OPTN Kidney Transplantation Committee Meeting
Expedited Placement Workgroup
Meeting Summary
May 15, 2025
Conference Call
Chandrasekar Santhanakrishnan, MD, Chair

Introduction

The Expedited Placement Workgroup met via WebEx on May 15, 2025, to discuss the following agenda items:

1. Welcome and Recap
2. Discussion: Managing Expedited Offer Filters at the Candidate Level

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

1. Welcome and Recap.

No decisions were made.

The Chair welcomed the Workgroup and remarked that the goal of this meeting is come to a consensus on opt out models and patient education, particularly the decisions that transplant programs would be making around expedited offers to inform what other tools may be needed.

The Workgroup reviewed a brief recap of candidate opt-in and out-out discussions. In December, the Workgroup initially supported a candidate opt-in functionality, so that candidates for whom expedited placement offers may not be suitable do not receive them. This would allow programs to make an intentional decision on an individual basis. The Data Advisory Committee reviewed this potential data element and was interested in receiving more details about the logistics of the proposal before endorsing. In March, the Workgroup discussed concerns with this approach, and determined that program-level filters may be adequate. In April, the Workgroup reiterated the need to manage the volume of expedited offers, and suggested exploring an approach similar to the functionality for expedited liver. The Workgroup had mixed feedback on whether candidates should default to opt in or opt out on implementation.

Summary of discussion:

There were no questions or comments.

2. Discussion: Managing Expedited Offer Filters at the Candidate Level

The Workgroup provided feedback about how to manage offer volume, with consideration for candidate characteristics, donor characteristics, and transplant program acceptance criteria.

Current tools provide flexibility for decisions based on donor characteristics, candidate characteristics, and transplant program acceptance criteria. The candidate record allows programs to vary donor acceptance criteria for individual candidates. Programs can also set listing defaults so that program acceptance criteria are applied to new candidate records. The update utility allows acceptance criteria to be updated for the entire waiting list. Typically, donor acceptance criteria screens candidate from the match run at time of match.

Offer filters are generally applied at the program level. Model identified filters are generated by the Offer Filters Model, and a program may choose to exclude certain candidate types or turn off the model identified filters. Program identified filters are created by the program, and can be modified by the program or exclude certain candidate types. Offer filters are generally applied each time an Organ Procurement Organization (OPO)

Under expedited placement, new expedited placement offer filters would be generated using the Offer Filters Model base don the "hard to place" donor cohort, and the program can choose to exclude certain candidate types so that they still receive offers.

Summary of discussion:

There were no questions or comments.

Recap: Expedited Offers and Simultaneous Evaluation.

Kidneys going through the expedited placement pathway will have some combination of the following characteristics:

- Donor meets at least two of the following clinical characteristics of "hard to place"
    - Donor history of hypertension greater than 5 years
    - Donor history of diabetes greater than 5 years
    - Donor age greater than or equal to 60 years
    - Donation after circulatory death (DCD)
    - Biopsy with glomerulosclerosis greater than 10 percent for both kidneys
- Or, six hours of cold ischemic time have accrued

Transplant programs can use existing donor acceptance criteria to screen candidates from some of these matches, and use offer filters to be bypassed for some of these offers. For example, programs can set a minimum and maximum donor age. A program may also use offer filters aligning with expedited placement initiation criteria and exclude candidates based on the exclusion criteria.

Within expedited placement, transplant programs can choose not to respond in simultaneous evaluation if they do not have any potential recipients (PTRs) who would accept the kidney, or if they do not have the resources to evaluate expedited offers at that time. Expedited offers may also appear differently in the system so that transplant programs can better prioritize and triage if necessary.

