OPTN/UNOS Kidney Transplantation Committee
Interim Report to the Board of Directors
January 14, 2013
Teleconference
John J. Friedewald, MD, Chair
Richard N. Formica, MD, Vice Chair

This report summarizes the discussion had and decisions made by the Kidney Transplantation Committee during its teleconference call held on January 14, 2013.

1. Kidney Allocation Proposal Feedback

The Committee's proposal to substantially revise the kidney allocation system concluded its public comment period on December 14, 2012. During this conference call, the Committee reviewed feedback submitted by individuals, organizations, and OPTN committees and regions.

The proposal received 225 submitted responses through the public comment portal. Of these, 121 (53.78%) supported the proposal, 96 (42.67%) opposed the proposal, and 8 (3.56%) had no opinion. All eleven OPTN regions reviewed the proposal during their fall 2012 meetings. One region opposed the proposal (Region 10), one region supported the proposal with amendments (Region 4) and the remaining nine regions supported the proposal. All of the OPTN regions provided comments regarding specific elements of the proposal. Several Committees also reviewed the proposal including Ethics, Histocompatibility, Living Donor, Minority Affairs, Operations and Safety, Pancreas Transplantation, Pediatric Transplantation, Transplant Administrators, and Transplant Coordinators.

Ciara Samana, UNOS liaison to the Kidney Transplantation Committee, reviewed the major themes identified from all of the submitted feedback. Of the comments submitted as "opposed" through the public comment portal by individuals or organizations, 43 cited concerns about the access for older candidates and 29 specifically cited concerns about access for candidates with polycystic kidney disease. Sixteen comments cited concerns relating to the EPTS model such as limited use of factors or a relatively low c-statistic. Eight comments requested that the waiting time definition not be expanded to include prior dialysis time. Eleven comments requested that the kidney payback system be retained. Seven comments referenced concern about the effects of the proposal on smaller programs, of these seven comments, of these, six request that the payback system be maintained.

The OPTN regions identified several aspects of the proposal for possible reconsideration. Regions 1 and 8 identified the need for policies to minimize unexpected positive crossmatches when organs are shared for very highly sensitized candidates. Region 1 suggested limiting the consent requirements based on kidney donor profile index (KDPI) to those kidneys with KDPI scores greater than 85%. Region 4 recommended extending priority for A2 and A2B organs to candidates with blood type O. Regions 2 and 4 suggested that reporting of unacceptable antigens for DQA1 and DPB1 be made a requirement to reduce the number of avoidable positive crossmatches. Regions 4 and 11 requested that the waiting time definition not be modified to include dialysis time accrued prior to listing. Region 9 requested that the definition

of waiting time be further expanded to all for time accrued from a glomerular filtration rate (GFR) less than or equal to 20 ml/min obtained prior to listing. Finally, Region 10 recommended that the kidney payback system be retained.

Definition of Waiting Time

The Region 4 representative shared some additional context regarding the region's recommendations to not include dialysis time prior to listing as part of the waiting time definition. The Region thought including this provision would serve as a disincentive for timely referral. For example, if a donation service area has a median waiting time of 5 years, a dialysis provider may decide not to refer a patient who had just started dialysis for transplant evaluation. Many on the Committee understood this concern, but pointed out other aspects of the policy that would encourage timely referral. Candidates would be able to receive zero antigen mismatch offers with little waiting time as would highly sensitized candidates (CPRA >=98%). Candidates could also continue to accrue waiting time prior to starting dialysis when listed with a GFR<=20ml/min. One Committee member pointed out that the kidney allocation policy needs a measure of disease severity, similar to the way that the model for end stage liver disease (MELD) provides a measure of disease severity for the liver allocation policy. For kidney disease, the measure of disease severity is time spent with end stage renal disease (defined as either a GFR<20 ml/min or the need for chronic maintenance dialysis).

The Committee then discussed whether the contribution of pre-listing dialysis time should be capped, as proposed by the Operations and Safety Committee. Some on the Committee remarked that capping the value would prevent candidates with substantial pre-listing dialysis time from "jumping" ahead of other candidates. Some members felt that dialysis patients who proactively sought out kidney transplantation early in their disease process should not be penalized by those who spend years on dialysis without seeking a transplant evaluation. Other members argued that there are many rational reasons why dialysis patients may delay seeking a transplant and that rewarding motivation to be evaluated should not necessarily be a part of the allocation system.

