OPTN/UNOS TRANSPLANT COORDINATORS COMMITTEE
SUMMARY

I. Action Items for Board Consideration:

- The Board is asked to approve modifications to Policy 3.3.6 (Center Acceptance of Organ Offers) requiring the reallocation of organs when the Donation after Cardiac Death (DCD) donor converts to brain death. This proposed policy change would require the reallocation of organs when the DCD donor converts to brain death and encourage the allocation of organs that had not previously been allocated. (Item 1, Page 3)

- The Board is asked to approve the Committee's request to recommend facilitating the release of recipient information by the transplant center to the OPO. The Committee prepared information and a consent form to facilitate the release of recipient information. This information regarding the benefits of sharing information with donor families will facilitate communication between OPO and transplant center personnel regarding recipient information that can be shared with donor families. (Item 2, Page 7)

II. Other Significant Items:

- The Committee discussed its experiences with UNet ^{SM} 2007. (Item 3, Page 8)

- The Committee discussed the confusion that exists regarding the number of red topped tubes of blood required for ABO verification when shipping organs. (Item 4, Page 8)

- Updates were given on the Organ Transplantation Breakthrough Collaborative and HRSA. (Item 5, Page 10)

- The Committee discussed the President's Goals. (Items 6-12, Page 10-12)

- The Committee considered policy proposals distributed for public comment. (Items 13 and 14, Pages 12 and 18)

- The Committee compared ABTC Certification between the transplant center and OPO. (Item 15, Page 21)

- The Committee sought clarification as to who in a transplant center is responsible for verifying potential transplant candidate citizenship or legal residency. (Item 16, Page 22)

- The Committee discussed the UNOS Bylaw that requires transplant centers to send letters to patients removed from the waitlist even when the patient dies shortly afterwards. (Item 17, Page 22)

This page is intentionally left blank.

REPORT OF THE
OPTN/UNOS TRANSPLANT COORDINATORS COMMITTEE TO THE
OPTN/UNOS BOARD OF DIRECTORS
June 26, 2007

Barbara Nuesse RN, BSN, CCTC, CPTC, Chair
Cheryl Edwards RN, MSN, CCTC, CPTC, Vice-chair

This report represents the OPTN/UNOS Transplant Coordinators Committee (TCC) deliberations for meetings held on October 27, 2006 and April 25, 2007, and monthly committee conference calls on December 6, 2006, January 9, 2007, February 15, 2007, and March 15, 2007.

1. When the Donation After Cardiac Death (DCD) Donor Converts to Neurologic Death. The Committee discussed the proposed policy change to OPTN/UNOS Policy 3.3.6 which requires the reallocation of organs when the DCD donor converts to brain death. In August 2006, the Policy Oversight Committee (POC) did not recommend that this proposal be submitted for Board approval following the support of public comment, the UNOS regions, and the OPTN/UNOS organ specific committees. At that time, the POC requested additional information regarding the impact on donor families and recipients, whether or not this policy would be a disincentive for centers to participate in DCD, and the frequency of occurrence.

   The Committee agreed that donor families' wishes should be the deciding factor whether or not organs are reallocated when the DCD donor converts to brain death. Members discussed experiences when families had opted to wait for the reallocation of organs, while others did not. There are currently no guidelines for the reallocation of organs when the DCD donor converts to brain death, and there is inconsistency in how this situation is handled throughout the United States. Members agreed that it is unfair for the current practice to continue without a national standard mandating that all organs be reallocated when this situation occurs.

   Members stressed that this should not be a transplant center issue, but a donor family driven issue. There is a perception of ownership when a center accepts an offer. However, the organ should be allocated to the sickest patient. All candidates must be told that all offers are tentative offers, including those from the brain dead donor, as conditions change during the donor management process. Some members explained that they provide specific information regarding a changing status (e.g. serology) so families can be prepared for a potential change in the offer.

   The Committee was unable to determine if there will be changes in a transplant center's willingness to accept DCD livers and with the absence of a national policy, this situation will continue to be dealt with differently. The Committee was committed to the Collaborative goal to increase yield or organs per donor.

   Some members opined that the Committee should add a data collection/tracking element to the proposal and would like to review those data in one year. However, members also felt that it was morally wrong to not move forward with the family's wishes. If policy allowed OPOs to reallocate DCD to brain dead donor organs, then more organs per donor may be transplanted.

   Motion: The Committee will collaborate with the OPO Committee and OAC Committee and work together to obtain the data that is being requested by the POC in order to further move this proposal to the Board for approval.

   Committee vote: 14 in favor, 0 opposed, and 0 abstentions.

A subcommittee was formed to identify data that will be needed and to assist in the construction of a spreadsheet to collect the data. Barbara Nuesse, Cheryl Edwards, Michael Thibault, Gary Burris, and Ann Roman were on this subcommittee.

The Committee suggested the following questions be included in the DCD to brain death data collection survey:

- What OPOs practice when there is a change in donor status? How often does this situation occur?
- What are the allocation outcomes?
- How many people are passing DCD organ offers and recommended that the subcommittee look at DCD refusal codes? (They agreed that the Liver Committee might be able to identify which centers do not accept DCD organs.)
- Will you transplant DCD organs? If so, what criteria do you use?

The Committee also discussed whether this policy should have a description of any acceptable exceptions to the policy, such as when the candidate has been brought to the hospital, or the donor has been taken to the Operating Room. After discussion, members agreed that this information should not be included. It was agreed that all patients should be instructed regarding the tentative nature of the DCD offer. All DCD offers are tentative because once life support is withdrawn, the patient may not die within the time frame designated by the OPO's policy. When transplant teams are mobilized, they are most likely local teams and members did not feel that this should be a consideration in organ reallocation. The Committee felt that inconvenience is not a justifiable excuse to ignore allocation policies.

It was anticipated that more thoracic organs and livers will be transplanted from donors who are pronounced dead by neurologic criteria. As such, it was agreed that the implementation of this change will help OPOs meet the program goals of increasing the number of organs donated and procured, and increase the number of organs transplanted per donor. The proposed policy change remains the same:

3.3.6 Center Acceptance of Organ Offers. If an organ is offered and accepted without conditions, the Host OPO and recipient transplant center shall be bound by this transaction unless there is mutual agreement on an alternative allocation of the organ. This policy shall not apply in the case of a DCD donor who deteriorates to brain death after an initial offer has been made. In this instance, the match must be re-run and organs must be allocated according to policies 3.5 - 3.11 to the highest ranked transplant candidates. Additionally, OPOs are encouraged to initiate allocations of organs that may have been ruled out due to the donor's DCD status (i.e. heart,, lungs, pancreas). In circumstances where an organ is not re-allocated despite the donor changing from a DCD donor to a brain dead donor, the host OPO is responsible for submitting documentation explaining the event.

