

**OPTN/UNOS Kidney Transplantation Committee  
Report to the Board of Directors  
November 14-15, 2011  
Atlanta, GA**

**Summary**

**I. Action Items for Board Consideration**

- None

**II. Other Significant Items**

- Ongoing Efforts to Revise the National Kidney Allocation System. (Item 1, Page 3)
- Review of Public Comment Proposals Regarding Evaluation, Consent and Follow-up of Living Donors. (Item 2, Page 7)
- Review of Proposed Revisions to and Reorganization of Policy 6.0 (Transplantation of Non-Resident Aliens). (Item 3, Page 8)
- Request to review effectiveness of kidney allocation for pediatric candidates. (Item 4, Page 9)
- Kidney Paired Donation Pilot Program Update. (Item 5, Page 9)
- Request from the Membership and Professional Standards Committee Regarding Living Donor Outcomes. (Item 6, Page 13)

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**OPTN/UNOS Kidney Transplantation Committee**  
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**John Friedewald, MD, Chair**  
**Richard Formica, MD, Vice Chair**

This report describes the Committee's deliberations during a conference call on August 26, 2011 and in person on September 19, 2011.

**1. Ongoing Efforts to Revise the National Kidney Allocation System**

The Committee met by teleconference in August to learn about recent developments regarding its work to develop a new national kidney allocation system. Jim Bowman, MD, from the Health Resources and Services Administration (HRSA) shared with the committee some concerns that the HRSA Division of Transplantation (DOT) had regarding the use of age matching in the concept document released in January 2011. After consulting with the HHS Office of General Counsel and HHS Office of Civil Rights HRSA expressed concern that the use of age matching as described in the document did not meet the requirements of the Age Discrimination Act of 1975. Dr. Bowman shared that according to the stipulations in the Act, age may be used if it is a proxy for medical variables. Therefore, the use of age in the calculation of estimated post transplant survival (EPTS) was not of concern because the evidence has shown that age is a suitable proxy for variables such as cardiovascular disease which are not available in the OPTN dataset. However, in the concept document, the use of age matching within 15 years appeared to be arbitrary in that candidates who are sixteen years older or younger than a donor are not substantially clinically different than those who have 14 years of age difference. The Age Discrimination Act restricts the use of age by facilities that receive federal funds. Based on the interpretation of the Act, transplant centers may be at risk of being sued for utilizing an allocation algorithm that incorporates age in the manner proposed.

Dr. Friedewald thanked Dr. Bowman for sharing this information with the Committee. Dr. Friedewald then asked the Committee members to consider ways in which the proposal could be modified to address the concerns presented. Prior to the September meeting, Committee members were asked to share potential ideas for revisions on the Committee's discussion board. A Committee member remarked that age matching was put forward as a possibility for kidney allocation because it allowed greater access for older candidates than other concepts considered. Another Committee member remarked that age matching was also chosen because it was easily understandable, a quality that has been demanded by the transplant community for any allocation system proposed. One Committee member asked if the Scientific Registry of Transplant Recipients (SRTR) could model ideas prior to the September meeting. While new modeling was not possible in the short time frame, the Committee was able to review previous models to better understand why some ideas were not pursued or put forth as proposals during the Committee's earlier work on this topic.

In September, Dr. Friedewald shared with the Committee that the President of the Organ Procurement and Transplantation Network (OPTN), Jack Lake, MD, had requested a proposal for consideration by the OPTN Board of Directors during its June 2012 meeting. Dr. Friedewald reminded the Committee that it had previously reviewed several policy alternatives to age matching and asked the Committee to consider whether any of those alternatives would be suitable for a proposal.

To frame the discussion, the Committee considered the limitations that it is seeking to address through revising the kidney allocation system. Mainly, these limitations are:

- higher than necessary discard rates of kidneys that could benefit candidates on the waiting list,
- variability in access to transplantation by candidate blood group and geographic location, and
- many kidneys with long potential longevity being allocated to candidates with significantly shorter potential longevity and vice versa. This results in unrealized graft years and unnecessarily high retransplant rates.

