

**OPTN/UNOS Operations and Safety Committee
Meeting Minutes
October 25, 2017
In-Person Meeting**

**David Marshman, CPTC, BS, Chair
Michael Marvin, MD, Vice Chair**

Introduction

The Operations and Safety Committee met in-person in Chicago, Illinois on 10/25/2017 to discuss the following agenda items:

1. Policy Oversight Committee Update
2. ABO Subtyping Guidance
3. Extra Vessels Project
4. TransNet
5. Patient Safety Series
6. Trends and Patterns in Patient Safety Cases Reported to the OPTN
7. ABO Verification Monitoring and Evaluation
8. Extra Vessel Disposition Reporting Database Evaluation

The following is a summary of the work group's discussions.

1. Policy Oversight Committee Update

Summary of discussion:

Members received an update on the Policy Oversight Committee (POC) activities. The POC approved two projects sponsored by the Operations and Safety Committee in July 2017. Members reviewed the POC comments for both of these projects. The OPTN Strategic Plan structure and goal allocations were reviewed. It was noted that this is an improved system by putting more structure and strategy into OPTN project work.

2. ABO Subtyping Guidance

Summary of discussion:

Members reviewed the most current version of the subtyping draft guidance document. This is a revision of the original 2011 subtyping guidance. A workgroup of members from the Committee as well as additional subject matter experts such as those from the blood banking community worked on this product. The project is in the evidence-gathering phase of the policy development process. Steps of the policy development process were reviewed. Prior to 2016, guidance did not go out for public comment. Now, OPTN proposed guidance is put out for public comment. This is being updated to help match updated ABO policy requirements, update other policy references, and implement a more plain language approach.

Issues identified regarding subtyping were reviewed as roughly 25% OPOs have had issues related to subtyping on UNOS routine audits. The issues include lack of clarity on OPTN policies; the need to perform subtyping on two different pre-transfusion specimens; difficulties in understanding/interpreting results nomenclature; promoting understanding importance of subtyping; and implications of erroneous results.

On the work group calls, members worked through terminology. They also reframed the document to emphasize that two out of three tests is not acceptable and when in doubt to go with primary blood type. It is noted that OPOs must develop individual policies to specify what

timeframe the OPO will use to define pre-transfusion. The difference between pre-red blood cell transfusions (RBC) versus hemodilution is explained. Although more molecular tests are available, molecular testing is not option in house at donor hospitals and usually takes up to seven days to complete. It was noted that it might be an option for living donors, but not for deceased donors. The guidance document will emphasize other resources such as the learning management system module available in UNOS Connect to make these complementary resources.

During the document review, the Committee requested that language addressing antibody production by neonates and infants be added. One member did not realize neonate expression was different and it was clarified that the expression does go up in time although there are differing opinions about the timeline. The work group experts will be asked if the infant will start expressing the organ antibodies over time. There has been discussion in regional meetings regarding splitting organs and the subsequent question would be if you could subtype infants how might this impact practice. Increasingly organs are being shared outside of DSAs. It was asked if the current recommendation needs to be strengthened, regarding when subtyping will not be done for neonates or those who have received pre-RBCs. It was noted that this needs to be individualized based on varying capacity and lab practices among OPOs. The Committee can also seek public comment feedback on whether more prescriptive timelines would be helpful.

The Committee also requested that the last paragraph in the technical information paragraph be revised, as it seems to be confusing or contradictory. The language was noted regarding the weak reaction, but many non-A¹s are mild low-level binding. This concept is confusing and from the safety perspective, any reaction is not safe for transplant. It is a binary decision, but other parts might suggest otherwise. It was noted that “weak” reactions are ones that do cause questions. The key points and language will be clarified. These revisions will be made in consultation with the blood bank and laboratory subject matter experts and sent back out to the Committee.