The Committee distributed the proposed policy change during the May 2006 Public Comment period (**Exhibit A**). All regions supported the proposed change' although a small number of people participated in the regional calls.

Public comment resulted in 62 responses regarding this policy proposal. Of these, 50 (80.65%) supported the proposal, 3 (4.84%) opposed the proposal, and 9 (14.52%) had no opinion. Of the 53 who responded with an opinion, 50 (94.34%) supported the proposal and 3 (5.66%) opposed the proposal.

Summary of Public Comment Responses

Region	Meeting Dates	Motion to Approve as Written	Voting Members Represented/ Total Voting Members	Percent of Total Voting Members Represented
1	7/10-11/06	1 yes, 0 no, 0 abstentions	1/19	5%
2	7/10-11/06	3 yes, 0 no, 0 abstentions	3/46	7%
3	7/10-11/06	1 yes, 0 no, 0 abstentions	1/41	2%
4	7/10-11/06	1 yes, 0 no, 0 abstentions	1/40	3%
5	7/10-11/06	6 yes, 1 no, 0 abstentions	7/47	15%
6	7/10-11/06	4 yes, 0 no, 0 abstentions	4/14	29%
7	7/10-11/06	1 yes, 0 no, 0 abstentions	1/25	4%
8	7/10-11/06	4 yes, 0 no, 0 abstentions	4/28	14%
9	7/10-11/06	1 yes, 0 no, 0 abstentions	1/21	5%
10	7/10-11/06	3 yes, 0 no, 0 abstentions	3/31	10%
11	7/10-11/06	3 yes, 0 no, 0 abstentions	3/34	9%

Following receipt of the comments, the Committee discussed the issues and decided to move forward with the proposal as it was due to the level of support that it received.

One year after the date of implementation, the Committee will review the available data regarding how often a DCD donor converted to brain death and how often the amended policy was not followed. At that time, the Committee will propose any necessary modifications to this proposal.

Evaluation Plan: The Transplant Coordinators Committee will evaluate the data after one year to determine how often this situation occurs, to determine if OPOs are complying with the allocation change for greater consistency, to determine if organs are being reallocated to sicker patients, and to determine if more organs are being recovered per donor.

The Policy Oversight Committee (POC) reviewed this policy at its August 16, 2006 meeting (**Exhibit B**). The POC had three concerns for the Committee to address:

- the impact on donor families and recipients

- whether or not this policy would be a disincentive for centers to participate in DCD
- the frequency of occurrence.

Based upon these concerns and the need for further review, the Committee addressed the issues identified by the POC and planned to submit the proposal to the Board in December 2006. However, in October 2006, the POC considered the Committee's response regarding the POC's three concerns, and again the POC did not recommend that the proposal be submitted for Board approval due to lack of supporting proposal data. The Committee provided a response (**Exhibit C**). At that time, the Committee discussed the need for a survey of OPOs to capture the frequency of occurrence as requested by the POC.

In February 2007, a survey was distributed to 18 participating OPOs (**Exhibit D**). The intent of the survey was to capture how often a DCD donor converts to brain death and to determine how OPOs were managing this situation.

At the March 23, 2007, Board of Directors meeting, Rich Luskin, Executive Director of the New England Organ Bank, opened the discussion regarding the DCD donor that converts to brain death. The Board discussed the proposed change to Policy 3.3.6 (Center Acceptance of Organ Offers) and supported its intent. The Board asked the Committee to reconsider the proposal to include specific concerns voiced by the Board and to return the proposal, as is or changed, at the June 2007 Board of Director's meeting. At the Committee's April 2007 meeting, the Committee considered the Board's request and addressed its concerns. In response, the Committee offered the following summary of discussion regarding this issue and an amendment to the original DCD to brain death proposal.

The Committee reconfirmed its support of the reallocation of organs in this situation and agreed that it is in the best interest of the donor family, sicker patients who may receive the reallocated organs, and those candidates who may be waiting for other organs that were not previously allocated.

The TCC discussed circumstances when it may not be appropriate to reallocate organs from the DCD donor that converts to brain death. These circumstances include:

- lack of donor family approval and consent
- donor instability
- the situation occurs within four hours of the scheduled operating room recovery time.

The TCC agreed that, most importantly, the decision to reallocate organs must be donor family and patient driven. Therefore, donor family approval and consent, as well as donor stability are paramount in consideration for reallocation. In order to account for logistical issues, the TCC felt that if the DCD donor is declared brain dead within four hours of the scheduled operating room recovery time, the OPO should have the option to not reallocate. As with all organ offers, the potential transplant recipient should be reminded that all organs offers are tentative and unforeseen issues may arise to prevent transplant. The TCC will continue to collect data until July 2007 to help determine how often a donor converts from DCD to brain death.

The Committee unanimously supported this proposed policy change with a vote of 14 in favor, 0 opposed, and 0 abstentions; therefore, it offers the following modifications for consideration by the Board of Directors:

***** RESOLVED, that the following modification to Policy 3.3.6 (Center Acceptance of Organ Offers) shall be approved, effective August 1, 2007.**

3.3.6 Center Acceptance of Organ Offers. If an organ is offered and accepted without conditions, the Host OPO and ~~recipient~~ intended recipient's transplant center shall be bound by this transaction unless there is mutual agreement on an alternative allocation of the organ.

3.3.6.1 Exception for DCD Donor who Converts to Brain Death After an Organ Offer has been Made. When a DCD donor converts to brain death, the match system must be re-executed and organs must be allocated according to policies 3.5 - 3.11. Policy 3.6.5.1 does not apply when a DCD donor converts to brain death. Additionally, OPOs are encouraged to initiate allocation of organs that may have been ruled out due to the donor's DCD status (i.e. heart, lungs, pancreas).

3.3.6.1.1 The Host OPO may choose not to re-allocate organs from a DCD donor who converts to brain death in the following circumstances: 1) lack of donor family approval and consent; 2) donor instability; or 3) the DCD donor converts to brain death within four hours of the scheduled operating room recovery time. The Host OPO must document the reason for not re-allocating organs when a DCD donor converts to brain death and make this documentation available upon request.

2. Transplant Center Release of Information to Provide to Donor Families**.** The Committee discussed the considerable difficulty members have in securing recipient information from transplant centers to provide to donor families. Several members reported the inability to get basic recipient information from their transplant center such as whether or not the organ was transplanted. The Committee agreed that, in order to comply with HIPAA regulations, transplant centers need to secure release forms from their patients. Representatives from the Patient Affairs Committee and Communications Committee participated on the subcommittee that the TCC formed at the last meeting.

