

OPTN/UNOS AD HOC TRANSPLANT COORDINATORS COMMITTEE

SUMMARY

I. Organ Availability Issues

Action Items for Board Consideration

- None

Other Significant Items

- The Committee supports the Ethics Committee white paper on living non-directed donation. However, the Committee is concerned about the allocation of these organs and requests that all appropriate committees address the issues surrounding the allocation of these living donor organs. (Item 2, Page 2)

II. Patient Access Issues

Action Items for Board Consideration

- None

Other Significant Items

- None

III. Other Issues

Action Items for Board Consideration

- That the OPTN/UNOS Board of Directors amend the OPTN/UNOS Bylaws to change the status of the Ad Hoc Transplant Coordinators Committee to that of a permanent standing OPTN/UNOS Committee. (Item 1, Page 1)

Other Significant Items

- None

OPTN/UNOS AD HOC TRANSPLANT COORDINATORS COMMITTEE

REPORT TO THE OPTN/UNOS BOARD OF DIRECTORS

**June 24-25, 2004
Minneapolis, MN**

**Judy Graham RN, MS, CCRN, CPTC, Chair
Barbara Nuesse RN, CCTC, Vice-chair**

1. **Formal Committee Charge.** At the previous meeting, the Committee members discussed potential goals, objectives and the Committee's formal charge. A Subcommittee was formed and met to draft a charge that was based on the Committee's comments. The Subcommittee drafted summary language, the Committee discussed the draft; and finalized the following language:

“The OPTN/UNOS Ad Hoc Transplant Coordinators Committee is charged with considering issues that affect the coordination of efforts related to organ procurement, organ allocation, and the entire transplant process. The issues to be considered are: organ procurement, organ allocation and the impact of technical innovations on allocation, operations, policies and all aspects of patient/family care. Underlying this charge is the strong advocacy position of these frontline healthcare providers for donors, donor families, transplant candidates and transplant recipients.”

“The Committee's scope of activities includes prioritization of issues, interpretation of data and policy development and educational projects. The Committee will also provide advice and input to the OPTN/UNOS Board of Directors and other OPTN/UNOS Committees.”

Motion: That the Committee approve the Committee's charge as written. The motion was approved by a vote of 16-0-0.

The members discussed the Committee's current Ad Hoc status and agreed that it should be changed to that of a permanent standing OPTN/UNOS Committee. As transplant coordinators are an essential and integral part of the procurement and transplant team, representatives of that community should have a voice and participate in the development of organ allocation policy as well as, have the ability to initiate concerns and address issues that affect the OPTN and UNOS

****RESOLVED, that OPTN/UNOS Bylaws Article VI, Section 6.1, Permanent Standing Committees, shall be modified as set forth below, effective June 25, 2004.**

ARTICLE VI - PERMANENT STANDING COMMITTEES

- 6.1 The Corporation shall have Permanent Standing Committees on Communications, Data Advisory, Ethics, Finance, Histocompatibility, Kidney and Pancreas Transplantation, Liver and Intestinal Organ Transplantation, Membership and Professional Standards, Minority Affairs, Organ Availability, Organ Procurement Organization, Patient Affairs, Pediatric

Transplantation, Thoracic Organ Transplantation, and Transplant Administrators, and Transplant Coordinators. Each geographic region shall be represented on each Standing Committee.

This resolution was approved by a vote of 14-0-0.

2. Living, Non-directed Organ Donation. The Ethics Committee requested that the Committee members review and comment on a draft white paper regarding living, non-directed organ donation. The Committee understands that the paper is in reference to family members that wish to donate an organ, but are not compatible with the candidate. The Committee agreed that the term “recipient” should be changed to “candidate” and that “non-directed donor” should be changed to “non-directed living donor.”

The Committee questioned the ethical implications for transplant centers marketing for individuals to donate to their pool of recipients and the center being solely responsible for the care of the donor. This situation appears self-serving as it benefits the individual transplant center’s patients. The Committee suggested that an independent party should be involved to protect the rights of the donor. One Committee member indicated that it was policy that OPO staff screens the potential donors in this situation.

