

**OPTN/UNOS Kidney Transplantation Committee  
Meeting Minutes  
October 23, 2017  
Richmond, VA**

**Nicole Turgeon, MD, FACS, Chair  
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**Introduction**

The OPTN/UNOS Kidney Committee (*the Committee*) met in-person in Richmond, VA on 10/23/2017 to discuss the following agenda items:

1. UNOS Research Orientation
2. Scientific Registry of Transplant Recipients (SRTR) Orientation
3. Improving Dual Kidney Allocation (Voting Item)
4. Improving En Bloc Kidney Allocation (Voting Item)
5. Deceased Donor-Initiated Chains Project Update
6. Simultaneous Liver-Kidney (SLK) and Enhancing Liver Distribution Update
7. Policy Oversight Committee (POC) Update
8. KAS Review Project Discussion and Breakout Groups

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

**1. UNOS Research Orientation**

The Kidney Committee Research Analyst presented a UNOS Research Department Orientation to the committee members. The orientation was given due to the major turnover of past committee members and the start of new committee members in July 2017. The purpose was to explain the purpose and responsibilities of the Research Department and the Research Analyst position for the Committee and its projects. As part of the committee support structure, the Research Department provides analyses in support of the policy change initiatives and for monitoring the change post-implementation. Other roles of the department are fulfilling data requests, scientific research, and database activities.

Another important item was the process of requesting data as a Committee:

- Data requests should be made through the process of committee discussion – and not by individual committee members.
- Results of the analysis are presented at a future meeting or conference call.
- Manuscripts based on the committee activities must be reviewed by HRSA prior to submission.

There were no questions from the Committee.

**2. Scientific Registry of Transplant Recipients (SRTR) Orientation**

The SRTR liaison for the Committee presented a SRTR Orientation to the committee members. The orientation was given due to the major turnover of past committee members and the start of new committee members in July 2017. The purpose was to explain the purpose and responsibilities of the SRTR and the SRTR liaison position for the Committee and its projects. As part of the committee support structure, the SRTR provides inferential analyses in support of the policy initiatives, particularly predictive modeling and simulations. Other roles of the SRTR are performing ongoing evaluations of the scientific and clinical status of solid organ transplantation, facilitating outside research on transplantation, and disseminating information to the transplant community through reports and publications.

Another important item was the process of requesting modeling for allocation changes as a Committee:

- Committee submits a formal data request to SRTR.
- SRTR submits an analysis plan, runs simulations and completes analysis, and submits a report back to the Committee.
- SRTR presents key findings from the report to the Committee.
- Committee weighs information from modeling results as well as medical, ethical, and practical considerations in making a decision on whether to pursue an allocation change.

There were no questions from the Committee related to the SRTR orientation.

There were comments concerning amalgamating transplant program surveys required during the year, and efforts from outside organizations to create a list of data fields that tie into waitlist mortality and whether they are all represented on the current UNet forms. UNOS staff and others in attendance did not have any updates on these items.

### **3. Improving Dual Kidney Allocation (Voting Item)**

This policy proposal was open to public comment from July – October 2017. The proposal received 23 comments on the OPTN website. All comments were from OPTN/UNOS Committees, regions, or professional societies. There were no individual comments on this proposal from the general public or transplant community. Seven committees requested presentations on this proposal and all were supportive of the proposal moving forward to the Board of Directors with no changes (Ethics, Minority Affairs, Membership and Professional Standards Committee (MPSC), Organ Procurement Organization (OPO), Operations and Safety, Patient Affairs, and Transplant Coordinators Committees). Five professional societies responded to feedback requests for the proposal, and all were supportive of the proposal moving forward to the Board of Directors (ANNA, AOPO, AST, ASTS, and NATCO). All eleven regions heard presentations for the *Improving Dual Kidney Allocation* proposal and ten regions supported proceeding to the Board of Directors. One region (Region 9) supported the proposal with amendments (see theme sections below for explanations).

The Committee discussed themes resulting from public comment, and how to proceed with the dual allocation policy changes.

