OPTN/UNOS Transplant Administrators Committee
Report to the Board of Directors
June 28-29, 2011
Richmond, VA

Summary

I. Action Items for Board Consideration

- None

II. Other Significant Items

- The Committee continues to support various committee Work Groups by providing the transplant administrator perspective on proposals prior to being released for public comment. (Item 1, Page 3)
- The Committee has two representatives on the newly formed Transplant Coordinators Committee (TCC) Patient Information Sharing Task Force. (Item 2, Page 5)
- The Committee will continue developing DonorNet® educational tools for the transplant community. (Item 3, Page 8)

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Report of the
OPTN/UNOS Transplant Administrators Committee
To The Board of Directors
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Gene E. Ridolfi, BA, RN, Chair
Timothy Stevens, RN, BSN, CTCC Vice Chair

The Committee meets monthly by conference call/Live Meeting except in April, when the Transplant Management Forum occurs, and July and October when the Committee meets in person.

1. **OPTN Committee Goal: To provide input regarding all proposals with potential to impact transplant program operations, and particularly with regard to: Member and patient communications regarding a new kidney allocation system and the OPTN kidney paired donation program (KPD); and Proposed revisions to living donor data submission policies and forms.** The Transplant Administrators Committee (TAC) has a representative on the KPD Financial Subcommittee. On March 23, 2011, the Committee received an update on the KPD pilot program. Some committee members continue to have concerns about the KPD billing protocol and how it's being addressed by the OPTN. HRSA will review a list of the Committee's concerns and respond at a later date. The subcommittee developed an anonymous survey to determine what physician groups would be willing to accept as reimbursement when participating in a KPD exchange. Due to a low response rate, the survey will be distributed again to gather more responses. The response deadline for the survey was May 6, 2011, and a follow- up call was held on May 13, 2011. There are still considerable concerns that reside with the transplant centers and the physicians regarding the reimbursement fee for KPD. There is a recommendation to include a broader representation of professional billing representatives on the KPD Financial Subcommittee. The Committee will continue to have representatives on the KPD Financial Subcommittee and will provide feedback related to transplant center operations and financial issues regarding the KPD Pilot Program. The TAC representative will also continue to provide the full committee with updates during the TAC monthly Live Meetings and in-person meetings.

   The Committee also provided feedback to the Living Donor Committee (LDC) regarding pre-public comment proposals and the Living Donor follow–up letters that went out to the transplant centers on March 3, 2011.

   The Living Donor Committee (LDC) presented an overview of two pre-public comment proposals on January 26, 2011. The LDC requested two TAC representatives review each proposal and provide feedback for the LDC to consider by February 2, 2011.

   The TAC's response to LDC's request for pre-public comment feedback on the Proposal to Improve the Packaging and Shipping Requirements of Living Donor Organ, Vessels and Tissue Typing Materials request is described below and was submitted to the LDC for consideration on February 2, 2011:

   - Globally, the proposed change adequately defines the transplant center's responsibilities
   - Transplant centers that will be performing this function may need additional time to develop specific policies, procedures and provide staff training

- The LDC might want to consider including a section in the proposed policy stating that the transplant center should include in the Memorandum of Agreement (MOA) with the OPO that the OPO will perform the packaging and labeling of an organ

The TAC's response to LDC's request for pre-public comment feedback on the Proposal to Improve Reporting of Living Donor Status is described below and was submitted to the LDC for consideration on February 2, 2011:

- The current proposal language should be changed to reflect that this is the responsibility of the transplant center performing the living donor nephrectomy
- Will the 90% reporting requirement disadvantage some programs more than others? The challenge with using a percentage is that the small centers may have difficulty with this. A center that does only 10 donor nephrectomies will only be allowed one patient "lost to follow-up" while a center with 100 donor nephrectomies will be allowed 10 patients "lost to follow-up"
- How will the accuracy of data be monitored and what will be the follow-up with centers that may not be reporting accurate data?
- With regard to determining a minimum threshold for categorizing living donors as "lost to follow-up," will there be criteria established with regard to attempted contacts for donor follow-up (i.e., minimum of three attempts made on different calendar dates at different time intervals or a requirement of at least one contact to recipient patient for assistance if possible)?
- The TAC Work Group liked the suggestion of a self-reporting mechanism for donors of a longer duration. However, definitions would have to be clear for the reporting categories and the responses might still be biased
- Was the Living Donor Committee able to identify the greatest barriers for reporting this information? If so, perhaps this should be included. Is there a possibility of streamlining the reporting process to help alleviate this barrier?

