OPTN Kidney and Pancreas Transplantation Committees
OPTN Utilization of Kidney and Pancreas Continuous Distribution Workgroup
Meeting Summary
October 12, 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 10/12/2022 to discuss the following agenda items:

1. Welcome and Announcements
2. Workgroup Purpose, Goals, and Scope
3. Recap: Released Organs
4. Dual Kidney Data Review
5. Discussion: Dual Kidney Functionality and Criteria
6. Closing Remarks

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

1. Welcome and Announcements

Staff and the Chair welcomed the Workgroup. There was no further discussion.

2. Workgroup Purpose, Goals, and Scope

Staff highlighted the purpose and goals of the Workgroup.

Presentation Summary:

Staff outlined the focus of the Workgroup, which is on aspects of kidney and pancreas allocation that fall outside the composite allocation score while transitioning to continuous distribution. The scope includes mapping current policy to continuous distribution with minimal modifications. Further iterations and enhancements to "Continuous Distribution 1.0" will be necessary and should be expected.

Summary of Discussion:

There was no further discussion.

3. Recap: Released Organs

Staff presented the current released organ policy and recommendations for possible changes.

Presentation Summary:

Staff highlighted current policy for released organs. According to OPTN Policy *8.8: Allocation of Released Kidneys*, a released kidney can be allocated following the match run or allocated using a released kidney match run with the transplant hospital as the center of the 250 NM circle. According to OPTN Policy *11.8: Allocation of Released Kidney-Pancreas, Pancreas or Islets*, released kidney-pancreas (KP), pancreas, or islets can be allocated by continuing down the match run or allocated to a potential recipient at the transplant center that originally accepted the organ. Staff explained the recent

recommendation that for kidney, pancreas, KP, and islets, existing policy will be maintained. However, for kidney, the recommendation is to incorporate an increased placement efficiency weight for released match runs.

Staff recapped prior discussion regarding this policy, including concerns about gaming the system, the need for more upfront communication about remaining and available typing materials, and concerns regarding the efficiency of the new match run. Staff presented the Workgroup with the option to do a modified released organ match run with increased weight for placement efficiency (to minimize travel and cold ischemic time) and carry over of a subset of refusals (to not offer organs to those who have already declined).

Summary of Discussion:

Staff asked what the Workgroup thought of this option. Members were generally supportive, especially because the recommendation would potentially reduce cold ischemic time. One member expressed a concern that centers who want to keep a kidney from a KP but cannot transplant the associated pancreas may have trouble finding a pancreas-only recipient within the proposed allocation scheme. This member also elaborated a concern of centers accepting a KP and then releasing the kidney, to game the system to only get the pancreas. The Chair explained that the reasoning behind the scheme originated from a concern that if the initial kidney is declined, it still may be viable and should be allocated based on the location it is now in. The Chair explained that different rules may be necessary for pancreas because there is not the same amount of cold time leeway, and may be harder to reallocate.

A member expressed confusion on the wording and thought that as proposed, center backup would be allowed for pancreas but not for kidney. Staff clarified that if you are reallocating a released KP and there is a KP patient at the center, you can give them both, however, you cannot use center backup for the kidney and the pancreas individually (into two separate patients).

Members voiced their support of the proposal after this clarification.

Next Steps:

Staff will take the Workgroup's concerns and thoughts to the OPTN Kidney and Pancreas Committees.

4. Dual Kidney Data Review

Staff first provided an overview of dual kidney transplantation then reviewed data from the OPTN Kidney Committee's recent data request.

Presentation Summary:

Staff introduced dual kidney as a classification for kidneys with Kidney Donor Profile Index (KDPI) 35-100 percent. The goal is to transition dual allocation into a continuous distribution framework. In Sequence C (KDPI 35-85 percent) of allocation, single offers are run first, then dual. In Sequence D (KDPI 86-100 percent), allocation runs single offers within 250 NM, then dual offers within 250 NM, and then single offers outside 250 NM, followed by dual offers outside 250 NM. Monitoring shows that nearly half of duals are allocated from single sequences, pointing to possible ineffectiveness of and inefficiencies in this policy. The Committee expressed support for a clear policy threshold for when OPOs may offer duals, offering more OPO discretion. The Committee submitted a data request to evaluate the use of the current dual kidney policy.

Staff recapped the Workgroup's prior discussions regarding "pain points" in dual kidney, focusing on inefficiencies and the need for alignment between transplant program opt-in for dual kidneys and

willingness to accept dual organs. The workgroup has the option to recommend a dual kidney offer filter to the OPTN Offer Filters Workgroup, which plans to put out a proposal for the January 2023 public comment cycle.

Next, staff explained an operational recommendation from the Committee to allocate dual kidneys in a dual-specific match run, which would include only candidates opted in to receive dual kidney offers. This would prevent candidates from appearing twice on the match run, which is inefficient in the current system.

Data Summary

Staff explained that the request included donor and recipient data for all deceased donor kidney transplants from 09/05/2019 to 04/29/2022. Data was stratified by KDPI and transplant type, and en bloc transplants were excluded.