UNOS may be able to assist potential donors in identifying living donor centers in their area or region and list them on the UNOS web site. Additionally, the term “advocacy” appears in the paper and implies that there is duty; the term should be used carefully and defined clearly. The Committee discussed the responsibilities of the OPTN and questioned its ability to set policy as the OPTN was established to serve deceased donors, not living donors.

Recommendation: The Committee supports the Ethics Committee white paper on living non-directed donation. However, the Committee is concerned about the allocation of these organs and requests that all appropriate committees, such as the OPO Committee, Transplant Administrators Committee, Kidney Pancreas Transplantation Committee and Ad Hoc Living Donor Committee, address the issues surrounding the allocation of these living donor organs. Additionally, UNOS should encourage OPOs and transplant centers to create cooperative procedures and standards to ensure that there is equitable organ allocation based on sound allocation principles and policies.

The Committee approved the recommendation by a vote of 16-0-0.

3. Proposed Policy Changes. The Committee discussed each of the proposed policy changes that were issued for public comment.

1. **Proposed Modifications to Local Voluntary Alternative System for Assigning Priority in Kidney Allocation to Original Intended Candidates for Living Donor Kidneys (Kidney and Pancreas Transplantation Committee)**

The Committee understands that this proposal would clarify a previous proposal approved by the Board to create a generic alternative system that would provide priority in the kidney allocation system for original intended candidates (ICs) for living donor kidneys who are incompatible with their living donors due to crossmatch results or ABO blood type, when the living donors donate organs to candidates on the list of patients waiting for deceased donor kidneys. Under the proposal, ICs would be ranked, in situations where more than one IC appeared on a match run, in order of date of donation from the living donor.

The Committee was concerned about patients who might change their mind and that these patients would be placed behind payback patients. Several Committee members questioned who would be responsible for paying for the living donor pretransplant workup.

The Committee approved the proposed policy change by a vote of 16-0-0.

2. Proposed Modifications to OPTN/UNOS Policies 3.5.3.3 (Mandatory Sharing) and 3.5.5 (Payback Requirements) (Exemption of Kidneys Recovered from Donation after Cardiac Death (DCD) Donors from Sharing Requirements for Zero Antigen Mismatched Kidneys or Payback) (Kidney and Pancreas Transplantation Committee)

The proposal would exempt Donation after Cardiac Death (DCD) donor kidneys from the requirements of the zero antigen mismatch kidney sharing policy, except at the local level of organ distribution, as well as, kidney payback policy. The Committee agreed that the intent of the proposal is to place DCD donor kidneys as rapidly as possible to avoid adverse impacts from increased cold ischemia time, as well as, increase organ donation by providing an incentive for transplant centers to develop and enhance their DCD donor programs.

The Committee discussed the result of the policy being the local use of these kidneys in order to minimize cold ischemic time and that it would exempt them from zero antigen mismatches and paybacks, and allow OPOs to use their kidneys locally. Committee members commented that if a center pumped the kidneys, ischemic time may not be an issue.

After discussion, the Committee commented that this change would help to streamline the process and promote a more expedient organ placement for these living donor organs. However, members were concerned about regional allocation with zero antigen mismatches and agreed that this issue should be reviewed prospectively to encourage regional sharing.

The Committee approved the proposed policy change by a vote of 15-1-0.

3. Proposed Modifications to OPTN/UNOS Policy 3.5.5 (Payback Requirements) (“ECD Kidney Exemption from Payback Sharing Requirements”) (Kidney and Pancreas Transplantation Committee)

The Committee discussed the proposed modifications that would exempt expanded criteria donor (ECD) kidneys from the requirements of the kidney payback policy. OPOs would retain the option to offer expanded criteria donor kidneys for payback, but would not be required to do so under the policy. The Committee discussed the intent of the policy that is to minimize cold ischemia time and maximize use of the ECD kidneys.

The Committee supported this policy change and agreed that ECD donor acceptance may increase over time. After discussion of the benefit of this change, the Committee recommends that this policy be reviewed again in 2 years.

The Committee approved the proposed policy change by a vote of 16-0-0.

