

OPTN Ad Hoc Disease Transmission Advisory Committee (DTAC)
Report to the Board of Directors
November 12-13, 2012
St. Louis, Missouri

Summary

I. Action Items For Board Consideration

- The Board is asked to approve Guidance for Reporting Both Potential Deceased and Living Donor-Derived Disease Transmission Events (Item 1, Page 2).
- The Board is asked to approve Guidance for Identifying Risk Factors for *Mycobacterium tuberculosis* (MTB) During the Evaluation of Potential Living Kidney Donors (Item 2, Page 2).

II. Other Significant Items

- The Committee reviewed public comment proposals, including the proposed policy rewrite effort and proposals scheduled for release on September 21, 2012 (Item 3, Page 3).
- The Committee reviewed potential donor-derived disease transmission events reported from January through May 2012 (Item 4, Page 4).
- The Committee reviewed updates to OPTN data regarding reported post transplant malignancies (Item 5, Page 7).
- The Committee discussed the timeline and process for the updated “PHS Guidelines for Reducing Transmission of Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV), and Hepatitis C Virus (HCV) Through Solid Organ Transplantation” (Item 6, Page 8).
- The Committee reviewed both new and continuing projects assigned by the Board (Item 7, Page 8).
- Committee members received an overview of the various standing and new subcommittees working on the assigned Board goals (Item 8, Page 9).
- The Committee discussed and prioritized abstract and presentation ideas for upcoming professional meetings and educational efforts (Item 9, Page 11).

**OPTN Ad Hoc Disease Transmission Advisory Committee
Report to the Board of Directors
November 12-13, 2012
Richmond, Virginia**

**Michael Green, MD, MPH, Chair
Daniel Kaul, MD, Vice Chair**

This report reflects the work of the Ad Hoc Disease Transmission Advisory Committee (DTAC) during its September 14, 2012, meeting in Chicago, Illinois, as well as all monthly case review conference calls held from May through October 12, 2012.

1. Guidance for Reporting Both Potential Deceased and Living Donor-Derived Disease Transmission Events (PDTE). The Committee provided feedback to the Living Donor Committee during the development of its proposed policy modifications to specifically require reporting of any suspected or confirmed living donor-derived disease transmission event (PDTE). The Committee reviews a growing number of living donor PDTE each year, and intended that this population be included in requirements as outlined in its 2010 rewrite of Policy 4.5 (Post-Transplant Reporting of Potential Transmission of Disease or Medical Conditions, Including Malignancy); however, its language did not specifically state living donors as an inclusion- only referencing donors in general. To complement the Living Donor Committee's efforts to clarify this point, the Committee updated its current guidance to transplant centers and OPOs regarding when and how to report a PDTE to more clearly include living donor recovery center and living donor transplant hospital requirements.

The Chair appointed a Living Donor Subcommittee to review recommended edits by support staff from both committees to the current guidance document. This group met on August 17, 2012, to consider the updated draft and provide feedback (**Exhibit A**). Subcommittee members noted that the inclusion of recommendations for OPOs, living donor recovery centers, as well as living and deceased donor transplant hospitals was a bit cumbersome. Recommendations were made to break down the language more clearly. Members suggested using bullets or shorter paragraphs to identify roles more clearly. These changes were incorporated into the final document.

The Subcommittee's final document was shared with the Committee for review (**Exhibit B**). After this evaluation, it was shared with the Living Donor Committee during its September 10, 2012 meeting. This group reviewed the draft document and had no additional feedback.