Data Review:

The most common combination of "hard to place" characteristics for deceased kidney donors recovered in 2023 include:

1. DCD and age 60 or greater (N = 469, 11.3 percent of donors with 2 or more characteristics)
2. DCD and greater than 10 percent glomerulosclerosis (N = 464, 11.2 percent)
3. Greater than 10 percent glomerulosclerosis and age 60 or greater (N = 388, 9.4 percent)
4. DCD and hypertension greater than 5 years (N = 375, 9.0 percent)
5. DCD, greater than 10 percent glomerulosclerosis, and age 60 or greater (N = 287, 6.9 percent)

32.69 percent of transplants in 2024 would have met the proposed expedited placement initiation criteria (N = 6,379 of 19,512 total transplants in 2024). In breaking this down by KDPI, the proportion of transplants meeting criteria for expedited placement increases as the Kidney Donor Profile Index (KDPI) increases. Particularly, 47.92 percent of transplants for KDPI 51-85 percent donors qualified for expedited placement. 79.35 percent of transplants for KDPI 86-100 percent donors qualified for

expedited placement. It was noted that these higher KDPI donors are not necessarily meeting more clinical criteria, but are meeting expedited placement criteria by cold ischemic time.

The vast majority of transplants that qualified for expedited placement went to adults, regardless of whether they were allocated in or out of sequence.

In looking at the average number of programs that are filtered per match for qualifying donors, regardless of where model parameters are set, expedited placement filters will filter off an additional 5 transplant programs. This estimate is conservative, because it only considers a program to be filtered if *all* candidates at the program are filtered off.

The expedited placement filters did not disproportionately filter candidates based on age, sensitization level, race/ethnicity, or sex. Mostly all unfiltered offers are going to adult candidates, which is similarly true of offers filtered by standard, expedited, and both filters.

Summary of discussion:

The Workgroup supported receiving feedback on tooling to support candidate-level filtering, allowing programs to opt candidates in or out of receiving expedited placement offers overall and based on a combination of distance from the donor hospital and cold ischemic time.

OPTN contractor staff asked the Workgroup if additional tools will be necessary to help manage expedited placement offer volume. If so, at what level would these decisions be made? At the program level, would you not want to see any offers based on certain donor characteristics, and what characteristics would be of interest? At the candidate level, would you not want to see expedited offers for candidates with certain characteristics, and what candidate characteristics would be of interest? Would that decision change over time based on candidate preferences and circumstances?

One member asked how many additional candidates would be filtered on the match. OPTN contractor staff explained that analysis was not done. The member remarked that 5 center is not a significant number of centers, and may not be effective enough to dramatically improve efficiency. OPTN contractor staff noted that this analysis considers a program as filtered only if *all* candidates at the program are filtered, and so the filtering may actually impact a much larger number of candidates.

A member asked if the data can be used to create a ratio, such that for every 14 candidates that are unfiltered, there are about 10 candidates that are filtered by the standard and expedited placement filters. The member noted that this could be applied to a larger group of organ offers to emphasize the impact to the match run. OPTN Contractor staff noted that it would be programs, not candidates. The member remarked that while 5 programs does not seem like many, that's 5 programs in a cohort of 25, which is a small analysis. OPTN contractor staff clarified that this model looked at 1 and 2 years of matches, and the data evaluated filtering using the average number of programs offered to before final acceptance, which was around 30. This analysis may vary for matches where acceptance happens earlier or later than average.

Staff asked, for programs who are not filtered by expedited placement or standard filters, if additional tooling will be necessary to manage offer volume. Specifically, if there are candidates who may not be willing to accept expedited offers and what their characteristics may be.

One member offered that it would be helpful to filter based on cold ischemic time in combination with nautical mile distance, with consideration for where the candidate lives. The member explained that their program has a number of candidates that live outside of the state, who may not be able to accept expedited offers due to travel time to the program. The member continued that their program is

typically able to accept offers for candidates that live within four or five hours of the transplant center, because these candidates are able to arrive quickly enough to ensure safe transplant and reduced ischemic time. The member explained that travel time is a big deal for out of state candidates, and that it is important to be sure that the organ is acceptable if the candidate does travel a great distance. This means that late review of biopsy slides is less feasible, due to larger logistical challenges.

A member remarked that patient willingness plays a critical role; transplant programs evaluating their patients will need to determine whether each candidate is willing to consider organs that are having difficulty being placed. The member noted that this is especially true for programs participating in IOTA. The member noted that there are a lot of reasons that an organ may require expedited allocation, but ideally the older patients with less waiting time will express willingness to accept these organs due to relative quality of life and survival benefit. The member continued that it is important to know patient willingness ahead of receiving the offer to avoid last minute declines and related inefficiency. Another member shared that their program counsels patients about the different types of offers, and noted that 40 percent of the offers their program receives come from outside of the geographic region.