4. Proposed Modifications to OPTN/UNOS Policies 3.5.5.1 (Kidney/Non-Renal Organ Sharing) and 3.5.5.2 (Deferment of Voluntary Arrangements) (Kidney and Pancreas Transplantation Committee)

The proposed modifications would increase the ABO blood group payback debt threshold from four to six in terms of an OPO's ability to retain local kidneys or receive shared kidneys to be used in a simultaneous kidney-pancreas transplant. The Committee agreed that the intent of the proposal is to provide additional flexibility in the payback system and enhance opportunities to use both kidneys and the pancreas from donors.

An OPO that cannot meet their payback obligations may have difficulty with this policy. As OPOs sometimes struggle to maintain a static or decreasing payback debt, they may limit their patients' access to transplantation. This policy eases the issue somewhat as coordinators may find it less difficult to decline a good organ just because the program has exceeded its debt limit.

The Committee approved the proposed change by a vote of 11-3-2.

5. Proposed Modifications to OPTN/UNOS Policies 3.5.5 (Payback Requirements) and 3.5.11.5.1 (Pediatric Kidney Transplant Candidates Not Transplanted within Time Goals) (Kidney and Pancreas Transplantation Committee).

The proposed modifications would elevate the priority at the local level of organ distribution assigned to high scoring, high panel reactive antibody (PRA) candidates and pediatric candidates who surpassed their transplant goals and place them ahead of payback debts and credits. This is supported by medical criteria justifying priority in allocation to highly sensitized patients and children versus no similar medical justification for payback offers specific to the patient group receiving the priority.

The Committee discussed the intent of this proposed change to provide better opportunities for pediatric candidates who surpass their transplant goals as well as high PRA candidates who would otherwise rank ahead of these children but for the pediatric preference. The Committee agreed that the only problem associated with this change is that there may be an increase in the kidney payback debt. However, the supportive information for this change is very compelling.

The Committee voted to approve the policy change by a vote of 16-0-0.

6. Proposed Modifications to OPTN/UNOS Policy 3.5.11.2 (Quality of Antigen Mismatch) (Kidney and Pancreas Transplantation Committee)

The Committee discussed the proposed increase from 2 to 6 allocation points awarded to pediatric candidates who have a zero DR mismatch with a standard criteria deceased kidney donor. The intent of this proposed change is to increase the number of transplants of well-matched kidneys into pediatric candidates while maintaining relatively short

pediatric candidate waiting time to transplant, and thus, minimize long-term sensitization in pediatric candidates who most likely will require subsequent transplants during their lifetimes.

The Committee discussed the beneficial nature of this change to advantage the pediatric candidate and agreed that it is beneficial because the pediatric patient should be transplanted as quickly as possible to eliminate problems associated with delayed development. The Committee discussed whether minority candidates would be disadvantaged and agreed that there would be minimal impact. However, this policy may influence highly sensitized patients. The most compelling argument for this policy change would be to keep the pediatric patient from becoming sensitized.

The Committee voted to approve the policy change by a vote of 16-0-0.

7. Proposed Implementation Protocol for Modifications to OPTN/UNOS Policy 3.8.1.5 (Islet Allocation Protocol) (Kidney and Pancreas Transplantation Committee)

The proposal would determine how pancreata, identified for islet transplantation, waiting time would be used to designate the candidate for whom the first pancreatic islet offer would be made. The intent of the policy is to better address the need for applying medical judgment in pancreatic islet transplantation decisions and to avoid islet wastage.

The Committee agreed that this policy gives the transplant center more discretionary power. This proposed change will allow patients to stay on the waiting list until they receive a sufficient amount of islet cells. The Committee agreed that this proposal also avoids wastage of pancreata. Several members of the Committee said that it is sometimes difficult for data coordinators to get feedback from centers, and this proposed change may help the system to be a little more flexible and open.

The proposed policy change was approved by a vote of 16-0-0.

