

**OPTN/UNOS Pediatric Transplantation Committee
Summary**

Action Item for Board Consideration:

- The Board is asked to approve revisions to the Transplant Candidate Registration (TCR), Transplant Recipient Registration (TRR), and Transplant Recipient Follow-up (TRF) forms for pediatric candidates and recipients as well as changes to how pediatric recipients are followed after five years post-transplant and through age 25. (Item 1, Page 3)

Other Significant Items:

- The Committee discussed the March 28-29 Pediatric Summit on Organ Donation and Transplantation. (Item 2, Page 6)
- The Committee considered the Organ Specific Working Group's continued work on developing proposals to address the Committee charge of reducing death on the pediatric wait list. (Item 3, Page 6)
 - Heart-Lung Working Group. (Item 3a, Page 7)
 - Liver-Intestine Working Group. (Item 3b, Page 7)
 - Kidney Working Group. (Item 3c, Page 7)
- The Committee discussed OPTN Final Rule requirements for organ allocation policy development. (Item 4, Page 7)
 - Thoracic organ allocation. (Item 4a, Page 7)
 - Liver and intestinal organ allocation. (Item 4b, Page 7)
 - Kidney allocation. (Item 4c, Page 8)
- The Committee was updated on the HHS Program Goals. (Item 5, Page 8)
- The Committee was updated on the activities of the Tiered Acceptance/DSA Task Force. (Item 6, Page 8)
- The Committee considered policy proposals distributed for public comment. (Item 7, Page 8)
- The Committee received a Winter/Spring update regarding UNOS IT Staff activities. (Item 8, Page 10)
- The Committee discussed real-time dialog to assist in placing pediatric organs. (Item 10, Page 11)

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**REPORT OF THE
OPTN/UNOS PEDIATRIC TRANSPLANTATION COMMITTEE
TO THE BOARD OF DIRECTORS**

**Richmond, Virginia
June 26, 2007**

**Stuart C. Sweet, MD, PhD, Chair
Simon Horslen, MD, Vice Chair**

The following report presents the OPTN/UNOS Pediatric Transplantation Committee's deliberations on matters considered during its March 27, 2007, and May 4, 2007, meetings.

1. Request for Revisions to Data Collection Forms for Pediatric Candidates and Recipients. This initiative originated in November 2004 as a Joint Subcommittee with the now defunct Data Working Group (DWG) and Data Advisory Committee (DAC) to discuss possible modifications to co-morbidity data collected in UNetSM during candidate registration, transplantation and follow-up in an effort to benefit data collection for the pediatric population. Joint Subcommittee members agreed that growth and mental development are crucial for children and may be more pertinent indicators of patients' progress, both on the wait list and post-transplant. The current forms were designed predominantly with the adult population in mind. They suggested information on other outcomes related to pediatrics be considered to provide a broader picture for this population pre- and post-transplant. After the DWG and DAC were discontinued, the Committee created the Data Revision Subcommittee, with representatives from each organ specialty, to develop a proposal.

As the Policy Oversight Committee (POC) process focused on streamlining the data collection process for adults by reducing the data collection burden on the transplant centers, the Pediatric Committee realized the importance of complementing this proposal for children without sacrificing data integrity and long term follow-up essential in providing care to children as they transition into adulthood. Members concentrated on review of the adult deletions to determine what would also be appropriate for children and adolescents, while drafting several new data fields to capture information regarding growth and development that are critical indicators of a child's progress both pre- and post-transplant. For each form, data elements common to all organ types were reviewed, followed by data elements specific to individual forms by organ type. All recommendations to retain or add data were supported with one or more of the Principles of Data Collection:

- Develop transplant, donation and allocation policies;
- Determine if Institutional Members are complying with policy;
- Determine Member-specific performance
- Ensure patient safety when no alternative sources of data exist; and
- Fulfill the requirements of the OPTN Final Rule

The Committee members considered the Board of Director's December 2006 operational statement for data collection, asserting that data collected and submitted by Institutional Members to the OPTN may differ in nature and character for specific populations, forming exceptions to Guiding Principles above (e.g. Pediatrics, Living Donors). For these exceptions to the foregoing principles, alternative sources of information must be explored and supported, duplication of existing efforts (e.g. registries) avoided, and sample data collection considered. The need and

purpose of any such exceptions must be clearly articulated and subject to Policy Oversight Committee and Board approval, and public comment. Members are hopeful that alternate sources of data collection may be of use in capturing data to allow for additional form revisions in the future, noting these alternate sources could potentially be incorporated into the OPTN database.

