OPTN Ad Hoc Multi-Organ Transplantation Committee
Meeting Summary
October 11, 2023
Conference Call

Lisa Stocks, RN, MSN, FNP, Chair

Introduction

The Ad Hoc Multi-Organ Transplantation (MOT) Committee, the Committee, met via WebEx teleconference on 10/11/2023 to discuss the following agenda items:

1. Simultaneous Heart-Kidney (SHK) and Simultaneous Lung-Kidney (SLuK) Check-In
2. Review of 9/13/2023 MOT Committee Meeting
3. Efficiency Task Force Overview
4. Discussion: Priorities for Public Comment

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

1. Simultaneous Heart-Kidney (SHK) and Simultaneous Lung-Kidney (SLuK) Check-In

The Committee reviewed the SHK/SLuK policies that were recently implemented on 9/28/2023.

Presentation summary:

- Eligibility criteria for simultaneous heart-kidney and lung-kidney allocation implemented on 9/28
- OPTN staff completed outreach ahead of implementation to heart & lung transplant programs with candidates missing data

Summary of discussion:

The Committee did not make any decisions; however, they did discuss feedback relating to the implementation of the safety net policy.

The Chair of the Committee highlighted the positive aspect of not having received any reports of issues with the implemented policy as it indicated the safety net was working as intended. A member shared feedback from her community, noting the success of the safety net system, where patients were getting transplants within a week to two weeks. The Chair acknowledged that this success wasn't as frequently reported for liver safety nets.

2. Review of 9/13/2023 MOT Committee Meeting

The Chair provided a review of the Committee's discussion during their 9/13/2023 meeting.

Presentation summary:

- Support for increased focus on efficiency
- Noted challenges with lung MOT allocation delaying liver, kidney allocation
- Consider where multi-visceral transplant fits in with other MOT
- Need to determine clear order of operations across match runs so that can be indicated in the system

- Consider impact on kidney pancreas (KP), kidney alone, pediatric kidney alone
    - Interest in combining KP and KI on one match run
    - Consider limits on kidney MOT allocation based on Kidney Donor Profile Index (KDPI)

Summary of discussion:

The Committee did not make any decisions and they did not discuss this item further.

3. Efficiency Task Force Overview

OPTN contractor staff provided additional details about the OPTN Taskforce on Efficiency and presented on attaining efficiency in allocation.

Presentation summary:

- There is a lack of efficiency in allocation which is leading to an unacceptable level of organ non-use
- Taskforce key responsibilities:
    - Evaluate existing data and recommendation regarding system challenges and improvements
    - Engage directly and frequently with the community to obtain data, feedback, and suggestions
    - Prioritize which issues to address, and recommend both short-term improvements and long-term strategies to address larger challenges
    - Frequently update the Executive Committee and Board of Directors
- Taskforce intends to create a roster of approximately 30 appointees inclusive of pediatric representation
- The goal is for the committees to work within its scope and support the taskforce through review of relevant policy and data collection projects and providing input as needed

Summary of discussion:

The Committee did not make any decisions; however, a member did express support for the task force.

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The Chair of the Committee expressed her excitement regarding the work that the task force aims to undertake. She emphasizes the need to improve efficiency within the system and encouraged the group to start brainstorming.

4. Discussion: Priorities for Public Comment

The Committee discussed the various topics that may be included in the January 2024 cycle for public comment.

Presentation summary:

Public Comment:

- In previous meetings, the Committee suggested sending out a request for feedback in January 2024 that is more focused on efficiency. Content could include:
    - Highlights from data reviewed by the Committee over the last year

    - Summary of Committee's discussions
    - More detailed, potential options for streamlining allocation
- The group's overall goal would be to give Organ Procurement Organizations (OPOs) more direction that would improve efficiency and avoid holding organs.

Previous Allocation Idea:

- Committee discussed that for 0-34% KDPI kidneys, one kidney would go to MOT or KP, and one kidney would go to pediatric or adult kidney-alone candidate
- It is estimated that this would shift 130-160 kidneys from MOT/KP candidates to kidney-alone candidates

Summary of discussion:

Decision #1: The Committee decided to propose policy language that specifies organs cannot be held as a backup for a potential MOT candidate if an offer has been accepted and the OR is scheduled. In addition, policy language would specify that bypassing MOT candidates in these cases would not be considered allocation out of sequence.

Decision #2: The group decided to ask for public comment for a concept statement that would raise the lung CAS threshold above 25. In addition, they would like to explore adding an MOT attribute in lung continuous distribution for the future.

Decision #3: The Committee decided to ask for public comment for a concept statement that would allocate one kidney to MOT candidates and the other to kidney-pancreas (KP) or kidney alone candidates for 0-34% KDPI kidneys.

Decision #1: The Committee decided to propose policy language that specifies organs cannot be held as a backup for a potential MOT candidate if an offer has been accepted and the OR is scheduled. In addition, policy language would specify that bypassing MOT candidates in these cases would not be considered allocation out of sequence.

The Chair questioned whether heart multi-organ policies were delaying the allocation of other organs. Members agreed that it was not causing delays except for cases where kidneys are being held back because the backup is a heart-kidney candidate. A member added that they would like to see a public comment proposal or discussion that establishes a two-to-four-hour window prior to the OR in which organ offers stand. This suggestion works toward creating efficiency in allocation to the transplantation community.

