

OPTN Kidney Transplantation Committee

Meeting Summary

October 8, 2021

Conference Call

Martha Pavlakis, MD, Chair

Jim Kim, MD, Vice Chair

Introduction

The Kidney Transplantation Committee (the Committee) met via teleconference on 10/08/2021 to discuss the following agenda items:

1. Welcome & Introductions
2. Cross-Committee Updates
3. Continuous Distribution Update and Discussion
4. Research Orientation
5. Kidney 6-Month Monitoring Report

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

1. Welcome and Introductions

Committee leadership welcomed everyone to the call, and the Committee members and supporting staff, Scientific Registry of Transplant Recipient (SRTR) representatives, and Health Resources and Services Administration (HRSA) representatives introduced themselves.

Summary of discussion:

The Committee had no comments or questions.

2. Cross-Committee Updates

Committee members on the Policy Oversight Committee, Reassess Race in eGFR Calculation Workgroup, Ad Hoc Multi-Organ Committee, Kidney Paired Donation (KPD) Workgroup, Medical Urgency Review Subcommittee, Offer Filters Workgroup, Kidney-Pancreas Continuous Distribution Workgroup, and Biopsy Best Practices Workgroup provided updates to the Committee.

Summary of discussion:

The Policy Oversight Committee will be reviewing post-public comment briefing papers going to the board in December, as well as public comment items set to be released in January.

The Reassess Race in eGFR calculation Workgroup is evaluating feedback gathered during the summer 2021 public comment period, which has been overwhelmingly supportive of eliminating race from waitlist qualifying eGFR calculations. The American Society of Nephrology and the National Kidney Foundation's joint task force on race in eGFR has also announced a couple of eGFR formulas that eliminate the race variable and improve accuracy.

The Ad Hoc Multi Organ Committee has been working to develop eligibility criteria for heart-kidney and lung-kidney, performing a literature review and gathering data. The Committee will review the proposed criteria on the next call.

The OPTN Operations and Safety Committee is sponsoring an Offer Filters Workgroup, which will include representation from the Kidney Committee and begin addressing mandatory offer filters in kidney allocation, based on identified criteria and policy.

The Kidney Medical Urgency Subcommittee held their first meeting in August, a report for which has been shared with the Committee. The Medical Urgency Subcommittee will meet in the fall to discuss options for developing further guidance on proper documentation.

The Biopsy Best Practices Workgroup is finishing up the *Minimum Donor Criteria Appropriate for Biopsy* and *Standardized Pathology Report* projects, and plans to release both projects as proposals in the January 2022 Public Comment cycle.

The KPD Workgroup has reviewed existing OPTN KPD Pilot Program (KPDPP) operational guidelines and KPD policy, identifying areas in need of further clarification or alignment with OPTN policy. In their review, the KPD Workgroup has found the operational guidelines to be largely out of date and repeated in OPTN KPD Policy, and is recommending the removal of the operational guidelines.

Staff explained that per the KPDPP operational guidelines, the process for modification or removal to the guidelines is for the KPD Workgroup to make a recommendation of modification or removal to the Kidney Committee, who then vote on the proposed change. The Chair asked whether there is any element of the guidelines not included in existing policy, or if there was anything that remained to be brought over from the guidelines to KPD policy. The Chair of the KPD Workgroup explained that nearly all of the guidelines are redundant with policy. Staff noted that there are a few minor things in the operational guidelines that could be incorporated into policy as part of the upcoming project to reviewing and update OPTN KPD Policy, but that these items were so minor they wouldn't have an effect on the daily operations of the KPDPP.

Vote: Does the Committee agree with the Workgroup's recommendation to remove the OPTN KPD Pilot Program Operational Guidelines?

The Committee voted unanimously to remove the KPDPP operational guidelines.

3. Continuous Distribution Update and Discussion

The Committee received an update on the progress of the Kidney-Pancreas Continuous Distribution project, including review of feedback gathered in public comment and discussion to develop rating scales for kidney-specific attributes.

