ASTS
American Society of Transplant Surgeons

Council & Committee Chair Meeting Agenda

April 29, 2017
Hyatt McCormick Place Hotel
2nd Floor, Regency Ballroom

Time	Agenda Items	Presenter	Tab	Action Items
Organizational Excellence				
7:30 AM	**Call to Order** • COI review • Meeting structure/strategic plan • In memoriam	T. Pruett	A	
7:45 AM	**Financial Update**	L. Ratner – C K. Gifford – S		
7:55 AM	**Foundation Report**	C. Miller – C M. K-Bullock – S	B	
8:10 AM	**Nominating Report** • Election results • Committee appointments • Recognition of outgoing cmte chairs	T. Pruett – C M. K-Bullock – S E. Proffitt – S	C	
8:20 AM	**Membership & Workforce Report** • Workforce survey manuscript • New member approval policy update • Collection of workforce metrics	J. Rocca – C K. Chavin – L N. Duan – S	D-1 D-2 D-3	1. Request feedback on WF survey manuscript 2. Request approval of update to the new member approval policy 3. Request feedback on selected WF metrics for systematic collection by ASTS
8:40 AM	**Bylaws Report** • Bylaws amendment for vote at business meeting • Non-clinical member participation policy	R. Pelletier – C K. Chavin – L L. Kulikosky – S	E-1 E-2 E-3	
8:50 AM	**Historian Report** • Future Chimera Chronicles	T. Peters – C D. Mossholder – S	F	4. Request approval for funding of future Chimera Chronicles
N/A	**Written Reports Only** • Communications – J. Heimbach		G	
Training & Professional Development				
9:00 AM	**ATC Report** • ATC 2017 update • Abstract categories • Abstract country comparison	D. Mercer – C N. Legge – S S. Fagan – G	H-1 H-2 H-3 H-4	

C = Committee Chair I = Incoming Chair R = Representative L = Councilor Liaison S = Staff Liaison G=Guest

	• Abstract comparison • Registration breakdown • Registration comparison • Registration domestic v. int'l • Exhibit & sponsorships • Exhibit comparison • ATC 2018 memo		H-5 H-6 H-7 H-8 H-9 H-10	
9:15 AM	**Vanguard Report** • 2017 WS report • 2018 WS planning	D. Ladner – C C. Esquivel – L N. Legge – S	I-1 I-2	
9:30 AM	**TAC, LLC Update**	M. Abouljoud – C C. Gordon – S		
9:40 AM	**Fellowship Training Report** • 2017 PD meeting • Match provider transition • Pancreas volume adjustment • 2017 Fellows Symposium • Non-Technical milestones	R. Hirose – C W. Chapman – L C. Gordon – S	J	5. Request feedback on administrative requirements for Transplant Surgery Fellowship
10:00 AM	**LDN Workshop Update** • March 2017 workshop • Future workshops	L. Ratner – L C. Gordon – S		
10:10 AM	**CME Report** • MOC at ATC • AJT MOC	M. Levine – C R. Sung – L N. Legge – S	K	
10:20 AM	**Business Practice Services Report** • 2017 Compensation Survey • 2017 Advanced LDP • Focused biz short courses	K. Andreoni – C O. Gaber – L L. Kulikosky – S	L	
10:35 AM	**ATP Report** • ATP at the Winter Symposium • ATP salary survey • ATP Certificate marketing	G. Smith – C W. Grant – L E. Proffitt – S	M	6. Request for approval of an ATP reception at the 2018 WS
10:45 AM	**Curriculum Report** • AU module revisions • AU new module development	M. Melcher – C W. Grant – L C. Gordon – S	N	
Research				
10:55 AM	**TTC Update** • Membership update • Initial working groups • ATC session • May F2F meeting	M. Stegall – R I. O'Doherty – G D. Kaufman – L K. Gifford – S		
11:05 AM	**Grants Review Report** • Grant recipient survey • Feedback to grant applicants • Modifications to portfolio	D. Foley – C G. Bumgardner – L M. K-Bullock – S	O	
11:20 AM	**RAPID Update** • Program update • Northwestern IT resources	D. Ladner – G K. Gifford – S L. Kulikosky – S		

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11:30 AM	**TransQIP Task Force Update**	R. Hirose – R L. Kulikosky – S		
11:40 AM	**VCA Report** • UNOS VCA cmte participation • AU module development • Inter-society VCA collaboration	S. Ildstad – C P. Abt – L N. Legge – S	P	
N/A	**Written Reports Only** • Cell Transplant – M. Wijkstrom • Sci Studies – C. Marsh		Q-1 Q-2	
11:50 AM	**Lunch**			

Optimal Patient Care				
12:30 PM	**Standards & Quality Report** • DCD reporting stds • Stds for graft assessment & reporting for ex-vivo perfusion	D. Axelrod – C K. Chavin – L L. Kulikosky – S	R-1 R-2 R-3	7. Request approval of joint survey (ASTS and AOPO) re: DCD reporting standards
12:45 PM	**Living Donation** • White House commitments • GIVE/LIVE initiative: Non-directed LD database	T. Baker – C D. Segev – L M. K-Bullock – S	S	8. Request feedback on development of anonymous non-directed LD database
1:05 PM	**PROACTOR Task Force Report** • AJT white paper submission • Next phase initiatives	M. Hobeika – C D. Segev – L E. Proffitt – S	T	
1:10 PM	**National Living Donor Assistance Center (NLDAC) Report** • Federal update • Donor lost wages study	K. Gifford		
N/A	**Written Reports Only** • Diversity Issues – J. Ortiz • Ethics – M. Millis • Pediatrics – C. Esquivel • Thoracic – A. Ardehali		U-1 U-2a U-2b U-3 U-4	
Advocacy				
1:20 PM	**Legislative Report** • March fly-in recap • Current legislation • ESRD demo project • Monitoring ACA changes	P. Tighe – Powers G.Bumgardner – L D. Mossholder – S	V	
1:35 PM	**Reimbursement and Regulatory Compliance Report** • Regulatory relief proposal • Joint efforts with Legislative	K. Abu-Elmagd – C O. Gaber – L D. Mossholder – S D. Millman – Powers	W	
1:50 PM	**MACRA Task Force Report** • Recent member education • ACS/Brandeis project	D. Reich – C D. Mossholder – S D. Millman – Powers	X	9. Requesting feedback on ASTS involvement with Brandeis project

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2:00 PM	**OPTN/UNOS Update**	M. Henry – R K. Gifford – S		
2:10 PM	**ABS Update**	M. Abouljoud – R K. Gifford – S		
2:20 PM	**ACS Update**	L. Teperman – R K. Gifford – S		
2:30 PM	**Alliance Update**	J. Magee - R K. Gifford – S		
N/A	**Written Reports Only** • AMA – T. Peters		Y	
2:40 PM	**Other Business**	T. Pruett		
3:00 PM	**Adjourn Committee Chair Meeting** **<u>Next Meeting:</u>** **January 11, 7:30-2:30** **Loews Miami Beach Hotel**	T. Pruett		

American Society of Transplant Surgeons

Mission

To advance the art and science of transplant surgery through leadership, advocacy, education, and training.

Vision

Saving and improving lives with transplantation.

Strategic Goals

Advocacy
Research
Training & Professional Development
Optimal Patient Care
Organizational Excellence

Core Values:

Integrity

We hold ourselves to a standard of professionalism that includes an awareness of our own imperfections as we seek fairness, justice, and inclusivity. Our behavior is guided by the awareness that we must continuously earn the public trust that makes transplantation possible.

Excellence

We commit to setting and achieving ambitious goals as we serve our members, our patients, and society at large.

Respect

We treat our patients, our colleagues, and our collaborators with respect, engaging in constructive debate and supporting each other in our work to save and improve lives.

Compassion

We strive to emulate the generosity and courage of the donors and their families who make transplantation possible and to offer hope to our patients.

Diversity

We cultivate the diversity of personal characteristics and individual qualities both in transplantation and among our members. Diversity is integral to the moral code by which we connect lives.

Forward Focus

We look toward the horizon and support those who are crafting innovative solutions to the problems our members and their patients face.

Thank you to our Contributors!

**levels are based on contributions as of 4/12/2017*

Starzl Club
Lifetime giving of $25,000 or more

Tom & Ruby Peters

President's Club
Lifetime giving of $10,000 - $24,999.99

Ronald W. Busuttil, MD, PhD
Jean C. Emond, MD
Carlos O. Esquivel, MD, PhD
Goran B. Klintmalm, MD, PhD
Charlie & Erica Miller
Kim M. Olthoff, MD
Peter G. Stock, MD, PhD

2017

Distinguished
$2500 and up
Chris & Patricia Marsh
Tom & Ruby Peters

Sponsor
$1000-$2499.99
John Duffy
Steven Rudich
Lewis Teperman

Contributor
$500-$999.99
Marwan Abouljoud
John Brems
Mark Hardy
Timothy Pruett

Associate
$100-$499.99
Ali Cheaito
Talia Baker
Kambiz Kosari
Jay Markowitz
Diego Reino

2016

Distinguished
$2500 and up
Ginny Bumgardner
Ronald Busuttil
John Colonna
Jean Emond
Carlos Esquivel
Fady Kaldas
Dixon Kaufman
Andrew Klein
Kelvin Lau
Dana & Jim Markmann
Charlie & Erica Miller
Kim Olthoff
Richard Perez
Henry Randall
John Roberts
Richard Simmons

Sponsor
$1000-$2499.99
Peter Abt
Vatche Agopian
David Axelrod
Andrew M. Cameron
William & Margaret Chapman
Kenneth Chavin
Bijan Eghtesad
Osama Gaber
R. Mark Ghobrial
John & Kim Gifford
John Goss
Douglas Hanto
Patrick Healey
Garrett Hisatake
Christopher Jones
Goran Klintmalm
Alan Langnas
Keri Lunsford
John Magee
Chris and Patricia Marsh
David Mulligan
Dorry Segev
Peter Stock
Kenneth Woodside
Ali Zarrinpar

Contributor
$500-$999.99
James Allan
James Eason
David Foley
Wendy Grant
Milan Kinkhabwala
Richard Knight
Marc Lorber
Elizabeth Pomfret
James Pomposelli
Abbas Rana
Lloyd Ratner
Alan Reed
Juan Rocca

Associate
$100-$499.99
Kenneth Andreoni
Prabhakar Baliga
Josh & Maggie Bullock
Christoph Broelsch
Ali Cheaito
Matthew Cooper
Kiran Dhanireddy
Joseph DiNorcia
Ty Dunn
Bruce Gelb
Stuart Greenstein
Julie Heimbach
Peter Horton
Matt Ingenthron
Igal Kam
Sandip Kapur
Tomasz Kozlowski
Susan Lerner
Matthew & Leslie Levine
Marc Melcher & Tami Daugherty
Michael Millis
Ronald Parsons
David Reich
Richard Ruiz
Georgeine Smith
Randall Sung
Martin Wijkstrom
Gazi Zibari

Friend/Partner
$1-$99.99
Mark Hobeika
Suzanne Ildstad
Diane Mossholder
Babak Orandi
Kazunari Sasaki
Krzysztof Zieniewicz

ASTS Committee Appointments 2017 – 2018

(Term expires at end of annual meeting in year indicated)

ADVANCED TRANSPLANT PROVIDERS COMMITTEE

Chair – Haley Hoy, PhD, NP	(2020)
Co-Chair – Eliana Z. Agudelo, PA-C	(2018) †
Karen M. Kerespi, MPAS, PA-C	(2018)
Jennifer M. Sharp, MS	(2018)
Marsha D. Bendle, MSBS, PA-C	(2019)
Kristi J. Reinschmidt, PA-C	(2019)
Heather Chambers, APRN-C, MSN	(2020)
Elizabeth A. Hall, PA	(2020)
Ana Maria Torres, ANP, MSN, RN	(2020)
Councilor Liaison – TBD	
Staff Liaison – Ellie Proffitt, CHES	

BUSINESS PRACTICE SERVICES COMMITTEE

Chair – Kenneth A. Andreoni, MD	(2018)
Co-Chair – David C. Mulligan, MD	(2018) †
James V. Guarrera, MD	(2018)
Jason R. Wellen, MD, MBA	(2018)
Kiran K. Dhanireddy, MD	(2019)
David A. Gerber, MD	(2019)
Gabriel T. Schnickel, MD, MPH	(2019)
Alvin C. Wee, MD	(2019)
Eddie Island, MD	(2020)
Assc. Mem. Liaison – Stacey L. Doll, MPA	*(2019)*
Councilor Liaison – TBD	
Staff Liaison – Laurie Kulikosky, CAE	

BYLAWS COMMITTEE

Chair – Ronald P. Pelletier, MD	(2018)
Co-Chair – Liise K. Kayler, MD	(2018) †
Vincent P. Casingal, MD	(2018)
Cosme Y. Manzarbeitia, MD	(2018)
Susanna M. Nazarian, MD, PhD	(2018)
Rakesh Sindhi, MD	(2018)
Adel Bozorgzadeh, MD	(2020)
Rainer W.G. Gruessner, MD, PhD	(2020)
Martin Hertl, MD	(2020)
Councilor Liaison – TBD	
Staff Liaison – Laurie Kulikosky, CAE	

CELLULAR TRANSPLANTATION COMMITTEE

Chair – Jason A. Wertheim, MD, PhD	(2020)
Co-Chair – Jeffrey H. Fair, MD	(2018) †
Marlon F. Levy, MD	(2018)
Kalpaj R. Parekh, MD	(2019)
Angeles Baquerizo, MD, PhD	(2020)
Todd V. Brennan, MD, MS	(2020)
Varvara A. Kirchner, MD	(2020)
Sayeed K. Malek, MD	(2020)
Ronald F. Parsons, MD	(2020)
Councilor Liaison – TBD	
Staff Liaison – TBD, Interim – Laurie Kulikosky, CAE	

CME COMMITTEE

Chair – Matthew H. Levine, MD, PhD	(2019)
Co-Chair – Dean Y. Kim, MD	(2018) †
Damanpreet S. Bedi, MD	(2018)
Niraj M. Desai, MD	(2018)
William F. Kendall, Jr., MD	(2018)
Kristian Enestvedt, MD	(2019)
Gregory J. McKenna, MD	(2019)
Flavio Paterno, MD	(2019)
Peter S. Yoo, MD	(2019)
Edie Y. Chan, MD	(2020)
Peter T. Kennealey, MD	(2020)
Adena J. Osband, MD	(2020)
Councilor Liaison – TBD	
Staff Liaison – Nerissa Legge	

**Nominating Committee Chair rotates annually to current President*

† Co-chairs are appointed annually with the option to renew for up to three years

COMMUNICATIONS COMMITTEE

Chair – Julie K. Heimbach, MD	(2019)
Co-Chair – Satish N. Nadig, MD, PhD	(2018) †
Amy L. Friedman, MD	(2018)
Amy E. Gallo, MD	(2018)
Christine A. O'Mahony, MD	(2018)
John B. Seal, MD	(2018)
Thomas J. Chirichella, MD	(2019)
Antonios Arvelakis, MD	(2019)
Ryan A. Helmick, MD	(2020)
Lori M. Kautzman, MD	(2020)
Linda L. Ohler, CCTC, FAAN, MSN	(2020)
Duncan P. Yoder, MD	(2020)
Councilor Liaison – TBD	
Staff Liaison – Diane Mossholder, MA	

CURRICULUM COMMITTEE

Chair – Marc L. Melcher, MD, PhD	(2019)
Co-Chair – Jason M. Vanatta, MD	(2018) †
Felicitas L.F. Koller, MD	(2018)
John F. Renz, MD, PhD	(2018)
Kelly M. Collins, MD	(2019)
Amy R. Evenson, MD	(2019)
Sameh A. Fayek, MD PhD	(2019)
Peter T.W. Kim, MD, MSc, FRCSC	(2019)
Sean C. Kumer, MD, PhD	(2019)
Harvey Solomon, MD	(2019)
Thomas A. Pham, MD	(2020)
Elizabeth M. Thomas, DO	(2020)
Councilor Liaison – TBD	
Staff Liaison – Chelsey Gordon, CHES	

DIVERSITY ISSUES COMMITTEE

Chair – Jorge A. Ortiz, MD	(2019)
Co-Chair – Jayme E. Locke, MD, MPH	(2018) †
Mohamed Akoad, MD	(2018)
Juan Carlos Caceido, MD	(2018)
Gabriel J. Echeverri, MD	(2018)
Stephen H. Gray, MD	(2018)
Reynold I. Lopez-Soler, MD, PhD	(2018)
Ganesh Gunasekaran, MD	(2019)
Beau Kelly, MD, MBA	(2019)
Paulo N. Martins, MD, PhD	(2019)
Constance M. Mobley, MD, PhD	(2019)
Sylvester M. Black, MD, PhD	(2020)
Councilor Liaison – TBD	
Staff Liaison – Ellie Proffitt, CHES	

