

**EXECUTIVE SUMMARY  
OF THE MINUTES**

**OPTN/UNOS**

**BOARD OF DIRECTORS MEETING**

**November 14-15, 2002**

**Alexandria, Virginia**

Dr. Barker called the meeting to order at 10:00 a.m. on November 14, 2002. A quorum was present, and 38 of the Board members were in attendance during the meeting.

The Board appointed Dr. Andrew S. Klein to fill the vacancy created by the resignation of Dr. Kenneth L. Brayman, as the Region 2 Councillor on the Board of Directors.

The Board approved several resolutions contained in the Consent Agenda in a single vote. The subject of the various individual resolutions follows here:

1. The Board reaffirmed the position that it is the transplant community's collective responsibility to develop and maintain the public's trust in the donation system.
2. The Board affirmed that there is an ethical justification to support "first person" consent regarding organ donation, and that the Transplant Community strive to honor the wishes of the decedent.
3. The Board approved a new Appendix C to Policy 3.0 for resolving discrepant donor and recipient HLA typing results in the OPTN database.
4. The Board approved modifications to Policy 3.5.3.3 (Mandatory Sharing) adjusting the priority assigned in allocating zero antigen mismatched kidneys for blood type B patients.
5. The Board approved modifications to Policy 3.5.5 (Payback Requirements), 3.5.5.2 (Exception for Prior Living Organ Donors), Policy 3.5.5.3 (Kidney Payback Debt Limit), Policy 3.5.11.5.1 (Pediatric Kidney Transplant Candidate Not Transplanted with Time Goals), and 3.5.11.6 (Donation Status) to assign ultimate priority in the allocation of standard criteria donor kidneys to living kidney donors who subsequently develop end-stage renal failure.
6. The Board approved modifications to Policy 3.5.5 (Payback Requirements), 3.5.5.2 (Exception for Prior Living Organ Donors), Policy 3.5.5.3 (Kidney Payback Debt Limit), Policy 3.5.11.5.1 (Pediatric Kidney Transplant Candidate Not Transplanted with Time Goals), and 3.5.11.6 (Donation Status) to be applied to OPOs operating with OPTN/UNOS approved alternative systems for allocating kidneys as well as the national system of kidney allocation.
7. The Board approved modifications to Policy 3.7.3 (Adult Patient Status) for Status 1A(e) patient listings to ensure the policy maintains a status category for exceptional cases.
8. The Board approved modifications to Policy 3.7.8 (ABO Typing for Heart Allocation) to require that organs be allocated to "born" candidates prior to being offered to any *in utero* transplant candidates.

9. The Board approved twelve requests for waiting time modification and denied two requests for waiting time modification, as recommended by the Kidney and Pancreas Transplantation Committee.
10. The Board approved modifications to Policy 3.6.4.1 (Adult Patient Status) and Policy 3.6.4.2 (Pediatric Patient Status) to reflect on-line submission of Status 1 Justification Forms, effective pending programming on the UNOS computer system.
11. The Board approved the reinstatement of waiting time in each of the four requests as recommended by the Liver and Intestinal Organ Transplantation Committee, pending receipt of all required signatures by UNOS.
12. The Board approved new transplant centers and programs, as well as changes in program status, and renewal of public members.
13. The Board approved the recommendation to encourage the Division of Transplantation to complete the public opinion survey currently on the Department's agenda, and recommends including questions regarding financial incentives and their impact on organ donation in this survey.
14. The Board approved the recommended dissolution of LifeGift's Thoracic Organ ALU in Texas.
15. The Board approved the thoracic variance application from the University of Utah Health Sciences Center, LDS Hospital, the VA (Veterans Affairs) Salt Lake Health Care System, and Primary Children's Medical Center.

The Board approved modifications to Policy 3.5.11.2 (Quality of Antigen Mismatch) modifying points assigned for HLA similarity between potential donor and recipient pairs with a delayed implementation date pending further study of the appropriate number of points to be assigned for HLA similarity. This modification was reconsidered and rescinded by the Board later in the meeting. In its place, the Board approved a resolution modifying Policy 3.5.11.2 (Quality of Antigen Mismatch) to delete the assignment of points for mismatches at the B locus and assign 2 points for a zero HLA DR mismatch and 1 point for a 1 HLA DR mismatch and that such modification shall be implemented on an interim basis and re-evaluated as expeditiously as possible for potential additional adjustment to HLA matching points allocation.

The Board approved modifications to Policy 3.5.3.3 (Mandatory Sharing) to modify the priority assigned in allocating zero antigen mismatched kidneys for sensitized patients to include patients with lower PRA levels among the patients who receive preference based on degree of sensitization.