Data summary:

The *Kidney-Pancreas Continuous Distribution Concept Paper* released for public comment in August of 2021 provides an overview of Continuous Distribution and the policy development approach, summarizes the attributes considered by the Kidney and Pancreas Committees, and outlines how these attributes align with NOTA and the Final Rule. The Concept Paper also seeks community feedback on these attributes and the progress of the project thus far.

Public Comment garnered community feedback from 11 regional meetings, eight OPTN Committees, six stakeholders and societies, and four individual comments. Recurring themes of this feedback included:

- Pediatric access
- Efficiency
- Kidney Donor Profile Index (KDPI)/Estimated Post Transplant Survival scores (EPTS)
- Disparities in access and disadvantaged patients
- Multi-organ transplant

- Patient education
- Community engagement

As the Kidney-Pancreas Continuous Distribution Workgroup discusses each attribute, they will continue considering potential impact to disadvantaged populations and other ethical implications. The OPTN Ethics Committee also released the *Ethical Considerations of Continuous Distribution* paper in the same August 2021 public comment cycle, and there is representation from the Ethics Committee on the Kidney-Pancreas Continuous Distribution Workgroup. Leadership from other relevant OPTN Committees are included in discussions regarding each attribute. There is also a focus on uniformity across organs in project approach in certain areas, particularly placement efficiency and geography, as well as educational materials for programs and patients.

Currently, the Kidney-Pancreas Continuous Distribution Workgroup is working to convert identified attributes into points, developing rating scales and weights for each attribute in order to build a draft framework. The Workgroup is nearly finished building rating scales for each attribute, and will soon begin conversations on weighting. Discussions on weighting for each attribute will be bolstered by results from an Analytical Hierarchy Process (AHP) Exercises.

The Kidney-Pancreas Continuous Distribution Workgroup has developed the following draft rating scales:

- Human Leukocyte Antigen (HLA) Matching (Kidney) – prioritization for DR locus antigen matching, with points assigned based on level of HLA mismatching
- Blood type (Kidney, Pancreas, KP) – non-linear scale, aligning blood type priority onto the same scale as the calculation Panel Reactive Antibodies (cPRA, or sensitization) utilizing the proportion of incompatible donors
- cPRA (Kidney, Pancreas, KP) – Non-linear scale
- Prior Living Donor (Kidney, Pancreas, KP) – Binary
- Pediatrics (Kidney, Pancreas, KP) – Binary
- Kidney after Liver Safety Net – Binary

The Committee was informed some of these attributes may be revisited as discussions continue within the Workgroup.

Summary of discussion:

The Chair remarked that the work of the Kidney-Pancreas Continuous Distribution Workgroup has become increasingly more challenging, and thanked members of the Workgroup for their dedication. The Chair also noted that participation from the Ethics Committee will be particularly helpful in conversations about weighting for each attribute.

Data summary:

There are several Kidney-specific attributes for which the Committee will need to determine rating scales, including Medical Urgency and En Bloc.

The Kidney Medical Urgency Policy *8.5.A.i: Medically Urgent Status* was implemented on March 15, 2021, and establishes a particular set of criteria qualifying a patient as medically urgent. Based on this policy, Staff recommended a binary rating scale, based upon the criteria.

En Bloc allocation is directed by Policy *8.6.B: Allocation of En Bloc Kidneys*, and En Bloc kidneys are allocated according to the same match run as kidneys KDPI 0-20 percent. OPTN Policy *5.3.G: Dual and En Bloc Kidney Acceptance Criteria* also requires transplant programs to specify if a candidate is willing to

accept En Bloc kidneys. The En Bloc policies were implemented in September of 2019, and there were 178 en bloc transplants in the first year post-policy. 76 percent of en bloc transplants went to low EPTS patients (0-20 percent). Based on this policy, Staff recommends utilizing a binary rating scale dependent on candidate opt-in and donor characteristics (less than 18kg and KDPI).

Summary of discussion:

Several members of the Committee expressed support for a binary medical urgency rating scale. The Vice Chair expressed support, and added that there will soon be an update on the medical urgency policy and its use. The Vice Chair continued that, after reviewing the cases, not all the centers that listed candidates as medically urgent actually met the definition. The Chair concluded that moving forward, there will need to be a focus on verifying medical urgency more quickly or prospectively, particularly if medical urgency will have significant weighting. The Chair agreed, noting that there will need to be a way to ensure it's done appropriately.

