OPTN/UNOS Pediatric Transplantation Committee
Interim Report: March 19, 2012 Meeting
Chicago, Illinois

David N. Campbell, M.D., Chair
Heung Bae Kim, M.D., Vice Chair

The following report presents the OPTN/UNOS Pediatric Transplantation Committee's deliberations and recommendations on matters considered during its March 19, 2012, meeting.

1. **Update Regarding Actions from the November 2011 Board of Directors' Meeting**

The Pediatric Transplantation Committee (the Committee) was reminded that the two proposals it put forward for the Board of Directors' consideration (*Eliminate the Requirement that Pediatric Liver Candidates Must be Located in a Hospital's Intensive Care Unit to Qualify as Status 1A or 1B*, and *List All Non-Metastatic Hepatoblastoma Pediatric Liver Candidates as Status 1B*) were adopted and have been implemented as of February 1, 2012.

The Chair proceeded to update the Committee on feedback he received regarding the split liver concept the Committee has been developing. Upon updating the Board of Directors on the Committee's recent and ongoing efforts, including the split liver concept, the OPTN President recommended that these split liver efforts be tabled. This recommendation was due in part to the Board of Directors' earlier, unanimous adoption of a split-liver, Committee Sponsored Alternative Allocation System (CAS) that was sponsored by the Liver and Intestinal Organ Committee (the Liver Committee). The OPTN President indicated that it would not be prudent to pursue additional split-liver allocation modifications until the impact of the CAS could be analyzed. With respect to this recommendation, the Committee agreed to table its current efforts to modify split liver allocation. Also with respect to the recommendation, the Committee expressed a desire to review annual results of the CAS. This review should begin with, and continue to include, the results of the Region 2 and OneLegacy split-liver alternative allocation systems that served as precursors to the split-liver CAS. Specifically, the Committee wants to review the number of these types of allocations and subsequent transplants that have occurred, the outcomes of those transplants, and the number of pediatric patients on the original match run within the OPO or region (depending on the framework of that particular alternative allocation system) that were prioritized above the recipient of the second liver segment and not given an organ offer.

2. **Addition of Pediatric Transplantation Experience Consideration in the Bylaws**

The Committee's organ-specific working groups have each discussed potential pediatric experience criteria for primary physicians/surgeons. Based on previous Committee feedback, these initial discussions were had with the intent that any transplant program intending to transplant pediatric patients must have recognized staff that meets any established criteria. Some concerns with this overarching approach were realized, and each working group discussed these concerns and what it felt the scope of this effort should be. To help facilitate the full Committee's discussion, UNOS staff provided a historical account of the recent events that precipitated the Committee's focus and discussion on this topic.

The Committee does not believe any data can be produced that directly links good outcomes and quality care to minimum experience criteria, but it seems intuitive to assume that competence is more likely

with repetition and increasing experience. The Committee has yet to hear an argument made that it is OK if those leading a transplant program at a children's hospital have no pediatric transplant experience- yet this is not a set expectation. Committee members noted that current primary surgeon/physician requirements in the bylaws were developed with minimal data, but the community ultimately supported those recommendations and members are strictly held to these requirements. Committee members reiterated once again that limiting access for pediatric transplant candidates is not the goal; rather, the goal is to establish a baseline of requirements to serve as a safety net to assure that pediatric transplant candidates are receiving the appropriate care for their unique medical condition.

Continuing to discuss possible evidence to support any recommendations, the Committee feels the duality of policy and bylaw development must be realized. It seems that thoughtful recommendations from the Committee will be the best piece of evidence that can be put forth. Allocation issues need to be supported by data that indicate that changes will improve the system; however, not every issue confronted by the OPTN can be addressed in the same manner. Policy proposals must be evidenced based, but there are different types of evidence- the Committee's expertise being one such type. With that in mind, it seems that any recommendation should err on the side of caution so that the requirements do not exclude clinicians that most would agree are qualified. Without robust numerical data, it seems the requirements bar will have to be set relatively low. Committee members believed that establishing baseline pediatric criteria will codify that pediatric transplantation requires caretakers with a unique set of skills. Having such criteria would then force children hospitals to consider if they are prepared to start a transplant program for a specific organ. Recognizing the skills necessary to properly care for pediatric transplant candidates, the Committee also thought that established pediatric experience criteria may make established transplant programs that primarily transplant adult candidates reconsider undertaking unique and challenging pediatric cases.