The Committee reviewed and provided the following feedback on the letters the LDC sent to transplant centers regarding reporting the status of each center's living donor follow-up:

- No one can argue with the importance of following live donors; however, it can be a real challenge and a drain on resources for programs to get information on donors who are two years out from donation. Donors are typically healthy and they don't always want to be bothered with follow-up care. They are working and do not want to take time out of their schedules to go to the transplant clinic. In addition, they relocate frequently and do not notify the transplant center. Committee members are concerned that the 90% benchmark may be a challenge and a resource burden
- The Committee would like to stress that all of these initiatives are good ideas and the right thing to do. However, when regulations and requirements are continuously being added, it also adds a burden on the transplant centers that are facing budget reductions due to decreases in funding for Medicare and Medicaid programs. In addition, this adds another regulatory burden on UNOS and/or CMS when auditing the programs for compliance
- In summary, the Committee believes that this data should be gathered on donors but is not sure that making it a requirement for transplant centers to have 90% follow-up is reasonable without some accommodations, especially if the transplant center can document that reasonable attempts were made to contact the donor

- Overall, the letter is too long and wordy. If the intention is to have transplant centers pay attention to the message, it should be shorter and more concise. Most transplant centers will probably just scan it or ignore it. Do we have the option to cut it down?

The OPO Committee requested that the TAC review and provide feedback regarding a pre-public comment proposal on Update and Clarification of Language in the Model Elements for Controlled Donation After Cardiac Death (DCD) Recovery Protocols. (Attachment III to Appendix B of the OPTN Bylaws.)

- Please provide any general comments about the changes.
    - Most hospitals have spent months writing their DCD policy and now have to re-write it only to change DCD to DCDD. This is a considerable waste of already constrained resources. The definition is not changing nor are the selection criteria for the patient experiencing a "non-brain death" death; this is simply changing the name of what we call that death.
    - This clarifies the process.

- Please comment on what impact the change in terminology from DCD to DCDD might have on OPTN members and the general public. Are there any unintended consequences that may result from this change?
    - The impact for the OPTN members is that each donor hospital and transplant center will have to change their policy simply because the wording of DCD to DCDD has changed. In most institutions, this is a cumbersome process that can take many months and consuming many resources in those months. Due to the amount of time it takes to change policy, many hospitals will be "out of compliance" as their policy will not be updated on the date this new change is effective, thus resulting in another item to be cited by UNOS. In some hospitals, it takes at least six months from the time a policy revision is made to go through the entire approval process. The Committee is not sure this will make any difference to the general public nor will they even be aware of it. The majority of the general public can't explain brain death, let alone DCD.
    - Terminology clears things for the medical professionals and always has the possibility of causing concern and doubt with the public.

- Please comment on what impact the following changes in terminology will have: Withdrawal of life sustaining "measures" to Withdrawal of life sustaining "Medical Treatment/Support," and the addition of "disease" included in the suitable candidate evaluation section.
    - None in either case.
    - Agree with new wording. It adds clarity.

2. **Patient Information Sharing Task Force**. The TAC has two representatives on the Transplant Coordinators Committee (TCC) Patient Information Sharing Task Force that continue to provide the full committee with updates during the TAC monthly Live Meetings and in-person meetings. There have been two conference calls and an in person meeting in Chicago on April 28, 2011. The goal of the Task Force is to develop guidelines regarding the standards for the sharing of donor and recipient information (i.e. type of work, parent, child, quality of life, etc) that should be provided to donor families and recipients, and the appropriate timeframe to share this information. Additionally, the group will identify why transplant hospitals prohibit the release of *non-identifiable information* based on the interpretations of related HIPAA regulations and how this affects the information shared. Below is the feedback the TAC provided to the Task Force on issues

they should consider when developing guidelines/standards for this practice pertaining to the transplant administrator's role.

- This is a great initiative. Please try and emphasize that when it comes to hospitals and the sharing of information, there does not appear to be "standardization" regarding the level of information that organizations are willing to share. Each hospital's patient privacy unit operates quite differently from one another. It was suggested that perhaps patient privacy representatives from different transplant hospitals also serve on the Task Force to discuss what content can be shared and what cannot be shared based on a general set of guidelines regarding privacy that each hospital is expected to follow.
- It becomes very easy for donor families to identify their loved one's recipients with increasing use of internet, dates and general locations of transplant. Transplant is still novel and is oftentimes published in the local newspapers.
- The recipient's diagnosis should not be disclosed as it is specific medical information about the patient.
- The transplant center should work on providing a "story" about the recipient, not the details of the transplant.
- One concern surrounds the sharing of quality of life. How will that be defined? Who should be responsible for making that assessment?
- One committee member was astonished that this is a problem. Some centers have been sharing basic information about transplant recipients with OPOs for at least twenty years and have never had an issue. Midwest Transplant Network (MTN) faxes the transplant center a form asking for recipient follow-up about a week after the patient has been transplanted. The form asks for age, profession, marital status, number of children and ages, and hobbies. The donor family letter from the MTN reads, "The heart recipient is a retired farmer in his late 50's from Missouri. He and his wife have three children and four grandchildren. He is looking forward to returning to his hobbies of hunting and helping with the annual church bazaar."
- The Task Force might want to consider contacting Midwest Transplant Network and to discuss their system.
- It was suggested that the reason that many transplant centers don't comply with this request are two-fold. First is a time constraint issue; transplant center staff often have a great deal of work to do, and this type of follow-up can inadvertently fall to the bottom of the "things- to-do list." Second and probably more applicable, is the simple fact that the legal or risk management departments of transplant centers lack a clear understanding of HIPAA's applicability in this regard and they are trained to not violate HIPAA at all costs. Therefore, it really would seem a matter of education and understating of HIPAA's applicability in this regard and not an unwillingness to cooperate with OPOs.
- It would very beneficial to ask for a legal opinion from either the UNOS attorney or even better the Department of Justice to provide the needed tool to educate hospital legal and risk management departments that this information can really be shared with the OPO, and ultimately with the donor's family.
- Keep the information requested simple. The overwhelming majority of families want to know: 1) that the organs were used, 2) the age and race of the recipient, 3) how did the organ do; is it working and 4) a little background about the person, family person, occupations, interests, etc.
- One committee member was amazed this is an issue and that centers would somehow interpret this as a HIPAA violation. This member's OPO sends via email an electronic link to a secure website where the transplant center fills out basic information about the recipients.