The following is a summary of transplant metrics for recipients:

- Primary diagnosis, blood type and Human Leukocyte Antigen (HLA) mismatch level distributions were similar between dual and single kidney transplants
- Dual kidney recipients had slightly higher:
    - Age, especially in KDPI 35-85 percent
    - ETPS, especially in KDPI 35-85 percent
    - Ischemic time, especially in KDPI 35-85 percent
    - Median distance from donor hospital to transplant hospital, only in KDPI 35-85 percent
- Single kidney recipients had slightly higher:
    - CPRA, especially in KDPI 35-85 percent
    - Median dialysis time, KDPI 35 percent and up
    - Body mass index (BMI), especially in KDPI 35-85 percent
    - Median distance from donor hospital to transplant hospital, only in KDPI 86-100 percent

The following is a summary of donor metrics:

- Serum creatinine was similarly distributed across KDPI categories 35-85 percent and 86-100 percent
- Dual kidney donors are more likely to:
    - Be a DCD donor, especially in KDPI 35-85 percent
    - Have a history of diabetes
    - Have a history of hypertension, especially in KDPI 35-85 percent
    - Have kidneys biopsied, and when biopsied have higher glomerulosclerosis

5. Discussion: Dual Kidney Functionality and Criteria

Summary of Discussion:

Staff asked if the Workgroup supports a recommendation to the Offer Filters Workgroup to include dual kidney as a criterion in the offer filters model. A member asked if the preemptive or mandatory filtering would be easy to change if a center has not historically accepted dual kidneys but wants to start. Staff answered that the Offer Filters Workgroup is working on this and is leaning towards default filters that centers can then turn on or off, instead of strictly mandatory filters. The member expressed concern about mandatory or default filtering from the transplant center perspective. The Chair clarified that the goal of the offer filter for dual kidney would be to make organ offers more quickly and efficiently and asked if this Workgroup is in favor of it as a concept. A member described that they are in favor because filtering would be in line with program behavior and would permit transparent monitoring. Most

Workgroup members expressed their support for recommending dual kidney as an offer filter and there was no voiced opposition.

Staff asked if the Workgroup supports building criteria for when an OPO can begin offering a dual kidney, and several members voiced support. The Chair explained that one difficulty in allocating is that OPOs are spending so much time going down match run results that the organs lose viability before they are allocated properly, and that guidelines would make this process run smoother.

Staff asked if candidate-based characteristics should be factored into the operation of proposed policy. One member stated that it might make sense to screen out younger patients from receiving high KDPI kidneys because the data shows high KDPI organs are most likely to be allocated to older patients, however, this may be controversial. This member stated that perhaps Estimated Post-Transplant Survival (ETPS) scores could be used as a proxy for this without controversy. This member went on to say that the transition to continuous distribution should account for most candidate-based issues. A member commented estimated glomerular filtration rate (eGFR) is something that might also need to be considered.

Staff then asked which donor-based characteristics should be factored into a set of dual kidney criteria. One member described that the groupings for KDPI may be too broad to reflect intricacies of acceptances and refusals. The Chair stated that criteria may need to be stricter for KDPI 86-100 percent because many transplant programs say they are interested in higher KDPI kidneys pending biopsy, then after biopsy they need to move to dual, but this is taking too long.

The Chair explained that one candidate-based criteria to consider is if the clinical team does not want to consider dual kidney transplant at all for a candidate, then screening them off the match run entirely could be helpful. There is a way to do this in the current system, but centers do not often use it. This would be something to consider in offer filters as well. One member advocated for center-wide filters of age or ETPS to screen for dual to reduce burden of centers having to decide if a patient is a candidate for dual or not on a candidate-by-candidate basis.

In all, members generally supported donor-based criteria as factoring into dual kidney allocation.

There was no further discussion.

Next Steps:

Staff will take the Workgroup's recommendation to include dual kidney as an offer filter to the Offer Filters Workgroup.

6. Closing Remarks

The Chair thanked committee members for their time and reminded them about the upcoming meeting on October 26, 2022.

Upcoming Meeting

- October 26, 2022

Attendance

- **Workgroup Members**
  - Valerie Chipman
  - Colleen Jay
  - Jason Rolls
  - Jaime Myers
  - Jonathan Miller
  - Renee Morgan
  - Sharyn Sawczak
- **HRSA Representatives**
  - Jim Bowman
  - Marilyn Levi
- **SRTR Staff**
  - Bryn Thompson
  - Peter Stock
  - Raja Kandaswamy
- **UNOS Staff**
  - Alex Carmack
  - Ben Wolford
  - Carly Layman
  - Carlos Martinez
  - Isaac Hager
  - Jesse Howell
  - Joann White
  - Kayla Temple
  - Keighly Bradbrook
  - Krissy Laurie
  - Lauren Mauk
  - Lauren Motley
  - Melissa Lane
  - Rebecca Marino
  - Sarah Booker
  - Thomas Dolan
  - Houlder Hudgins