ETHICS COMMITTEE

Chair – Sander S. Florman, MD	(2020)
Co-Chair – Elizabeth A. Pomfret, MD, PhD	(2018) †
Charles C. Canver, MD	(2018)
Elmahdi A. Elkhammas, MBBS	(2018)
Stephen C. Rayhill, MD	(2018)
Joshua D. Mezrich, MD	(2019)
Deborah B. Adey, MD	(2020)
Ramesh K. Batra, MBBS, MRCS	(2020)
James J. Wynn, MD	(2020)
Councilor Liaison – TBD	
Staff Liaison – Diane Mossholder, MA	

FELLOWSHIP TRAINING COMMITTEE

Chair – Ryutaro Hirose, MD	(2019)
Co-Chair – TBD	(2018) †
Irene K. Kim, MD	(2018)
Gregory R. Veillette, MD	(2018)
Clark Andrew Bonham, MD	(2019)
Tayyab S. Diwan, MD	(2019)
Patrick G. Dean, MD	(2019)
Steven I. Hanish, MD	(2019)
Amit D. Tevar, MD	(2019)
Parsia A. Vagefi, MD	(2019)
Kendra D. Conzen, MD	(2020)
Anthony C. Watkins, MD	(2020)
Councilor Liaison – TBD	
Staff Liaison – Chelsey Gordon, CHES	

GRANTS REVIEW COMMITTEE

Chair – David P. Foley, MD	(2019)
Co-Chair – Philip Y. Wai, MD	(2018) †
Burcin Ekser, MD, PhD	(2018)
Masato Fujiki, MD	(2019)
Sunil S. Karhadkar, MD	(2019)
Adam D. Griesemer, MD	(2020)
Keri E. Lunsford, MD, PhD	(2020)
Trevor W. Reichman, MD, PhD	(2020)
Ali Zarrinpar, MD, PhD	(2020)
Councilor Liaison – TBD	
Staff Liaison – Maggie Kebler-Bullock	

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LEGISLATIVE & REGULATORY COMMITTEE

Chair – James J. Pomposelli, MD, PhD	(2020)
Co-Chair – Anil S. Paramesh, MD	(2018) †
Michael Angelis, MD	(2018)
Bruce E. Gelb, MD	(2018)
Kishore R. Iyer, MBBS	(2018)
Gary S.G. Xiao, MD	(2018)
Vanessa R. Humphreville, MD	(2019)
Raja Kandaswamy, MD	(2019)
Bonnie E. Lonze, MD, PhD	(2019)
Tsuyoshi Todo, MD	(2019)
Avinash Agarwal, MD	(2020)
Antonio diCarlo, MD, CM	(2020)
Michael R. Marvin, MD	(2020)

Councilor Liaison – TBD
Staff Liaison – Diane Mossholder, MA

LIVING DONATION COMMITTEE

Chair – Michael A. Zimmerman, MD	(2020)
Co-Chair – Amit K. Mathur, MD, MS	(2018) †
Sophoclis P. Alexopoulos, MD	(2018)
George E. Loss Jr., MD, PhD	(2018)
Martin I. Montenovo, MD	(2018)
Giuliano Testa, MD	(2019)
Debra K. Doherty, MD	(2020)
James R. Rodrigue, PhD	(2020)
Vaughn E. Whittaker, BS, MB	(2020)

Assc. Mem. Liaison – Ashley H. Seawright, DNP, ACNP-BC (2019)
Councilor Liaison – TBD
Staff Liaison – Maggie Kebler-Bullock

MEMBERSHIP AND WORKFORCE COMMITTEE

Chair – Sunil K. Geevarghese, MD, MSCI	(2020)
Co-Chair – Fady M. Kaldas, MD	(2018) †
Robert R. Redfield, MD	(2018)
Henkie P. Tan, MD, PhD	(2018)
Chandra S. Bhati, MS, MRCS, FEBS	(2019)
Jean I. Tchervenkov, MD	(2019)
Atushi Yoshida, MD	(2019)
Diego M. Di Sabato, MD	(2020)
Marwan M. Kazimi, MD	(2020)

Councilor Liaison – TBD
Staff Liaison – Ning Duan

***NOMINATING COMMITTEE**

Chair – Jean Emond, MD	(2018)
Timothy L. Pruett, MD	(2019)
Charles M. Miller, MD	(2018)
Dixon B. Kaufman, MD, PhD	(2020)
William C. Chapman, MD	(2018)
Carlos O. Esquivel, MD, PhD	(2018)
Dorry L. Segev, MD, PhD	(2018)
Peter L. Abt, MD	(2019)
Wendy J. Grant, MD	(2019)
Randall S. Sung, MD	(2019)

Staff Liaison – Ellie Proffitt, CHES

SCIENTIFIC STUDIES COMMITTEE

Chair – Ty B. Dunn, MD, MS	(2020)
Co-Chair – Cristiano Quintini, MD	(2018) †
Erik B. Finger, MD, PhD	(2018)
Benjamin Philosophe, MD, PhD	(2018)
Joseph R. Leventhal, MD, PhD	(2019)
Shunji Nagai, MD, PhD	(2019)
David D. Lee, MD	(2020)
Burcin Taner, MD	(2020)
Kenneth J. Woodside, MD	(2020)

Councilor Liaison – TBD
Staff Liaison – Ellie Proffitt, CHES

STANDARDS AND QUALITY COMMITTEE

Chair – David A. Axelrod, MD, MBA	(2019)
Co-Chair – Jacqueline A. Lappin, MD	(2018) †
Jeffrey B. Halldorson, MD	(2018)
Justin R. Parekh, MD	(2018)
Robert J. Stratta, MD	(2018)
Mary T. Killackey, MD	(2019)
Shimul A. Shah, MD, MHCM	(2019)
Debra L. Sudan, MD	(2019)
Pedro R. Sandoval, MD	(2020)

ASA Liaison – Susan Mandell, MD, PhD
Councilor Liaison – TBD
Staff Liaison – Laurie Kulikosky, CAE

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THORACIC ORGAN TRANSPLANTATION COMMITTEE

Chair – David P. Mason, MD (2020)
Co-Chair – Bryan A. Whitson, MD, PhD (2018) †
Phillip Camp, MD (2018)
Nilto C. De Oliveira, MD (2019)
Christian A. Bermudez, MD (2020)
Matthew G. Hartwig, MD (2020)
Councilor Liaison – TBD
Staff Liaison – Ellie Proffitt, CHES

VANGUARD COMMITTEE

**Term ends after the Winter Symposium in the year indicated*

Chair – Daniela P. Ladner, MD, MPH (2019)
Co-Chair – M.B. Majella Doyle, MD, MBA (2018) †
Truman M. Earl, MD, MSCI (2018)
Karim J. Halazun, MD (2018)
Garrett R. Roll, MD (2018)
Arika L. Hoffman, MD (2019)
Nitin N. Katariya, MD (2019)
Jennifer E. Verbesey, MD (2019)
Kristopher P. Croome, MD (2020)
Councilor Liaison – TBD
Staff Liaison – Nerissa Legge

VASCULARIZED COMPOSITE ALLOGRAFT COMMITTEE

Chair – Suzanne T. Ildstad, MD (2018)
Co-Chair – Suzanne V. McDiarmid, MD (2018) †
Darla K. Granger, MD (2018)
Gerry S. Lipshutz, MD (2018)
Thiago Beduschi, MD (2019)
Kenneth L. Brayman, MD, PhD (2019)
Andreas G. Tzakis, MD (2019)
Dicken S. Ko, MD (2020)
Kadiyala V. Ravindra, MD (2020)
Councilor Liaison – TBD
Staff Liaison – Nerissa Legge

2017 ATC PLANNING COMMITTEE

ASTS Representatives

Chair – Matthew Cooper, MD (2018)
Co-Chair – Devin E. Eckhoff, MD (2019)
Co-Chair-elect – Lisa S. Florence, MD (2020)
Linda C. Cendales, MD (2018)
Susan L. Orloff, MD (2018)
Renee E. Bennett, RN, BSN, CCTC (2019)
Michael B. Ishitani, MD (2019)
Srinath Chinnakotla, MD (2020)
Michael J. Englesbe, MD (2020)
Richard J. Knight, MD (2020)
Linda Sher, MD (2020)
Dean Y. Kim, MD (2018)
Staff Liaison – Nerissa Legge

GOVERNMENT AND SCIENTIFIC LIAISONS

OPTN/UNOS Board
Mitchell L. Henry, MD (2018)
American Board of Surgery
Marwan S. Abouljoud, MD (2021)
American College of Surgeons
Lewis W. Teperman, MD (2019)
American Medical Association
Thomas G. Peters, MD
The Alliance
John C. Magee, MD

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ASTS Bi-Annual Committee Report

Committee Name: Membership & Workforce
Staff Liaison: Ning Duan

Chair/Co-Chair: Juan Rocca, MD / Sunil Geevarghese, MD
Council Liaison: Kenneth Chavin

☒Yes, I would like to request time for a verbal report during the council and committee chair meeting.

☐No, my written report is sufficient; I do not need time to present verbally, but I will attend the meeting.

Please Indicate any Committee Initiatives Needing Formal Council Vote or Feedback:
(Please indicate the desired amount of time on agenda for each item. Please note that time allotments cannot be guaranteed)

- New Member Approval Policy (reviewed and approved by Bylaws Committee)
- Approval of Workforce report manuscript publication, with or without revisions.
- Approval of Selected WF metrics for systematic collection by ASTS.

Review of Recent Committee Accomplishments (if applicable):

- Workforce Survey Report

Outline of the Committee's Top Priorities:

Priority	Anticipated Completion Date	Budgeted Initiative?	Related Attachments?
Workforce Survey Report Manuscript	May 2017	Yes (3k)	Yes
Selection of Workforce metrics for systematic ongoing collection by ASTS	May 2017		

Are you satisfied with the level of engagement from the committee? If not, what would help better engage the other committee members?

Future Ideas for Consideration (if applicable):

- Institutional Membership. Changes required in individual member approval process prior to considering institutional members.

Abdominal Transplant Surgery Workforce Status Report

Introduction

The number of surgeons currently practicing in abdominal organ transplantation in United States is estimated in 1200. UNOS registrations as primary transplant surgeon totals xxx, xxx kidney, xxx liver , xxx pancreas and xxx intestine distributed in 235 abdominal transplant centers. The American Society of Transplant Surgeons (ASTS) conducted two different surveys addressing the transplant surgeons' workforce in the past decade, the last one in 2010, examined in detail the demographics, medical education, professional training, certifications and appointments, clinical practice and family and lifestyle characteristics of abdominal transplant surgeons in the United States. After incorporating an entire generation of transplant surgeons that received formal and structured training in abdominal organ transplantation it is believed that the practice of transplant surgeons has changed into a more focused and self-sustaining one. There is limited information describing the current practice of transplant surgeons in United States and how its advances has demanded variations on the surgeons' profile being incorporated to the workforce. The present survey was designed to describe the current practice of transplant centers and examine their transplant surgeons' characteristics to estimate changes in the workforce and how this can impact the incorporation of future surgeons currently in training.

Methods

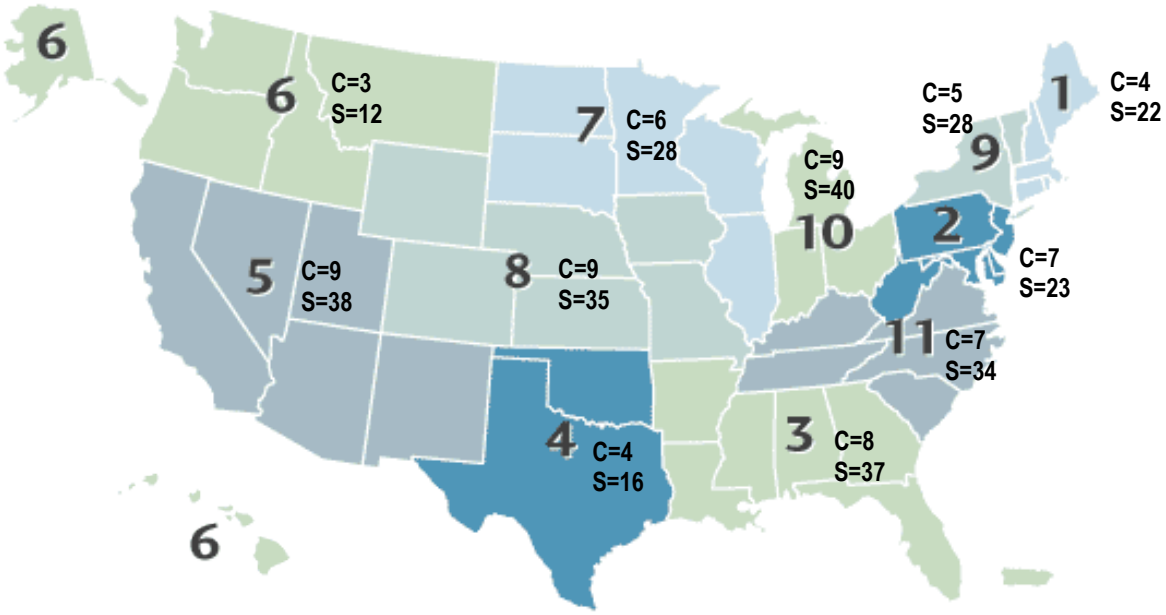
Members of the ASTS Workforce and Membership Committee designed a survey addressed to surgical program directors of all transplant centers in United States and (some) in Canada. The survey questionnaire requested information about the transplant programs, the transplant surgeons involved in the program and the estimated changes in the staffing of the program over the next 3 years. Specific questions regarding the program characteristics, current surgeons' characteristics, estimated staffing changes and future surgeons' characteristics are summarized in table 1 and fully displayed in appendix 1. A number a questions were asked to identify transplant programs and program directors in order to avoid duplicate responses about the surgeons involved in each program, since different transplant programs can coexist in the same transplant center sharing all, part or none of the transplant surgeons. These were de-identified for statistical analysis. Questions about the specific transplant surgeons were unidentified at all times, only labeled alphabetically for analytic purposes. The survey was approved by the ASTS Council for distribution to transplant program directors of 235 transplant centers by several e-mail notifications throughout 2016 (February-October). Eighty-four program directors responded to the survey representing 71 transplant centers (30.2%) and 313 transplant surgeons. Since survey respondents did not answer all survey questions, tables and figures which depict survey data refer to the number 'N' of respondents as the number of survey participants who responded to the particular survey question. Results were compiled and analyzed by the committee and

presented to the ASTS Council. **The committee received ASTS Council endorsement in 2017 to proceed with submission of the results for publication. (… this is pending review of this manuscript and IRB approval vs societal approval…need to discuss).**

Results

The survey responses represented 71 abdominal transplant centers from a total of 235 identified (30.2% response rate), with a median distribution of responding centers per region of 7 (IQR 4.5-8.5). The responses accounted for a total of 313 abdominal transplant surgeons with a median distribution per region of 28 (IQR 22.5-36) and a median distribution per center of 4 (IQR 3-6) **(figure 1).**

Figure 1.
Distribution of responding Transplant Centers (C) and number of Transplant Surgeons (S) per UNOS region.



1. Transplant centers

Each transplant center counted with a median of 1 program surgical director (IQR 1-2, range 1-6) and a median of 4 transplant surgeons (IQR 3-6, range 1-11). The presence of non-transplant surgeons (performing surgeries for the transplant programs, i.e. organ procurements, live donor nephrectomies, or assisting transplant procedures) was on an average of 0.88±1.6 (range 1-6). The surgical activities of the 71 transplant centers and the annual volumes are summarized in **table 1a.**

When centers were examined by major transplant practices, 64.8% (n=46) performed both adult liver and adult kidney transplantation, with a median annual kidney volume of 119.5 (IQR 80-180), a median annual liver volume of 64 (IQR 35-90) and a median number of transplant surgeons of 5 (IQR 4-7). Centers performing only kidney transplantation represented 19.7% (n=14), with a median annual kidney volume of 51 (IQR 30-75) and a median number of transplant surgeons of 2 (IQR 2-3), while Centers performing only adult liver transplantation represented 5.6%, with a median annual liver volume of 90(IQR 45-115) and a median number of transplant surgeons of 4.5 (IQR 3.5-5.5), **table 1b.**

Table 1a. Types of practice by center and annual volumes

Practice	N (%)	Annual Volume, Median (IQR)
Adult Liver	50 (70.4%)	65 (35 – 100)
LD Liver	30 (42.2%)	6 (2-14.5)
Peds Liver	31 (43.6%)	9 (4-15)
Adult Kidney	60 (84.5%)	100 (65-167.5)
LD Kidney	60 (84.5%)	25 (16-60)
Peds Kidney	37 (52.1%)	8 (4-15)
Pancreas	50 (70.4%)	8 (3.5-12)
Intestine	14 (19.7%)	5 (1-12)
HPB surg	49 (69.0%)	75 (50-100)
Access Surg	40 (56.3%)	90 (25-200)
Gen Surg	45 (63.3%)	100 (40-125)
Peds Surg	18 (25.3%)	20 (10-63)

Table 1b. Liver and kidney transplant practices, annual volumes and transplant surgeons.