There is certainly the need for the Task Force to inquire with hospitals as to why the do not share this information. Then an approach needs to be made to educate/address those reasons.

- It is best to provide basic information to the donor families – which organ was transplanted, age, occupation, family, hobbies.
- A legal representative needs to be involved with this Task Force. Information shared with the donor family includes: what organs have been used and the state that the recipient resides; however, the center's Compliance Officer stated that the center cannot release any specific information on the recipient to the donor, including whether they are deceased unless the recipient previously consented to the release of information.
- One committee member's center has not had any issues with releasing this information to the OPOs. Some of the forms from the OPOs have requested social security number of the recipient and those are not released.

The Pancreas for Technical Reasons Work Group minutes were reported to the Committee. No other meetings with this Work Group have occurred since October 7, 2010. It was reported that the Work Group recommended that pancreata recovered for technical reasons from a donor weighing less than 35 kg should be reported as not transplanted and pancreata recovered for technical reasons from a donor weighing more than 35 kg should be reported as transplanted. Pancreata recovered for use in a pancreas-alone or SPK transplant should continue to be reported as transplanted (if the organ is transplanted) regardless of the donor weight. The Committee will continue to have a Work Group representative provide the full committee with the Work Group's updates on the TAC monthly Live Meetings.

The Committee received an overview of Policy 6.0 Transplantation of Non-Resident Aliens and provided feedback to the Ad Hoc International Relations Committee (AHIRC) in regards to:

- Which policies in 6.0 cannot be measured as written?
  - 6.2.3- How do you monitor the charges for all non-resident aliens?
  - 6.2.4- This cannot be measured.
  - 6.2.5 – The Committee felt this policy is unrealistic especially for centers that only perform one or two of these transplants a year and it is unclear on how to establish a mechanism for community participation and how to review candidate acceptance criteria.
  - 6.2.6- The Ad Hoc International Relations Committee (AHIRC) needs to consider including specific language that will support training for this population and include how to measure.
  - 6.4.4 – This cannot be measured.
- What concepts in Policy 6.0 should the AHIRC consider revising?
  - 6.1.1- The TAC requested that the definition of Non-Resident Alien be clarified.
  - 6.2.5 – If this policy is not eliminated, then the AHIRC should clarify the definition of community participation.
- What concepts in Policy 6.0 should the AHIRC consider eliminating?
  - The TAC thought that the AHIRC should consider eliminating 6.2.5, 6.2.6 and 6.3.
  - The AHIRC should consider addressing outcomes/survival but question the ability to follow-up with non-resident aliens once they return to their country of origin. The Committee thought it would be interesting to know what percent of non-resident alien patients are listed as "lost to follow up." The Committee also shared some of their transplant center policies and procedures regarding transplanting non-resident aliens.

The TAC has representatives on various committee Work Groups. Those Work Groups include: KPD, KPD Financial Subcommittee, Policy Rewrite, Pancreas for Technical Reasons, Transplant Coordinator Committee Patient Information Sharing Task Force and the Operations and Safety Vessel Policy and Vessel Packaging and Labeling. At this time, these TAC representatives participate in Live Meetings with these Work Groups to provide the transplant administrator perspective on proposals that evolve from the Work Group's sponsoring committees. These representatives are also responsible for reporting any Work Group updates and activities on the TAC monthly Live Meetings.

