**OPTN/UNOS Kidney Transplantation Committee**
**Meeting Summary**
**April 18, 2016**
**Chicago, IL**

**Dr. Mark Aeder, Chair**
**Dr. Nicole Turgeon, Vice Chair**

*Discussions of the full committee on April 18, 2016 are summarized below. All committee meeting summaries are available at http://optn.transplant.hrsa.gov/.*

## Committee Projects

### 1. Simultaneous Liver Kidney (SLK) Project

The intent of the SLK project is to provide medical eligibility criteria to allocate a kidney with a liver from the same donor, provide clear SLK allocation rules for OPOs, and create a "safety net" for liver recipients who are dialysis dependent or have significant kidney dysfunction within a year of their liver transplant. In December 2016, the Committee voted to recommend distributing a revised SLK proposal for a second round of public comment beginning in January 2016. During the April 2016 meeting, the Committee discussed the public comment feedback and the recommendations of the SLK working group to determine whether the proposal should be changed before sending to the OPTN/UNOS Board of Directors for review. This proposal will be presented at the June 2016 Board meeting for approval.

Because the proposal represents over 10 years of work and compromises from groups representing the many different perspectives and received overwhelming support from the OPTN regions in the Spring 2016 public comment cycle, the SLK working group and the Kidney Committee voted unanimously to recommend that the proposal move forward to the Board with no post-public comment changes. However, the Committee did consider and discuss changes based on public comment.

*Changes considered but not adopted: SLK medical eligibility criteria*

The SLK medical eligibility criteria being recommended to the Board of Directors enjoys wide range support from the 11 OPTN regions, the AUA, NKF, and the many OPTN/UNOS committees that reviewed and provided comment on the proposal. However, a review of the comments from the American Society of Nephrology (ASN) and ASTS highlight the difficulty the working group faced in achieving wide ranging clinical consensus on these criteria. The ASN suggests that the medical criteria for CKD and sustained acute kidney injury are too liberal, while the ASTS suggests they are too conservative.

The ASTS and Region 9 suggested that the Committee consider revising the duration of time (from 6 weeks to 4 weeks) that a liver-kidney candidate must be on dialysis or have continued GFR ≤25 to meet the SLK eligibility standard for sustained acute kidney injury. The ASTS comments reflect that there were differing opinions and practices among their own membership about the appropriate duration. During policy development, the working group and Committee actively debated the duration of dialysis. It was generally, although not universally, felt that 12 weeks was too long. Much of the debate centered around 6 versus 8 weeks. In the end, the Kidney Committee representatives compromised and agreed to 6 weeks because of concerns that candidates for SLK have

MELD scores that portend a poor 3 month survival and 6 weeks duration was more favorable to the patient. In the end, the Committee decided on the six week duration as a reasonable compromise, since there were strong voices arguing for both more and less dialysis time prior to SLK eligibility. The Committee discussed that the implementation of the safety net should address concerns expressed about the duration being too strict.

*Changes considered but not adopted: SLK allocation*

The proposed new SLK allocation rules were also widely supported by the OPTN regions, the AUA, NKF, and other OPTN/UNOS committees (including the OPO and Liver and Intestinal Organ Committees). However, the ASTS and Region 7 expressed concerns about whether the expanded requirements for regional liver-kidney allocation go far enough. The ASTS suggested that the OPO should be required to allocate the kidney with the liver to regional candidates with MELD at least 30. Region 7 (the only region to vote to oppose the proposal) offered that the OPO should be required to share the kidney with the liver to all regional candidates, regardless of MELD. The working group and the Committee discussed these comments and agreed that it is not appropriate to make either of these changes for the below reasons:

- The proposal is designed to align the new liver-kidney allocation policy with the current liver alone allocation policy. The current liver-kidney allocation policy does not require sharing beyond the local DSA, although the current liver alone allocation policy mandates regional liver sharing for candidates with MELD score of at least 35. Making this rule consistent also decreases complexity in implementing any new rules by ensuring that liver-kidney offers will still be made using the liver match run and a consistent allocation scheme.
- Using the addition of MELD score for regional liver-kidney sharing acknowledges that there must be a balance in access for liver-kidney and kidney alone candidates and that kidney alone candidates face a large supply/demand mismatch for organs and additional time on dialysis results in worse outcomes.