Practice	N (%)	Kidney Volume Median (IQ)	Liver Volume Median (IQ)	Median Txp Surgeons
Adult L+K	46 (64.8%)	119.5 (80-180)	64 (35-90)	5 (4-7)
Adult K only	14 (19.7%)	51 (30-75)		2 (2-3)
Adult L only	4 (5.6%)		90 (45-115)	4.5 (3.5-5.5)

2.1. Current Transplant Surgeons, demographics

Of the 313 transplant surgeons reported at the 71 transplant centers there was complete data submission for further analysis in 242. The average age of the transplant surgeons was 49±9 years (range 30-70). Female surgeons represented 13.1% (n=31), the incorporation of female surgeons to the workforce steadily increased since 1980 from 3.7% to 18.37% after 2010 **(See table 2, figure 2).**

Regarding the longevity of their practice**,** the amount of years in transplant practice showed a median of 14 years (IQR 8-21), while the median estimated remaining years in practice were 15 (IQR 10-25). **(working on graph that can show workforce inflow and outflow of this cohort…)**

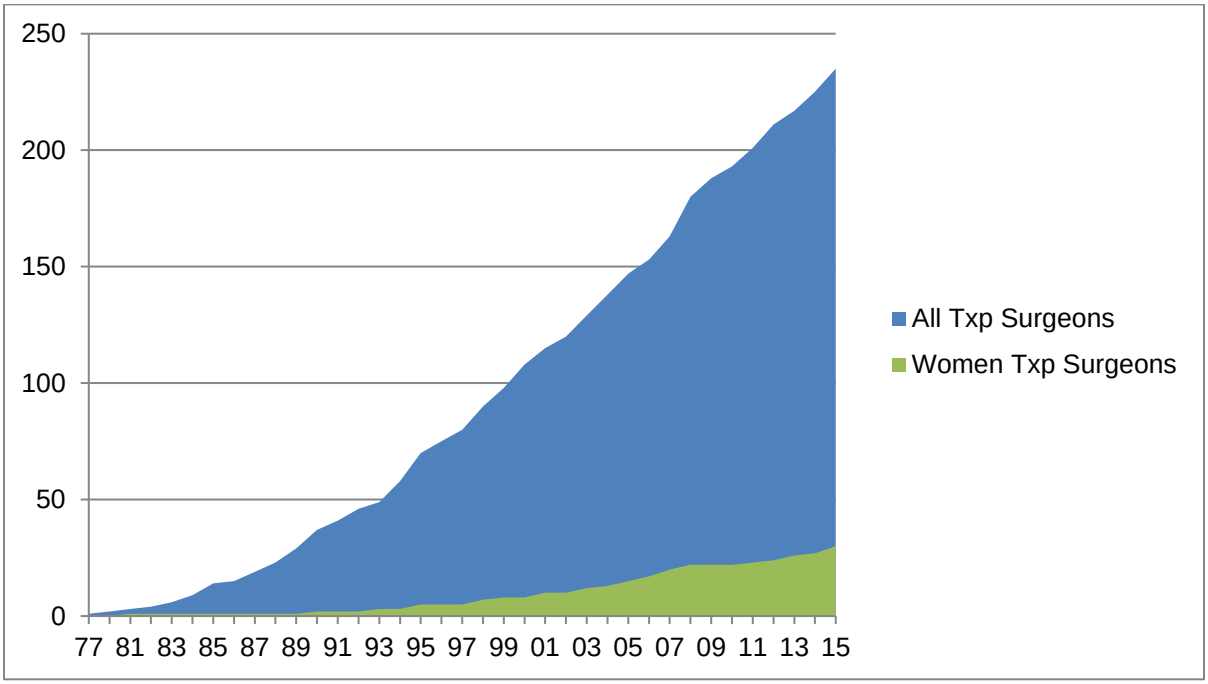
Table 2. Incorporation of transplant surgeons to the workforce

Missing values n= 5

* last period made of 6 years

Period	All Transplant Surgeons N	(%)	Women Transplant Surgeons N	(%)
70-79	2	(0.84)	0	(0.0)
80-89	27	(11.4)	1	(3.7)
90-99	69	(29.1)	7	(10.1)
00-04	40	(16.9)	5	(12.5)
05-09	50	(21.1)	9	(18.0)
10-15*	49	(20.7)	9	(18.4)

Figure 2. Incorporation of transplant surgeons to the workforce (n=237)



2.2 Current Transplant Surgeons, type of practice

See **table 3** for details of types of practice by surgeon and their median years in practice

Table 3. Types of practice by surgeon and median years in practice

Practice	N	(%)	Years in Practice, Median (IQR)	
DD procurement	197	(81.0 %)	12	(7-19)
Adult Liver	174	(71.6%)	13	(8-21)
LD Liver	66	(27.1%)	16.5	(10-21)*
Peds Liver	92	(37.8%)	18	(12-23)*
Adult Kidney	203	(83.5%)	13	(7-20)
LD Kidney	129	(53.0%)	10	(6-17)
Peds Kidney	113	(46.5%)	15	(8-22)*
Pancreas	149	(69.3%)	11	(7-18)
Intestine	26	(10.7%)	16.5	(8-22)*
HPB surg	146	(60.0%)	13	(7-21)
Access Surg	94	(38.6%)	13	(7-21)
Gen Surg	163	(67.0%)	13	(8-20)
Peds Surg	41	(16.8%)	19	(13-25)*
Admin role	150	(61.7%)	17	(11-23)*
Transplant Leadership	134	(55.1%)	17	(11-23)*
Non-txp leadership	77	(31.6%)	18	(11-24)*
Extra-Inst Leadership	89	(36.63)	18	(14-25)*

* Surgeons' years in practice above the median of 14

Most of the transplant surgeons performed both adult liver and adult kidney transplantation 59.3% (n=144), while 24.3% (n=59) performed only adult kidney transplantation, 12.4% (n=30) only adult liver transplantation and 4.1% (n=10) performed other transplants excluding adult liver or adult kidney.

The practice of non-transplant-related surgeries by transplant surgeons represented 60% for

Hepatobiliary Surgery, 38.6% Access Surgery (either angioaccess or for peritoneal dialysis) and 67% General Surgery cases was (excluding HPB, Access and living donors).

The practices associated with a more senior workforce (years in practice above median of 14 years) were Living Liver Donor surgery, Pediatric Liver transplantation, Pediatric Kidney transplantation, Intestinal transplantation, pediatric surgery (non-transplant) and dedication to administrative roles and leadership roles.

Regarding transplant-specific time on call, the average number of days on transplant-call in a month was 11.6 ±5.8 (0-31), Median 10 (IQR 7-15). **(can probably expand more on this analysis…)**

The surgeons' dedication to research activities was reported in 75.7% (n=184), the majority was in Clinical research 62% ((n=151), followed by Translational research 25.1% (n=61) and 17.2% (n=42) for basic research (reporting overlap was allowed since these activities can co-exist). The role of principal investigator of funded research was reported for 25% (n=63) of the surgeons.

2.3. Current Transplant Surgeons, training background.

Eighty-six percent (n=208) of the practicing transplant surgeons (n=242) were reported to have their surgical residency training in United States or Canada (board eligible), of whom only 7 did a residency in Urology and the remainder 201 completed a residency in General Surgery. Forty surgeons completed residency training in another country, once immigrated 6 of them completed a second residency in US-Canada (leaving n=34, 14% surgeons with residency training not in US-Canada).

Regarding Transplant surgery-specific training, 92.1% (n=223) of surgeons were reported to complete an ASTS-accredited Transplant Fellowship. Of the remainder 19 practicing surgeons without ASTS-accredited fellowship training, 13 were US-Canada trained residents (10 GenSurg, 3 Uro) who received non-ASTS transplant fellowship in US-Canada, 10 of which started practicing transplant prior to 1999, while other 6 non-US trained residents continued into a non-ASTS fellowship in US-Canada (4) or another country (2), 5 of them started their transplant practice prior to 1999**. Figures 3a and 3b.**

Figure 3a. Residency training of current transplant surgeons.

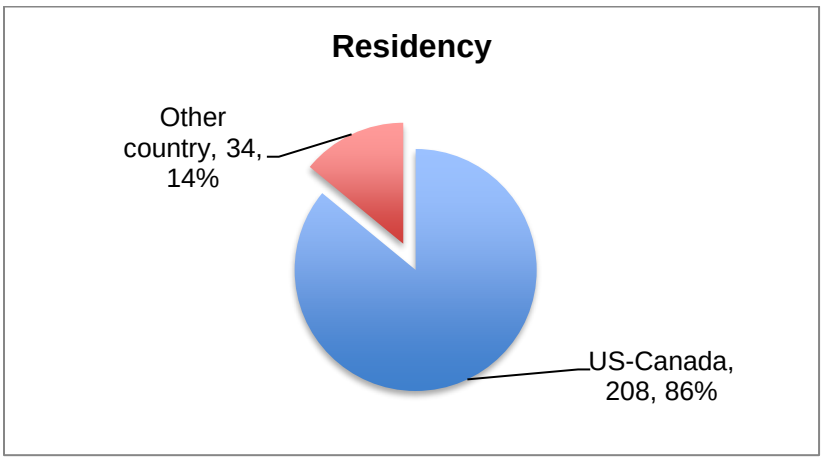
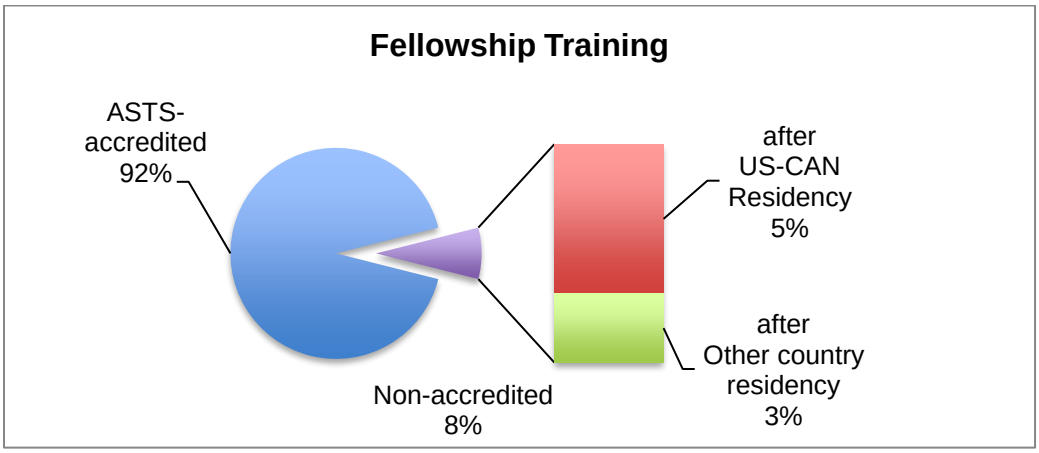


Figure 3b. Fellowship training of current transplant surgeons



3. Surgeon staffing of Transplant Centers and recruitment of Future Surgeons

Transplant Centers were asked to report on their staffing conditions, to estimate the number of surgeons leaving the center over the next 3 years (outflow), and the recruitment planning for surgeons in the same period of time (inflow).

The mean for surgeons leaving the center over the next 3 years was 0.50±0.64 (n=64 centers) and the mean for future surgeons being recruited in the same period was 1.08±0.69 (n=60 centers). The overall inflow/outflow of surgeons for all transplant centers was positive with a mean differential of +0.58.

The surgical staffing status was reported by centers (n=64, 7 missing) as Understaffed by 25% (n=18), Just Right by 62% (n=44) and Overstaffed by 3% (n=2). For the Understaffed group the outflow mean was 0.50±0.71 while the inflow mean was to 1.55±0.61, increasing the mean differential to +1.04. All 18 centers in this group were planning to recruit at least 1 surgeon over the next 3 years. For the Just-Right group, the outflow mean was 0.50±0.63 while the inflow mean was 0.90±0.63, decreasing slightly the mean differential to +0.40 however it remained positive for inflow. In this group, 30/44 centers were planning to hire at least one surgeon over the next 3 years. For the overstaffed group, the inflow and outflow of surgeons broke even with a differential =0 (group of only 2 centers with 1 surgeon leaving and 1 being recruited). **Figure 4.**

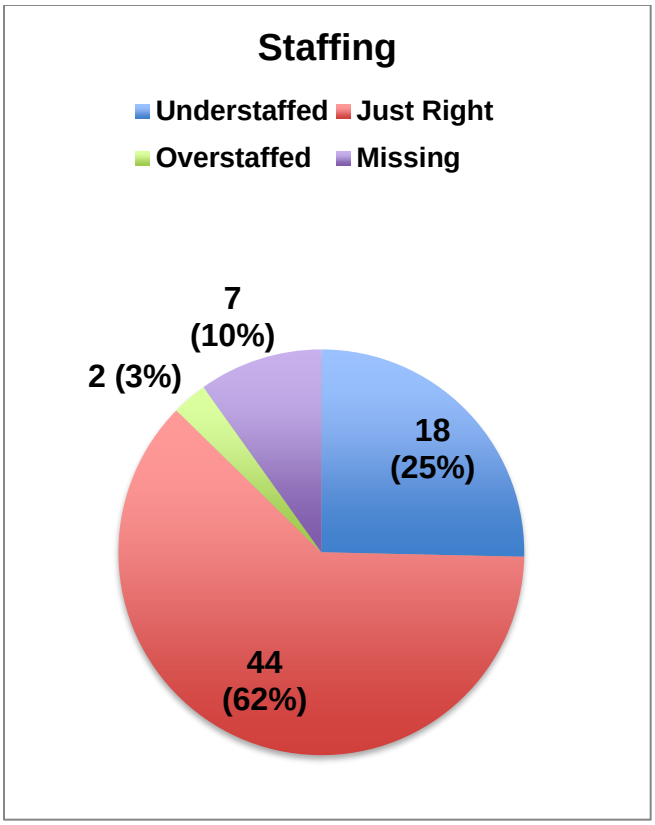
Figure 4. Transplant Center staffing and inflow/outflow of surgeons within next 3 years.

All Transplant Centers (n=64)
Surgeons leaving center: Outflow mean 0.5±0.6
Surgeons to be recruited: Inflow mean 1.08±0.7
Mean differential + 0.58 (inflow)

Understaffed Transplant Centers (n=18)
Surgeons leaving center: Outflow mean 0.5±0.71
Surgeons to be recruited: Inflow mean 1.55±0.61
Mean differential + 1.04 (inflow)
18 centers (100%) planning to recruit at least 1 surgeon.

Just-Right Transplant Centers (n=44)
Surgeons leaving center: Outflow mean 0.5±0.63
Surgeons to be recruited: Inflow mean 0.90±0.63
Mean differential + 0.40 (inflow)
30 centers (68%) planning to recruit at least 1 surgeon

Overstaffed Transplant Centers (n=2)
Surgeons leaving center: 1
Surgeons to be recruited: 1
Mean differential = 0



Forty-eight Transplant Centers reported plans to recruit a total of 61 surgeons over the next 3 years. When the recruiting centers were categorized by type of transplant practice (n=61): 69% (n=42) performed both Adult Liver and Adult Kidney transplantation, 16% (n=10) only Kidney transplantation, 8% (n=5) only Liver transplantation and the remainder 6% (n=4) performed other types of transplants (pediatrics, intestine). When categorized by annual transplant volumes (n=58, combining either liver, kidney or pancreas), centers performing more than 150 transplants/year (n= 29) were planning to recruit 56% of the surgeons (n=34), centers performing between 75 -150 transplants/year (n=14) were planning to recruit 27% of the surgeons (n=17) and Centers performing less than 75 transplants/year (n=15) were recruiting 16% of the surgeons (n=10).

Sixty of the planned recruitments reported were categorized by surgeon experience level (n=60). The demand for Junior-level surgeons was 61.6% (n=37), Mid-Level 28.3% (n=17) and Senior level 10% (n=6). **Figure 5a.**

The total planned recruitments over the next 3 years (n=61) represent a 19.5% of the total reported workforce (n-313), while the planned recruitment of Junior level surgeons (n=37) represent 11.8% of the total reported workforce.