The subcommittee developed a draft brochure that discusses the sharing of information and an attached consent form that lists specific information that the recipient can agree to share. One member recommended the insertion of the following question: Would you be willing to correspond with your donor family? Committee members agreed that this information could be added to UNet^{SM} to facilitate the exchange of information.

Motion: That each candidate receive the attached brochure (**Exhibit E**) during the evaluation process and provide the candidate with the opportunity to return the "Release of Information" form demonstrating their wishes for the transplant center to release information. A copy of this consent form will be maintained in the patient's medical record. This proposal should be submitted for public comment.

The Committee supported the proposal by a vote of 13-0-0.

Following the Committee meeting, the subcommittee continued to develop the brochure and to secure legal recommendations for the consent form. At that time, UNOS noted that there are insufficient resources to produce the brochure and to add to the work load of the Department of Evaluation and Quality (DEQ). UNOS suggested that the brochure be recommended for use by transplant center and OPO personnel and then be made available on the UNOS website.

The Committee unanimously supported this proposed recommendation with a vote of 14 in favor, 0 opposed, and 0 abstentions; therefore, it offers the following recommendation for consideration by the Board of Directors:

***** RESOLVED, that the OPTN/UNOS Board of Directors strongly recommend the use of the attached release of recipient information brochure (Exhibit E) to donor families as a best practice.**

3. UNet^{SM} 2007. The Committee agreed that UNet^{SM} 2007 is a valuable system with a promising future. UNet^{SM} 2007 particularly works well with marginal and high risk donors as OPOs are able to make offers more expeditiously. Several Committee members shared concerns regarding the new system. Within the last 30 to 45 days, one member experienced language barriers with several Help Desk specialists who did not seem to understand DonorNet® issues and were unable to help. Several members noted that the offline utility does not work. There were reports that DonorNet® has added 10-12 hours to OPO organ placement time because centers were clicking on Provisional Yes. Also, there is no response mechanism to notify the coordinator that the organ has been accepted. Members noted that an electronic notification of back-up offers would be beneficial. The Committee also questioned whether the automation of DonorNet® may lead to more mistakes due to the assumption of information that will not be relayed verbally.

4. Policy 2.5.5 (Organ Procurement Quality), Policy 3.5.9 (Minimum Information/Tissue for Kidney Offer), and 5.5.6 (Standard Organ Package Specifications). There was discussion regarding the confusion that exists regarding the number of red topped tubes of blood required for ABO verification when shipping organs. Policy 2.5.5 (Organ Procurement Quality) and Policy 3.5.9 (Minimum Information/Tissue for Kidney Offer) require the Host OPO to provide the potential recipient's transplant center with one 7 to 10 ml. clot (red topped tube) of blood for each kidney and pancreas. Policy 5.5.6 (Standard Organ Package Specifications) requires a red topped tube of blood to accompany each organ and tissue typing material. UNOS cited an OPO for sending only one red topped tube of blood with each kidney. The audit report indicated that policy requires the host OPO to send two red topped tubes of blood with each kidney and pancreas to the accepting center; one tube for ABO verification and one tube for tissue typing. The TCC questioned if the OPO Committee's intention, when developing these policies, was to require that two blood samples accompany each kidney and pancreas. Although OPOs verify ABO twice, members agreed that one red topped tube provides an adequate amount of blood for ABO verification. Members reported that some OPOs send one tube and some send two tubes, demonstrating that there is some inconsistency in the interpretation of these policies.

   Motion: The Committee requested that the OPO Committee review these policies and determine the original intent regarding the total number of red topped tubes of blood that must accompany each organ. UNOS staff discussed this issue with all appropriate parties to expedite the clarification and resolution of the issue.

   The Committee approved the motion by a vote of 14-0-0.

   The OPO Committee reviewed the policies and noted that the intent of the policies was that one red topped tube of blood be sent to the receiving OPO or transplant center. The TCC appreciated the OPO Committee's clarification on the number of red topped tubes of blood required to

accompany each organ for ABO verification. The TCC discussed how to prevent further confusion and ensure consistency in the interpretation of these policies.

Motion: The Committee proposed that the following modifications to Policy 2.5.5 and Policy 3.5.9 be circulated for public comment:

2.5.5 Each OPO, with their respective histocompatibility laboratories, will establish minimum written requirements for tissue typing material required to generate match runs for local or regional placement of all organs. Organ procurement organizations will establish minimum requirements for tissue typing material required for local disposition of livers, hearts and lungs. In view of the frequent need for regional shipment of pancreas and kidney allografts, however, sufficient specimens for several crossmatches are required. Minimal typing material to be obtained for <u>each</u> kidney and pancreas will include the following:

- ~~One 7 to 10ml. clot (red topped) tubes, plus~~
- 2 ACD (Yellow top) tubes
- 3 to 5 lymph nodes
- One 2 X 4 cm. wedge of spleen in culture medium, if available.

3.5.9 <u>Minimum Information/Tissue for Kidney Offer</u>.

<u>3.5.9.1 Essential Information for Kidney Offers.</u> The Host OPO must provide the following information to the potential recipient center with each kidney offer:

(i) Donor name and Donor I.D. number, age, sex, and race;
(ii) Date of admission for the current hospitalization;
(iii) Diagnosis;
(iv) Blood type;
(v) HLAA, B, Bw4, Bw6, and DR antigens;
(vi) Current history of abdominal injuries and operations;
(vii) Pertinent past medical or social history;
(viii) Current history of average blood pressure, hypotensive episodes, average urine output, and oliguria;
(ix) Final urinalysis;
(x) Final BUN and creatinine;
(xi) Indications of sepsis;
(xii) Assurance that final blood and urine cultures are pending;
(xiii) Pre- or post-transfusion serologies as indicated in 2.2.7.1 (pre-transfusion preferred);
(xiv) Current medication and transfusion history;
(xv) Recovery blood pressure and urine output information;
(xvi) Recovery medications;
(xvii) Type of recovery procedure (e.g., en bloc); flush solution and method (e.g., in situ); and flush storage solution;
(xviii) Description of typing material available, including, as a minimum for each kidney:
- ~~One 7 to 10ml. clot (red topped) tubes, plus~~
- 2 ACD (yellow top) tubes

- 3 to 5 lymph nodes
- One 2 X 4 cm wedge of spleen in culture medium, if available

(xix) Warm ischemia time and organ flush characteristics; and

(xx) Anatomical description, including number of blood vessels, ureters, and approximate length of each, injuries to or abnormalities of the blood vessels, ureter(s) or kidney.