*Changes considered but not adopted: Safety net for liver recipients*

The safety net element of this proposal enjoys the most support and consensus of any other element of the proposal. However, there was feedback concerning the placement of safety net priority among the deceased donor kidney allocation sequences. This is also an area where the Committee has received conflicting feedback throughout the public comment cycles. Some commenters have suggested that there should be no additional priority for liver recipients in sequence B (the allocation sequence when the donor's KDPI score is 20-34%), even though local adult liver recipients would only be prioritized within this sequence after the highly sensitized and local pediatric candidates.

Others (notably the ASTS and Region 9) expressed concern that there is no additional safety net priority in sequence A of kidney allocation. The working group and the Kidney Committee discussed this concern and decided against recommending additional priority in sequence A for the following reasons:

- While liver recipients will not receive additional safety net *priority* for kidneys in sequence A, they are not excluded from receiving these offers altogether. For instance, a liver recipient who is highly sensitized would still appear in the highly sensitized match classification in sequence A. A liver recipient with an EPTS in the top 20% would still appear in this classification within the sequence. And, liver recipients in the OPO's DSA will still appear in the "all local adults" match classification in sequence A.

- The main goal of sequence A is to provide more life years from kidney transplantation. In previous public comment periods, the regions and other commenters have expressed concern that the new safety net classification may act as a disincentive for a liver recipient to find a living kidney donor. The Committee contends that sequence A kidneys perform similar to living donor kidneys, and exempting a special classification for liver recipients in this sequence may provide incentives for liver recipients to seek a living kidney donor.

**2. Kidney Allocation System (KAS) Clarifications & Clean Up**

KAS was implemented on December 4, 2014. Since that time, the Committee and UNOS staff have identified several clarifications that are needed in the policy language. The Committee had developed a proposal that included these changes for public comment. The KAS Post-Implementation Subcommittee (the Subcommittee) had previously reviewed the public comment feedback and developed recommendations for the Committee to consider. The Committee reviewed the public comment feedback and the Subcommittees recommendations to determine whether the proposal should be changed before sending to the OPTN/UNOS Board of Directors for review. This proposal will be presented at the June 2016 Board meeting for approval.

This proposal received comments primarily on the proposed changes to mandatory sharing and the informed consent requirement for multi-organ candidates for kidneys based on KDPI greater than 85%. As a result, the Committee did not recommend any post-public comment changes to the proposed policy on maintaining consistency through kidney allocation policy with regard to *Policy 5.9: Released Organs*, correcting match classification language, or clerical changes. Ultimately, the Committee only made one post-public comment to change the timeframe for obtaining consent up until the time of transplant. The Committee's considerations on mandatory sharing and the informed consent requirement are outlined below.

*Mandatory Sharing*

The majority of the regions (7 of 11) supported the proposed changes. Several committees, including the OPO Committee, also expressed support for these changes.

*Comment Theme: Increase in Cold Ischemia Time (CIT) and Discard Rate*

Multiple groups (including those that supported the proposed changes) expressed concern that a prolonged allocation time will increase CIT and the discard rate. Despite concerns expressed during public comment, subcommittee members reiterated that although there may be many candidates on the match run in these classifications, this may be the only ("once in a lifetime") offer for a very highly sensitized candidate in these classifications. An OPO could still use other currently available bypass codes to place the kidney in the event that the kidney becomes at risk for discard. Due to the overall level of support for the proposed changes, the Subcommittee did not recommend any changes to this part of the proposal.

