OPTN Kidney Transplantation Committee Meeting
Meeting Summary
July 28, 2025
Conference Call

Jim Kim, MD, Chair
Arpita Basu, MD, Vice Chair

Introduction

The Kidney Transplantation Committee met via WebEx on July 28, 2025 to discuss the following agenda items:

1. OPTN Update
2. Kidney Project Updates
3. Project Prioritization

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

1. OPTN Update

The Committee received an overview of OPTN updates.

Presentation summary:

Critical comments and HRSA directives are posted and available to be read on the OPTN website. The following HRSA directives are current:

- Normothermic Regional Perfusion (NRP)
  - HRSA directed the OPTN to develop a plan to propose policies, policy definitions, data collection, technical and quality standards, and standard practices that address patient safety for organ procurement organizations using NRP in patients from whom organs may be procured, and OPTN data collection regarding the attempted and/or successful use of NRP in patients from whom organs may be procured
- Donation after Circulatory Death (DCD) Policy:
  - HRSA directed the OPTN to develop policies to improve safeguards for potential DCD patients and increase information shared with patient families regarding DCD organ procurement
- Rabies Transmission
  - HRSA directed the OPTN to propose improvements to policy to reduce the risk of donor-derived rabies
- Allocation Out of Sequence (AOOS):
  - HRSA directed the OPTN to:
    - Establish an AOOS Workgroup, with representatives from across the OPTN Committees, associated RACI roles for Workgroup members
    - Establish an execution plan to include finalized task list for the first 90-day project phase, including:

- Evaluate member compliance in the aggregate by OPTN member and identify members with patterns and/or large volumes of AOOS. (Membership and Professional Standards Committee (MPSC))
- Send notices and/or direction to members to mitigate non-compliance. (MPSC)
- Send a notice to OPTN members highlighting applicable OPTN policies and definitions, including appropriate application of the wastage provision. (OPTN)
- Develop an administrative definition for the "offer" of an organ by an OPO to a transplant center, including minimum requirements for notification and information accuracy. (AOOS Work Group)
- Review OPTN policies for possible updates to the term “offer” and its related policies. (AOOS Work Group)

▪ Additional tasks are included in the directive and described in more detail on the OPTN website

The new OPTN Board of Directors began term on July 1, 2025. The new Board is comprised of individuals elected during the special election which concluded earlier in the spring. More information about the new Board is available on the OPTN website. During their meeting on June 9-10, the OPTN Board approved a resolution to discontinue non-critical meeting support for committees without active projects, exempting the Patient Affairs Committee (PAC), for the fourth quarter of the fiscal year 2025 (July, August, September). That includes the following committees: Vascularized Composite Allograft, Transplant Administrators, and International Relations.

HRSA issued the following directive (effective July 1) regarding policy work related to CD: *“As the OPTN undertakes actions to comply with HRSA’s directive on allocation out of sequence (AOOS)remediation, HRSA has determined it is both prudent and responsible to pause new policy work related to CD to ensure that new AOOS policies are effective and evidence-based and ensure fairness in the OPTN allocation system. Pausing all new work related to CD until the OPTN has addressed AOOS is a HRSA decision to ensure that when the OPTN makes a new allocation policy, it does so with transparency, robust, reliable data, and accountability to all patients the system is designed to serve.”* Based on this directive, all CD-related projects will be paused until further notice.

Summary of discussion:

One member asked who the Kidney Committee representatives are on the AOOS Workgroup, and it was clarified that the Chair and Vice Chair are representing the Kidney Committee on this Workgroup. The member expressed strong feelings about allocation out of sequence and volunteered to join the AOOS Workgroup.

A member expressed disappointment with the pause on Continuous Distribution, and noted that this work could continue while allocation out of sequence efforts are underway. The member added that continuous distribution is where the transplant community needs to go, and once implemented, will alleviate many of these other concerns. The member also volunteered to support the AOOS Workgroup.

The Chair thanked the Committee members for their work on Continuous Distribution and the Expedited Placement projects, noting that the Committee is still waiting to hear more feedback from HRSA. The Chair noted that the direction is unclear, but that HRSA has specific directives for Committees to focus on. The Chair added that though Continuous Distribution has been shelved for now, there are a number of components of the Continuous Distribution project that the Committee could pivot and focus on.

The Chair expressed gratitude for the Committee's comments, and noted the Committee's frustration, particularly since the Committee has been working to develop Continuous Distribution for quite some time. The Chair added that the Committee has a lot of other topics to direct attention to in the next few months.