3. **OPTN Committee Goal: To develop educational strategies for members regarding more effective use of DonorNet®**. The Committee's DonorNet® Work Group is working in conjunction with the TCC, Operations and Safety the OPO Committees on developing DonorNet® educational materials. The focus of the Work Group, at this time, is to examine the use of non-standardized abbreviations and the inadequate documentation of donor information in DonorNet® **(Exhibit A)**. The Operations and Safety, Transplant Coordinators, and OPO Committees' recommendations were reviewed and Work Group approved suggestions were incorporated into the document. The list of standardized abbreviations was also reviewed for plain language, by the UNOS Department of Evaluation and Quality and UNOS Director of Policy. On April 13, 2011, the Work Group had a conference call to review and discuss the recommendations received from AOPO and NATCO. Based on those recommendations, the Work Group decided to accept and add the following additional abbreviations to the list of acceptable abbreviations:

   - BD - Brain Dead
   - DCD - Donation after Circulatory Death
   - CVVHD – continuous veno-venous hemodialysis & remove CAVHD
   - ETOH – alcohol
   - NKDA - No Known Drug Allergies

   The plan is to disseminate the standardized abbreviations to the transplant community through the DonorNet® help document, professional listservs, AOPO portal, NATCO and with any other DonorNet® educational/informational materials that are distributed to the transplant community from UNOS by June, 2011. The Work Group will also consider developing other DonorNet® educational resources.

4. **OPTN Committee Goal: To work with staff to develop potential strategies for improving the quality of data submission**. The Committee will provide ideas regarding improving program specific reports by discussing concerns with the program specific reports and ideas to address those concerns.

5. **UNOS Private - 2011 Transplant Management Forum**. The 2011 Transplant Management Forum was held April 18-20 in Denver, Colorado. A total of 427 participants attended the meeting. The Committee accepted a total of 32 abstracts. There were 50 exhibitors, 9 sponsors and 7 abstract award sponsors supporting the meeting. The agenda included nine plenary sessions and four breakout session tracks. The 2012 Transplant Management Forum will be in Puerto Rico on April 25-27. The Committee has received several suggestions for 2012 sessions and has had several exhibitors expressing their interest in participating in the 2012 forum. Agenda planning will begin in July.

6. **UNOS Private - Staffing Survey**. The Committee continues to evaluate how the staffing survey might be helpful and useful for the MPSC as it evaluates new program applications or considers the performance of centers having outcome problems. The 2010 Staffing Survey was released on the Transplant Administrators section of the UNOS Secure Enterprise Web Site in late February. The deadline for submitting a survey has been moved up to June 30 (vs. December 31 previously) with the idea that limited time will force administrators to act. Several reminders to submit the survey have been sent to the community by UNOS e-Newsletter, UNOS Update Magazine, UNOS Regional Meetings, UNOS Transplant Management Forum and Transplant Administrator listserv messages. The goal for the 2010 Staffing Survey is to have 75% of all transplant programs complete the surveys. As of mid-May, response rates range from 9% for lung to 18% for kidney programs, continuing the trend of declining participation over the past few years. Starting in early June, comparison statistics for transplant program staffing with the 2010 data will be available to any member who has already submitted a survey. As in prior years, only programs that complete surveys for their organ specific programs will have access to the summary and comparison data.

   The TAC Staffing Work Group is in the midst of reviewing the survey tool and report with an eye towards making it more useful, easier to complete, and in turn increasing participation. The Work Group held a workshop at the 2011 Transplant Management Forum in Denver to gather feedback from fellow administrators on their thoughts about the survey. The majority of the workshop attendees felt it was worth keeping survey active. They also provided several ideas that may lower barriers and encourage administrators to submit a survey. The TAC is considering how best to incorporate these ideas for next year's survey.

7. **UNOS Private - Request for Information**. The Committee continues to explore how the Request For Information (RFI) payer group could assist UNOS in understanding the perspectives and concerns of payers while balancing the needs of transplant centers for adequate reimbursement. The Committee held its bi-annual payers meeting in July 2010, and the Payer Work Group met with selected payers in Chicago to discuss updates/changes that should be made to the current RFI. The two updates the payers approved included the removal of Readmission Rates question, and made some revisions to the VADs table on the heart RFI to include only the past three years of data and centers only need to report that a device was use for bridge to transplant. Annual updates along with the payer approved revisions to the RFI were submitted to UNOS in October 2010. The updates were made and the January 2011 release deadline was met. Due to the SRTR contractor transition, the RFI SRTR files are now uploaded by SRTR to a UNOS SharePoint site. UNOS staff uploads the RFI SRTR data to the RFI as requested by the transplant center. Future Work Group initiatives include developing a FAQ document and RFI field definitions.