The revised guidance document was then reviewed by the full Committee during its meeting in Chicago on September 14, 2012, for a final vote. After careful review, the Committee voted unanimously to recommend the guidance document for consideration by the Board of Directors:

****RESOLVED, that the updated guidance document "Guidance for Reporting Both Potential Deceased and Living Donor-Derived Disease Transmission Events (PDTE)," set forth in Exhibit B, is hereby approved, effective November 12, 2012.**

Committee vote: 18 in favor, 0 opposed, 0 abstentions

2. Guidance for Identifying Risk Factors for *Mycobacterium tuberculosis* (MTB) During the Evaluation of Potential Living Kidney Donors. The Committee provided technical expertise to

the Living Donor Committee as it drafted proposed requirements for potential living donor evaluation. The Committee agreed that, at a minimum, those potential living donors be believed to be at risk for *Mycobacterium tuberculosis* (MTB) exposure should be tested as part of the evaluation process. Because the term “at risk” for exposure or infection may be difficult for some readers to apply or understand, the Committee agreed to draft a guidance document, meant to accompany the Living Donor Committee’s policy proposal, to be utilized by living donor recovery centers to recognize potential exposure risks when evaluating potential donors.

The Chair appointed a subcommittee to develop this guidance, and the group met briefly on August 10, 2012, to discuss a plan for drafting the document and make writing assignments. Because several of the subcommittee participants had recently completed the Report of 2010 Consensus Conference on Donor Derived Tuberculosis, the subcommittee based much but not all of the content and recommendations on the recently published Consensus Conference report. A draft document was formulated independently among the subcommittee members and circulated for review and editing.

The Subcommittee’s draft guidance document (**Exhibit C**) was then shared with the full Committee, and discussed during its meeting on September 14, 2012. The Committee members questioned why the document was targeted specifically to potential living kidney donors and not living donors in general. It was noted that the Living Donor Committee’s current policy proposal is specifically focused on kidney donors. Members discussed whether the document might change in any way for potential living liver donors. The Liver and Intestinal Transplantation Committee is currently working with the Living Donor Committee to develop evaluation guidelines. This Committee will remain available to provide expertise as needed in reviewing similar language related to the evaluation of potential liver recipients, but does not anticipate significant changes by organ. It was suggested that perhaps a single guidance document could cover this topic, with separate tables created to provide organ specific recommendations.

The group shared lengthy discussion regarding the need to make the document very clear to a reader who may only focus on tables and figures without carefully reading the text. A Committee member suggested pulling text out of paragraph form and bulleting it to more visibly highlight risk factors for MTB in individuals living in low risk regions, including the United States. After careful consideration and editing, the Committee voted unanimously to recommend this guidance document for consideration by the Board of Directors:

****RESOLVED, that the updated guidance document “Guidance for Identifying Risk Factors for *Mycobacterium tuberculosis* (MTB) During the Evaluation of Potential Living Kidney Donors,” set forth in Exhibit C, is hereby approved, effective November 12, 2012.**

Committee vote: 19 in favor, 0 opposed, 0 abstentions

3. Review of Policies and Bylaws Issues for Public Comment. The Committee reviewed public comment proposals released in July and September 2012.

The Committee reviewed the policy rewrite proposal released for public comment July 2, 2012 during an August 2, 2012, teleconference. The Committee utilized its expertise to specifically review the rewrite of current policy sections 2.0 and 4.0, commenting on new policy sections two and fifteen. While a formal vote was not requested, the Committee was supportive of this effort with some recommended modifications (**Exhibit D**).

The Committee completed a preliminary review of the six policy proposals released for public comment on September 21, 2012, during its face-to-face meeting on September 14, 2012.

- 1) Proposal to Substantially Revise the National Kidney Allocation System (*Kidney Transplantation Committee*)

Upon review, the Committee determined that it had no comment regarding this issue.

- 2) Proposal to Require Reporting of Every Islet Infusion to the OPTN Contractor within Twenty-Four Hours of the Infusion (*Pancreas Allocation Committee*)

Upon preliminary review, the Committee determined that it had no comment regarding this issue. After release of the proposal, which occurred after the Committee's face-to-face meeting, members recognized the value of capturing this information as it relates to tracking islet recipients who may have received an infusion from a donor reported as a potential donor-derived disease transmission event. The Committee supports this proposal, but will discuss it in depth during its November 1, 2012 conference call.

