OPTN Ad Hoc Multi-Organ Transplantation Committee
Meeting Summary
June 14, 2023
Conference Call

Lisa Stocks, RN, MSN, FNP, Chair

Introduction

The Ad Hoc Multi-Organ Transplantation Committee, the Committee, met via Citrix GoToMeeting teleconference on 06/14/2023 to discuss the following agenda items:

1. Multi-Organ Transplantation (MOT) Inactive Code
2. Data Presentation and Discussion

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

1. Multi-Organ Transplantation (MOT) Inactive Code

The OPTN IT contractor staff mentioned that community members with MOT only candidates did not have a designated inactive code which would allow them to continuously turn down single organ offers. Therefore, the OPTN IT contractor staff presented their solution which would add an inactivation reason of "Candidate requires multi-organ transplantation only, isolated offers not accepted," to effectively inactivate a registration for MOT patients and prevent them from showing up on specific match runs.

Summary of discussion:

Decision #1: The Committee supported the solution to create an inactivation code for MOT candidates.

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There were no clarifying questions from the Committee and no opposing thoughts following the presentation. Therefore, the Committee supported implementation of the proposed inactivation code.

Next steps:

The OPTN IT contractor staff will continue working to roll out the implementation of the added inactivation code by or before September. They will continue to keep all candidates active until the change has been released and will provide the community with adequate notice of such changes.

2. Data Presentation and Discussion

An OPTN contractor staff presented the results from a data request that the Committee submitted in March, following their review of the concept paper *Identify Priority Shares in Kidney Multi-Organ Allocation*. The Committee requested additional data to inform a policy proposal regarding kidney multi-organ allocation.

Data Summary:

The OPTN contractor staff reviewed and presented the final data request report titled *Examining Kidney Priority for Multi-Organ Candidates Compared to Kidney Alone Candidates*[1].

Main Points from the Data Request:

- Kidney-pancreas (KP), liver-kidney (SLK), heart-kidney (SHK), and other kidney multi-organ transplants made up approximately 10% of adult and less than 5% of pediatric kidney transplants between 3/15/2021 and 12/31/2022
- Most MOT kidney transplants result from donors < 50 years old and from donor kidneys with a KDPI < 35%
- One year graft survival rates indicate graft survival was highest for KPs and lowest for SHKs between 3/15/2021 and 12/31/2022
- For donors who donated both kidneys, over 75% resulted in both kidneys going to kidney alone (KA) candidates and 2% resulted in both kidneys going to KP or MOT candidates
- The next candidates on the kidney match run analysis for donors who donated both kidneys and one went to a KA candidate, and one went to a KP or MOT candidate revealed that if the multi-organ recipient received a KP transplant, the next candidate on the match run was a pediatric candidate 25% of the time, and 10% of the time when the multi-organ recipient received a different kidney MOT combination
- Regardless of the multi-organ recipient organ combination, the most common removal reason for the next candidate on the kidney match run was deceased donor transplant

Summary of discussion:

Decision #1: The Committee decided that, for donors that are donating both kidneys with a Kidney Donor Profile Index (KDPI) between 0-34%, one kidney would be allocated to candidates on the MOT or KP list, and the second kidney would be allocated to pediatric and adult candidates on the kidney alone list.

Decision #2: The Committee supported that, with the new allocation scheme, MOT candidates would maintain the first choice for kidneys.

Decision #3: The Committee agreed that they still need to address how MOT combinations would be prioritized in the kidney allocation scheme.

Decision #4: The Committee agreed that more granular data is required to address concerns regarding access to kidneys for pediatric candidates.

Decision #1: The Committee decided that for deceased donors who are donating both kidneys which have a Kidney Donor Profile Index (KDPI) between 0-34%, one kidney would be allocated to candidates on the MOT or KP list, and the second kidney would be allocated to pediatric and adult candidates on the kidney alone list.