8. **Public Comment Responses**. The Committee discussed and made recommendations for the following proposals released for public comment:

   1. **Proposal to Require Collection of Human Leukocyte Antigen (HLA) Type for Thoracic Organs (Thoracic Organ Transplantation Committee)**

      Committee Response: No comment

   2. **Proposal to Clarify Adult Heart Status 1A Language to Enable Consistent Interpretation of Policy and Reflect Current Programming in UNet℠ (Thoracic Organ Transplantation Committee)**

      Committee Response: No comment

3. **Proposal to Clarify which Transplant Program has Responsibility for Elements of the Living Donation Process and to Reassign Reporting Responsibility for Living Donation from the Recipient Transplant Program to the Transplant Program Performing the Living Donor Nephrectomy or Hepatectomy. (Living Donor Committee and Membership and Professional Standards Committee)**

   Committee Response: The Committee voted to support this proposal as written (12- Support, 0 -Oppose, 0-Abstain)

4. **Proposal to include Qualifications for a Director of Liver Transplant Anesthesia in the OPTN Bylaws (Membership and Professional Standards Committee)**

   Committee Response: The Committee discussed and supported this proposal with the following language modifications. The Committee would like the MPSC to consider changing the proposal language from Director of Liver Transplant Anesthesia to "Qualified or Lead Anesthesiologist". This would prevent potential financial issues for the transplant centers and other issues surrounding the politics of using the title "Director". The Committee agreed the proposal language should focus more on the position's responsibilities than the title of "Director". (11-Support with language modifications, 0-Oppose, 0-Abstain)

5. **Proposal to Modify the Requirements for Transplant Hospitals that Perform Living Donor Kidney Recoveries (Membership and Professional Standards Committee)**

   Committee Response: The Committee discussed and supported this proposal as written (12-Support, 0-Oppose, 0-Abstain).

6. **Proposal to Prohibit Storage of Hepatitis C Antibody Positive and Hepatitis B Surface Antigen Positive Extra Vessels (Operations and Safety Committee)**

   Committee Response: The Committee discussed this proposal and did not support the proposal as written. (0-Support, 12- Oppose, 0-Abstain) The Committee did not think one situation necessitates the development of a policy prohibiting the storage of Hepatitis C antibody positive and Hepatitis B surface antigen positive extra vessels. The Committee supports having a time-out process but not restricting the storage of these vessels.

7. **Proposed Model for Assessing the Effectiveness of Individual OPOs in Key Measures of Organ Recovery and Utilization (Membership and Professional Standards Committee)**

   Committee Response: The Transplant Administrators Committee discussed this proposal via conference call/Live Meeting on February 23, 2011, and again on March 8, 2011. The Committee did not vote but was in overall support of the proposal. The Committee agrees that this effort will provide a more objective measure of OPO performance that is more data driven and less open for individual interpretation. However, the Committee recommends that the MPSC consider including the following variables in future models:

   - Transplant center acceptance rates
   - Incidents of transplantation
   - Size of waitlist by organ
   - Concerned that data is compared against a national mean
   - Patient waitlist characteristics

- Need further detailed analysis regarding acceptance utilization of DCD organs (Pancreas, Lung and Heart)
- Need to address the relationship between OPO performance and transplant outcomes, and
- Need to consider the following important characteristics for adequate organ function measurements and they are reported through the DDR:

Heart	Liver	Lung	Kidney	Pancreas
Ejection Fraction	Tbili	Abnormal CXR	Biopsy results	Amylase results
Cardiac enzymes	AST	Chest Trauma		Lipase results
History of cancer	ALT	Chest tube insertion		
History of heavy alcohol use	Liver function studies			
HCV positive	Biopsy results			

The TAC believes this is a step in the right direction but has some concerns regarding how the data will be used in the future and how this model will affect transplant centers overall and in reference to transplant center acceptance rates.

8. Proposal to Update and Clarify Language in the DCD Model Elements (Organ Procurement Organization and Organ Availability Committees)

Committee Response: The impact for the OPTN members is that each donor hospital and transplant center will have to change their policy to reflect the change. In most institutions, this is a cumbersome process that can take many months, consuming many resources in those months. Because it can/does take many months, many hospitals will be "out of compliance" as their policy will not be updated on the date this new change is effective, thus resulting in being cited by UNOS. In some hospitals, it takes at least six months from the time a policy revision is made to go through the entire approval process.

The Committee also had some suggestions regarding the proposal language and suggested that the policy include a definition of circulatory death that is consistent with other professional societies across the country.

Regarding the language at the bottom of page 8 and top of page 9 under section B Protocols, "OPOs and transplant centers shall establish protocols that define the roles and responsibilities of the OPO and transplant centers for the evaluation and management of potential donors, organ recovery and organ placement in compliance with OPTN policy."

A committee member pointed out a potential conflict with this language and the language in UNOS Policy 2.0 (Standards for OPOs). In Policy 2.0, the responsibility for the evaluation and management of organ donors rests solely on the "Host OPO." This wording would potentially conflict with the wording in Policy 2.0 by having one policy that makes it a shared responsibility (OPO and transplant center) and one that makes it the responsibility of the Host OPO.

The following suggested wording would more accurately capture the intent of what is attempting to be conveyed and avoids the unintended conflicts between the wordings of the two policies:

Suggested wording:
B. Protocols
OPOs in consultation with their affiliated transplant centers shall establish protocols that define the roles and responsibilities of the OPO and transplant centers for the evaluation and management of potential DCD donors, DCD organ recovery, and DCD organ placement, in compliance with OPTN policy.