- Facilitated Placement for Dual Kidney Allocation
- Splitting Dual Kidneys and Releasing per *Policy 5.9*

#### *Facilitated Placement for Dual Kidney Allocation*

Though most commenters (except Region 9) supported this proposal as a necessary first step in updating and tracking dual kidney transplantation, Regions 5, 9, and 11 referred to an expedited/facilitated dual kidney allocation as the logical next step in the process. There is precedence for this pathway in the current *Policy 11.6: Facilitated Pancreas Allocation*. This current dual kidney allocation proposal establishes a dual kidney allocation in the match run, which will assist in tracking which transplant programs accept and ultimately transplant dual kidney offers. This proposal will give the community the allocation and tracking needed to determine whether a facilitated dual kidney policy is necessary in the future. The Committee felt that the first step to improving efficiencies with dual kidney allocation was first to implement a policy solution that included offering duals via a match run. The Committee agreed that updating current policy to include clear criteria and an allocation scheme is an appropriate first step to addressing the core problem of discards of high KDPI kidneys. The Committee may opt to take up facilitated or expedited placement as a project in the future as it applies to kidney allocation in general; however, the Committee did not want to preemptively design a facilitated placement solution for this small subset of kidneys.

### *Splitting Dual Kidneys and Releasing per Policy 5.9*

Most commenters supported the Kidney Committee's decision to follow *Policy 5.9* when splitting dual kidneys at an accepting program. Region 9 and AOPO submitted comments that advocate for the accepting program to keep both kidneys upon splitting kidneys originally allocated as dual kidney offers. The reason given was to lessen cold ischemia time on the second kidney, thereby preventing possible discard of the organ. OPTN data shows that for donors with a KDPI of 85% and above (636), only 1.4% (9) had at least one kidney leave the original accepting center for transplant in the last six years. Considering that this policy would include dual kidney allocation in the match run earlier in the offer process, incidences of increased cold ischemia and a remaining kidney leaving the original accepting center are expected to decrease. The Committee found that alignment with current *OPTN Policy 5.9* is the most transparent and patient-centered method to managing released kidneys, even if rare.

The Committee decided that every effort should be made to follow the OPTN's established allocation sequences. Deviating from these sequences without conducting due diligence to the next candidate on a given match run would be in opposition to the core values of the OPTN. The Committee was consistent in its discussion of this topic, as it was intently discussed earlier in the process as well. Post-implementation monitoring will help the Committee review these scenarios.

The Committee voted to send the dual kidney allocation policy language to the Board of Directors with no changes (19-yes, 0-no, 0-abstentions).

#### **4. Improving En Bloc Kidney Allocation (Voting Item)**

This policy proposal was open to public comment for the second time from July – October 2017. The proposal received 25 comments on the OPTN website. Comments were from OPTN/UNOS Committees, regions, professional societies, and individuals in the transplant community. Seven committees requested presentations on this proposal and all seven of them were supportive of the proposal moving forward to the Board of Directors with no changes, but suggested specific monitoring plans (Ethics, MPSC, OPO, Operations and Safety, Patient Affairs, Pediatric Transplantation, and Transplant Coordinators Committees). Five professional societies responded to feedback requests for the proposal and four were supportive of the proposal moving forward to the Board of Directors (ANNA, AOPO, AST, and ASTS). NATCO opposed the proposal as written but provided recommendations. All eleven regions heard presentations for the en bloc allocation proposal and nine regions supported proceeding to the Board of Directors. Two regions (Region 5 and 8) supported the proposal with amendments.

The Committee discussed the following three themes resulting from public comment, and how to proceed with the en bloc allocation policy changes.

- Weight threshold for mandatory en bloc kidney allocation
- Releasing second kidney from a split en bloc unit according to *Policy 5.9: Released Organs*
- Other themes

#### *Weight threshold for mandatory en bloc kidney allocation*

A majority (21 of 25) of the commenters support the current 18kg weight threshold for en bloc kidneys. Four commenters opposed the 18kg weight threshold; three of which (NATCO, Regions 2, 5) suggested a weight threshold of 15kg and one simply suggested a lower weight threshold.

The reasoning in the lower threshold recommendation is to force an increase in splitting above 15kg, which will increase the number of transplants. Changing the weight threshold to 15kg would eliminate centers that perform en bloc transplants using higher weight donors from receiving match offers. The en bloc match run will only include those centers that opt in for their

candidates for the established weight threshold. Lowering weight threshold would involve changing proposal policy language, but would not have further effect on IT or other costs.

