OPTN Kidney and Pancreas Transplantation Committees
OPTN Utilization of Kidney and Pancreas Continuous Distribution Workgroup
Meeting Summary
September 21, 2022
Conference Call

Valerie Chipman, RN, BSN, Chair

Introduction

The OPTN Utilization of Kidney and Pancreas Continuous Distribution Workgroup (The Workgroup) met via Citrix GoTo teleconference on 09/21/2022 to discuss the following agenda items:

1. Welcome and Announcements
2. Workgroup Purpose, Goals, and Scope
3. Review and Discussion: Released Organs
4. Review and Discussion: Facilitated Pancreas
5. Introduction: Operational Considerations of Dual Kidney
6. Adjourn

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

1. Welcome and Announcements

The Chair welcomed the Workgroup members.

Summary of discussion:

There were no questions or comments.

2. Workgroup Purpose, Goals, and Scope

Staff reviewed the purpose of the Workgroup. The Utilization of Kidney and Pancreas Continuous Distribution Workgroup will focus on the aspects of kidney and pancreas allocation that fall outside of the composite allocation score while transitioning to a continuous distribution framework. There will be a practical focus on utility and efficiency with diverse allocation-experienced perspectives. Operational topics include, but are not limited to, dual kidney allocation, minimum acceptance criteria screening, and facilitated pancreases. The goal of the Workgroup will be to contribute to the creation of Continuous Distribution 1.0. Mapping current policy to a continuous distribution framework with few modifications and minimal changes to current operational requirements as outlined in policy. Some bigger projects may have to wait to be incorporated into future versions of continuous distribution.

Summary of discussion:

There were no questions or comments.

3. Review and Discussion: Released Organs

Staff briefly reviewed released organ policies, including *OPTN Policy 8.8: Allocation of Released Kidney*, and *OPTN Policy 11.8: Allocation of Released Kidney-Pancreas, Pancreas, or Islets.* The Workgroup reviewed feedback from the OPTN Organ Procurement Organization (OPO) Committee on the allocation of released organs. The OPO Committee put emphasis on reducing cold time of these organs and

maximizing marginal kidneys. The OPO Committee also recommended time requirement for transplant programs for declining an offer, and to allow center backup at OPO discretion.

The OPTN Kidney-Pancreas Continuous Distribution Workgroup discussed the allocation of released organs and realized the difficulty in standardizing released allocation across organs because the differences between kidney and pancreas released allocation are clinically necessary. There were also concerns regarding gaming around transplant center backup and should be used only for very specific situations. The Kidney-Pancreas Continuous Distribution Workgroup stated their preference for a new match run centered around the previous accepting center with an increased weight on placement efficiency. Their recommendation for kidney continuous distribution is to give the host organ procurement organization the option to either continue allocation according to the original match run, or use a released kidney match run using the location of the kidney when it is released. This would include incorporating an increased efficiency weight for released match runs. For pancreas, kidney and pancreas, and islets their recommendation is to maintain existing policy.

Summary of discussion:

The Chair stated that monitoring centers that are gaming the system and holding the transplant centers who are doing so accountable would be very appropriate. A member agreed that monitoring and gathering the data is good, but that there may not be an appropriate use for the data itself. The Chair suggested publishing the data for review by the transplant community, suggesting that perhaps the transparency alone would help curb the practice; anything beyond that might have to wait for the text version of continuous distribution. A member recommended handing the data over to the OPTN Membership and Professional Standards Committee for review.

A member expressed concern regarding tissue typing sample availability, particularly if there will be enough left to run a cross match with patients further down the list. The Chair agreed and added that logistically for OPOs having to make new calls to centers unable to perform virtual cross matches would make it difficult to place a kidney anywhere but the original transplant center.

A member asked if there has been any consideration given to implementing for kidney placement something similar to expedited liver placement, which would allow programs to list candidates as willing or able to take expedited organs. Staff responded that dual kidney allocation mirrors that intention, as the release match run does put more emphasis on utilization.

Staff asked the Workgroup, since there is concern regarding cold time, if the recommendation provided by the Kidney and Pancreas Workgroup was feasible and efficient enough. A member expressed concern about the impact to utilization of running the released organ match, which could add to the cold time of kidneys that are more likely to be marginal kidneys.

The Chair asked if there was a way to indicate if there is enough blood samples for crossmatches to be performed during the match run for a released organ. Staff recorded the idea to be revisited later.