Committee vote: 14 in favor, 0 opposed, and 0 abstentions.

5. Organ Transplantation Breakthrough Collaborative and HRSA Update. Franki Chabalewski, RN, MS, UNOS Professional Services Coordinator, gave an update on the success of the Collaborative. A large focus of this year's Collaborative was pediatric and in March 2007, a Pediatric Summit was organized and well attended. At the April 2007 Learning Session 2, the Collaborative announced that in the future, there will be regional participation incorporated into the regional meetings with one annual National Learning Congress to be held in Nashville, TN October 9-10, 2007. Topics will vary by region.

Nancy Carothers, RN, HRSA, provided the Committee with HRSA educational materials regarding organ donation and discussed various initiatives such as the 400,000 Donor Designation Project that the department coordinates. She also presented a "Physicians' Kit" for primary care physicians. The kit, which can be placed in physicians' offices, comprises information cards, posters, "discussion" cards, calendar and donor cards. Ms. Carothers requested feedback from Committee members regarding the concept and content.

At the Committee's April 25, 2007, meeting, Ms. Carothers informed the Committee of several donation-related educational materials available for everyone. A booklet titled, *Partnering with Your Transplant Team*, is now available in Spanish and can be ordered through UNOS or the HRSA Information Center. Also, HRSA recently developed a Primary Care Physicians test kit which will be available in English and Spanish on May 2, 2007; 1-866-ASK-HRSA or send through Nancy Carothers at DOT. The kit includes a table top poster, an examining room poster, informational cards, a card for the physician to help answer donation-related questions, a tear-off pad on how to join the donor registry, and a calendar with information on it. To encourage patients to talk about organ donation with their doctors, informational items, including a video, will be placed in the waiting room at the doctor's office. Also, volunteer OPO professionals and transplant physicians will be speaking with the local primary care physicians about organ donation. HRSA feels that donation should be a normal part of end of life discussions with the PCP. This will first be tested in El Paso and Dallas on a volunteer basis. Since this is a pilot test, HRSA welcomes feedback and suggestions.

6. Transplant Center Redesign. Geri Libetti represents the Committee on the HRSA Transplant Center Redesign project. Ms. Libetti was included in two site visits made by the Lewin Group that is currently under contract with HRSA to evaluate high performing transplant centers. The Lewin Group will present its recommendations on May 16 and 17. Ms. Libetti reported on Jade Purdue's Transplant Center Redesign presentation at the Transplant Administrators meeting in Washington DC on April 23-25. Key question: What can transplant centers do to expand and improve systems to increase volume and improve results (by next Tuesday).

7. Develop best practices for improving communications between OPO coordinators and transplant center coordinators during actual offer process. The Committee discussed this directive and agreed that the problems that may have occurred in the past will likely be solved through the implementation of the new DonorNet® system. The Committee felt that communication will improve with the help of the Rapid Response Task Force. After the implementation of UNet^{SM} 2007, the Committee will review previous issues to ensure that the new system does not create new communication issues.

8. Develop best practices for communications between OPO and Transplant Center coordinators after offer process including notification of transplant center of outcome of offers refused and transplanted elsewhere. Some members voiced their concerns about working on this issue and established that it may not be the OPO's responsibility to "track down" the information to share with the transplant center. However, the Committee agreed that it is important for transplant centers to be aware of their 'turndown rates', especially when a refused organ is successfully transplanted elsewhere. Transplant centers are aware that DSA monthly reports demonstrate these data. Transplant centers will become more aware of these data as they become more aware of the reports. More education may be required. The Committee discussed a possible modification to DonorNet®. The Committee suggested that transplant centers receive a report indicating the placement outcome of organs that the transplant center refused (similar to bypass code notification to center).

9. Provide plans for collaboration with Organ Availability Committee to improve placements through the Organ Center. The Committee agreed that a subcommittee should collaborate with the OAC and the Organ Center to improve placements. Cheryl Edwards will serve as the representative from the Committee. The Committee felt that the new DonorNet® system should enhance placement; however, OPOs are penalized for allocating organs out of sequence. Transplant centers must review listing criteria in order to prevent futile organ offers.

10. Participate in the cooperative working group formed by the Operations Committee and in conjunction with the OPO Committee and Organ Availability Committee-with a rapid response mechanism (utilizing live meeting manager, conference calls) to evaluate the effect and potentially trouble shoot, the implementation of the simultaneous donor notification UNet^{SM} 07. Barbara Nuesse has been the TCC representative to this task force. After initial implementation of DonorNet® in Region 2, the UNOS IT department addressed issues related to the DonorNet® process. The Rapid Response Task Force discussed these issues and worked to problem solve prior to the national implementation date of DonorNet®. The TCC congratulates the members of the Operations Committee, as well as the dedicated staff of the UNOS IT department for their hard work. They have developed a process that will facilitate the placement of donor organs and ultimately increase organ transplants.

11. Provide a plan to develop training modules for transplant coordinators. A subcommittee was formed to address this issue. Cheryl Edwards will chair the subcommittee, and Susan Noska, Joe Nespral, Gary Burris, and Kim Fox will serve as members.

    The subcommittee met by conference call and agreed that UNOS should not duplicate NATCO's educational efforts by producing training modules. The subcommittee agreed that the Committee

would have the ability to review the UNet[SM] tutorials and provide input regarding how to present information to coordinators.

The subcommittee reviewed the list of UNet[SM] tutorials to determine if they were current and appropriate. The subcommittee reconvened at the April meeting to discuss a path forward. It was important for tutorials to be identified as having either a donation or a clinical transplant focus.

The Committee agreed that the DonorNet® tutorials were very clear, helpful, and well done.

12. Develop guidelines for appropriate list management practices to avoid unnecessary offers. Tiered acceptance criteria are currently being developed by the DSA Task Force and the OPO Committee. Geri Libetti will look at this issue with the Transplant Center Redesign project.

It was suggested that a brochure be developed that discusses what types of things can be found on UNet[SM], such as "How do you find a policy?"

13. Public Comment Proposals Distributed for Public Comment August 28, 2006.

1. Proposal for National Kidney Paired Donation (KPD) Program (Kidney Transplantation Committee)

The Committee discussed the intent of this proposal of providing the steps for implementation of a program to match live donors and their intended candidates with other live donor/intended candidate pairs when it is determined that the live donors cannot donate to the persons they initially hoped would receive their kidney. Such matching enables multiple transplants to occur where the transplant opportunities otherwise would be lost. The proposal is designed to maximize the number of living donor kidney transplants allowing the possibility for some candidate or candidate/donor pair prioritization consistent with the system for deceased donor kidney allocation, and acknowledging logistical constraints and system improvements that will become more feasible as experience with the program is evaluated.