In a single vote, the Board approved the following five resolutions, as recommended by the Liver and Intestinal Organ Transplantation Committee:

1. Amendments to Policy 3.6.4.4 (Liver Candidates with Hepatocellular Carcinoma (HCC)) such that the MELD score assigned to patients with Stage T1 and T2 HCC tumors be lowered 8% and 15% mortality risks corresponding to MELD scores of 20 and 24, respectively.
2. Amendments to the UNet<sup>sm</sup> HCC application form to collect additional data from patients with tumors that have been downsized due to ablative therapies. Cases in which the original size of the tumor is greater than a stage T2 HCC, as defined in

- Policy 3.6.4.4 (Liver Candidates with Hepatocellular Carcinoma (HCC)) should be automatically referred to the RRB for prospective review and shall be effective subsequent to a national HCC conference to be held in 2003.
3. Amendments to Policy 3.6.4.4 (Liver Candidates with Hepatocellular Carcinoma (HCC)) be amended to state that patients with chronic liver disease whose alpha-fetoprotein level is  $\geq 500$  nanograms on at least one occasion may be listed as a Stage I HCC without RRB review even though there is no evidence of a tumor based on imaging studies.
  4. Amendments to Policy 3.6.4.4 (Liver Candidates with Hepatocellular Carcinoma (HCC)) to state that HCC applications meeting the criteria outlined in Policy 3.6.4.4 be automatically granted the appropriate MELD/PELD score; those applications not meeting the criteria in Policy 3.6.4.4 will be submitted for prospective RRB review.
  5. Amendments to Policy 3.6.4.4 (Liver Candidates with Hepatocellular Carcinoma (HCC)) to include pediatric HCC patients.

The Board approved modifications to Policy 3.6 (Allocation of Livers) and Policy 3.9.3 (Organ Allocation to Multiple Organ Transplant Candidates) to state that, regarding liver-intestine allocation, the liver may be allocated using the intestine list unless there is a Status 1 Liver Patient in the Region, with implementation concurrent with circulation for public comment.

The Board actively discussed a proposed policy change to prohibit further multiple listing of patients however, the Board took no action on the proposal pending public comment and further committee review of the refinements to the proposal.

The Board approved the recommendation that any usage of Potential Transplant Recipient refusal code 991 (Donor Medical Urgency) would require written verification from the OPO to the UNOS Policy Compliance Department.

The Board approved modifications to Policy 7.1 (OPTN Reporting Definitions) to provide for the definitions of solid organ transplant, follow-up period, and graft failure, and approved modifications to Policy 7.5 (Submission of Feedback Information) to allow coordinators sufficient time to submit the forms even when handling back-to-back cases.

The Board directed formation of a Joint Subcommittee among the Kidney & Pancreas Transplantation, Liver & Intestinal Organ Transplantation, Thoracic Organ Transplantation, OPO, and Membership & Professional Standards Committees together with representatives of ASTS, AST, AOPO, and NATCO as well as an individual with expertise in medical malpractice law, to evaluate further the American Society of Transplant Surgeons (ASTS) proposal for credentialing of organ recovery surgeons and make recommendations as may be deemed appropriate regarding details of the proposal for submission to the ASTS.

The Board received a presentation from Marlon Levy, M.D., from Baylor All Saints and Sam Holtzman, President of LifeGift Donation Center (LifeGift) regarding the formation of a single local waiting list for liver allocation and the potential dissolution of the LifeGift ALU for liver allocation. Following these presentations and an extensive discussion, the Board approved the dissolution of the LifeGift ALU for liver allocation and strongly recommended that LifeGift and

Southwest Transplant Alliance work together to form a common local waiting list for liver allocation, in the interests of patients.

The Board then directed that modifications to Policy 3.5.11.2 (Quality of Antigen Mismatch) approved earlier in the meeting be applied to OPOs operating with OPTN/UNOS approved alternative systems for allocating kidneys as well as the national system of kidney allocation, except in the case of OPOs that request exemptions from application of the modifications to their alternative systems when such requests have been approved by the Kidney & Pancreas Transplantation Committee.

The Board then approved in a single vote the following three resolutions, as recommended by the Thoracic Organ Transplantation Committee:

1. Modifications to the template of the Thoracic Justification Forms to capture all data currently provided by the centers through the use of drop down boxes to select the appropriate data and provide entry fields to capture specific data where appropriate throughout the justification form.
2. The recommendation that the minimum acceptable donor weight for heart allocation be limited to 30% below the listing weight of the patient, and the maximum acceptable donor weight for heart allocation be limited to 100% above the listed weight of the patient. These fields may be changed by the centers if they deem it necessary. There is also a recommendation that the on-line data fields for height and weight be required to help calculate and validate the acceptance ranges.
3. The recommendation that the minimum acceptable donor height for lung allocation be limited to 8 inches below the listing height of the patient, and the maximum acceptable donor height for lung allocation be limited to 12 inches above the listed height of the patient. These fields may be changed by the centers if they deem it necessary. The Committee also recommends that the on-line data fields for height and weight be required to help calculate and validate the acceptance ranges.

The Board directed the Membership and Professional Standards Committee to work with NATCO to consider the definition of “Transplant Coordinator” and report to the Board at its June 2003 meeting.

The Board approved the Region 1 Sharing Agreement to make adjustments to the current allocation of kidneys in Region 1 to address historical situations in which the approved Region 1 system for kidney distribution and allocation did not operate on the UNOS computer system.

The Board adopted the slate of nominees for election of members to the Board of Directors, as recommended by the Nominating Committee.

The Board approved a white paper entitled “Split vs. Whole Livers for Transplantation” as a reference point for persons and entities considering the issues involved, with the caveat that the white paper is not to be construed as a national policy on split liver transplantation.

The Board directed its organ-specific committees to review UNOS bylaws regarding histocompatibility requirements for appropriateness to such organ and potential modifications in consideration of present clinical practices.