Upon considering the POC's proposed modifications to adult transplant recipient follow-up, members stressed the importance of following children for as long as possible to better understand the physical and development effects of transplant on children as they continue to grow, transitioning into adulthood. Committee members agreed following the growth and development of these children is vital. It was acknowledged that children are not fully formed at five years post-transplant, and some consequences related to transplant may not even occur within the first five years after transplant. Members noted that although they agreed to eliminate many of the same fields to be deleted for adults, it was not done with the understanding that collection time would be dramatically truncated. Additionally, aspects of the interrelation of graft and recipient as related to growth and development were discussed as important for potential collection. This type of information could be useful in modifying allocation policy to promote successful graft and recipient pairing, and will be critical if the transplant community continues to consider net benefit as a driving factor in allocation. It was also suggested that closer follow-up of pediatric recipients during transition to adult care might help us understand medical and psychosocial factors contributing to graft loss. While the Committee believes these young recipients should be followed well into adulthood, it recognizes the added burden placed on adult transplant programs as many of these children leave freestanding pediatric hospitals, transitioning to adult care. Committee members agree that the responsibility of this long-term data collection should ultimately be moved away from the OPTN and to the various organ specific pediatric registries for organ transplantation as long as the registries can accurately represent a subset of the pediatric transplant community.

The Committee submitted its proposed changes to the data collection forms for pediatric candidates and recipients for public comment on March 2, 2007 (**Exhibit A**). Its recommended revisions to the TCR, TRR and TRF data collection forms appear below in summary:

Summary of Proposed Data Revisions:

- Across all organs, a total of 41 data elements were recommended for deletion on TCR forms, 106 data elements were recommended for deletion on TRR forms, and 91 data elements were recommended for deletion on TRF forms (See **Exhibit A, Appendix A**).
- 3 fields to be added for date of height and weight measurement, cognitive development and motor development on TCR, TRR and TRF forms for all organs (See **Exhibit A, Appendix B**).
- Organ specific (See **Exhibit A, Appendix B**)
 - Kidney and Kidney-Pancreas: 6 fields to be added for growth hormone therapy as a marker for growth delay and questions regarding bone disease on TCR, TRR and TRF forms;
 - Liver – 3 fields to be added when vascular thrombosis graft loss is selected as a cause of graft loss on TRR and TRF forms;
 - Intestine - 5 fields to be added for medical factors on TCR form; 1 field for total bilirubin to be added on TCR, TRR and TRF;

- Thoracic – 6 fields to be added for pulmonary insufficiency and prior thoracic surgery on Heart, Lung and Heart-Lung TCR forms; and 1 field to be added on type of life support on Lung and Heart-Lung TCR and TRR forms.
- Modifications involving pop-up definitions and modifications on some fields for user clarity and convenience; and additional options listed under current questions (See **Exhibit A, Appendix B**).

Note: With the deletions of certain data elements on viral detection section as proposed for adults, questions on viral detection at time of transplant have been simplified to the following: HIV serostatus, CMV IgG, CMV IgM, HBV Core Antibody, HBV Surface Antigen, HCV Serostatus and EBV Serostatus with Positive, Negative, Not Done, and Unknown/Cannot Disclose as options; and viral detection collection has been limited to CMV IgG and CMV IgM on Kidney and Kidney-Pancreas TRF forms at one and two years post-transplant (See **Exhibit A, Appendix C**).