The Vice Chair reminded the Committee of recent efforts that established criteria for living donor transplant programs. He stated that these efforts relied on the intuitive notion that a living donor transplant program and its patients will be better served with experienced individuals in leadership roles. There is some precedent for a committee of experts to recommend reasonable criteria without the support of empirical data. To cease work on these due to low volumes and the inability to produce statistically significant data would indicate passive support of the current bylaws that contain no stipulations for pediatric transplantation experience. As such, a question was raised if any Committee member would feel comfortable telling a parent of one of their patients that the bylaws silence on this matter is best, leaving them the responsibility to vet the transplant center and its leadership more thoroughly.

Acknowledging the difficulty proving a strong correlation between minimal case volume experience and competency, a Committee member suggested the requirement could be that a candidate proposed to fill a key personnel role must have a current superior write a letter that attests to the competency and experience of the individual. Committee members were hesitant to support this as the sole requirement. Although the committee believes that most would approach such a task sincerely, there were concerns that personal relationships could yield biased letters. Committee members indicated that these letters of recommendation could be valuable as one component of any potential criteria.

The Committee discussed sending a survey to evaluate the experience of clinicians currently serving in these leadership roles at pediatric hospitals. The information obtained could be pared down to a mean level of experience that could then be used for the requirements. Committee members argued that such a survey will give insight into these professionals' current experience, *not* their experience when

they began serving in these leadership roles. Any pediatric experience requirements would set a minimum level of expectations, and a survey probing into current experience would not be very insightful to this point. Another approach would be to survey those programs that have had a recent key personnel change, but this may not provide a sufficient sample. Ultimately, the idea of survey did not gain much traction.

Committee members stated that there are a number of avenues and opportunities for upcoming transplant physicians and surgeons to gain training and experience that have not been available in the past. Past efforts to establish pediatric experience criteria have been stifled in part because the community did not want to disadvantage transplant programs at children hospitals as it was unsure of the requirements that should be set. Committee members opined that with time and the maturation of organ transplantation, this is no longer the case. Criteria have been set in the bylaws for primary physicians and primary surgeons that are mainly applied to centers that predominantly transplant adult patients. The benefits resulting from these well established requirements should also be extended to those transplant programs that primarily transplant pediatric patients.

Technical skill is important to consider, but the judgment of pediatric primary surgeon or physician is also important, if not more so. There are additional complexities to these pediatric cases, and the diseases that precipitate a child's need for transplant are not the same as those diseases that commonly ail adult transplant patients. Committee members stated that numbers alone won't absolutely speak to this needed judgment and felt a letter of recommendation could accommodate this consideration.

The Committee proceeded to discuss the scope of this project moving forward. A Committee member stated that she believed the Committee should first focus on those centers that primarily transplant pediatric patients, defining a "pediatric center" as one that transplants patients younger than 18 years of age more than 50% of the time. Bylaw requirements should mandate that the leadership at those centers have a certain level of pediatric experience. She did not believe that the Committee would be able to develop recommendations that would be accepted by the transplant community that regulate every center intending to transplant all patients under the age of 18. It was her opinion that the establishment of requirements that focused on those centers that primarily transplant pediatric patients would naturally result in more complicated cases being referred to these pediatric hospitals as they would then be explicitly and formally recognized as having professionals that specialize in pediatric transplantation. Committee members commented that taking this approach would likely be more readily accepted by the greater transplant community. Appreciating Committee members' concerns about pediatric patient safety at all centers, Committee members opined that moving towards this goal deliberately and in a stepwise fashion would be better than trying to address this issue with one large, potentially contentious, proposal, which could ultimately result in the status quo with no requirements being set.

Alluding to large centers that do a significant number of pediatric transplants, with adult transplants representing the majority of the procedures done, Committee members expressed concern that these centers would not be expected to meet the same standards. As such, these Committee members felt that the pediatric patient population at these centers may not be as well served. Committee members responded that there is no mechanism currently to separate these larger centers into pediatric and adult entities. To do so would require the creation of a pediatric primary surgeon and a pediatric primary physician. Separating these centers into pediatric/adult distinctions and creating new key personnel roles is an option that could be pursued, but some Committee members had strong concerns that recommending this more complex solution would not be well received among the transplant

community. Recommendations were made to focus on those centers that primarily transplant pediatric patients as a first step. Once those requirements are established, the impact and effectiveness of these requirements can be evaluated. Successful efforts that focus on transplant centers primarily transplanting pediatric patients could then be used as a foundation to develop a broader set of recommendations.