The Committee also considered again whether to allow for pre-listing time to be awarded for candidates who are not on dialysis but who had a GFR <=20ml/min as recommended in some comments. The Committee was hesitant to make this change because it would remove the current incentive for early listing. Additionally, while the start of chronic maintenance dialysis is well documented and indicates the start of ongoing treatment for ESRD, the date when a patient's GFR drops below 20 ml/min is less indicative of the start of ESRD. Some patients may have a GFR score that improves over time. Further, there is no central database of GFR values like there is for dialysis start dates. The Committee declined to include time prior to listing with a GFR<=20ml/min as part of the proposal.

The Committee did not decide to modify the proposed definition of waiting time but will continue to consider capping the contribution of pre-listing dialysis time either at a uniform value for all

candidates (e.g., 4 years) or at a value based on median waiting time for each donation service area. This discussion will be continued at the Committee's next meeting on March 25, 2013.

Including O Candidates in the Priority for Kidney from Blood Type A2/A2B Donors
Several individually submitted comments and Region 4 recommended that blood type O candidates be given priority for kidneys from blood type A2 and A2B donors. In the proposal, only candidates with blood type B who meet certain titer requirements receive priority for kidneys from these donors. The Committee was reminded that the A2/A2B priority was designed as a committee sponsored alternative system by the Minority Affairs Committee. The purpose of the system, as designed, was to reduce disparities faced by minority candidates.

Wida Cherikh, PhD, UNOS Biostatistician reviewed with the Committee the relationship between blood type and ethnicity. As of January 4, 2013, 34.5% of 49,679 candidates with O blood type were African American while 45.6% of 15,188 candidates with B blood type were African American. Additionally, Dr. Cherikh shared that the ability of a candidate to meet the titer requirements is linked to blood type. Data from the Midwest Transplant Network OPO showed that of 109 B candidates who have had at least one year of anti-A titer history (at least 4 quarterly anti-A titers performed), 75% (82/109) had consistently low titers. By contrast, of 235 O candidates who have had at least one year of titers done, only 31% consistently had low anti-A titers. Thus, the likelihood of finding a patient with a consistently low anti-A titer history is much greater for B candidates than O candidates. Furthermore, no significant difference existed between African American and Caucasian B candidates with respect to the incidence of candidates with a consistently low anti-A titer history. In Caucasian candidates, 77% (54/70) had a low titer profile compared with 69% (24/35) of African American patients who have a low anti-A titer history. In light of this additional data, the Committee decided not to modify this portion of the proposal.

Access for Older Candidates
The Committee considered comments regarding access for older candidates. Forty-three comments submitted through the public comment portal, including those submitted by the Polycystic Kidney Disease (PKD) Foundation and the American Association of Kidney Patients (AAKP) cited concerns about the potential for diminished access for older candidates. Additionally, the OPTN/UNOS Ethics Committee recommended that the Committee consider the balance between two ethical principles, justice and utility.

The Committee reviewed these comments carefully and analyzed prior versions of the proposal. Efforts to increase the number of available kidneys from deceased donors are outside of this proposal and so any change to the kidney allocation system will result in shifts of the number of transplants projected for candidates with specific characteristics. Of particular concern throughout this process has been access for older candidates. The proposal does not include any hard age cutoffs. The determination of whether to list a patient for kidney transplant would remain the responsibility of the transplant physicians and surgeons who evaluate patients. No OPTN policy (proposed or existing) prohibits the listing of a candidate for kidney transplantation based on age or any other criteria.

The Committee reviewed prior considered allocation approaches, including life years from transplant (LYFT), age matching, national sharing, and combinations of these three approaches and found that the current version returns only approximately one quarter of the possible life years projected under the most aggressive approach (national sharing of kidneys combined with LYFT based allocation). However, the current version provides 52% of transplants to candidates over the age of 50, unlike the most aggressive approach which provided only 10% of transplants to candidates over the age of 50. As candidates over the age of 50 make up 63% of the current kidney transplantation waiting list, the Committee finds this trade off to be a fair compromise.