Long-Term Follow-up:

The Pediatric Committee proposes pediatric recipients be followed using pediatric TRF forms for five years after transplant. Beyond five years after transplant and until the pediatric recipients reach 25 years of age, they should be followed using TRF forms with limited data elements similar to those recommended by the OPTN/UNOS organ specific committees for adults (see **Exhibit A, Appendix D**), but also including *for all organs* the following data elements specific to pediatrics:

- Recipient height and weight, and the date of measurement;
- Cognitive and Motor Development (as specifically proposed in **Exhibit A, Appendix B**);
- Functional outcome (with recipients transitioning from the Lansky Scale to the Karnofsky index at age 18);
- Serum Creatinine;
- Diabetes (Yes/No) and whether Insulin Dependent Diabetes;
- Presence and Type of Post-Transplant Malignancy Since Last Follow up; and
- Coronary Artery Disease (CAD) Since Last Follow-up (Yes/No).

Upon reaching age 26, pediatric recipients will be followed using the adult TRF forms with limited data elements as outlined in **Exhibit A, Appendix D**.

The POC's newly formed Data Management Subcommittee (DMC) considered this proposal during a May 2, 2007, teleconference. Upon review, the DMC suggested that collecting follow-up data on pediatric recipients through age 25 may have an impact on the quality of available data as the differential loss to follow up in this age range (18-25) may be substantial, particularly for those patients whose transplants occurred in early childhood. In order to assess the impact of extending the period of pediatric follow up, the DMC recommended this change be implemented initially for a three year period, which corresponds with the current Office of Management and Budget (OMB) requirements for form evaluation and expiration. Data should be assessed after a two year submission period to evaluate the impact of loss to follow up on the quality of the data obtained from pediatric transplant patients between ages 18-25. At this time, changes may be recommended for the next data collection form review period, to be submitted in March 2010. The DMC will share its discussion as part of the POC's May 17 review of this proposal.

During the May 4, 2007, conference call, Committee members reviewed and responded to all public comment feedback from individuals, regional meetings and other interested Committees. Overall, responses were supportive of this change in data collection for children. The Committee was updated on suggestions from the DMC, and agreed with recommendations to re-evaluate recommended changes to the TRF form prior to the next OMB submission in 2010. Members agreed that an assessment of the impact of changing follow-up requirements as compared to the number of recipients lost to follow-up would be appropriate. Implementation Plans (**Exhibit B**) and a copy of the Briefing Paper (**Exhibit C**) outlining the Committee's responses to public comment were submitted to the POC for consideration during its May 17, 2007, meeting.

After discussion, the Committee voted unanimously to submit the following for consideration by the Board of Directors. Committee vote: 11 in favor, 0 opposed, 0 abstentions.

*** **RESOLVED, that revisions to data elements on the Transplant Candidate Registration (TCR), Transplant Recipient Registration (TRR), and Transplant Recipient Follow-up (TRF) forms for pediatric candidates and recipients as well as changes to follow-up for pediatric recipients after five years post transplant and through a recipient's 25 birthday (as set forth in Exhibit A, appendices A through D) are hereby approved, effective September 1, 2007 and pending programming in UNetSM.**

2. Discussion Regarding the March 28-29, 2007 Pediatric Summit on Organ Donation and Transplantation. During its March 27 meeting, the Committee briefly discussed the format (**Exhibit D**) of the day and a half meeting to be held following this Committee meeting, bringing pediatric intensivists, pediatric transplant physicians and surgeons, OPO staff and other clinicians working in pediatric organ donation and transplantation together to address the problem of death on the pediatric wait list. The Committee's Heart-Lung (**Exhibit E**), Kidney (**Exhibit F**) and Liver-Intestine (**Exhibit G**) Working Groups were to share data requested and reviewed over the past five months as they worked to address Dr. McDiarmid's charge to this Committee- reduce death on the pediatric wait list. The current focus appears to be redirecting organs from 0-10 donors to 0-10 candidates, which should have little to no affect on the adult population. Ideas were to be shared with Summit participants, and discussion was expected to perhaps further some of the ideas that have already been generated within the individual Working Groups

During the May 4 conference call, the Committee reviewed summary slides, outlining questions and discussion highlights from each of the Organ Specific Working Group sessions held as part of the Summit (**Exhibit H**). The Working Groups plan to reconvene again prior to the June 26 Board of Directors meeting to review and discuss additional data requested during the Summit.

