OPTN Lung Transplantation Committee
Meeting Summary
October 21, 2020
Conference Call

Erika Lease, MD, Chair
Marie Budev, DO, Vice Chair

Introduction

The Lung Transplantation Committee met via Citrix GoTo teleconference on 10/21/2020 to discuss the following agenda items:

1. Overview – Meeting Goals
2. Exchange Rates
3. Pairwise Comparisons

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

1. Overview - Meeting Goals

The goal for the meeting was to understand different perspectives on attribute preferences and prepare the Committee to re-take the analytical hierarchy process (AHP) exercise on 10/23/2020. The AHP results can help inform how much weight should be placed on each attribute of the composite allocation score. The attributes are medical urgency, post-transplant survival, candidate biology, pediatric age, prior living donor, and placement efficiency.

Previously, the Committee reviewed how the community ranked the attributes overall. The Committee also reviewed how the community's overall results compared to the Committee's results and current policy, as estimated by the revealed preference analysis. The Committee observed a large difference between the role of proximity in current policy and how placement efficiency might be prioritized based on the AHP results. Furthermore, the lung allocation score (LAS) is currently weighted 2/3 for medical urgency and 1/3 for post-transplant survival, but the AHP results indicated interest in shifting this balance. During this meeting, the Committee began discussing each pairwise comparison from the AHP exercise, which asked participants to indicate their preferences between pairs of attributes.

2. Exchange Rates

UNOS staff explained how the Committee can use exchange rates to evaluate the pairwise comparisons in terms of how their weights translate into impact on allocation. UNOS staff also showed how to use the sensitivity tool to evaluate exchange rates.

Summary of discussion:

Exchange rates reflect the change in one attribute that is equivalent to a change in another attribute in terms of the effect on the composite score. For example, if being "x" miles closer results in a one-point increase in the composite score, and a "y"-point increase in LAS also results in a one-point increase in the composite score, then the distance/LAS exchange rate is x/y miles per LAS point.

The Committee reviewed exchange rates for eight pairs of attributes.

- LAS components: medical urgency vs. post-transplant survival

- Distance vs. medical urgency
- Distance vs. post-transplant survival
- Distance vs. LAS
- Distance vs. pediatric priority
- Distance vs. prior living donor priority
- Distance vs. blood type
- Distance vs. Calculated Panel Reactive Antibodies (CPRA)

LAS Components: Medical Urgency vs. Post-Transplant Survival

In the LAS, a candidate's medical urgency score is based on the predicted days of survival without a lung transplant within a year, and the candidate's post-transplant survival is based on predicted days of survival with a lung transplant within a year. The LAS increases when predicted days of survival *without* a lung transplant are lower, and when predicted days of survival *with* a lung transplant are higher. If medical urgency and post-transplant survival were weighted 50/50, LAS would be a pure measure of net benefit: survival days with and without transplant. With the 2/3 versus 1/3 weighting, the LAS values days of net benefit more for candidates with higher likelihood of dying soon on the waitlist relative to candidates expected to survive longer without a transplant. Accordingly, the implied LAS exchange rate is 2:1, where one fewer day of estimated waiting list survival is valued equally as two extra days of estimated post-transplant survival.

In comparison, the Committee AHP results had an exchange rate of 2.8 and the community AHP weighted waitlist survival and post-transplant survival about equally, with an exchange rate of 0.9. That means the Committee values one fewer day of waitlist survival as much as 2.8 extra days of post-transplant survival, whereas the community values one fewer day of waitlist survival as much as 0.9 extra days of post-transplant survival.

A member asked what components most factor into a candidate's estimated post-transplant survival. SRTR staff said there are publications showing that age is the biggest indicator of post-transplant survival, both short-term and long-term, when controlling for all donor and recipient variables. OPTN policy outlines the coefficients in LAS, where larger coefficients indicate that the variable has a larger impact on the LAS. These variables include being on a ventilator, diagnosis group, and creatinine. SRTR staff pointed out that these variables do not exist in a vacuum. For example, diagnosis group D has a higher coefficient relative to other diagnosis groups, but those patients tend to be older. There is not one characteristic that determines the estimated post-transplant survival.