One member asked if the medical urgency binary scale would be binary for each component of medical urgency or binary overall, and the Chair clarified it would be a binary yes or no as to whether or not the candidate met the medical urgency criteria.

A member asked if the Kidney Medical Urgency Review Subcommittee would still exist under Continuous Distribution. Staff noted that the Subcommittee would continue, unless the Committee decided to remove it and create a Kidney Review Board. The possibility of a review board will be part of future Workgroup discussions.

The Workgroup achieved consensus to utilize a binary rating scale for medical urgency.

Staff remarked that KDPI is masked in en bloc allocation because it reflects the expected post-transplant survival of receiving one kidney, not two. The motivation for the en bloc policy was to standardize which donors were en bloc donors, and address that KDPI would not be helpful to their allocation. Staff shared that if the Committee decides to have a continuous scale for KDPI and EPTS, it is possible that an arbitrary KDPI will need to be assigned to en bloc donors to direct allocation. The Vice Chair asked for clarification, noting that en bloc kidneys don't have a KDPI of 0-20 percent, but are allocated on match runs of KDPI 0-20 percent. Staff explained that, if the Committee decided to keep the KDPI allocation sequences, the solution would be to give en bloc kidneys the same amount of points as a 0-20 percent KDPI kidney, as they are now. If KDPI is a continuous scale where a 0 percent KDPI kidney and a 10 percent KDPI kidney are allocated differently, then the Committee may need to assign a KDPI value to en bloc donors as they decide those en bloc kidneys should be allocated. Staff also shared that the Kidney Donor Risk Index (KDRI) includes a coefficient to account for en bloc, and that en bloc KDRI value may be a better reflection of the actual graft survival of the kidneys.

One member remarked that it doesn't make sense to have the en bloc rating scale be binary, as there are donor factors such as size that go into the decision making. Smaller en bloc kidneys will function differently than 18 kilogram (kg) en bloc kidneys. The member recommended modelling the data. The Vice Chair agreed, adding that 18kg donor kidneys can often be split. The Vice Chair asked if the recommendation for the binary is whether the recipient that shows up on the match run has opted in or out of receiving en bloc offers. Staff clarified that the division of patients who will receive en bloc offers and those who will not is established before a match is run with patients opting in to receive those offers on the waitlist. Staff noted that this rating scale is to figure out where on the match run patients should fall, or how patients should be prioritized relative to each other. For en blocs, KDPI isn't an accurate measure, so the Committee will need to define which group of patients should receive these offers, and if en blocs should be treated similarly to a low KDPI kidney.

The Chair remarked that donor weight could be put on a sliding scale, so that an en bloc would be allocated differently as a 10kg or 17kg donor. One member commented that en bloc would be more of a donor factor than a recipient factor, and if it's a donor factor, one en bloc is not the same as another. Larger en blocs are better grafts. Another member agreed that not all en blocs are the same, and asked if there could be a consideration to subdividing them, particularly as they become increasingly small. The member continued that this is likely a weight at which there is different risk and outcome. The Chair added that the en bloc attribute considers both donor and recipient factors, and noted that the role of KDPI will be discussed by the Workgroup later as well.

Staff explained that, similar to KDPI and EPTS matching, en bloc considers both donor and candidate characteristics. The donor characteristics in this case are conditional, establishing criteria that determine certain allocation pathways with priority for certain candidates. On the candidate side, it is a binary opt in or opt out. There are two decisions to make.

An SRTR representative commented that the recipient characteristics will be similar for en blocs, and typically consider size and disease severity. Size mismatch, significant vascular disease, and other candidate characteristics are considered in accepting an en bloc kidney. The SRTR representative agreed that, for the candidate it is binary as to whether or not they want to receive the offers.

Staff clarified that the Committee is being asked to decide how patients that have opted in for an en bloc kidney offer should be ranked relative to each other, and whether they want to continue directing en bloc kidneys to low EPTS and pediatric patients. The current system aligns that priority with KDPI.

The Vice Chair commented that this decision will be difficult while other decisions related to KDPI and KDPI-based allocation sequences still need to be made. Another member agreed.