One member remarked that some programs may benefit from a standard education or materials, but noted that written consent may be too large of a requirement. Another member noted that a full informed consent could have unintended consequences, and create unnecessary paperwork in a process aimed at efficiency. The member explained that, for many new patients who are overwhelmed with the process, this informed consent process for high KDPI kidneys – or hard to place kidneys – can be additionally overwhelming. The member explained that these patients are overwhelmed and often have limited understanding of the overall process, and the process of informed consent can make these organs seem disproportionately risky to accept. Another member agreed, and noted that it is important to help patients understand that organs offered through expedited placement may be suitable and beneficial organs for transplant. One member also noted that many patients are also not appropriate candidates for expedited placement offers, and it may be helpful to have a way to differentiate on the waitlist. The member continued that it is important to move efficiently, especially late at night, and that it is helpful to pre-identify which patients are appropriate and willing to receive these offers. The member added that this could help reduce cold ischemic time.

OPTN contractor staff shared data on the percent of offers filtered and not filtered. Utilizing the 1 year training cohort, the expedited placement offer filters will filter a little less than a third (31.6-33.6 percent, depending on donor evidence threshold) of offers, while the combined will filter off about 19 percent of offers.

A member remarked that this will be more efficient, as long as centers utilize these filters and the expedited placement process is structured such that this efficiency is maximized. The member explained that program variation also has an impact, particularly program preparedness to receive these offers and whether programs have candidates for whom such offers are appropriate. The member noted that it is important for programs to evaluate their lists prior to receiving these offers to determine which candidates should receive expedited offers and which candidates are not appropriate potential recipients for these offers. Another member agreed. The member remarked that programs need to have a plan and be prepared to receive these expedited offers and ensure patients are informed and willing. The member continued that additional tools to support programs in this endeavor would be helpful, particularly in pre-identifying which candidates may be an appropriate match.

The Chair referenced liver expedited placement, specifically the candidate opt-in element. The Chair supported a candidate opt-in for kidney expedited placement, noting that this would additionally improve efficiency and ensure expedited offers are made to patients who are appropriate matches.

OPTN contractor staff explained that programs may opt candidates into receiving expedited liver offers individually on the candidate record. This could be similarly recreated to opt candidates in or out of receiving expedited liver offers that their program may qualify for, based on acceptance based model-generated filters. OPTN contractor staff noted that something could also be constructed at the program level, such that programs could exclude themselves from receiving expedited offers with specific cold ischemic time or from greater distances.

One member remarked that having more tools to filter recipient characteristics would be helpful or transplant centers, particularly because the filters are so specific to donor characteristics. The member noted that this would increase flexibility and efficiency, as the program could help programs filter patients who may not be appropriate to receive these offers, such as patients not yet on dialysis. The member explained that this would additionally provide transparency and standardization for programs and patients as well. The Chair noted that the Workgroup could develop a list of candidate factors and characteristics. A member agreed, and noted that programs could check both the donor and candidate characteristics to improve their expedited placement filtering and make the process more efficient.

One member remarked that the OPTN waitlist system is somewhat limited in capturing candidate characteristics, citing specifically that candidate estimated glomerular filtration rate is not captured, only how a candidate qualifies to accrue waiting time. The member explained that candidates may not be on dialysis but still appropriate to consider expedited placement offers, particularly if they have low eGFRs. The member continued that candidate characteristic filtering may be outside of the scope of this project, and that it may be necessary for programs to evaluate and opt candidates in on an individual basis. Other members agreed.

The Chair offered that additional filtering criteria could be simple, focusing on cold ischemic time and distance. The Chair noted that preemptive dialysis may not be a good criterion, specifically with concerns for data quality. The Chair remarked that kidney-specific characteristics would be more helpful, but these data points may not be collected in the OPTN computer system.