The kidney, minority affairs (MAC), and organ procurement organization (OPO) committees were identified as project stakeholders and their pre public comment feedback will be sought. The language will also be reviewed by UNOS communication, policy, and member quality departments. The Operations and Safety Committee is scheduled to meet on November 30, 2017. Members will be voting at this meeting to send the subtyping guidance to the POC/Executive Committee for approval to go out for January 2018 public comment. Regional representatives will be presenting the document and training will be provided. When presenting proposals, Committee members are asked discuss proposals from the Operations and Safety Committee perspective.

3. Extra Vessels Project

Summary of discussion:

The Committee is sponsoring an extra vessels project that is currently in the evidence-gathering phase. The project timeline and progress were reviewed. The project has three parts: removing the requirement for the extra vessels sharing justification, amending the extra vessel label requirements and associated programming in UNet, including TransNet, and making overall OPTN policies consistent with the Final Rule that states that extra vessels are considered part of the organ with which they are procured. The goal is for the Committee to discuss outstanding questions today. The plan is for the Committee to vote on proposed language at its November 30 meeting to then forward to the POC/Executive Committee for approval to go out for public comment in January 2018.

The extra vessels project has been worked on by the TransNet subcommittee because much of the project addresses labeling and therefore TransNet use.

Part 1: Extra vessels justification.

The current policy requires that when transplant hospital share extra vessels that a justification is submitted for consideration by the Membership and Professional Standards Committee (MPSC). The Committee has been asked to look at removing this requirement by the MPSC and the Member Quality (MQ) department. This is based on the following information:

- Since August 2015, extra vessels are reported in TIEDI.
- Disposition reporting improved from 50% to nearly 100% (for at least one disposition per donor with extra vessels recovered)
- Less than 1% of extra vessels are shared (sent to another hospital)
- In 2016, 69 extra vessels were reported as “sent to another hospital” in TIEDI
- Preparing and reviewing justifications creates unnecessary work (no associated policy violations)

The Committee was asked if reporting sharing should be included in the reporting requirements. The Committee did affirm that reporting sharing should be required by the sending transplant hospital. The current requirements are to provide a justification from the receiving hospital versus reporting sharing by the sending hospital in the TIEDI system. It was noted that this optional functionality currently exists in the TIEDI reporting system and would not require additional programming.

The pros for adding a sharing requirement would be that the data will be cleaner and there will not be ambiguity about what to do for a shared extra vessel. It would assure that receiving hospital would have the extra vessels in their pending list within a reasonable timeframe to complete their reporting. TIEDI is already set up to do this already and no programming will be needed. It will be easier to track vessels and improve follow up (e.g. infectious disease). The original transplant hospital will have a record and documentation in UNet. The potential cons would be a possible perception that this would be an extra burden (n = 43 centers/67 vessels), concerns about a new potential policy violation, and arguments that is not needed as receiving programs can report extra vessels use without the extra vessels being reported as sent. The TIEDI reporting system was shared with Committee members so that they could visualize the current system and questions being asked.

It was noted that changing the requirement but requiring reporting is not a substantial burden due to the small numbers and that the reporting is necessary for the consistency of treating extra vessels as organs as required by the Final Rule. It is also necessary from a safety perspective. It was asked how a sharing requirement would impact the reporting requirements for the receiving hospital. The Committee considered a shorter reporting timeframe for sharing since the sending hospital would have up to seven days to enter it into the system but decided that it could be confusing. In addition, the receiving transplant hospital can enter a new report without first receiving the shared report. The Committee discussed and decided that the sharing reporting timeframe should be the same as the other reporting timeframe (seven days) following the change in the extra vessels disposition. It was noted that the Committee should frame this change as modifying versus removing the requirement regarding sharing extra vessels as there will still be a requirement to report as opposed to having no record of where and when extra vessels are shared. The proposed language is suggested to state that extra vessels

dispositions, including sharing, use, and destruction be reported within seven days of the sharing, use, and destruction.