A member noted that the binary opt in should not be calculated as part of a candidate's composite allocation score. The member continued that if this is a donor factor and not a recipient factor, there will be need for more data. Staff noted that the candidate opt in interacts with donor factors, making the en bloc attribute about the interaction of donor and candidate characteristics.

Staff shared that the Committee doesn't need to make a decision today, and that this decision can be revisited as new information becomes available. Staff noted that a donor could be determined as an en bloc donor or not (a binary distinction) using the current en bloc donor criteria, and that the candidate opt in be used as binary as well. Staff recommended utilizing a binary rating scale and revisit the attribute after KDPI discussions and modelling. The Chair asked if the binary rating scale keeps en bloc allocation as similar as possible to current en bloc allocation, and staff confirmed it would.

The Committee achieved consensus to utilize a binary scale for the en bloc attribute, with the caveat to revisit the attribute after modelling and KDPI discussions.

4. Research Orientation

Staff presented an orientation to the UNOS Research Department and their role in OPTN Committee support.

Data summary:

Key roles of the OPTN include collecting and maintaining data for all solid organ transplants in the United States, facilitating organ distribution and transplantation, establishing equitable allocation policies, monitoring members for policy compliance, publishing and reporting data, and promoting organ availability.

UNOS is the OPTN Contractor, and it collects and maintains waiting list and transplant related data, augments OPTN data with additional sources, and sends monthly copies of OPTN data to the SRTR contractor. The SRTR Contractor also augments the data with additional sources based on their own analytical conventions to create SRTR data.

Committee support is one of the many Research Department responsibilities. The Research Department also has a data analytics team that provides analytical support to members, the community and internal UNOS department and management of the analytical data set. There is also a team outside of Research that works with Data Governance to provide support for maintaining accurate and complete data. The Research Analytics team includes research and data scientists and serves two primary functions: to deliver analytical support to the OPTN Committees to enhance policymaking and conducting scientific research to improve the knowledge of transplantation. Our data science team also develops new technologies for future data analysis and brainstorms ideas for improving the system.

When it comes to Committee support and supporting policy development, primarily organ allocation. To the extent possible, policies are evidence based, and the research department provides analyses in support of policy change initiatives and for monitoring the change post-implementation. When it comes to a Committee data request, Research support will help build a data request that addresses a specific research hypothesis aligned with the project, determine the type of analysis needed, and supplement OPTN data as necessary. The SRTR handles inferential analyses, which utilizes modeling to predict how changes could affect outcomes. Committee data requests should follow Committee or workgroup discussion. Once the request is complete and a data report is available, the results are presented to the requesting Committee or Workgroup. HRSA reviews any reports for occasional disseminated information.

The Research Department also helps with non-Committee data requests, which can be submitted from the OPTN website and the service portal. Both the OPTN site and service portal also have several reports and data tables from which custom reports can be built. That data is refreshed weekly. The service portal also features several toolkits such as Organ Offer Reports and Kidney Waitlist Management tools.

Research performs several self-initiated research and data visualization projects for further understanding of transplantation and representation of the OPTN. Some of these projects include the equity in access report, which measures and monitors equity in access to transplant for lung, liver, kidney, and heart; the OPTN data reports; and the Recovery and Usage Map, which provides detailed information about recovery and transplantation of deceased donor kidneys.

The UNOS Research Department also collaborates with professionals in the transplant community to further the science of transplantation, to represent OPTN for Community of Practices Initiatives, to present at national and international transplant conferences, and to public in scientific journals.

The UNOS Research Department staff includes many highly trained individuals with a variety of background and about 175 years of combined experience working with OPTN data.

Summary of discussion:

The Chair thanked Staff for the overview. The Committee had no additional comments or questions.

5. Kidney 6-Month Monitoring Report

The Committee reviewed the *6-Month Post-Implementation Report for the Removal of DSA and Region from Kidney Allocation policy*.