Eighteen Understaffed centers were recruiting a total of 25 surgeons (41.7%), 12 Junior, 12 Mid-level and 1 Senior, while 30 Just-right centers were recruiting 34 surgeons (56.7%), 25 Juniors, 4 Mid-level and 5 Senior. **Figure 5b.**

Figure 5a. Categorization of planned recruitments by experience (n=60)

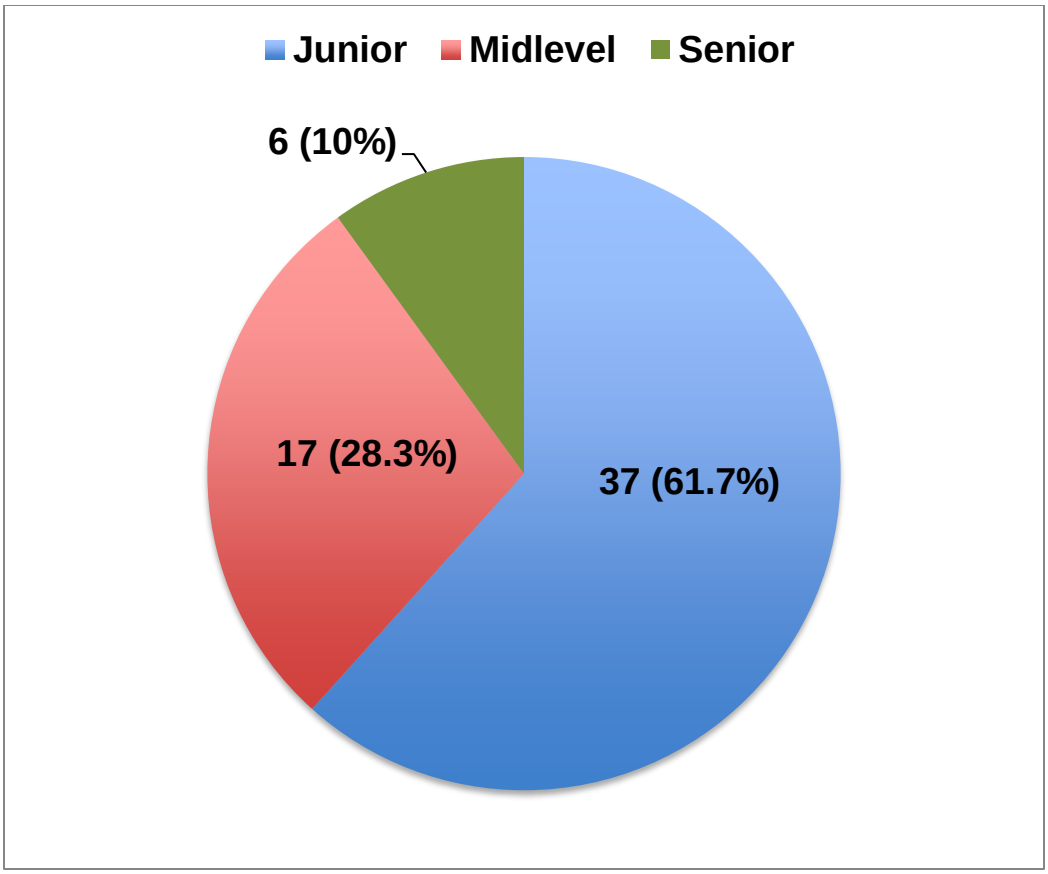
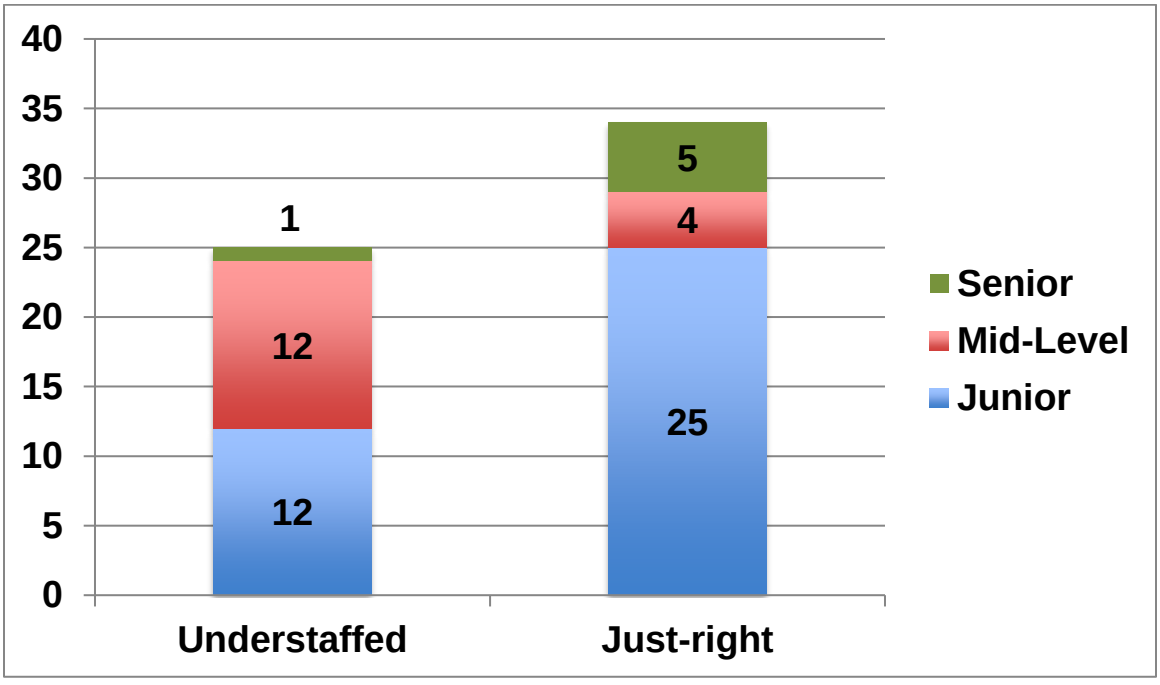


Figure5b. Distribution of planned recruitments (n=60) by Center staffing (Undersatffed vs. Just-right) and Surgeon experience level (Junior, Mid-level, Senior).



ASTS New Member Approval Process
Policy & Procedures

Background

In August 2016, we upgraded to a new AMS (Association Management System) that allowed ASTS to immediately process dues payment and provide member benefits at the time of new membership application, rather than following completion of the formal review process. To better serve our potential future members, the policy outlined below will allow for faster applicant access to ASTS benefits while also maintaining the society's formal application and approval process.

Policy

A probationary approval period will exist for all membership applicants (Regular, International, Associate, Candidate, and Trainee) that will temporarily grant the applicant member benefits (with the exception of voting and receiving a membership certificate) until completion of a formal application approval process as outlined below. Approved members will then be submitted to the membership via the ASTS website for invited comments.

Procedures

1. A probationary approval period is granted to all membership applicants who have submitted a complete application and have paid the annual dues.
2. The probationary approval period is communicated to the applicant, including that their membership can be denied after the completion of the formal review process.
3. All completed applications will be screened by ASTS staff prior to entering the formal review process.
4. The formal membership application approval process will occur monthly for Regular, International, and Associate members.
5. Regular, International, and Associate member applicants will be submitted to the membership and workforce committee, or a subcommittee of the membership and workforce committee charged with the process of formal application review and approval.
6. Regular, International, and Associate member applicants approved by the membership and workforce committee will then be forwarded to the council for formal approval.
7. Regular, International, and Associate member applicants approved by the membership and workforce committee and ASTS council will be submitted to the general membership for a comment period.
8. The aforementioned steps will be completed over a month, with the process being completed and new members being welcomed before the next month's applicants are reviewed for approval.
9. Candidate and Trainee member applicants will be reviewed and approved by ASTS staff on a monthly basis.
10. Trainee members transitioning to Regular membership will be added to the next month's formal approval process for Regular membership as outlined above.
11. Applicants who are denied membership in the society will receive a full refund of the annual dues paid.

ASTS Bi-Annual Committee Report

Committee Name: Bylaws
Chair/Co-Chair: Ron Pelletier/Liise Kayler
Staff Liaison: Laurie Kulikosky
Council Liaison: Ken Chavin

☒Yes, I would like to request time for a verbal report during the council and committee chair meeting.

☐No, my written report is sufficient; I do not need time to present verbally, but I will attend the meeting.

Please Indicate any Committee Initiatives Needing Formal Council Vote or Feedback:
(Please indicate the desired amount of time on agenda for each item. Please note that time allotments cannot be guaranteed)

- None

Review of Recent Committee Accomplishments (if applicable):

- Completion of the Non-clinical member participation policy – Approved by the EC in March 2017
- Review of the proposed bylaws change for elections for president elect position
- Worked with membership & Workforce cmte on updates to the new member approval policy

Outline of the Committee's Top Priorities:

Priority	Anticipated Completion Date	Budgeted Initiative?	Related Attachments?
Continued monitoring of proposed bylaws changes and policies			

Are you satisfied with the level of engagement from the committee? If not, what would help better engage the other committee members?

I am satisfied

Future Ideas for Consideration (if applicable): None at this time

SECTION 5. There shall be a Nominating Committee consisting of the President, President-Elect, two most recent Past Presidents, and the six most senior Councilors-at-Large. Each committee member must adhere to an expanded conflict of interest policy that precludes a voting member of the committee from casting a vote for him/her self and/or casting a vote for/against a candidate from the same institution. The committee will review the nominations from the general membership and put forward a ballot to eligible voting members that contains six candidates for the three councilor positions, three names for the secretary or treasurer position and one name for the president-elect position**.**

Proposed Bylaws Changes:

SECTION 5. There shall be a Nominating Committee consisting of the President, President-Elect, two most recent Past Presidents, and the six most senior Councilors-at-Large. Each committee member must adhere to an expanded conflict of interest policy that precludes a voting member of the committee from casting a vote for him/her self and/or casting a vote for/against a candidate from the same institution. The committee will review the nominations from the general membership and put forward a ballot to eligible voting members that contains six candidates for the three councilor positions and~~,~~ three names for the secretary or treasurer position ~~and one name for the president-elect position~~**.** Upon successfully completing his/her term, the secretary or treasurer will be considered the primary candidate for the president-elect position and the single candidate on the ballot. On the year when no secretary or treasurer is to be elected, a competitive ballot with three names for the president-elect position will be put forward to the membership.

ASTS Non-Clinical Member Participation on Committees
Policy & Procedures

Background

ASTS Members (Associate and Regular) can sometimes leave their positions as clinicians within transplant to work for corporate/industry companies connected to transplant. The issue of whether these members should be permitted to participate as committee members came up during the 2016 committee nominations process. An Associate Member who works for a device company inquired about ASTS' policy on this. The bylaws do not currently address this in either the membership or committee sections, nor does ASTS have a separate policy and procedures document to address the issue.

Proposed Policy

ASTS is committed to governance free of conflict. ASTS views non-clinical (such as a pharmaceutical or a device company employee) member participation as a potential conflict of interest to the mission of the Society. However, such employment should not, in and of itself, be considered a conflict of interest. Rather in situations where non-clinical members seek Society participation, candidacy should be weighed on a case-by-case basis. Thus, any non-clinical member seeking to serve ASTS in a volunteer capacity (including Committees, Council, and Executive Committee) will be vetted for potential conflicts of interest by the Nominating Committee. The Nominating Committee shall report their findings and recommendations to the Executive Committee for final determination regarding participation. Existing ASTS members serving on committees or in a leadership capacity who change from clinical to non-clinical employment shall undergo the same vetting and participation acceptability determination.

This recommendation can be outlined in the ASTS policy document and need not be included in the Society's bylaws.

ASTS Bi-Annual Committee Report

Committee Name: ASTS Historian
Chair/Co-Chair: Tom Peters
Staff Liaison: Diane Mossholder
Council Liaison: Entire Council

☒Yes, I would like to request time for a verbal report during the council and committee chair meeting.

☐No, my written report is sufficient; I do not need time to present verbally, but I will attend the meeting.

Please Indicate any Committee Initiatives Needing Formal Council Vote or Feedback:

(Please indicate the desired amount of time on agenda for each item. Please note that time allotments cannot be guaranteed)

- Example one: Request 5 min to discuss Chimera Chronicles re: future efforts and funding.
- Example one

Review of Recent Committee Accomplishments (if applicable):

- Example Accomplishment one: Chimera Chronicles continued first person sourced history of the ASTS and organ transplantation
- Example Accomplishment two:

Outline of the Committee's Top Priorities:

Priority	Anticipated Completion Date	Budgeted Initiative?	Related Attachments?
New Chimera Chronicles Honorees	2019	Possible	No

Are you satisfied with the level of engagement from the committee? If not, what would help better engage the other committee members?

Yes

Future Ideas for Consideration (if applicable):

ASTS Bi-Annual Committee Report

Committee Name: **Chair/Co-Chair:**
Staff Liaison: **Council Liaison:**

☐Yes, I would like to request time for a verbal report during the council and committee chair meeting.

☒No, my written report is sufficient; I do not need time to present verbally, but I will attend the meeting.

Please Indicate any Committee Initiatives Needing Formal Council Vote or Feedback:
(Please indicate the desired amount of time on agenda for each item. Please note that time allotments cannot be guaranteed)

- none

Review of Recent Committee Accomplishments (if applicable):

- Survey page added to the website: this page lists the future, current, and past surveys approved by the ASTS council for distribution to targeted or all of the membership. It was created to increase awareness and participation on ASTS surveys.
- "Update your membership" e-mail sent out which resulted in many members providing updated information regarding current contact information. We will repeat this effort annually and also request members review their contact information during dues renewal in order to improve our ability to communicate with membership

Outline of the Committee's Top Priorities:

Priority	Anticipated Completion Date	Budgeted Initiative?	Related Attachments?
Social media primers- at ASTS booth	ATC 2017	no	No
Chimera	ongoing	no	no
Website optimization	2017	yes	no

Are you satisfied with the level of engagement from the committee? If not, what would help better engage the other committee members? Yes

Future Ideas for Consideration (if applicable): We are investigating the idea of a ASTS members-only group chat on Facebook where members could communicate and post content. We are also

considering having Communications Committee members identify content that members may be interested in to post on the ASTS website in order to drive traffic to the website.

Agenda Form

Agenda Item: ATC 2017 Report
Submitted by: Ms. Shannon Fagan

Below is a brief recap of ATC 2017 Registration, Abstract Submission and Exhibits/Sponsorship as of April 6, 2017. The Congress is 6 weeks earlier in the year than 2016.

Key Milestones:

- December 2, 2016 – Abstract Deadline
  - This deadline is always the first Friday in December. Although the meeting is 6 weeks earlier than 2016, the deadline was kept the same as attendees are accustomed to this deadline and it would not conflict with other affiliated meeting submission deadlines.
- December 20, 2016 – Registration Opened
  - Registration has traditionally opened in late January. This year it was opened in December to encourage attendees were making arrangements early.
- February 6, 2017 – Abstract Notifications Sent
  - Notifications have been sent by February 20th. They were sent early this year to encourage attendance and travel.

Detailed reports are enclosed as attachments.

REGISTRATION

Registration and Revenue 3 Weeks Out
Comparison 2017 - 2015

Attendee Type	Chicago April 6, 2017		Boston May 19, 2016		Philadelphia April 9, 2015	
	#	Income	#	Income	#	Income
Scientific Pre-meeting Attendees	809	$113,955	863	$111,061	681	$82,502
Scientific Congress Attendees	3,253	$1,631,945	3,626	$1,837,430	3,086	$1,526,575

Totals above do not include exhibit/sponsorship attendees, guests or media.