Distance vs. Medical Urgency

In current policy, one fewer day of survival on the waiting list is valued as much as being 1.2 nautical miles (nm) closer to the donor hospital. This means that if a candidate has 100 days of waiting list survival and is more than 1.2 nm closer to the donor hospital than a candidate with 99 days of waiting list survival, the candidate with 100 days will get the offer (all else being equal). In contrast, based on the Committee AHP results, one fewer day of waiting list survival is valued as much as being 47 nm closer to the donor hospital. For the community AHP results, this distance was 27.2 nm.

Distance vs. Post-Transplant Survival

In current policy, one more day of post-transplant survival is only valued as much as being 0.6 nm closer to the donor hospital. Based on the Committee AHP results, one additional day of post-transplant survival is valued as much as being 16.9 nm closer to the donor hospital, compared to 29.5 nm based on the community AHP results. UNOS staff noted that exchange rates are not constant from 0 out to 5,000

nm since the distance rating scales are not completely linear, so the exchange rates shown apply to longer distances, beyond the transition from ground travel to air travel.

Distance vs. LAS

Based on the Committee AHP results, one LAS point is worth about 243 nm. In comparison, in current policy, one LAS point is worth about 5.7 nm, and based on the community AHP results, 1 LAS point is worth about 184 nm.

Distance vs. Pediatric Priority and Prior Living Donor Priority

For both pediatric status and prior living donor status, the priority exceeds the maximum distance points, so a pediatric candidate or a prior living donor anywhere in the country would be prioritized for an offer over an adult candidate or a non-living donor located at the donor hospital.

Distance vs. Blood Type

In current policy, having ABO blood type identical to the donor is valued as much as being 288 nm closer to the donor hospital. Based on the Committee AHP results, a blood type O candidate would get a boost equivalent to 1,985 miles compared to a blood type AB candidate. Based on the community AHP results, this boost would be equivalent to being 1,645 nm closer to the donor hospital.

Distance vs. CPRA

Current policy does not provide any priority for CPRA. Based on the Committee AHP results, a candidate with a CPRA of 99.99% would get a boost equivalent to being 3,960 nm closer to the donor hospital relative to a candidate with a CPRA of 0%. Based on the community AHP results, the 99.99% CPRA candidate would get a boost equal to 3,275 nm.

Discussion

If the Committee were to create a composite allocation score based on current policy, distance would be "expensive" in that it would matter more in allocation than most other candidate characteristics. In other words, priority for other factors like LAS, pediatric age, and blood type would not "buy," or overcome, many nautical miles. Accordingly, this system would remove the hard boundaries that exist in current policy but would not distribute lungs very far based on differences in other factors. It is estimated that a score based on current policy would send lungs about 278 nm further for a pediatric candidate vs. an adult candidate, all else being equal. An attendee suggested that lungs may actually be sent farther for pediatric candidates since the revealed preference analysis did not perfectly capture how allocation from pediatric donors is managed by current policy.

UNOS staff gave an overview of how far a score-based policy derived from the Committee AHP results and from the community AHP results would distribute lungs based on other candidate characteristics. For example, a composite score based on the Committee AHP results would send lungs about 47 nm further for each fewer day of predicted waitlist survival.

A member said it would be interesting to share these results with the transplant community to show them how their results translate into a score-based policy. This would help people to think about how their preferences compare to what they are actually willing to do operationally.

3. Pairwise Comparisons

The Committee discussed each pairwise comparison from the Committee and community AHP results. After discussing each pairwise comparison, the members took an informal poll to indicate their preference.

Summary of discussion:

AHP Results

The Vice Chair asked if UNOS will be redistributing the AHP exercise to the community to get more feedback. UNOS staff said there will not be time to redo the exercise prior to submitting a modeling request to SRTR, but the exercise could be shared again during public comment. Since the community AHP exercise had fewer than 200 respondents, a member asked if the sample size was large enough to be representative of the community. UNOS staff said that since the exercise was not a formal public opinion survey, there was no need to achieve a certain sample size; it is more important to get feedback from informed participants. A member shared that some patients were stressed out by taking the exercise in that they felt like they were playing God. Patients were really concerned about whether the organ was placed with the right person where the organ could perform well.