	National Sharing +LYFT	*LYFT*	*Age Matching+ Longevity Matching*	*Age Matching*	*Longevity Matching*
Gain in life years	34,026	25,794	15,223	14,044	8,380
Proportion of kidneys transplanted into recipients >50 years old	10	29	46	45	52

In response to concerns about older candidates having access to "the best" kidneys (defined by commentors as those with KDPI scores in the top 20%), the Committee requested additional analysis (Exhibit A). This analysis found that the EPTS formula is influenced substantially by factors other than age. Though younger candidates are more likely to be in the Top 20%, a 50-year old candidate who is not on dialysis, does not have diabetes, and has not had a prior transplants would have an EPTS of 18%. Conversely, the analysis found it is possible for a 25 year old who has diabetes, to have an EPTS score higher than 20% while a 25 year old who has been on dialysis for two years and had a prior transplant has an EPTS of just 7%, well inside the Top 20%. Several Committee members remarked that kidneys from donors with KDPI scores higher than 20% are still excellent quality kidneys. Kidneys from donors with KDPI scores between 21% and 49% are, by definition, better than the "average" kidney. Excellent function is also obtainable from kidneys with higher than average KDPI scores.

Overall, the vast majority of pediatric candidates and nearly 97% of adults with ages between 18 and 25 had EPTS scores <20%. Among candidates age 26-35, 80.6% were in the EPTS Top 20%, with some having EPTS as low as 1% and others as high as 67%. Over 10% of candidates between ages 46 and 55 were in the Top 20%, with EPTS ranging from 12% to 98%. The candidates in the Top 20% range in age from 0 to 54, with a median age of 35, whereas candidates outside of the Top 20% ranged in age from 1 to 91, with a median age of 58.

Following review of this information, the Committee decided that it had arrived at an acceptable compromise between increasing life years (utility) obtained by the system while maintaining access for candidates of all ages (justice). Further, the Committee determined that the proposed system would allow for relatively easy adjustment in response to changing donor or

waitlist characteristics. If unintended consequences arise (e.g., the proportion of transplants for older candidates markedly decreases under the proposed allocation system), the system could be easily adjusted to decrease the proportion of kidneys allocated to candidates with higher EPTS scores. Having this flexibility to make incremental changes to the allocation system in response to changing conditions would be a marked improvement over the current system.

Retaining the Kidney Payback System

Several comments submitted through the public comment portal and from OPTN/UNOS Regions indicated the need to retain the kidney payback system. Currently, when an organ is shipped from one Organ Procurement Organization (OPO) to another OPO for a 0-ABDR mismatch candidate or as part of a multiorgan transplant, the receiving OPO incurs an obligation to payback a kidney to the originating OPO. The kidney payback system has been fraught with administrative challenges and has not demonstrated a beneficial impact on individual patients. However, many comments pointed out that the payback system instills a sense of fairness and self-governance within the kidney allocation system. These comments pointed out that without the payback system in place, transplant programs may be tempted to "draw" offers using highly sensitized candidates and then transplant the received kidney into a backup candidate when the kidney is not compatible with the original intended candidate. There would be no penalty for this behavior because the receiving OPO would no longer be required to return a kidney to the originating OPO.

Several on the Committee discussed whether the payback system could be modified to address the scenario described above. One member remarked that when a kidney is found to be unsuitable for the original intended candidate, it should be transplanted into the next highest candidate listed at a different center within the receiving OPO's donation service area (DSA). With this approach, the incentive to draw offers by a program would be removed and the kidney could be transplanted with less cold ischemic time than if it were returned to the originating OPO. A Committee member pointed out that there are several OPOs that serve a single kidney transplant program. In these cases, regional placement of the kidney would be required which would likely result in just as much (perhaps) more cold ischemic time than if the kidney were returned to the originating OPO. Other members suggested that the Committee include punitive constructs in the policy to deter this kind of acceptance behavior. For example, instances where kidneys are transplanted into candidates other than those originally intended could be reported to the Membership and Professional Standards Committee (MPSC) for review and possible action.

A member of the Committee who has worked extensively with the Kidney Paired Donation (KPD) Work Group shared the experience of that group in reducing the incidence of unexpected positive crossmatches. An advisory committee reviews all instances of unexpected positive crossmatches within seven days and requires that transplant programs submit corrective action plans. Another member shared that the incidence of unexpected positive crossmatches may be reduced after the ability to list DQA and DPB antigens is programmed into UNet^{sm} (expected later in 2013).