The Committee considered this feedback and voted to keep the current proposed 18kg donor weight for mandatory allocation. The Committee anticipated this theme of questioning based on earlier public comment and had supporting data available for all presentations, which helped garner buy-in and support. The data on en bloc transplants still supports this change and mitigates disadvantaging centers that are transplanting single kidneys in the 15-18kg weight threshold at a rate of about 50%. The Committee is concerned that further lowering the threshold would disadvantage centers performing en bloc transplants in this weight range. This proposal allows for en bloc kidneys in this weight range to be transplanted as singles by being split if deemed appropriate by the transplanting surgeon.

Given that the intent of this policy is to increase transplants in part by facilitating procurement of lower weight donors, the Committee wanted to accommodate programs currently doing en bloc transplants with kidneys from donors in the at least 15kg but less than 18kg weight range.

#### *Releasing second kidney from a split en bloc unit according to Policy 5.9 Released Organs*

In response to Board of Director's feedback, and to provide more data during the most recent public comment period, The Committee teamed with UNOS IT staff to ensure en bloc allocations will be configured with IT programming to create two match runs at once: the first for en bloc allocation with KDPI masked, and the second for single allocation in case of the need to split, with KDPI shown. Instructions to use the single match run only in the event of a split will be included. This will allow the OPO to immediately identify the next candidate on the list without having to run a new match as soon as the surgeon indicates they are planning to split the pair.

While the Committee acknowledged the concern over added cold ischemia on the second kidney, the members agreed that confusion or lack of exposure to the application of *Policy 5.9* in practice might be driving some to oppose its inclusion in this project. *Policy 5.9* is current practice for OPOs and transplant programs. For donors less than 18kg, just 1.6% of offers, in which both kidneys were accepted between 2010 and 2015, had at least one kidney transported outside of the accepting center.

Most commenters supported the Kidney Committee's decision to follow *Policy 5.9* when splitting en bloc kidneys at an accepting program. The OPO Committee, NATCO, and Regions 2, 8, and 9 submitted comments that advocate for the accepting program to keep both kidneys upon splitting kidneys originally allocated as en bloc kidney offers. The reason given was to lessen cold ischemia time on the second kidney, thereby preventing possible discard of the organ. OPTN data shows that over six years, 56 kidney pairs from donors under 18kg were split, and only 21 offers had at least one kidney travel to a new center for transplant. It's important to note that none of the transplanted kidneys from the previously mentioned 21 donors left the accepting candidate's DSA. The Committee reinforced during each presentation that alignment with *Policy 5.9* is the most transparent and patient-centered method to managing released kidneys, even if rare. The Committee decided that every effort should be made to follow the OPTN's established allocation sequences. Deviating from these sequences without conducting due diligence to the next candidate on a given match run would be in opposition to the core values of the OPTN. The Committee was consistent in its discussion of this topic, as it was intently discussed earlier in the process as well. Post-implementation monitoring will help the Committee review these scenarios.

#### *Theme 3: Other Concerns*

The concept of split en bloc kidneys incentives or disincentives is tied to the right of first refusal for the second kidney when splitting. A few members from the Pediatric Transplantation Committee and an individual surgeon commenter stated that the decision to release the second kidney after splitting according to *Policy 5.9* at the proposed 18kg weight threshold does not incentivize surgeons to split the en bloc kidneys. The intent of the proposed policy is to direct

OPOs to allocate en bloc kidneys and to continue to allow splitting en bloc kidneys under the clinical judgment of the transplant team. The purpose of this policy is not to incentivize any surgical decisions, but allow the transplant team to make those decisions using their medical judgment.

There were several comments (from members on Patient Affairs Committee, Regions 2 and 6) directed at the potential effect of the en bloc kidney proposal on the pediatric population receiving small single kidneys. If the en bloc kidneys are split and the KDPI of the remaining kidney is above 85 percent, then pediatric candidates do not receive that offer. A select number of pediatric programs (in select regions) are transplanting small single kidneys into pediatric patients routinely. Although en bloc kidneys are not typically transplanted into (small) pediatric candidates, they can be transplanted into adolescents. Pediatric programs will still have access to small kidneys, providing they opt-in to receiving en bloc kidney offers. Screening pediatric candidates off KDPIs of 85 percent or above is not a new practice, it is current allocation, and does not change with this proposal. The Committee decided that education for pediatric programs is essential to prepare them for the opt-in system changes, as well as monitoring the effect of the policy changes on the pediatric population.