UNOS staff gave an overview of the 1-9 rating scale used in the AHP exercise, and reminded the Committee that the numerical value selected impacts the exchange rates and overall results. A member said that reviewing the distance exchange rates was unsettling in terms of how the AHP results translate into a composite score, and the member's answers would have been different if there had been some numbers applied to the comparisons. UNOS staff previously considered using a discrete choice experiment, which would have involved asking people to respond with their preferences based on more detailed scenarios. However, UNOS staff chose to use AHP because discrete choice experiments do not work as well with a patient population. The AHP exercise was a phase in this process, and the Committee is not locked into using those numbers as the attribute weights. The member suggested using an approach more similar to a discrete choice experiment to help the Committee refine the scores.

Medical Urgency vs. Post-transplant Survival

Most demographic groups weighted post-transplant survival more heavily than medical urgency. In the AHP exercise, post-transplant survival was defined as survival within one year after transplant. Many participants also submitted comments that considered longer-term survival. UNOS staff asked the Committee whether they want to consider one-year post-transplant survival or longer-term post-transplant survival when they re-take the AHP exercise.

Members said they responded based on one-year survival, and they would have responded differently had they been asked to consider long-term survival. This is why the Committee's results weighted medical urgency more heavily that the community results, despite the Committee's interest in incorporating longer-term post-transplant survival in allocation. The Chair said it is almost a given that recipients will live one year after transplant, so one-year post-transplant survival is not a good discriminator for allocation. The Chair observed that no demographic group supported the current LAS weighting of 2/3 medical urgency to 1/3 post-transplant survival, so placing more emphasis on post-transplant survival would be moving in the right direction. A member said that it is also important to place weight to medical urgency to ensure that the system is transplanting people who really need it.

A member said the variables that the OPTN collects pre-transplant do not predict longer term post-transplant survival, so the Committee should complete the exercise based on one-year survival because that is what can be estimated based on OPTN data. A member asked why OPTN data cannot predict longer-term survival. SRTR staff said there are many questions about long-term survival, for example, whether there are predictors of two-year survival that are different than predictors of one-year survival. The Committee chose to update the cohort used to calculate LAS because the old cohort was not as predictive of new cohorts. That limits the data available for SRTR analysis, because older data will not be predictive for patients currently awaiting transplant. SRTR staff offered to look at two-year survival, since predictors of one-year and two-year survival are probably similar, but it would need to be a

different project running in parallel with continuous distribution. Any data used in the allocation system has to be information that is known at allocation. For many patients, the information available at the time of transplant becomes less relevant as the timeframe for estimating post-transplant survival is extended. Members agreed that looking at two-year post-transplant survival rather than one-year post-transplant survival would not dramatically change how members weight these attributes.

A member said that older patients with lots of medical problems sometimes receive organs over younger patients who could have much longer post-transplant survival. The member asked if it is possible to have a composite score which both complies with regulations, and represents the medical problems and advanced age of patients who get high allocation scores. For example, a 70-year-old patient with cystic fibrosis (CF) is probably not going to live to age 80. The Chair said this goes back to equity and utility. If the Committee wants to increase utility, then it might be appropriate to use a measure other than post-transplant survival to capture that. The member suggested considering post-transplant survival at one year since that is the data available while the Committee works towards incorporating longer-term survival. A member agreed with this approach, since estimating survival at three or five years post-transplant also depends on the patient's age at transplant.

A member said that one cannot predict whether a patient will live five years based on data known at the time of transplant. SRTR staff said that holding all other variables constant, age is the biggest predictor of post-transplant survival. For recipients between the ages of 25-50, post-transplant survival is consistent, but it declines below age 25 and above age 50. A member said that age is incorporated in LAS as a surrogate marker for frailty, and while age is a strong measure of frailty, post-transplant survival is not all about age. An attendee said that the impact of age becomes clear when it washes out all the other variables that are not predictive. If the OPTN can get meaningful data at the time of transplant to distinguish between candidates, then the OPTN should lean on that data.