The Committee decided that this allocation scheme would be the best choice, as it would not necessarily change the ratios of allocation too much but would have a significant impact on the timing and scheme

[1] *Examining Kidney Priority for Multi-Organ Candidates Compared to Kidney Alone Candidates*. Richmond, VA: United Network for Organ Sharing, 2023.

of allocation itself. More specifically, this plan would ensure that at least one kidney would go to a kidney alone candidate compared to the previous allocation scheme where both kidneys may have been tied up in a MOT and KP allocation. Grouping KP and MOT candidates for the allocation of one kidney should reduce issues with organs being held up and accruing additional cold ischemic time. Even though the grouping may lead to a slight reduction in offers for KP candidates, they would still receive some priority for offers. Overall, the proposed system should increase access to quality kidneys for adult and pediatric patients on the kidney alone list.

The Committee also mentioned that this allocation scheme would help address the community's concerns regarding multi-visceral, MOT, and KPs being the main drivers of allocation. With the proposed allocation scheme, the group suspected that around 130-160 donor kidneys with a KDPI of 0-34% would be moved around to benefit both adult and pediatric kidney alone candidates. Therefore, those on the kidney alone OPTN Waiting List would gain additional priority and have access to better quality kidneys. In addition, such a change may influence transplant centers to consider taking kidneys with a KDPI in the range of 35-85% for their MOT candidates.

The Committee decided against recommending that one kidney be allocated to MOT and the other be allocated to the kidney alone list because they thought that this would not change much and was too similar to the current allocation scheme. In addition, the group decided the plan would not account for the quality of organs that needed to be moved around as well. Therefore, the Committee determined that allocation should be more dependent on the sequence of kidneys with a KDPI ranging between 0-34%.

Decision #2: The Committee supported that, with the new allocation scheme, MOT candidates would maintain the first choice for kidneys.

The Committee had discussed whether the proposed allocation scheme would change who received the first choice for a kidney. The group had agreed that due to the complex and technical nature of MOT organ recoveries, MOT would maintain the first choice.

Even though there may be situations in which pediatric candidates may need longer vessels and may require the first choice, such instances are far and few and can be determined on a case-by-case basis. The group determined that since such cases do not happen frequent enough, it does not need to be outlined in policy.

Decision #3: The Committee agreed that they still need to address how MOT combinations would be prioritized in the kidney allocation scheme.

Members of the Committee recognized that they still must address how MOT combinations would be prioritized in kidney allocation. While they acknowledged that continuous distribution could help, it may not have a significant impact in the first iteration. In addition, prioritization must be determined as it is not currently outlined in policy and is left to the discretion of Organ Procurement Organizations.

Decision #4: The Committee agreed that more granular data is required to address concerns regarding access to kidneys for pediatric candidates.

The Committee identified that there is a disparity for children in terms of access to quality kidneys. More specifically, pediatric candidates are sometimes unable to get kidneys from what would be considered "ideal donors" because the creatinine is too low and KDPI does not necessarily adjust for pediatric donors. In addition, the actual size of the donor is not a part of the current algorithm.

Another issue was that pediatric candidates were the next candidate on the match run 25% of the time when the kidney went to a KP patient and 10% of the time when an MOT patient received a different

MOT combination. There was concern that pediatric candidates are losing quality kidneys to KP and MOT candidates. However, the Committee determined that to address this disparity, they would need additional and more granular data.

Upcoming Meeting(s)

- July 12, 2023, 3PM EST

Attendance

- **Committee Members**
  - Lisa Stocks
  - Sandra Amaral
  - Jim Bowman
  - Marie Budev
  - Alden Doyle
  - Rachel Engen
  - Shelley Hall
  - Marilyn Levi
  - Heather Miller-Webb
  - Oyedolamu K Olaitan
  - James Sharrock
- **HRSA Representatives**
  - Shelley grant
- **SRTR Staff**
  - Katherine Audette
- **UNOS Staff**
  - Alex Carmack
  - Jenna Reformina
  - Julia Foutz
  - Paul Franklin
  - Dzhuliyana Handarova
  - Nick Marka
  - Jonathan Miller
  - Laura Schmitt
  - Kaitlin Swanner
  - Susan Tlusty
  - Ben Wolford