- 3) Proposal to Remove the OPTN Bylaw for Combined Heart-Lung Transplant Program Designation (*Thoracic Organ Transplantation Committee and Membership and Professional Standards Committee*)

Upon review, the Committee determined that it had no comment regarding this issue.

- 4) Proposal to Change the Composition of the OPTN Finance Committee (*Finance Committee*)

Upon review, the Committee determined that it had no comment regarding this issue.

- 5) Proposal to Change the OPTN/UNOS Bylaws to Better Define Notification Requirements for Periods of Functional Inactivity (*Membership and Professional Standards Committee*)

Upon review, the Committee determined that it had no comment regarding this issue.

- 6) Proposal to Modify the Imminent and Eligible Neurological Death Data Reporting Definitions (*OPO Committee*)

Upon review, the Committee determined that it had no comment regarding this issue.

4. Review of Reported Potential Donor-Derived Disease Transmission Events (PDTE). The Committee completed its semi-annual review of potential disease transmission events reported to the Patient Safety System. Overall, eighty-seven cases, reported from January through May 2012, were reviewed and classified based upon the probability of donor-derived transmission.

Starting on January 1, 2012, classifications were assigned for an overall event as well as for each organ recipient involved in a PDTE. The Committee believes this organ specific data will provide meaningful insight into donor-derived disease transmission to the transplant community, and plans to share its 2012 findings at the 2013 American Transplant Congress. Committee members hope that data may eventually show that some organs from known positive donors

can be used without consequence rather than discarded. Of the eighty-seven cases reviewed, fourteen were classified overall as proven or probable transmissions to date.

The Health and Human Services (HHS) ex officio member for the Centers for Disease Control and Prevention (CDC) presented a brief overview of how the CDC determines whether to lead a reported PDTE, and the process used to investigate a potential transmission from a public health perspective (**Exhibit E**). This representative then reported on several case reviews led by the CDC to provide additional educational points for new Committee members.

Reported Potential Donor-Derived Disease Transmission Events Not Posted for Full Committee Review. Committee staff and leadership continued to employ a triage system to reduce staff work load and Committee member email fatigue where possible, when full Committee review was deemed unnecessary. Case management staff used previously agreed upon criteria with the approval of the Chair and Vice Chair to remove a number of potential cases from the forty-five day review process. An overview of potential cases triaged in 2012 through June as compared to 2011 reports was provided to the Committee (**Exhibit F**) during its face-to-face meeting.

From January through June, 2012, the Committee reviewed ninety-five PDTE. In addition to these reported events, another thirty-two were reported and triaged. In all cases however, the OPO is still required to notify all recipient centers and provide evidence of these contacts with a completed Potential Disease Transmission Report form (**Exhibit G**). These triaged events were broken down into the following categories:

- Nine duplicate reports (recipient center(s) and Host OPO reported event);
- Nine positive sputum cultures with no lungs transplanted;
- Four positive Human T-Lymphotropic virus (HTLV) test on donor, but negative confirmatory results;
- Three non-malignant mass or extremely limited expectation for transmission;
- Three events incorrectly reported as PDTE (were other patient safety issues);
- Two Cytomegalovirus (CMV) reports where donor and recipient mismatch was known pre-transplant; and
- Two positive blood or urine cultures that were ultimately noted as probably contaminants.

Based upon this mid-year total, the 2012 yearly total of triaged events is expected to exceed last year's. The Committee hopes that additional educational efforts and promotion of its guidance document on reporting PDTE will help transplant and OPO professionals better understand the reporting requirements. Committee members encouraged educational efforts through the OPTN and professional societies to really emphasize this area of reporting and policy, as well as promoting the guidance document it developed in 2011 to assist the community in better understanding what and when to report a potential transmission event.

