

OPTN Ad Hoc Multi-Organ Transplantation Committee

Meeting Summary

March 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 03/12/2025 to discuss the following agenda items:

1. Welcome and updates
2. Allocation table for DCD adult donors with KDPI of 35-85%
3. Match re-runs
4. Eligibility for multi-organ offers

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

1. Welcome and updates

The Committee was advised that the in-person meeting will no longer be held in Detroit on April 4th. Instead, the Committee will meet virtually from 1:00-4:00pm Eastern time. A Co-Chair updated the Committee on feedback received thus far at regional meetings, highlighting that most feedback has been positive, with most feedback on priority of pediatric, kidney-pancreas, and multi-visceral candidates. Another member added they had received similar feedback during a regional meeting presentation.

A Co-Chair reminded the Committee that final decisions on the policy components will need to be made by mid-April to ensure all deadlines for Summer 2025 Public Comment are met.

2. Allocation table for DCD adult donors with KDPI of 35-85%

A small group of Committee members met and reviewed data to develop an allocation table for DCD adult donors with KDPI 35-85%.

Summary of presentation:

OPTN Contractor staff presented a table which is based on the allocation tables for DCD adult donors with KDPI of 0-34% and DBD adult donors with KDPI of 35-85%. The order of priority in the first half of the table aligns with the order in the table for DCD adult donors with KDPI of 0-34%. This table includes Kidney classifications 8-14 for consistency with the table for DBD adult donors with KDPI of 35-85%. The small group recommended, based on median appearance data, placing these classifications just below Kidney classification 7 and above the Liver classifications (starting with classification 6).

Summary of discussion:

The Committee agreed to include the draft table for DCD adult donors with KDPI of 35-85% in the upcoming policy proposal.

A small group member commented that the group had been satisfied with the outcome during the discussion and other Committee members agreed with the approach. The Co-Chair confirmed with members there was no disagreement with the approach.

Next steps:

The new table will be added for the policy proposal going out for summer public comment

3. Match re-runs

Staff presented on potential policy requirements for rerunning matches and multi-organ allocation tables.

Summary of presentation:

Staff provided an overview of the potential requirements and process:

Step 1: OPO runs matches that they expect to place organs on

Step 2: OPO indicates which matches they expect to place organs on (i.e., which matches should be included in the allocation plan)

Step 3: OPO initiates allocation plan

Step 4: System generates allocation plan

Step 5: System displays allocation plan

Staff discussed potential scenarios:

- Lungs are initially deemed not viable for transplant and OPO is pumping to see if they can improve
- Donor variables, such as KDPI, may change as allocation progresses

Staff presented potential requirements on re-running matches and allocation plans. If policy requires that a new match be run, then a new allocation plan must be run. If policy does not require that a new match be run, then the OPO could continue with the existing match and allocation plan or generate new ones. This approach ensures compliance with existing policies requiring match reruns, for example, when a donor transitions from DCD to DBD and does not place additional burdens on OPOs.

Summary of discussion:

A Co-Chair noted that some OPOs run kidney matches ahead of other organ matches to expedite kidney placement, suggesting that policy should not require OPOs to run all matches at the same time. Another member also highlighted that while kidney matches are often run earlier due to the availability of HLA (human leukocyte antigen) data, the timing of running other organ matches might vary based on donor evaluation status. For example, a lung match might be delayed if the lungs are initially deemed non-viable but are being re-evaluated for potential suitability.

Staff acknowledged this variability, suggesting that OPOs should strive to run matches for all organs at the same time to maintain consistency. They highlighted that the proposed policies would also allow flexibility in cases where some organs are not ready for allocation. This would ensure that OPOs can make decisions based on the most up-to-date information and manage any changes in organ viability or donor conditions. A co-Chair expressed their concerns about the feasibility of this approach, particularly in situations where the timing of organ readiness varies. They explained that, in practice, once the HLA for kidneys is back (often 48 hours before other organs are ready), OPOs would typically wait to run

liver, heart, and lung matches. If all organs are run at the same time but some are not ready, it could delay the allocation of kidneys, which are ready earlier, or risk violating the 8-hour OPTN policy for liver allocations. Another member also raised concerns about the potential for being out of compliance with the 8-hour policy if matches for abdominal organs (like the liver) were generated too early, before they are ready for allocation.

Another member raised a concern regarding the current allocation process for kidneys, particularly in multi-organ allocations. They highlighted that kidneys are often placed on backup status for multi-visceral organ transplants, and current policies don't resolve this issue effectively. Specifically, the member pointed out that kidney offers are often not finalized until shortly before the cross-clamp, leading to delays. They proposed an IT solution to address these challenges, suggesting the creation of a dynamic allocation list that updates in real time. This would allow OPOs to access up-to-date match information instantly. The member emphasized that a system solution should streamline the process for OPOs, making it easier for them to run all match runs with a single action, without needing to check and re-check the status of each organ. They offered that real-time updates would eliminate the need for back-and-forth adjustments and provide a more efficient approach to organ allocation, especially in urgent cases.

Staff provided further context by explaining that the team conducted a review of six different allocation scenarios and assessed the variables involved in each, such as KDPI, BMI, ABO, donor age, and whether the liver was being allocated with another organ. It was explained that changes to certain donor variables could change the allocation process. For instance, a donor with a 0-34% KDPI in the 18-69 age range could lead to 24-36 different allocation outcomes, depending on how those variables evolve.