The Committee also reviewed additional data. During the 12 months post-KAS implementation:

- about 6-7% of match runs for a kidney with a KDPI 0-85% included more than 10 registrations appearing in mandatory share classifications (CPRA 99-100 and zero-ABDR mismatches)

- about 3%-5% of match runs for a kidney with a KDPI greater than 85% included more than 5 registrations appearing in mandatory share classifications (CPRA 99-100 and zero-ABDR mismatches)

For "easy-to-match" donors, there may be dozens or even hundreds of candidates in the mandatory share classifications on a match run. A committee member noted that histocompatibility testing requirements, implemented on January 21, 2016, take into account HLA-DQA1 and HLA-DPB1 as unacceptable antigens to automatically avoid those donors if these unacceptable antigens are listed. These measures may further reduce the number of candidates that appear in the mandatory share classifications.

The Committee also reviewed the bypass code utilization for the first and second six months after KAS implementation. The data show that:

- In the first six months post-KAS, 22 OPOs used the code to bypass 902 candidates on 52 different match runs.
- In the second six months post-KAS, 28 OPOs used the code to bypass 537 candidates on 49 different match runs.

This means that some but not all 58 OPOs are using this bypass code which supports the Committee's belief that very highly sensitized candidates may not be treated equitably across the country.

After reviewing this data and the Subcommittee's recommendation, the Committee agreed and did not make any changes to this portion of the policy proposal (18 yes, 0 no, 1 abstention). The Committee maintains that KAS was intended to make the system more equitable for highly sensitized patients and not just those patients that are in the first 10 or first 5 on the match run. Committee members also noted that concerns about discard rate and CIT may be better addressed through other projects such as the system optimization project sponsored by the OPO Committee which will look at the organ offer process as a whole. The IT Customer Council (created by UNOS IT comprised of Transplant Coordinators, Surgeons, Lab Directors, etc.) is also considering leading a project to collaborate with the committees and UNOS staff to identify and create more definitive bypass and refusal codes to identify issues that may affect organ placement.

*Comment Theme: Changes Will Need to Be Monitored*

The OPO Committee and ASTS noted that the impact of the proposed changes should be monitored and evaluated.

The proposal's evaluation plan does not outline additional evaluation outside of the ongoing monitoring for KAS. UNOS already tracks discard rates by KDPI on a monthly basis. If approved by the OPTN/UNOS Board of Directors, the Kidney Committee could request a deeper analysis if there was an increase in discards or CIT post-implementation.

*Informed Consent for Multi-Organ Candidates for Kidneys Based on KDPI Greater than 85%*

In general, most of the OPTN committees that commented on the proposal favored obtaining consent as proposed in the public comment document. The Thoracic, Liver, and Patient Affairs Committees supported obtaining informed consent prior to transplant. The Pancreas Transplantation Committee did not believe there should be a requirement due to the rarity of using a high KDPI kidney for a simultaneous pancreas-kidney

transplant. The Pancreas Committee also expressed concern that the requirement would put policy in place of medical judgement.

The regions were split on this clarification with six regions either in favor of the proposed clarification as written or changing the timeframe to prior to transplant. Five of the regions did not believe this informed consent requirement should apply to multi-organ candidates.

*Comment Theme: Maintaining Consistency with Kidney-Alone Policy and Consent for Other High-Risk Designations*

The Membership and Professional Standards Committee (MPSC) and the American Society for Transplant Surgeons (ASTS) supported obtaining consent as proposed to maintain consistency with both kidney-alone policy and other issues that patients need to be informed on (such as potential infections or other high-risk designations).

*Comment Theme: Lack of Data on Risks/Outcome for Multi-Organ Candidates*

The main theme among the regions was that without the data on risks/outcomes for multi-organ candidates, transplant programs cannot inform on the risks. However, the American Society for Transplantation (AST) also noted that without data we do not know that KDPI does *not* impact outcomes.

Subcommittee members noted that it would be difficult to determine the impact of the KDPI score on a SLK recipient that accounts for all factors. However, a subsequent, post-public comment literature review identified two papers that demonstrated poorer renal outcomes in simultaneous liver-kidney recipients with extended criteria donor (ECD) kidneys.