8. Proposed Modifications to OPTN/UNOS Policy 3.8.1.6 (Mandatory Sharing of Zero Antigen Mismatch Pancreata) (Kidney and Pancreas Transplantation Committee)

The proposed modifications would eliminate requirements for sharing isolated pancreata for zero antigen mismatched patients except for highly sensitized candidates, defined as candidates with panel reactive antibody (PRA) levels of 80% or higher. The Committee understands that the proposal was developed out of concerns over the lack of demonstrated survival benefit for isolated whole pancreas transplantation when compared to the demonstrated survival benefit for simultaneous pancreas-kidney transplantation. The intent is to allow for increased simultaneous pancreas-kidney transplantation by not requiring sharing of zero antigen mismatched pancreata, except for highly sensitized candidates whose opportunities for an isolated pancreas offer are limited.

After discussion, the Committee agreed that the data support the proposed policy change and approved this change by a vote of 16-0-0.

9. Proposed Modifications to OPTN/UNOS Policy 3.6.2.1 (Allocation of Blood Type O Donors) (Liver and Intestinal Organ Transplantation Committee)

This proposal would increase the threshold for allocation of blood type O donors to blood type B candidates from a MELD/PELD score of 20 to a MELD/PELD score of 30 and is intended to better equalize the donor pool for O and B candidates. The data show that the change would reduce the number of blood type O livers transplanted into blood type B patients and increase the number of blood type O livers transplanted into blood type O recipients by the same number, without affecting the death rate in either population.

The Committee opined that this proposed policy change does not disadvantage any group and does assist type O patients. There were no specific concerns identified.

The proposed policy change was approved by a vote of 16-0-0.

10. Proposed Modifications to OPTN/UNOS Policy 3.6.2.1 (Allocation of Blood Type O Donors). (Liver and Intestinal Organ Transplantation Committee)

This proposal would allow any remaining blood type compatible candidates to appear on the match run list for blood type O donors after the blood type O and B candidate list has been exhausted at the regional and national level. Under current policy, these patients do not appear on the match run and are therefore not eligible for organ offers. It is anticipated that this change may reduce organ wastage in some instances.

The Committee questioned whether the original policy is significantly impacted if this policy only changes allocation after the national level of allocation and that it does not address the fact that the national type O waiting list would never be exhausted on a national level. Concerns were also voiced regarding this policy providing an opportunity for some members to potentially bend the rules to benefit their patients.

After discussion, the committee agreed that exhausting the national O list is unrealistic and therefore in conflict with the rationale for this policy. The Committee supports adding compatible blood types, and agreed that all compatible patients should be on the list.

The proposed policy change was not approved by the Committee by a vote of 6-8-1.

11. Proposed Modifications to OPTN/UNOS Policy 3.6.4.4.1 (Adult Patient Reassessment and Recertification Schedule) and 3.6.4.2.1 (Pediatric Patient Reassessment and Recertification Schedule). (Liver and Intestinal Organ Transplantation Committee)

This proposal specifies that patients whose MELD/PELD scores remain uncertified will be reassigned to a MELD/PELD score of 6. Pediatric patients whose uncertified score is less than 6 would remain at that lower, uncertified PELD score. Under the current policy, some patients who are uncertified are allowed to remain indefinitely at an uncertified MELD/PELD score.

This proposed policy change seems to facilitate enforcement of compliance and the Committee agreed that this proposed change would encourage centers to update patient

information for recertifying scores. The Committee discussed that the proposed policy change may be in conflict with the proposed changes in policy changes number 13. The Committee also questioned whether or not candidates with a MELD score of 6 would or should be considered inactive.

The proposed policy change was approved by a vote of 16-0-0.

12. Proposed Modifications to OPTN/UNOS Policy 3.6 (Adult Donor Liver Allocation Algorithm). (Liver and Intestinal Organ Transplantation Committee)

This proposal would modify the sequence of allocation for adult donor livers such that organs would be allocated to local and regional candidates with MELD/PELD scores of 15 or higher prior to candidates with MELD/PELD scores less than 15. The intent of the policy is to direct livers towards those patients who are likely to receive the greatest benefit from liver transplantation.

The proposal utilized a threshold of a MELD score of 15 and may be in conflict with proposed policy 13 where the threshold is listed as a MELD score of 10. The summary of data describe patients with a MELD score of less than 10 and questioned if all the data that were analyzed were from patients with a score below 10, instead of less than 15. If there are a small number of people affected by this change, the Committee was unsure as to why allocation policy would be changed for this small number of individuals.

