OPTN Kidney Transplantation Committee
Meeting Minutes
August 19, 2019
Conference Call

Vince Casingal, MD, Chair
Martha Pavlakis, MD, Vice Chair

Introduction

The OPTN Kidney Transplantation Committee (the Committee) met via teleconference on 08/19/2019 to discuss the following agenda items:

1. Pediatric Committee Manuscript
2. Committee Orientation
3. Public Comment Review
4. Medical Urgency Discussion

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

1. Pediatric Committee Manuscript

A member of the Pediatric Committee gave a brief overview of a Pediatric Committee manuscript detailing a four year Kidney Allocation System (KAS) data request and invited any interested members to join in the work.

Summary of discussion:

There was no discussion by the committee.

Next steps:

Any interested committee members will reach out to UNOS staff.

2. Committee Orientation

A member of UNOS staff presented an orientation to the full committee.

Summary of discussion:

There was no discussion by the committee.

3. Public Comment Review

A member of UNOS staff presented some of the themes of public comment feedback regarding the current kidney allocation proposal

Data summary:

The following feedback themes have been received on the OPTN website:

- Positive comments about living donor prioritization
- Concerns about organ procurement organization (OPO) performance
- Concerns about logistical realities (such as travel and costs)

Region 7 was more supportive of the proposal whereas Region 3 was very critical. In region 3 there was a sense of very little trust in the process and that the financial burden is especially heavy for poorer OPOs.

Summary of discussion:

The Chair shared that the feedback from the Membership and Professional Standards Committee (MPSC) was focused on the administrative side of the medical urgency criteria and local backup. The feedback during the national webinar was similar to the feedback in Region 3. The Vice Chair shared that reoccurring feedback was a lack of concern in the community regarding current levels of geographic disparity in access to transplantation and stressed the need to further emphasize greater national equity. In addition, there was sentiment that the modifications to the modeling were improperly done and any number of increased discards was unacceptable.

Next steps:

The Committee will continue to receive public comment updates at the next committee meeting.

4. Medical Urgency Discussion

A UNOS staff member presented some of the clinical criteria currently utilized by DSAs to determine a candidate's medical urgency under current policy.

Data summary:

OneLegacy utilizes the following criteria:

- Two consultations from vascular surgeons confirming loss of vascular access
- Consult stating that peritoneal dialysis cannot be performed

Region 1 adheres to the following procedure:

- Emergency status should be limited to a life-threatening circumstance: life threatening is restricted to inability to maintain access for dialysis. The emergency request is based upon the inability to dialyze because no further access is attainable. The policy infers that a leg graft access was either attempted or is contraindicated. Thus, all possible options for vascular and peritoneal access must have been attempted including the placement of a permcath. However, failure of catheter access alone is not a requisite determinant for emergency candidacy.
- Regarding priority of medically urgent candidates: If there are two or more medically urgent candidates for a renal allograft only, the patient with the longest waiting time at the medically urgent status will receive the first available allograft.

Summary of discussion:

One member commented that they felt the suggested criteria were "spot on" in their definition and specificity. A UNOS staff member asked if there were any medically urgent criteria in the committee member's area. The member responded that they were unaware of any criteria and had never come across a medically urgent patient on the match run. A UNOS staff member explained that currently there is no classification for medically urgent patients and thus far haven't appeared on the match run, however the proposed policy would create a classification for medically urgent patients.

A member shared that a concern was raised at Region 7 about patients who may have been non-compliant with previous transplants receiving the medically urgent classification. Therefore the member wanted to raise the issue of considering non-compliance as part of the medical urgency classification.

Another member added that in Region 1 there was an additional criteria that the patient have expected mortality of one week or less. This committee member expressed reservations about including this particular criteria on a national scale. The member suggested that a request for the medically urgent classification be signed off at the director level and also agreed with the suggestion of considering non-compliance a barrier to the classification and specifying that the patient must undergo all standard evaluation processes by the program.

The Chair asked if there were other circumstances besides loss of vascular access and loss of dialysis access that the Committee would consider or an appeal process. The Vice Chair commented about an experience where a patient was ineligible to receive previous wait time due to a transplant failing on day 91 but that regardless the Vice Chair was in favor of keeping the criteria narrow. Another member commented in support of considering additional language for unique cases that fall outside of the specified criteria.

The Chair asked for clarification of where the medically urgent classification would fall, particularly in relation to 100% highly sensitized and pediatric patients. A UNOS staff member responded that currently the medically urgent classification are arranged by KDPI in the prioritization tables.

- 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

A member noted that the Committee also should determine if the medically urgent classification would be limited to 500 NM or would be offered nation-wide.

Next steps:

The Committee will continue to have discussions regarding the medically urgent classification based on public comment feedback.

Upcoming Meetings

- September 16, 2019, Teleconference
- October 21, 2019, Chicago
- November 18, 2019, Teleconference

Attendance

- **Committee Members**
  - Vincent Casingal
  - Ajay Israni
  - Valinda Jones
  - Mary Killackey
  - Jim Kim
  - Lisa Matthias
  - Deepak Mital
  - Cathi Murphey
  - Martha Pavlakis
  - Dierdre Sawinski
  - Erica Simonich
  - Julia Steinke
  - Nicole Turgeon
  - Andrew Weiss
- **HRSA Representatives**
  - Jim Bowman
  - Marilyn Levi
  - Robert Walsh
- **SRTR Staff**
  - Bert Kasiske
  - Bryn Thompson
- **UNOS Staff**
  - Scott Castro
  - Beth Coe
  - Peter Goldin
  - Tina Rhoades
  - Leah Slife
  - Wes Stein