Committee members pointed out a few risks with these requirements. If the requirements are too stringent the proposal won't pass. If the requirements are not restrictive enough then they don't have as much impact and there is a risk that administrators of children's hospitals will not vet candidates to lead transplant programs as carefully as long as the candidate meets the established bylaw requirements. Committee members acknowledged that setting specific case volumes does have some flaws. Some of these same flaws are also present on the adult side; however, the key personnel bylaw requirements are well accepted at this point and have yielded more benefit than harm. As such, Committee members replied that now is the time to introduce pediatric-specific requirements for pediatric centers, and by doing so, formally recognize the unique nature of caring for pediatric transplant candidates and recipients.

The Committee supported a motion (17 support, 1 oppose, 1 abstention) that the pediatric committee try to set some minimum numbers of pediatric experience to qualify to be pediatric primary surgeon or physician. The Committee is pursuing these efforts because it recognizes that the care necessary for pediatric transplant candidates and recipients is unique and different than the care necessary for adult transplant candidates and recipients. Additionally, the bylaws current silence on this matter presents safety risks for pediatric transplant patients.

Moving forward, Committee members recommended that these requirements primarily focus the requirements on experience and training with those most challenging cases for each particular organ group, not just a set number of pediatric transplants. A question was raised if the current bylaw requirements would be expected in addition to the pediatric experience requirements to be developed. Considering the goal to assure key personnel at pediatric centers have pediatric transplantation experience, the Committee agreed that it would be most important for key personnel at pediatric transplant centers to meet the requirements that the Committee aims to develop.

Committee members asked if UNOS already had defined "pediatric center." UNOS staff replied that the there is not a formal definition, noting the current language in the bylaws that incorporates the "pediatric pathway" applies to "transplant programs serving predominantly pediatric patients." This reference to the "pediatric pathway" motivated additional comments supporting the Committee's focus on those centers that primarily transplant pediatric candidates. Instead of petitioning the Membership and Professional Standards Committee (MPSC), and having a few members of it review the candidate's qualifications, the Committee, with an extensive pediatric representation, should determine requirements that the MPSC can definitively use for key personnel at these pediatric centers. Committee members opined that drafting requirements to modify the pediatric pathway would likely be more readily accepted in the community. The intent of this pathway must be modified so that it is not solely an option, but so that it is required for those centers that primarily transplant pediatric patients. The Committee concluded it discussion with agreement to for the subcommittees to focus on organ specific recommendations to be included in the bylaws for key personnel at those centers that primarily transplant pediatric patients.

3. **Discussion of the OPTN Final Rule Requirements for Organ Allocation Policy**

3a. Thoracic Organ Allocation Policy Review

December 14th Teleconference with Heart Subcommittee of the Thoracic Committee- Continue Pediatric Heart Policy Review Update- The Committee Chair provided an update on the Thoracic Working Group's efforts to update and modify pediatric heart allocation policy. These efforts are being undertaken along with members of the Heart Subcommittee of the Thoracic Organ Transplantation Committee (the Thoracic Committee). The Committee reviewed potential changes that are being discussed which include redefining the Status 1A and Status 1B criteria for pediatric heart candidates, modifying the eligibility criteria for an ABO-incompatible heart transplant, modifying the allocation priority of ABO-incompatible heart potential transplant recipients, and eliminating the option to list heart candidates as *in utero.* Specifically, the tentative recommendations for pediatric heart Status 1A criteria are:

a) Requires assistance with a ventilator;
b) Requires assistance with a mechanical circulatory support device;
c) Requires assistance with an intra-aortic balloon pump;
d) Has ductal dependent pulmonary or systemic circulation with ductal patency maintained by stent or prostaglandin infusion;
e) Has a congenital heart disease diagnosis (excluding minor lesions such as atrial septal defect, ventricular septal defect, PDA, or biscupid aortic valve); is admitted to the listing center hospital; and, requires infusion of high dose or multiple inotropes
f) By exception

For pediatric heart Status 1B:

a) Has a diagnosis of cardiomyopathy and requires infusion of one or more intravenous inotropic agents
b) Has a diagnosis of congenital heart disease and requires infusion of low dose single inotrope
c) By exception

Regarding ABO-incompatible heart transplants, the tentative recommendation is to increase the isohemagglutinin titer level to 1:16, and prioritize qualified ABO-incompatible heart potential transplant recipients with those in each respective "secondary ABO" match run classification.