Part 2: Revise extra vessel label requirements and synchronize systems

The second part of the extra vessels proposals will bring DonorNet and TransNet/OPTN Polyplastic Extra Vessels Labels into synch. Policy requires all infectious disease testing results to be on the extra vessels label on the outside of triple sterile barrier (orange and white polyplastic label). Currently not all infectious disease results are on the label and there is not room to provide for all current results including some additional tests that OPOs might perform outside of policy requirements. Policy requires all infectious disease results to be verified prior to extra vessels use. The requirement for all infectious disease results can mean frequent changes. Keeping label revisions and programming in synch requires resources for both the OPTN and members who must buy new labels when revised. The current test result options do not match and “unknown” has been identified as an ambiguous result. A result should always be available even it is pending or not done.

The current label policy, DonorNet infectious diseases screening page, and poly-plastic extra vessels label were reviewed to illustrate the issues on the differences in tests, test names, and test results. Since TransNet started there have been 270,802, infectious disease results entered into TransNet. Of these, 55 were unknown and 7,047 were pending. Since 6/1/17, when mandatory use went into effect, there have been 5,990 infectious disease results entered. Of these, over one quarter (n=1,539) were pending and 8 were unknown. The majority of these are likely to be results not related to HIV, HBV, or HCV as recent data for evaluating policy requiring the match to be re-executed have found only 139 cases of these results changing to positive.

The TransNet work group considered three options:

1. Keep policy as is-Make polyplastic labels bigger and print four versus three TransNet labels
2. Limit label results to policy required tests (have bar code scan for additional results)
3. Limit label results to HIV, HBV, and HCV test results (have bar code scan for additional results)

TransNet Work Group and the Ad Hoc Disease Transmission Advisory Committee (DTAC) have both recommended option 3 (Limit label results to HIV, HBV, and HCV test results (have bar code scan for additional results)). DTAC members stated that other results (e.g. CMV) are not likely to stop use of extra vessels in an emergency although follow up would need to be done afterwards.

Reasons in support of this recommendation include that the polyplastic label and TransNet programming can be maintained without the need for frequent changes. Having the barcode scan for the most recent results could help promote use of TransNet among transplant hospitals. There will be the ability to message more clearly about vessels that cannot be stored. It would still be possible to add additional tests in DonorNet if desired without making as many changes downstream. The results that are most likely to be pending at recovery will then get a scan for the most recent results. Currently there is no requirement to update the results on the extra vessels label and from the TransNet label data; it appears that many results are not the final results.

In addition, DonorNet will be updated with five infectious disease results options that are currently on the Deceased Donor Registration (DDR) form following a customer advocacy request that was programmed at the NATCO annual meeting. These include results for HTLV NAT; West Nile Virus serology and NAT; and Chagas serology and NAT.

It was discussed that the result is important when you get to the OR. The question was asked how many are pending at that time as that is what matters. As a surgeon the acceptance happens in the OR but that is not what the definition is in the data according to DonorNet. The data as requested is not available. It is based on converting the match run status to organ accepted. For every donor there is a cross clamp time and one member suggested that might be more accurate. There is no way to link those elements together. The re-execute the match run data and process was the best available to analyze the data. It was noted that the decision before the Committee could probably be made based on the available data. Although there are a small number of re-execute the match cases, it is in place to stop an accidental unintended disease transmission which is a never event.

OPO representatives indicated that they have not seen anyone mobilize a team with pending results although the results might not have yet be updated in DonorNet. The Committee will try to get more details on the pending TransNet data. The TransNet label is completed closer to the time of recovery as it is done in the OR.

It was noted that when extra vessels must be used in an emergent situation that being able to have the HIV, HBV, and HCV results on the label would be the most important. The bar code scan would provide the ability to access other results. Results from CMV would not stop a procedure but would impact post-transplant actions. It was asked if West Nile Virus would stop an action. It was noted that those might not be on the label and the bar code scan would give the capability to access these results. It was also noted that West Nile Virus is not a policy-required test. It was also noted that some results come back after transplant. Two OPOs did talk about placing West Nile Virus positive donors that are not symptomatic. Some OPOs do test for other conditions such as Strongyloides. It was noted that these results could not be currently reported in DonorNet so that OPOs create their own forms to require a signature to make sure results have been reviewed. The IT part of this proposal would address that issue.