The Committee will formulate organ specific proposals aimed at addressing the Committee's charge of reducing pediatric wait list death, vetting these proposals through the organ specific committees with the intent of sharing a detailed plan with the Board in February 2008.

3. Overview of Organ Specific Working Group Activities. Each of the Organ Specific Working Groups reported during the March 27, 2007, meeting. All are in the preliminary stages of formulating policy changes to redirect the smallest donor organs to the youngest candidates without affecting adult transplant numbers.

- 3a. Heart-Lung Working Group Presentation. The Heart-Lung Working Group presented the latest iteration of data it reviewed during its March 5 conference call (**Exhibit I**). This information was incorporated into the Group's presentation during the physician-surgeon track of the Pediatric Summit, to be held on the following day.

This group will reconvene in May or June 2007 to discuss feedback from the Pediatric Summit

- 3b. Liver-Intestine Working Group Presentation. The Liver-Intestine Working Group presented the latest iteration of data it reviewed during its March 2 conference call (**Exhibit J**). This information will be incorporated into the Group's presentation during the physician-surgeon track of the Pediatric Summit, to be held on the following day.

This group will reconvene in May or June 2007 to discuss feedback from the Pediatric Summit and begin formulating modifications to current policy or new policy to address its charge.

- 3c. Kidney Working Group Presentation. The Kidney Working Group presented the latest iteration of data it reviewed during its March 6 conference call (**Exhibit K**). This information will be incorporated into the Group's presentation during the physician-surgeon track of the Pediatric Summit, to be held on the following day.

This group will reconvene in May or June 2007 to discuss feedback from the Pediatric Summit and begin formulating modifications to current policy or new policy to address its charge.

4. OPTN Final Rule Requirements for Organ Allocation Policy.

- 4a. Status of Thoracic Organ Allocation Policy Review. The Committee was reminded of an upcoming teleconference for the newly formed Joint Pediatric-Membership and Professional Standards Subcommittee to review center-specific outcomes reporting for pediatric lung programs during its March meeting. The Joint Subcommittee was formed to consider concerns raised that including children 12 and older in adult outcomes (due to the LAS score system age requirements) may disadvantage pediatric programs under review. Appointments were made from both Committees, and a call was scheduled for May 11, 2007.

- 4b. Status of Liver and Intestinal Organ Allocation Policy Review. The SRTR presented the results of an updated analysis (**Exhibit L**) on results of recalculating the PELD coefficients at the March 27, 2007, meeting. This presentation provided an update to information considered during the January 19, 2007, meeting. Additional variables not in the current PELD equation were tested. None were found to be significant predictors of wait list mortality, and no significant interactions between variables were found. The SRTR will use the Liver Simulated Allocation Model (LSAM) to estimate waiting list mortality and net change in the number of transplants resulting from an allocation system using updated coefficients (PELD 2) for pediatric patients compared with an allocation system using current coefficients (PELD 0) for pediatric patients. Results will be shared upon completion of this modeling.

The Committee continued to discuss concerns regarding adolescent liver candidates with MELD>25 during its March 27 meeting, and how to work with the Liver and Intestinal

Organ Allocation Committee to determine whether allocation priority should be adjusted to better serve this population. During the May 4 Committee conference call, UNOS Research staff noted updated transplant and wait list data for this population will be presented during the July 12, 2007, meeting to assist members in determining how to address these concerns and best address the Liver Committee

- 4c. Status of Kidney Allocation Policy Review. The Committee received an update on the February 8, 2007, Public Forum held to share progress made on kidney allocation policy development during its March 27 meeting (**Exhibit M**). It was noted there have been no recommended changes to pediatric allocation at this time, with pediatric candidates still receiving preference for donors <35 years of age.