SRTR staff noted that the Committee previously decided to hold off on considering long-term survival so as not to delay continuous distribution. UNOS staff summarized that the data currently available to rank candidates is one-year post-transplant survival. There are some members who would like to consider longer-term survival and some would like to consider one-year. UNOS staff suggested considering one-year survival when taking AHP, and the Committee can consider rebalancing medical urgency and post-transplant survival after evaluating the longer-term survival data. Members agreed with this approach.

Poll: 9 – medical urgency; 2 – equal; 3 – post-transplant survival

Medical Urgency vs. Candidate Biology

A member said it is more important to give an organ to someone who needs it in the near term rather than someone who can wait longer for a better match. However, there are situations where it would be appropriate to give additional points to someone who is hard to match. The Chair agreed that if the LAS is equal between two candidates, it is appropriate to give a boost to candidates who are extremely hard to match based on biologic reasons. These people often turn into medically urgent patients because they wait on the list for a long time. A member said there is a certain threshold where candidate biology should overcome medical urgency. For example, the member would not want to transplant someone with chronic obstructive pulmonary disease (COPD), who can wait a long time, over someone with idiopathic pulmonary fibrosis (IPF), who is getting sicker while they wait because they are hard to match.

The liaison from the OPTN Histocompatibility Committee said that a candidate with a 99.99% CPRA needs to be given priority early on, or there will be no donors that the candidate can accept by the time they reach a medically urgent status. A member agreed and said that it is the extremely sensitized patients who are disadvantaged by a framework that pits medical urgency against candidate biology.

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Members discussed the possibility of desensitizing patients to improve their access to transplant. A member said that desensitization only improves donor access if those unacceptable antigens are removed from UNet^{SM} so the candidate is listed with a lower CPRA. A member said that it is important to consider that there are a lot of components to candidate biology, and some are hard stops that prohibit transplant, whereas some are more modifiable.

A member said that transplant programs have to assess for whom it will make the most difference to get a transplant right away, whether it is a patient on extra corporeal membrane oxygenation (ECMO), for whom it is a big deal, versus someone who has a high CPRA but could wait a bit longer. For biology, you need to have some system to level the playing field. When it comes down to it, with any given organ offer, it is really that medical urgency that determines who needs the organ now.

Poll: 8 – medical urgency; 5 – equal; 0 – candidate biology

Medical Urgency vs. Increase Access for Patients Under the Age of 18

UNOS staff noted that the weight placed on pediatric priority in the community AHP results would outweigh any distance, but that does not mean that any pediatric candidate would be ranked before any adult candidate. A member said it seems like people who are younger do not necessarily live longer, and was not sure how to justify why a child should be ranked above other people. For example, the member was not sure how age should factor in if a transplant center has a 45-year-old healthy CF patient and a child with a complicated medical situation and one-year survival. A member did not rank pediatric age above medical urgency because of cases with teenagers who did not do as well post-transplant as older adults. SRTR staff shared that five-year survival is about 50% for patients under the age of 18.

The Chair said that a previous project increased pediatric priority because pediatric candidates were not getting the access they needed to get organ offers. An attendee said that priority was given to younger children in part because of language in the National Organ Transplant Act (NOTA) that says to consider the unique needs of children. Pediatric priority 1 and 2 were established to move away from ranking these candidates by waiting time so that sicker kids could get access. Priority was also given to patients under the age of 12 over patients aged 12-17. The under-12 group is a really small population of patients as only about 50 to 75 of these transplants are performed each year, and prioritizing the under-12 improved their projected waitlist mortality without harming projections for older kids or adults. Outcomes for adolescents tend to be worse. A member said that outcomes aside, it is important for pediatric candidates to have a boost to access because of how little they have lived.