The Committee voted to send the en bloc kidney allocation policy language to the Board of Directors in December 2017 with no changes (19-yes, 0-no, 0-abstain).

## **5. Deceased Donor-Initiated Chains Project Update**

Prior to discussing public comment results, the KPD Program Manager presented an overview of the proposed models covered in the concept paper. Due to the amount of new committee members at the meeting, an overview was essential to productive discussion about public comment.

- The candidate-driven KPD exchange was reviewed. The pair consents to participate in a KPD exchange. The candidate will receive a deceased-donor kidney in exchange for the donor donating her living donor kidney. The candidate is then registered on the waitlist and receives elevated priority due to the pair's willingness to participate in the exchange. The candidate receives the offer from the deceased donor, accepts the offer, and is transplanted. A KPD match is then run with the donor in it as the deceased donor pair. A match is found for her. She continues the chain and donates her kidney. At the end of the chain, the donor either becomes a bridge donor or donates directly to the wait list.
- The list exchange KPD chain was reviewed. The pair consents that the candidate would receive the deceased-donor kidney in exchange for the donor donating her kidney. In the list exchange chain, the donor donates first, before the candidate is transplanted. There is a maximum of four candidates who are matched, and at the end of the chain the donor either bridges or donates to the wait list. Then the Candidate receives increased priority on the wait list, is offered a kidney from a diseased donor, accepts, and is transplanted.
- The donor-driven KPD exchange was also reviewed, which is a little bit more complex in terms of policy and logistics. The pair consents that the candidate is getting a deceased donor in exchange for the donor donating her kidney. In this system, however, a deceased donor kidney is actually re-directed away from the wait list allocation into a KPD program. The deceased donor would still have a wait list for all other organs and one kidney, but their information would also be entered into the program to start a chain. The candidate is matched with a deceased donor kidney, accepts the offer, and is transplanted. The donor can then find out who she is matching that same day although she won't donate the same day. The rest of the chain moves forward at a later date and time. In the end, as in the other systems, the donor either bridges or goes to the wait list.

This concept paper was open to public comment from July – October 2017. The paper received 29 comments on the OPTN website. Comments were from OPTN/UNOS Committees, professional societies, and individuals in the transplant community. There were no regional comments on the concept paper. Seven committees requested presentations on this concept

and all seven of them were supportive of the concept moving forward to further discussions regarding policy change (Minority Affairs, Ethics, Patient Affairs, Living Donor, OPO, Transplant Coordinators, and Transplant Administrators Committees). Five professional societies responded to feedback requests for the paper and all were supportive of the proposal moving forward to further discussion (AST, ASTS, NATCO, National Kidney Registry, and Living Kidney Donors Network). There were a wide range of seventeen individual comments that supported and opposed the concept.

The Committee discussed the following three themes resulting from public comment:

- Donor Loss
- Equity and Access
- Model Preference

#### *Donor Loss*

There were strong concerns over the candidate transplant occurring first – which may result in donor loss from the chain. Two of the three proposed models include the candidate transplant happening prior to donor donation. The Committee shared these concerns, but also were curious to the true extent of donor loss by backing out voluntarily, as compared to donor loss due to sickness or extended timelines.

#### *Equity and Access*

There were strong concerns over disadvantaging populations, especially ABO blood type ‘O’ candidates, racial/ethnic minorities, and those less likely to have a living donor. This concern was expressed for all three proposed models. The Committee shared these concerns, and discussed the need for very specific answers and data needed to demonstrate to the community that this project has the potential to increase transplants by a currently unknown amount, and that disadvantaging others is minimal or nonexistent. The SRTR will need to assist with modeling or optimizations once given specific constraints and parameters for the chosen model.

#### *Model Preference*

There were concerns with the logistics and practicality of all three proposed models, with the list exchange model garnering the most support. The candidate driven model had some support and the donor driven model had the least amount of support. Surprisingly, a hybrid model of list exchange and candidate driven was brought up several times in public comment. There was no clear winning model based on community feedback. The Committee shared these concerns, and discussed the models at length. There was also no clear winner by the Committee.

The Committee left future decision points in the hands of the KPD Deceased Donor Chains Workgroup members. Any policy changes or future concept papers from the Workgroup are required to be approved by the Committee before proceeding to the community for feedback. It was also discussed that a possibility remains that this project may not move forward if certain ethical and logistical hurdles cannot be overcome.

