

OPTN Ad Hoc Multi-Organ Transplantation Committee

Meeting Summary

August 10, 2022

Conference Call

Lisa Stocks, RN, MSN, FNP, Chair

Introduction

The Ad Hoc Multi-Organ Transplantation (MOT) Committee met via Citrix GoToMeeting teleconference on 08/10/2022 to discuss the following agenda items:

1. Match Run MOT Update
2. Proposed Changes to Liver-Kidney Allocation
3. Review Multi-Organ Policies

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

1. Match Run MOT Update

On July 22, 2022, a technical modification was implemented on the Heart, Lung, and Heart-Lung match runs to indicate when a candidate needs both a liver and a kidney. A visual cue was added to indicate to organ procurement organizations (OPOs) when they are required to share at least one of the additional organs (liver or kidney).

2. Proposed Changes to Liver-Kidney Allocation

The former Chair of the Liver and Intestine Transplantation Committee presented their proposed changes to simultaneous liver-kidney (SLK) allocation. The Liver Committee is requesting feedback from the MOT Committee prior to presenting the project to the Policy Oversight Committee (POC) for approval in September. The goal of this proposal is to expand the required shares from 250 nautical miles (nm) to 500 nm. The current policy only requires OPOs to offer both organs to patients who are 250 nm away and it is permissible to offer the organs to patients who are between 251-500 nm away.¹ This change would align SLK with the recent Board approved eligibility criteria for simultaneous heart-kidney (SHK) and simultaneous lung-kidney (SLuK) allocation.

Summary of discussion:

The Chair inquired about the impact of this policy change on areas with a high population density, such as the Northeast or Southeast. The presenter responded that the same principles and concerns of access apply across all geographies. The presenter was supportive of consistency across kidney MOT combinations to aid in both patient and OPO understanding of the policies.

A member asked if there was data showing the number of times when only livers were offered to patients between 251-500 nm away when they met the eligibility criteria to receive both organs. This question was getting at the behaviors of OPOs in allocating permissible shares to SLK patients at this distance. The presenter noted the challenge of locating data for instances that did not occur, which would require an immense manual analysis of organ offers. The presenter added that there are also

¹ OPTN Policy 9.9 Liver-Kidney Allocation.

other factors, like organ quality, that may impact a transplant center's decision to turn down an offer as well.

A member shared their experience suggesting that in most cases the OPOs will allocate these permissible SLK shares but opined that the OPO should not have the discretion to decide whether a patient receives the organ offer or not. Additionally, the member considered that this policy will likely stabilize behaviors that vary regionally by making these shares required instead of permissible.

A member asked if the Liver Committee had data on the number of liver patients between 251-500 nm who receive a kidney from the safety net. The presenter suggested that in most cases the transplant hospital would likely pass on the liver-alone offer and wait to receive a SLK offer to best meet the needs of their patient.

A few members voiced support for consistency across the kidney MOT policies, noting that this discrepancy was identified when developing the SHK and SLuK policy but the modification to SLK was out of scope for that proposal. However, the member noted that there are times when kidney-alone patients ought to take priority over MOT patients and suggested developing criteria for priority kidney-alone patients. Additionally, the member suggested developing proposals that would reduce the challenges associated with receiving a final organ acceptance in order to reduce kidney discard rates.

3. Review Multi-Organ Policies

The Chair reviewed the existing MOT policies and highlighted the required kidney MOT shares. The Chair identified gaps in the existing policies, specifically with regards to how OPOs should work through offering various organs off of different match runs. The Chair introduced a variety of options the Committee could opt to pursue.

Summary of discussion:

With ongoing references to OPO discretion, a patient on the Committee inquired how OPOs decide what order to allocate organs in and if allocation behaviors were specific and distinct between different OPOs. Members with OPO experience shared their processes for making these decisions, which ultimately results in high-level discussions by individuals with medical expertise, such as the medical director. A member noted that an ongoing challenge is determining who the right versus left kidneys will be allocated to. The ultimate consensus was that coordinators are not the ones left to make these challenging decisions, but instead they occur in a collaborative manner with high-level, qualified individuals.