Case Classification Process and Committee Member Roles. The Chair thanked Committee members for their diligence in reviewing PDTE and assigning case classifications using the classification algorithm to the individual recipient level for all reports (**Exhibit H**). Additionally, he noted his appreciation on behalf of the Committee to the HHS ex officio member from the CDC for improved discussions and the introduction of subject matter experts into the discussions as needed to address both specific and general questions.

New Committee members were asked to discuss any questions or comments regarding the case review process, including application of the classification algorithm. Historically, case presentations on the Committee's monthly conference calls were assigned to infectious disease, malignancy or pathology specialists. Due to growing case volume and the clarity provided by the algorithm, the Chair requested feedback from the Committee on whether all members might be comfortable in reviewing and presenting cases. No opposition was noted, and this new case assignment process was employed on the October 11, 2012 conference call.

Standard Operating Procedures for Staff Managing the Case Review Process. In order to streamline the points of entry for reporting of patient safety related issues, PDTE case management staff was relocated to the Department of Evaluation and Quality. Because this process is now in a new department, staff felt it was important to carefully document each step of the case review intake and management process. As part of this effort, staff worked closely with Committee leadership and other subject matter experts on the Committee to define a list of standard questions for case categories including bacterial, fungal, malignant, viral and other reports (**Exhibit I**). The Committee reviewed this list during its face-to-face meeting on September 14, 2012, and had no additions or edits.

Disease Transmission Reporting by Donor Service Area (DSA) and Region. Since its September 2010 meeting, the Committee has discussed variation in reporting within the various regions and donor service areas (DSAs). As a result, bi-annual data was requested to better understand the potential for underreporting as the Committee works to review cases and assess the risk of donor-derived disease transmission. The Committee reviewed this latest round of updated data during its September 2012 face-to-face meeting (**Exhibit J**).

Potential donor-derived disease transmission reports from January 2006 through June 2012 were reviewed. For 2011 and 2012, cases that were reported but not reviewed by the full Committee (as described above) were also included in the data. Cases were stratified by DSA/Host OPO and region where donor recovery took place.

It was noted that one small OPO has had no reports during this time period. When data was reviewed by region, it was noted that all regions had reported at least five cases in the last year, from July 2011 through June 2012; however, there were twelve OPOs with no cases reported during this one-year time period. This is expected as some OPOs recover a small number of donors per year. The percentage of 2010-2011 deceased donors with a reported case varies by region (0.9-3.2%), but less than 3.5% in all regions. Across DSAs, the percentage with a reported case ranges from 0 to 14.4%.

Similar data was reported at regional meetings last year after concerns regarding potential underreporting of potential transmission events were discussed by the Committee, as great variation was noted between DSAs. This latest data report shows an increase in reporting, but no significant differences between regions when looking at cases classified as probable or proven. The Committee agreed that continuing to work with both underreporting and over reporting regions will result in more uniform reporting and better assessment of the true risk of disease transmission.

After completion of the data review, the Committee decided that updated results of this analysis would be provided in each face-to-face meeting packet, but results will only be presented to the committee at future spring meetings when year-end data is available. This will begin with the March 2013 meeting.

5. Review of Updated Malignancy Data. The Committee reviewed two OPTN data reports on post-transplant recipient malignancy during its September meeting.

Update on Donor Related Malignancies Not Reported to the Improving Patient Safety Portal.

Over the course of the last six face-to-face meetings, the Committee has reviewed data related to donor-related malignancies reported on the post-transplant malignancy (PTM) form, but not to the Improving Patient Safety portal as a potential donor-derived disease transmission event. The Committee reviewed an update of this information during the September 2012 face-to-face meeting (**Exhibit K**).

Post-transplant malignancies reported as “donor related” on the PTM forms with a diagnosis date of January 2007 through June 2012 were compared with reports to the Improving Patient Safety portal. A total of seventy-nine donor related malignancies were reported, and thirty-three (43%) were reported as potential donor-derived disease transmission events. After validations completed in August, there were seventy-seven cases remaining after records corrections. It was noted that the nine of the ten cases reported with a diagnosis date in 2011 were also reported to the Improving Patient Safety portal.