One member asked about the Committee's work on the "hard to place" definition, noting that this could support the AOOS work.

2. Kidney Project Updates

The Committee reviewed the status of their active projects.

Presentation summary:

The Kidney Committee has the following active and outstanding projects:

- Kidney Continuous Distribution
    - Status: paused
- Kidney Expedited Placement
    - Status: not reviewed by the OPTN Policy Oversight Committee (POC) in preparation for public comment
        - POC Leadership notified to expect a letter from HRSA with more feedback
- Kidney Paired Donation (KPD): Align KPD Blood Type Matching and Establish Donor Re-Evaluation Requirements
    - Status: currently on track for implementation Fall 2025

Summary of discussion:

There were no questions or comments.

3. Project Prioritization

The Committee reviewed several project ideas that the Committee has previously considered and recommended.

Presentation summary:

Expanding the Role of Longevity Matching in Kidney Allocation

Currently, the top 20 percent KDPI kidneys are matched to top 20 percent EPTS candidates, categorically. Previously, the Kidney Committee heavily discussed expanding longevity matching in Continuous Distribution, but ultimately decided to maintain top 20 percent matching. The Committee cited potential inadequacies in KDPI and EPTS calculations within the whole range, and impacts to access for middle EPTS candidates.

This project could involve Massachusetts Institute of Technology (MIT) and Scientific Registry of Transplant Recipients (SRTR) resources. MIT previously explored several options for achieving this.

Update Estimated Post Transplant Survival (EPTS) and Kidney Donor Profile Index (KDPI) Calculations

Longevity matching conversations have given way to conversations on how to update KDPI and EPTS. KDPI was also recently updated to remove hepatitis C virus status and race. Alternative models for EPTS and KDPI have been explored in the literature.[1,2]

This project could also involve both SRTR and MIT resources.

Waiting Time Inversion

This concept is based on the idea that long-waiting time candidates will be highly prioritized on a greater number of match runs, and thus may be less likely to accept a "hard to place" organ. Candidates with extended dialysis times may be less compatible with more medically complex organs, due to dialysis related complications. This concept proposes to offer higher KDPI/"hard to place" kidneys to candidates with less qualifying time who maybe more medically appropriate due to less time on dialysis.

The Kidney Committee has mentioned and considered this briefly before, and the Expedited Placement Workgroup also briefly considered this as well. This concept was discussed in the Winter 2025 Kidney Continuous Distribution Update.[3]

Waiting Time Inversion was discussed in the American Society for Transplantation's Cutting Edge of Transplantation (CeoT) and in literature as a potential method to reduce non-use.[4,5]Potential benefit to reducing time on dialysis has also been cited in the literature. [6,7]

This project could require SRTR and MIT resources.

Increase Pediatric Priority for Donors Less than 18 Years Old with KDPI 35-85 Percent

The Kidney Committee originally had a pediatric priority expansion project that was folded into Continuous Distribution. In Continuous Distribution, the Committee planned to expand pediatric priority to include donors less than 18 years old with KDPI 35-85 percent. The community and the Committee have been supportive and expecting this change.

This project may require SRTR resources.

Re-Evaluate Requirements for Waiting Time Reinstatement Due to Primary Non-Function

The Committee has touched on this in previous discussions, noting increased use of more medically complex kidneys may result in greater incidence of early graft failure or non-function. This effort would evaluate primary non-function requirements, and consider the implications of expanding waiting time reinstatement opportunities for candidates who experience no or minimal graft function.

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[1] Van Walraven et al. "Predicting potential survival benefit of renal transplantation in patients withchronic kidney disease." CMAJ (2010)

[2] Senanayake, et al. "Development and validation of a risk index to predict kidney graft survival: thekidney transplant risk index." BMC Medical Research Methodology (2021)

[3] *Update on the Continuous Distribution of Kidneys, Winter 2025*, OPTN Kidney Transplantation Committee.

[4] Cooper M, "Regulatory and financial considerations that impact transplant center practice – whatchanges would increase transplantation." Cutting Edge of Transplantation presentation, 2018.

[5] Stewart et al, "Oversimplification and misplaced blame will not solve the complex kidneyunderutilization problem." Kidney360, 2022.

[6] Aufhauser et al (2018) – patients with greater time on dialysis prior to transplant had progressivelydecreased graft and patient survival

[7] Kadatz et al (2023) – Pre-emptively transplanted recipients of KDPI 86-100% kidneys have comparableoutcomes to dialyzed recipients of KDPI 51-84% kidneys

Expand Intended Incompatible Blood Type Matching to Allow O Candidates to Receive Offers from A, non-A1 Donors

The Committee recently received a recommendation from a member to consider expanding blood type intended incompatible matching to include A, non-A1 to O candidates. This type of matching is allowable in the OPTN KPD system currently.

