OPTN Transplant Coordinators Committee
Meeting Summary
February 16, 2022
Conference Call

Stacy McKean, RN, Chair
Natalie Santiago-Blackwell, RN, MSN, Vice Chair

Introduction

The Transplant Coordinators Committee (the Committee) met via Citrix GoToMeeting teleconference on 2/16/2022 to discuss the following agenda items:

1. Public Comment Item Presentations

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

1. Public Comment Item Presentations

The Committee received brief summaries on policy proposals currently undergoing public comment. The public comment cycle runs from January 27, 2022 through March 23, 2022. The sponsoring committees identified the Transplant Coordinators Committee as a potential area for targeted feedback.

Data summary:

The following proposals were presented to the Committee for feedback by representatives of the sponsoring committees:

- *Continuous Distribution of Kidneys and Pancreata Request for Feedback*
  - This proposal is a request for feedback on how one candidate attributes should be weighed against each other in the context of a candidate's kidney or pancreas composite allocation.
- *Reassess Inclusion of Race in Estimated Glomerular Filtration Rate (eGFR) Equation*
  - This proposal will require programs to calculate eGFR using an equation that does not use a black race variable. The proposal does not specify a certain equation to use.
- *Establish Minimum Kidney Donor Criteria to Require Biopsy and Standardize Kidney Biopsy Reporting and Data Collection*
  - These two proposals, jointly presented on by the Chair of the Kidney Committee, will, first, establish a set of criteria that detail when a kidney must be biopsied. Second, they will designate a standard format and set of criteria to report on procurement kidney biopsies.
- *Establish Eligibility Criteria and Safety Net for Heart-Kidney and Lung-Kidney Allocation*
  - This proposal will designate specific clinical requirements for when a kidney should be transplanted in conjunction with a heart or lung transplant. The criteria used will mirror the eligibility criteria used for safety net kidneys in simultaneous liver-kidney transplant.

- *Pediatric Candidate Pre-Transplant HIV, HBV, and HCV Testing*
    - This proposal will extend the timeline of when required Human Immunodeficiency virus (HIV), Hepatitis B virus (HBV), and Hepatitis C virus (HCV) must be performed to a 30 day window prior to transplant. This will impact candidates under the age of 11.
- *Ongoing Review of National Liver Review Board (NLRB) Diagnoses*
    - This proposal will update NLRB guidance documents on hepatocellular carcinoma (HCC), ischemic cholangiopathy, and polycystic liver disease.

The full proposals, as well as the kidney and pancreata Analytic Hierarchy Process (AHP) exercise, can be found in the public comment section on the OPTN website.

Summary of discussion:

- *Continuous Distribution of Kidneys and Pancreata Request for Feedback*

  A member inquired whether individuals not involved in transplant would understand the use or medical need for some choices (e.g. safety net kidney). The presenter, the Chair of the Kidney Committee, noted that a description of each choice accompanies the options. A second member then asked whether different weights were given to dialysis candidates in comparison to non-dialysis candidates. Currently, the presenter noted, due to continuous distribution mirroring the existing system, there is not. A third member suggested that the Kidney Committee could consider weighting time spent active on the list differently than inactive on the list. A fourth member asked if there were plans to weight the DR Haplotype match differently than the highly sensitized match. The presenter said they could take this consideration back to their committee for review. It was also suggested that the composite allocation score should continue to be easily available to programs, similar to how easily accessible kidney scores are, such that programs can prepare their highest ranked candidates pre-emptively for transplant.

- *Reassess Inclusion of Race in Estimated Glomerular Filtration Rate (eGFR) Equation*

  A member supported the proposal, noting that it leveled the playing field for everybody. Additionally they suggested this could also protect donors whose eGFR was underestimated. Another member added that this could spur more programs to independently calculate eGFR rather than relying exclusively on their testing laboratory. It was also noted that labs should assess their own calculators to ensure there is not an "automatically built in" black race variable. It was proposed that a calculator could be added to UNet, which would calculate based off the provided data in the system. The presenter noted the Kidney Committee considered this, but rejected it due to formulas constantly being updated, as well as a desire to not be prescriptive in their policy. A member inquired whether there was any consideration given to allowing programs to retroactively examine their listings for black candidates and provide them additional wait time if their eGFR was found to be incorrect. The presenter replied that the Kidney Committee had considered this a number of times, but could not find a way to accurately pin down when to backdate wait time to. A member expressed concern that programs could have experience pushback if disadvantaged candidates are not receiving compensation for the time they missed on the waitlist due to inaccurate eGFR assessment. The Vice Chair proposed

the idea of the Committee producing a guidance document to develop best practice policies when adopting a race-neutral eGFR formula.