The seventy-seven donors represented a total of two hundred twenty-one recipients. A total of ninety-three recipient deaths were recorded, from fifty-six donors. This represents 42% of the two hundred twenty-one recipients in the data set. Thirty-eight of these deaths (from 33 donors) were reported as related to the malignancy itself (17% of the two hundred twenty-one recipients). It is possible that other deaths may have been malignancy-related, but this was unclear in the center’s follow-up reporting.

It was noted that there continue to be cases reported on the PTM forms as donor related but not reported as potential donor-derived disease transmission events, but significant improvement has been seen in the past two year. Staff consistently points members to the article in the February 2010 DTAC Newsletter for guidance on this topic: (<http://transplantpro.org/patient-safety/newsletters/>). Staff will also work to develop a standing process for review of cases reported on the PTM form, but not reported for this Committee’s consideration, and for following up with centers that make reports to one site but not the other if donor-derived disease is suspected.

The Committee briefly discussed the need to update definitions. The current “donor related” reference on the PTM forms may be causing confusion as to whether a report is suspected to be a donor-derived transmission or a malignancy that results due to immunosuppression provided as a result of transplantation. The Transplant Coordinator Committee is working on reviewing and updating all of the help documentation in UNetSM related to this form and others. This may be an opportunity to address these concerns and provide clarity.

A Committee member questioned whether it might be worthwhile to set a time limit from transplant for reporting post-transplant malignancies as donor transmitted. For example, cases reported a certain number of years after transplant would be classified as donor-derived and not donor transmitted. This may be a project for the Committee’s Malignancy Subcommittee to consider and develop guidance.

Beginning with the March 2013 meeting, these results will be updated with each meeting, but only presented to the Committee yearly, during the fall meetings.

Potentially Unnecessary Discard of Kidneys with Small Sized Renal Cell Carcinoma. Renal Cell Carcinoma (RCC) is the most commonly reported potential donor-derived malignancy. During its September meeting, the Committee reviewed data on the number of kidneys discarded due to RCC (**Exhibit L**). This is concerning to the Committee due to the potential for unnecessary discards based upon the low potential for transmission in many cases.

The data included all deceased donors recovered in 2010 and 2011 where kidneys were discarded (recovered for transplant, but not transplanted) due to RCC identified from two sources:

- Reported to the Improving Patient Safety Portal as a potential RCC transmission; or
- Discard reason on the Deceased Donor Registration (DDR) form related to RCC.

Results indicated that over 2,500 kidneys were discarded each year. Current data collection tools do not allow for the quantification of an exact number discarded for reason of RCC. During this time, at least sixty-one kidneys from thirty-five individual deceased donors were discarded due to RCC. Placement was confirmed for all but one of these donors. The number of offers documented on these donor match runs ranged from two to over five thousand individual potential recipient offers. Most frequently, these kidneys were declined due to donor age, donor quality, or organ specific donor issues.

The Committee believes education is needed regarding the appropriate use of these kidneys, as small RCCs can be excised and the kidney still implanted successfully. Additionally, there is little risk to utilizing the contra-lateral unaffected kidney based upon the Committee's review of reported potential RCC transmissions. A Committee member plans on developing a on this topic to use as an educational tool. The Committee's Malignancy Subcommittee may pursue additional opportunities for education in this area, beyond the original DTAC News article that was published in the February 2010 e-newsletter.

6. US Public Health Service Guidelines for Reducing Transmission of Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV) and Hepatitis C Virus (HCV) through Solid Organ Transplantation. The Committee briefly discussed revisions to the US Public Health Service (PHS) Guidelines. The Chair noted that the Committee's Policy Subcommittee will focus on the new guidelines when they are released to determine if any change to OPTN policy will be necessary.