Through a new system, the Committee intends to achieve several objectives including:

- Better approximating graft longevity and recipient longevity so that the potential survival of every transplanted organ can be realized within biological reason and acceptable levels of access for those on the waiting list.
- Improving offer system efficiency and organ utilization through the introduction of a new scale for kidney quality, called the kidney donor profile index (KDPI).
- Making comprehensive data better available to patients and transplant programs to guide them in their renal replacement choices.
- Reducing differences in transplant access for populations described in the National Organ Transplant Act (e.g., candidates from racial/ethnic minority groups, pediatric candidates, and sensitized candidates).

The Committee determined that even without age matching, it had a solid foundation for a new allocation system through the inclusion of other existing elements. These elements include longevity matching, a sliding points scale for sensitized candidates, inclusion of the A2/A2B kidneys for B candidates rules, and allowing waiting time to begin from the start of dialysis.

The Committee then examined results from a prior simulation run that did not include age matching (**Exhibit A**). Run 37 used the current kidney allocation rules with a few modifications (use of dialysis time instead of waiting time and inclusion of the A2/A2B rules). Run 37 also included longevity matching for the 20% longest lived kidneys (as approximated by kidney donor profile index [KDPI]) which were allocated first to the 20% of candidates with the longest potential survival (as approximated by estimated post transplant survival [EPTS]).

The results from Run 37 indicate that the distributions would be similar to those currently observed for race/ethnicity, degree of HLA mismatch, and blood group. There was a slight decline observed in the proportion of transplants for highly sensitized candidates. Similar to other proposed approaches, the proportion of transplants for older candidates also declined, though not as substantially. A representative from the Ethics Committee remarked that this decline is ethically acceptable as everyone who is old had a chance to be young, but not everyone who is young will have the chance to be old. The Committee asked its HRSA representative if the decline in transplants for older candidates would constitute a legal problem. The representative stated that the proportion of transplants by age categories is not legally

problematic, the actual use of age as a non-medically justified bright line in an allocation system is. A member reminded the Committee that the simulation modeling did not take into account changes in acceptance behavior and that it was likely that the number of transplants in the older age categories would not change as much as behaviors changed under a new system. Another member remarked that the results indicate the need for increased efficiency in placement for kidneys with higher KDPI scores.

The Committee considered whether a system based on longevity matching would be acceptable to the public. Several members remarked that the age matching was put into place because the public had requested a simple system and the transplant community had requested predictability. There was concern that moving away from age matching would resurrect these prior objections of complexity and unpredictability. Other members pointed out that the primary complaint against the system proposed in the 2011 concept document was age discrimination. The Committee determined that by eliminating the age matching component, it could be responsive to the concerns about predictability and age discrimination by offering a system in which the majority of kidneys would be allocated according to the currently used allocation rules and only a small proportion would be allocated according to new rules. In this way, the Committee will be able to make relatively minor but important changes to the current system for all candidates (e.g., introducing a sliding scale for CPRA, initiating waiting time from the start of dialysis, and incorporating the A2/A2B rules) while testing out longevity matching on a relatively small proportion of candidates. If longevity matching works as intended, it could result in transplants that last longer, thereby lessening the demand for retransplants and slightly easing the demand for kidneys.

#### *Regional Sharing for Higher KDPI Kidneys*

The Committee discussed whether to modify allocation for kidneys with KDPI scores  $\geq 85\%$ . The concern is that these kidneys may not be offered widely enough or placed quickly enough to prevent discards. Currently, these kidneys are labeled as being from expanded criteria donors (ECD) and are offered only to those candidates who consent in advance to receive them. The Committee agreed to do a simulation run that would offer kidneys with KDPI scores  $\geq 85\%$  first regionally to those who consent to receive them. Similar to the current ECD allocation system, this simulation run would not include points for HLA-DR matching. By offering these kidneys regionally first, the Committee is addressing the issue of geographic disparities in kidney transplantation. For example, this system would make available those kidneys that would be discarded in one OPO due to shorter waiting times but utilized in a neighboring OPO with longer waiting times.