The Committee agreed to further explore options for curtailing acceptance behavior that results in transplantation of candidates other than those originally intended or in increased kidney discards during its March 2013 meeting.

Consent Requirements for Kidneys based on Kidney Donor Profile Index

The proposed policy requires that consent be obtained from all candidates regarding the highest KDPI each would be willing to accept. Some comments questioned the unintended consequences of this policy requirement. Since KDPI is a relatively new metric, clinicians are still gaining familiarity with it. To obtain true informed consent based on KDPI, clinicians need to be able to effectively explain the metric to patients and have patients select a maximum threshold for KDPI acceptance. More experience with the metric is needed to achieve this informed consent.

The Committee decided to alter the proposal based on this feedback. Rather than requiring all candidates to consent to a maximum KDPI score, the Committee decided to require consent only for those kidneys with a KDPI score of >85%. Centers would still have the option to set program and candidate acceptance criteria based on KDPI but for most candidates, this acceptance criteria would not be tied to a separate consent process.

Access for Candidates with Polycystic Kidney Disease (PKD)

Several comments, including one submitted by the PKD Foundation, focused on access for candidates with PKD. Candidates with autosomal dominant PKD develop renal failure over the course of decades and typically do not develop ESRD until the sixth decade of life.

Based on the modeling provided in the proposal, the number of recipients who received transplants in 2010 with a primary diagnosis of PKD was 830 and was simulated to be 910. Under the proposed policy, PKD candidates are projected to receive 830 transplants. When analyzed according to age categories, there did appear to be a projected decline in the number of transplants to candidates with PKD in age categories 50-64, from 475 actual transplants in 2010 to 412 projected under the proposed policy, and for candidates ages 65 and older from 140 actual transplants in 2010 to 103 transplants projected under the proposed policy.

Additionally, since the proposed policy prioritizes kidneys from donors with KDPI scores in the top 20% to candidates with EPTS scores in the top 20%, many comments stated that candidates with PKD would be ineligible for the very best kidneys based on the use of age in the EPTS calculation. As pointed out by the PKD Foundation, candidates with this condition tend to have fewer comorbid conditions (such as diabetes) which lead to poor post-transplant outcomes. The Committee reiterated that the EPTS calculation is heavily influenced by factors other than age. Though younger candidates are more likely to be in the Top 20%, a 50-year old candidate who is not on dialysis, does not have diabetes, and has not had a prior transplants would have an EPTS of 18%.

The Committee decided that it would not make changes to the EPTS calculation to include the diagnosis of PKD as suggested in several comments. While the calculation does include

diabetes, this factor is not tied to the candidate's primary diagnosis and is treated as a comorbid condition which affects survival.

2. Discussion of Implementation Issues for Estimated Post Transplant Survival (EPTS)

Darren Stewart, MS, UNOS Biostatistician, reviewed with the Committee some implementation issues encountered with the EPTS calculation. Mr. Stewart asked the Committee for guidance on how to handle missing and "unknown" values for diabetes status, number of prior transplants, and dialysis start date when calculating EPTS.

Mr. Stewart explained that diabetes status will be a new required field when adding a candidate to the waitlist (on the "candidate record"). While it is currently collected on the transplant candidate record (TCR), it is a static, one-time data entry (even though the value may change after listing) with "unknown" provided as a valid selection (about 700 candidates). Before the new kidney allocation system is implemented, transplant programs will be asked to enter diabetes status on the candidate record for candidates already on their list. At this time, "unknown" and "type unknown" will *not* be options. The diabetes status from TCR will be displayed for user's reference. Upon KAS implementation, if diabetes status is missing on the candidate record, the candidate's diabetes status from the TCR will be used for EPTS.

Mr. Stewart explained the three options available if diabetes status on the TCR is "unknown".

- Do not calculate an EPTS score. This approach would prevents an adult candidate from appearing on matches.
- Calculate EPTS score assuming current diabetes status is "Yes." This approach uses the least beneficial value principle, which encourages updating of data.
- Calculate EPTS assuming current diabetes status is "No."

The Committee decided to utilize the second option, which would assume that any values left as "unknown" would be considered as "yes" for the EPTS calculation.