TransNet staff shared that a preliminary analysis of pending TransNet results showed generally 50 or less instances for HIV, HBV, and HCV results. The most common pending results at TransNet extra vessels label generation were for EBV and "Other" results. A mockup of a potential extra vessels label was shared to show how the label might look with just HIV, HBV, and HCV results. One member did talk about the need to communicate results from other tests such as Chagas. It was noted that to access and read the TransNet barcode, a user name, and password would not be required. The user would have to navigate to the TransNet website.

The Committee would need to make a decision point on whether the scan would pull from DonorNet or TransNet. The Committee talked about the need to establish which is the true source of information. The option of trying to name all tests in DonorNet was mentioned but it was also discussed that if the hospital is not on TransNet they might not see a result. An expedited donor might be recovered with pending TransNet results but results must be updated in DonorNet. The Committee decided that DonorNet must be the source of truth and everything else will be an adjunct. The idea of going to the attachment was discussed but then serology results would all have to be combined into a single file. TransNet allows an import of the most recent DonorNet results. By making the proposed changes, then the results would be pulled from DonorNet. OPOs must update all results in the DDR and the reverse logic is that the DDR updates DonorNet. The need to have DonorNet versus TransNet be the source of record was decided. Before producing the label in TransNet, the results in DonorNet system can be downloaded. Potentially one set of results on label, TransNet, and DonorNet as well as somethings not recorded in DonorNet. It was suggested that a drop down could be done-for infectious disease as for bronchoscopy. Pending results are not allowed in the DDR.

The best system to work within would be DonorNet. Because of an ever-expanded list of infectious disease tests, the bar code would be best use of OPTN resources and that the proposal will limit policy required label results to HIV, HBV, and HCV.

It was noted that the Committee does want to capture other serologies. More research into using other fields with drop downs or single name fields will be done. It was also noted that all conditions on the list of special pathogens must be reported per disease transmission policy. These are also reported to the OPTN. The Committee can look at this data as well as be reassured that there are paths to get the other results to the transplant hospitals. These reports apply to both organs and extra vessels.

Part 3: Revise policy references to extra vessels to be consistent with the Final Rule

The Committee was provided the background on this part of the project including the rationale behind transferring authority from FDA to HRSA for extra vessels oversight when used for organ transplantation. The Final Rule states that vessels (including extra vessels) are subject to allocation requirements and policies for the organ for which they were procured. Not all OPTN policies were written using the logic in CFR §121.7 as many were developed before it was written. OPTN and Final Rule terms differ slightly. When the term “vessels” is used in the Final Rule it means both vessels attached to the organ as well as what OPTN defines as “extra vessels”. In addition, OPTN policies sometimes uses the term “vessels” versus “extra vessels” although the intent is governing extra vessels. The following Final Rule definitions were shared with members.

§121.2 *Definitions.* Organ means a human kidney, liver, heart, lung, pancreas, intestine (including the esophagus, stomach, small and/or large intestine, or any portion of the gastrointestinal tract), or vascularized composite allograft (defined in this section). Blood vessels recovered from an organ donor during the recovery of such organ(s) are considered part of an organ with which they are procured for purposes of this part if the vessels are intended for use in organ transplantation and labeled “For use in organ transplantation only.”

§121.7 *Identification of organ recipient...* e) Blood vessels considered part of an organ. A blood vessel that is considered part of an organ under this part shall be subject to the allocation requirements and policies pertaining to the organ with which the blood vessel is procured until and unless the transplant center receiving the organ determines that the blood vessel is not needed for the transplantation of that organ.

A staff analysis was conducted to correct the identified issues. OPTN staff policy analyzed what policies would fit the logic and what would need to be addressed to be consistent with the Final Rule. The analysis found that: 99 policy references could be impacted by logic; 49 would already fit the logic; 35 references would need to be changed; 5 would be moved to other sections; 4 are possible changes; and 6 would need committee consultation.