Members of the Committee discussed ways outside of the allocation system to increase utilization of kidneys from donors with higher KDPI scores. For instance, one member suggested that kidneys with high KDPI scores should be excluded from the program specific reports. In this way, the penalty for transplanting higher KDPI kidneys is removed and utilization would subsequently improve. Some members remarked that the manner in which centers are evaluated by third party payers has more to do with access for older candidates than any proposed allocation system.

#### *Details Regarding the Sliding CPRA Scale*

Darren Stewart, MS, UNOS Biostatistician, presented his findings from the data analysis requested by the Committee during its March 2011 meeting (**Exhibit B**). The Committee was interested in determining how to establish a sliding scale for sensitization points. This analysis was intended to guide the

Committee on both the starting point for the sliding scale and the slope. The Committee suspected that the relationship between sensitization and access to compatible kidneys was not linear. This analysis was also requested to determine the break point where candidates may require more than additional points to achieve equitable access.

Mr. Stewart shared the results of the analysis (**Exhibit C**). As of the end of 2010, nearly two-thirds of kidney candidates were reported as being non-sensitized (CPRA=0%), but about 11% were “very highly sensitized,” with a CPRA of 95% or higher. Though about 5% of candidates had CPRA of 100%, this group accounted for less than 1% of the transplants.

Demographically, candidates who were younger, female, and African American tended to have a higher likelihood of being very highly sensitized (CPRA $\geq$ 95%). There was only a weak relationship between blood type and CPRA, with types O and B having a slightly higher chance of being highly sensitized.

Offer rates decreased substantially as CPRA increased, though the data showed an artificial spike in offer rates for candidates with CPRA just over 80%, presumably due to the four allocation points awarded to candidates with CPRA $\geq$ 80%. On average, non-sensitized patients received about 17 offers per year, while fully sensitized (CPRA=100%) patients received only 0.09 offers per year, a 187-fold difference, in spite of the four-point advantage. If not for the additional priority given to sensitized candidates for zero-antigen mismatches, it appears that the decrease in offer rates would be even more dramatic for those with CPRA approaching and equal to 100%.

Though there are some similarities, transplant rates showed a somewhat different pattern as a function of CPRA than did offer rates. As CPRA increased from 0% to around 60%, transplant rates held constant at around 200 transplants per 1,000 patient-years, in spite of the steady decline in the offer rate. As CPRA increased beyond 60%, transplant rates decreased moderately up to a CPRA of 79%. When CPRA reached 80%, the transplant rate increased dramatically, more than doubling the rate of non-sensitized or moderately sensitized candidates, in spite of the fact that the offer rates for the CPRA=80-84 group were still substantially lower than for the non-sensitized and moderately sensitized groups.

When offers and transplants from donors outside of a +/-15 year window around the candidate’s age were excluded, both the offer rates and transplant rates showed a roughly 50% decrease across all CPRA groups, suggesting that such a policy would not have a disproportionate impact on the highly sensitized patients. However, even though the relative impact was roughly constant as a function of CPRA, the impact on the absolute number of days until the next offer was much greater for very highly sensitized candidates. Lastly, 0.7% of kidney offers were refused due to positive crossmatch. This rate was higher for offers to highly sensitized candidates, zero-mismatch offers, and local offers.

The Committee thanked Mr. Stewart for his work and reviewed recommendations from the Histocompatibility Committee presented by the Chair of that Committee, Nancy Reinsmoen, PhD (**Exhibit D**). Since sensitized patients cannot receive kidneys from all donors due to their immunological response, Dr. Reinsmoen requested that sensitized patients be exempt from any restrictions placed on the donor pool. Restricting offers by age (+/-15 years) or by longevity matching (EPTS 20%) would have a disproportionate adverse effect on sensitized candidates. The Committee agreed and discussed ways to broaden the donor pool for sensitized candidates. Based on the data analysis presented by Mr. Stewart, the Committee determined that very highly sensitized candidates (i.e., those with CPRA  $\geq$ 98%) are most

in need of a separate category that supersedes all other categories since their likelihood of receiving an acceptable offer is so remote.