A Workgroup member offered up the idea of using the Kidney Donor Profile Index score (KDPI) of a released kidney might be a better way to determine if another match run or local backup is the proper course of action.

4. Review and Discussion: Facilitated Pancreas

According to *OPTN Policy 11.7.A,* transplant hospitals qualify to receive facilitated pancreases if they have transplanted a minimum of two pancreases recovered from deceased donors at hospitals more than 250 nautical miles from the transplant program, including those transplanted as part of a multi-organ transplant. Those transplant hospitals that do qualify must notify the OPTN in writing if they are

willing to participate. According to *OPTN Policy 11.7.B,* OPOs are permitted to make facilitated pancreas offers if no offer has been accepted three hours prior to the scheduled donor organ recovery. Those facilitated offers can only be made to transplant programs that participate in facilitated pancreas allocation and in order of the match run. OPOs will only have access to facilitated allocation after all pancreas and kidney-pancreas offers made to candidates registered at the transplant programs within 250 nautical miles of the donor hospital have been declined. This bypasses pancreas alone candidates from centers that are not likely to accept the organ.

The OPTN Pancreas Transplantation Committee recommends allowing OPOs to make facilitated pancreas offers in no offer has been accepted five hours prior to the scheduled donor organ recovery, apply bypasses to kidney-pancreas and pancreas-only candidates, and bypass all candidates at non-facilitated programs regardless of CPRA or ABDR mismatch level. Additionally, the Pancreas Committee is considering applying facilitated pancreas bypasses to candidates registered at transplant hospitals more than 100 nautical miles from the donor hospital. The intent of this is to increase utilization of pancreas by allowing for more localized pancreas offers and thereby increasing the chance for utilization. The match run would not bypass those candidates who are within of 100 nautical miles from the donor hospital and those candidates listed at qualifying facilitated pancreas programs at any distance from the donor hospital. The Pancreas Committee is also working on new qualifying criteria and are seeking input on how transplant centers could qualify for facilitated pancreas. The concern is there might be a misalignment of the distance and the application with the qualifying criteria could be confusing. In certain cases, a program could accepted a facilitated pancreas but doing so would not qualify them to continue receiving facilitated pancreas offers.

A staff member explained that the change occurring within the system would be an automatic opt-in for centers that except facilitated organs and patients within 100 nautical miles, rather than a declarative opt-in for facilitated programs at 250 nautical miles.

Summary of discussion:

One member pointed out that transplant programs cannot control how far away they are from the donor or what offers they receive nearby, and so it does not seem fair to say a program does not qualify for facilitated pancreas for these reasons. Accepting any facilitated pancreas offer should count towards a center qualifying as a facilitated program. Another member said that centers that are more aggressive and willing to take a facilitated pancreas could be filtered out despite the fact they would take these organs.

Staff noted that there seems to be general support for aligning distances, and asked the Workgroup if the 100 nautical mile radius seemed appropriate. A member said that it makes sense to keep the number at 250 nautical miles, in alignment with current circles policy, to identify centers that will take facilitated pancreases versus those that only take local pancreas. Another member agreed that it would make sense considering that going out to far would dissuade some centers that would want to come get the pancreas themselves. Staff noted that the committee wanted to shrink the distance so that only candidates on the match run would be within 100 nautical miles and bypassing the non-aggressive centers outside of 100 nautical miles. The member agreed that this idea makes sense, and then asked a logistical question regarding the grouping of those on the match runs based on distance. Staff said that the only candidates not bypassed are those within 100 nautical miles and those candidates outside 100 nautical miles at facilitated programs, and currently it is set to 250 nautical miles. The member agreed this makes sense.

The Chair asked about the possibility of a program remaining certified for facilitated pancreas if they accept a facilitated kidney, thereby demonstrating the ability and willingness to accept these types of organs. A member agreed that this would make sense and should be considered.

A member stated that being a facilitated program only matters, in this instance, if they are 101 nautical miles away.

A member said they like the fact the OPO can move into the facilitated category when needed versus having to go through classifications in order to get to a facilitated organ.

The Workgroup agreed that the distance utilized in bypassing for facilitated pancreas should be the same distance utilized in the qualifying criteria for facilitated pancreas.