The Committee discussed the six issues requiring consultation. For quality and documenting organ quality for abnormality or surgical damage, the Committee unanimously decided that extra vessels could have exemption clause. In addition, they unanimously felt that members would not need minimum tissue typing materials for extra vessels.

One member did go back to question of needing useful iliac extra vessels when importing a pancreas. It was ultimately decided that this was discussion among surgeons and that to put a definition in policy would not be needed.

The Committee discussed the verification requirements for extra vessels and the fact that the “all infectious disease” language is included. It was asked if the current language contains all appropriate verifications and how do we define “all infectious disease results” It was proposed

and agreed to limit this language to HIV, HBV, and HCV to be consistent. It was also noted that these verification policies apply to procedures that are not the index transplant.

It was also decided that there does not need to be a carve out for extra vessels regarding transportation costs for kidneys. It was noted that this would be a rare circumstance and maybe would happen for pediatric or enbloc kidneys. Although there will be a cost if shipped separately, it was decided that it would not be proposed to exempt extra vessels when sent separately from kidneys.

Finally the Committee discussed informed consent related to PHS increased risk and extra vessels. This issue was raised at the prior meeting and data were requested. Data were discussed. There were 26 cases of extra vessels used in secondary recipients that were also increased risk. This was 14% of all extra vessels used in secondary recipients. The Committee felt that to be consistent with organs, to be consistent with PHS recommendations, and for patient safety reasons that informed consent should be obtained for these situations. The need for not only consent, but also for post-transplant recipient monitoring as required by policy, was mentioned as vessels can transmit HIV, HBV, or HCV. For elective cases, it was noted that consent could be obtained but that it would not always be possible in emergency cases. The Committee discussed the need to have an exception clause that would allow the recipient to be informed of increased risk extra vessel use after the procedure but that then the post-transplant monitoring would need to be done. Policy language will be developed to reflect the Committee's discussion and decision.

The Committee has addressed parking lot issues through this proposal. The POC had questioned whether OPOs stored vessels but it was noted that OPOs do not routinely do this and if they do, they are in an agreement acting on behalf of the transplant hospital.

4. TransNet

Summary of discussion:

Operations and Safety is charged with reviewing TransNet usage among OPOs. The OPO usage data were reviewed. The data show the impact of mandatory use and use is now at 98-99% where a TransNet case is created. In September 2017, 100% of donors had a TransNet case created and 98% had at least one organ shipped using TransNet. An analysis of transplanted organs starting June 1 through September 30 also showed that use has not dipped below 90% of all transplanted organs being shipped using TransNet. Living donor is not set up for TransNet use at this time. It was asked if this will be mandated at some point and it was noted that this is a Committee point of discussion. Individual OPO use was also presented but there were no trends of any individual OPOs falling below certain thresholds. Monitoring will continue.

Staff provided a current updates for OPO TransNet. The training environment will start today for version 5.6 that will allow for VCA programming. The version will be released to production in time for mandatory use for packaging and labeling VCA organs. The 6.0 version will be a database rewrite sometime in 2018.

TransNet for transplant hospitals is continuing but a slow process. Staff are developing a brochure that OPOs can give to transplant hospitals to help promote use. It can help with check in and with match after organ receipt. It can help with policy compliance. For the 22 facilities using TransNet currently, they are generally using it on 100% of organs. Staff are working with 10 centers to get up and running. Members were urged to go back and work on implementing Transnet in their own organizations as Committee members need to be the leaders. Committee member use is important to have some real experience as the Committee might consider policy later. It was noted that transplant hospitals need someone who can take on the project and

provide education to nurse personnel. Often transplant hospitals will create a SME to drive the project and provide regular updates. Because it is the same database as UNet often, they do not have to go through hospital security. Hospital IT will have to put a printer on the network to make the system work. It can take months although it is a simple task. Transplant hospitals will need bar code scanners that cost about \$300.

One member shared that they put an icon on all OR computers and taught all nurses. Their one glitch was with living donors but they taught staff to manually enter the data. They also had a respected physician champion for the project. Members will be provided staff contacts to help set up TransNet at their hospitals.