Members agreed that this proposal is premature as it has not been deemed legally permissible and questioned if there are studies planned to examine the additional costs incurred for centers, recipients and donors as well as the risk of public solicitation, which would be difficult to control. One member discussed the issues and problems encountered with their OPOs paired kidney program. Their protocols mandate that both the donor and recipient are taken to the OR at the same time so that no one is disadvantaged if the surgery does not proceed. This situation can cause specific challenges when there are large distances between the donor and recipient.

For a paired exchange program to be successful there will need to be a large number of participants registered as donors and recipients. Frequently, candidates for organs and donors are very selective about who manages their healthcare and specifically who will perform the nephrectomy. Recipients may be somewhat coercive if a donor does not wish to go to a specific surgeon or center. It is clear that there needs to be an element of trust and familiarity in order to have accountability and trust. Logistics may be difficult with large distances and may not work on a national system. The Committee supported the concept of a paired exchange program and agreed that this may diminish the use of independent brokers.

Motion: That the Committee support the concept of a paired exchange. In light of concerns voiced by the Transplant Administrators Committee regarding cost and logistics, the Committee requests that the Kidney Transplantation Committee have a representative from the Transplant Administrators Committee participate in further discussions and deliberations.

The Committee supported the proposed change by a vote of 14-0-0.

The Committee agreed that the proposal was difficult to read and understand, and voiced concern that the general public would have a very difficult time reading and understanding it.

2. Proposed Allocation System for Broader Sharing for Livers in Region 8 (Liver and Intestinal Organ Transplantation Committee)

This proposed alternative allocation system is intended to create a system for broader sharing for livers in Region 8. It also suggests that the SRTR model this proposal for every region of the country and analyze its potential impact.

The Committee understands that the proposed changes stratify Meld scores, ultimately will eliminate paybacks, and acknowledges that the sickest patients will get priority. It does not support HCC or exceptional cases. Members agreed that this change will be a good sharing system and understands that it may increase costs, as there will be additional costs incurred for travel. Members also agreed that this proposal will encourage collegial conversation.

The Committee supported the proposed change by a vote of 13-0-1.

3. Proposed Modifications to OPTN/UNOS Policy 3.6.4.2 (Pediatric Candidate Status) (Liver and Intestinal Organ Transplantation Committee)

This proposed modification will change the requirement for recertification and updated labs for pediatric Status 1B candidates with metabolic diseases and hepatoblastoma from seven days to three months. The Committee recognized that the current recertification schedule for Status 1B does not take into account that candidates with metabolic diseases and hepatoblastoma, unlike candidates with chronic liver disease with decompensation, do not require such frequent lab work due to static lab results. This proposed modification will also reduce the requirement for red blood cell replacement for combined liver-intestine candidates in order to meet Status 1A criteria.

The Committee stated that it is appropriate to decrease the requirement for lab work and reduce the requirement for red blood cell replacements in order to meet Status 1A criteria. This change will also help to decrease the paperwork necessary for the pediatric patient.

The Committee supported the proposed change by a vote of 14-0-0.

4. Proposed New OPTN/UNOS Policy 3.11.4.2 (Combined Liver-Intestine Organ from Donors 0-10 Years of Age) (Liver and Intestinal Organ Transplantation Committee)

This proposal will allow combined liver-intestine grafts to be allocated to national candidates from the liver waiting list if there is no local Status 1A or 1B candidates or candidates with a PELD score of 20 or greater. The intent of this proposal is to increase the availability of smaller size organs for pediatric liver-intestine candidates.

Presently it is possible to have two different match runs, the liver and the intestine. It is up to the OPO to determine how the match will be run. The organs will still be allocated locally first. However, there was some confusion as to whether the same list is used for liver and combined liver and intestine, or if the combined liver and intestine list should be run separately (this list is not currently available). Some members did not feel that this policy language clarified the policy or that this policy addresses paybacks. Members also agreed that enforcing compliance may be difficult, unless a separate match run is generated where only combined liver and intestine candidates print up.

The Committee supported the proposed change by a vote of 13-0-1 if the payback component is eliminated from the policy. The elimination of paybacks would be in keeping with the spirit of the new liver allocation proposal for region 8.

Motion: That the Liver/Intestinal Committee considers making the following change to the proposal: Allow for a match run to be generated where the list is combined liver and intestine candidates. This list will facilitate, and ensure that liver/intestine candidates are receiving organ offers as per policy.

5. Proposed Modifications to OPTN/UNOS Policies 3.6.4.4 (Liver Transplant Candidates with Hepatocellular Carcinoma) (Liver and Intestinal Organ Transplantation Committee)

This proposal will change the listing criteria for liver candidates with hepatocellular carcinoma (HCC) from the current Milan criteria to the UCSF expanded criteria. Recent studies indicate that the current criteria for orthotopic liver transplantation (OLT) can be modestly expanded while still preserving excellent post-transplant survival.

The Committee understands that this UCSF protocol has been adopted in several regions, with some objections. The removal of the ultrasound as a mandatory test was discussed. . Members noted that there does not seem to be a good methodology to determine tumor spread or size and there seems to be a discrepancy between the size and number of tumors. This discrepancy often is related to different radiologic methodologies used. The Committee questioned how many patients would be added to the list with the implementation of this policy.

The Committee supported the proposed change by a vote of 14-0-0.

6. Proposed Modifications to OPTN/UNOS Policy 3.6.11 (Allocation of Livers for Segmental Transplantation) (Liver and Intestinal Organ Transplantation Committee)

This proposal will utilize specific criteria to identify potential split liver donors on every OPO match run while also identifying candidates who have indicated they would be willing to accept a segmental graft. The intent of this proposal is to initiate discussions between the OPOs and the transplant centers and possibly increase the utilization of split liver transplants.

The Committee identified patient education needs. When a donor is listed, there are currently no data elements as suggested in the policy. The Committee agreed that there needs to be some interpretation, due to the fact that, as written, the decision to pursue the split organ is left up to the OPO. It identifies the donors as potential for split livers and specifies on the list who will identify the surgeon who will accept a split liver. Concerns were voiced that this proposed change does not follow a national standard.

The Committee agreed that this is a transplant center issue, requires resources, and it is the transplant surgeon's responsibility to determine the suitability of an organ to be split, not the OPOs. If this proposal does pass, the TCC recommends that these organs should remain within the local area or with other groups that are familiar with each other. It was also unclear as to who will determine who will be offered a segment. It was agreed that this policy may help the transplant centers in identifying those organs which may be suitable for splitting, but should in no way be considered a mandate.

