Moving Points in Nephrology

Living Donor Kidney Transplantation: Best Practices in Live Kidney Donation—Recommendations from a Consensus Conference

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Live donor kidney transplantation (LDKT) is a superior option for most patients with ESRD compared with dialysis and deceased donor kidney transplantation (1). Much effort occurs in transplant and nephrology communities to educate and advocate for early transplant referral and live donor transplantation. Despite this, LDKT rates are declining annually (2). Reasons are multifactorial; however, practice variations in processes for referral, access to resources, and utilization of options, such as paired kidney exchange, contribute to disparities in rates of LDKT. Identifying what works, followed by wide dissemination of recommendations, is critical to improve practice and access to LDKT.

The American Society of Transplantation's Live Donor Community of Practice is a group of clinicians with expertise in living kidney donation (LKD) formed in 2012 to advocate, support, and advance knowledge in the care of the live organ donor. Members of the Live Donor Community of Practice recognized the need to identify effective strategies to improve access to LDKT/LKD and improve LKD education and evaluation processes. To this end, a consensus conference was held on June 5–6, 2014, in Rosemont, Illinois, and was supported by 11 transplant, nephrology, and patient services organizations (Table 1).

Sixty-seven transplant surgeons, nephrologists, allied health providers, patients, and other key stakeholders used a structured forum to identify and disseminate best practices in the following topics, perceived to have a high likelihood to improve LDKT rates, access, and processes when implemented:

1. LDKT educational processes for patients with CKD/ESRD;
2. Potential living donor educational processes;
3. Strategies to optimize efficiencies in the LKD evaluation;
4. Strategies to reduce disparities; and
5. Strategies to reduce systemic barriers to LKD and LDKT.

The development of the meeting and workgroups, rationale for the topics, process of creating consensus, and top recommendations are outlined in more detail in an overview meeting report (3). Recommendations included strategies to educate patients with CKD and ESRD, potential living donors, and the public; efficiencies in processes; policy initiatives; and a research agenda. An important and recurring theme was the importance of coordination and communication between providers throughout the continuum of disease to most effectively reach patients and their support systems. This moving points edition will address consensus conference recommendations for a collaborative approach to care, education, and access to improve overall practice in LDKT and LKD.

Five articles address how transplant centers and community nephrology care teams can partner for improved practices. In the first article, "Living Donor Kidney Transplantation: Improving Education Outside of Transplant Centers about Live Donor Transplantation—Recommendations from a Consensus Conference," (4) workgroup members identified relevant literature and six main recommendations for best practice in LDKT outreach. Patients with CKD and their family members and friends clearly benefit from comprehensive and early LDKT education in a variety of settings, including primary care, nephrology offices, and dialysis centers. Workgroup members reached solid consensus to promote quality teaching, conducted throughout the chronic disease adjustment process and by providers that patients already know and trust, as the most promising way to improve transplant listing rates and follow through with the LDKT process. In turn, workgroup members identified recommendations to improve dialysis transplant education collaboration and offer quality control in the provision of transplant education.

The second article, "Living Donor Kidney Transplantation: Facilitating Education about Live Kidney Donation—Recommendations from a Consensus Conference," (5) facilitates discussion and clarification of emerging data regarding live kidney donor outcomes (6,7). Live donor safety is paramount, and all providers discussing LDKT with patients and families must understand the risks and be well versed in them so that appropriate counseling can occur. Workgroup members, consisting of nephrologists, surgeons, allied health professionals, and a living donor, reviewed emerging understanding of outcomes and risks: surgical, long-term medical, and psychosocial. Strategies

Table 1. Societies, organizations, and companies that provided financial support for the consensus conference

Society/Organization/Company Name
American Foundation for Donation and Transplantation
American Kidney Fund
American Society of Transplantation
American Society of Nephrology
American Society of Transplant Surgeons
American Transplant Foundation
Interlink
NATCO
National Kidney Foundation
The Transplantation Society
United Network for Organ Sharing

are discussed for individual counseling by nephrologists and primary care providers.

The third article, "Living Donor Kidney Transplantation: Improving Efficiencies in Live Kidney Donor Evaluation—Recommendations from a Consensus Conference," (8) reviews components of the LKD evaluation as mandated by the Centers for Medicare Services and Organ Procurement and Transplantation Network policies. The article provides some clarity surrounding regulations about various aspects, including candidacy guidelines (that may vary between centers) and confidentiality of potential donor evaluation findings. It then offers suggestions for potential efficiency improvements resulting from partnerships between community physicians and transplant teams.

LDKT and LKD rates vary on the basis of ethnicity, age, sex, geography, and income. The fourth article, "Living Donor Kidney Transplantation: Overcoming Disparities in Live Kidney Donation in the US—Recommendations from a Consensus Conference," (9) identifies historical and emerging trends in LDKT and LKD, which may exacerbate existing disparities. In the absence of coordinated action by the nephrology and transplant communities, such disparities will persist and limit access to LDKT/LKD. The workgroup identified novel strategies developed to attenuate LDKT and LKD disparities, priorities for research, and policy initiatives that may increase access to LDKT—the most optimal treatment for transplant candidates.

The final article, "Living Donor Kidney Transplantation: Reducing Financial Barriers to Live Kidney Donation—Recommendations from a Consensus Conference," (10) identifies resources currently available to assist transplant candidates and potential live donors during the process and gaps that will require systemic change. Although poorly characterized in the literature, the financial effect of LKD on the living donor is not insignificant and has unknown effects on LKD decision-making and rates of LDKT. The workgroup outlined variability in practice, summarized available problem-solving strategies for use with LKDs and transplant candidates, and offered a set of actionable steps to promote the concept of LKD financial neutrality. The workgroup concluded that such systems-wide change will require broad engagement and action.

At the consensus conference it became overwhelmingly clear that promoting best practice in LKD processes and access must be a community initiative involving all CKD/ESRD stakeholders. Partnerships with primary care physicians, nephrologists, dialysis centers, transplant programs, payers, policymakers, and researchers are needed to demystify and debunk the process, evaluate the effect of education practice changes, and respond to the changing climate of LDKT care.

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Disclosures

None.

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