Data summary:

The new kidney allocation policy was implemented on March 15, 2021 and comprised of several policy changes, including:

- 250 nautical mile (NM) circle drawn around the donor hospital to replace DSA and region
- Proximity points assigned based on distance between listing center and donor hospital
- Increased prioritization for pediatric candidates and prior living donors
- Related policy changes to defining medical urgency for kidney candidates, released organs, and donors recovered in Alaska

This analysis compares waiting list, transplant, and donor utilization pre- and post-policy. This set of data will allow the Committee to look at transplants for which all appropriate and timely data is submitted.

Waiting list mortality was defined as the number of removals due to death or other removals where death was identified within 14 days of removal using external sources, and dividing that total by the total amount of time spent by the patient on the list over that time period. This is death per 100 patient years, and that's the number of deaths expected if there were 100 patients waiting for a year. Waitlist mortality decreased from 7 to 4.5 per 100 patient years. The pre-policy rate of 7 was higher than usual. The rate from 2019 is more similar to the post-policy rate and more typical, and the rate from 2020 is higher than usual but not as high as the pre-policy rate. The change in mortality likely has little to do with the policy change and more likely due to the ongoing COVID-19 pandemic and decreases related to vaccination rollouts.

The number of transplants increased from after policy implementation. Deceased Donor transplant rates look at the number of transplants occurring during a period of time and divide that by the total collective time kidney patients spent on the waiting list at an active status over that time period. The report is restricted to active status because if patients are not receiving offers, they are typically not getting deceased donor transplants at that time. This is transplants per 100 patient years, and can be interpreted as the number of transplants among 100 patients waiting for an entire year. The overall transplant rate increased from 32 to 39 transplants per 100 active patient years after the policy change.

There were some demographic changes in the patients receiving transplant. All age groups saw an increase in the number of transplants after policy implementation, and the proportion of transplants to pediatrics increased from 3 percent to almost 3.5 percent. The distribution of age for adult recipients didn't really change, and most patients continued to be between the age of 50 and 64 at the time of transplant. Transplants for candidates aged 18 to 34 increased from 34 to 42 transplants per 100 active patient years, and rates for candidates 35-49 increased from 29 to 34 transplants per 100 active patient years. Rates for candidates aged 50 to 64 increased from 17 to 20 transplants per 100 patient years.

For pediatric candidates, the transplant rate for candidates aged 11 to 17 increased from 146 to 312 transplants per 100 active patient years after policy implementation, but there was not a change in transplant rate for candidates aged 10 or younger.

There was an increase in total number transplants across all recipient ethnicity groups, and there was a change in the distribution of ethnicity for transplant recipients. The proportion of transplants to Hispanic recipients increased from 19 percent to 21 percent and the proportion of transplants to white recipients decreasing from 38 percent to 35 percent. There was also an increase in transplant rate for Hispanic patients, going from 27 to 36 transplants per 100 active patient years. The transplant rate for Black patients increased from 32 to 40 transplants per 100 active patient years, as did the rate for Asian candidates going from 23 to 28 transplants per 100 active patient years. There was no change in transplant rates for candidates of other ethnicities.

There were changes in transplant based on cPRA, the number of transplants increased across all cPRA groups, but looking at the distribution, the proportion of transplants to patients with cPRA 80-97 percent increased from 6 percent to 12 percent. The transplant rate also increased for this group from 37 to 73 transplants per 100 active patient years. Candidates with cPRA 0 percent and 20-79 percent also saw an increase.

Roughly 82 percent of deceased donor kidney recipients are on dialysis at time of transplant before and after the policy change, and among these recipients median time on dialysis increased from 4 to 4.5 years after the policy implementation. This is in line with expectations from the modelling, and this is showing that patients with higher dialysis times in areas that had low access to transplant are getting transplanted under the new system. It's possible this is a bolus effect that will temper over time. The transplant rate for candidates on dialysis for three or more years at listing increased from 74 to 100 transplants per 100 active patient years and transplant rates did not change for preemptive listing candidates or candidates with less than three years of dialysis time.