After discussion, the Committee approved the proposed policy by a vote of 10-3-3.

13. Proposed Modifications to OPTN/UNOS Policy 3.6.4.1 (Liver Allocation, Adult Patient Status) (Liver and Intestinal Organ Transplantation Committee)

The Committee discussed the proposed change that would institute minimum listing criteria of a MELD score of 10 for adult candidates, with the exception of candidates meeting the requirements of Policy 3.6.4.4 (Liver Transplant Candidates with Hepatocellular Carcinoma) and 3.6.4.5 (Liver Candidates with Exceptional Cases). Patients with Stage T1 HCC could be listed with their laboratory MELD score upon prospective agreement by the Regional Review Board. Patients listed at the time the policy is implemented whose MELD score is less than 10, as well as candidates whose MELD scores fall below the threshold of 10 after appropriate listing, would not be removed from the list. The Committee discussed the analyses of OPTN data that indicates that there is no demonstrable benefit of transplantation below a MELD score of 10 during the first year post-transplant.

The Committee agrees that this policy addresses some of the discrepancies that may exist between regions for transplanting patients with specific MELD scores and suggests that each region should determine their MELD score threshold.

After discussion, the proposed policy change was approved by a vote of 15-0-1.

14. Proposed Modifications to OPTN/UNOS Policies 3.6 (Pediatric Donor Liver Allocation Algorithm & Allocation Sequence for Patients with PELD or MELD Scores Less than or Equal to 6 (All Donor Livers)), 3.6.4.2 (Pediatric Patients Status), 3.6.4.2.1 (Pediatric Patient Reassessment and Recertification Schedule),

3.6.4.3 (Pediatric Liver Transplant Candidates with Metabolic Diseases), and 3.6.4.4.1 (Pediatric Liver Transplant Candidates with Hepatoblastoma). (Liver and Intestinal Organ Transplantation Committee)

The Committee discussed the proposed modifications regarding adolescent pediatric liver candidates (age 12-17) being assigned a MELD score rather than a PELD score. For the majority of adolescent liver candidates, a calculated MELD score offers an increase in allocation score and, thus, an increase in opportunity for transplant. Based on the variables included in allocation score calculation in the MELD system, MELD scores may also offer a more accurate picture of mortality risk and disease severity for adolescent candidates. Adolescents will, however, maintain pediatric status in the policy, including assigned priority for children in the allocation of pediatric donor livers.

The Committee agreed that the adolescent patient will be provided a more equitable opportunity for transplant and approved the proposed policy change by a vote of 15-0-0.

- 15. Proposed Modifications to the Region 5 Status 1 Sharing Agreement (Liver and Intestinal Organ Transplantation Committee) The proposed changes to the Region 5 Status 1 sharing agreement would eliminate the provision for payback for Status 1 shares. The definition of Status 1 for both adult and pediatric candidates will be redefined to better identify patients in urgent need of a liver.**

After a brief discussion, the Committee agreed not to comment on this issue.

- 16. Proposed Modifications to OPTN/UNOS Bylaws Appendix B Attachment 1 (Standards for Histocompatibility Testing) Standard H3.100, Proposed New Policies for Kidney Transplantation - 3.5.17 (Prospective Crossmatching), for Pancreas Transplantation - 3.8.8 (Prospective Crossmatching), and Proposed Appendix D to Policy 3.**

After discussion, the Committee approved the proposed change by a vote of 15-0-0.

- 17. Proposed New OPTN/UNOS Policy 3.7.17 (Crossmatching for Thoracic Organs) (Histocompatibility Committee)**

The proposed new policy 3.7.17 (Crossmatching for Thoracic Organs) would require all thoracic organ transplant programs and their histocompatibility laboratory to have a joint written policy that sets out the circumstances when a crossmatch is necessary.

The Committee approved the proposed change by a vote of 15-0-0.