### **6. Simultaneous Liver-Kidney (SLK) and Enhancing Liver Distribution Update**

The Research Analyst presented early post-implementation monitoring results for the SLK implementation in August 2017. The data presented included:

- Medical eligibility of SLK registrations pre and post-SLK implementation: The early results show that implementation estimates for the eligible/ineligible registrations were in line with the early monitoring results.
- SLK transplants per 30 days: The early results show that SLK transplants have slightly decreased in number but it is much too soon to draw any conclusions from two month results.

- Pediatric SLK transplants per 30 days: The early results show that pediatric SLK transplants have slightly increased in number but it is much too soon to draw any conclusions from two month results.
- Kidney-Pancreas transplants per 30 days: In the policy development process, the Pancreas Committee expressed concerns about the impact of the SLK proposal on kidney-pancreas transplant rates. The early results show that kidney-pancreas transplants have remained stable, if not increased, after SLK implementation, but it is much too soon to draw any conclusions.
- Safety net – eligibility of kidney after liver registrations: The early results for the safety net provision shows that candidates are qualifying as needed, but it is much too soon to draw any conclusions.
- Long term (6-month, 1-year, 2-year) monitoring plan:
  - SLK transplants, including geography and diagnosis
  - Safety net, including registrations pre- versus post-policy, kidney transplants into eligible registrations, and waiting list mortality and transplant rates
  - Kidney after liver transplants, including number of living donor transplants
  - SLK policy effects on specific patient populations and geographic location

There were questions from committee members related to plans for other organ combination policies. The Committee Liaison assured the Committee that multi-organ projects were currently being discussed at the POC level. The Research Analyst provided reminders that SLK qualifying fields were previously in the system but were not used for SLK eligibility until implementation, so the increased eligibility of registrations may be due to candidates that were eligible prior to implementation but not under older allocation.

The Liver Committee Liaison presented an update on the Enhancing Liver Distribution proposal and potential implications for SLK.

The Committee strongly urged the Liver Committee to discuss and factor in the effect of this proposal on kidney sharing throughout the nation. The Committee seeks answers to how the details of the proposal noted below will affect kidney and simultaneous kidney/liver sharing. It is not known how this proposal will affect other organ sharing practices or behaviors.

- Proximity circles with 150-nautical mile radius around the donor hospital
- Expanded regional sharing, Share 32 to candidates within the region and/or circle
- Three MELD or PELD points to candidates within the circle or DSA
- Separate allocation for DCD donors and donors at least 70 years old

The Committee understood that it was never the intention of the Liver Committee to change the SLK sharing threshold. There may not be any direct effect on the current SLK policy but there will be effects on SLK due to the broadened liver distribution. Parts of the country will have increased number of liver candidates on the match run, which may increase competition between liver-alone and SLK candidates. SLKs account for approximately 10% of total liver transplants, and that is a large percentage that may be affected by this proposal. The extent of this effect is unknown due to no modeling, optimizations, or research.

Current limitations of the SRTR modeling system do not allow cross organ (liver-kidney) modeling, but the Committee strongly recommended that the Liver Committee use simple research methods that do not involve modeling to estimate and discuss repercussions on kidney sharing.

The Committee was concerned with the policy development of this proposal, as it was handled primarily by the Liver Committee in an isolated silo of discussion and debates. As a comparison, the SLK proposal – that affected acceptance criteria and sharing – was developed within a subcommittee with representatives from at least six other committees and external experts in the field. During the development of the SLK proposal, there was strong debate and

discussions, but that happened within the parameters of different perspectives and points of view.

The Committee agreed that the following impacts should be monitored during the proposal implementation, but strongly urged the Liver Committee to investigate these issues prior to Board of Directors voting.

- Impact of liver redistribution on kidneys
  - Where are kidneys going with SLK?
  - What happens to patients on the kidney waitlist?
    - Does the kidney wait time increase?
    - Where are kidneys coming from?
    - Where are kidneys going?
- Does the proposal increase the geographic disparities among kidney sharing?

While the Committee agreed that geographic disparities need to be addressed in the current liver allocation system, the Committee also recommends that it is prudent and wise to measure how changing one organ's geographic disparity affects another's.