One member remarked that most programs are seeing candidates regularly, and thus have an opportunity to education and discuss management and transplant strategies with the patient. The member continued that patient eGFR, distance, and other factors can be discussed with the patient to make a binary decision on whether to opt in to receive expedited placement offers for more medically complex kidneys. The member continued that this complex decision making can be simplified in this candidate opt-in approach. The member remarked that this does not necessarily need to be a consent process, but programs should discuss these offers with patients. Another member agreed, supporting further that additional consent forms are not necessary to opt patients in. The member pointed out that there are standard consent and ample opportunities for patient consideration, refusal, acceptance, and consent in the offer evaluation, acceptance, and transplant process. Other members agreed.

The Chair summarized that expedited placement filters may simply operate using patient willingness to consider expedited placement offers and distance. The Chair remarked that distinct characteristics may not be necessary at the candidate level. The Chair noted that there could be filters at the program level for specific donor characteristics, and candidate level opt-in or opt-out.

OPTN contractor staff noted that based on the needs identified, it is possible to have a candidate-level opt-in functionality, and could develop a way for programs to manage offers by preventing some candidates from receiving offers based on a combination of distance and cold ischemic time. OPTN contractor staff asked if distance and cold ischemic time screening would vary based on whether the donor was brain dead or DCD. One member noted that distance and cold ischemic time would not vary based on brain death or DCD donor, but mostly speak to the logistics, specifically transportation time

and cold ischemic time at arrival. The member continued that this is helpful on a candidate level, particularly when considering patients who live a distance from the transplant hospital. The member explained that it is helpful to ensure the candidate receiving the offer can be admitted early, with completed labs, to reduce delays – especially for kidneys with high cold ischemic times.

A member expressed concerns about structuring expedited kidney the way expedited liver is structured. The member shared that currently, programs with candidates opted in put in provisional yes responses without reviewing the offer. The member expressed concerns for programs becoming overwhelmed with the number of offers and not adequately reviewing offers, thus slowing down the process and preventing success of expedited placement. The member continued that this problem could be exacerbated in transplant-program dense regions of the country. The member added that there should be clear criteria and requirements.

One member recommended monitoring metrics and data on program performance, to ensure that programs do not opt in to receive expedited placement offers without ever accepting them. The member noted that it is important to ensure expedited placement tools are utilized effectively in order to ensure success. A member agreed, expressed support for including such a structure in the expedited placement proposal. The member added that programs will need to understand this process from implementation, and opt their program and candidates in or out accordingly.

OPTN contractor staff noted that the Workgroup previously supported mandatory kidney expedited placement offer filters, but shared that OPTN Kidney Committee leadership expressed concern with programs having the opportunity to demonstrate changing acceptance practices. It was suggested to include a process where programs who have not accepted any expedited kidney offers in a 6 month period have their expedited placement filters automatically applied. The Kidney Committee will discuss this more next week. Another member agreed that there should be a way for programs to demonstrate changing acceptance behavior, particularly in the case of staffing changes.

With consideration for tools within the expedited placement process, the Workgroup noted that there are some candidates who will not want to see expedited placement offers, both overall and based on a combination of distance from donor hospital and cold ischemic time. The Workgroup supported tooling to accommodate this, as well as receiving additional public comment feedback. The Chair added that standard offer filters will also exist, allowing programs to modify their filters overall.

One member expressed support for including candidate demographics in monitoring for the kidney expedited placement policy, particularly in evaluating filtering and candidate opt-in. Other members agreed, noting that these tools should be applied fairly and with clear, clinical reasoning.

Upcoming Meeting(s)

- June 9, 2025, 3:00 ET

Attendance

- **Workgroup Members**
  - C.S. Krishnan
  - Carrie Jadlowiec
  - Micah Davis
  - Leigh Ann Burgess
  - Anja DiCesaro
  - Tania Houle
  - Jillian Woftowicz
  - Jim Kim
  - George Surratt
  - Jason Rolls
- **SRTR Staff**
  - Bryn Thompson
  - Jon Miller
  - Peter Stock
- **UNOS Staff**
  - Kaitlin Swanner
  - Carly Rhyne
  - Thomas Dolan
  - Houlder Hudgins
  - Kayla Temple
  - Asma Ali
  - Carlos Martinez
  - Sarah Booker
  - Cass McCharen
  - Amelia Deveraux