On Page 9, section E, *"***Withdrawal of Life Sustaining Medical Treatment/Support ~~Measures/Patient Management~~** Before withdrawing life-sustaining medical treatment or ventilated support, the OPO is required to conduct a timeout to:"

The wording as proposed is vague and could be left open for interpretation.

Suggested wording:
Before withdrawing life-sustaining medical treatment or ventilated support, the OPO must communicate with the surgical recovery team including the surgeons and operating room personnel, and other health care professionals that will be present during the withdrawal of life sustaining treatment ~~is required to conduct a timeout~~ to:

1. Verify the patient's identification, etc.

Feedback on the last sentence in Section E on page 10 which reads as follows:

"No member of the Organ Recovery team or OPO staff may guide or administer palliative care or declare death."

This sentence may be overly broad and restrictive in its construction. For example, the health care team members that may be withdrawing treatment and providing the actual comfort care can and frequently do have questions for the OPO staff before, during and after the DCD process. So while the OPO staff member will not actually administer comfort care medications, or withdraw the endotracheal tube, they may be asked guidance questions by the healthcare team members. The Committee is concerned that the wording as proposed would not allow the OPO staff to answer such questions for fear of "guiding" such activities.

Also, the definition of palliative is becoming increasingly broad, and it may include simple comfort measures such as putting an extremity in a more comfortable position for a patient, and is not the type of care we are concerned that an OPO staff member might be engaged in performing.

Suggested wording:

No member of the Organ Recovery team or OPO staff may guide or administer palliative care comfort/palliative care medications prior to circulatory death, nor may they declare the patient's death.

Also, on page 10, Section F, under pronouncement of Death there is the following statement:

"Pronouncement of death can only be made after a sufficient time period has passed, as defined by hospital policy."

The problem with this statement is that OPOs still perform DCD recovery in hospitals that do not have DCD Hospital Policies. Therefore, it is impossible for those hospitals to comply with policies they do not have. Also, it is not the OPTN's responsibility to assure that hospital's have such policies nor are they responsible for the hospital's compliance with their own policies. Since it is not the OPTN's responsibility to oversee all the hospitals in the country in this manner, the last proposed clause of "as defined by hospital policy" should be deleted. (11-Support with suggested changes, 0-Oppose, 0-Abstain)

9. Proposal to List All Non-Metastatic Hepatoblastoma Pediatric Liver Candidates as Status 1B (Pediatric and Liver and Intestinal Organ Transplantation Committees)

Committee Response: The Committee discussed and unanimously supported this proposal as written. (11-Support, 0-Oppose, 0-Abstain)

10. Proposal to Eliminate the Requirement that Pediatric Liver Candidates Must be Located in a Hospital's Intensive Care Unit to Qualify as Status 1A or 1B (Pediatric Transplantation Committee)

Committee Response: The Committee discussed and unanimously supported this proposal as written. (11-Support, 0-Oppose, 0-Abstain)

11. Proposal to Encourage Organ Procurement Organizations (OPO) to Provide Computed Tomography (CT) Scan if Requested by Transplant Programs, And to Modify Language in 3.7.12.3 for Currency and Readability (Thoracic Organ Transplantation Committee)

Committee Response: The Committee discussed and unanimously supported this proposal. However, the Committee would like the Thoracic Organ Transplantation Committee to take into consideration that there may be resistance from the abdominal surgeons due to the potential delay in abdominal organ procurement by the thoracic surgeons, additional costs, and transplant centers could receive resistance from OPOs for requesting CT scans for standard criteria organs.(11-Support, 0- Oppose, 0-Abstain)

12. Proposal to Require Updates of Certain Clinical Factors Every 14 Days for Lung Transplant Candidates with Lung Allocation Scores (LAS) of at Least Fifty, And to Modify Policy 3.7.6.3 for Currency and Readability (Thoracic Organ Transplantation Committee)

Committee Response: The Committee discussed and unanimously opposed this proposal. The Committee agreed that this policy adds a significant layer of complexity for lung programs. The number of policy changes and the new requirements in those changes are making it extremely difficult for centers to reach 100% compliance. This policy creates a significant workload for transplant centers making it difficult for centers to remain in compliance, takes away from actual patient care, impacts transplant centers' financial resources and increases UNOS audit time. The Committee questioned the data supporting the decision to change the policy to a 14 day requirement and would like to know if there is

any supporting data regarding the percentage of patients that are receiving transplants with a LAS greater than 50 that would have had a LAS of less than 50 if retested at the suggested 14 days. (0-Support, 11-Oppose, 0-Abstain)

13. Proposal to Allow Outpatient Adult Heart Transplant Candidates Implanted with Total Artificial Hearts (TAH) Thirty Days of Status 1A Time (Thoracic Organ Transplantation Committee)