- 18. Proposed Modifications to OPTN/UNOS Policy 6.4 (Exportation and Importation of Organs – Developmental Status). (Ad Hoc International Relations Committee)**

This proposed change would ensure the accuracy and fairness of organ allocation when organs are offered into the U.S. from foreign countries by requiring higher standards of verification from the foreign exporters. The proposed policy changes would ensure that imported organs would first be available to the OPO or transplant center that arranged to import them. The Committee understood that the policy would require:

1. Foreign donor organizations would provide verification of donor consent, brain death, and donor ABO.
2. Organ importers would obtain verification that foreign entities are medical centers authorized to export organs.
3. Imported organs will be first allocated locally to the OPO or transplant center that arranged the import.

The Committee agreed that organs should be allocated based on the national sharing system, which is initiated by the OPO, not the transplant center. If a transplant center receives a referral, the center should contact the OPO to ensure that the imported organ follows the legitimate organ allocation scheme.

Motion: In the proposed policy change in 6.4.2.3, the terms “or transplant center” be removed. The motion was approved by a vote of 14-0-0.

After discussion, the Committee approved the proposed change with the removal of the terms “transplant center” by a vote of 15-0-0.

19. Proposed Guidelines for Living Liver Donor Evaluation and Proposed Guidelines for Living Kidney Donor Evaluation. (Ad Hoc Living Donor Committee).

This proposal would establish specific guidelines for potential living kidney and liver transplant recipient and donor evaluation, including provisions for an independent donor team, psychiatric and social screening, and appropriate medical, radiologic, and anesthesia evaluation.

The Committee agreed that the proposal provides broad guidelines and provides some measure of protection for the donor. Most importantly, one member of the donor’s team must always be involved with the donor. The Committee voiced concerns regarding who the donor advocate might be and what the advocate’s responsibilities would include. Additionally, the question arose as to whether it is the OPTN and/or UNOS’ responsibility to dictate practice when living donation is not currently under the auspices of the OPTN. It was also unclear as to why the presence of physical or sexual abuse of the donor is explored within the psychiatric and social screening.

The Committee approved the proposed policy change with a vote of 13-1-0.

20. Proposed Guidelines for Living Kidney Donor Evaluation (Item 2 of 2) (Ad Hoc Living Donor Committee)

The Committee discussed the purpose of the proposal being the establishment of guidelines for evaluation of potential living kidney transplant recipients and donors, and the inclusion of recommendations for an independent donor team, psychiatric and social screening, and appropriate medical, radiologic, and anesthesia evaluation. Concerns were voiced regarding the potential duplication of staff that might be necessary to implement this change.

The Committee approved the proposed policy change with a vote of 13-1-0.

21. Proposed Modifications to OPTN/UNOS Policy 3.1.4 (Patient Waiting List) (Ad Hoc Operations Committee)

The proposed policy change modifies processes for ensuring the accuracy of a transplant candidate's ABO type on the waiting list; requiring transplant centers to enter and maintain transplant candidate data electronically using UNetsm; requiring transplant candidate ABO typing on two separate occasions prior to listing; and listing transplant candidates with their actual ABO type. This proposal also addresses the applicability of ABO verification processes for living donor transplant recipients and donors.

Concerns were voiced regarding the availability of Organ Center personnel to facilitate the listing process only in the event of a computer failure. Members agreed that the Organ Center should be available during weekend, nighttime or holiday hours or “emergencies” when only one person may have accessibility to UNetsm. The policy also does not specify who the second person verifying ABO typing should be or what type of qualifications that individual might need to have.

The proposed policy change should include that the Organ Center should be able to assist with the verification in urgent situations where there is not a second person available on a weekend or nighttime.

The Committee discussed the time limitation when a fulminant liver patient arrives at the hospital and that the lack of the second typing should not prohibit a patient from being listed. Members agreed that it is preferable to have the second test completed prior to the match run, as opposed to prior to listing. The Committee opined that the proposed change is too restrictive and that the proposal language should be changed to “prior to transplant,” not “prior to listing.”

The Committee did not approve the proposal as written by a vote of 0-12-1.

Motion: That the Ad Hoc Operations Committee and other appropriate committees should consider the following specific issues that are of concern: expanding the availability of the organ center, clarification of two separate blood samples versus two typings on one sample, clarification of “grandfathering” older patients, allowing patients with fulminant failure to be listed as active without two blood typings while the second blood typing is pending, staffing issues, and insurance concerns regarding funding of the second blood draw.