Currently, blood type O and B patients have lower transplant rates compared to A and AB patients.[8]

Removal of the Kidney Minimum Acceptance Criteria Screening Tool (KiMAC) and National Kidney Allocation Requirements

The Kidney Committee originally planned to remove the National Kidney requirement with Continuous Distribution. This requirement states that OPOs must hand off allocation at the national level (outside of 250 nautical miles) to the Organ Center. This requirement exists due to the Organ Center's use of the KiMAC tool, which predates Offer Filtering. The KiMAC was reconsidered by the Utilization Considerations Workgroup and by the OPTN Operations and Safety Committee. The Utilization Considerations Workgroup initially paired it down significantly. Upon further review, the OPTN Operations and Safety Committee recommended removal of the KiMAC, noting the questionnaire is no longer as clinically relevant, and may provide more data burden than is necessary with Offer Filters in play.

Reconsider Pre-Emptive Kidney Transplant

Pre-emptive kidney transplant has been heavily discussed in literature and the community.[9] In 2022, NASEM's "Realizing the promise of equity in the Organ Transplantation System" (pg 131) recommended eliminating pre-dialysis waiting time.[10] In 2023, an article by Schold, Huml, Husain, and Mohan recommended addressing disparities in other ways, maintaining the benefits of delayed need for dialysis, reduced complication rates, lower mortality, and longer graft survival rates.[11]

Released Kidneys in Multi-Organ Combinations

The Vice Chair recommended investigating and evaluating how kidneys released from multi-organ combinations are re-allocated. This may intersect with an upcoming project from the Ad Hoc Multi-Organ Transplantation Committee to prioritize multi-organ and single organ allocation. This proposal will prioritize offers to certain kidney-along candidates prior to KP and multi-organ offers, the current released kidney policy still applies.

Open Call

The Committee was asked to share other thoughts and ideas.

Summary of discussion:

One member expressed support for reconfiguring EPTS and KDPI, noting that a lot of allocation is predicated on the need for a common measuring system. The member explained that the quality of the

[8] OPTN/SRTR 2023 Annual Data Report, Kidney.
[9] Kumar et al, "Kidney transplant does not offer any mortality benefits: a study of trends in pre-emptivekidney transplantation over the last two decades," 2025
[10] National Academies of Sciences, Engineering, and Medicine, *Realizing the Promise of Equity in the Organ Transplantation System*, 2022.
[11] Schold, Huml, Husain, and Mohan, "Why the academies got it wrong about changing pre-emptivewaiting time in kidney transplantation" (2023)

measuring system impacts the capability and capacity of the system. The member added improving KDPI and EPTS could reduce non-use by improving donor and recipient matching.

The member also noted a wide variety of organ acceptance behavior across the country, and noted that the OPTN Expeditious Task Force considered developing a collective definition of non-transplantable, utilizing a panel of surgeons and doctors for kidney, liver, heart, and lung. This would allow the community to develop a hypothetical consensus around expectations of what is transplantable and safe. The member explained that every clinicians has had their own training and formative experiences, and that it would make sense to try to develop a consensus around which donor offers are truly usable. The member added that this could be helpful guidance, though it may be out of scope for the Committee. The member added that community-wide education based on expert opinion would have a benefit in reducing the need to allocate organs out of sequence, especially if these organs were used more locally because local programs recognized the opportunity. The member added that OPOs would feel less pressured to ensure placement.

The Chair remarked that the Kidney Committee may have an advantage in coming further along in developing Continuous Distribution, and has thought through different iterations since first starting the project. Initially, the focus was to shift the system into a continuous distribution model, and then the goal posts shifted to improving the system. The Chair continued that the Committee has an opportunity to look at these components that are important in allocation, keeping in mind HRSA's directives. The member agreed that Continuous Distribution is a step in the right direction towards placing the right organs with the most appropriate candidate.

One member expressed support for removal of the national kidney requirement and the KiMAC, noting that OPOs would be able to allocate those organs more quickly without that requirement. The member continued that handing off allocation to the organ center is inefficient, and that their OPO can allocate more quickly.

The Chair remarked that it may also be important to manage the expectations of the larger transplant community. The Chair added that the Committee has heavily discussed patient education, particularly regarding different types of offers. The Chair remarked that there are a lot of complexities, and that not even all of the clinicians involved understand. The Chair added that being able to educate patients on these types of offers, especially medically complex organs and why they may be beneficial, would be helpful in the long run.