Mr. Stewart then asked the Committee to consider the field for number of prior transplants. Number of prior transplants will be a new required field when adding a candidate to the waitlist. The OPTN can determine this number accurately for *most* patients by linking to OPTN database by SSN. However, social security number matching is not always accurate and some transplants may not be in the OPTN database (e.g., overseas tx; prior to 1987). Prior to implementation of the new kidney allocation system, programs will be asked to enter number of prior transplants on the candidate record for candidates already on their list. The number of prior transplants from OPTN database will be *displayed* for user's reference. The Committee then considered the following options for how a candidate's EPTS score should be calculated when the number of prior transplants on candidate record has not been updated.

- Do not calculate an EPTS score. This approach would prevent an adult candidate from appearing on matches.

- Calculate EPTS score assuming patient had at least one prior transplant. This approach utilizes the least beneficial value principle, which encourages updating of data.
- Calculate EPTS score using the "calculated" number of prior transplants by linking to OPTN database by SSN.

The Committee decided to utilize the third option to determine the number of prior transplants used for the EPTS score when the field is not updated by the transplant program.

Finally, Mr. Stewart asked the Committee to consider how to handle situations where a candidate's dialysis start date is missing. Dialysis start date is an existing field already on the waitlist but it is missing for 400 candidates (most added prior to July, 2000) who are listed as being on dialysis. Prior to implementation of a new kidney allocation system, programs will be asked to update this information where missing. The *most recent initiation* of chronic maintenance dialysis from the CMS CROWN database will be displayed on the candidate record for user's reference. Mr. Stewart reminded the Committee that dialysis start date affects not only EPTS, but also waiting time points and then asked how a candidate's EPTS score (and waiting time points) should be calculated when dialysis start date on candidate record is missing? Two options were presented:

- Do not calculate an EPTS score. This approach would prevent an adult candidate from appearing on matches.
- Calculate EPTS (& waiting time) using dialysis start date from CMS CROWN database. If no match is found, EPTS will not be calculated, and an adult candidate will not appear on matches. The KAS pre-implementation tool will alert centers that an update is needed.

The Committee decided to utilize the second approach to use the dialysis start date from the CMS CROWN database. In cases where no match is found for the candidate in the database, the EPTS will not be calculated and the candidate will not appear on matches.

3. Discussion of Variance Transition Plans

Ms. Samana reviewed with the Committee two variance transition plans that were circulated as part of the kidney allocation public comment proposal. Southwest Transplant Alliance (TXSB) and Region1 both requested transition plans to mitigate the effects of converting from their alternative allocation systems to a new kidney allocation system. The requirements for submitting a transition plan were that each plan must take place in a single step, be implemented prior to the start of the new kidney allocation system and end with the implementation of the new kidney allocation system.

As described in the public comment proposal the transplant programs in Region 1 proposed a single stage transition plan that would reduce the maximum number of population distance points from the current of 10 points down to 6 points (Exhibit B and C). Other aspects of the variance would remain in place until the transition to the new national system. Population

distance points are unique to Region 1 and have significant influence on the allocation of kidneys. Reducing these points from 10 to 6 is expected to be less disruptive than a sudden, total elimination of points as would occur if no transition plan were put into place.

No specific comments were submitted regarding this transition plan. The Committee voted to send the Region 1 transition plan to the OPTN/UNOS Executive Committee to determine where it should be placed within the IT scope of work. Ideally, the Committee would like to see the transition plan implemented soon after passage of the new kidney allocation system (anticipated in June 2013).

****Resolved that the transition plan submitted by the kidney transplant programs and OPOs in Region 1 and circulated for public comment, be placed in the IT scope of work. (15 in favor, 0 opposed, 0 abstentions).**

The Committee then turned its attention to the transition plan submitted by TXSB. As described in the public comment proposal, Southwest Transplant Alliance (TXSB) uses the standard distribution and allocation system with the following exception. For distribution of standard and expanded criteria donors, the system divides the OPO into four sub-units – Dallas area, Tyler area, El Paso area, and Galveston area. Kidneys recovered within each sub-unit are distributed, first, according to a single waiting list for the sub-unit, and then to patients within the entire OPO according to a single OPO-wide list. Candidates appear in the "Local KI" classifications if they are listed at a transplant center in the same subunit as the donor hospital. TXSB proposed that the subunits be combined into a single local unit based on the donation service area. Potential recipients who are in the same subunit as the donor hospital would then receive three additional points during the transition period. The transition period would last until the implementation of a new national kidney allocation system.