UNOS staff asked the Committee to consider the impact on pediatric candidates if more priority is assigned to medical urgency. The Chair said there might be lost opportunities to transplant pediatric candidates and more waitlist deaths because they have less access to donors. An attendee said the under-12 candidates are incorporated in the continuous distribution system by assigning them an LAS equivalent, so their ability to access organs will be limited because their medical urgency will not change based on clinical characteristics. The assumption is the predictors in pediatrics is the same as adults, and if that is not the case, then those patients may be underserved. The access issue might be mitigated by broader distribution and incorporating height in the candidate biology rating scale, though the height factor would also give points to a small adult or teenager. Pediatric priority would give the same boost to all candidates under the age of 18. A member said it seems like if the weights are applied appropriately, then the pediatric patients shoot to the top and get the first shot at organ offers.

A member favored higher access for pediatric candidates since giving this priority will not have much of a negative impact on other groups. The values of a society are reflected in how it treats the youngest and oldest – the people who are most vulnerable – so it is appropriate from an ethical standpoint to give this priority. A member said they feel okay about a 50-year-old losing out on an organ offer to a 14-year-

old, even if the 50-year-old will live longer, because that patient has had 50 years to live. UNOS staff said this is the "fair innings" argument, in that people should be able to get the same amount of "innings" and children have not had those opportunities. SRTR staff said the counter-argument is that children do not meet the utility standard because their post-transplant survival may be poor, but national policy gives priority to children based on the fair innings principle. The adolescent population still has one of the worst waitlist mortality rates of any group. The denominator is small, so there are big shifts in the rates, but they have poor survival on the waitlist. A member asked how many pediatric candidates are dying on the waitlist. SRTR staff said the rates are high but the counts are low, because it is a small population. A member expressed concern that there are kids that will not get organs and there are older people who may have already had that opportunity. The member is concerned that her granddaughter, who has a serious heart defect, will need a heart and will not be able to get one.

Poll: 1 – medical urgency; 1 – equal; 13 – pediatric age

Medical Urgency vs. Prior Living Donor

A member chose medical urgency over prior living donor with the idea that if it was a tie, prior living donation could be a tiebreaker, but otherwise medical urgency should be priority. The member said it is okay to give some priority, but if the organ offer is between a prior living donor and someone about to die, then the more medically urgent person should get the organ.

Members wondered if prior living donors might have worse post-transplant outcomes. A member favored increasing access for prior living donors, regardless of outcomes, because it seems morally fair since they donated into the system. The Chair said it cannot be assumed that prior living donors will have worse outcomes, and shared that she had two patients who needed lungs after donating kidneys and had good outcomes.

A member expressed surprise that organ procurement organizations (OPOs) were so much more in favor of living donors. A member said her OPO primarily works in kidney, and she assumed that people who previously donated would want priority. The Vice Chair said that when this was discussed with the Patient Affairs Committee, a lot of donors felt uncomfortable that they would be given priority compared to someone with higher medical urgency.

A member said it is rare for a prior living donor to need a lung, and it is more likely that a prior living donor would need a kidney. A member agreed that this is more important for kidney transplant. If a patient has complications from living kidney donation, it lowers their renal function and the patient may have to go on dialysis and wait for five years before getting a transplant. If a kidney donor needs a lung, it is not because they donated the kidney that they need a lung. A member said this is such a rare event that it does not need to be incorporated into allocation for lung. A member asked if the Committee needs to retain prior living donor priority in the model so that it can roll into continuous distribution for kidney. UNOS staff said that the Committee is setting a precedent in terms of if, how, and why prior living donation is considered in continuous distribution, but it will not necessarily apply across organs.

A member said that kidney and lung transplant are unrelated. Patients can do other good things for society but they do not get more priority for a lung because of that. The member asked why prior living donation should be weighted more than adoption or another altruistic act. UNOS staff said the policy to give priority to prior living donors in kidney allocation came from the Kidney Committee with support from the Ethics Committee. The Lung Committee could choose to restrict priority to prior living lung donors. A member said the Committee should not spend a lot of time on this since it is so rare.