A Committee member asked how the new, proposed Status criteria will impact pediatric heart candidates' Status 1A/Status 1B/Status 2 distribution. This has not been formally modeled, but it is believed that the recommendation to list cardiomyopathy patients that require inotropic infusions as Status 1B will significantly decrease the number of pediatric heart candidates that are waitlisted as Status 1A at any given time. The impetus for making these changes is because the Status 1A/1B distribution is currently skewed in such a way that the majority of pediatric heart candidates are listed as Status 1A, yielding a system where the allocation of hearts is more dependent on waiting time than urgency. Based on the data reviewed by the Working Group, it is believed that these proposed changes will impact heart allocation so that urgency is a more prominent factor.

The Committee was notified that the policy language modifications to address these four topics are being finalized, and a teleconference for members of the two Committees to review and discuss this progress is scheduled for the beginning of April. The Committee was also reminded that these recommendations to modify policy are intended to be distributed for public comment in the fall, and

may be adjusted in the interim. The Committee will be asked for feedback and to vote prior to any proposal being finalized.

Evaluation of ABO-Incompatible Heart Policy- UNOS Research support for the Committee, Wida Cherikh, Ph.D., presented an analysis of the impact of the ABO-incompatible heart policy modifications that were implemented in November 2010. To summarize the results of the analysis:

- Only 34% of the 195 non-AB registrations added to the heart alone waiting list before the age of 2 years and in Status 1A or 1B at listing indicated a willingness to accept a heart of an incompatible blood type.
- Of the registrations still waiting on January 31, 2012, 37% were willing to accept a heart of an incompatible blood type.
- None of the candidates listed between the ages of 1 and <2 indicated a willingness to accept an ABO-incompatible heart.
- All 16 ABO-incompatible heart alone transplants during 11/22/10-11/21/11 were performed in recipients less than a year old at both listing and transplant.
- Of the 16 recipients of ABO-incompatible heart alone transplants performed in the year following policy implementation, one recipient died at 51 days post-transplant with "cerebrovascular" noted as the primary cause of death. At time of death, the titer value was reported to be 1:2.

A committee member asked if, for comparison purposes, the waiting time for ABO-compatible transplants was evaluated. This comparison did not occur in this analysis, but could be incorporated in future analyses, along with a comparison to those who received an ABO-identical transplant. It must be understood though that the comparison will only have a small number of ABO-incompatible transplants to evaluate.

Evaluation of Broader Sharing of Lungs from 0-11 Year Old Donors and Simple Priority System for 0-11 Year Old Lung Candidates- UNOS Research staff proceeded to present an analysis of policy changes implemented in September 2010 that resulted in broader sharing of lungs from 0-11 year old donors, and the establishment of a two-tier priority system for lung candidates that are younger than 12 years of age. To summarize the results:

- The number and percentage of pediatric additions to the lung waiting list aged 0-11 and 12-17 decreased during the 14 months following policy implementation, although overall number of additions increased post-policy.
- Over half (62%) of the pediatric additions aged 0-11 during the 14 months post-policy were listed in Priority 1.
- On January 31, 2012, 33% of registrations aged 0-11 were waiting in Priority 1.
- Across all donor age groups, there was not much change in the distribution of deceased donor lung dispositions during the 14 months post-policy as compared to the 14 month period pre-policy.
- The total number of lung transplants performed in recipients aged 0-11 and 12-17 decreased following policy implementation.
- The percentage of Zone B transplants performed in 0-11 recipients from 0-11 donors has increased since policy implementation.

- During 14 months post-policy implementation, 21 out of the 22 recipients aged 0-11 received their lung alone transplant from 0-11 year old donors in Priority 1, most of which were Zone B transplants.
- There was no significant change in death or transplant rate post- vs. pre-policy for any age group.

