

**OPTN/UNOS Kidney Transplantation Committee
Meeting Minutes
January 8, 2018
Teleconference**

**Nicole Turgeon, MD, FACS, Chair
Vincent Casingal, MD, Vice Chair**

Introduction

The OPTN/UNOS Kidney Committee met via teleconference on 01/08/2018 to discuss the following agenda items:

1. Announcements and Kidney Committee-related Updates
2. Improving Access for Pediatric and Highly Sensitized Kidney Candidates
3. En Bloc and Dual Kidney Implementation Questions

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

1. Announcements and Kidney Committee-related Updates

The Kidney Committee Chair reported to the rest of the committee members the main kidney-related action items from the Board of Directors Meeting in December 2017.

- Improving En Bloc Kidney Allocation proposal passed Board of Director's voting on discussion agenda (35 yes, 2 no, 1 abstention).
- Improving Dual Kidney Allocation proposal passed Board of Director's voting on consent agenda (40 yes, 0 no, 0 abstentions).
- The Board of Directors created an Ad Hoc Geography Committee, composed of Board members, other Committee leadership, and professional society representatives. The Geography Committee will discuss equity and access issues, focusing on geographic organ distribution principles and models. Recommendations will be reported to the Board of Directors in June 2018.
 - The Chair explained that the recommendations coming from the Committee may lead to a directive from the Board of Directors to each organ specific committee to analyze their geographic allocation using the principles and models.

The Committee was reminded of the upcoming 2018 spring regional meeting schedule. Regional representatives were given specific expectations regarding attending regional meetings and presenting the Kidney Committee update. The Committee will have an update during the regional meetings but do not have a proposal out for public comment. The Kidney Committee update slides include:

- IT implementation plans for kidney projects
- KPD Deceased Donor Chains project updates
- Improving Access for Highly Sensitized and Pediatric Kidney Candidates project updates

2. Improving Access for Pediatric and Highly Sensitized Kidney Candidates

The Committee was updated on the status of the Improving Access for Highly Sensitized and Pediatric Kidney Candidates project. The project form was sent to the Policy Oversight Committee (POC) and will be reviewed during their February 16 teleconference. If approved by the POC, the project will need to be approved by the Executive Committee before resources are committed to the project. This is a multi-year project and a concept paper will be sent prior to data modeling, which will influence a policy change proposal.

The Committee members were polled on their level of interest in the new project, whether it be more of an interest in the highly sensitized topic or the pediatric access topic. These polling results will help start the formation of work groups dedicated to these project topics.

In order to make sure all Kidney Committee members were on the same page moving forward with this project, the Kidney Committee Research Liaison presented relevant data and evidence to the Committee:

- Highly Sensitized Data Post-Kidney Allocation System (KAS)
 - Waiting list mortality rates had no significant changes post KAS Year 2 vs. Year 1
 - Transplants dropped for Calculated Panel Reactive Antibodies (CPRA) 99-100% in the 2nd year post-KAS
 - Pre-KAS, CPRA 80-89% had the highest transplant rates, and this shifted to CPRA 99-100% post-KAS
 - Post-KAS Year 2, transplant rates to CPRA 100% dropped slightly, and increased for all other CPRA
 - Offer rates increased for all CPRA groups except the very highly sensitized candidates
 - Transplants to CPRA 99-100% patients rose sharply after KAS but have tapered to around 10%
 - Transplant rate 31 times higher for CPRA 99.5-99.6% versus CPRA 99.99+%
 - Differences in median waiting time (MWT) based on precise CPRA value are profound: half year for patients with CPRA just rounding to 100%, versus 20+ years for CPRA 99.99+% patients, a 40-fold difference
 - The Committee asked questions about this data point and the Research Liaison clarified that CPRA by decimal point is not used in current allocation, the CPRA is rounded to nearest whole number
- Pediatric Access Data Post-KAS
 - Candidates aged 18-34 and 35-49 had significant decreases in waitlist mortality rates post-KAS Year 2 versus Year 1
 - Pediatric 0-5 age group increase in waitlist mortality is not significant; the sample size is very small, so any death substantially raises the rate
 - Percent of transplants to younger candidates (18-49) decreased slightly, and transplants to 50+ candidates increased slightly
 - Transplant rates were higher overall, as well as for almost every age group; the slight decrease for ages 6-10 was not significant
 - Post-KAS, most regions had higher or similar percent of pediatric transplants Year 2 versus Year 1; regions 7, 10, and 11 had a decrease in pediatric transplants, while regions 1 and 8 saw increases
 - Offer rates were higher post-KAS Year 2 versus Year 1 for all age groups, and there was a drop in acceptance rates Year 2 for pediatric age 6-10
 - Pediatric survival rates increased post-KAS Year 1

3. En Bloc and Dual Kidney Implementation Questions

To prepare for the future implementation of the Improving En Bloc and Dual kidney Allocation projects, the Committee will review and discuss implementation questions during multiple meetings to assist in answering questions for IT programming.

The implementation question for this meeting surrounded the documentation of splitting en bloc kidneys or not transplanting dual kidneys together. As donor weight increases (new policy states 18kg), more instances of splitting occurs. Surgeons must have a way to document that the kidneys were not transplanted together per the new policy.

- Where should the split kidney scenario be documented?
 - The Committee stated it was always the intent of the Committee that the reasons would be documented in DonorNet[®], and not in the medical record. Documenting

in the medical record would not give immediate access to data that the Committee outlines in the evaluation plan for the approved proposal. Documenting instances of not transplanting the kidneys together in DonorNet allows UNOS and the Kidney Committee to monitor if centers are accepting en bloc or dual offers just in order to split.

- Who is responsible for entering the data into DonorNet?
 - The Committee decided that policy language states the transplant program, specifically the transplant surgeon or accepting transplant program, must document why the kidneys were not transplanted together as accepted. Therefore, a transplant program representative must document the reason.
- How should the new field in DonorNet function?
 - The Committee used their experience within DonorNet to discuss best ways that this new field should function. The Committee decided that having a checkbox indicating if the en bloc or dual kidneys were not transplanted together was the easiest option. If the user checks the box, then the user must choose a reason from a drop down menu of applicable reasons.
 - The Committee discussed various reasons why a transplant surgeon would decide to not transplant the en bloc or dual kidneys together. Since the transplant program would not decide to split until after organ acceptance, the reasons can be limited to few options.
 - Donor size or weight
 - Kidney size
 - Kidney anatomical damage or defect

Upcoming Meetings

- February 12, 2018 Teleconference
- March 12, 2018 In-Person in Chicago, IL
- April 9, 2018 Teleconference