

**OPTN Kidney Committee Meeting
Meeting Minutes
July 11, 2019
Conference Call**

**Vincent Casingal, MD, Chair
Martha Pavlakis, MD, Vice Chair**

Introduction

The Committee met via Citrix GoToTraining teleconference on 07/11/2019 to discuss the following agenda items:

1. Welcome and Announcements
2. Medical Urgency
3. Local Back Up
4. Minimum Acceptance Criteria
5. Next Steps

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

1. Welcome and Announcements

The Chair gave a brief overview of the previous committee call. The Committee conducted an informal straw poll on the last call to gauge committee preferences based on closer examination of two leading frameworks.

Poll results of committee members and stakeholders:

- 500.500.4.8 (12 votes – 67%)
- 250.250.2.4 (6 votes – 33%)

Poll results of committee members only:

- 500.500.4.8 (10 votes – 67%)
- 250.250.2.4 (5 votes – 33%)

2. Medical Urgency

The Chair gave a brief overview of the medical urgency policy revision discussed on the last committee call. *OPTN Policy 8.2.A: Exceptions Due to Medical Urgency* which will need to be changed as it contains donation service area (DSA) within current language.

UNOS staff also reviewed three key decision points for the Committee's consideration:

- Who would review the applications for the new "medically urgent" status?
- Where should the new "medically urgent" classification be placed in the existing allocation tables?
- How should two or more medically urgent candidates be ordered on the same match run?

Committee members preferred for applications for the new "medically urgent" status to be reviewed by a subcommittee in order to promote consistency in how these cases are reviewed. Some committee members expressed concern that a national subcommittee would be too cumbersome and suggested a local subcommittee of some kind with an established national standard for what would be considered

“medical urgency”. UNOS staff informed the Committee the public comment proposal intends to request community feedback on this issue to inform further development.

The Committee then discussed where the new “medically urgent” classification would reside in the allocation tables. Committee members identified placement on the allocation tables would ultimately be determined by the national standard of what’s considered “medically urgent”. For purposes of collecting further feedback through the public comment period, the Committee elected that the priority position of the medically urgent classification would differ depending on the KDPI of the available kidney. Proposed placement of the medical urgent classification within each allocation table is summarized below:

- For Allocation of Kidneys from Deceased Donors with KDPI Scores less than or equal to 20%, medically urgent candidates would be placed at Classification 7 after 100% cPRA 0-ABDR mismatch, 100% cPRA, local prior living donors, and local pediatrics
- For Allocation of Kidneys from Deceased Donors with KDPI Scores Greater Than 20% but Less Than 35%, medically urgent candidates would be placed at Classification 7 after 100% cPRA 0-ABDR mismatch, 100% cPRA, local prior living donors, and local pediatrics
- For Allocation of Kidneys from Deceased Donors with KDPI Scores Greater than or Equal to 35% but Less than or Equal to 85%, medically urgent candidates would be placed at Classification 6 after 100% cPRA 0-ABDR mismatch, 100% cPRA, and prior living donors
- For Allocation of Kidneys from Deceased Donors with KDPI Scores Greater than 85% , medically urgent candidates would be placed at Classification 5 after 100% cPRA 0-ABDR mismatch, and 100% cPRA

The Committee also discussed how to allocate organs to two or more medically urgent candidates on the same match run. The Committee decided to include time on the waitlist with medically urgent status as secondary criteria.

Next Steps

The Committee will evaluate feedback received throughout the public comment period in order to develop national criteria for “medically urgent” status and refine the proper placement on the allocation tables.

3. Local Back Up

UNOS staff reviewed current *Policy 5.9: Released Organs* discussed on the previous committee call. The practice known as “import back up” or “local back up” is utilized to prevent ischemic time and inefficiencies in organ allocation by providing OPOs for options regarding what to do with organs that are not transplanted into the original, intended recipient. Due to the potential for increased frequency of decisions related to granting back up with broader sharing and removal of local and regional designations, the policy will need to be updated to create consistency and accountability while promoting efficiency and preventing discards.

UNOS staff presented the Committee with draft policy language based on the decision points discussed on the previous committee call. The organ procurement organization (OPO) that accepted the kidney would reallocate the organ based on the import match run, but limited to a 150 NM circle around the accepting hospital.

The Committee discussed the possibility of including a second 500 NM circle prior to the organ being allocated nationally if a candidate is not found within the 150 NM circle. The Committee agreed the closer the organ is kept to the accepting hospital to reduce cold ischemic time (CIT) would be best.

4. Minimum Acceptance Criteria

UNOS staff reviewed current OPTN Policy 5.1: Minimum Acceptance Criteria and OPTN Policy 5.1.A: Kidney Minimum Acceptance Criteria which contains DSA. The new proposed language removes DSA and specifies transplant programs will submit minimum acceptance criteria for offers for deceased donor kidneys more than 500 NM away.

There were no comments from the Committee.

5. Next Steps

UNOS staff will finalize the draft policy language to submit to the Committee for final review and approval on the July 15, 2019 call.

Upcoming Meetings

- July 15, 2019 - Teleconference