OPTN Ad Hoc Multi-Organ Transplantation Committee
Meeting Summary
February 12, 2025
Conference Call

Lisa Stocks, RN, MSN, FNP, Chair
Zoe Stewart Lewis, MD, PhD, MPH, FACS, Chair

Introduction

The OPTN Ad Hoc Multi-Organ Transplantation Committee (the Committee) met via WebEx teleconference on 02/12/2025 to discuss the following agenda items:

1. Welcome and updates
2. Potential revisions to multi-organ eligibility criteria
3. Identify any further data needed for policy proposal
4. Simultaneous Liver-Kidney one year monitoring report
5. Open forum

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

1. Welcome and updates

The Committee was informed about shifts of the regional meetings to virtual format, requiring a change to the breakout discussions for the committee's request for feedback.[1] The Committee was reminded about the upcoming in-person meeting date and location.

The Committee was updated on the additional allocation table that a small group will develop for DCD donors aged 18+ with KDPI of 35-85%. The Committee received an overview of the agenda for the meeting.

No decisions were made.

2. Potential revisions to multi-organ eligibility criteria

The Committee reviewed the current eligibility criteria policy and discussed potential revisions. The Committee focused on heart-lung, heart-liver, heart-kidney, lung-liver, lung-kidney, liver-kidney.

Data summary:

- Eligibility criteria determines whether secondary organ(s) would follow the primary organ
  - Satisfying eligibility criteria means that a multi-organ candidate may receive a multi-organ offer; it does not impact priority, it is a minimum requirement
- Current OPTN policy includes medical eligibility criteria for some multi-organ combinations
  - Criteria for multi-organ-kidney combinations address both the primary organ and the kidney (including GFR/CrCl thresholds and diagnosis)

[1] https://optn.transplant.hrsa.gov/policies-bylaws/public-comment/establish-comprehensive-multi-organ-allocation-policy/

    - Criteria for other organs as secondary organs (e.g. heart-lung, lung-liver) is typically based on the candidate's need for the primary organ

The Committee considered the following considerations:

- Should there by criteria for some/all primary organs to "pull" other organs?
- Should there be criteria for some/all secondary organs to follow primary organs?
- Should criteria for multi-organ offers be consistent across organ types or is variation needed?
    - E.g. should the criteria for hearts pulling lungs be the same as for hearts pulling livers?
    - Note: Simultaneous Liver-Kidney (SLK) has different criteria for kidney vs. Simultaneous Heart-Kidney (SHK) and Simultaneous Lung-Kidney (SLuK)
- Potential elements of criteria:
    - Status or score
    - Active status
    - Distance

The Committee was asked to review the following options in their deliberations:

- Liberal approach/promote MOT (subject to availability) – no minimum requirements for heart-lung, heart-liver, and lung-liver offers from the heart, lung, or liver matches
- More conservative approach – minimum requirements for primary organs to pull other organs
- Restrictive approach – minimum requirements for both primary and secondary organs

Summary of discussion:

No decisions were made.

The Co-Chair sought clarity on whether the Committee is making recommendations to other organ-specific committees on policy changes or introducing possible changes as the MOT Committee. A member offered that the Lung-MOT Workgroup examined some of these potential changes at a recent meeting, with heart and liver representatives, and requested additional data to support decision making. The member advised that having each organ-specific group develop the standards could be preferable.

The current criteria for heart-liver and lung liver was presented to the Committee. For hearts to pull livers as a secondary organ the candidate must be Adult Heart Status 1, 2, or 3 and within 500 nautical miles (NM) OR any active pediatric status candidate. For lungs to pull livers, the lung candidate must have a lung allocation score (LAS) score of 25 or greater. It was noted that there are no restrictions on livers following hearts and lungs. The committee discussed potential need for criteria for livers pulling lungs and hearts, as current policy is silent on this matter.

OPTN Contractor Staff then addressed the criteria for heart-liver transplants, noting that while there are criteria for hearts pulling livers, there are none for livers pulling hearts. The Committee discussed the possibility of developing restrictions for this scenario, reviewing whether a more liberal or restrictive approach should be taken.

A member raised a question about the order of allocations, suggesting that most heart allocations occur before liver allocations, which would mean that high-acuity livers pulling hearts would only happen after the highest acuity hearts and lungs had been allocated. Staff confirmed that the proposed allocation tables put Liver Classification 1 at the top of the allocation tables, followed by the highest priority heart classifications, making it possible for high-status livers to pull hearts.

The Co-Chair added that, if the tables were adopted, it would be unlikely for a Status 3 heart to pull a liver, aligning with current policy. It was noted that exceptions might be needed for rare cases where a high MELD patient with a lower heart status needed both organs.

Another member emphasized the need for policy around these rare scenarios to prevent confusion, even if they are infrequent. A member suggested potential creation of a national MOT review board to adjust points for multi-organ patients, which other members supported, noting that exceptions are already being submitted to meet CAS requirements for multi-organ lung offers.

Staff then reviewed the current criteria for heart, lung and liver pulling kidneys. They noted that there are requirements for the primary organs (hearts, lungs, and livers) and restrictions on the kidney needed to go along with those organs. The committee was asked whether these criteria should be revised as part of the upcoming policy proposal or if they are working well as they are.

A Co-Chair expressed concern about rushing the process to fit the upcoming policy proposal, emphasizing the need for due diligence. One member agreed, noting that further data was needed for a more granular understanding, particularly with heart and lung transplants.