The primary concern noted was ensuring consistency in allocation plans, especially when donor variables change, which could affect the match run. The team is working on a backend solution to manage these changes effectively while maintaining an accurate and updated allocation plan. The member reiterated that the solution must be practical for OPOs and stressed that OPOs should not be expected to retract offers once they've been made, especially if the donor's condition changes.

A Co-Chair expressed their support for this approach and sought further clarification on how the process would apply to specific organ matches. They asked if kidney, intestine, pancreas, and VCA (vascularized composite allograft) matches are run as soon as HLA data is available, even before multi-visceral allocations are confirmed, would a new allocation plan need to be run once a match run for thoracic organs and the liver is done.

Staff sought further clarification on how OPOs would typically handle such a process, as once organs are allocated, it is not permissible to retract an offer, but in the event organ availability changes during the running of a match run and allocation plan, the match run and allocation plan would need to be rerun to ensure organs are allocated appropriately. An example was provided that if an initial match was run without considering the lungs (because they were not deemed viable), and the liver was allocated first, then the lung match could later be added with a highly prioritized lung-liver candidate. In this case, the lung candidate would miss out on the multi-organ offer because the liver had already been placed. Pulling back the liver would be inconsistent with current policy, so instead, the lungs would be allocated to the highest priority candidate where the second organ is still available.

A Co-Chair pointed out that the premise of organ availability is defined in policy language, but this definition provides some flexibility, which OPOs need. They emphasized that flexibility is important to accommodate various situations that arise in organ placement. They also suggested that it might be helpful to solicit additional insight from the OPO Committee.

A member raised a question about the current inconsistencies in multi-organ allocation practices across different OPOs. They pointed out that the system lacks uniformity, and OPOs often adapt to circumstances in different ways. They asked what barriers exist to driving consistency in the allocation process and suggested that the OPO committee and colleagues could play a role in helping achieve this. A member advocated for a more standardized approach to organ allocation to ensure consistency between OPO practices and transplant centers. They emphasized the importance of building IT tools that support a consistent, simpler, and more efficient solution for multi-organ transplants across OPOs and transplant centers. A Co-Chair agreed, emphasizing that questions should be asked to pinpoint why there is such variability across OPOs and how standardization and efficiency can be introduced. Other members offered their agreement to this assessment as well. A member agreed, also highlighting that for some donors, the time-sensitive nature of the procurement can factor in the lack of standardization. They advocated sufficient flexibility to ensure no increase in organ non-use.

Staff asked for clarification on the process, particularly regarding the timing of kidney and thoracic organ match runs. They wanted to understand whether running a kidney match earlier than thoracic matches could result in kidneys being allocated to kidney-alone candidates and becoming unavailable for multi-organ candidates. They also inquired if removing the requirement to offer kidneys to multi-organ candidates before kidney-alone candidates would help address this issue. A Co-Chair clarified that once kidneys are allocated to multi-organ candidates, they are effectively unavailable for other candidates, as this allocation process can take time as recipients need to be found, cross matches need to be run, and transplant programs need to run samples. A member suggested that virtual cross-matching might help expedite the process in some cases. The Co-Chair added that the proposed policy changes regarding multi-organ kidney allocation would not necessarily impact the timing of the match runs but could improve how kidneys are allocated.

A member highlighted the growing frequency of expedited scenarios, where organs are allocated after certain conditions (like HLA or serology results) are met. They stressed the importance of having flexibility in such situations, where organs might be placed on machines, and allocation happens once all information is available. They urged that the focus be on addressing standard processes without penalizing those who pursue new options when circumstances evolve.

Staff suggested the Committee focus on a timepoint at which it would be appropriate to initiate an allocation plan. If something changes (e.g., a critical infection is identified), the allocation plan would need to be rerun to accommodate the new information. They proposed that the system should validate whether all organs fit into a unified allocation plan, with the example that a DCD match cannot be combined with a DBD match because they require different plans. This approach would help address the variability in the system and ensure the process runs smoothly.

The Co-Chair offered that policy language needs to be precise regarding this and further feedback will need to be received from the OPO Committee. A member emphasized that OPOs would likely support standardization as long as it didn't restrict their ability to make adjustments based on real-time circumstances.

Staff clarified for the group that while the use of IT enhancements might be optional, following the multi-organ allocation policy is mandatory. It was emphasized that policy language will need to be as explicit as possible in detailing what is required and mandatory of OPOs. This ensures that allocations are consistent with policy standards.

Next steps:

The Committee will seek additional feedback from the OPO Committee. Staff will continue exploring IT solutions to ensure consistency and ease in using the allocation tables developed by the Committee.

4. Eligibility criteria for multi-organ offers

This item was not discussed due to lack of 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 other topics to discuss.

Summary of discussion:

There were no other topics to discuss.

Upcoming Meetings

- April 4, 2025
- April 9, 2025

Attendance

- **Committee Members**
 - Lisa Stocks, Co-Chair
 - Vincent Casingal
 - Chris Curran
 - Rocky Daly
 - Jonathan Fridell
 - Shelley Hall
 - Jim Kim
 - Oyedolamu Olaitan
 - Deanna Santana
 - Chris Sonnenday
 - Nicole Turgeon
- **SRTR Staff**
 - Avery Cook
 - Jon Miller
- **UNOS Staff**
 - Houlder Hudgins
 - Sara Langham
 - Sarah Roache
 - Erin Schnellinger
 - Kaitlin Swanner
 - Stryker-Ann Vosteen
 - Ben Wolford