The median distance from donor hospital for deceased donor kidney transplants increased from 70 to 125NM. Organs overwhelmingly stayed inside the 250NM circle used in allocation. Prior to implementation, 80 percent of transplants occurred within 250NM of the donor hospital, after implementation the proportion changed to 85 percent. Regional and national transplants increased, while "local" DSA transplants decreased. Region 2 saw a decrease in the number of transplants and Region 1 saw no change, but the remaining Regions saw an increase in the number of transplants. The number of transplants increased at 37 DSAs, decreased at 17 DSAs, and saw no change at 3 DSAs. The number of transplants increased at 145 centers after policy implementation and decreased at 71 centers.

Median cold ischemic time increased from 17 to 19 hours after policy implementation. Delayed graft function increased from 31 percent of transplants to 32 percent of transplants.

There was an increase in the number of donors post policy, with little shift in KDPI. Discard rate decreased from 24 to 22 percent, with the largest change seen for kidneys KDPI 86-100 percent which saw a decrease from 67 percent to 62 percent. The overall offer rate increased from 141 to 208 offers per active patient year, and offer rates increased across candidate characteristics. The overall acceptance rate decreased from 2.4 to 1.8 acceptances per one thousand offers, and this decrease was seen in varying degrees across candidate characteristics. There was an increase in acceptance rates for cPRA 80-97 percent patients, with other cPRA groupings seeing a decrease. The acceptance rate increased for candidates outside of the DSA. The median sequence number of the final acceptance increased from 10 to 16. Roughly 0.1 percent of all refusals were due to positive cross match.

Since implementation, 14 candidates utilized the Medically Urgent status. Of these, 4 received deceased donor transplants within 3-5 days, 2 were removed from status without transplants, and the remaining 8 were still waiting. Of those, 5 remained in medical urgency status from March 15 through the end of the cohort period, June 30, 2021.

The discard rate for kidneys recovered from a donor with an import match was 31 percent, and the discard rate for kidneys recovered from donors with a released organ match was 22 percent, similar to the overall discard rate.

Transplant volumes increased, particularly for pediatric candidates, Black and Hispanic patients, patients with higher dialysis time, and cPRA 80-97 percent patients. The overall discard rate did not increase. More kidneys are distributed outside the donor hospital DSA, but most stay within 250NM. Offer rates increased, and acceptance rates decreased.

Summary of discussion:

One member asked for clarification on transplants per 100 active patient years and whether the number of inactive patients differed in the two cohorts. Staff explained that the report does break down the numbers of active and inactive patients, and that the percent of inactive patients on the waitlist was constant over both cohorts.

A member remarked that the pre-policy time period was marked by significantly active COVID-19 levels, and that many centers had operational issues leading to inactivation of candidates. The member asked if the post-policy data was compared to the year before the start of the COVID-19 pandemic. Staff clarified that this data has not been compared to the year before COVID-19 happened, and there would be similar challenges looking at March 15 2020. The cohorts presented are similarly linked on either side of the policy, which creates a much more fair comparison. Staff noted that while some changes can be attributed to the policy, some are independent of the allocation changes or in addition to the external changes.

One member asked if the challenges posed by COVID-19 in the pre-policy cohort have made the post-policy changes look better than they are, and if there is a way to clarify this. Staff responded that it is difficult to identify the best pre-policy cohort, with going back as far as the pre-pandemic era not an appropriate comparison. There are still challenges from COVID-19 present in the post-implementation cohort that were not present in the pre-COVID-19 era. The Chair remarked that the death on dialysis metric would likely be the most affected by COVID-19 and the least affected by the policy change, and so that metric could have a pre-pandemic pre-implementation cohort for comparison. The Chair noted that regional variability in COVID-19 prevalence and incidence over time makes it nearly impossible to tease apart the effects of the pandemic and the effects of the policy.

A member asked what the driver was behind the slight reduction in acceptance rate and transplant rate for patients with cPRAs 98-100 percent. The Chair asked the Committee to postulate potential reasons for that reduction. Staff commented that there is an increase in the number of acceptances proportional to what would be expected with the increase in the number of donors, but with organs in broader distribution, the number of offers being sent out is increasing more quickly. In this case, the denominator (number of offers) is increasing faster than the numerator (number of acceptances), and so the change in rate can be attributed to the increase in offers overall rather than reduction in acceptances. Staff added that the change in transplant rate for cPRA 98-100 percent patients is not significant, and there is overlap in rates between pre- and post-implementation. Staff offered that this change in transplant rate could be a small sample size issue, as the 98-100 percent range are not as big as other cPRA groups, and so have larger confidence intervals.