The Committee supported the proposed change by a vote of 14-0-0.

7. Proposed Modifications to OPTN/UNOS Policy 3.6.4.1 (Adult Candidate Status) (Liver and Intestinal Organ Transplantation Committee)

This proposal will change the Status 1A criteria for candidates with primary non-function of a transplanted liver within 7 days of implantation. The requirement for an AST $\geq$ 5000 will be lowered to $\geq$ 3000. Additionally, there would be no AST requirement for those recipients of segmental grafts. The policy modification will also require the Regional Review Boards (RRBs) to retrospectively review Status 1A and 1B cases that do not meet the criteria as outlined in the policy.

The Committee discussed that this proposal changes the definition of status 1A with a patient that has a primary non-function and agreed that the change in requirements was reasonable. Additionally, by deleting AST as a requirement for status 1A on patients receiving segmental grafts, this will continue to encourage centers to split liver organs.

The Committee supported the proposed change by a vote of 14-0-0.

8. Proposed Modifications to OPTN/UNOS Bylaws Appendix B Attachment 1, Section VI (Transplant Surgeon and Physician) and Section XII (Transplant Programs) (Liver and Intestinal Organ Transplantation Committee)

This proposal will establish minimum criteria for intestinal surgeons, physicians, and transplant programs. The Committee chose not to comment on this proposal.

9. Proposed Modifications to OPTN/UNOS Policy 3.6.4.7 (Combined Liver-Intestine Candidates) (Liver and Intestinal Organ Transplantation Committee)

This proposal will provide an additional 23 MELD/PELD points for candidates whose ages fall within the 0-17 year old range, who are awaiting a combined liver-intestine transplant, and who are registered on both waiting lists. Current policy allows for candidates awaiting a combined liver-intestine transplant who are registered on both waiting lists to automatically receive an additional increase in their MELD/PELD score equivalent to a 10% risk of 3-month mortality. The intent of this proposal is to provide a better opportunity for these candidates to receive a transplant.

There are no requirements listed for liver-intestine transplants combined. The Committee concluded that this policy may disadvantage liver patients. It was recommended that the Liver and Intestinal Committee monitor outcomes and compare the single liver and the liver-intestine recipients.

The Committee supported the proposed change by a vote of 14-0-0

10. Proposed Modifications to OPTN/UNOS Policy 3.6.2.2 (Liver Allocation to Candidates Willing to Accept an Incompatible Blood Type) (Liver and Intestinal Organ Transplantation Committee)

This proposal will change the MELD/PELD score requirement for candidates who are willing to accept a liver from a donor of any blood type. The requirement will change from 25 or greater to 30 or greater. The intent of this proposal is to maintain consistency between Policy 3.6.2.1 and Policy 3.6.2.2.

The Committee supported the proposed change by a vote of 14-0-0.

11. Proposed Modifications to OPTN/UNOS Policy 3.8.2 (Waiting Time Adjustment) (Pancreas Transplantation Committee)

The proposed policy change will provide a mechanism for candidates listed for pancreas or pancreatic islet transplant to transfer waiting time between the whole organ and pancreas islet cell lists. The objective is to accommodate candidates who experience a change in medical status that may affect their ability to tolerate the whole pancreas transplant procedure as well as candidates whose transplant centers discontinue an islet cell transplant program after candidate listing.

The Committee supported the proposed change by a vote of 14-0-0.

12. Proposed Modifications to OPTN/UNOS Policy 3.8.1 (Pancreas Organ Allocation) (Pancreas Transplantation Committee)

This proposal would modify pancreas allocation policy by assigning priority based upon candidate sensitization, using a more precise standard to define sensitization than panel reactive antibody (PRA) level as presently used in organ allocation, in addition to waiting time. The proposal is expected to improve efficiency of pancreas allocation by better indicating among truly sensitized candidates those who are most likely to be acceptable recipients for particular organs and assigning them priority when compatible organs become available. The Committee agreed that this proposed change will expedite placement.

The Committee supported the proposed change by a vote of 14-0-0.

13. Proposed Modification to OPTN/UNOS Policy 3.7.2 (Geographic Sequence of Thoracic Organ Allocation) Modification of Zone D and Addition of Zone E (Thoracic Organ Transplantation Committee)

The purpose of this proposal is to modify the zones for thoracic organ allocation to accommodate the needs of Hawaii and potentially serve other organ procurements organizations as well. Zone D will be modified to be greater than 1500 miles and up to and including 2500 miles from the donor hospital. Zone E will be created to be greater than 2500 miles from the donor hospital.

The Committee supported the proposed change by a vote of 14-0-0.

14. Proposed Modification to OPTN/UNOS Policy 3.7.6 (Lung Allocation) Addition of $PaCO_2$ in the Lung Allocation System (Thoracic Organ Transplantation Committee)

The purpose of this proposal would add current and change in $PaCO_2$ to the Lung Allocation System using the lower 90% confidence limit for hazard ratio for candidates ages 12 and up registered for lung transplantation. CO2 is an indicator for mortality while waiting and should be an indicator for a patient to move higher on the list.

The Committee supported the proposed change by a vote of 13-0-0.

15. Recommended Histocompatibility Guidelines" (Histocompatibility Committee)

The Histocompatibility Committee is proposing a set of "Guidelines" to be posted on the OPTN website that reflect the consensus of the Committee regarding state-of-the-art practices that will serve the best interest of the patient and help the OPTN/UNOS achieve its goals of expediting organ placement and minimizing organ wastage.

The Committee supported the proposed change by a vote of 14-0-0.

16. Proposed Modifications to OPTN/UNOS Policy 3.5.11.3 (Panel Reactive Antibody) (Histocompatibility Committee)

The Histocompatibility Committee proposes a modification to Policy 3.5.11.3 Panel Reactive Antibody. This new policy would replace PRA with a Calculated Probability of an Incompatible Donor. This value would be based on candidate's defined unacceptable antigens as entered into the wait list system. This is an attempt to standardize PRA.

The Committee supported the proposed change by a vote of 14-0-0.

17. Proposed Modification of Policy 2.2 (Evaluation of Potential Donors) (Membership and Professional Standards Committee)

The proposed modification clarifies the responsibilities of the Host OPO in undertaking specified evaluations of potential donors. In addition, it establishes the requirement that when specified evaluations are undertaken and the information is not available that the Host OPO must explain those circumstances.

The Committee discussed the appropriateness of the language change regarding the verification of death and also making it mandatory to conduct ABO and HIV testing.