Committee Response: The Committee discussed and supported this proposal. The Committee suggested that the Thoracic Organ Transplantation Committee continue to discuss the inequities of this policy. They agreed that the total artificial heart population that is discharged from the hospital with a portable driver needs to be addressed and suggested further discussion regarding the new sub-segment of patients with mechanical circulatory support. The Committee also discussed the fact that this proposal proposes changing policy to accommodate a clinical trial. The Committee commented that the reason for this policy proposal is that hospitals are now able to discharge patients with total artificial hearts and under current policy the patient would lose his/her Status 1A time. In essence, the proposed policy change is being driven by the fact that patients with total artificial hearts can be discharged with a portable driver, which is currently in clinical trial. (10-Support, 0-Oppose, 1-Abstain)

14. Proposal to Improve the Reporting of Living Donor Status (Living Donor Committee)

Committee Response: The Committee did not vote on the proposal, but had the following questions and comments.

- Does this proposal specifically address which center should be responsible for the living donation process and if not it needs to be addressed in the proposal.
- The Committee was concerned that some centers will not be able to achieve compliance with this proposal.
- The Committee questioned the value of collecting this data and stated that this is an unfunded mandate and has a significant impact on transplant centers' resources.

15. Proposal to Improve the Packaging, Labeling and Shipping of Living Donor Organs, Vessels and Tissue Typing Materials (Living Donor Committee)

Committee Response: The Committee did not vote on the proposal, but the Living Donor Committee needs to be aware that there is concern from some transplant centers across the country that a mandate was not made making OPOs responsible for the shipping of living donor organs. The overall feeling is that the OPO is the expert in the labeling, packaging and shipping of organs. The lower volume of events for specific transplant centers will potentially create opportunity for error.

16. Proposed Committee-Sponsored Alternative Allocation System (CAS) for Split Liver Allocation (Liver and Intestinal Transplantation Committee)

Committee Response: The Committee did not vote and had no concerns regarding this proposal.

17. Proposal to Standardize Label Requirements for Vessel Storage and Vessel Transport (Organ Procurement Organization (OPO) Committee)

Committee Response: The Committee did not vote and had no concerns regarding this proposal.

18. Proposal to Require Confirmatory Subtyping of Non-A1 and Non-A1B Donors (Operations and Safety Committee)

Committee Response: The Committee did not vote and had no concerns regarding this proposal.

19. Proposal for Improved Imaging Criteria for HCC Exceptions (Liver and Intestinal Transplantation Committee)

Committee Response: The Committee did not vote on this proposal, but made the following comments/recommendations.

- The proposal needs to specifically state certify the imaging reports and if the transplant center needs to retain that documentation for compliance.

20. Proposal to Reduce Waiting List Deaths for Adult Liver-Intestine Candidates (Liver and Intestinal Transplantation Committee)

Committee Response: The Committee did not vote on this proposal, but made the following comments/recommendations.

- A committee member commented that there may be areas in the country where living donor livers are an alternative for smaller adults but there is an impact on access for some small adults due to living donation not being available in their local area. These candidates do not have the means to travel and/or insurance that covers travel and housing to the areas where living donation is available.
- Some centers have a significant number of deaths on their wait list and cannot receive enough organ offers; therefore, to not accept a liver because another candidate needs a liver/intestine is not logical.
- The Committee recommends broader national liver sharing policies. It is difficult to support a policy that may potentially redirect organs away from organ poor regions as deaths on the wait list continue to increase for liver alone candidates in this population. If policy changes are going to be considered for liver and intestine recipients, then changes for liver alone recipients should also be considered.
- The Committee is interested to know if an analysis was done to determine the impact on deaths on the liver alone wait list after determining the number of livers that might leave a region for a liver/intestine allocation. Specifically, what is the impact on candidates who are less than 62 inches on the liver alone wait list and already have a slightly higher death rate than those candidates who are greater than 62 inches?
- The Committee suggested also using MELD/PELD for liver/intestine candidates.

TRANSPLANT ADMINISTRATORS COMMITTEE	MONTH	October	November	December
	DAY	14-15	15	15
	FORMAT	In Person Meeting	Live Meeting	Live Meeting
NAME	COMMITTEE POSITION			
Gene E. Ridolfi BA, RN	Chair	X	X	X
Timothy Stevens RN, BSN, CCTC	Vice Chair	X		X
Sharon Mathews MS, RN, CPTC	Regional Rep.	X	X	X
Sylvia Odom RN, MSN, NHS, CCTC	Regional Rep.			
Katherine Stark MHSA	Regional Rep.		X	
Kim Barnett RN, BSN, CCTC	Regional Rep.	X	X	X
Amy Peele	Regional Rep.	X	X	X
Pamela Hester RN, BSN, CCTC	Regional Rep.	X		X
Sara O'Loughlin MHA	Regional Rep.	X	X	X
Nancy Long RN, CCTC	Regional Rep.	X	X	X
Nancy Metzler	Regional Rep.	X	X	X
Katherine Evers RN, BSN, MBA	Regional Rep.	X	X	
Robert Teaster RN, MBA, CPTC	Regional Rep.	X	X	X
Leroy Walker	At Large	X	X	X
Vikram Acharya BS, MPH	At Large	X		X
James Cutler CPTC	At Large	X	X	X
David Hefner	At Large	X	X	X
Jacqueline Colleran	At Large			
Angel Carroll MSW	Liaison	X	X	X
Cherri Carwile	Assistant Liaison	X	X	X
Jude Maghirang MS	Support Staff	X	X	X
Lin McGaw RN, MEd	Director Professional Services	X		X
Bertram Kasiske	SRTR Liaison	X	X	
Jeff Schmid	UNOS Conference Planning	X		X
Kerrie Cobb	UNOS Staff Support		X	
Mesmin Germain, MBA, MPH	Ex. Officio			
Robert Walsh	Ex. Officio	X	X	
Holly Berilla MSW	Ex. Officio	X		X