This motion was approved by a vote of 11-1-0.

22. Proposed Modifications to OPTN/UNOS Policy 3.2.3 (Match System Access) (Ad Hoc Operations Committee)

The proposed modifications would require two separate determinations of the donor's ABO type prior to initiating the organ recovery incision, and additional specific policy language for the process of distributing organs using the match.

The Committee discussed the language in the proposed change being limited to the “local OPO level,” with the understanding that this eliminates the transplant center from the process. Several members disagreed with the part of the proposal that states all organs will be allocated only to those on the match run as there are exceptions and there should

be some flexibility those exceptions. Members also agreed that credit is not given for transplanting organs that might otherwise be wasted, however, OPOs may be reprimanded when the list is not followed. If all ABO compatible allocations must be on the match run, there is no accounting for designated donation, or other situations that warrant a variation, such as an anomaly in anatomy or organ function that make it difficult, if not impossible, to place the organ.

The Committee discussed the need for two individuals from the OPO with UNetsm access to verify and document the determination of the blood type. This proposal places a procedure and is beyond the scope of the policy. The Committee agreed that there should be some accountability to ensure that the donor and recipient are the same blood type.

The Committee did not approve the proposed policy change by a vote of 2-10-0

23. New OPTN/UNOS Policy 3.4.7 (Allocation of Organs During Regional/National Emergency Situations), .3.4.7.1 (Regional/National Transportation Disruption), and 3.4.7.2 (Regional/National Communications Disruption) (OPO Committee)

The Health Resources Services Administration (HRSA) has requested the OPTN to develop policies for maintaining the organ matching and allocation process during times of regional or national emergencies that compromise telecommunication, transportation, or the function of or access to the OPTN wait list or matching system. OPTN staff drafted the proposed policies for consideration by the OPO Committee.

The Committee agreed that there should be an alternative methodology and system established to contact OPOs, transplant centers, and UNOS in the event of an emergency. The Committee recommends that the Organ Center develop an alternate phone list for OPOs and transplant centers in the event specific lines go down and an alternate phone or methodology to contact/access UNOS.

The Committee approved the policy by a vote of 12-0-0.

24. Proposed Modification to the Criteria for Institutional Membership, OPTN/UNOS By-Laws, Appendix B, Section III (C) (Transplant Programs): Proposed Modifications to Item (15) (Social Support) (Transplant Administrators Committee)

This proposed By-law modification that delineates a transplant program's specific responsibilities in providing psychiatric and social support services (psychosocial services) for transplant candidates, recipients, living donors, and family members. Individuals trained in psychiatry, psychology or social work may provide these services. These individuals should be designated members of the transplant team, and work with patients and families in a compassionate and tactful manner in order to facilitate access to and continuity of care.

The Committee was concerned about the budgetary implications of this proposal. Additionally, within the text, the term "advocacy" appears and the Committee questioned what is meant and implied by the term. The Committee agreed that the term advocacy should be clarified or defined, as the legal definition carries with it a duty to perform.

The proposed policy change was approved by a vote of 11-0-0.

25. Proposed Modification to the Criteria for Institutional Membership, OPTN/UNOS By-Laws, Appendix B, Section III (C) (Transplant Programs): Proposed New Item (20) (Clinical Transplant Pharmacist) (Transplant Administrators Committee)

This proposed change to the OPTN/UNOS By-laws delineates the specific responsibilities of a clinical transplant pharmacist in an active transplant program. The goal of the proposal is to provide additional detailed information about the essential care provided by pharmacists and teams led by pharmacists, in an effort to assure that this care remains available to transplant recipients and the transplant team. The Committee understands that it is not the goal of this change to create a membership requirement such as the existing requirement for primary physician or surgeon. Members agreed that the role of the pharmacists in identifying interactions between medications is extremely beneficial to the patient.

The Committee approved the proposed Bylaw change with a vote of 12-0-0.

