

**OPTN/UNOS Kidney-Pancreas Workgroup
Meeting Minutes
March 22, 2019
Conference Call**

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Introduction

The Workgroup met via teleconference on 03/22/2019 to discuss the following agenda items:

1. Regional Feedback Recap
2. Proximity Points
3. Acceptance Model
4. Metrics
5. Pediatric Priority

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

1. Regional Feedback Recap

The workgroup reviewed feedback from various regions.

Data summary:

Trends:

- Support for hybrid model over fixed distance circles
- No clear preference on which proximity point combination is preferred
- 300NM circle is less preferred
- Support for pancreas/KP having different allocation from kidney than having the same allocation
- Kidney and Pancreas will propose separate policies but modeling combinations will be the same

Regional feedback on points within the circle does not have consensus, however there is some preference for steep points. The regional feedback on points outside the circle also does not have consensus.

2. Proximity Points

The workgroup voted on point variations and then will later narrow down which points for which circles later.

Summary of discussion:

Vote: No points:

Yes – 86%

No – 14%

A UNOS staff member suggested that the workgroup consider two different values for proximity points inside the circle to be able to compare to each other.

The Pancreas Vice Chair also expressed support for the Kidney Vice Chair's sentiment that proximity points inside a small circle did not make as much sense because the difference between going 90 NM to 120 NM is not a big deal. However that could change if the circle is

larger like 500 NM where there may be a difference. The Pancreas Chair said that waiting time is a significant factor for diabetics and therefore there should be little other factors that trump that and there is not significant difference in cold ischemic time inside the smaller circles.

A UNOS staff member noted that the pancreas members did not have a lot of interest in points inside the circle that the workgroup could consider choosing one value to model for proximity points. The Kidney Chair disagrees with the suggestion to rule out the option of points inside the circle and would like to request multiple point options for inside the circle in order to have more information rather than less. The UNOS staff member indicated that there is a limited number of modeling results possible and so it may not be probable to ask for two types of points inside the circle. The Pancreas Chair noted that his concern was that there would not be sufficient modeling options to do two types of inside points. The Kidney Chair acknowledged that limitation may be the case and the current strategy would be to ask for as many modeling options as possible and then to pare down as necessary.

The Kidney Chair asked for suggestions on the two different values for inside points. The current suggestion is 4 and 6. The Kidney Vice Chair spoke in opposition to 20 points as they felt that number alone is simply too high to be palatable to the community. A UNOS staff member referenced the table in the slides which provided an example of how the different values of proximity points would modify the order of the match list. One member of the workgroup expressed concern at using values as high as 6 or 8 for points inside a small circle and asked if it was possible to measure smaller point values for smaller circles and larger point values for larger circles. The UNOS Staff member explained that approach would complicate the modeling request and it would not be possible to do all the potential permutations.

Vote: Points 4 & 10 Inside the Circle

Yes - 86%

No – 14%

Vote: Which points value would the workgroup prioritize? 4 or 10?

4 – 63%

10 – 38%

Vote: Points 8 & 20 Outside the Circle

Yes – 86%

No – 14%

Vote: Which points value would the workgroup prioritize? 8 or 20?

8 – 86%

20 – 13%

3. Acceptance Model

A staff member of SRTR gave a presentation regarding the types of acceptance models.

Data Summary:

SRTR used six different models in the December report.

- Kidney-alone model for pediatric candidates
- Kidney-alone model for adult candidates from donors with KDRI < 1.05
- Kidney-alone model for adult candidates from donors with KDRI 1.05-<1.75
- Kidney-alone model for adult candidates from donors with KDRI >1.75

- Kidney-pancreas model
- Pancreas model

Assumptions

Because offer acceptance models were created with historical data (match runs from 2017), they assume that acceptance behavior will ‘remain the same’ under the new allocation rules.

What does ‘remain the same’ mean?

The effects of candidate and donor characteristics are the same under new allocation systems.

The probability of acceptance at every offer number remains the same.

Assumptions: Local indicator

The acceptance models from the December 2018 report included a “local” indicator. If an organ was offered from the local DSA, it was more likely to be accepted.

This likely contributed to lower transplant counts because fewer offers at the beginning of the match run were made “locally” under broader sharing proposals.

Under the alternative allocation schemes, a “local” organ offer is likely less important because local DSA no longer has an important role in allocation. Thus, we expect behavior to change in this respect.

Summary of Discussion:

How do you account for the fact that there are a number of kidneys and pancreata offered outside of the local area for reasons that are not captured in modeling? The acceptance model and KPSAM covers all the kidneys offered locally, regionally and nationally. We shouldn’t choose one model over another just so the data looks better. We don’t have data that predicts future behavior so we want to relax that requirement so that the modeling can be more flexible. I would be careful to say the “data is the data” because any modeling is simply making projections on a set of assumptions. They are a direct result of choices we make on which assumptions to use. The Pancreas Chair weighed in saying that it is a way to optimize the modeling.