No data was available to alleviate the Committee's concerns. Therefore, the Kidney Committee did not support a proposal that has unknown consequences to kidney sharing and SLK sharing.

## **7. Policy Oversight Committee (POC) Update**

The Kidney Committee Vice Chair presented a POC update. The POC represents all Vice Chairs from all Committees. The POC is responsible for reviewing projects/proposals at three points in the policy development process:

- New project reviews in the Analyzing the Problem phase before proceeding to the Evidence Gathering phase – for example, in July 2017, POC recommended to the Executive Committee to approve the following projects.
  - Update Guidance for ABO Subtyping Organ Donors for Blood Groups A and AB (Operations and Safety Committee)
  - Extra Vessels: Reducing Reporting Burdens and Clarifying Policies (Operations and Safety Committee)
  - Informed Consent Clarification (Ad Hoc Disease Transmission Advisory Committee)
- Ongoing project reviews (once a year) in the Evidence Gathering phase – for example, in May 2017, POC recommended that the Executive Committee approve to continue 23 active projects based on their progress and importance to the community.
- Public comment project review in the Evidence Gathering phase before proceeding to the Public Comment phase – for example, in July 2017, POC recommended that the Executive Committee approve 13 projects for public comment release.

The Committee also discussed the OPTN/UNOS project strategic alignment and how current/future Kidney Committee projects fit into the alignment.

## **8. KAS Review Project Discussion and Breakout Groups**

The Committee divided into three breakout groups to discuss the following topics and reported back to the entire Committee their thoughts, opinions, and response to moving forward with the projects.

- Improving Access for High CPRA Kidney Candidates (Goal 2)
- Improving Access for Pediatric Kidney Candidates (Goal 2)
- Reducing Discards for High KDPI Kidneys (Goal 1)

### *Improving Access for High CPRA Kidney Candidates*

- Problem Statement



- Disadvantages for true 100% CPRA candidates
- Group agreed with 10% transplant rate of high CPRA patients (8% on waitlist)
- What does the Committee currently know about the problem?
  - Inequity at 100%, not getting transplanted similarly across high CPRA candidates
  - Discrepancy in waiting time and offers when you get to 99.5% CPRA and above
  - 99.5% and above round to 100% CPRA
  - Concern about disparities in UNet and the OPTN CPRA calculators with two or four decimal places
- Does the Committee have enough evidence to establish a problem exists? If not, what information or data does the Committee need to further analyze the problem?
  - The Committee has a lot of data already
    - Abstract about granular CPRA decimal points
    - KAS 2 year data
    - Other literature reviews and publication references
  - Waitlist mortality based on granular two decimal point percentages for 99.5% CPRA and higher
  - Number of patients at risk at each granular level
  - Number of transplants for these 100% CPRA candidates
  - Wait time of highly sensitized patients and quality of kidneys transplanted
  - Number of outcomes at the more granular levels
    - To make decisions on how to prioritize and give points, the data above will help with solution-based pathways. The Committee does not need the data above to proceed to the POC.
- Based on what we know now, what are some potential solutions?
  - Adjust priority points
  - Allocation classification changes
  - Possibly keep points for desensitized patients
    - Currently, the OPTN does not have data on desensitization
  - Have up to four decimal places within the UNet system
- Are there any potential controversy or barriers?
  - Perception that these patients are retransplant patients
    - Actually they are majority minorities, female with prior pregnancy
    - Of all retransplants, 44% are 99-100% CPRA
    - Some centers are against desensitization
    - Some think highly sensitized patients get too much priority currently
    - Sending blood ahead of time is an OPO barrier
- Is this the right time to take on this project?
  - The Committee unanimously decided Yes

### *Improving Access for Pediatric Kidney Candidates*

- Problem Statement
  - Delayed graft function increased for peds post KAS – true
    - Is it correlated with worse outcomes?
    - 1 year survival for pediatrics increased
    - 1 year graft survival for pediatrics increased
  - Waitlist times increased post KAS for peds
    - Is the main question pediatric access or pediatric wait time?
  - Decrease in allocation of low KDPI (0-20%) to pediatrics
    - Every pediatric age bucket, the median KDPI remained the same or improved
    - 6-10 years old did decrease post KAS year 1 but rebounded in post KAS year 2 to where it was pre-KAS
    - Median always below 20% KDPI