A member of the PHS's Expert Review Panel updated the Committee on the process thus far. After public comment was completed and reviewed, a revised document was circulated for additional review and feedback from the Panel. Substantive changes were shared at the American Transplant Congress this summer in a presentation. The PHS is now considering this feedback, with a final document expected for release later this year or early in 2013.

The Chair noted that changes to the guidelines may impact both CMS and OPTN site surveys, so a careful review of related OPTN policy by the Committee's Policy Subcommittee will be critical once the updated Guidelines are released. Additionally, once released, the Committee's Donor Testing Survey Subcommittee will need to reconvene to begin formulating a new survey to capture changes in OPO donor testing practices as related to these new Guidelines.

7. Review of 2012-13 Committee Goals. The Committee briefly reviewed goals for 2012-13 (**Exhibit M**). These goals were first reviewed by the Policy Oversight and Executive Committees before Board approval in June 2012. Projects include:
 - Survey of OPOs on Changes to Donor Screening Practices (a follow up to the October 2008 survey);

- Updates to the Improving Patient Safety portal where potential donor-derived transmission events are reported by OPOs and transplant centers;
- Review of minimum screening requirements for deceased donor evaluation (due to changing test kit availability);
- Modifications to how new donor information received post-transplant is reported to recipient centers (possible voice-to-voice requirement in policy);
- Potential modifications to Policies 2.2.5, 2.2.6, and 3.2.4: Whether match runs should be re-run when serology results are updated;
 - A member noted that it will be important to note the frequency of discordant serology results for HIV, HBV, HCV and EBV. There will be a different component of weight depending on the disease.
 - Differences related to hemodilution, blood transfusion, etc also must be considered here.
 - Preliminary data is already requested to determine how many donors are being changed from pending to positive or negative to positive with or without change in match run.
- Education regarding the importance of completing and communicating Toxoplasma screening during the evaluation of deceased donors.

8. Introduction of Subcommittees and Appointments. Committee members received a brief introduction and overview of both standing and new subcommittees formed to address the Committee's goals for 2012-13 (**Exhibit N**). Members were encouraged to volunteer to serve on at least one subcommittee during their tenure.

Newsletter Subcommittee. Committee members reviewed the November 2011 edition of the DTAC News, which highlighted this group's abstracts presented at the 2011 American Transplant Congress. The Committee was awaiting the release of a September edition of the newsletter (**Exhibit O**).

Encephalitis Subcommittee. This group's guidance for recognizing potential meningoencephalitis in potential deceased donors was approved by the Board in June 2012. To complete this effort, the subcommittee hopes to draft a manuscript for publication.

Joint Ad Hoc DTAC-OPO Subcommittee on Sharing Updated Donor Information Learned Post-Transplant. Policy 2.2.4 currently requires the Host OPO to notify recipient centers when there is new or changed donor information learned after organ recovery and transplant. This notification must take place within 24 hours of the OPO receiving this new information. The Committee noted several instances of ineffective communication noted during review of potential donor-derived disease transmission reports. Some resulted in avoidable recipient morbidity and mortality.

While policy now requires prompt notification, it does not specifically state how this notification should be completed. For example, some Host OPOs may fax new information to recipient centers or call the importing OPO in the case of an exported organ. There is risk for information going unnoticed, getting lost, or not making it to the appropriate person at a recipient transplant center. A joint subcommittee with representation from the OPO Committee was convened on February 10, 2012, to discuss current communication practices and potentials for delays that may negatively impact organ recipients. While the Joint Subcommittee did not agree that a change in policy was needed to require voice-to-voice contact, all agreed that education and guidance would be helpful. It was suggested that OPOs with effective methods of

communication may be asked to share best practices with the community. Members agreed that evidence is critical to encourage the OPO community and raise awareness of poor outcomes related to delays in communication. The Committee feels strongly that policy language changes are critical to enhance patient safety in this area. A member noted that this needs to be framed as a patient safety issue and not a compliance issue to emphasize why voice-to-voice communication is so important.