The Committee supported the proposed change by a vote of 14-0-0.

18. Proposed Modifications to OPTN/UNOS Policy 3.5.9 (Minimum Information/Tissue for Kidney Offer) (Organ Availability Committee)

The proposal would require that the Host OPO provide biopsy results for both kidneys of all ECD and DCD donors and at the request of the surgeon and/or OPO for non ECD or DCD kidneys. The wedge technique for renal biopsy is to be utilized obtaining a tissue sample measuring at least 10 mm x 5 mm x 5mm. This sample size is calculated to capture approximately 100 glomeruli. Capture of less than 25 glomeruli will be considered an inadequate biopsy and documentation on the donor form to explain rationale for inadequacy of tissue sample will be

required. Separate standard report forms for frozen and permanent sections will be required for the tissue samples. This modification is intended to standardize renal transplant biopsy procedures and reporting methodologies to allow meaningful analysis in the determination of kidney allograft outcome data.

The Committee's discussion concluded that as this policy is written, no offer can be made until the kidney biopsy has been done. The Committee felt that in light of the fact that biopsy results will not be available until the patient is in the OR, it will, in most cases, delay the timing of the offer, not accelerate it. A recent paper demonstrated that biopsy results may not be the best way to determine renal function. This policy has the potential to increase allocation time and increase cold time. The need for a biopsy is a medical decision, and it should be made at the surgeon's discretion. That being said, there needs to be a standardization process put in place when these biopsies are requested. A biopsy should not be mandated prior to offering a kidney.

The Committee did not support the proposed change by a vote of 0-14-0.

Recommendation: Biopsy results should not be a part of the minimal requirement for DCD donors, and only applied to ECD donors at the discretion of the surgeon. OPOs should provide a biopsy specimen to the accepting center on ECD donors. The Committee supports attempts to standardizing biopsy specimen size.

The Committee supported the recommendation by a vote of 14-0-0.

19. Proposed Modifications to Appendix B of the OPTN Bylaws (OPO Committee).

The Organ Procurement Organization (OPO) Committee is proposing an amendment to Appendix B of the OPTN Bylaws that would require, by January 1, 2007, all OPOs and transplant hospitals to develop protocols to facilitate the recovery of organs from DCD donors. Further, the amendment would also require all OPOs and transplant hospitals to comply with the above required DCD protocol. The proposed amendment addresses HHS Program and donation and transplantation community goals of supporting the development and implementation of protocols to facilitate DCD organ recovery, increasing the number of DCD donors, and increasing the number of organs transplanted per DCD donor.

The Committee agrees that transplant centers should have DCD policy for centers. Members understand that this does not require centers to utilize DCD donors; however, that should not preclude them from having a policy.

The Committee supported the proposed change by a vote of 14-0-0.

14. Public Comment Proposals Distributed for Public Comment March 2, 2007.

1. Proposed Modifications to Data Elements for Pediatric Candidates and Recipients on UNet^{SM} Transplant Candidate Registration (TCR), Transplant Recipient Registration (TRR) and Transplant Recipient Follow-up (TRF) Forms (Pediatric Transplantation Committee)

The proposed changes to the UNet^{SM} data collection forms are intended to complement the recently approved deletions to the adult OPTN data collection forms. These deletions to the pediatric forms will help streamline data collection and reduce the data collection burden on the

transplant centers. The Pediatric Transplantation Committee reviewed all the deletions for adult patients. The Committee elected to remove many of the same elements on the pediatric forms, while recommending the addition of several elements specific to the pediatric transplant population. The decision to retain an item already designated for removal for adults or to add a new field was based upon the OPTN Principles of Data Collection, primarily the development of future allocation policies for pediatric transplant population. In response to the initiative to limit data collection beyond 5 years post-transplant, the Committee also recommended that the OPTN follow pediatric recipients using the pediatric TRF forms for five years after transplant. Beyond five years after transplant and until the pediatric recipients reach 25 years of age, these recipients should be followed using TRF forms with limited data elements similar to those recommended by the OPTN/UNOS organ specific committees for adults, but also including specific data elements pertinent to pediatric issues, especially growth and development, for all organs. Upon reaching age 26, pediatric recipients will be followed using the adult TRF forms with limited data elements.

The Committee supported the concept of the policy proposal, but it recommended more objective cognitive and development measurement language in Appendix B. The Committee was concerned about the data collection burdens that will be placed on the transplant center staff.

Committee vote: 11 in favor, 1 opposed, and 2 abstentions.

2. Proposed Modifications to OPTN/UNOS Policy 7.1.5 "Reporting Definitions" and OPTN/UNOS Policy 7.3.2 "Submission of Organ Specific Transplant Recipient Registration Forms and Submission of Living Donor Registration Forms."

This policy modification will fulfill an OPTN contractual obligation to collect information on all living donors at the time of donation and for at least two years after the donation. The Living Donor Committee is recommending that the two-year Living Donor Follow-up (LDF) form include the same data elements that are currently being collected at one-year post donation. The longer follow-up period will provide valuable information on the experience, safety, and health implications for living donors. Transplant center compliance with living donor follow-up is especially important since no alternative source of data exists.

The Committee discussed the usefulness of the information that a 2 year follow-up would provide. Members questioned if it is UNOS' responsibility to mandate this type of data collection and the liability and responsibility that it might create. However, the Committee approved this policy proposal.

Committee vote: 14 in favor, 0 opposed, and 0 abstentions.

3. Proposed Modification to OPTN/UNOS Policy 7.3.3 "Submission of Living Donor Death and Organ Failure Data" (Living Donor Committee)

Under current policy, transplant programs must report all instances of live donor death and failure of the live donor's native organ function within 72 hours after the center becomes aware of these events. This proposed policy modification defines living donor "native organ failure" as (1) placing living liver donors on the National Liver Transplant Waitlist and (2) living kidney donors requiring dialysis. This proposal limits the reporting period to five years, which will provide valuable information on the short-term health and safety implications for living donors.

The Committee approved this policy proposal; however, the Committee recommended that organ transplant be defined as the need for dialysis, listing for transplant or preemptive transplant.

Committee vote: 14 in favor, 0 opposed, and 0 abstentions.

4. Proposed Modifications to the UNet^{SM} Living Donor Registration (LDR) and Living Donor Follow-up (LDF) Forms (Living Donor Committee)

The Living Donor Committee is proposing to add one new data element to the Living Donor Follow-Up (LDF) form and three new data elements to the Living Donor Registration (LDR) form. The additional data elements would document important information, including:

- attempts to contact a donor classified as "lost to follow-up";
- the date and the living donor's status during the most recent contact between the donor and the recipient transplant center; and
- whether living donor organ recovery and transplant of that organ occurred at the same center.