The Committee observed that the increase in Zone B transplants is an encouraging, expected result from these policy changes. The Committee also commented on the absence of change in death rates relative to broader sharing of lungs from 0-11 year old donors that should expand the number of offers 0-11 year old lung candidates receive. The Committee noted that there were adult candidates transplanted with lungs from 0-11 year old donors, but no 0-11 year old lung candidates transplanted with lungs from an adult donor. Adult candidates being transplanted with these donor lungs is not problematic as it is likely that there were no 0-11 year old lung candidates actively listed in each respective geographic region when these transplants occurred. The concern is that when these candidates are actively listed, and there is an adult donor that may be appropriate (e.g. for a 9 year old lung candidate), they are unlikely to receive an offer because these potential transplant recipients are prioritized after those potential recipients 12 and older that are ordered by their lung allocation score (LAS), even if the 0-11 year old candidate is a more urgent case. Attempts to address this phenomenon may impact the death rate; however, it was stated that any allocation modification would likely yield only a couple of 0-11 year old lung candidates transplanted with adult donor lungs in any given year.

The Committee will continue to review these data on an ongoing basis.

3b. Kidney Allocation Policy Review

Update- Memo to Kidney Committee RE: Criteria for Pediatric Kidney Candidates to Accrue Waiting Time- The Committee was reminded of its discussion during the September 2011 meeting. This discussion ended with a motion to send a memo to the Kidney Transplantation Committee (Kidney Committee) that suggested potential criteria for pediatric candidate's to accrue waiting time, including a mechanism to review any unique pediatric kidney candidates that did not meet this threshold. Subsequent to this meeting, the Kidney Working Group further discussed these recommendations. During this later discussion, the Kidney Working Group recognized that establishing minimal GFR criteria for pediatric kidney candidates to begin accruing waiting time will not address the perceived issue regarding preemptive listing for pediatric priority- candidates could still be listed and would appear on match runs without having accrued any waiting time. Additionally, any review of cases not meeting the threshold would add more complexity to the system and likely require significant resources relative to the few numbers of cases needing review. Furthermore, the data reviewed at the Committee's September 2011 meeting that analyzed the latest pediatric data (2006-2007) for preemptive kidney listings that showed GFR>30 ml/min/1.73m^2 listings are spread across all age groups, with the highest percentage (relative to all preemptive listings in each respective age group) appearing in the 14 year old age group, not the 17 year old age group.

Considering this discussion, the Committee was asked to contemplate sending a memo to the Kidney Committee that recommended no policy changes regarding pediatric kidney candidates' accrual of waiting time. The Committee then reviewed a memo that had been drafted to communicate this message. Ultimately, the Committee unanimously supported a motion (21 support, 0 oppose, 0 abstentions) to support the Kidney Working Group's recommendation to send the updated memo.

Update on a Potential Regional Sharing System for Highly Sensitized Pediatric Kidney Candidates- The Committee was updated on the Kidney Working Group's ongoing discussions with members of the Kidney and Histocompatibility Committees. To summarize those discussions:

- Call participants explored what would define "highly sensitized" for this allocation system. It was assumed that the 80% threshold would be used, but there were questions if that was the correct value. An earlier pediatric data analysis of the number of pediatric candidates added to the kidney waiting list over a 20 month period (ending 5/31/2011) by their CPRA at listing showed 33 candidates listed with a CPRA ≥80%. Call participants agreed that a CPRA of 80% or greater should be the threshold for any additional pediatric priority that is granted due to the candidate's immunological sensitivity. Call participants have also requested an analysis to verify that the anticipated impact, which considered PRA, is consistent in the transition to CPRA.
- An explicit goal of this project is to minimize the number of positive crossmatches that occur after the shipment of the kidneys. With guidance from members of the Histocompatibility Committee, call participants felt confident that CPRA would work effectively if *all* available sensitivities are reported, including some that are not currently collected by the OPTN. The system should also include a review process of those positive crossmatches to promote additional, ongoing efforts to minimize the number positive crossmatches realized after a kidney has been shipped.
- Reallocation of the kidney in the event of positive crossmatches continues to be considered. It is possible that the Host OPO, and the transplant centers served by that OPO, would want the kidney shipped back to be reallocated locally. The only solution raised thus far is to provide the Host OPO the option of having the kidney shipped back, though such a policy element may not be as reasonable in more geographically dispersed regions.