Reports Enclosed

1. 2017 Registration Category Totals
2. 2017 – 2007 Registration Total Comparison
3. 2017 – 2012 Registration Comparison Domestic vs. International

ABSTRACT SUBMISSION

Abstract Totals 8 Year Comparison

Location	Year	Total
Chicago	**2017**	**2164**
Boston	2016	2361
Philadelphia	2015	2039
*San Francisco**	*2014*	*3528*
Seattle	2013	2209
Boston	2012	2141
Philadelphia	2011	2229
San Diego	2010	2224

WTC

Abstract Presentation Totals

Category	2017	2016	2015
	Chicago	**Boston**	**Philadelphia**
Abstracts Submitted	**2,215**	2,361	2,039
Video Abstracts Submitted	**12**	16	0
Plenary Abstracts Accepted	**19**	18	18
Mini-Oral Abstracts Accepted	**N/A**	N/A	N/A
Oral Abstracts Accepted	**564**	558	504
Poster Abstracts Accepted	**1,234**	1,222	1,179
Number of Plenary Sessions	**4**	4	4
Number of Video Abstract Presentations	**7**	9	0
Number of Mini-Oral Sessions	**N/A**	N/A	N/A
Number of Concurrent Oral Sessions	**79**	81	72
Percentage of acceptance	**81%**	76%	83%
Number of Attendees*	**3,253**	3,723	3,853
Number of Invited Presentations	**579**	599	465

Reports include Late Breaking Submission

*Total as of April 6, 2017

Reports Enclosed

1. 2017 Category Totals
2. 2017 - 2015 Country Comparison
3. 20017 – 2010 Presentation Comparison

EXHIBITS/SPONSORSHIP

Exhibit and Sponsorship Total Comparison 2017 – 2013

	ATC 2017*	ATC 2016	ATC 2015	ATC 2013
	Chicago	Boston	Philadelphia	Seattle
Exhibit Total	$ 477,900	$ 566,910	$ 613,980	$ 595,068
Sponsorship Total	$ 541,000	$ 624,000	$ 624,000	$ 417,150
Satellite Symposium Total	$ 375,000	$ 600,000	$ 290,000	$ 150,000
Grand Total	**$ 1,393,900**	**$ 1,790,910**	**$ 1,527,980**	**$ 1,162,218**
Budget	$ 1,460,500	$ 1,152,500	$ 1,083,000	$ 979,000
Variance	**$ (66,600)**	**$ 638,410**	**$ 418,903**	**$ 183,218**

* As of April 6, 2017

Additional Comments:

- Exhibit companies have downsized in 2017
- More 10 x 10 booths then in past years, which reduces overall exhibit revenue

Reports Enclosed

1. 2016 vs. 2015 Exhibit and Sponsorship Totals
2. 2016 – 2007 Exhibit Sales Comparison

Motion or action required: N/A

ATC 2017

Abstract Category Totals

Category #	Category Name	Original Submission	Late Breaking	Total
1	Regulatory Issues	13	1	14
2	Acute Rejection	38		38
3	Antigen Presentation / Allorecognition / Dendritic Cells	17		17
4	B-cell / Antibody	26		26
5	Endothelial Cell Biology	20		20
6	Immunosuppression Preclinical Studies	16		16
7	Innate Immunity; Chemokines, Cytokines, Complement	49		49
8	Islet Cell and Cell Transplantation	16		16
9	Lymphocyte Biology: Signaling, Co-Stimulation, Regulation	43		43
10	Tolerance / Immune Deviation	69		69
11	Xenotransplantation	21		21
12	Autoimmunity	7		7
13	Biomarkers, Immune Monitoring and Outcomes	56		56
14	Histocompatibility and Immunogenetics	10		10
15	Proteomics / Genomics Pharmacogenetics	10		10
16	Stem Cell, Cellular Therapies and Regenerative Medicine	40		40
17	All Infections (Excluding Viral Hepatitis in Liver Transplantation)	112	2	114
18	Donor Management: All Organs	20	3	23
19	Heart and VADs: All Topics	52		52
20	Kidney Antibody Mediated Rejection	115	1	116
21	Kidney Complications: Late Graft Failure	52		52
22	Kidney Complications: Other	215	3	218
23	Kidney Immunosuppression: Desensitization	31	1	32
24	Kidney Immunosuppression: Induction Therapy	43	3	46
25	Kidney Immunosuppression: Novel Regimens and Drug Minimization	87	2	89
26	Kidney: Acute Cellular Rejection	30		30
27	Kidney: Cardiovascular and Metabolic	47		47
28	Kidney: Deceased Donor Issues (DCD)	109	5	114
29	Kidney: Living Donor Issues	110	5	115
30	Kidney: Pediatrics	55	2	57
31	Kidney: Polyoma	32		32
32	Liver - Hepatocellular Carcinoma and Cholangiocarcinoma Malignancies	32	2	34
33	Liver - Kidney Issues in Liver Transplantation	27	1	28
34	Liver Retransplantation and Other Complications	42		42
35	Liver: Immunosuppression and Rejection	32	2	34
36	Liver: Living Donors and Partial Grafts	28		28
37	Liver: MELD, Allocation and Donor Issues (DCD/ECD)	56	1	57
38	Liver: Pediatrics	30		30
39	Liver: Viral Hepatitis	11	1	12
40	Lung: All Topics	32	1	33
41	Non-Organ Specific: Disparities to Outcome and Access to Healthcare	59	1	60
42	Non-Organ Specific: Economics, Public Policy, Allocation, Ethics	64		64
43	Non-Organ Specific:Organ Preservation/Ischemia Reperfusion Injury	23		23
44	Pancreas and Islet: All Topics	61	5	66
45	PTLD/Malignancies: All Topics	17	1	18
46	Small Bowel: All Topics	12		12
47	Tolerance: Clinical Studies	13		13
48	VCA	8	1	9
49	Surgical Issues (Open, Minimally Invasive): All Organs	22	3	25
50	Psychosocial and Treatment Adherence	26	1	27
51	Basic for Late Breaking		11	11
	Total	**2156**	**59**	**2215**

ATC Abstract Comparison by Country
2017, 2016, 2015

COUNTRY	2017	2016	2015
Argentina	12	9	5
Australia	20	25	22
Austria	10	17	20
Bahrain	2	2	2
Bangladesh		1	
Belgium	9	6	10
Brazil	37	49	45
Chile		1	
China	92	48	72
Colombia		7	5
Cote D Ivoire		1	
Croatia		3	
Czech Republic	3	4	
Denmark	3	1	
Egypt			2
Finland	1	2	3
France	65	54	44
Germany	78	80	86
Hungary	1		
India	11	4	3
Ireland	3	2	2
Israel	2	1	
Italy	9	29	14
Japan	65	87	87
Korea	91	95	74
Kuwait	2		
Lebanon	1		
Mexico	19	10	20
Mongolia		1	
Netherlands	35	43	45
New Zealand			1
Nigeria		1	
Norway	5	9	2
Pakistan	1		
Peru	1		
Poland	9	14	11
Portugal	3	3	3
Romania			1
Russian Federation	1	4	
Saudi Arabia	3	11	13
Singapore	5	1	1
South Africa	1	1	
Spain	49	40	33
Srilanka		1	
Sweden	3	6	8
Switzerland	8	10	6
Taiwan	14	23	18
Thailand	5	3	3
Turkey	19	19	8
United Arab Emirates			1
United Kingdom	85	94	100
Uruguay		1	
Total International	**783**	**823**	**770**
United States	1265	1432	1177
Canada	108	106	92
Total International	**1373**	**1538**	**1269**
GRAND TOTAL	**2156**	**2361**	**2039**

ATC Abstract Presentation Comparison
2017 - 2010

Category	2017	2016	2015	2013	2012	2011	2010
	Chicago	Boston	Philadelphia	Seattle	Boston	Philadelphia	San Diego
Abstracts Submitted	**2,215**	2,361	2,039	2,209	2,141	2,229	2,224
Video Abstracts Submitted	**12**	16	0	0	0	0	0
Plenary Abstracts Accepted	**19**	18	18	20	20	19	19
Mini-Oral Abstracts Accepted	**N/A**	N/A	N/A	N/A	N/A	N/A	N/A
Oral Abstracts Accepted	**564**	558	504	495	539	589	556
Poster Abstracts Accepted	**1,234**	1,222	1,179	1,213	1,226	1,120	1,176
Number of Plenary Sessions	**4**	4	4	5	4	4	4
Number of Video Abstract Presentations	**7**	9	0	0	0	0	0
Number of Mini-Oral Sessions	**N/A**	N/A	N/A	N/A	N/A	N/A	N/A
Number of Concurrent Oral Sessions	**79**	81	72	78	74	84	79
Percentage of acceptance	81%	76%	83%	78%	83%	78%	79%
Number of Attendees	**3253**	3,723	3,853	4,171	4,454	4,520	4,060
Number of Invited Presentations	**579**	382	329	369	331	304	216

Includes Late Breaking

ATC Registration Comparison
By Category
2017 - 2015

A.	Revenue	2015 Final	2016 Final	2017 Budget No.	2017 April 6 Projection	2017 Fee	2017 Budget	2017 April 6 Projection	Comments
1	**Registration Congress**								2017 Based numbers on a review of Philadelphia, Boston and Seattle
1.1	Member - Pre	915	915	900	1005	$ 495.00	$ 445,500.00	$ 497,475.00	Increase of $45
1.2	Member - Onsite	158	238	50	100	$ 620.00	$ 31,000.00	$ 62,000.00	Increase of $45
1.3	Nonmember - Pre	1031	1139	1050	892	$ 950.00	$ 997,500.00	$ 847,400.00	Increase of $55
1.4	Nonmember - Onsite	363	413	300	350	$ 1,050.00	$ 315,000.00	$ 367,500.00	Increase of $55
1.5	Trainee member - Pre	149	168	150	205	$ 125.00	$ 18,750.00	$ 25,625.00	Increase of $25
1.6	Trainee member - Onsite	12	39	5	10	$ 150.00	$ 750.00	$ 1,500.00	Increase of $25
1.7	Trainee nonmember - Pre	267	290	250	272	$ 225.00	$ 56,250.00	$ 61,200.00	Increase of $35
1.8	Trainee nonmember - Onsite	57	111	30	30	$ 330.00	$ 9,900.00	$ 9,900.00	Increase of $35
1.9	ASTS Non doctoral Member -Pre	11	31	15	12	$ 285.00	$ 4,275.00	$ 3,420.00	Increase of $45
1.10	AST Non-doctoral member - Pre	38	12	35	56	$ 285.00	$ 9,975.00	$ 15,960.00	Increase of $45
1.11	ASTS Non doctoral Member Onsite	0	6	2	2	$ 370.00	$ 740.00	$ 740.00	Increase of $45
1.12	AST Non-doctoral member - Onsite	4	2	2	2	$ 370.00	$ 740.00	$ 740.00	Increase of $45
1.13	Non-doctoral nonmember - Pre	254	285	250	245	$ 425.00	$ 106,250.00	$ 104,125.00	Increase of $55
1.14	Non-doctoral nonmember - Onsite	73	99	50	50	$ 505.00	$ 25,250.00	$ 25,250.00	Increase of $55
1.15	Senior/Emeritus Member - Pre	6	4	5	16	$ 175.00	$ 875.00	$ 2,800.00	No Increase
1.16	Senior/Emeritus Member - Onsite	0	3			$ 225.00	$ -	$ -	No Increase
1.17	Student Registrants	40	31	10	20	$ 50.00	$ 500.00	$ 1,000.00	No Increase
1.18	Comps	407	457	450	419	$ -	$ -	$ -	
	Total Congress	***3785***	***4243***	***3554***	***3686***		***$ 2,023,255.00***	***$ 2,026,635.00***	
2.0	**Registration Pre-meeting Symposia**								
2.1	PG course member - Pre	222	240	225	268	$ 150.00	$ 33,750.00	$ 40,200.00	Increase of $15
2.2	PG course member - Onsite	45	64	65	65	$ 200.00	$ 13,000.00	$ 13,000.00	Increase of $15
2.3	PG Nonmember - Pre	134	224	225	193	$ 255.00	$ 57,375.00	$ 49,215.00	Increase of $25
2.4	PG Nonmember - Onsite	94	96	120	120	$ 305.00	$ 36,600.00	$ 36,600.00	Increase of $25
2.5	PG trainee member - Pre	48	59	50	65	$ 50.00	$ 2,500.00	$ 3,250.00	Increase of $10
2.6	PG trainee member - Onsite	4	9	5	5	$ 80.00	$ 400.00	$ 400.00	Increase of $10
2.7	PG Trainee nonmember - Pre	55	59	55	46	$ 95.00	$ 5,225.00	$ 4,370.00	Increase of $20
2.8	PG Trainee nonmember - Onsite	17	29	10	10	$ 120.00	$ 1,200.00	$ 1,200.00	Increase of $21
2.9	ASTS Non doctoral Member - Pre	1	4	2	5	$ 95.00	$ 190.00	$ 475.00	Increase of $15
2.10	AST Non-doctoral member - Pre	10	7	10	12	$ 95.00	$ 950.00	$ 1,140.00	Increase of $15
2.11	ASTS Non doctoral Member - Onsite	0	1	1	1	$ 115.00	$ 115.00	$ 115.00	Increase of $14
2.12	AST Non-doctoral member - Onsite	1	3	1	1	$ 115.00	$ 115.00	$ 115.00	Increase of $14
2.13	Non-doctoral nonmember - Pre	43	52	50	56	$ 130.00	$ 6,500.00	$ 7,280.00	Increase of $20
2.14	Non-doctoral nonmember - Onsite	9	20	10	10	$ 160.00	$ 1,600.00	$ 1,600.00	Increase of $20
2.15	Emeritus	3	0	0	3	$ 50.00	$ -	$ 150.00	
2.16	Emeritus - Onsite	0	1	2		$ 50.00	$ 100.00	$ -	
2.17	Speakers	132	148	150	125		$ -	$ -	
	Total Postgraduate Course	***818***	***1016***	***981***	***985***		**$ 159,620.00**	**$ 159,110.00**	

ATC Registration Comparison Final
2017 - 2007

Category	2017 Chicago	2016 Boston	2015 Philadelphia	2013 Seattle	2012 Boston	2011 Philadelphia	2010 San Diego	2009 Boston	2008* Toronto	2007* San Francisco
Pre-Meeting Courses (only)	53	74	68	54	106	123	62	77		
Pre-Meeting Courses & Annual Mtg	731	930	758	712	967	1113	1142	1140		
Annual Meeting (only)	2,340	3,292	3027	3405	3381	3284	3230	3374		
Total Attendee	**3,124**	**4,296**	**3853**	**4171**	**4454**	**4520**	**4434**	**4591**	**4100**	**4478**
Exhibitor	177	516	514	598	686	931	838	906		
Guest	20	100	46	57	59	104	46	93		
Media	9	19	12	14	31	35	40	31		
Grand Total	**3,330**	**4,931**	**4425**	**4840**	**5230**	**5590**	**5358**	**5621**	**4100**	**4478**

*As of April 6, 2017
** Reports Not Broken Out, Only Total

ATC Registration Comparison
2017 - 2012

3 Weeks Out Comparison		2017 to 4/6/2017	2016 to 5/19/2016	2015 to 4/9/2015	2013 to 4/25/2013	2012 to 5/10/2012
		Chicago	Boston	Philadelphia	Seattle	Boston
Pre-Meeting Courses	Domestic	45	35	47	29	61
	International	8	7	10	11	15
	Total	**53**	**42**	**57**	**40**	**76**
Pre-Meeting Courses & Congress	Domestic	453	500	407	398	572
	International	278	339	243	246	285
	Total	**731**	**839**	**650**	**644**	**857**
Annual Congress	Domestic	1,549	1,605	1,451	1,383	1,470
	International	791	1,099	913	1,285	1,140
	Total	**2,340**	**2,704**	**2,364**	**2,668**	**2,610**
Attendee Total		**3124***	**3,585**	**3,071**	**3,352**	**3,543**
Exhibitor	Domestic	166	214	208	196	351
	International	11	10	11	16	15
	Total	**177**	**224**	**219**	**212**	**366**
Guest	Domestic	13	23	6	2	4
	International	7	6	6	1	0
	Total	**20**	**29**	**12**	**3**	**4**
Media	Domestic	3	6	4	0	0
	International	6	8	1	0	0
	Total	**9**	**14**	**5**	**0**	**0**
Other Total		**206**	**267**	**236**	**215**	**370**
GRAND TOTAL		**3,330**	**3,852**	**3,307**	**3,567**	**3,913**

*Does not include 129 pending non-member trainees to provide institution letter on trainee status