This group will continue to address this issue over the coming year, including new representation from both committees.

Toxoplasma Education Subcommittee. During its September 2011 meeting, the Committee discussed several recent cases involving transmission of toxoplasmosis from donor to recipient. There is currently no requirement for screening potential deceased organ donors for Toxoplasma. During its rewrite of Policy 2.0, the Committee proposed that this screening become a requirement. A number of concerns regarding cost and feasibility were raised during the Spring 2010 public comment, and this proposed requirement was removed from the proposal before consideration by the Board. In light of these recent transmission events, the Committee chose to revisit this issue.

Review of PDTE reports indicated that only three of the fifteen reported PDTE were classified as probable or proven transmission events, though significant morbidity and mortality was involved in these events. Due to limited data and little support for policy requirements in this area, the Committee plans to develop an educational effort to raise awareness for the importance of Toxoplasma screening and communication of results. This new subcommittee will partner with the Instructional Innovations Department to utilize new technology or educational formats to draw attention to this issue.

Policy Review Subcommittee. This subcommittee will consider a number of questions arising from the OPO community regarding screening versus diagnostic testing and changing test and platform availability:

- Concerns regarding the use of the term “commercially available” within Policy 2.2.4 and the desire for a clear definition of what this term means.
- Questions related to the new 4th generation antigen-antibody tests that are approved as diagnostic and not screening tests by the FDA.
- Questions related to VDRL (a positive versus negative test) and RPR (an up and down level test that can be monitored) testing versus STS results for checking donors for Syphilis. RPR and VDRL are diagnostic test kits. It was suggested that the exceptions language within Policy 2.2.4 should be modified to indicate that diagnostic testing is acceptable for Syphilis rather than using the language, “... for VDRL/RPR.”

Joint Ad Hoc DTAC-OPO-Operations and Safety Subcommittee. This group was tasked by the Board with considering whether policy should be created or modified to require that a deceased donor match run be regenerated when serologies are reported as positive prior to allocation or recovery. Concerns were raised that some OPOs may be allocating organs off preliminary match runs generated prior to the receipt of final serologies. When a new match run is not generated to reflect a donor’s positive serology (particularly Hepatitis B or Hepatitis C), potential candidates may receive organ offers when they should be screened due to the donor’s positive result. This creates a potential patient safety concern. The subcommittee was made aware of at least two instances where offers for positive donor organs were made for recipients unwilling to accept them, but transplant did not occur.

This group will convene for its first meeting on October 19.

9. Brainstorming for Abstract and Presentation Ideas to Continue to Educate the Transplant Community. The Committee brainstormed to develop a number of ideas to continue educational efforts to enhance patient safety by reducing potential donor-derived disease transmission. These ideas included:
 - Abstract submissions for the American Transplant Congress and other professional meetings.
 - Staff cautioned committee members that less emphasis should be put on scholarly journals. A recommendation was made to reach out to the transplant and OPO coordinator community to promote awareness and recognition of the types of events that should be reported as a PDTE.
 - Due to volume, there may need to be some limitation regarding the number of abstracts prepared for any one meeting. Staff resources are limited to prepare data reports for the many ideas generated by this unique community.
 - Increasing engagement within the malignancy and pathology communities.
 - Populating the committee with dedicated malignancy and pathology experts has been challenging. The Malignancy Subcommittee will be tasked with identifying professional societies or other resources for identifying these specialists within the transplant field.
 - Alerting medical examiners and coroners regarding the need for prompt follow-up with OPOs on findings relevant to recipient health.
 - The Committee has seen a number of reported PDTE with delayed communication of information learned during autopsy that is relevant to acute recipient care. While autopsy generally occurs within several days of death, it sometimes takes months for the final report to be generated and conveyed to the donor's Host OPO. Delays as long as six to nine months have been noted.
 - A Committee member indicated that AOPO has a working relationship with the National Association of Medical Examiners (NAME). This may provide an opportunity to partner with AOPO to reach out to NAME to raise awareness of the importance of communicating these findings quickly.
 - Transplanting organs from Hepatitis B positive donors into immunized (but not infected) recipients.
 - The Committee received a question from a transplant center regarding the frequency of transplanting Hepatitis B positive donors into negative but immunized recipients. The number of times this has occurred is very low, and the Committee does not promote this practice.
10. Welcoming New Committee Members. The Chair welcomed new Committee members who began terms on July 1, 2012.