Because the majority of the responses supported obtaining informed consent, the Subcommittee recommending keeping the requirement, but changing the timeframe for obtaining the consent up until the time of transplant. This decision was largely driven by the idea that a multi-organ candidate's circumstances may change from the time of registration to the time of transplant. A multi-organ candidate that may not initially consent prior to receiving organ offers for a kidney with a KDPI greater than 85%. However, as the need for a transplant becomes more urgent, the candidate may be willing to accept these kidneys. This change will allow the greatest degree of flexibility for obtaining consent, but it would not prevent transplant programs from creating more stringent standards for their particular program if they chose (i.e. to obtain consent at the time of listing or prior to receiving offers).

The Committee reviewed this recommendation and reiterated many of the same concerns expressed during the development of this proposal. Namely that the other organ drives the offer. Several committee members also agreed with the concerns over the limited data to explain adequately the risks to a multi-organ candidate. Conversely, other committee members agreed that there should be consistency with kidney-alone policy. Individual committee members also expressed the following:

- While candidates must consent for a higher risk kidney, they do not have to consent for a higher risk liver.
- Because the other organ drives the offer, the consent may not be explained by a member of the renal community who is familiar with the risks of accepting a high KDPI kidney.
- Committee members were concerned that this was pro forma formality rather than a true understanding of the scope of the risks.

Ultimately, committee members agreed that the majority of the public comment responses supported obtaining informed consent. While some might find it ideal to obtain consent prior to receiving offers, allowing up until the time of transplant gives programs the most flexibility and is patient-centric. The Committee approved the post-public comment change (17 yes, 0 no, 2 abstentions).

**3. Improving Allocation of Double and En Bloc Kidneys**

The Committee received an update on the status of this project. The purpose of this project is to increase the utilization of high KDPI and en bloc kidneys. To date, the work group focused on developing this project has reviewed data on the current volume of double and en bloc kidney utilization and the centers performing a high volume of these transplants. “High volume” centers still have very few of these transplants. The work group will be splitting into two smaller subgroups. One will focus on double kidney allocation and the other will focus on en bloc kidney allocation. Committee leadership will also be reaching out to the high volume centers and OPOs to ask them to participate in the work group as content experts. The projected timeline for development is public comment in spring 2017 and Board of Director’s review in June 2017.

**Implemented Committee Projects**

**4. Kidney Allocation System (KAS) Post-Implementation Data**

The Committee reviewed 1-year post-implementation data on KAS and feedback from the spring 2016 regional meetings. Topics included:

- Waiting list trends
- Transplants by recipient age
- Transplants by recipient sensitization level (CPRA)
- Transplants by dialysis duration, diagnosis, race, gender, ABO
- Transplants for prior living donors
- Multi-organ and dual kidney transplants
- Longevity matching, geographic distribution, cold ischemic time
- Kidney utilization
- Early post-transplant outcomes

The Committee discussed the following while reviewing the data:

*Candidate Registrations:* The decline in candidate registrations may be affected by a change in listing practices. Now that KAS allows for backdating of dialysis time to qualify for waiting time, centers may be waiting to list patients, especially those in the older patient population.

*Pediatric Transplants:* Transplant rates for pediatric patients (ages 0-17) have fallen slightly, but the difference is not statistically significant overall. A decrease in transplants for pediatrics with ages 11-17 with a CPRA 80-100% has also been observed. The affect appears to be greater on those adolescents with a CPRA of 80-94%. The Pediatric Committee has also discussed this issue and would like more time to pass to allow KAS to stabilize. They would like to see additional data at the 18-24 month timeframe to determine if this is an issue that requires action.

The Kidney Committee agreed with this approach. Committee members noted that it will be important to evaluate this population based on the CPRA as there may be different issues affecting the access of a pediatric patient that has a CPRA of 80% compared to one with a CPRA of 100%. Committee members noted that with the increase in multi-

organ transplants, there are fewer kidneys available for the kidney-alone list, some of which may have been suitable for pediatric candidates. The Pediatric Committee is also interested in this potential effect and would like to look at this idea at both a regional and national level.

Committee members also noted that the bolus effects among transplants for the very highly sensitized and patients with long dialysis times may impact pediatric access to transplants. The belief is that once the bolus effects have subsided, the pediatric population may see further improvement. The Committee is encouraged that overall pediatric transplant rates have rebounded and believes that it is too premature to take any action at this time. However, the Committee will continue to monitor the system.