Poll: 5 – medical urgency; 0 – equal; 0 – prior living donor; 10 – remove prior living donor priority

Medical Urgency vs. Improve Placement Efficiency

A member said cases with extreme medical urgency or high CPRA will trump the need for efficiency, but efficiency has value in terms of lower costs, involving less people, and getting a donor to transplant more quickly. The member said it is important for their program to avoid flying if possible. A transplant team from his center died in a plane crash, so having to fly for an organ weighs on their decisions.

A member said they would not prioritize efficiency over medical urgency, but there is value in efficiency and minimizing time to acceptance. A member responded that placement efficiency is a surrogate for distance, so that sounds like an argument to place organs locally instead of at a distance. A member responded that placement efficiency is not just about distance, and suggested giving a benefit to people that use perfusion devices so an entire transplant team is not put at risk on flights. The member said that local recovery can also help transplant some organs that might otherwise be turned down. UNOS staff said that one rating scale uses distance as a measure of placement efficiency. The other rating scale reflects relative cost based on the difference in cost between driving and flying.

A member said that the strongest argument for efficiency is that it may reduce the number of discards and increase the number of transplants with the same level of resources. However, the connection between efficiency and increasing the number of transplants may not be well delineated. A member suggested that if a patient located farther away comes up earlier in the allocation sequence, then transplant programs might have more time to prepare to accept an offer or organize local recovery, particularly for marginal organs.

A member said that every big transplant center that has good outcomes does so because they are able to look at a lot of offers. Centers that have local procurement teams and can accept offers farther out can increase the number of transplant opportunities. There are going to be discards if allocation takes too long and the candidates are far away. A member said that the Committee can allocate extra points to people who are willing to use that model. However, local recovery is patchy and a lot of people do not want to do it if there is no benefit for their transplant center. A member said that efficiency also has to take into account that smaller centers have less access to organs, and the Committee does not want to harm smaller programs by placing too much emphasis on efficiency. A member asked if smaller programs would be disadvantaged. SRTR staff said that their modeling does not show center-specific data. UNOS staff said these are important considerations for assigning the weight for placement efficiency, as the OPO Committee is very concerned about efficiency with broader distribution.

Poll: 14 – medical urgency; 1 – equal; 1 – placement efficiency

Post-Transplant Survival vs. Candidate Biology

The Vice Chair said people may favor candidate biology since these candidates may be disadvantaged in terms of access to transplant. There is not a lot of data on how many lung candidates are highly sensitized, and some single-center studies have indicated that outcomes are worse for highly sensitized candidates. The Vice Chair said her answer would be different based on longer-term post-transplant survival, but candidate biology is as important or more important than one-year post-transplant survival, particularly in terms of blood type. The Vice Chair was less sure about candidate height and sensitization since they may not be as much of a barrier to transplant as blood type.

A member said that people may favor post-transplant survival in order to maximize the benefit of a scarce resource. At the extremes, candidate biology becomes more of a factor that needs to be considered, like for an extremely sensitized patient or extreme candidate height. For someone with a really high CPRA, desensitization may not be a viable approach. Some sort of threshold would make sense, though most of the time post-transplant survival would outweigh candidate biology.

A member said that since most people survive one year after transplant, and the composite allocation score will only estimate post-transplant survival at one year, it makes sense to give equal or more priority to candidate biology. A member agreed, noting that while the OPTN does not have a lot of data to better predict post-transplant survival at longer timeframes, there is a lot of data in terms of the limited access to donors for candidates with biological constraints.

A member asked if CPRA could be weighed separately from blood type and candidate height. UNOS staff said the rating scale that combines these three attributes does weight each of them differently. For example, it is possible for a candidate to get a score up to 1.0 for CPRA but not for blood type. This approach is based on candidate data and can be built upon in the future.

Poll: 18 – candidate biology, 1 – equal preference, 0 – post-transplant survival

Post-Transplant Survival vs. Increased Access for Patients Under the Age of 18

A member favored giving extra years to younger patients since it is more valuable to give opportunities to children than giving the same number of life years to someone who is 60 or 70. A member said it is probably not more important to give more benefit to a 17-year-old than a 19-year-old, but would generally lean towards benefitting kids.