A Committee member asked if this additional priority will be above those receiving multi-organ transplants, specifically simultaneous kidney-pancreas transplants (KP transplants). Members of the Kidney Working Group responded that this priority is only intended to apply to isolated kidney allocation- the primary advantage being prioritizing highly sensitized pediatric kidney potential recipients that are in the region above the prioritized, highly sensitized, adult kidney potential recipients. The Committee member replied that the root of his question is a concern that a non-sensitized kidney-pancreas transplant recipient would receive a kidney that would otherwise be suitable, and allocated to, a highly-sensitized, pediatric candidate waiting for an isolated kidney. Committee members echoed the concerns, and expressed similar thoughts in the spring of 2010 when the Pancreas Transplantation Committee (Pancreas Committee) was seeking comment on its proposal to modify how pancreata are allocated. Although the Pancreas Committee was aware of the concern, modeling results indicated that the proposed changes would not significantly impact pediatric kidney transplantation. As such, it was challenging for the Committee to build much support for its concerns. Hypothesizing that the number of pediatric kidney transplants is not large in a nationwide analysis to reflect these concerns, Committee members suggested analyzing transplant rates and the average time spent on the waiting list for pediatric kidney candidates in regions with large KP programs as compared to those in regions with smaller KP programs. Recognizing that the new pancreas allocation system has been adopted by the Board and is waiting implementation, the Committee was asked to be mindful of this in the future and propose changes if data encourages action.

To conclude this discussion, and looking forward, the Committee was alerted that a teleconference including members of the Histocompatibility and Kidney Committees would be scheduled to continue

these efforts and review a completed data request. It will be critical to involve the OPO Committee as these efforts evolve.

KPSAM Analysis of Allocation Changes Using CPRA- Representatives from the Scientific Registry of Transplant Recipients (SRTR) presented Kidney-Pancreas Simulated Allocation Model (KPSAM) results requested by the Kidney Working Group. As alluded to earlier, the KPSAM was requested to verify that regionally sharing kidneys for highly sensitized pediatric candidates would produce similar results considering CPRA, as compared to past analyses use of PRA.

For this data request the acceptance models were updated using 2010 OPTN match run data, KPSAM input files were updated using 2010 candidates and organ arrivals with CPRA for allocation, and results were averaged across 10 iterations. To summarize the results, the following conclusions were made with respect to the current allocation system:

- For zero mismatch allocation, giving priority to highly sensitized pediatric candidates over adult candidates resulted in almost no change in the transplant count from the baseline run.
- For non-zero mismatch allocation, regional sharing for highly sensitized pediatrics resulted in an increase in transplant number and a shift in transplants from local pediatrics to regional pediatrics.
- Increase in regional transplants was seen in donors <35 yrs.
- Regional sharing of older donors for highly sensitized pediatrics would not seem to notably increase transplants.

Committee members commented that these data are similar to past analyses using PRA. Committee members also commented that though these numbers are relatively small as compared to annual kidney transplants, the magnitude of the changes it is pursuing are anticipated to significantly impact the number the highly sensitized pediatric kidney candidates on the waiting list.

3c. Liver and Intestinal Organ Allocation Policy Review

Evaluation of Broader Sharing of Livers and Liver-Intestines From 0-10 Year Old Donors- UNOS Research staff presented an impact analysis of policy changes that shared livers and liver-intestines from 0-10 year old donors more broadly, which was implemented by UNOS on November 18, 2010. To summarize the findings of the analysis:

- After policy implementation, number and percentage of all liver alone transplants performed in 0-11 recipients from 0-10 donors increased.
- Number of Status 1A liver alone transplants performed in 0-11 recipients from 0-10 donors increased almost 3-fold, from 16 pre-policy to 43 post-policy.
- Although number of liver-intestine transplants from 0-10 donors went down from 41 to 31 following policy implementation, the percentage transplanted into 0-11 recipients increased from 91% to 97%.
- There was no increase in the percentage of livers and intestines recovered and transplanted from 0-10 donors post-policy and a slight decrease in the percentage of 0-10 and 11-17 livers discarded.
- Although not statistically significant, there was a decrease in waiting list death rate during the 10 months following policy-implementation, both overall and in Status 1A, for all pediatric age groups.

