OPTN Ad Hoc Multi-Organ Transplantation Committee
Meeting Summary
April 11, 2022
Conference Call

Alden Doyle, MD, MPH, Chair

Introduction

The Ad Hoc Multi-Organ Transplantation (MOT) Committee met via Citrix GoToMeeting teleconference on 04/11/2022 to discuss the following agenda items:

1. Review public comment feedback on *Establish Eligibility Criteria and Safety Net for Heart-Kidney and Lung-Kidney Allocation*
2. Discuss possible post-public comment changes

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

1. Review public comment feedback on *Establish Eligibility Criteria and Safety Net for Heart-Kidney and Lung-Kidney Allocation*

UNOS staff provided an overview of the feedback received during public comment. There was overall support for the proposal, especially in developing eligibility criteria and a safety net for MOT patients. There was feedback on the impact of heart patients, concerns for pediatric patients, emphasis on post-implementation modeling, and suggestions for future work.

Summary of discussion:

A member suggested that there was not overall support for the proposal, highlighting comments about the glomerular filtration rate (GFR) requirement and biological differences between heart and liver. A member agreed with the concerns for heart patients and noted that while there are fewer heart transplant programs nationwide, the themes in public comment feedback were consistent from the heart community. A member inquired if it would be possible to identify what feedback nephrologists provided. Unfortunately, the only direct way to review the feedback from nephrologists would be to review the feedback from the OPTN Kidney Transplantation Committee. A member added that the American Society for Pediatric Nephrology supported the proposal and highlighted that the GFR threshold for MOT candidates is higher than for kidney-alone candidates.

A member shared their surprise about the feedback that the proposal would negatively impact kidney alone pediatric patients, adding that the eligibility criteria and safety net sequencing would limit access to MOT patients and likely increase access for pediatric kidney-alone candidates. A member noted the challenge of modeling for pediatric patients, given the small size of the populations, and emphasized the importance of post-implementation monitoring to understand the policy's impact on pediatrics.

2. Discuss possible post-public comment changes

UNOS staff shared two possible post-public comment changes for the Committee to consider:

1. Requires shares for status 4 and 5 heart candidates meeting kidney criteria
    a. Supported by AST, ASTS, ISHLT, NATCO, Heart Committee, Kidney Committee, OPO Committee leadership, Region 3, Region 8, Region 11, and University of Minnesota

2. Address organ procurement organizations (OPO) concerns regarding late turndowns
    a. Recommend addressing via member education rather than policy change

The Committee reviewed what the revised policy language would look and provided supplemental data to aid in the discussion and subsequent decision.

Summary of discussion:

A member expressed support for including at least status 4 in the policy, noting the small numbers of patients it would impact and emphasizing the short life expectancy if those patients do not receive a transplant. The member added that due to the smaller size of heart transplant programs, poor outcomes can have a greater negative impact on the program and cause programs to be hesitant to transplant. A member added that pediatric programs have the same issue of smaller populations and impact of a bad outcome on center metrics; however, this may require a broader, system-wide discussion because this is not something that is specific to MOT.

A member asked for more data on waitlist mortality and outcomes for heart status 4 and 5 patients. The member agreed that if these patients are not able to move up in status as their medical urgency increases, then they ought to be included in the eligibility criteria. A member explained the general treatment methods, which include the placement of a left ventricular assist device (LVAD), dialysis, and inotropes, and a general overview of the patient population in heart status 4 and 5.

A member noted that the lung-kidney and liver-kidney eligibility criteria both have a score that indicates the patient's severity, and allowing all heart statuses would remove the medical severity cut off for heart. A member expressed concern that as the Committee moves forward in developing policies for other MOT kidney combinations it could cause a large strain on the kidney alone list in the future. A member responded that all of the severity scores will need to be revisited when each organ type transitions to continuous distribution and by then there will be more data to appropriately adjust the policies as needed.

A member noted that once the policy is expanded to include status 4 and 5, it will be much more challenging to restrict the eligibility criteria in the future. The member was supportive of consistency across organ types and suggested including all lung and liver statuses if all heart statuses would be included. Unfortunately, there is not a comparable continuous heart score to use like there is in liver and lung allocation. The Heart Committee intends on developing that in continuous distribution, but for the time being, the statuses are the only way they are able to allocate to patients.

A member added that the Committee has emphasized consistency with the simultaneous liver-kidney (SLK) policy, but urged that patients will understand that different organs will have different policy implications. As a counterpoint, it was argued that kidney patients will have a harder time accepting that when they have an extended wait time and years on dialysis. The Chair added that research shows the kidney alone patient who was next on the waiting list does not do well and reminded the Committee that their responsibility is to find a balance between these conflicting interests.

A member shared their support for including heart status 4 and 5 and keeping the glomerular filtration rate (GFR) requirement, adding that they felt it was a reasonable compromise.

The Committee took an informal poll, and the majority of the members expressed support for including status 4 and 5 heart candidates meeting kidney criteria in the eligibility criteria for required shares.

Next steps:

UNOS staff will revise the policy based on today's discussion and circulate that text before the April 14 official Committee vote.

Upcoming Meetings

- April 14, 2022
- April 25, 2022
- May 9, 2022
- June 13, 2022

Attendance

- **Committee Members**
  - Alden Doyle
  - Emily Perito
  - Garrett Erdle
  - James Sharrock
  - Jennifer Prinz
  - Keren Ladin
  - Kurt Shutterly
  - Marie Budev
  - Nicole Turgeon
  - Sandra Amaral
  - Shelley Hall
  - Vincent Casingal
- **HRSA Representatives**
  - Raelene Skerda
- **SRTR Staff**
  - Katie Audette
- **UNOS Staff**
  - Cole Fox
  - Elizabeth Miller
  - Eric Messick
  - Erin Schnellinger
  - Holly Sobczak
  - James Jobes
  - Kaitlin Swanner
  - Liz Friddell
  - Matt Cafarella
  - Melissa Lane
  - Michelle Rabold
  - Rebecca Goff
  - Rebecca Marino
  - Rebecca Murdock
  - Roger Brown
  - Ross Walton
  - Susan Tlusty