A member struggled with the idea of giving more weight to a 17-year-old CF patient over a 19-year-old CF patient, particularly if the 19-year-old is expected to survive longer. It is hard to compare these patients, especially if the Committee does not think that priority should be given to prior living donors as a reward for their altruism. It seems like a double standard to give priority to some people based on societal expectations. The member asked how a transplant program can justify giving an organ to a 17-year-old over a 19-year-old who is close to death. A member shared those concerns but said that is not a common situation. It is more likely that a match run would have a 17-year-old and several older adults.

A member said the Committee should not weigh what a person might do if they live versus their likelihood of survival. SRTR staff said that the ethical justification is not based on a decision about who is a better person or more likely to contribute to society. The fair innings principle is simply about giving the same opportunities. If the offer is between a 50-year-old Gandhi versus a 17-year-old troublemaker, the argument is that the 50-year-old has had more innings than the 17-year-old. In other words, it is based on the net number of years gained, not the value of the person or their societal contribution.

An attendee said that the value of prioritizing post-transplant survival is being a good steward of that gift of life and to optimize the life that is given to any recipient. The attendee asked for clarification as to whether the rationale is to prioritize candidates under the age of 18 because they are supposed to have more years of life left in them, or whether post-transplant survival in this context is based on the quality of the organ and whatever condition the recipient had. If it is the former, then it seems like the younger recipient would always be favored because in theory, they have more years of life remaining. A member affirmed that the idea is to give priority to a candidate under the age of 18, even if they have lower expected post-transplant survival relative to a candidate over the age of 18, because the candidate under the age of 18 has not experienced as many years of life.

A member said that pediatric patients are a vulnerable population. Whether the goal is to transplant the patient who needs it or for the patient to live as long as possible, it is reasonable to err on the side of giving preference to pediatric candidates.

Poll: 1 – post-transplant survival; 2 – equal; 14 – pediatric age

Post-Transplant Survival vs. Increase Access for Prior Living Donor

Members did not have additional thoughts on this pairwise comparison, given their previous discussion on removing prior living donor priority from the composite allocation score.

Poll: 6 – post-transplant survival; 0 – equal; 0 – prior living donor; 10 – remove prior living donor priority

Next steps:

The Committee will meet on 10/23/2020 to continue discussing the pairwise comparisons from the AHP exercise and finalize the rating scales to send to SRTR for modeling.

Upcoming Meetings

- October 23, 2020
- November 12, 2020

Attendance

- **Committee Members**
  - Erika Lease, Committee Chair
  - Marie Budev, Committee Vice Chair
  - Alan Betensley
  - Whitney Brown
  - Staci Carter
  - Ryan Davies
  - June Delisle
  - Mindy Dison, Visiting Board Member
  - Cynthia Gries
  - Julia Klesney-Tait
  - Jasleen Kukreja
  - Dennis Lyu
  - Dan McCarthy
  - Kenneth McCurry
  - Michael Mulligan
  - John Reynolds
  - Marc Schecter
  - Nirmal Sharma
  - Kelly Willenberg
- **HRSA Representatives**
  - Jim Bowman
- **SRTR Staff**
  - Yoon Son Ahn
  - Katie Audette
  - Melissa Skeans
  - Maryam Valapour
  - Andrew Wey
- **UNOS Staff**
  - James Alcorn
  - Julia Chipko
  - Craig Connors
  - Shannon Edwards
  - Rebecca Goff
  - Nang Thu Thu Kyaw
  - Elizabeth Miller
  - Rebecca Murdock
  - Liz Robbins Callahan
  - Amanda Robinson
  - Janis Rosenberg
  - Darren Stewart
  - Kaitlin Swanner
  - Susan Tlusty
  - Ross Walton
  - Sara Rose Wells
  - Joann White

- **Other Attendees**
  - Masina Scavuzzo
  - Jennifer Schiller
  - Stuart Sweet