Consolidate multi-organ policies to clarify workflow

A member encouraged the Committee to develop a resolution that would allow flexibility not to violate a policy by failing to offer a required share MOT due to a late turn down of a single organ. The member urged that increasing utilization and decreasing organ discard need to be at the forefront of allocation policies to balance equity with efficiency. Members also shared concern about situations where the offers they have accepted are retracted after patients have arrived at the hospital and prepared for surgery. A member compared this issue to situations where a donor who has been declared dead by cardiac criteria (DCD) transitions to brain death and the match is re-run and allocated elsewhere. Both of these scenarios have organ offers retracted and depict the transplant centers in a poor light to their patients.

The Chair suggested that the Committee address the issues described previously within MOT policies and establish a binding definition of when an organ is accepted. The Chair suggested that this definition could help to address the issue between DCD and brain dead donors and the impact on heart allocation.

Establish required shares for kidney candidates

A member suggested developing a dynamic match run that guided the coordinator through it and provided indicators for when it was time to move to the next match run.

“Priority tier” match run

A member inquired if the priority match would indicate which kidney-alone patients had priority over MOT candidates. The Chair responded that characteristics for kidney-alone patients who have been identified as being a priority share would be placed on this match run and shared the example of pediatric patients with a 100% CPRA. The Committee would have to decide, for example, if a status 1A liver-kidney candidate or a status 1 heart-kidney patient is more medically urgent, and who should be offered the kidney first.

Members discussed how to approach identifying priority shares and agreed that the framework should be developed by this Committee and involve the appropriate stakeholders. The group identified a few patient types that should always have priority: 100% CPRA pediatric kidney candidates, 100% CPRA adult kidney candidates, 100% CPRA Kidney-Pancreas adult or pediatric patients. A representative from HRSA shared that the Kidney Committee developed a workgroup to identify medically urgent kidney patients and encouraged the MOT Committee to work collaboratively with the Kidney Committee to consider the work they have already done on this topic.

A member questioned what the end goal of this proposal would be, considering how the organs are transitioning to continuous distribution and adding additional match runs may further complicate allocation. The member suggested that the current issue is that there are multiple match runs and OPOs are unable to clearly navigate them so the resolution may not be adding additional match runs. A member added that since each organ-specific committee is developing its own continuous distribution allocation framework, it is not being calibrated in a manner that the composite allocation score (CAS) for one organ type is comparable to another organ type.

A member suggested developing a technology tool that would indicate where to allocate next from the donor. This would be a technology change that could guide coordinators to which match run is next, as opposed to making a policy revision. A member suggested looking for any data on waitlist mortality and mortality rates for different MOT combinations. The Chair suggested looking at mortality data for pediatric patients with high CPRA as well.

Upcoming Meetings

- September 14, 2022
- October 12, 2022
- November 9, 2022
- December 14, 2022

Attendance

- **Committee Members**
 - Chris Curran
 - Jennifer Prinz
 - Jim Sharrock
 - Keren Ladin
 - Lisa Stocks
 - Marie Budev
 - Rachel Engen
 - Sandra Amaral
 - Shelley Hall
 - Vince Casingal
- **HRSA Representatives**
 - Adriana Martinez
 - Jim Bowman
 - Marilyn Levi
- **SRTR Staff**
 - Bryn Thompson
 - Jon Snyder
 - Jonathan Miller
- **UNOS Staff**
 - Ben Wolford
 - Erin Schnellinger
 - Holly Sobczak
 - Kaitlin Swanner
 - Kimberly Uccellini
 - Krissy Laurie
 - Laura Schmitt
 - Lindsay Larkin
 - Matt Belton
 - Matt Cafarella
 - Rebecca Fitz Marino
 - Ross Walton
- **Other Attendees**
 - James Trotter