Vote: Which model do you prefer?

Donor & Candidate Characteristics – 43%

Donor Characteristics – 57%

4. Metrics

Data Analysis:

- KP/pancreas/kidney will have the same metrics for these selected circle sizes for our hybrid framework
- SRTR bandwidth will dependent on # of circle variations, # of proximity point variations, and what metrics/stratifications should be included

Cumulative list of metrics, in order of potential priority

- Count (%) of transplants
- Transplant rates
- Variance in transplant rates

- Time on dialysis (days) distribution at transplant
- Variance in time on dialysis (days) distribution at transplant
- Organ travel distance distribution (NM) for transplants
- Percent of organs traveling over 250 NM
- Count (%) of waitlist deaths
- Waitlist mortality rates – overall only
- One year post-transplant graft survival rates
- One year post-transplant patient survival rates

Metrics by DSA, in order of potential priority

- Change in Count (%) of transplants
- Variance in transplant rates
- Variance of median dialysis time (days) at transplant
- Change in count (%) of waitlist deaths
- Waitlist mortality rates – overall only
- Transplant rates

Analysis subgroups, in order of priority

- Vulnerable populations: race/ethnicity, age, blood type, gender, ABDR mismatch, CPRA, time on dialysis, diagnosis
- SES related: insurance status, median income by recipient zip code, urbanicity
- KDPI: 0%-20%, 21%-34%, 35%-85%, 86%-100% (transplant only)
- EPTS: 0%-20% vs. 21%-100%
- Geographic: local/regional/national, OPTN region, DSA
- Donor type: DCD vs not (transplant only)

CPRA:

0, 1-19, 20-29, 30-39, 40-49, 50-59, 60-69, 70-79, 80-84, 85-89, 90-94, 95, 96, 97, 98, 99: 98.5- < 98.75, 98.75- < 99.0, 99.0- < 99.25, 99.25- < 99.5, and 100: 99.5- < 99.6, 99.6- < 99.7, 99.7- < 99.8, 99.8- < 99.9, 99.9- < 99.95, 99.95- < 99.975, 99.975- < 99.99, 99.99- < 100

Condensing to the following CPRA groups:

0-80, 80-90, 90-94, 95-97, 98, 99, 100

Metrics in red represent metrics that the UNOS staff member would recommend removing and metrics in purple represent the metrics that the UNOS staff member would recommend adding or modifying.

Organ center data shows that the switch from driving to flying is approximately 250 NM.

Discussion Summary:

The Kidney Vice Chair said that they would like to continue to see the one-year metrics but felt that transplant rates were less significant because it was behavior driven. The Pancreas Chair felt that transplant rates were very important to keep. The Kidney Chair felt that the one-year

metric was not very significant and had not come up much in public comment. The Kidney Vice Chair said while he felt the metric was utilized by the community that he did not feel strongly.

Vote: Cumulative list of metrics and DSA metrics

Yes – 100%

No – 0%

Therefore the UNOS staff will include the metrics above in red as time permitting and they will be the first to be eliminated based on bandwidth of the SRTR.

The Pancreas Chair felt that it was unnecessary to model so many subgroups and that the workgroup could focus on just XXX metric and incorporate the rest on the next round of modeling. A UNOS staff member explained that this is the only and last round of modeling before submitting a policy proposal.

A UNOS staff member recommended condensing the CPRA metric down to a much smaller amount of groups.

Vote: Subgroup metrics & CPRA modifications

86% - Yes

14% - No

5. Pediatric Priority

Data analysis:

A UNOS staff member presented the three identified options for the Kidney committee to model in regards to pediatric priority.

- **Do nothing** since pediatrics see more access under new geography boundaries
- Move PLD and **local pediatrics** below highly sensitized
- Move PLD and **all pediatrics** below highly sensitized

Summary of Discussion:

The Kidney Chair explained that this was a project that the Kidney Committee had been working on before the need to change geography. The Pancreas Chair spoke in support of XXX option. One member of the workgroup spoke in support of at least modeling an option that would increase pediatric priority so the workgroup could have additional data and explore that option.

Vote: Options to change pediatric priority

Do Nothing – 40%

Local pediatrics – 40%

All pediatrics – 20%

Vote: Top options changing pediatric priority

Do Nothing – 50%

Local Pediatrics – 50%

The Kidney Chair said that based on the tied results of the poll that the leadership would need to discuss the pediatric options.

Lastly, the committee voted on an order of prioritization for circle sizes as following: 500 NM, 250 NM, 150 NM.

Vote: Do you support this prioritization of 500, 250, 150NM? Therefore 150 NM will be the first to be eliminated.

Yes – 83%

No – 17%

Upcoming Meeting

- March 28, 2019