5. Introduction: Operational Considerations of Dual Kidney

The Workgroup reviewed Dual Kidney. Dual Kidney is a classification for kidneys with KDPI between 35 percent and 100 percent (Sequence C and D). Centers opt-in candidates to receive dual offers, candidates appear twice on the match run, once for single kidney and again for dual kidney. The monitoring reports shows nearly half, 44.44% of duals are allocated from the single sequence. OPOs are responding that this is done to avoid organ wastage, and that the match run is too long to get to the dual candidates. The goal of continuous distribution is to incorporate dual allocation into the framework and to address the inefficiencies that have been identified with minimal system impact. For Sequence C, which has KDPI between 35 percent and 85 percent, dual candidates appear at the bottom of the match run meaning all single offers come first. For Sequence D, which is KDPI between 86 percent and 100 percent, single kidney candidates within 250 nautical miles are listed first and then dual candidates within 250 nautical miles, this is followed by single then dual candidates outside of 250 nautical miles. There is support for a clear policy threshold to be able to offer dual, and to give OPOs some discretion to offer dual kidneys. There has been an expressed need for system tools to be able to exclude single-offer only candidates, support for dual kidneys to be allocated from a new separate dual kidney match run that is inclusive of all potential dual candidates. There has also been interest in education for transplant programs on opting candidates in for dual kidney offers.

One potential option for KDPI between 35 percent and 85 percent could be that OPOS must offer these organs as single up until some policy-designated point, then they can offer as dual. For kidneys with a KDPI greater than 85 percent, OPOs could offer these organs with X&Y characteristics at their own discretion. The idea is that specific criteria dictates when an OPO may begin allocating dual kidneys. The Workgroup requested data on dual kidney transplants including both donor and candidate characteristics. In order to allocate kidneys as dual, the OPO must run a new, dual-specific match run. The match run would include only candidates opted-in to receive dual kidney offers. This solves for problems with potential solutions where candidates appear one time on the match run, inclusive of top of the match run candidates who may accept a dual offer but not single kidney. The new match run could carry over some specific, relevant refusals.

<u>Summary of discussion:</u>

A member stated that having some sort of time stamp for dual kidney offers would make sense. Accepting one kidney when both are equally good is confusing, so having the ability as an OPO to reach out to the center and ask if they are interested in accepting both kidneys would be helpful. The member is not opposed to having an additional match run, and that it is difficult to get to the bottom of the current list which is why dual allocation is low.

Another member agreed that there is too much time post procurement on the kidneys before an offer is received. The current policy does not expediate the kidneys as intended and creates too much cold time.

The bigger issue is all the single offers that have to be bypassed in order to get to the dual candidates. Pushing offers to the dual list is, probably, the only way to fix the issue. The member also pointed out that when dealing with marginal kidneys, it is safer for the program to only accept one rather than risk accepting both and affecting one-year graft survival rates. The member asked if prioritizing geography within continuous distribution might be helpful while considering dual kidney allocation. Staff noted that the the Workgroup could recommend giving an increase weight to proximity for the OPTN Kidney Committee to consider. The member also suggested that implementing a filter that only considers centers that are most likely to accept dual offers might also lead to higher acceptance, similar to facilitated organ offers.

The Chair offered the idea of some kind of facilitated dual kidney match run that prioritizes geography. Two other members voiced support for this idea.

6. Adjourn

The Workgroup was adjourned.

Upcoming Meeting

- September 29, 2022; 4 PM Eastern Time.

Attendance

- **Workgroup Members**
  - Valerie Chipman
  - Ben Wolford
  - Colleen Jay
  - Jason Rolls
  - Jillian Wojtowicz
  - Nikole Neidlinger
  - PJ Geraghty
  - Raja Kandaswamy
  - Renee Morgan
  - Sharyn Sawczak
- **HRSA Representatives**
  - Jim Bowman
  - Marilyn Levi
- **SRTR Staff**
  - Bryn Thompson
  - Grace Lyden
  - Jonathan Miller
- **UNOS Staff**
  - Alex Carmack
  - Houlder Hudgins
  - Jesse Howell
  - Joann White
  - Joel Newman
  - Kayla Temple
  - Keighly Bradbrook
  - Krissy Laurie
  - Lauren Mauk
  - Lauren Motley
  - Melissa Lane
  - Rebecca Fitz Marino
  - Sarah Booker
  - Shavon Goodwyn
  - Tommie Dawson