It was noted that tissue has been using this technology successfully for quite some time. It was also asked about if TransNet might integrate with EMRs. Building APIs is on the UNOS IT roadmap (2nd half of next year but not certain). This is going to be a customer advocacy project. EPIC is the one EMR showing interest. UNOS would build the OPTN half and the EMR would have to build their half. Those that would be interested in beta testing a potential EMR interface can volunteer to TransNet staff and they will be contacted when this is ready to start.

5. Patient Safety Series

Summary of discussion:

Alden Doyle and Kimberly Taylor provided data and discussion on patient safety. Part of the mission of OPTN/UNOS Operations and Safety Committee's Patient Safety Advisory Group (PSAG) is to provide education and information on patient safety. This group reviews patient safety data and advises on recommended or needed system changes, receives education topic referrals from MPSC or other sources, provides consultation and collaborates with UNOS Instructional Innovations to produce safety products, and collaborates with patient safety staff to understand aggregate root causes when possible without compromising confidential medical peer review. Examples of previous topics identified by PSAG include lack of documentation in allocation deviations, storage of prohibited vessels and other vessels requirements, and delayed communication.

An overview of instructional metrics show that PSAG provided materials are used extensively. By looking at data on four different education offerings from PSAG (SFT100, SFT101, SFT108, SFT107, etc.), over 8,000 registrants have taken continuing education credit courses on topics such as organ discards, hemodilution, and ABO verification. UNOS Connect also provides instructional events periodically.

Current work being conducted by PSAG involves protocols for recipient post-transplant testing after receiving a PHS Increased Risk organ. In June 2017, PSAG decided to work on general patient safety and reporting for the next product. By July 2017, MPSC sent a referral to PSAG, namely recipient follow up post-transplant of a PHS Increased Risk organ. PSAG approved work on this topic in August 2017 and conducted a meeting in September 2017 requesting additional information on the referral from MPSC. In addition, outside subject matter experts have been brought on to aid on this task, including current and former OPTN/UNOS Disease Transmission Advisory Committee (DTAC) leadership.

6. Trends and Patterns in Patient Safety Cases Reported to the OPTN

Summary of discussion:

Read Urban, Kate Breitbeil, and Susan Tlusty provided discussion on evolving trends in patient safety cases and data over the first half of 2017. The background and purpose of aggregating such data involves reviewing reported patient safety situations, identifying safety gaps, and addressing high frequency and high impact events. This information is updated semi-annually.

As previously mentioned, this data are for the first six months of the 2017. While previous data were categorized by center, UNOS currently performs back-end categorizations following investigation into issues. These categories include one or more high level category as well as one or more subcategory. Moreover, some cases are determined to be non-issues or are reported in error.

147 cases have been identified. Of these cases, the majority arrived via the patient safety system, followed by the UNOS Research Department and other means. Compared to January to June of 2016, the number of cases received has decreased. Case subjects are split between organ procurement organizations (OPOs) and transplant centers. Histocompatibility labs account for a small amount of case subjects. Reporting types also involve fairly even splits between OPOs, transplant centers, and other means (UNOS Research Department and DTAC constitute most of the “other” category). 47 percent of all the cases reported were self-reported. 16.4 percent of all reported cases were non-issues. Testing and data entry involved 14.4 percent and 13 percent respectively. Transplant procedure issues and living donor adverse events each constituted 11 percent. Packaging, shipping, communication, recovery procedures, labeling, and transportation all accounted for under 10 percent in each categories (ranging from 6.8 percent to as low as 4.8 percent).

Delving more deeply into some of the subcategories provided additional insight to the Committee. With regards to the 13 percent of reports on data entry, DonorNet events involved the most issues (13 of 19 total). The remaining six cases in data entry involved Waitlist. Of the 21 testing related events, hemodilution errors accounted for 8 cases. Another 8 cases involved HLA issues. The remaining events included issues with culture, discrepant results, and ABO. For transplant procedure events, 15 of the 16 total falls into the “other” category. However, most of the “other” issues involved storage of prohibited vessels (13 of 15 “other,” thus 13 of 16 total in the subcategory). Finally, for living donor adverse events, 5 living donor deaths occurred, but these were not donation-related. All living donor deaths are reviewed by MPSC as well. There was also 10 aborted procedures.