Dr. Reinsmoen then presented the Histocompatibility Committee's recommendation to use the offer rate ratios for the 40-49, 50-59, and 60-69% CPRA groups to model the feasibility of a sliding scale starting at each group. The Committee agreed that points should be made more biologically relevant. The current point assignment of four points for CPRA $\geq$ 80% has been shown to be arbitrary and result in an artificial boost for candidates with CPRA $\geq$ 80%, resulting in a higher transplant rate for these candidates than those who are still very sensitized but do not receive any additional priority. The Committee agreed, based on the time to offer analysis (**Exhibit E**) that candidates with extreme sensitization (i.e., CPRA $\geq$ 98%) may require 75 or more points to achieve similar waiting times to their unsensitized counterparts.

Dr. Reinsmoen also presented a request for the Kidney Committee to develop an alternative system with broader sharing regions for these patients. In this alternative system, transplant programs would be required to upload all anti-HLA antibody specificities. The Kidney Committee is currently working with the Pediatric and Histocompatibility Committees to develop such a program for pediatric candidates. Eileen Brewer, MD, from the Pediatric Committee provided an update on its work to develop such an alternative system. Currently, 23% of pediatric patients have a CPRA  $\geq$ 80%. For these highly sensitized pediatric candidates, the rate of transplantation within one year of listing is estimated at only 1.6%. The Pediatric Committee plans to present an alternative system that focuses on regional sharing to broaden the donor pool for these candidates. To avoid situations where kidneys are shipped and then found to have a positive crossmatch, HLA-DP typing would be required for donated kidneys offered through this system and transplant programs would be required to upload all of the unacceptable antigens for all participating candidates.

#### *Inclusion of Points for HLA-DR Matching*

The Committee has previously debated whether to include points for HLA-DR matching. The evidence suggests that well-matched grafts results in lower sensitization levels for repeat transplants. Some Committee members did not believe that this benefit was substantial enough to warrant the decrease in predictability in time to transplant associated with these allocation points. Ultimately, the Committee decided that since the survival benefit was most important for recipients who are likely to require a second or third transplant, the points would only be given for kidneys with a KDPI score  $<$ 85%. The Committee voted to include points for HLA-DR matching (15 in favor, 3 opposed, 2 abstentions) for all kidneys in one simulation run and for kidneys with KDPI scores  $<$ 85% in the expedited placement simulation run.

## **2. Review of Public Comment Proposals Regarding Evaluation, Consent and Follow-up of Living Donors**

Christie Thomas, MD and Matt Cooper, MD from the Living Donor Committee presented three proposals related to the consent, medical evaluation and follow-up of living donors. These proposals were brought forward at the request of the Health Resources and Services Administration (HRSA) and were based

substantially on the joint work of representatives from the American Society of Transplant Surgeons (ASTS), the American Society of Transplantation (AST), and NATCO.

The Committee reviewed the proposals and offered feedback on each. Regarding the consent proposal, members of the Committee were concerned with the requirement that living donors must understand the mortality risk of the recipient. Some on the Committee asked how this understanding would be evaluated and the acceptable mechanisms for communicating mortality risk. Dr. Thomas explained that the Living Donor Committee was requesting a best attempt based on either center or national data. The Committee expressed that this requirement was overly prescriptive and vague and should be re-examined by the Living Donor Committee. Additionally, members of the Committee asked how this requirement could be met within Kidney Paired Donation (KPD) programs. With KPD, the recipient is not known at the time of donor evaluation or consent, so communicating mortality risk for the recipient is not possible at these time points.

For the medical evaluation proposal, the Committee asked for clarification regarding evaluation requirements for conditions such as cancer. For example, would a dermatology consult be required to rule out skin cancer, or could the evaluating transplant physician conduct these examinations? Additionally, the Committee asked about the appropriate time points for evaluations. The proposed policy does not set a timeframe, yet several on the Committee expressed that it would be inappropriate to use a cardiology evaluation from five years prior as part of a donor's medical evaluation. The Committee suggests that the Living Donor Committee provide some timeframes in the proposed policies.