The Committee proposed a policy that would stipulate "Once primary offers are accepted and the OR is scheduled, the OPO should proceed with the allocation of remaining organs. Once those remaining organs are offered, the offer is binding and cannot be retracted for a MOT backup. Bypassing a MOT candidate due to previous placement of a single organ is not considered allocation out of sequence." Members stated that it is important to outline that OPOs will not be subject to a penalty for allocating accordingly.

The Chair asked the Committee if they had any knowledge of concerns being raised around current heart-lung allocation. A member stated that they had specific concerns about the process of lung allocation, particularly holding the liver until placement of the lung.

Decision #2: The group decided to ask for public comment for a concept statement that would raise the lung CAS threshold above 25. In addition, they would like to explore adding an MOT attribute in lung continuous distribution for the future.

The group discussed various potential approaches for modifying lung MOT. They explored options such as raising the lung Composite Allocation Score (CAS) threshold above 25, incorporating an MOT attribute in lung CAS to elevate lung MOT candidates in the match run, or stipulating offers to high-urgency liver candidates before lung-liver candidates. It was suggested that lung-liver candidates should be prioritized for urgent status, possibly by adjusting their position on the list, to ensure efficient organ utilization and to prevent delays.

Members proposed re-evaluating the priority of lung-liver patients on the list, especially focusing on the mortality rates of these candidates. Some suggested implementing an MOT attribute in lung CAS, like other organs, to boost the candidates' positions in the match run. However, concerns were raised regarding this approach due to the absence of defined qualifications and policy for thoracic-liver combinations. This could potentially cause unease in the community if points were awarded without such qualifications. While creating this attribute was seen as a viable long-term solution, it was acknowledged to be a time-consuming process.

The group suggested and agreed that raising the lung CAS threshold above 25 would best address the issue at hand. This option would provide for proper allocation to the sickest candidates and would also be a more immediate solution. Members also discussed the role of OPOs and their decision-making process regarding how far down the lung list they should proceed before offering organs to liver patients. The group stated that defining a specific point down the match run that OPOs must go to prior to allocating to liver alone patients might be valuable to include in public comment.

Decision #3: The Committee decided to ask for public comment for a concept statement that would allocate one kidney to MOT candidates and the other to kidney-pancreas (KP) or kidney alone candidates for 0-34% KDPI kidneys.

The Committee was asked whether the initial proposal to allocate one kidney to MOT or KP and one to pediatric or adult kidney alone candidates was sufficient for public comment feedback. A pediatric representative stated that while this scheme would only move around 130-160 kidneys, it would greatly benefit pediatric patients as it has the potential to transplant 10% of pediatric patients waiting on the list.

A few members disagreed and argued that this proposal should not go out for public comment. They stated that this allocation scheme would disadvantage KPs as they would not get the priority they need and would be less competitive. Therefore, the Committee decided to revise their initial proposal to group KP with the kidney alone candidates. They believed that this would be a better option as it would still provide KP with the priority they require and would still shift kidneys toward the kidney alone list.

A Committee member commented that if this does go to public comment, it would be important to consider how many kidneys would be allocated to KPs instead of pediatric candidates on the kidney alone list. OPTN contractor staff indicated that initial estimates reveal that around 63, 0-34% KDPI kidneys would be available to kidney or KP candidates; however, a specific breakdown is required to determine what the split would look like between KP and pediatric patients.

An individual added that it would be important to include a stipulation in which OPOs would only have to allocate down to KPs to a certain point on the list. He mentioned that ambiguity in this area can lead to OPOs allocating too far down, thus causing delays and efficiency concerns.

Considering that the group has been debating this topic for a while, they have decided to send a concept statement regarding allocating one kidney to MOT and one kidney to KP or kidney alone for 0-34% KDPI kidneys for public comment. This proposal is not meant to change the entire allocation system.

However, it is intended to provide direction to OPOs as well as address concerns with allocation to those candidates closer to the top of the list.

Next steps:

Prior to the next Committee meeting, OPTN contractor staff will draft public comment documents and distribute these to the group. The Committee will then provide feedback and edits to discuss at the November meeting.

Upcoming Meeting(s)

- November 8, 2023

Attendance

- **Committee Members**
  - Lisa Stocks
  - Sandra Amaral
  - Vincent Casingal
  - Chris Curran
  - Rachel Engen
  - Jonathan Fridell
  - Shelley Hall
  - Heather Miller Webb
  - Oyedolamu Olaitan
  - Jennifer Prinz
  - Nicole Turgeon
- **HRSA Representatives**
  - Marilyn Levi
- **SRTR Staff**
  - Katherine Audette
- **UNOS Staff**
  - Robert Hunter
  - Kaitlin Swanner
  - Jenna Reformina
  - James Alcorn
  - Julia Foutz
  - Jessica Higgins
  - Sara Langham
  - Krissy Laurie
  - Taylor Livelli
  - Jon Miller
  - Laura Schmitt
  - Susan Tlusty
  - Ross Walton
  - Ben Wolford