The last piece of the trends and patterns report involved cases that caused or contributed to non-recovery or discard. This excludes that 24 cases that were determined to be non-issues, which leaves 122 cases remaining. There were 9 non-recovery cases as a result of living donor adverse effects, 6 discard cases related to packaging/shipping/labeling issues, and 6 delays of transplantation due to transportation/packaging issues.

The next steps for this data are to observe trends over the course of two years as data becomes available. Vessel sharing cases are no longer included in patient safety data, yet they will still be reviewed by MPSC. Moving forward, harm analysis classifications will be merged with post-case classifications in order to contextualize safety implications and the impact to patients for all events.

7. ABO Verification Monitoring and Evaluation

Summary of discussion:

Read Urban continued to provide data analysis for the committee, now focusing on ABO verification monitoring and evaluation from July 1, 2016 through June 1, 2017. This monitoring and evaluation was approved by the Board of Directors in June 2015. It involves clarifying and strengthening ABO determination, reporting, and verification for donors and candidates while also aligning OPTN and CMS requirements. Implementation of this program began on June 23, 2016.

This program includes four different data sources. First, it includes patient safety data, which is subcategorized as related to labeling, typing, reporting, and ABO issues. Second, it includes

recipients not appearing on the match run (NOMR), which is categorized as directed donation or “other” reasons not on the match run. Third, it includes data on candidates and donors added to UNet with modifications of ABO between initial entry and secondary verification. Finally, data includes ABO Proficiency Training offered via UNOS Instructional Innovations. Some notes arising from discussion include pulling data for changes related to 0 mismatch kidneys, breaking ABO data recipient by age and by center, and looking for additional patterns by CTR, user, and incorporation into subtyping guidance document.

8. Extra Vessel Disposition Reporting Database Evaluation

Summary of discussion:

Read Urban again presented data collected and analyzed on extra vessel disposition reporting and evaluation. This involved data spanning January 1, 2017 to June 30, 2017. This proposal was implemented in November 2015 and included electronic reporting to monitor vessel usage. The proposal was conceived with the help of OSC, the Vessels Policy Work Group, and UNOS staff. Much of the data collected came from the OPTN Donor, Transplant, and Vessel data, in which the vessel data is linked via donor identification and patient identification populated in the database. Currently, UNOS Research is unable to track the exact number of vessels sent and unreported. Between January and June 2017, 99.7 percent of donors with at least one organ reported as sent with vessels were in the database.

Upcoming Meeting

- TBA

Attendance

- **OSC Members**
 - David Marshman
 - Laura O'Melia
 - Diane Brockmeier
 - Bridgette Diedrich
 - Viken Douzjian
 - Elisa Gordon
 - Dean Henderson
 - Shyla Haldeman
 - Edward Hollinger
 - Ben Keebler
 - Michael Marvin
 - Luis Mayen
 - Jennifer Reese
 - Chandrasekar Santhanakrishnan
 - Eugenia Steffens
 - Mark Wakefield
 - Celeste Williams
 - Karlie Wipperling
 - Alden Doyle
- **HRSA Representatives**
 - Raelene Skerda
 - Joyce Hager
- **SRTR Representatives**
 - Katie Audette
- **Other Representatives**
 - Ryutaro Hirose
 - Nicole Turgeon
 - William Mahle
- **OPTN/UNOS Staff**
 - Susan Tlusty
 - Kate Breitbeil
 - Erica Inge
 - Elizabeth Miller
 - Rob Patterson
 - Amy Putnam
 - Read Urban
 - Emily Womble
 - Ronald Brown
 - Kimberly Taylor
 - Lee Bolton
 - Michael Curry
 - Abigail Fox
 - Chelsea Haynes
 - Matt Prentice
 - Ellie Willard
 - Michelle Wilson