A Co-Chair raised a question about the ability to rewrite existing policy and the need to work with individual organ committees. Staff agreed, stating that it would be prudent to work closely with the home committees.

Staff explained that the liver-kidney policy predated the existence of the MOT committee, while the heart-kidney and lung-kidney criteria were developed by the committee and reviewed by the heart and lung committees. A member questioned the need to revise the liver criteria, suggesting that the focus should be on the other criteria being reviewed.

Another member highlighted the difference between the committee's holistic view and the individual organ committees' focus on their own organs. They suggested considering the impact on KDPI for some combinations, like liver-kidney with elevated creatinine.

One member emphasized the need to identify areas where existing policy and the proposal might contradict or create confusion. Staff suggested assessing whether current policy should be incorporated into the upcoming policy proposal and developing policy where current policy is silent, for example, for heart-liver and lung-liver offers from the liver match.

A member suggested that this issue might be more relevant to the liver committee and emphasized the need to avoid opening the door to massive changes. The Chair proposed breaking the issue into smaller parts, with subcommittees addressing specific areas. Another member noted that the lung committee's MOT subcommittee includes liver representation, so they could work on it together.

Next steps:

The Committee will continue to consider incorporating current eligibility criteria and developing criteria where current policy is silent.

3. Identify any further data needed for policy proposal

The Committee discussed whether further data is needed for the final policy proposal.

Data summary:

Staff discussed the final opportunity to gather data for the Committee, emphasizing the need to ensure all necessary data is collected and reviewed. They highlighted existing requests, including data for 18+ DCD donors with KDPI 35 to 85%, and examining multi-organ recipients not covered by current allocation tables.

Staff introduced an additional potential data request to understand how frequently organs would be allocated within the proposed tables versus how often additional organs would be left for OPOs to place. They highlighted that the current tables cover about 50 allocation classifications, with 400 total, and the need to consider the impact on the whole system, not just multi-organ donors and candidates.

Staff discussed the pros and cons of this potential data request. The potential benefits include facilitating a more comprehensive view of anticipated project impact and identifying whether additional classifications should be incorporated into the allocation tables. A potential challenge is that this is a large request and there will not be a lot of time to discuss and make adjustments based on the results, prior to the Summer 2025 public comment period.

The committee was asked to consider whether this data would be valuable or if there were other priorities for the final data request.

Summary of discussion:

The Committee agreed to add the additional data request.

A Co-Chair voiced support for this, highlighting that OPOs would likely be very interested in this information. Other members agreed with this approach.

Next steps:

Staff will draft the final data request for leadership's approval.

4. Simultaneous Liver-Kidney one-year monitoring report

The Committee heard the SLK one-year monitoring report from Contractor staff.

Data summary:

OPTN Contractor Staff presented the one-year monitoring report on the expanded required simultaneous liver-kidney (SLK) allocation policy. The policy expanded the required share radius for SLK offers from 250 to 500 nautical miles (NM), aiming to improve equity and access to transplantation for SLK candidates. The policy did not change medical requirements but expanded the geographic threshold for required SLK offers.

The monitoring report compared data from one year before and after the policy implementation. Key findings included:

- A slight increase in the number of SLK registrations from 2,156 pre-policy to 2,175 post-policy.
- A slight increase in SLK registrations removed due to death or being too sick to transplant.
- A slight decrease in the number of SLK transplants from 816 pre-policy to 788 post-policy.
- Consistent distribution of allocation MELD/PELD scores.
- An increase in SLK transplants from donors with a KDPI of 35% or greater and from DCD donors.
- No significant change in the median distance between donor and transplant hospitals despite the expanded geographic threshold.

Overall, the policy achieved its goal of expanding the geographic threshold without significantly impacting the number of SLK transplants or access to kidney-alone or kidney-pancreas transplants.

Summary of discussion:

No decisions were made.

The Co-Chair noted that there were no significant changes observed. A member inquired about regional and geographic data on transplants. Staff confirmed that the full report included regional impact data, noting increases in SLK transplants in regions 4, 9, 10, and 11, and decreases in other regions. A Co-Chair recalled that the policy aimed to address practices by some OPOs in the center of the country that weren't allocating past 250 miles. They noted increases in regions 7 and 11. The Co-Chair queried whether there were unintended consequences the Committee needed to review. Staff confirmed that no unintended consequences were flagged, and the conclusions were similar to the 6-moth monitoring report.

Next steps:

None at this time.

5. Open forum

There were no open forum requests from the public for this meeting. A Co-Chair asked if committee members had any additional topics to discuss.

Summary of discussion:

There were no additional topics to discuss.

Upcoming Meetings

- February 26, 2025
- March 12, 2025

Attendance

- **Committee Members**
  - Lisa Stocks, Co-Chair
  - Zoe Stewart Lewis, Co-Chair
  - Marie Budev
  - Vincent Casingal
  - Rachel Engen
  - Jonathan Fridell
  - Jim Kim
  - Precious McCowan
  - Sharyn Sawczak
  - Nicole Turgeon
- **SRTR Staff**
  - Avery Cook
  - Jon Miller
- **UNOS Staff**
  - Sarah Booker
  - Houlder Hudgins
  - Sara Langham
  - Kelsi Lindblad
  - Sarah Roache
  - Kaitlin Swanner
  - Susan Tlusty
  - Stryker-Ann Vosteen
  - Ross Walton
  - Ben Wolford