John Friedewald, MD, Committee Chair shared with the Committee a conversation he had with OPO and transplant professionals from TXSB following the conclusion of public comment. During this conversation, TXSB stated that it intended for its transition plan to begin with the implementation of a new kidney allocation system. Members of the Committee pointed out that the solicitation letter for transition plans pointed out in three separate areas that transition plans would not be allowed to continue past the point of implementation of a new kidney allocation system. Further, members of the Committee were concerned that modifying this transition plan to allow it to run with the new allocation system would be fundamentally unfair to other OPOs who followed the requirements and did not submit such requests. The Committee decided it would not entertain TXSB's request with a vote of 11 in favor, 2 opposed and 2 abstentions. Correspondence will be sent to TXSB letting it know of this decision. If TXSB decides that its transition plan to should be implemented prior to a new kidney allocation system, the Committee will reconvene and vote to send the plan to the Executive Committee for review.

4. Adding a CPRA Threshold to Donor Pre-select Tool in the OPTN KPD Pilot Program

Prior to the January meeting, the Committee reviewed a recommendation from the KPD Work Group to add a CPRA threshold to the donor pre-select tool in the OPTN KPD Pilot Program.

Over 90% of match offers are declined. 20% of matches have not reported a refusal reason. 40% might have accepted the match, but the exchange was terminated by another pair.

Of the remaining 40% of refused matches:

- 33% refused due to an actual or virtual positive crossmatch
- 7% due to "candidate involved in a pending exchange (with another program)
- 60% due to various other donor or candidate reasons including: Donor unacceptable due to age, weight, size, medical history etc.

When a match is declined, the remaining matches in that exchange are frequently terminated as well, increasing the overall decline rate.

Currently, the operational guidelines for the OPTN KPDPP allow transplant hospitals to determine which candidate unacceptable and which "all other' unacceptable will be added to the KPD database in UNet^{SM}. Some centers do not add all their unacceptable in an effort to find a donor more suitable for desensitization with the candidate. In addition, an unacceptable antigen may be 'acceptable' on its own, but unacceptable in combination with other unacceptable antibodies for certain donor antigen profiles. These matched donors have been declined by their matched candidates do to a positive virtual crossmatch.

Although candidates are given a variety of choices to rule out donors prior to matching, donor frequently fall just outside the acceptable limit. For example, a candidate can set a maximum BMI of 35 and therefore match with a donor with a BMI of 34.9, in which the candidate may decline. In addition, a candidate may decline for a combination of donor characteristics, in which they would not decline on one characteristic independently. For example, a candidate may set a minimum CrCl of 80 and willing to accept a 65 year-old donor with a CrCl of 80, but the 32 year-old donor with a CrCl of 80 would be unacceptable and declined.

The proposed solution considered was for transplant centers to pre-accept or pre-refuse potentially matched donors prior to actually matching using a Donor Pre-Select Tool.

The purpose of the donor pre-select tool is to increase the efficiency of the KPD system by decreasing the number of match offers that are declined. The donors in the pre-select tool are all the eligible donors who could potentially match with a particular candidate. These are not match offers, but rather donors who could potentially match the candidate in a future match run.

The Donor Pre-Select allows transplant centers to preview *potential* matched donors and indicate whether they would possible accept or refuse the donor if their candidate matched in a match run. It allows the system to screen out offers that would not be accepted based on basic donor information such as antigen profile, age, height, and BMI.

Entering a pre-acceptance will allow the candidate to potentially match with that donor, the transplant center is not committing to accepting any future match offers.

Entering a refusal will prevent the candidate from matching with that donor in future match runs.

The refusal reasons by candidate sensitivity level were analyzed (by Darren Stewart, UNOS Biostatistician) to see if a large percentage of refusal (due to virtual or actual positive crossmatch) were occurring for highly sensitized candidates.

The crossmatch related refusal rate showed an increasing trend as CPRA increases from 3.8% for CPRA=0% to over 25% for CPRA>90%.

In addition, as number of antibody specificities increases, the crossmatch refusal rate also increases.

When candidates with a CPRA of 90-100 and candidates with 10 or more antibody specificities are analyzed together, the crossmatch refusal rate was 81.8%.

Given this information the KPD Workgroup supported a recommendation to require programs with candidates with a CPRA of 90% or higher to use the Donor Pre-select tool. These highly sensitized candidates would only match if a donor is pre-accepted. The Workgroup will start with 90% as the threshold required in the automated KPD solution and monitor outcomes.