ATC Exhibit Sponsorship Totals
2017 vs. 2016

Revenue	2016 Budget	2016 Final	2017 Budget	2017 April 6 Projection	Comments
Industry					
Exhibits	$ 600,000.00	$ 566,910.00	$ 585,000.00	$ 477,900.00	Large companies downsized booths in 2016 from 2015, and in 2017
Support					
Key Cards	$ 45,000.00	$ 45,000.00	$ 50,000.00	$ 45,000.00	2017 support item
Banner, Escalator, Column Wraps,	$ 150,000.00	$ 152,000.00	$ 150,000.00	$ 120,000.00	2017 Includes banners, wall clings, escalator mats and escalator banners
Mobile App	$ 50,000.00	$ 60,000.00	$ 60,000.00	$ 65,000.00	$55,000 for mobile app, 1 @ $5,500 and 1 @ $5,000 for app upgrade
Cyber Café	$ -	$ 10,000.00	$ -	$ 25,000.00	Until 2016, wasn't supported in 3 years
Digital Signs	$ 50,000.00	$ 50,000.00	$ 55,000.00	$ 50,000.00	2017 support item
Lanyards	$ -	$ -	$ -	$ -	ACCME does not allow support
Schedule at a Glance	$ 30,000.00	$ 30,000.00	$ 32,500.00	$ -	
List Rentals	$ 20,000.00	$ 27,500.00	$ 25,000.00	$ 33,000.00	2017 supported item 6 @ 5,500 each
Charging Stations	$ 40,000.00	$ 35,000.00	$ 40,000.00	$ 40,000.00	2017 support item
Attendee Meeting Bag	$ -	$ -	$ -	$ -	ACCME does not allow support
Attendee Meeting Bag Insert	$ 7,500.00	$ -	$ -	$ -	2016 Not providing a meeting bag; alternative options for inserts are doctor's bag and virtual bag
Doctors Bag & Single Insert	$ -	$ 10,000.00	$ 12,000.00	$ -	Not supported in 2017
Doctors Bag Insert	$ -	$ 44,000.00	$ 40,000.00	$ 27,500.00	2017 support item
Benches	$ -	$ 15,000.00	$ 18,500.00	$ 15,000.00	2017 support item
Footprints	$ 10,000.00	$ 10,000.00	$ 12,500.00	$ 10,000.00	2017 support item
Gobo Logo	$ -	$ 60,000.00		$ -	Only in 2016
Virtual Bag Insert	$ -	$ 3,000.00	$ 5,000.00	$ -	New in 2016 in place of attendee meeting bag
Transplant Games	$ -	$ 20,000.00	$ -	$ -	Only in 2016
Notebook	$ -	$ 40,000.00		$ -	
Wifi				$ 30,000.00	2017 support item
Bus Transportation				$ 35,000.00	Only needed in 2017
Photo/Selfie Lounge				$ 25,000.00	New in 2017
Best in Congress Posters				$ 20,000.00	New in 2017
Satellite Symposia	$ 150,000.00	$ 600,000.00	$ 375,000.00	$ 375,000.00	2016 - 8 Luncheon symposia @ $75,000 each; 2017 - 5 Luncheon symposia @ $75,000 each
Total Industry	***$ 1,152,500.00***	***$ 1,778,410.00***	***$ 1,460,500.00***	***$ 1,393,400.00***	

ATC Exhibit Sales Comparison
2017 - 2007

Category	2017	2016	2015	2013	2012	2011	2010	2009	2008	2007
	Chicago*	**Boston**	**Philadelphia**	Seattle	Boston	Philadelphia	San Diego	Boston	Toronto	San Francisco
Number of Exhibit Booths	72	73	78	77	89	92	76	83	80	89
Sales Committee	$477,900	$ 566,910	$ 613,980	$ 595,068	$ 567,300	$ 552,069	$ 515,080	$ 487,580	$ 469,000	$ 468,420
Square Feet Committed	15,400	17,400	19,000	18,300	19,900	20,200	18,500	18,000	19,300	19,800

*As of April 6, 2017

Agenda Form

Agenda Item: ATC 2018 Report
Submitted by: Ms. Shannon Fagan

The ATC 2018 Program Committee will hold an in-person program meeting in June 2017. The program committee will review the following:

1. Important deadlines.
2. Abstract 2017 categories to develop 2018 categories.
3. Submitted program proposals from the Program Submission for all invited symposia sessions.
4. State of the Art presenters.
5. ATC Night Out

Below is a brief recap of the items reviewed and detailed reports are enclosed.

IMPORTANT DEADLINES

- April 12, 2017
  - Open program submission.
- May 24, 2017
  - Program submission deadline.
- June 13 – 14, 2017
  - Tentative dates for in-person program planning committee meeting.
- October 5, 2017
  - Abstract site opens.
- December 1, 2017
  - Abstract deadline.
  - This will allow appropriate time for review and completion prior to Christmas and New Year holiday.
- December 13, 2017
  - Registration and Housing Open.
- January 23 - 25, 2018
  - Tentative dates for full program committee abstract selection meeting.
- May 2, 2018
  - Pre-registration Deadline (4 weeks prior to Congress).
- June 2 – 6, 2018
  - Congress

Motion or action required: N/A

ASTS Bi-Annual Committee Report

Committee Name: Vanguard Committee
Chair/Co-Chair: Daniela Ladner/ Majella Doyle
Staff Liaison: Nerissa Legge
Council Liaison: Carlos O. Esquivel, MD, PhD

☒Yes, I would like to request time for a verbal report during the council and committee chair meeting.

☐No, my written report is sufficient; I do not need time to present verbally, but I will attend the meeting.

Please Indicate any Committee Initiatives Needing Formal Council Vote or Feedback:
N/A

Review of Recent Committee Accomplishments (if applicable):

- 2017 Winter Symposium update (attached)

Outline of the Committee's Top Priorities:

Priority	Anticipated Completion Date	Budgeted Initiative?	Related Attachments?
2018 Winter Symposium Planning Meeting	May 2017	Yes	No

Are you satisfied with the level of engagement from the committee? If not, what would help better engage the other committee members? Yes

Future Ideas for Consideration (if applicable): N/A

17th Annual State of the Art Winter Symposium Registration Overview

The 2017 ASTS State of the Art Winter Symposium saw slightly decreased registration numbers compared to the 2016 Winter Symposium. 2016 was a special year with the inclusion of the Surgeons General Panel, and 2017 registration numbers were more comparable to 2015 numbers, as illustrated below. This year, complimentary trainee registration was only offered to trainees that had an accepted abstract. Trainees without an accepted abstract received reduced registration rates, over 50% off the member rate. The following table compares registration numbers for each category between the 2017, 2016, and 2015 Winter Symposium.

	Pre-Registration Deadline			**Onsite Final Registration**		
	1/5/2017	1/6/2016	1/5/2015	1/29/2017	1/17/2016	1/18/2015
Speaker	77	98	83	102	122	106
ASTS member	100	93	99	147	142	122
Non-ASTS member	41	52	41	62	73	53
Comp Trainee	80	N/A	N/A	89	N/A	N/A
Trainee	21	121	101	29	139	114
ATP	6	20	0	9	19	5
Staff	7	8	9	7	8	9
Exhibitor	35	81	32	94	107	107
Total w/o Guests	***367***	***365***	***365***	***539***	***610***	***516***
Guest	5	22	16	11	24	29
Total Registration	***372***	***495***	***381***	***550***	***634***	***545***

Even though overall registration numbers were down compared to last year, revenue was only $820 less compared to 2016. The following table shows an overall comparison of registration revenue between 2017, 2016 and 2015.

	2017 Revenue	**2016 Revenue**	**2015 Revenue**
ASTS member	$96,488	$88,265	$69,015
Non-ASTS member	$49,838	$65,142	$38,615
Trainee	$7,925	N/A	N/A
ATP	$4,350	$5,738	N/A
Exhibitor	$30,225	$28,750	$30,995
Guest	$1,000	$2,750	$4,575
TOTAL REVENUE	**$189,825**	**$190,645**	**$143,200**

2017 Trainee Category Registration Breakdown

Trainee Category	**Number of Registrants**
ASTS Fellow Candidate Member	42
Graduate/Doctoral Student Member	13
Medical Student Trainee Member	8
Non-ASTS Fellow Candidate Member	2
Post-Doctoral Fellow Member	4
Resident Trainee Member	8
Non-Member Trainee	39

ASTS Bi-Annual Committee Report

Committee Name: Fellowship Training Committee
Chair/Co-Chair: Ryutaro Hirose/Jonathan Fryer
Staff Liaison:
Council Liaison: Will Chapman

☒Yes, I would like to request time for a verbal report during the council and committee chair meeting.

☐No, my written report is sufficient; I do not need time to present verbally, but I will attend the meeting.

Please indicate any Committee Initiatives Needing Formal Council Vote or Feedback:

(Please indicate the desired amount of time on agenda for each item. Please note that time allotments cannot be guaranteed)

- *Administrative Requirements for Transplant Surgery Fellowship (request 7 – 10 minute update)*

Review of Recent Committee Accomplishments (if applicable):

- *Managed Time Policy – Work Hour Monitoring Plan implemented for all fellows starting in 2017*

Outline of the Committee's Top Priorities:

Priority	Anticipated Completion Date	Budgeted Initiative?	Related Attachments?
2017 Program Directors Meeting	End of 2017	Yes	No
Transition to new Match provider	October 2017	No	No
Pancreas Volume Adjustment	October 2017	No	No
Standardized Fellowship Application for Match	October 2017	No	No
Non-Technical Milestones	June 2018	No	No
11th Annual Surgical Fellows Symposium	October 2017	Yes	No

Are you satisfied with the level of engagement from the committee? If not, what would help better engage the other committee members?

Yes

Future Ideas for Consideration (if applicable):

1. *Joint meetup and educationally focused committees*

ASTS Bi-Annual Committee Report

Committee Name: CME Committee
Staff Liaison: Nerissa Legge

Chair/Co-Chair: Matthew Levine, MD, PhD & Dean Kim, MD
Council Liaison: Randall Sung, MD

☒Yes, I would like to request time for a verbal report during the council and committee chair meeting.

5-10 min is sufficient.

☐No, my written report is sufficient; I do not need time to present verbally, but I will attend the meeting.

Please Indicate any Committee Initiatives Needing Formal Council Vote or Feedback:
(Please indicate the desired amount of time on agenda for each item. Please note that time allotments cannot be guaranteed)

Review of Recent Committee Accomplishments (if applicable):

- Revised process for approval of requests for interactions with other organizations (Endorsements and Joint Providerships)
- Implemented committee review process for ongoing AJT MOC initiative
- Implemented committee review process for ongoing Trans-SAP program
- Completed annual PARS reporting to the ACCME

Outline of the Committee's Top Priorities:

Priority	Anticipated Completion Date	Budgeted Initiative?	Related Attachments?
AJT MOC- Providing MOC for select AJT articles	Ongoing	Yes	No
Trans- SAP MOC-Adding to the current list of available modules on the Academic Universe	Ongoing	Yes	No

Are you satisfied with the level of engagement from the committee? If not, what would help better engage the other committee members? Yes, the committee meets every month for an hour via a conference call, and there is also frequent communication via email/phone in between the scheduled monthly calls.

Future Ideas for Consideration (if applicable): A possible idea for consideration is a need for ongoing discussion/engagement with council to study CME/MOC utilization and develop pricing structure to maximize utilization and revenue.

ASTS Bi-Annual Committee Report

Committee Name: Business Practice Services
Chair/Co-Chair: Ken Andreoni/David Mulligan
Staff Liaison: Laurie Kulikosky
Council Liaison: Osama Gaber

☒Yes, I would like to request time for a verbal report during the council and committee chair meeting.

☐No, my written report is sufficient; I do not need time to present verbally, but I will attend the meeting.

Please Indicate any Committee Initiatives Needing Formal Council Vote or Feedback:
(Please indicate the desired amount of time on agenda for each item. Please note that time allotments cannot be guaranteed)

- none

Review of Recent Committee Accomplishments (if applicable):

- Transplant Surgeon Compensation Survey fielded February-April 2017. Results to be released in May
- ALDP planning cmte working on agenda. Registration to open at the end of April

Outline of the Committee's Top Priorities:

Priority	Anticipated Completion Date	Budgeted Initiative?	Related Attachments?
2017 Advanced LDP at Kellogg	September 2017	Yes	No
Compensation / RVU survey	May 2017	Yes	No
New short business courses, organ specific 'how to bill for…"	Explore for 2018	No	No

Are you satisfied with the level of engagement from the committee? If not, what would help better engage the other committee members? Yes

Future Ideas for Consideration (if applicable): Organ specific business short courses

ASTS Bi-Annual Committee Report

Committee Name: Advanced Transplant Providers
Chair/Co-Chair: Georgeine Smith/Haley Hoy
Staff Liaison: Ellie Proffitt
Council Liaison: Wendy Grant

☒Yes, I would like to request time for a verbal report during the council and committee chair meeting.

☐No, my written report is sufficient; I do not need time to present verbally, but I will attend the meeting.

Please Indicate any Committee Initiatives Needing Formal Council Vote or Feedback:

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- ATP reception at 2018 Winter Symposium

Review of Recent Committee Accomplishments (if applicable):

- ATP Award, ATP poster category, and ATP Session at 2017 Winter Symposium
- Successful ATP Reception at 2017 Winter Symposium
- Committee progress on the ATP Certificate of Educational Achievement
- ATP Salary Survey approved by Council and currently in editing stages

Outline of the Committee's Top Priorities:

Priority	Anticipated Completion Date	Budgeted Initiative?	Related Attachments?
Marketing of ATP Certificate of Educational Achievement	Ongoing	N/A	No
Distribution of ATP Salary Survey to ATP members of ASTS	In progress	N/A	No

Are you satisfied with the level of engagement from the committee? If not, what would help better engage the other committee members?

Future Ideas for Consideration (if applicable):

ASTS Bi-Annual Committee Report

Committee Name: Curriculum Committee
Chair/Co-Chair: Marc Melcher/Jason Vanatta
Staff Liaison: Chelsey Gordon
Council Liaison: Wendy Grant

☒Yes, I would like to request time for a verbal report during the council and committee chair meeting.

☐No, my written report is sufficient; I do not need time to present verbally, but I will attend the meeting.

Please Indicate any Committee Initiatives Needing Formal Council Vote or Feedback:

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- No initiative needing council vote, request 5-minute verbal update on committee's progress.

Review of Recent Committee Accomplishments (if applicable):

- Developed process to identify modules with content that needs to be updated.
- Developed process to update and create new modules.
- Committee reviewed 51 out of 119 modules (42.85%).

Outline of the Committee's Top Priorities:

Priority	Anticipated Completion Date	Budgeted Initiative?	Related Attachments?
Review 65% of modules to consider updating	October 2017	Yes	No
Identify new content for Academic Universe	Ongoing	N/A	No
Identify new content creators	Ongoing	N/A	No

Are you satisfied with the level of engagement from the committee? If not, what would help better engage the other committee members?

Committee members have done an excellent job of reviewing modules, submitting suggestions, and updating "Goals and Objectives".

Future Ideas for Consideration (if applicable):

ASTS Bi-Annual Committee Report

Committee Name: Grants Review
Chair/Co-Chair: **David Foley/Phil Wai**
Staff Liaison: Maggie Kebler
Council Liaison: Ginny Bumgardner

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☐No, my written report is sufficient; I do not need time to present verbally, but I will attend the meeting.

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Review of Recent Committee Accomplishments (if applicable):

Priority	Anticipated Completion Date	Budgeted Initiative?	Related Attachments?
Faculty Development Grant Feedback to Applicants	May 1, 2017	No	No
Grant Award Winner Survey Results Analysis	May 1, 2017	No	No
Recommend a Modification of Grants Portfolio			

○

Outline of the Committee's Top Priorities:

Goal: Establish the impact of the past awards on the research careers of the awardees to assess the return on investment in order to justify the continued funding of the awards.

1. Analyze the survey that was given to past winners of ASTS Grants. This survey was sent out in March, 2017. We will review all results and present them to council.
2. Provide feedback to the submitters of the faculty development award proposals. Reviews to be completed by members of the grants review committee and made available to the submitters.
3. Revise the Grants Portfolio to expand the number of awards with the current ASTS Foundation support and that received from industry.
4. Change the existing ASTS award database into a more comprehensive database that can be populated prospectively and queried retrospectively. We aim to make minor changes to the application process so that data can be collected at the time of submission and automatically populated into the database.
5. Review the application titles from the past 10 years to determine the research focus of the submissions divided into clinical, basic, outcomes, translational, and health services research.

Are you satisfied with the level of engagement from the committee? If not, what would help better engage the other committee members?

Yes. The committee is engaged with the review of grants

Future Ideas for Consideration (if applicable):

See above.

ASTS Bi-Annual Committee Report

Committee Name: Vascularized Composite Allograft Committee

Chair/Co-Chair: Suzanne Ildstad, MD & Susan McDiarmid, MD

Staff Liaison: Nerissa Legge

Council Liaison: Peter Abt, MD

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☐No, my written report is sufficient; I do not need time to present verbally, but I will attend the meeting.

Review of Recent Committee Accomplishments (if applicable):

- Presentation and Participation in UNOS VCA Committee and draft report
- Progress in academic module section on VCA
- Moving to improve inter-society communication for VCA committees

Outline of the Committee's Top Priorities:

Priority	Anticipated Completion Date	Budgeted Initiative?	Related Attachments?
Collaboration of VCA Committee Chairs (UNOS Chair, AST, ASTS, ASRT)	Ongoing	Yes	No

Are you satisfied with the level of engagement from the committee? If not, what would help better engage the other committee members? Yes

Future Ideas for Consideration (if applicable):

ASTS Bi-Annual Committee Report

Committee Name: Cell Transplant
Chair/Co-Chair: Wijkstrom/Wertheim
Staff Liaison: Laurie Kulikosky
Council Liaison: Peter Abt

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☒No, my written report is sufficient; I do not need time to present verbally, but I will attend the meeting.

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- Not sure whether the Grant needs vote/another vote.

Review of Recent Committee Accomplishments (if applicable):

- Approval of Grant for Cellular Therapeutics/Transplantation.