Due to time constraints, the Committee agreed to review the follow-up proposal during a subsequent meeting.

### **3. Review of Proposed Revisions to and Reorganization of Policy 6.0 (Transplantation of Non-Resident Aliens)**

Peter Reese, MD, Vice Chair of the Ethics Committee, and Gabriel Danovitch, MD, Chair of the Ad hoc International Relations Committee presented a joint proposal regarding Policy 6.0 (Transplantation of Non-resident Aliens). This proposal clarifies the data collected about the citizenship and residency of donors and recipients. The proposal also amends the audit trigger policy, allowing the Ad Hoc International Relations Committee to review the circumstances of any transplant of non-US residents/non-US citizens and make a public report.

The Committee carefully considered the proposal. One member stated that the proposal was necessary because public trust in the system is so essential to its proper functioning, Transplantation of non US citizens has garnered the attention of the American public in recent years. While the Committee was appreciative of the proposals attempt to make transplantation of non-resident aliens more transparent, it did not issue a formal vote of support and will continue to consider this issue in subsequent meetings.

#### 4. Request to review effectiveness of kidney allocation for pediatric candidates

Steve Almond, MD, of Driscoll Children’s Hospital in Texas, asked the Committee to review the pediatric transplant rates at his center and in his OPO (**Exhibit F**). Dr. Almond was concerned that waiting times were increasing for pediatric candidates and that factors such as multi-organ transplants, especially simultaneous liver-kidney, and kidney-pancreas, were contributing to the increase. The Committee reviewed the analysis but was not convinced by the data that pediatric waiting times had increased since the implementation of Share 35. The Committee found that time since listing for pediatric candidates was not a robust metric because many pediatric candidates are listed and then inactivated until their disease has progressed. The Committee suggested looking at active versus inactive time, the time from listing to first offer, and the number of turndowns to better assess the situation. The Committee also expressed concern that the data presented were based on eleven pediatric candidates and that these eleven candidates were then stratified into age brackets.

Dr. Brewer, from the Pediatric Committee, remarked that a number of factors may contribute to longer waiting times for pediatric candidates. Among these, there has been a decline in the number of living donors. While the Committee was not convinced by the analysis that pediatric waiting times had increased substantially since the implementation of Share 35, it did remark that the pediatric situation may improve through a few of the initiatives of the kidney allocation system revision. Among these, kidneys with KDPI scores <35% will be allocated preferentially to pediatric candidates. Currently, the threshold is based on donor age. By changing over to a KDPI based threshold, the Committee believes that pediatric candidates will have access to higher quality organs.

#### 5. Kidney Paired Donation Pilot Program Update

Dr. Friedewald presented the recent update from the Kidney Paired Donation Pilot Program (KPDPP) and shared the results from the August 2011 and September 2011 match runs (below).

Participants included in the match
149 candidates
158 total donors
4 NDDs (1 blood type O, 2 blood type B, 1 blood type AB)
42 centers from 11 regions had at least one eligible pair.
Results
20 candidates from 7 regions matched
Chain with 12 links (1 NDD, 11 pairs, and 1 waiting list candidate)
Two 3-ways and one 2-way
7 highly sensitized candidates matched

Participants included in the match
129 candidates
139 total donors
4 NDDs (3 blood type B, 1 blood type AB)
39 centers from 11 regions had at least one eligible pair.
Results
8 candidates from 5 regions matched
Two 3-ways and one 2-way
4 highly sensitized candidates matched

Dr. Friedewald explained that, despite a slow beginning, there are many matches currently proceeding to transplant (**Exhibit G**). The reason for there being fewer matches at the beginning of the program is that many pairs are hard to match in the Pilot. Sixty-three percent of candidates in the August 2011 match run were highly sensitized. However, with the increase in the number of pairs in the pool and the implementation of donor chains, more matches were being found.