TRANSPLANT ADMINISTRATORS COMMITTEE	MONTH	January	February	March
	DAY	26	23	23
	FORMAT	Live Meeting	Live Meeting	Live Meeting
NAME	COMMITTEE POSITION			
Gene E. Ridolfi BA, RN	Chair	X	X	X
Timothy Stevens RN, BSN, CCTC	Vice Chair	X	X	X
Sharon Mathews MS, RN, CPTC	Regional Rep.	X	X	X
Sylvia Odom RN, MSN, NHS, CCTC	Regional Rep.			
Katherine Stark MHSA	Regional Rep.	X		X
Kim Barnett RN, BSN, CCTC	Regional Rep.		X	X
Amy Peele	Regional Rep.	X	X	X
Pamela Hester RN, BSN, CCTC	Regional Rep.		X	
Sara O'Loughlin MHA	Regional Rep.	X	X	X
Nancy Long RN, CCTC	Regional Rep.	X		X
Nancy Metzler	Regional Rep.	X	X	X
Katherine Evers RN, BSN, MBA	Regional Rep.	X	X	
Robert Teaster RN, MBA, CPTC	Regional Rep.	X	X	
Leroy Walker	At Large	X	X	X
Vikram Acharya BS, MPH	At Large	X		X
James Cutler CPTC	At Large	X	X	
David Hefner	At Large		X	
Jacqueline Colleran	At Large			
Angel Carroll MSW	Liaison	X	X	X
Cherri Carwile	Assistant Liaison	X	X	X
Jude Maghirang MS	Research Support Staff	X	X	X
Kerrie Cobb	UNOS Staff Support	X		X
Lin McGaw RN, MEd	Director Professional Services			
Bertram Kasiske MD, FACP	SRTR Liaison			
Adrine Chung	SRTR Liaison	X		
Tabitha Leighton	SRTR Liaison		X	X
Jon Snyder PhD, MS	SRTR Liaison			X
Mesmin Germain, MBA, MPH	Ex. Officio			
Robert Walsh	Ex. Officio			
Holly Berilla MSW	Ex. Officio		X	X

TRANSPLANT ADMINISTRATORS COMMITTEE	MONTH	May	May
	DAY	17	25
	FORMAT	Live Meeting	Live Meeting
NAME	COMMITTEE POSITION		
Gene E. Ridolfi BA, RN	Chair	X	X
Timothy Stevens RN, BSN, CCTC	Vice Chair	X	X
Sharon Mathews MS, RN, CPTC	Regional Rep.	X	X
Sylvia Odom RN, MSN, NHS, CCTC	Regional Rep.		
Katherine Stark MHSA	Regional Rep.	X	X
Kim Barnett RN, BSN, CCTC	Regional Rep.	X	
Amy Peele RN	Regional Rep.		X
Pamela Hester RN, BSN, CCTC	Regional Rep.	X	X
Sara O'Loughlin MHA	Regional Rep.	X	X
Nancy Long RN, CCTC	Regional Rep.	X	X
Nancy Metzler	Regional Rep.	X	X
Robert Teaster RN, MBA, CPTC	Regional Rep.	X	X
Leroy Walker	At Large		
Vikram Acharya BS, MPH	At Large		
James Cutler CPTC	At Large	X	
David Hefner	At Large		X
Angel Carroll MSW	Liaison	X	X
Cherri Carwile	Assistant Liaison	X	X
Jude Maghirang MS	Research Support Staff	X	X
Kerrie Cobb	UNOS Support Staff		
Cheryl Hall	UNOS Support Staff	X	X
Lin McGaw RN, MEd	Director Professional Services		
Bertram Kasiske MD, FACP	SRTR Liaison	X	
Adrine Chung	SRTR Liaison		X
Tabitha Leighton	SRTR Liaison	X	
Jon Snyder PhD, MS	SRTR Liaison		
Mesmin Germain, MBA, MPH	Ex. Officio		
Robert Walsh	Ex. Officio		X
Holly Berilla MSW	Ex. Officio		