The Committee felt that living donors should be made aware of and agree to follow-up.

The Committee approved this policy proposal.

Committee vote: 14 in favor, 0 opposed, and 0 abstentions.

5. Proposed Modifications to Data Elements on UNet^{SM} Deceased Donor Registration (DDR) Form. (Organ Availability Committee)

This policy proposal would add new data elements to the OPTN Deceased Donor Registration (DDR) form. Collecting more specific details on the recovery process for individual DCD donors will help the transplant community develop transplant, donation and allocation policies, one of the OPTN guiding principles for future data management. In addition, the majority of these proposed data elements were recommended as a result of the 2005 National Conference on Donation after Cardiac Death.

The Committee rejected this policy proposal and made the following recommendations to Table 1:

- eliminate Agonal Phase Begins and/or O2 sat drops below 80 (Date/Time)
- change Cardiac Death to Declaration of Death
- allow N/A as entries for Abdominal Aortic Cannulation, Thoracic Aorta Cannulation, and Portal Vein Cannulation
- Systolic, Diastolic and Mean Arterial Pressure should be measured in 5 minute intervals, and Urine Output should be measured as Total Urine Output if able to be measured.

Committee vote: 0 in favor, 14 opposed, and 0 abstentions.

6. Proposed Imminent Neurological and Eligible Death Definition Data Elements (OPO Committee)

This proposal outlines the development of data requirements aimed at generating a greater understanding about all imminent neurological and eligible deaths, as defined by the OPTN.

By providing these data, OPOs can:

- help the OPTN increase its knowledge about donor potential;
- identify the prevalence of cases in which clinical brain death parameters are met but brain death is not declared;
- improve the validity of reported donor data; and
- collect data that may also possibly help to develop future reporting definitions for DCD potential and DCD eligible donors.

Since both definitions and the collection of data are mandated under the OPTN contract and are approved by the OPTN/UNOS Board of Directors, UNOS seeks input from the transplant community and public on the implementation of the data collection.

The Committee was concerned about the impact that this proposed policy will have on OPO operations. The Committee scheduled a conference call with Charlie Alexander, Chair of OPO Committee. Further discussions tabled at this time.

7. Proposed Modifications to OPTN and UNOS Bylaws, Appendix A2-1, Section 2.06A, (b), (3) "Probation," (4) "Member Not in Good Standing," (5) "Suspension of Member Privileges," (6) "Termination of Membership or Designated Transplant Program Status," (7) "Action Specified in OPTN Final Rule." (Patient Affairs Committee)

These proposed Bylaw changes would require Members to provide written notification to patients who are being evaluated for transplant, candidates on the waiting list, and transplant recipients within 30 days after the following adverse actions occur:

- Probation
- Member Not in Good Standing
- Suspension of Member Privileges
- Termination of Membership or Designated Transplant Program Status and
- Action Specified in OPTN Final Rule

Both patients being evaluated and candidates listed during the duration of the adverse action must also be informed. The objective is to provide prompt notification of Member violations that might impact treatment services and patient safety.

The Committee discussed this policy proposal and posed the following questions:

- Is this program specific or transplant center?
- Does UNOS mandate the verbiage for the probation letter?

The Committee approved this policy proposal.

Committee vote: 14 in favor, 0 opposed, and 0 abstentions.

15. Mandatory ABTC Certification. There are currently no OPTN/UNOS policies that require mandatory ABTC certification. CMS requires a transplant center to employ at least one ABTC certified clinical coordinator; however, CMS does not have similar requirements for OPOs. The

Committee felt that it is not UNOS' responsibility to mandate or monitor ABTC certification at transplant centers and OPOs.

16. Transplant Candidate Citizenship. The Committee sought clarification as to who in a transplant center is responsible for verifying potential transplant candidate citizenship or legal residency. Susan Noska will pose this question on the Collaborative ListServe in order to gather more information. This topic will be discussed during conference calls and at the October 2007 TCC meeting.

17. Letters sent to patients removed from the waitlist who then die shortly afterwards. Committee members spoke to the distress that family members experience when a patient becomes too sick to remain on the list, dies, and then receives the mandatory letter that the candidate had been removed from the wait list. The Committee discussed this issue and recognized that the spirit of the patient notification bylaw was not to cause duress. The Committee agreed that it could recommend specific language that might be used in members' letters that might be more appropriate for this particular situation. Allan Davis will draft a warm letter for transplant coordinators to send to removed candidates. The letter will acknowledge the family's grief, but also include the necessary information as noted in Bylaws Appendix B (Patient Notification). Susan Noska will also share a letter that she sent to a potential transplant recipient that died shortly after being removed from the waitlist.

TRANSPLANT COORDINATOR COMMITTEE		7/1/2006 to 12/31/2006	1/1/2007 to 6/30/2007
	MONTH	OCTOBER	APRIL
	DAY	27	25
	FORMAT (select)	In Person	In Person
NAME	POSITION		
Barbara Nuesse RN,BSN,CCTC,CPTC	Chair	X	X
Cheryl Edwards RN, MSN, CCRN, CPTC	Vice Chair	X	X
Susan Noska RN, CCTC, CNN	Regional Rep.	X	X
Geri Libetti RN, CCTC	Regional Rep.	X	X
Michael Thibault RN,BSN,CPTC	Regional Rep.	X	X
Judy Boughton RN, CCTC	Regional Rep.	X	X
Heather Sebanc RN, BSN, MBA	Regional Rep.		
Rae Sullivan RN	Regional Rep.	X	X
Lynette Fix RN, BA, CCTC	Regional Rep.		X
Allan Davis BS, RN, CPTC	Regional Rep.	X	X
Maureen Burke-Davis RN, MSN	Regional Rep.		X
Ann Roman MS, ANP-CS	Regional Rep.	X	
Kim Fox RN, BSN, CCTC	Regional Rep.	X	X
Gary Burris RN, CPTC	Regional Rep.	X	X
Neal Evans RN, CPTC	At Large	X	
Joseph Nespral CPTC	At Large	X	X
Cynthia Wofford RN,BSN	At Large	X	X
Nancy Carothers RN	Ex Officio	X	X
Richard Laeng MPH	Ex Officio		
Franki Chabalewski RN, MS	Committee Liaison	X	X
Nichole Pettus, MS	Committee Liaison		X
Maureen McBride, PhD	Research Liaison	X	
Stephen Miklandric	IT Support Staff	X	
Darcy Davies, MS	Research Liaison		X