The Workgroup recommended those donors who are a zero antigen mismatch are excluded from the 90% threshold requirement. This will significantly delay the donor pre-select tool from going live. Of the over 200 matches offered in the OPTN KPDPP thus far, only 1 offered has been a zero antigen mismatch. We could have this as added, pending programming at a later date and continue to collect data on the number of zero mismatches offered.

The group also recommended that the data be provided to transplant program to explain why the pre-select tool is important. Finally the Workgroup recommended use of this tool for candidates listed with a lot of lower level unacceptable antigens.

The KPD Workgroup considered not requiring the donor-preselect for any candidate or for candidates with a CPRA >= to 80%. However, given the data the KPD Workgroup thought requiring candidates with a CPRA of >=90% would significantly decrease the match decline.

The KPD Workgroup voted to send the following resolution for consideration by the Kidney Transplantation Committee (9 in favor, 0 opposed, 0 abstentions). The Committee voted to support the following resolution with a vote of 13 in favor, 0 opposed, and 0 abstentions.

****RESOLVED, that a candidate with a CPRA of greater than or equal to 90% is required to have a donor pre-accepted using the Donor Pre-select Tool. If the donor is not pre-accepted the candidate will not have the possibility to match in future match runs with that donor, unless the donor is a zero antigen mismatch and the KPD Operational Guidelines be revised as set forth in Attachment A, pending programming and an additional four weeks after programming complete.**

Attendance
OPTN/UNOS Kidney Transplantation Committee
Interim Report to the Board of Directors
January 14, 2013
Teleconference

John J Friedewald, MD	Chair	X
Richard N. Formica Jr., MD	Vice Chair	
Ronald D. Perrone MD	Regional Rep. Reg. 1	X
Adam M. Frank M.D.	Regional Rep. Reg. 2	X
Nicole A. Turgeon M.D.	Regional Rep. Reg. 3	X
Adam Bingaman M.D., Ph.D.	Regional Rep. Reg. 4	X
Kunam S. Reddy MD	Regional Rep. Reg. 5	X
Nicolae Leca MD	Regional Rep. Reg. 6	
Erik Finger M.D., Ph.D.	Regional Rep. Reg. 7	
Clifford D. Miles M.D.	Regional Rep. Reg. 8	X
Michael Gallichio MD	Regional Rep. Reg. 9	X
Jeffrey D. Punch MD	Regional Rep. Reg. 10	X
Jeffrey Rogers MD	Regional Rep. Reg. 11	
Mark I. Aeder MD	At Large	X
Sandra Amaral MD	At Large	X
Blanche M. Chavers MD	At Large	
Noelle Dimitri LICSW, CCTSW	At Large	X
Pang-Yen Fan MD	At Large	
Sundaram Hariharan MD	At Large	
Patricia M. McDonough RN, CPTC, CCTC	At Large	X
Peter P. Reese MD	At Large	
Nancy L. Reinsmoen PhD, D(ABHI)	At Large	X
Teresa J. Shafer RN, MSN	At Large	
Anton Skaro M.D., Ph.D.	At Large	
Ron S. Taubman	At Large	X
Rachael S. Wong DrPH	At Large	X
Marla Jill McMaster MA, CAPT-USNR(Ret)	Visiting Board Member	X
James S. Bowman III, MD	Ex. Officio	X
Monica Lin Ph.D.	Ex Officio	X
Bernard Kozlovsky	Ex Officio	X
Sally Gustafson MS	SRTR Liaison	X
Ajay Israni MD, MS	SRTR Liaison	X
Bertram L. Kasiske MD	SRTR Liaison	X
Susan N. Leppke MPH	SRTR Liaison	X
Nicholas Salkowski PhD	SRTR Liaison	X
Ciara J. Samana MSPH	Committee Liaison	X
Wida S. Cherikh Ph.D	Support Staff	X
Kerrie F. Cobb	Support Staff	
Maureen A. McBride Ph.D.	Support Staff	X
Joel Newman	Support Staff	X
Darren E. Stewart	Support Staff	X

Anna Kucheryavaya	Support Staff	X
James Alcorn	Support Staff	X
Gena Boyle	Support Staff	X
Lee Ann Baxter Lowe PhD, ABHI	Guest	X