26. Proposed Modifications to OPTN/UNOS Policy 3.7.6 (Status of Patients Awaiting Lung Transplantation), Policy 3.7.9 (Time Waiting for Thoracic Organ Candidates), Policy 3.7.9.2, (Waiting Time Accrual for Lung Candidates with Idiopathic Pulmonary Fibrosis (IPF), and Policy 3.7.11 (Allocation of Lungs). (Thoracic Organ Transportation Committee)

The proposed policy change will replace the current lung distribution system with a new system that would allocate lungs to transplant candidates based on their risk of dying on the waitlist and their possibility for survival following the transplant. The current system assigns priority to transplant candidates based solely on their time on the waitlist and will be supplanted by a lung distribution algorithm that prioritizes lung transplant candidates based on a weighted balance of their pre-transplant medical urgency and post-transplant survival benefit.

The Committee discussed the proposed policy change and understands that if all lab values were not available or submitted, the patient's score would default to the lowest possible score. Members discussed some of the ramifications of the additional testing that will be required and understand that data collection and analysis will be ongoing in order to improve the system based on the resulting data. Additional time for reporting of lab values may be needed by transplant center staff. This proposed policy also delineates pediatric patients and takes size into consideration.

The Committee agreed that most of the required tests are already completed by the transplant center, but are presently not reported to UNOS. This change would require additional staff time and effort during the evaluation phase, particularly if tests such as a cardiac catheterization are required. The Committee assumed that values for scoring are currently being developed and the data will assist in quantifying scores.

Those patients age 11 and under will continue to receive organ offers based on waiting time. Since pediatric patients are listed early in order to accrue waiting time, pediatric patients should be able to be placed on an inactive status without penalty and continue to accrue waiting time. By placing these patients on an inactive status, it will prevent numerous calls for placement of organs during the timeframe when the patient is not ready for transplant.

The Committee agrees that this policy is beneficial and approved the proposed change to the lung allocation policy by a vote of 10-0-1.

4. **Information Technology Update.** Stephanie Whitman, UNOS Manager, Technology QA/Communications, provided the Committee with an information technology update. In June, the following changes will occur: 1) ABO verification will be in place and will affect all candidates and donors from that point forward; 2) all Tiedi® forms have been significantly changed and UNOS is currently waiting for OMB approval; 3) and the PTR codes are also changing and will be labeled as the 800 series. These will include additional justification text and bypass codes.

Members stated that they can enter the UNetsm system, however they cannot print a list once they run it as a report writer must be downloaded prior to printing. Frequently hospitals have blocked downloading programs into their computer systems for security purposes. A recommendation was made to have a widely accessible downloader within the UNetsm structure without an independent report writer being needed.

OPTN/UNOS Transplant Coordinators Committee Meeting

April 2, 2004

Chicago, IL

Committee Members Attending

Judy Graham RN, MS, CPTC, CCRN

Barbara Nuesse RN, CCTC

Cheryl A. Edwards RN, MSN, CCRN, CPTC

Scott Demczyszyn NREMT-P, CPTC

Barbara Moran RN

Randall C. Heyn-Lamb RN, BSN, CPTC

Wayne Dunlap RN, BSN, CPTC

Lynette Fix

Alan Davis BS, RN, CPTC

Wendy Johnson RN, BSN, CCTC

Marian O'Rourke RN, CCTC

Jenny Hoover RN, CPTC

Carolyn Olivarez LVN, CPTC

Sally Keck RN, MS, CCTC

Leo J. Jacob

Chair, Region 9 Representative

Vice-Chair

Region 1 Representative

Region 2 Representative

Region 3 Representative

Region 5 Representative

Region 6 Representative

Region 7 Representative

Region 8 Representative

Region 10 Representative

At-Large Member

At-Large Member

At-Large Member

At-Large Member

At-Large Member

Committee Members Unable to Attend

Diana F. Thacker RN, BSN, CPTC

Region 11 Representative

Division of Transplantation

Nancy Carothers RN, Public Health Analyst

UNOS Staff Attending

Franki Chabalewski, RN, MS, Staff Liaison

Lin McGaw RN, MEd, Director, Professional Services Department

Alan Ting, PhD, Director, Research Department

Stephanie Whitman, IT Support