- There was a significant increased transplant rate in Status 1A for liver alone candidates aged 0-11 at listing.

4. **Review and Consideration of Public Comment Proposals Released March 16, 2012**

4a. Proposal to Revise the Lung Allocation Score System
A member of the Thoracic Committee presented this proposal for the Committee. After minimal discussion, the Committee unanimously voted to support the proposal as written (21 support, 0 oppose, 0 abstentions).

4b. OPTN Bylaws Substantive Rewrite of Appendix A: Application and Hearing Procedures for Members and Designated Transplant Programs
UNOS staff that supports the MPSC presented the proposal for the Committee. After minimal discussion, the Committee unanimously voted to support the proposal as written (20 support, 0 oppose, 0 abstentions).

4c. Proposal to Establish Kidney Paired Donation (KPD) Policy
UNOS staff managing the UNOS KPD program presented the proposal for the Committee. After minimal discussion, the Committee unanimously voted to support the proposal as written (20 support, 0 oppose, 0 abstentions). The Committee requested a resource for members that specifically lists what would be audited for these policies and how members are expected to comply.

4d. Proposal to Include Bridge Donors in the OPTN Kidney Paired Donation Program
The Committee proceeded to review the second kidney paired donation proposal which introduces bridge donors to the KPD program. After minimal discussion, the Committee voted to support the proposal as written (18 support, 0 oppose, 1 abstention).

4e. Proposal to Require Reporting of Unexpected Potential or Proven Disease Transmission Involving Living Organ Donors
The liaison to the Living Donor Committee presented the proposal for the Committee. After minimal discussion, the Committee unanimously voted to support the proposal as written (19 support, 0 oppose, 0 abstentions).

4f. Proposed Changes to the Donation after Cardiac Death (DCD) Model Elements
The liaison to the Organ Procurement Organization (OPO) Committee presented the proposal for the Committee. After minimal discussion, the Committee unanimously voted to support the proposal as written (19 support, 0 oppose, 0 abstentions).

4g. Proposal to Clarify Priority Status for Prior Living Organ Donors who Later Require a Kidney Transplant
The Committee's crossover representative to the Kidney Committee presented the proposal for the Committee. After minimal discussion, the Committee unanimously voted to support the proposal as written (19 support, 0 oppose, 0 abstentions).

OPTN/UNOS Pediatric Transplantation Meeting
March 19, 2012
Chicago, Illinois

NAME	COMMITTEE POSITION	In Person
David Campbell, MD	Chair	X
Heung Bae Kim, MD	Vice Chair	X
Laura O'Melia, CPNP	Regional Representative	X
Stephen Dunn, MD	Regional Representative	X
Alfonso Campos, MD	Regional Representative	X
Jose Almeda, MD	Regional Representative	
Debra Strichartz, RN, BA, CCTC	Regional Representative	
Andre Dick, MD, FACS	Regional Representative	X
Sharon Bartosh, MD	Regional Representative	
Jeffrey Lowell, MD	Regional Representative	X
Kishore Iyer, MD	Regional Representative	X
Jeff Shuhaiber, MD	Regional Representative	
Kathy Jabs, MD	Regional Representative	X
Sandra Amaral, MD	At Large	
Eileen Brewer, MD	At Large	X
John Bucuvalas, MD	At Large	X
Blanche Chavers, MD	At Large	X
Shylah Haldeman, RN	At Large	X
Clifford Chin, MD	At Large	X
Carmen Cosio, MD	At Large	X
Alan Farney, MD, PhD	At Large	X
Simon Horslen, MB, ChB	At Large	Phone
Kimberly Hoagwood, PhD	At Large	
William Mahle, MD	At Large	X
Debbi McRann, RN	At Large	Phone
Douglas Milbrath	At Large	X
Gary Visner, DO	At Large	X
Jerry Wright, RN, CPTC	At Large	
James Bowman, MD	HRSA	X
Ba Lin, MS, MPH	HRSA	Phone
Jodi Smith, MD	SRTR- MMRF	X
Wida Cherikh, PhD	UNOS Research	X
Chad Waller, MS	Committee Liaison	X
Jory Parker	UNOS Business Analyst	Phone