In order to maintain an efficient pilot program, the KPD Work Group (KPDWG) asked the Committee to provide guidance on how to handle a chain break in the Pilot (**Exhibit H**). When long chains are found in a KPD program, one of the matches in the chain often will not be accepted for reasons such as an unacceptable crossmatch. When a chain breaks, there are several options. All of the pairs can be entered in the next match run, or the chain can proceed up to the point where the chain breaks. There can also be different decisions based on how long the viable portion of the chain is, such as:

- At least X number of candidates in the viable portion of the chain
- If the chain breaks more than Y candidates before the end of the chain

The KPD Work Group thought that any transplants were better than no transplants. However, in the case of blood type O non-directed donors (NDDs), the Work Group considered having a minimum number of transplants. Additionally, the NDD should be able to choose whether to be entered in a later match run or to donate to the shorter chain and should be informed of this possibility in advance. Furthermore, an NDD should not be asked to re-enter a match run indefinitely.

In the short term, the KPD Work Group recommended using the proposed solution below so that there is some consistency in how broken chains are treated in the OPTN KPD Pilot Program.

The proposed solution is:

- If the NDD has a non-O blood type (A, B, AB), then the chain will proceed up to the link where it breaks regardless of the number of transplants that result.
- If the NDD has a blood type of O, then:
  - If the chain *can reach 5 or more transplants* before breaking (regardless of the total length of the chain), then the chain *will proceed* up to the link where it breaks.
  - If the chain includes less than 6 pairs total and the chain *can reach 50%* of the transplants before breaking, then the chain *will proceed* up to link where it breaks.
  - If a chain includes less than 6 pairs total and the chain *cannot reach 50%* of the transplants before breaking, or if a chain that is 6 or longer *cannot reach 5 transplants*,

then the NDD will be given the option to donate to the shorter chain or to enter the next match run with the possibility of finding a longer chain.

A NDD will not be asked to wait longer than three months from the match run where a chain started by that NDD was first found before donating to a chain, regardless of the length of the chain. Elements will be added to the informed consent explaining to all NDDs that they may be in a position to choose to donate to a shorter chain or to wait for another match run with the possibility of finding a longer chain. If the operating room date is not set for a chain at the time of the next match run, but the crossmatches have been performed and the donors have been approved up to the point where the chain breaks, then the final donor could be entered in the next match run to repair the chain. The donor in this situation must agree to be entered in the next match run and must be informed in advance that this situation could arise. Five was chosen because most chains started by a blood type O NDD are longer than 5, and it would be likely that the NDD could find a chain longer than 5 if entered in a later match run.

Dr. Friedewald explained that the KPD Work Group considered proceeding with the chain regardless of the length. There was concern that this approach would not maximize the benefit of the blood type O NDD. The KPD Work Group noted that requiring all of the pairs to enter the next match run would be frustrating to participants. It would also be inefficient because transplant centers would have put a lot of effort into organizing the viable portion of the chain already.

The KPD Work Group agreed that a better long term solution should be developed and recommended having a smaller group develop potential solutions, such as a choice of chain length based on the likelihood of the blood type O NDD being able to find a longer chain, the amount of time the NDD would be willing to wait, or having back-up options for links in the chain that have a higher likelihood of breaking.

The Committee then considered the following resolution:

**\*\* RESOLVED, that the proposed solution above be adopted and the KPD Operational Guidelines be revised as set forth in Attachment A, effective pending notice to members. (20 in favor, 0 opposed, 1 abstention)**

Next, the Committee considered a proposal to revise a cap on the number of transplants that can take place in any given chain. As the size of the number of pairs in the KPD Pilot Program increases, there is a risk that the current optimization algorithm would not run.

The public comment proposal to include donor chains in the KPD Pilot Program proposed having a chain cap of 3 pairs with the possibility for a final donor to be a bridge donor. There were concerns about using bridge donors so early in the Pilot. However, if bridge donors were not used, then capping chains at 3 pairs could result in missing many matches that could be found in a longer chain. Therefore, the Kidney Transplantation Committee modified the chain cap to be 20. The number 20 was chosen because it was the cap used by other KPD programs at the time and because most chains that had been found in other programs were shorter than 20 already.