*A2 and A2B Subtype to Blood Type B Recipients*: The Committee discussed the small but meaningful increase in these transplants. The Committee is already participating in a project with the Minority Affairs Committee that is considering developing guidance on this topic.

*Transplant Volume by Center (Pre- and Post-KAS, small-volume centers <50 transplants per year)*: The Committee discussed the effects of KAS on small-volume centers. There has been substantial pre- vs. post-KAS variability among small programs. Small centers are more likely to be affected by random variation. Committee members noted that small centers may have participated in a variance in the old KAS and may have been getting undue access. Since those variances were removed with the new KAS, small center transplant volume may be normalizing. At the spring regional meetings, a couple of small centers noted that KAS has reduced their number of transplants and they are interested in pursuing a new variance. However, there have been no formal requests so far.

*Post-KAS Access to Transplants by EPTS Score:* Candidates with an EPTS score of 0-20% have a transplant rate of 0.21 transplants per active patient year on the waiting list (i.e., approximately 5 years for every 1 transplant), compared to 0.17 for candidates with EPTS 21-100%. A committee member noted that there were concerns during the development of KAS that matching the top 20% EPTS score with the top 20% KDPI kidneys would discourage living donation and also affect acceptance criteria. This committee member stressed the importance of explaining to the community that a low EPTS score does not guarantee fast access to a transplant.

*Discard Rate:* The Committee discussed the increase in discard rates over the first year of KAS. Although there may be a number of contributing factors that result in a discard, the reasons reported for discard are very similar pre vs. post-KAS. The top two reasons reported include biopsy findings and exhausting the match run without finding a recipient. The Committee already has one project underway focused on decreasing the discard rate of high KDPI kidneys. This project will create policy to facilitate the allocation of dual kidneys. There has been an increase in DCD discards compared to brain dead donors. A committee member noted that the community is still learning the optimal way to utilize the DCD kidneys. Another committee member noted that there may be a correlation between DCD kidneys and increased PHS high-risk due to heroin usage that is resulting in increased discards. The Committee remains watchful and would like more time to pass to determine if any action is needed.

*Delayed Graft Function:* The percentage of recipients requiring dialysis within the first week after transplant increased from 24.4% to 29.2% post-KAS. One committee member was concerned by the increase in DGF, which appears to be driven mostly by transplanting more recipients with high dialysis time. Other committee members felt that although there may be an increase in DGF, it is only one of the indicators of the system.

Recipients could go on to have functioning kidneys with similar outcomes to recipients that do not have DGF. The Committee also considered whether the increase may be coming from the types of kidneys recovered, specifically DCD donors that may be causing DGF. Other committee members were concerned about the financial impact on the transplant centers due to increased cases of DGF which cause a longer length of stay or readmission. Committee members feel that this will need to be monitored further.

## Other Significant Items

### 5. KPD Work Group Update & Discussion of Potential Projects

*Topic: KPD Metrics*

The Committee reviewed data on national trends in KPD and the OPTN KPD program. Paired donations have been relatively flat in the last 4 years around 550-600 transplants per year. KPD represents about 10% of living donation kidney transplants. The OPTN KPD accounts for approximately 45 KPD transplants per year. In 2015, 63 match offers were sent per month on average, but they did not all result in transplants which is a common challenge for all KPD programs.

UNOS research is analyzing the use of the donor pre-select tool and center practices for screening criteria to improve the match success rates. Technical advisors on the KPD Work Group have also suggested algorithmic changes to improve the match success rate. The Committee asked the following questions:

- Is one of the challenges the difficulty in matching certain blood types? Yes, KPD pairs (either the donor, candidate, or both) may have difficult to match blood types. A difficult to match blood type in combination with a candidate's CPRA may limit the likelihood that the pair will find a match.
- Is there a change in recipient CPRA over time? The percentage of highly sensitized candidates has remained steady.
- Is there any way to identify the number of compatible pairs that have been listed? UNOS does not track the level of compatibility between donors and candidates and compatible pairs are difficult to identify within the current system.

