performance metrics
- Revise the match run based on observed behaviors
- Remove the barriers to having a living donor-only program, especially in rural areas

- Need to develop a nationally sourced, easily understood set of educational material that explains to patients the benefits of accepting a high KDPI kidney and the drawbacks of opting to stay on dialysis

9. MPSC Allocations Review

On January 19, 2024, the Membership and Professional Standards Committee (MPSC) met to discuss current post-transplant outcomes monitoring and allocation reviews. The Committee considered removing the threat of post-transplant outcome review monitoring as a potential disincentive to utilization and growth, as well as ways to reduce the burden of reviewing non-compliance of allocations out of sequence cases.

After hearing an update on the January 19 meeting, Task Force members shared their opinions on the current post-transplant outcomes, concerns about patient safety and equity, possible areas for improvement in the existing system, and recommendations for change.

Next Steps

Task Force leadership plans on meeting with MPSC leadership to discuss what changes the Task Force would like to see and what potential changes raise concerns among the Task Force.

10. Next Steps

a. Task Force representatives to speak at each regional meeting about the work the Task Force has done so far and solicit feedback on the proposed projects
b. Task Force leadership is working on organizing workstreams for securing commitments, rescue pathway variance protocols, and the non-use study.

Upcoming Meetings

- February 29, 2024, 10am – 12pm – virtual
- April 2, 2024, 10am – 12pm – virtual

Attendance

- **Task Force Members**
  - Woodlhey Ambroise
  - Marie Budev
  - Laura Butler
  - Kevin Cmunt
  - Christopher Curran
  - Donna Dickt
  - Alden Doyle
  - Kyle Herber
  - Dean Kim
  - Catherine Kling
  - Michael Kwan
  - Kenny Laferriere
  - Jennifer Lau
  - Pat Ledbetter
  - Kevin Lee
  - Deborah Levine
  - Matthew Levine
  - Jeff Lucas
  - John Lunz
  - David Marshman
  - Barry Massa
  - Ginny McBride
  - Colleen McCarthy
  - Jennifer Milton
  - Silas Norman
  - James Pittman
  - Christine Radolovic
  - Lloyd Ratner
  - Jason Rolls
  - Marc Schecter
  - Jesse Schold
  - Marty Sellers
  - Marcus Simon
  - Lisa Stocks
  - George Surratt
  - Nicole Turgeon
  - Dennis Wagner
  - Sena Wilson-Sheehan
  - Matthew Wadsworth
- **Task Force Advisors**
  - Dianne LaPointe Rudow
- **HRSA Representatives**
  - Chris McLaughlin
- **CMS Representatives**
  - Katie McDonald

    - Jean Moody-Williams
- **Invited Guests and Speakers**
    - Michael Goldstein
    - Brandi Krushelniski
- **SRTR Contractor Staff**
    - Ryo Hirose
    - Jon Snyder
    - Nick Wood
- **OPTN Contractor Staff**
    - James Alcorn
    - Keighly Bradbrook
    - Kate Breitbeil
    - Jadia Bruckner
    - Aileen Corrigan-Nunez
    - Rebecca Goff
    - Bonnie Felice
    - Darby Harris
    - Bridgette Huff
    - Ann-Marie Leary
    - Rebecca Fitz Marino
    - Carlos Martinez
    - Joel Newman
    - Beth Overacre
    - Rob Patterson
    - Laura Petrosky
    - Tina Rhoades
    - Kristen Sisaithong
    - Dale Smith
    - Kaitlin Swanner
    - Kayla Temple
    - Alison Wilhelm
    - Carson Yost
- **Facilitators**
    - Jacob Filon
    - Leelah Holmes
    - Chloe Keller
    - Esther Kim
    - Kylee Talwar
    - Chris Zinner