Outline of the Committee's Top Priorities:

Priority	Anticipated Completion Date	Budgeted Initiative?	Related Attachments?
Complete Islet Cell Transplant Status Paper	June 2017	No	No
Complete Report on ASTS-TERMIS meeting	June 2017	No	No
Suggest new Modules and updated previous Modules for the Academic Universe	July/August 2017	No	No

Are you satisfied with the level of engagement from the committee? If not, what would help better engage the other committee members?

It has been difficult to get the Committee members engaged and excited. We're about to have a major turnover in the Committee.

Future Ideas for Consideration (if applicable):

ASTS Bi-Annual Committee Report

Committee Name: Scientific Studies
Chair/Co-Chair: Chris Marsh/Ty Dunn
Staff Liaison: Maggie Kebler/Ellie Proffitt
Council Liaison: Dorry Segev

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☒No, my written report is sufficient; I do not need time to present verbally, but I will attend the meeting.

Please Indicate any Committee Initiatives Needing Formal Council Vote or Feedback:

(Please indicate the desired amount of time on agenda for each item. Please note that time allotments cannot be guaranteed)

- Council's input regarding the Marijuana paper and whether this receives a stamp of approval from ASTS or coming out of the scientific studies committee of ASTS.

Review of Recent Committee Accomplishments (if applicable):

- KPD paper to be submitted AJT.
- DCD Liver paper submitted to Liver Transplantation.
- Marijuana paper circulated to council for review.
- Microsteatosis survey completed and now soliciting transplant program and OPO participation in a multicenter study to look at variability of pathology reading of intra-op frozen section analyses of liver biopsies.

Outline of the Committee's Top Priorities:

Priority	Anticipated Completion Date	Budgeted Initiative?	Related Attachments?
Collaboration with PhD students in Spain on DCD practices in the US	May 2017	N/A	No
Microsteatosis multicenter pilot study	June 2018	Yes	No
Enhancing Organ Donation & Transplantation RFI	open	Grant proposal	no

Are you satisfied with the level of engagement from the committee? If not, what would help better engage the other committee members? Yes, satisfied

Future Ideas for Consideration (if applicable):

- Analysis of the use of virtual crossmatching in kidney allocation for high PRA patients.

- Analysis of the impact of the new UNOS simultaneous liver kidney policy across region and programs.

ASTS Bi-Annual Committee Report

Committee Name: Standards and Quality
Chair/Co-Chair: David Axelrod/Winston Hewitt
Staff Liaison: Laurie Kulikosky
Council Liaison: Ken Chavin

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☐No, my written report is sufficient; I do not need time to present verbally, but I will attend the meeting.

Please Indicate any Committee Initiatives Needing Formal Council Vote or Feedback:

(Please indicate the desired amount of time on agenda for each item. Please note that time allotments cannot be guaranteed)

- Request support for joint survey to transplant centers and OPOs

Review of Recent Committee Accomplishments (if applicable):

- TransQIP Alpha Phase completion

Outline of the Committee's Top Priorities:

Priority	Anticipated Completion Date	Budgeted Initiative?	Related Attachments?
Establishing standards on DCD reporting – Discussions with AOPO are ongoing. They support sending a survey out to their members.	June 2017- Survey	No	Yes
Development of Standards for the Graft Assessment and Reporting for Ex-Vivo Perfusion	Ongoing	No	No
Support TransQIP Task Force	2017-2018	Yes	No
Surgical Quality Alliance (SQA) and MACRA Taskforce participation	Indefinite	Yes	No
Establishing standards for renal pathology specimens and professionals involved. Complete work on the development of standardized renal pathology time zero biopsy form. Discuss the options for QAPI assessment of time zero biopsy reports.	Not determined	No	No

Are you satisfied with the level of engagement from the committee? If not, what would help better engage the other committee members?

Future Ideas for Consideration (if applicable):

Development of Standards for the Graft Assessment and Reporting for Ex-Vivo Perfusion

Develop standards for documentation and training for non-renal perfusion. - As the use of ex-vivo mechanical support of organs increases, the role of the transplant surgeon to monitor and assess these organs will increase. The standards committee is interested in developing a systematic approach to reporting of organ function.

The growth in the use of ex-vivo perfusion for non-renal allografts has increased dramatically with support of liver, hearts, and lungs. These machines are now in clinical trials. Unlikely renal transplant, ex-vivo support is generally being performed and directed by individual transplant centers and directed by transplant surgeons. However, there are no uniform assessments of graft function or perfusion adequacy (e.g. flow and resistance in renal transplant). Lack of common reporting may limit acceptance of these grafts should the center's primary recipient be unsuitable for transplant. While currently limited, a proactive attempt to define appropriate standards for liver perfusion would be beneficial for future technological developments.

ASTS/AOPO DCD Liver Project

Transplant Center Survey

The ASTS and AOPO recognize that current utilization of DCD liver allografts is suboptimal. Wide variations in current DCD recovery practice contribute to poor liver utilization.

We aim to improve DCD liver utilization by identifying and implementing best practice standards in DCD liver recovery.

This survey represents the first step in this process. We are soliciting input from OPOs and transplant surgeons regarding both current practice and BEST practice in DCD liver recovery, recognizing that variations in hospital policy/procedure may impact practice.

This survey will help inform a policy document which identifies factors associated with the greatest likelihood of DCD liver acceptance and successful transplantation. Our ultimate goal is to help standardize DCD liver recovery according to best practices to more effectively save lives with these under-utilized organs.

Please answer honestly and frankly. Responses will remain confidential and no public attribution of individual practices or opinions will be published.

General Information

1. My role in my transplant center is:
    a. Liver program director
    b. Attending (staff) transplant surgeon
    c. Transplant fellow
    d. Other (free text)

2. Over the past 3 years my center has performed approximately:
    a. 5 or less DCD liver transplants
    b. 5-10 DCD liver transplants
    c. 11-20 DCD liver transplants
    d. 21-50 DCD liver transplants
    e. >50 DCD liver transplants

3. Over the past 3 years I have personally performed:
    a. 5 or less DCD liver recoveries
    b. 5-10 DCD liver recoveries
    c. 11-20 DCD liver recoveries
    d. 21-50 DCD liver recoveries
    e. >50 DCD liver recoveries

Donor and Recipient Selection Criteria

1. What is your upper limit of age for DCD liver donors?
    a. 40 or less
    b. 50
    c. 55
    d. 60
    e. We do not have an upper limit of donor age.

2. What is your upper limit of BMI for DCD liver donors?
    a. 30
    b. 35
    c. 40
    d. 45
    e. We do not have an upper limit of donor BMI.

3. Which of the following conditions represent exclusion criteria for DCD liver donors? (may select more than one)
    a. Diabetes Mellitus
    b. Hepatitis B Infection

c. Hepatitis C Infection
d. Prior laparotomy
e. Prior sternotomy
f. None of these conditions represent exclusion criteria
g. Other (free text)

4. Do you consider death-prediction tools when deciding whether or not to accept a DCD liver offer?
    a. No
    b. Yes, we use established tools (e.g. University of Wisconsin tool)
    c. Yes, we use our own criteria

5. How often do you have access to non-invasive diagnostics (i.e. ultrasound, cross-sectional imaging) at the time of DCD liver offer?
    a. Never
    b. Rarely
    c. Sometimes
    d. Often

6. How often do you have access to pre-withdrawal liver biopsy when considering a DCD liver offer?
    a. Never
    b. Rarely
    c. Sometimes
    d. Often

7. How far are you willing to travel to potentially recover a DCD liver?
    a. Within DSA/Driving Distance
    b. Within DSA/Flight
    c. Regionally/Nationally <1000 miles
    d. Regionally/Nationally >1000 miles

8. Are you willing to accept DCD livers recovered by surgeons not affiliated with your transplant center staff?
    a. No
    b. Yes, but only our OPO's designated recovery surgeon(s)
    c. Yes, but only surgeons we know
    d. Any recovery surgeon

9. Do you require that an attending transplant surgeon performs the DCD liver recovery?
    a. Yes
    b. No

10. Does your center routinely send two surgeons to perform the DCD liver recovery?
    a. Yes
    b. No

11. Which of the following represent your exclusion criteria for RECIPIENTS with respect to DCD liver offers? (may select more than one)
    a. MELD>30
    b. MELD>35
    c. Patient in ICU
    d. Patient on renal replacement therapy
    e. Hepatocellular carcinoma with exception points
    f. Liver/Kidney recipients
    g. Status 1A recipients
    h. Pediatric recipients
    i. Other (free-text)
    j. None of these critieria

12. Do you require that the potential liver recipient is physically in the hospital at the time of DCD liver recovery to help minimize cold-ischemia time?
    a. Yes
    b. No

Pre-Recovery Practices

1. Do you routinely perform a debrief/huddle with all individuals involved with the DCD recovery process prior to withdrawal of life support?
    a. Yes
    b. No

2. What is your PREFERRED location for withdrawal of care in the potential DCD liver donor?
    a. Operating room
    b. Location near operating room (e.g. PACU)
    c. ICU

    d. No preference

3. Which of the following locations for withdrawal of care are NOT acceptable to you when considering a DCD liver recovery? (may select more than one)
    a. Operating room
    b. Location near operating room (e.g. PACU)
    c. ICU same floor as operating room
    d. ICU requiring elevator transport
    e. None of these locations are unacceptable

4. What pre-withdrawal medications are required when considering a DCD liver offer?
    a. Heparin
    b. Mannitol
    c. Other (free text)
    d. No medications

Calculation of Warm Ischemia Time

1. What is your definition of the beginning of warm ischemia time?
    a. Withdrawal of support
    b. Hemodynamic parameter (i.e. SBP<80) (free text)
    c. Oxygenation parameter (i.e. O2 sat <80) (free text)

2. What is your definition of the end of warm ischemia time?
    a. Aortic flush
    b. Aortic cross-clamp
    c. Other (free-text)

3. What is the maximal allowable liver warm ischemia time (as calculated by your criteria)?
    a. 20 minutes
    b. 30 minutes
    c. 40 minutes
    d. It depends on review of the hemodynamic/oxygenation trends during the warm ischemia period.
    e. Other (free text)

Recovery Procedure

1. What is your goal time from incision to cannulation?

a. 2 minutes
b. 3 minutes
c. Other (free-text)

2. Assuming that total warm ischemia time is within your criteria – if the incision to cannulation time is longer than expected, will you still accept the liver for transplantation?
    a. Yes
    b. No

3. What flush solution do your prefer for DCD liver recovery?
    a. UW/SPS
    b. HTK
    c. Other

4. Do you routinely use medications added to the flush solution during DCD liver recoveries?
    a. Heparin
    b. TPA
    c. Other (free text)
    d. No additives

5. What volume of flush solution do you infuse into the aorta during a normal DCD liver recovery?
    a. <5 liters
    b. 5-8 liters
    c. > 8 liters

6. Do you utilize pressurized aortic flush when recovering DCD livers?
    a. Yes
    b. No

7. Do you perform in-situ flushing of the portal system during DCD liver recovery?
    a. Yes
    b. No

8. Do you perform back-table flushing of the portal system during DCD liver recovery?
    a. Yes
    b. No

9. Do you perform retrograde (hepatic-vein) flush on the back-table during DCD liver recovery?
    a. Yes
    b. No

10. Do you measure the time from end of flush to liver removal?
    a. Yes, and we use this data when making acceptance decisions.
    b. Yes, but we do NOT use this data when making acceptance decisions
    c. No

11. Do you utilize post-recovery liver biopsy to make acceptance decisions?
    a. Never
    b. Rarely
    c. Sometimes
    d. Often

12. If you use biopsy data to determine liver acceptance, what is the maximum amount of macrosteatosis acceptable?
    a. <10%
    b. <20%
    c. <30%
    d. <40%
    e. Other (free text)

DCD Liver Transplant Procedure

1. What is the goal cold-ischemia time for DCD liver transplantation?
    a. <3 hours
    b. <4 hours
    c. <6 hours
    d. <8 hours
    e. Other (free-text)

2. Does a second team start the hepatectomy prior to organ arrival at the center to minimize cold-ischemia time?
    a. Yes

b. No

3. Do you perform the recipient operation differently when using a DCD liver?
    a. No, I perform the operation the same way.
    b. Yes, I use arterial infusions (e.g. TPA, verapamil)
    c. Yes, I use veno-veno bypass
    d. Yes, I place t-tubes in DCD liver transplants
    e. Yes, I perform simultaneous arterial/portal reperfusion
    f. Other (free text)

4. If you perform arterial infusions, what infusions do you use and when? (Select all that apply)
    a. TPA in the hepatic artery prior to reperfusion
    b. TPA in the hepatic artery after portal reperfusion, but before arterial reperfusion
    c. Verapamil in the hepatic artery prior to reperfusion
    d. Verapamil in the hepatic artery after portal reperfusion, but before arterial reperfusion
    e. Other (free text)

Discussion Questions:

1. What do you believe is the most important organ-recovery factor influencing DCD liver transplant outcomes?
2. What is the most important recovery factor to standardize to improve DCD liver outcomes and utilization?

ASTS/AOPO DCD Liver Project

OPO Survey

The ASTS and AOPO recognize that current utilization of DCD liver allografts is suboptimal. Wide variations in current DCD recovery practice contribute to poor liver utilization.

We aim to improve DCD liver utilization by identifying and implementing best practice standards in DCD liver recovery.

This survey represents the first step in this process. We are soliciting input from OPOs and transplant surgeons regarding both current practice and BEST practice in DCD liver recovery, recognizing that variations in hospital policy/procedure may impact practice.

This survey will help inform a policy document which identifies factors associated with the greatest likelihood of DCD liver acceptance and successful transplantation. Our ultimate goal is to help standardize DCD liver recovery according to best practices to more effectively save lives with these under-utilized organs.

Please answer honestly and frankly. Responses will remain confidential and no public attribution of individual practices or opinions will be published.

General Information

1. My role in my OPO is
    a. Medical Director (Chief Medical Officer)
    b. Managing Director of Clinical Operations (or similar title)
    c. Chief Executive Officer
    d. Other (Free Text)

2. Approximately how many DCD livers has your OPO recovered for transplantation each year over the past 3 years?
    a. <10 livers
    b. 11-20 livers
    c. 21-30 livers
    d. > 30 livers

3. Most of the DCD livers recovered in our DSA are placed:
    a. Locally (i.e. centers within our DSA)
    b. Regionally
    c. Nationally

4. Does your OPO utilize expedited placement to transplant centers known for utilizing DCD livers? (may select more than one)
    a. Yes, we use expedited placement to local centers
    b. Yes, we use expedited placement to regional centers
    c. Yes, we use expedited placement to national centers
    d. No

5. Does your OPO have a process in place to certify recovery surgeons specifically to perform DCD liver recoveries?
    a. No, any donor surgeon certified by our OPO can perform DCD liver recoveries.
    b. Yes, we require that donor surgeons are certified to perform DCD liver recoveries.

6. Does your OPO employ a recovery surgeon who recovers DCD livers for other centers?
    a. No
    b. Yes
    c. We do employ a recovery surgeon, but centers routinely send their own surgeons to recover DCD livers

7. Does your OPO allow two separate teams to be present at the time of DCD organ recovery to separately recover the liver and the kidneys?
    a. Yes, we allow two separate recovery teams
    b. No, we only allow one abdominal recovery team to be present

8. Does your OPO counsel families that delaying withdrawal of care may be necessary to facilitate successful liver placement?
    a. Yes
    b. No

Donor Selection Criteria

1. What is your OPO's upper limit of age when considering offering a liver from a DCD donor?
    a. 40 or less
    b. 50
    c. 55
    d. 60
    e. We do not have an upper limit of donor age.

2. What is your OPO's upper limit of BMI when considering offering a liver from a DCD donor?
    a. 30
    b. 35
    c. 40
    d. 45
    e. We do not have an upper limit of donor BMI.