One member remarked that one of the IOTA requirements is that programs attest to or document education with patients pertaining to what sorts of donors and offers they are comfortable accepting. The member shared that their program is trying to develop a document to give to patients upon evaluation to talk through a list of donor types, including social risk factors, viral hepatitis, DCD, and another of other donor types. The member added that being able to educate patients ahead of receiving the offer can make receiving these offers easier, and makes for a more efficient process. The member added that this also allows programs to decline the offer in the first place if the patient is known not to be interested in that type of offer. The member continued that there is a challenge in the volume of information to be communicated to a patient, and that there is no guarantee that patients will read the medical education materials. The member concluded that it is important to give patients the knowledge they need without overwhelming them, and emphasized the importance of communicating what people need to know and what the opportunity cost of these organs versus remaining on dialysis. The member continued that it is important this education is accessible, understandable, and brief.

OPTN contractor staff asked if the education effort would be in alignment with pulling the education requirement out of the expedited placement proposal, so that the KDPI consent is replaced with

education requirements related to accepting “hard to place” and some high KDPI kidneys relative to risk on dialysis. One member agreed that this would take the place of that requirement. The member added this should be brief and informational, and allow the candidate to indicate the types of offers they are interested in accepting, allowing the candidate to update that information as they chose. The member noted that a patient’s thoughts and comfort level may change as they spend more time on dialysis, and so it is important that this information is always revisable. The member added that it is more of a guideline for the transplant program as opposed to a consent. The member emphasized the importance of transparency and patient education, and the challenge of communicating essential information to support shared decision making.

One member asked if any centers have done virtual education around this topic, noting this could be well suited for that formatting. The member added that this allows other family members to understand the information, even if they can’t attend the clinic visit. The member added that a candidate with other family members who are in healthcare but not necessarily transplant may know some information, but not necessarily enough. The member continued that virtual education could facilitate those family members to be more involved in the conversation. Another member agreed, noting that video-based is better than written documents. The member also agreed that it important to ensure patients and family members have a solid understanding, especially for those family members with health care experience but not necessarily transplant experience. Another member remarked that one pediatric program utilized an app to supports step-by-step education. A member agreed this would be helpful for younger patients.

The Chair remarked that including community nephrologists in education efforts is important, noting that these nephrologists play an important role in talking to their patients. The Chair shared that some nephrologists will take patients out of accepting a kidney, sharing an experience where a community nephrologist talked a patient out of accepting a pediatric en bloc kidney. The Chair explained that this required more conversation with the nephrologist. The Chair added that even those involved in transplant don’t necessarily have a well rounded understanding, particularly as the system is so complex. The Chair added that revamping KDPI and education could go hand in hand.

One member expressed appreciation for the call for ideas.

One member expressed support for re-evaluating requirements for waiting time reinstatement due to primary non-function.

A member expressed support for developing a definition of non-transplantable, noting that there is a lot of room for learning and growth even amongst trained transplant physicians and surgeons. The member shared an experience where one transplant surgeon declined to accept any higher KDPI offers, even for patients who were quite a bit older.

The Committee emphasized the following projects:

- Update EPTS and KDPI Calculations
- Re-Evaluate Requirements for Waiting Time Reinstatement Due to Primary Non-Function
- Removal of the KiMAC and National Kidney Allocation Requirements
- Develop Definition of Non-Transplantable
- Education on “Hard to Place” Kidneys

The Chair thanked the Committee for their time, and noted that the Committee will hopefully receive more direction from HRSA in the next few weeks. The Chair commented that the Committee has a number of topics to discuss in the future, even without Continuous Distribution.

Upcoming Meetings

- August 18, 2025

Attendance

- **Committee Members**
  - Jim Kim
  - Arpita Basu
  - Curtis Warfield
  - Eloise Salmon
  - Jason Rolls
  - John Lunz
  - Kristen Adams
  - Leigh Ann Burgess
  - Marc Melcher
  - Patrick Gee
  - Prince Anand
  - Tania Houle
  - Toni L. Bowling
- **SRTR Staff**
  - Bryn Thompson
  - Jodi Smith
  - Jon Miller
- **UNOS Staff**
  - Kayla Temple
  - Kaitlin Swanner
  - Keighly Bradbrook
  - Asma Ali
  - Cole Fox
  - Houlder Hudgins
  - Sarah Booker
  - Thomas Dolan