With the increase in the number of pairs in the Pilot, the optimization algorithm requires more memory and time to run. It is possible that the algorithm would not run if the number of pairs continues to increase. Programmers believe that they can develop a way for the algorithm to run with the increased number of pairs, but it requires the removal of the chain cap.

The proposed solution is to remove the chain cap to reduce technical difficulty. Doing so would allow

the programmers to develop a solution that is likely to be more sustainable going forward. This change in the chain cap would not be implemented until a new version of the algorithm is programmed and tested. If other adjustments need to be made to the chain cap in the future, those issues will be forwarded to the Kidney Transplantation Committee at that time.

The KPD Work Group considered keeping the cap at 20. The initial reason for the chain cap was to reduce logistical complexity. When the chain cap was increased after public comment, it already increased the logistical complexity. The KPD Work Group believes that increasing the chain cap beyond 20 is not likely to greatly increase logistical complexity and that the greater risk is that the algorithm would not be able to run if the number of pairs increases.

The Committee then considered the following resolution:

**\*\* RESOLVED, that the cap on the number of pairs in a chain be removed and the KPD Operational Guidelines be revised as set forth in Attachment A, effective pending programming. (20 in favor, 0 opposed, 0 abstentions)**

Finally, the Committee considered a recommendation to permanently suspend the requirement for HLA-DP typing. Dr. Friedewald reminded the Committee that the requirement that every donor have HLA-DP antigen typing prevented some donors from being entered in the OPTN KPD Pilot Program. The 2008 KPD Pilot Program proposal included requirements for extensive HLA antigen typing, which included HLA-DP, in order for donors to be eligible to be entered in match runs. The intent of these requirements was to make the Pilot more efficient by reducing the risk of unexpected positive crossmatches. Some centers do not perform HLA-DP antigen typing on donors because of the additional expense of the testing. At its March 2011 meeting, the Kidney Transplantation Committee suspended the requirement to enter HLA-DP antigen typing for donors in the OPTN KPD Pilot Program for six months. Centers could still list HLA-DP antigens as unacceptable for candidates and could still enter HLA-DP antigen typing for donors if it is available. However, donors without HLA-DP antigen typing would now be eligible for match runs. The intent of the suspension of the HLA-DP antigen typing requirement was to encourage the entry of more pairs in the OPTN KPD Pilot Program. The Kidney Transplantation Committee planned to assess the change in requirements at the end of the six month period. Since implementation of the suspension none of the donors without HLA-DP who matched were refused because of a positive crossmatch. Additionally, none of the candidates who matched to donors without HLA-DP had DP antigens marked as unacceptable or all other antibody specificities.

Based on these findings, the Committee considered the following resolution:

**\*\* RESOLVED, that HLA-DP antigen typing be optional for donors in the OPTN KPD Pilot Program and the KPD Operational Guidelines be revised as set forth in Attachment B, effective pending notice to members. (20 in favor, 0 opposed, 0 abstentions)**

## **6. Request from the Membership and Professional Standards Committee Regarding Living Donor Outcomes**

In August, the Membership and Professional Standards Committee asked the Kidney Transplantation Committee to consider the findings of Peter Reese, MD, regarding variations in living donor transplant rates. Dr. Reese presented his findings to the Committee in September (**Exhibit I**).

Dr. Reese explained that living donor kidney transplantation is the optimal treatment for most patients with end-stage renal disease. Variation in live donor transplant across centers may depend on the center population and its practices. This variation suggests the possibility that candidates at some centers lack access to live donor transplant which may pose an under-recognized ethical problem. Dr. Reese explained that the Kidney Committee could provide feedback to transplant centers about rates of live donor transplant offers an opportunity for under-performing centers to change practice. He shared a method for establishing performance methods and suggested that this information could be given routinely to centers or provided upon request.

The Committee thanked Dr. Reese for his work. Several on the Committee remarked that this work could be used as an opportunity to partner with under-performing centers. The Committee cautioned the MPSC from using these methods as a way of punishing centers for not doing living donor transplants.