Concerns were raised regarding sensitized pediatric candidates priority within the current allocation system. Under current policy, pediatric priority falls in the allocation algorithm after zero antigen mismatched candidates, sensitized candidates (PRA \geq 80%) who otherwise would rank highest in allocation priority, combined kidney non-renal organ candidates, and prior living organ donors. This preserves priorities for these candidate groups, which have been established based upon medical criteria, including utility of outcomes and biological barriers to transplantation.

Concern regarding how a highly sensitized pediatric candidate may be disadvantaged in cases where there is a highly sensitized adult candidate was acknowledged. UNOS staff will review the number of times a highly sensitized pediatric candidate has been usurped by a highly sensitized adult candidate. The Committee is currently aware of only one incident where a pediatric candidate may have been in this scenario. The Committee will receive follow-up on the number of incidents, and a Joint Subcommittee will be formed with the Kidney Transplantation Committee if necessary to address this issue.

5. Update on HHS Program Goals. The Committee was provided an update on the HHS Program Goals during its March 27 meeting (**Exhibit N**). The purpose of these goals is to increase the number of deceased donors, the average number of organs transplanted from deceased donors, and the total number of deceased donor organs transplanted. Although the goals for organs transplanted and DCD donors were not met for 2006, there continues to be excellent performance in procuring non-DCD donors. The OPTN will continue with projections and focus on actual 2006 results at the regional/DSA level to help identify trends.
6. Review of Tiered Acceptance/DSA Task Force Activities. During the March 27 meeting, the Committee heard an overview of the tiered acceptance project, which is being designed by the Operations Committee to improve efficiency in the organ placement process (**Exhibit O**). The Committee reviewed information approved in general concept by the Liver and Intestinal Organ Transplantation Committee during its March 6, 2007, meeting. After discussion, the Committee agreed it was unclear on how useful or beneficial such an approach would be for pediatric candidates. The Committee requested future information and updates regarding this system as the new DonorNet[®] goes live for all DSAs. The Committee felt it needed this additional information to make educated decisions regarding the utility of tiered acceptance for the pediatric population and, if utilized, to select appropriate elements and set up appropriate profiles for children.
7. Review of Policies and Bylaws Currently Issued for Public Comment on March 2, 2007. The Committee reviewed the seven proposals currently out for public comment during its March 27 meeting, and provided the following feedback:

- a. *Proposed Modifications to Data Elements for Pediatric Candidates and Recipients on UNetSM Transplant Candidate Registration (TCR), Transplant Recipient Registration (TRR), and Transplant Recipient Follow-up (TRF) Forms (Pediatric Transplantation Committee)* The Committee sponsored this proposal and consider all individual and regional feedback during a May 4, 2007, conference call in preparation for presenting this proposal to the Policy Oversight Committee and the Board of Directors. Please see discussion item #1.

- b. *Proposed Modifications to OPTN/UNOS Policy 7.1.5 "Reporting of Definitions" and OPTN/UNOS Policy 7.3.2 "Submission of Organ-Specific Transplant Recipient Registration Forms and Submission of Living Donor Registration Form" (Living Donor Committee)* After discussion, the Committee determined there was no specific pediatric issue requiring further comment. Members did underscore the lack of long-term follow-up for these living donors. The number of living donors lost to follow-up was concerning to the Committee. It was recognized that because there is no current requirement to retrieve this information, marking these individuals as "lost to follow-up" still meets the criteria for a completed form. Members believe this attempt to collect meaningful data is a first step in addressing this problem.

- c. *Proposed Modifications to OPTN/UNOS Policy 7.3.3 "Submission of Living Donor Death and Organ Failure Data" (Living Donor Committee)* After discussion, the Committee determined there was no specific pediatric issue requiring further comment.