One member asked if there was a change in the distribution for donors with KDPI less than 35 percent, and why adolescent pediatric patients saw a large increase in transplant rates while children under 10 did not. Staff responded that the vast majority of pediatric transplants were from kidneys with KDPI 34 percent or lower. Staff noted that KDPI is a function of weight, and so many of the 6-10 year old pediatric donors tend to have a KDPI above 35 percent, a sequence of kidneys for which pediatric patients are not given priority. Staff asked if there were other reasons such as size matching or other medical concerns that require surgeons to be more selective about kidneys transplants into kids under 10. Another member commented that there is an increase in transplant rate for the 18-34 year old patients as well.

A member asked if the increase in deceased donors is distributed evenly among KDPI groups, and Staff noted that there has been an increase in the number of donors across all KDPI groups. Another member pointed out that Organ Procurement Organizations (OPOs) are facing significant pressure to increase

performance measures, resulting in more donors across the board. Another member agreed, and added that the increase in donors and offers has had unintended consequences for how centers handle their offers. One member expressed the same concern, sharing that it is difficult to screen and evaluate offers in such large volumes, particularly when there are many back up offers made that will never become primary. The member added that improved clarity and streamlining is needed here, and offered hope that mandatory offer filters will improve efficiency. Another member remarked that the filters will need to be granular, dynamic, and multifactorial, allowing doctors to “stack” risk factors in creating specific criteria. Other members agreed. Staff shared that the Offer Filters project will include multifactorial filtering.

One member remarked that going forward, it will be important to tighten up an understanding of the criteria for medical urgency.

An SRTR representative asked Staff to comment on the correlation and value of the predictive modelling performed by the SRTR through the Kidney-Pancreas Simulated Allocation Model (KPSAM). Staff remarked that the KPSAM was considerably accurate with the most important metrics, particularly transplant volumes for high dialysis time patients, pediatrics, cPRA and other results. The KPSAM was not able to model the pandemic, so the changes in death rates were not anticipated. Other aspects of the modelling lined up well with the actual outcomes.

The Vice Chair asked if the SRTR was analyzing data on COVID-19 surges, and if that data could help reveal how significant pandemic changes are in this policy analysis. An SRTR representative remarked that there are several analyses on the SRTR website related to COVID-19 geographically and nationally, and that data such as waitlist mortality isn’t surprising. The SRTR representative shared that there are major challenges in looking at incidence and incidence by region, as incidence of COVID-19 may not fall equally on all hospitals in a region, and not all data related to incidence is reliable. The representative concluded there is difficulty having confidence in the COVID-19 data.

Upcoming Meetings

- October 18 – Teleconference
- November 15 – Teleconference

Attendance DONE 10/25

- **Committee Members**
 - Martha Pavlakis
 - Jim Kim
 - Vincent Casingal
 - Arpita Basu
 - Amy Evenson
 - Asif Sharfuddin
 - Bea Concepcion
 - Caroline Jadlowiec
 - Deirdre Sawinski
 - Elliot Grodstein
 - Eric Simonich
 - Jim Kim
 - Julie Kemink
 - Marion Charlton
 - Nidyanandh Vadivel
 - Peter Lalli
 - Peter Kennealey
 - Precious McCowan
 - Sanjeev Akkina
 - Stephen Almond
- **HRSA Representatives**
 - Jim Bowman
 - Marilyn Levi
 - Raelene Skerda
- **SRTR Staff**
 - Bryn Thompson
 - Jon Miller
 - Peter Stock
- **UNOS Staff**
 - Lindsay Larkin
 - Ross Walton
 - Kayla Temple
 - Amanda Robinson
 - Amber Wilk
 - Ben Wolford
 - James Alcorn
 - Joel Newman
 - Katrina Gauntt
 - Lauren Motley
 - Leah Slife
 - Melissa Lane
 - Mohamed Abbas Roshanali
 - Ruthanne Leishman
 - Sara Moriarty
 - Sarah Booker

- **Additional Attendees**
 - Dave Weimer