OPTN Ad Hoc Disease Transmission Advisory Committee (DTAC)	MONTH	JULY	AUG	AUG	SEPT	SEPT	OCT
	DAY	12	2	15	14	20	11
	FORMAT (select)	Live Meeting/ Phone	Phone	Live Meeting/ Phone	Face-to-Face	Live Meeting/ Phone	Live Meeting/ Phone
NAME	COMMITTEE POSITION						
Michael Green MD, MPH	Chair	X	X	X	X	X	X
Daniel Kaul MD	Vice Chair	X	X	X	X	X	X
Walter Bell, MD	At Large	X		X	X		X
Scott Biggins, MD	At Large	X			X	X	X
Dave DeStefano, MBA, CPTC	At Large			X	X phone		X
Edward Dominguez MD , FACP, FIDSA	At Large	X		X	X	X	
Afshin Ehsan M.D.	At Large						
Donna Ennis, RN, BS, CCTC	At Large	X	X		X	X	X
Thomas Gross MD, PhD	At Large	X	X	X		X	
Mary Klassen-Fischer, MD	At Large	X	X	X	X	X	X
Camille Kotton, MD	At Large	X		X	X	X	X
Shimon Kusne MD	At Large			X	X		X
Yuk Law, MD	At Large				X		
Marilyn Menegus, PhD	At Large	X	X	X	X	X	X
Rachel Miller MD	At Large	X	X	X	X		X
Martha Pavlakis MD	At Large	X		X	X phone		X
Timothy Pruett MD	At Large		X		X	X	X
Dianne LaPointe-Rudow, ANP, DrNP, CCTC	At Large	X	X	X	X phone	X	X
Phillip Ruiz Jr , MD	At Large		X				
Nicole Siparsky, MD	At Large	X			X		
Michael Souter, MD	At Large		X		X		
Linda Weiss, MS, MT (ASCP)SM, CTBS	At Large	X	X			X	X
Cameron Wolfe, MD	At Large	X		X	X	X	
Emily Blumberg, MD	Ex Officio	X		X	X	X	X
Karen Near, PhD	Ex Officio - HHS	X	X	X	X	X	X
Susan Hocevar, MD	Ex Officio- HHS	X		X	X phone	X	X
James Bowman, MD	HRSA	X		X		X	X
Bernard Kozlovsky MD, MS	HRSA		X				
Raelene Skerda, RPh, Bpharm	HRSA			X			
Melissa Greenwald, MD	FDA guest		X	X	X		
Matt Kuehnert, MD	CDC guest				X phone		
Shandie Covington BS	Committee Liaison	X	X	X	X	X	X
Sarah Taranto	Support Staff	X			X	X	
Shyni Mohan	Support Staff		X		X phone	X	
Cheryl Hall	Support Staff				X phone		

James Alcorn	UNOS staff				X		
Rebecca Anderson	UNOS staff			X			
Kate Breitbeil	UNOS staff	X		X			
Leonard Carinci	UNOS staff			X			
Leigh Kades	UNOS staff		X				
Cassandra Meekins	UNOS staff	X		X	X phone	X	
Kimberly Parker	UNOS staff	X		X	X phone	X	
Sue Montgomery, MD	CDC SME						X