- d. *Proposed Modifications to the UNetSM Living Donor Registration (LDR) and Living Donor Follow-up (LDF) Forms (Living Donor Committee)* After discussion, the Committee voiced concerns regarding freestanding pediatric programs that must track adult living donors. The Committee voted in support of this proposal, but requests the Living Donor Committee clarify the responsibility of transplant centers that utilize a living donor organ but do not see or treat the living donor. Current policy places the responsibility of follow-up on the recipient transplant center. This is not practical in the case of freestanding pediatric centers, and may not be practical in other instances as well. Members voiced concerns that pediatric programs should share responsibility for providing long term follow-up information about adult living donors with the programs/physicians that procured the donor organs. The Committee recommends information regarding the living donor's center be collected and the Living Donor Committee consider how to use this information to follow these individuals more effectively. (Committee vote: 12-0-0)

- e. *Proposed Modifications to Data Elements on UNetSM Deceased Donor Registration (DDR) From (Organ Availability Committee)* Committee members questioned whether the Organ Availability Committee's requested information might be more practically gathered as part of a research project, where these data elements could be gathered at centers interested in participating. It was acknowledged that this level of detail would be beneficial in placing organs by allowing better assessment for the DCD organ at time of offer. A member suggested that many OPOs may already be doing this, though not to the specifications outlined within the proposal. Additionally, an intensivist on the Committee questioned whether this data collection might interfere with

withdrawal of care protocols in place at some pediatric centers. The necessity of minute-by minute urine output was also questioned by members. After discussion, the Committee voted to support the proposal, but requests the Organ Availability Committee consider: (1) selecting an end date for this level of data collection, then reviewing what was collected and its benefits and/or unintended effects on the DCD recovery process, (2) the necessity of minute-by-minute urine output collection, and (3) the effects of these requirements on withdrawal of care protocols already in place in many pediatric centers. (Committee vote: 12-0-0)

- f. *Proposed Imminent Neurological and Eligible Death Definition Data Elements (OPO Committee)* After consideration, members questioned whether there is a mechanism within HRSA to evaluate pediatric ICUs and whether the proposed definitions are broad enough. Would a pilot study, including community hospitals without transplant programs, be more appropriate in capturing this information? Members questioned whether pediatric numbers may be underestimated using these definitions. It was acknowledged that current practice includes real time or retrospective medical records reviews. This is not information currently being reported in UNetSM. The added burden of transitioning from aggregate to individual data was acknowledged for the OPO community, but is required by the new OPTN contract. After discussion, the Committee voted to support the proposal, but asks the OPO Committee to consider whether this proposal may adequately address the pediatric population. A recommendation was made to consider a review of this data after a period of time to determine if the ranges set within these definitions have been appropriately set for pediatric patients. (Committee vote: 12-0-0)
- g. *Proposed Modification to OPTN and UNOS Bylaws, Appendix A2-1, Section 2.06A, (b) "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)* After discussion, the Committee determined there was no specific pediatric issue requiring further comment.

8. Winter/Spring IT Update. During its May 27, 2007, meeting, the Committee received an update from UNOS IT Staff regarding the continued roll out of DonorNet 2007[®] in DSAs across the country (**Exhibit P**). An update on the Enterprise System Redesign Project, a ground up redevelopment of the Systems utilized at UNOS to support the OPTN, was also provided. The current system does not allow for increased efficiency and productivity, and reporting capabilities are insufficient for the OPTN's current needs. Work is being done to develop a format compatible with electronic health records (EHRs) that will be used in hospitals across the country as well as to increase interfacing with other databases that will allow for sampling for research purposes. Staff noted that the final iteration of this project may be the creation of a separate pediatric allocation system. It was noted that a number of staff will be reassigned to this project, pulling resources from Committee support personnel to complete this process.
9. Update Regarding Actions from the March 23, 2007, Board of Directors Meeting. The Committee discussed actions from the March 2007 Board of Directors meeting (**Exhibit Q**). Of specific interest to this committee were the Board approved modifications to Policy 3.7.6.1 (Lung Allocation - Candidates Age 12 and Older) to include PCO₂ in the Lung Allocation Score using the lower 90% confidence limits for the hazard ratios associated with the most recent values of PCO₂ and an increase in PCO₂ greater than or equal to 15% in the previous six-month period.