*Topic: Outreach Interviews*

The Committee also reviewed recent outreach efforts that targeted hospitals that:

- Did not enter pairs into the OPTN KPD in 2015
- Have a high decline rate (defined as receiving >21 offers, but had a decline rate of 55% or greater)
- Have a low decline rate (defined as receiving >21 offers, but had a decline rate of less than 35%)
- Have active living donor programs with 15-40% of overall transplant volume from living donation, but with little or no KPD

UNOS staff are conducting interviews with several of the hospitals that meet these criteria in order to identify barriers to participation in KPD and improvements for the OPTN KPD. These interviews are ongoing and will be completed by the end of April.

Based on the interviews conducted to date, several themes have emerged that generate success and challenges for KPD. Overall, the hospitals noted that key contributors to success are having a hospital culture that supports KPD, outreach and education for living donors, and mentioning KPD as an option early in the process and often. Hospitals with a low decline rate noted several successful strategies including: entering

immunologically compatible pairs with a benefit for size or age, re-evaluating donors and candidates, entering non-directed donors into KPD, and involving finance as soon as possible in the match offer process.

The reported barriers to KPD focus on the logistics and complexity of KPD that take a great deal of hospital staff resources. Finance continues to be a problem for hospitals. It also appears that programs in the OPTN program are not fully utilizing the donor pre-select tool and are not aware or using many of the available resources that the OPTN offers. Hospitals have offered a number of ideas to improve the match success rate in the OPTN KPD. UNOS staff and the KPD Work Group will assess the final results to determine which ideas are feasible and cost-effective.

Committee members asked for specific information about the challenges for the financial component of KPD. UNOS staff noted that the complexities of negotiating contracts between hospitals with competing insurance companies increases the hospital staff time to come to agreement. These negotiations take place each time a match is made. Staff turnover and inexperience working with KPD can also contribute to the difficulties in creating a contract.

A committee member noted KPD will continue to experience match failures without standardizing MFI cut-offs. A committee member suggested that holding phone calls to discuss unacceptable antigens and MFI cut-offs prior to crossmatch for KPD exchanges. Another suggestion would be to put the “riskier” pairs with more unacceptables at the end of a chain so that the other matches in the chain are less likely to fall apart. The committee member also suggested that cases where KPD exchanges that are declined due to unacceptables be referred to the Histocompatibility Committee for review.

*Topic: Project Idea – Repairing OPTN KPD Exchanges*

The Committee was asked to review and approve the KPD Work Group’s request to begin a project that focuses on repairing exchanges that fall apart after the match offers have been made. This project would only affect the OPTN KPD.

Currently, the OPTN KPD only has one remedy for repairing chains outlined in policy. If one match in the chain cannot proceed to transplantation, the chain is truncated up to the point of the refusal. The pairs before the refusal would be transplanted, but the pairs after the refusal would not. The chain's last donor may donate to the deceased donor waiting list or be a bridge donor. Policy and programming do not allow the chain to be re-evaluated to see if other solutions are possible.

For example, in January 2016, the OPTN KPD had arranged 7 transplants (two chains joined by a bridge donor). The crossmatches were completed and the surgery dates had been set, but the first candidate in the first chain was suddenly unable to be transplanted because their paired donor declined to donate. In this case, because the chain broke at the beginning of the first chain, all other matches in both chains had to be terminated. The NDD that made these chains possible also ultimately declined to donate in KPD due to too many terminations.

The project would seek to create a broad policy that allows for multiple types of repairs. Because KPD is an evolving field, the policy will need to allow for multiple types of repairs, not just those that might be possible in the current framework of KPD. Consequently, the policy will need to strike a balance between being broadly written to allow for these repairs, but also allow for transparency.