- *Establish Minimum Kidney Donor Criteria to Require Biopsy and Standardize Kidney Biopsy Reporting and Data Collection*

  A member suggested that there could be an unintended increase in cold ischemic time due to pathology now being required, but unavailable at certain facilities. In addition, it may slow down operating room (OR) timings if a biopsy has to be done on procurement. To the first suggestion, the presenter noted that the accepting center does not have to wait until the data for the biopsy has returned before accepting the organ. The presenter also responded saying that the proposal does not stipulate when the procurement biopsy must be done, so it could be done after the conclusion of the OR. The Chair noted that there could be an increase in costs for organ procurement organizations (OPOs) as some organizations would be required to send out slides and support documents to external pathologists each time due to pathology unavailability at some recovery facilities. Furthermore, there could be a need for staff training on preparing biopsy slides. Finally, they suggested that there could still be inconsistency amongst biopsy reads, as it is still different pathologists reading the slides. The Chair also inquired what would happen if an accepting program did not want a biopsy, but met the minimum criteria – in this case, would a test be required exclusively for data collection purposes? The presenter replied that, from the data they gathered, it is more frequent an occurrence that biopsies are requested and refused, rather than not needed but performed regardless. However, they did add that they would bring this scenario back to their committee for consideration. Finally, they Chair asked whether this process would increase efficiency in instances where a re-biopsy is performed by the accepting center, due to not trusting the initial biopsy. They suggested this could be an opportunity for education, as the way to reduce repeat biopsies is to create a trust in the practices between programs. A member suggested that, in addition to the required reporting, there could also be a required sharing of slides in cases when pathology is completely unavailable to biopsy a kidney that would be required by the policy. This would help alleviate the burden on programs where there is a heavy reliance on external pathology.

- *Establish Eligibility Criteria and Safety Net for Heart-Kidney and Lung-Kidney Allocation*

  A member supported the proposal, noting that it will be easier to understand than current policy, and mimicking existing simultaneous liver kidney (SLK) policy further increases that understanding. A member also inquired what the Heart Committee's feedback was on 30 mL/min as an appropriate eGFR to qualify for simultaneous heart kidney (SHK). Staff responded that the Heart Committee had reviewed a consensus conference from 2019 which recommended a threshold of 30-44 mL/min, but felt that up to 44mL/min was too high. A member asked how kidneys will be prioritized for the first year following heart transplant, as SHKs tends to pull kidneys more frequently than isolated kidneys, but some candidates will have need for a kidney transplant due to their previous heart transplant. This was supported by a second member who added that heart transplant patients are more likely to become sensitized following transplant than liver candidates, making them more difficult to find a kidney for. They identified this as a notable difference between existing SLK policy and proposed SHK policy. Staff

responded that this situation was considered by the histocompatibility committee, but ultimately they felt that sensitization should not be a basis for allocation. They did note that they would take this feedback back to the histocompatibility committee for reconsideration.

- *Pediatric Candidate Pre-Transplant HIV, HBV, and HCV Testing*

  A member wondered why age 11 was chosen as the cut off for the policy, rather than 12, which mimics the PELD score cutoff. In addition, they also asked whether the Committee had considered using weight rather than age as their metric. The presenter responded that their Committee had evaluated the data surrounding weight in relation to age, and that roughly correlated to age 11. Furthermore, they added that age 11 was where risk of HIV, HBV, and HCV still remained very low. It was also suggested that the policy should refer to a candidate's age at transplant, rather than their age at waitlisting, as there could theoretically be a period of years in between the two. Another member also posed the question of whether there were any plans in place to re-test candidates who currently had that significant period of time in between their evaluation and transplant. The presenter noted again that, based off of the data, a change in risk status was still very unlikely for candidates under 11. The Committee was in favor of grandfathering in patients under the policy so they would not have to have repeat testing. It was also proposed that the policy might benefit from not stipulating a timeframe for when serologic testing was needed, based off the low likelihood of a donor's risk status changing within that age group. The presenter responded they would return this feedback to the committee.

- *Ongoing Review of National Liver Review Board (NLRB) Diagnoses*

  A member inquired whether, with the proposed changes, ischemic cholangiopathy would have a higher score than any hepatocellular carcinoma diagnosis. The presenter confirmed this, noting that the case count of ischemic cholangiopathy was exceedingly low. A second member supported the proposal, adding that it would also likely increase the number of patients willing to accept a DCD graft. Additionally, they complimented the proposal for addressing the confusing existing language within NLRB exceptions. Finally, they supported the elimination of the 6 month waiting period, hoping that it would encourage programs to use local and regional therapies available to treat the HCC.

Next steps:

Presenting committee members will return feedback to their committees for consideration.

Upcoming Meeting

- March 16, 2022

Attendance

- **Committee Members**
    - Stacy McKean
    - Natalie Santiago-Blackwell
    - Donna Campbell
    - Jill Campbell
    - Lisa Gallagher
    - Rosa Guajardo
    - Sharon Klarman
    - Angele Lacks
    - Kelsey McCauley
    - Jamie Myers
    - Melissa Walker
    - Rachel White
- **HRSA Representatives**
    - Vanessa Arriola
    - Raelene Skerda
- **SRTR Staff**
- **UNOS Staff**
    - Matthew Cafarella
    - Cole Fox
    - Isaac Hager
    - Robert Hunter
    - Lindsay Larkin
    - Courtney Jett
    - Elizabeth Miller
    - Laura Schmitt
    - Kaitlin Swanner
    - Kayla Temple
    - Susan Tlusty
    - Ross Walton
- **Other Attendees**
    - Lara Danziger-Isakov
    - Martha Pavlakis
    - James Trotter