Additionally, it was noted that the Board approved modifications to the Bylaws, Appendix B, Attachment I, Section VI “Transplant Surgeon & Physician,” and Section XII(C) “Transplant Programs,” to clarify what “on site” means with relation to the availability of transplant surgeons and physicians to provide service to their patients in need of organ transplantation. The objective is to make existing criteria regarding physician and surgeon availability more specific. The Board also approved additional amendments to this proposal to require transplant programs to provide a copy of the Program Coverage Plan to patients and to require programs have a surgeon and physician available 24/7/365.

10. Real Time Dialogue to Aid in Placing Pediatric Organs. The Committee's January 2007, recommendation to require a match run be generated for every consented organ was discussed during the February 2007, OPO Committee meeting. As a result of this discussion, the Committee's request for consideration during the March 23 Board of Director's meeting was rescinded. After conferring with OPO colleagues, the Committee understood there are legitimate reasons why match runs for consented organs may not be run. It was suggested this idea be reframed and introduced at the April 2007, Collaborative Learning session as a PDSA to encourage real time partnership between pediatric transplant professionals and OPOs working to place small or marginal pediatric organs in conjunction with the Pediatric Committee charge. It is hoped that this real-time dialogue with pediatric transplant professionals will assist OPO personnel in determining when to continue pursuing placement of pediatric organs in instances where placement may be prematurely halted or organs may not be considered for recovery at all. It is anticipated that this effort may help in the Committee's efforts to meet its charge of decreasing pediatric death on the wait list by making more organs available to the most critical candidates.
11. Recognition of Outgoing Committee Members, Terms Ending June 30, 2007. Dr. Sweet acknowledged those Committee members whose terms were expiring in June 2007 for their time and participation on the Pediatric Transplantation Committee. Each outgoing member will receive a certificate recognizing his or her participation.

PEDIATRIC TRANSPLANTATION COMMITTEE

	MONTH	MARCH 2007	MAY 2007
	DAY	27	4
	FORMAT (select)	In Person	Live Meeting/ Teleconference
NAME	POSITION		
Stuart Sweet M.D.	Chair	x	x
Simon Horslen MD	Vice Chair	x	x
Craig Lillehei MD	Region 1 Rep.		x
Thomas Fishbein MD	Region 2 Rep.		
Ian Carmody MD	Region 3 Rep.		
John Goss MD	Region 4 Rep.		
H. Albin Gritsch MD	Region 5 Rep.		x
Patrick Healey MD	Region 6 Rep.	x	
Sharon Bartosh MD	Region 7 Rep.		x
Ross Shepherd MD	Region 8 Rep.	x	
Morris Schoeneman MD	Region 9 Rep		alternate attended
Joanne Dupuis RN	Region 10 Rep.	x	x
Debra Dodd MD	Region 11 Rep.	x	x
Estella Alonso MD	At Large		x
Kathie Collins RN,CCTC	At Large	x	
Sharon DiSano MS, ARNP	At Large	x	x
Susan Dunn MBA,RN, BSN	At Large	x	
George Mallory Jr , MD	At Large	x	x
Robert Mazor M.D.	At Large	x	
Amy Palermo	At Large	x	
Pasala Ravichandran M.D.	At Large		
Jorge Reyes MD	Ex Officio	x	
Elizabeth Ortiz-Rios MD, MPH	Ex Officio	x	x
Jade Perdue MPA	Ex Officio	x	
INVITED GUESTS			
Ruth McDonald M.D.	Guest	x	
Anil Mongia M.D.	Region 9 Alternate		X
UNOS STAFF			
Shandie Covington	Committee Liaison	x	x
Wida Cherikh Ph.D	Research Liaison	x	x
Berkeley Keck, RN	Asst Executive Director	x	
John Lombardi	IT Support Staff	x	
Jennifer Mekolichick	IT Support Staff		x
ARBOR RESEARCH STAFF			
Mary Guidinger MS	SRTR Liaison	(by phone)	
William Harmon MD	SRTR Liaison	x	
John Magee MD	SRTR Liaison	x	