Committee members discussed at-length the balance between transparency and the operational ability to make real-time decisions depending on the unique complexities of each exchange. Committee members believe that the policy should be as flexible as possible. Committee members noted that the timing of the repair and the end-result of repairing the chain will also need to be taken into consideration. For example, if a chain breaks at the end, the donor that will now be the new end of the chain should be evaluated for likelihood of matching (e.g. O donor vs. AB donor) and whether that should impact the type of repair that is made. A committee member noted that making improvements to the program would help build confidence in the OPTN KPD.

The Kidney Committee unanimously voted to send this project to the Policy Oversight Committee for approval.

*Topic: Project Idea – Allowing Deceased Donor Chains in the OPTN KPD*

This project was previously approved in June 2013, but was put on hold in 2014. The KPD Work Group requested that they be allowed to work on this project again. Deceased donor chains have great potential for increasing the number of transplants. Although KPD chains may ultimately end in donation to the waitlist, deceased donor kidneys are not used to begin chains. Currently, the kidney allocation system for the deceased donor waitlist and KPD are separated in terms of both allocation policy and IT programming. Allowing for other possibilities may better utilize both deceased donor and KPD donor kidneys.

Using deceased donors to initiate chains, similar to how NDDs are used, could greatly expand the number of transplants overall as each deceased donor kidney could unlock multiple transplant opportunities.

Due to the complexities involved in both KAS and KPD, it is expected that this project will require multiple years of development and multiple rounds of public comment.

The KPD Work Group may consider developing a concept paper for feedback prior to developing policy.

Committee members did not like the idea of pursuing a concept paper as an intermediate step to developing policy. Based on previous experiences, a committee member felt that concept papers are not the best avenue for developing these potential changes. Concept papers are distributed for public comment and capture the general ideas of what would be proposed, but not the specifics. The Committee may find itself in a position that they must write the policy to address the public comment, rather than developing a policy that the public can comment on.

The Committee considered whether this was the appropriate time to revisit this project considering the existing workload and the desire to work on the KPD repairs project. If approved by the BOD, two projects will be entering the implementation phase, which means that they will not be taking as much committee member volunteer time. Committee members are also sponsoring one project and participating in two other projects sponsored by the OPO and Minority Affairs Committees. Committee members noted that the untapped potential of using a deceased donor as a non-directed donor will increase KPD, thereby, removing patients from the waitlist. Realizing this untapped potential would be worth the effort of the increased work load. Committee leadership believes that the Committee has the member resources available to work on this project.

The Committee unanimously voted to send the project to POC for approval.

6. **Review of 2015 KDPI and EPTS Reference Populations**

   As required by policy, the Committee performed its annual review of the KDPI and EPTS reference populations. The KDPI reference population is based on all kidneys recovered in the previous year. EPTS only impacts longevity matching for the top 20% in sequence A (e.g. less than or equal to 20% KDPI). The Committee voted to adopt new KDPI and EPTS mapping tables based on these reference populations.

7. **Update from the Policy Oversight Committee**

   The Committee reviewed an overview of recently approved projects and strategic goal alignment. Currently, the OPTN is under allocated under goal 1 which is focused on increasing the number of transplants and goal 3 which pertains to improving outcomes.

8. **Update on the Minority Affairs Committee (MAC) Project on A2/A2B Deceased Donor Kidney Transplants to Blood Type B Recipients**

   KAS policy allows for kidneys from A2 and A2B blood subtypes (also known as non-$A_1$ or non-$A_1B$) to be transplanted into blood type B candidates if the transplant program has obtained written informed consent from the candidate to accept these kidneys. The transplant program must also establish a written policy on its titer thresholds for these transplants and reconfirm the candidate's eligibility every 90 days. As of the 6-month post-implementation report, 47 A2/A2B transplants have occurred during the six months after KAS implementation compared to just six over the six months prior to KAS. Though small in absolute numbers, this increase is highly statistically significant ($p<0.0001$) and suggests that this aspect of the policy has already started to make a difference in access to transplants for blood type B patients. MAC is interested in learning why more centers are not utilizing this aspect of KAS and is developing a survey to find out more information. MAC may use this information to pursue a guidance document, but will need the survey results before making any final determinations.

**Upcoming Meetings**

- May 16, 2016
- June 20, 2016