- Decrease in living donor transplant to pediatrics
  - 6-10 age group living donor transplants decreased
  - Other age groups remained steady or improved
  - Approximately 20% of transplants for pediatrics is living donor
- Pediatrics possibly not disadvantaged, are they advantaged enough? What does it look like?
- What is the definition of a “good” kidney? How does the Committee define it?
- What does the Committee currently know about the problem?
  - Regional transplants – overall pediatric transplant went down, increased in post KAS year 2 but not all the way
  - Good kidneys in sequence C and D – allocation prioritizes A and B but not C and D
  - Longer wait times for pediatrics without living donors, blood type B, African Americans
    - Is this true? This is part of solution data, not POC data
  - Developmental delays – handicapped for life justifies increased priority
  - Could the decrease be in part to listing behaviors?
  - PHS increased risk donors – some hesitant to use, especially in pediatrics
- Does the Committee have enough evidence to establish a problem exists? If not, what information or data does the Committee need to further analyze the problem?
  - What’s the right metric for measuring pediatric transplant?
  - What will this advantage look like?
  - How long do pediatrics wait right now? Ideally 6 months to 1 year
    - Is it on OPTN website?
  - Are low KDPI kidneys going to retransplants?
  - Are SLKs taking optimal kidneys from pediatrics?
    - Abstract being written and Committee will have data later
  - Pediatrics active on list but refusing offers because not ready for transplant?
  - Ethical white paper on ethical principles on pediatric priority within organ transplantation available
- Based on what we know now, what are some potential solutions?
  - Using different indices for child and adolescent donors
  - Priority for pediatrics may equal decrease in living donor transplant priority
  - Incorporate into deceased donor chains – encourage donors to donate to list to get better match
  - Prioritize pediatrics as much as the highly sensitized
  - Better longevity matching
  - Donor age rather than KDPI
  - Extra points for every month on list
  - Children stratified with other children
- Are there any potential controversy or barriers?
  - Impact on rest of waiting list, living donor rates
  - Not worth it to change KDPI – SRTR cannot simulate, not worth the effort
- Is this the right time to take on this project?
  - The Committee unanimously decided Yes, with a commitment to include the Pediatric Committee as a partner in the process

### *Reducing Discards for High KDPI Kidneys*

- Problem Statement
  - Positive correlation between high discard rates and high KDPI scores
  - Does labeling as high KDPI have an impact?
    - Abstract available that states labeling does not have an impact

- Scarce resource – still underutilizing high KDPI kidneys as evidenced by the approximate 50% discard rate
  - How current is the 50% discard rate data? 2016 data, exact percentage depends on year
- What does the Committee currently know about the problem?
  - Fear – there may be a penalty for using high KDPI kidneys – is the COIIN project addressing this?
  - Data shows close to 50% discard rate – the challenge is acknowledged but is the cause (the denominator) the high KDPI kidney?
  - What should the discard rate be? What is ideal? Realistic?
- Does the Committee have enough evidence to establish a problem exists? If not, what information or data does the Committee need to further analyze the problem?
  - No, therefore, should the Committee begin to collect more granular data?
  - No good outcome measures
  - Is 50% still correct? Data states yes
  - What is quality of life after transplant with high KDPI kidneys?
- Based on what we know now, what are some potential solutions?
  - A first step would be collecting more data to answer questions (how, when, and what?)
    - Would this be policy? Or additional data fields on forms?
    - To add fields, that would be an OMB process (TIEDI)
- Are there any potential controversy or barriers?
  - SRTR modeling may take undefined amount of time
  - Need more data fields to force collection of useful data
  - Perceived regulatory incidents?
  - No financial incentives
  - Data not getting back to community
    - The Committee does not know why the kidney is truly being discarded – new refusal codes?
- Is this the right time to take on this project?
  - Possibly not yet – acknowledgement of problem but the Committee needs more info before moving forward
    - How does the Committee get the info/data needed?
    - Could new data fields be a viable project?

UNOS staff will meet and discuss the breakout group reports and decide which data is already available, what is solution-based and will need to wait until project approval, and what data is truly needed before proceeding to POC.

The Committee decided to discuss official recommendations for the three topics and action items based on the discussion during the next Kidney Committee meeting on November 6, 2017.

### **Upcoming Meetings**

- November 6, 2017 Teleconference
- December 11, 2017 Teleconference
- January 8, 2017 Teleconference