3. Which of the following conditions represent exclusion criteria for DCD liver donors? (may select more than one)
    a. Diabetes Mellitus
    b. Hepatitis B Infection
    c. Hepatitis C Infection
    d. Prior laparotomy
    e. Prior sternotomy
    f. None of these conditions represent exclusion criteria
    g. Other (free text)

4. Does your OPO consider death-prediction tools when deciding whether or not to offer a liver from a DCD donor?
    a. No

b. Yes, we use established tools (e.g. University of Wisconsin tool)
c. Yes, we use our own criteria

5. How often do perform non-invasive diagnostics (i.e. ultrasound, cross-sectional imaging) when offering a liver from a DCD donor?
    a. Never
    b. Rarely
    c. Sometimes
    d. Often

6. How often do you perform a pre-withdrawal liver biopsy when offering a liver from a DCD donor?
    a. Never
    b. Rarely
    c. Sometimes
    d. Often

Pre-Recovery Communication and Withdrawal of Support

1. Does your OPO require that a communication “huddle” is performed prior to initiating withdrawal of life support?
    a. No
    b. Yes, but recovery surgeons are not required to participate
    c. Yes, recovery surgeons must participate in this huddle

2. Does your OPO require that an attending physician performs the withdrawal of life support and declaration of death when performing DCD recoveries?
    a. Yes
    b. No, any physician (including residents) can serve in this role
    c. No, any provider (including NP/PA) can serve in this role
    d. Different hospitals in our DSA have different policies about who can perform the withdrawal of support and declaration of death

3. Does your OPO require that separate physicians perform withdrawal of support and declaration of circulatory death?
    a. No, the same physician can perform both
    b. No, our OPO does not require this but some hospitals in our DSA have this requirement
    c. Yes, our OPO requires that two different physicians perform these roles

4. Does your OPO provide education or guidance to the declaring physician regarding determination of death (i.e. differentiating between pulselessness and cessation of electrical activity)?
    a. Yes
    b. No

5. Unless dictated by hospital policy or logistical challenges, our OPO preference is to perform the withdrawal of care
    a. In the operating room
    b. Outside the operating room in a nearby area (e.g. PACU)
    c. In the ICU
    d. Other (free-text)

6. Does offering a liver from a DCD donor change the preferred location for withdrawal of support?
    a. No, we proceed in the same manner regardless of organs offered
    b. Yes, we move to a location near the operating room when the liver is offered
    c. We prefer that withdrawal of care is performed in the operating room when a liver is offered
    d. We ONLY will recover a liver from a DCD donor when withdrawal of support is performed in the operating room.

7. In our DSA, what percentage of the time is withdrawal of care performed in (free-text, answers must total 100%)
    a. Operating Room
    b. Location near operating room (e.g. PACU)
    c. ICU
    d. Other

8. What proportion of hospitals in your OPO allow family members in the OR to facilitate withdrawal of life support in this location?
    a. None
    b. A few
    c. Many
    d. Most
    e. We do not offer this to families when withdrawal of support is performed in the operating room

9. What medications does your OPO administer to DCD liver donors prior to withdrawal (may select more than one)
    a. Heparin
    b. Lasix
    c. Mannitol
    d. No medications

10. Do some hospitals in your DSA prohibit the administration of medications to a DCD donor pre-withdrawal of support?
    a. No, all hospitals allow administration of medications
    b. A few hospitals prohibit administration of medications
    c. Many hospitals prohibit administration of medications
    d. Most hospitals prohibit administration of medications
    e. Our OPO does not administer pre-withdrawal of support medications

Post-Withdrawal of Support and Determination of Death

1. What is your OPO's standard maximum wait-time after withdrawal of life support before determining that the donor did not progress?
    a. 60 minutes
    b. 90 minutes
    c. 120 minutes
    d. Other

2. How often are vital signs recorded after withdrawal of support?
    a. Every minute
    b. Every five minutes
    c. Other

3. What is the length of the observation (hands-off) period?
    a. 3 minutes
    b. 5 minutes
    c. It depends on specific hospital policy

4. Does the OPO require the declaring physician to confirm death at the end of the observation (hands-off) period?
    a. Yes
    b. No
    c. It depends on specific hospital policy

5. If withdrawal of life support takes place outside the OR, which of the following are allowed during the observation (hands-off) period? (select all that apply)
    a. Transfer to OR
    b. Prep/drape by OR staff
    c. Prep/drape by recovery surgeons
    d. None – the patient must remain in the withdrawal location until after the observation period
6. Recovery surgeons are allowed in the OR
    a. During observation (hands-off) period?
    b. Only at the end of the observation (hands-off) period?

Calculation of Warm Ischemia Time

1. What is your OPO's definition of the beginning of warm ischemia time?
    a. Withdrawal of support
    b. Hemodynamic parameter (i.e. SBP<80) (free text)
    c. Oxygenation parameter (i.e. O2 sat <80) (free text)

2. What is your OPO's definition of the end of warm ischemia time?
    a. Aortic flush
    b. Aortic cross-clamp
    c. Other (free-text)

Recovery Procedure

1. Which flush solution does your OPO routinely use for DCD liver donors?
    a. UW/SPS
    b. HTK
    c. Other

2. Do your OPO routinely add additional agents to the flush when recovering DCD livers?
    a. Heparin
    b. TPA
    c. Other (free text)
    d. No additives

3. What volume of flush solution does your OPO routinely infuse into the aorta during a normal DCD liver recovery?
    a. <5 liters
    b. 5-8 liters

c. > 8 liters

4. Does your OPO utilize pressurized aortic flush when recovering DCD livers?
    a. Yes
    b. No

5. If DCD lung recovery is taking place, does the liver or lung come out first?
    a. Liver
    b. Lung
    c. We do not offer DCD lungs in our OPO

6. How often are you able to place a DCD liver which is declined intraoperatively?
    a. Never
    b. Rarely
    c. Sometimes
    d. Often

Discussion Questions:

1. In your opinion, what is the most important factor influencing your ability to place a DCD liver?
2. In your opinion, what is the most important factor leading to a positive experience for the donor family?
3. What is the most important factor to standardize to improve DCD liver recovery?

ASTS Bi-Annual Committee Report

Committee Name: Living Donor Committee
Chair/Co-Chair: Baker/ Zimmerman
Staff Liaison: Maggie Kebler
Council Liaison: Dorry Segev

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Background: (15 minutes)

- White House Commitment with ORGANIZE, UCM, CC, Baylor and Mount Sinai (June 2016)
- ORGANIZE and UCM build out of GIVE/LIVE with Farenheit 212 (https://projects.invisionapp.com/share/8H8IJ1I3K#/screens)
- Development of Anonymous Non-directed living donor database (UCM)

The interest of the ASTS to stay actively involved in the development of GIVE/LIVE and the anonymous living donor database/ registry needs to be discussed. The extent of such a commitment should also be determined.

Review of Recent Committee Accomplishments (if applicable):

- GIVE LIVE build out with ORGANIZEhttps://projects.invisionapp.com/share/8H8IJ1I3K#/screens
- Initiation of Anonymous non-directed living donor database (UCM)
- "Social Media and Organ Donation – The Next Frontier" sunrise symposium at ATC 2017

Outline of the Committee's Top Priorities:

Priority	Anticipated Completion Date	Budgeted Initiative?	Related Attachments?

Are you satisfied with the level of engagement from the committee? If not, what would help better engage the other committee members?

Need more frequent conference calls/engagement

ASTS Bi-Annual Committee Report

Committee Name: PROACTOR Task Force
Chair/Co-Chair: Mark Hobeika
Staff Liaison: Ellie Proffitt
Council Liaison: Dorry Segev

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- None

Review of Recent Committee Accomplishments (if applicable):

- White paper submitted to AJT and returned with reviewer comments
- Task-force leadership planning for Phase II initiative recommendations

Outline of the Committee's Top Priorities:

Priority	Anticipated Completion Date	Budgeted Initiative?	Related Attachments?
Revise white paper and re-submit to AJT	May 2017	N/A	No
Develop Phase II initiatives for the task force	Ongoing	N/A	No
Compile Phase III Organization of Proposed Initiatives to Present to ASTS Council	Future	N/A	No

Are you satisfied with the level of engagement from the committee? If not, what would help better engage the other committee members? Moderately satisfied. We are scheduling conference calls to engage task force regarding completion of Phase I and beginning of Phase II.

Future Ideas for Consideration (if applicable):

ASTS Bi-Annual Committee Report

Committee Name: Diversity Issues
Chair/Co-Chair: Jorge Ortiz/Jayme Locke
Staff Liaison: Ellie Proffitt
Council Liaison: Carlos Esquivel

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- None

Review of Recent Committee Accomplishments (if applicable):

- Submission of website analysis for cultural sensitivity.
- Coordination with Novartis & UNOS for future collaborations.
- Coordination with paired donor network for future collaboration.

Outline of the Committee's Top Priorities:

Priority	Anticipated Completion Date	Budgeted Initiative?	Related Attachments?
Grant application to determine effect of paired donor exchange on minorities	October 2017	N/A	No
Grant application to provide translation services for transplant websites.	October 2017	N/A	No
Evaluation of blood groupA2 organs for B recipients.	October 2017	N/A	No

Are you satisfied with the level of engagement from the committee? If not, what would help better engage the other committee members?

Yes

Future Ideas for Consideration (if applicable):

Discussion of travel bans and how they will affect delivery and receipt of care.

ASTS Bi-Annual Committee Report

Committee Name: Ethics
Chair/Co-Chair: Michael Millis/Sander Florman
Staff Liaison: Diane Mossholder
Council Liaison: Peter Abt

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- None

Review of Recent Committee Accomplishments (if applicable):

Reviewed ASTS statements (see attachment for recommendations)

Outline of the Committee's Top Priorities:

Priority	Anticipated Completion Date	Budgeted Initiative?	Related Attachments?
Review current ASTS statements	June 2017	No	Yes
Propose new Statements	Jan 2018	No	No
Examine ethical conflict btw institutional benefit and pt benefit	June 2018	No	No

Are you satisfied with the level of engagement from the committee? If not, what would help better engage the other committee members? yes

Future Ideas for Consideration (if applicable):

Review ASTS statements for appropriateness, accuracy, and timeliness

Archived Statements

- ASTS Statement of Professionalism May 2015
  PDF, 101.80 KB
- ASTS Statement on Conscious DCD May 2015
  PDF, 92.58 KB
- ASTS-AST Statement on Lung Allocation Policy June 6, 2013
  PDF, 403.71 KB
- Recent Living Donor Death June 12, 2012
  PDF, 61.61 KB
- Letter to the Editors of the Wall Street Journal March 19, 2012
  PDF, 98.23 KB
- Transplantation of Organs from HIV Infected Deceased Donors July 22, 2011
  PDF, 133.54 KB
- ASTS Press Release - Arizona Transplant Cuts Based on Flawed Data December 9, 2010
  PDF, 329.37 KB
- Living Liver Donor Deaths August 13, 2010
  PDF, 47.72 KB
- Istanbul Declaration
  PDF, 56.22 KB
- ASTS Confidentiality and Conflict of Interest Policy
  PDF, 33.06 KB
- Non-ASTS Fellows in Parallel Tracks at ASTS Accredited Programs June 30, 2009
  PDF, 13.06 KB
- Recommended Guidelines for Controlled DCD Organ Procurement and Transplantation May 11, 2009
  PDF, 88.90 KB
- Proposal - Health Insurance as Incentive for Living Kidney Donation February 6, 2009
  PDF, 29.23 KB
- Draft - Definition of a Transplant Surgeon December 11, 2008
  PDF, 45.51 KB
- Procuring Surgeon Criteria July 25, 2008
  PDF, 23.83 KB
- Volunteer Non Directed Live Donations June 1, 2008
  PDF, 20.99 KB
- Fellowship Workload Practices January 24, 2008
  PDF, 15.63 KB
- Paired Kidney Donation May 29, 2007
  PDF, 20.57 KB
- Directed Donation and Solicitation of Donor Organs October 23, 2006
  PDF, 30.32 KB
- Live Vascular Grafts January 15, 2005
  PDF, 831.89 KB

Review excluded statements specifically attributable to a standing committee; however, those that are either general in nature or relating to an ethical issue have been considered.

All of the statements are accurate but many seem very dated and some of those that are out of date should put into a separate part of the website or eliminated altogether.

Those are:

Recent LD Death June 12 2012

Letter to Editors of WSJ March 18 2012

ASTS Press Release - AZ transplant cuts…

Living liver donor deaths AUG 13 2010

Live Vascular grafts

The Draft Definition of a transplant surgeon needs to be finalized or eliminated.

We recommend the following statements be reviewed for possible updating:

Volunteer non-directed live donors
Paired Kidney Donation
Directed donation and solicitation of donor organs

ASTS Bi-Annual Committee Report

Committee Name: Pediatrics Task Force
Chair/Co-Chair: Carlos Esquivel
Staff Liaison: Ellie Proffitt
Council Liaison: N/A

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Please Indicate any Committee Initiatives Needing Formal Council Vote or Feedback:

(Please indicate the desired amount of time on agenda for each item. Please note that time allotments cannot be guaranteed)

- None

Review of Recent Committee Accomplishments (if applicable):

- Pediatric transplant survey distributed to ASTS membership
- White paper on the effect of the KAS on pediatric patients in progress

Outline of the Committee's Top Priorities:

Priority	Anticipated Completion Date	Budgeted Initiative?	Related Attachments?
Collect membership data on pediatric transplant	July 2017	N/A	No
KAS effect on pediatric patients white paper	In progress	N/A	No

Are you satisfied with the level of engagement from the committee? If not, what would help better engage the other committee members?

Future Ideas for Consideration (if applicable):

ASTS Bi-Annual Committee Report

Committee Name: Thoracic Organ Transplantation
Chair/Co-Chair: Abbas Ardehali/David Mason
Staff Liaison: Ellie Proffitt
Council Liaison: Will Chapman

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- None

Review of Recent Committee Accomplishments (if applicable):

- None

Outline of the Committee's Top Priorities:

Priority	Anticipated Completion Date	Budgeted Initiative?	Related Attachments?
Committee call after ATC to discuss committee initiatives for the upcoming year	June 2017	N/A	No
Recruitment of thoracic members to ASTS	Ongoing	N/A	No
Application for a joint symposium at 2019 ISHLT annual meeting	February 2018	N/A	No

Are you satisfied with the level of engagement from the committee? If not, what would help better engage the other committee members?

- Committee needs to develop new project ideas/initiatives to increase engagement in 2017

Future Ideas for Consideration (if applicable):

- Develop ideas to recruit more thoracic members to join ASTS

ASTS Bi-Annual Committee Report

Committee Name: Legislative
Staff Liaison: Diane Mossholder/Kim Gifford

Chair/Co-Chair: Sherilyn Gordon Burroughs/Jim Pomposelli
Council Liaison: Ginny Bumgardner

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Please Indicate any Committee Initiatives Needing Formal Council Vote or Feedback:
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- n/a

Review of Recent Committee Accomplishments (if applicable):

- Fly-In March 22, 2017: visits to 23 Congressional offices
- Monitoring health care legislation in Congress

Outline of the Committee's Top Priorities:

Priority	Anticipated Completion Date	Budgeted Initiative?	Related Attachments?
Joint effort with Regulatory Committee on ASTS-initiated CMS ESRD Demonstration Project	Pending	Yes	No
Comprehensive Cost Analysis of Kidney Transplant vs Dialysis Report	Pending	No	No
New immuno bill draft	Pending	No	No

Are you satisfied with the level of engagement from the committee? If not, what would help better engage the other committee members? Yes

Future Ideas for Consideration (if applicable):

Monitoring ACA changes/replacement to ensure transplant patients' needs are addressed

ASTS Bi-Annual Committee Report

Committee Name: Reimbursement & Regulatory Compliance
Staff Liaison: Diane Mossholder/Kim Gifford
Chair/Co-Chair: Kareem Abu-Elmagd/Anil Paramesh
Council Liaison: Osama Gaber

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- n/a

Review of Recent Committee Accomplishments (if applicable):

- Fly-In March 22, 2017: visits to 23 Congressional offices
- Call with CMS regarding hazard ratio/CoP enforcement process changes
- Formation of Demo Task Force to help Ms. Millman draft legislative proposal
- Formation of Readmissions Task Force to inform regulatory component of the 21st Century Cures bill, paving the way for transplant admissions to be excluded from the hospital penalty formula.

Outline of the Committee's Top Priorities:

Priority	Anticipated Completion Date	Budgeted Initiative?	Related Attachments?
Joint effort with Legislative Committee on ASTS-initiated CMS ESRD Demonstration Project	Pending	Yes	No
			No
			No

Are you satisfied with the level of engagement from the committee? If not, what would help better engage the other committee members? Yes

Future Ideas for Consideration (if applicable):

ASTS Bi-Annual Committee Report

Committee Name: MACRA Task Force | **Chair/Co-Chair: D. Reich (Powers: D. Millman)**
Staff Liaison: D. Mossholder / K. Gifford | **Council Liaison:**

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Please Indicate any Committee Initiatives Needing Formal Council Vote or Feedback: ***(4 min)***

- Requesting feedback regarding the ACS/Harvard/Brandeis AAPM project (Advanced Alternative Payment Model), in light of ASTS' new legislative effort to create a shared savings demo. Will discuss pros/cons of pursuing both efforts or alternatively backing away from working with ACS/Brandeis to develop a transplant-specific AAPM. ACS/Brandeis preliminarily interested in our proposal to develop a payment model that adjusts for donor and recipient risks, offset by savings from earlier transplant.

Review of Recent Committee Accomplishments (if applicable): ***(3 min)***

- Continued analysis of new MACRA regulations on the MIPS (Merit-based Incentive Payment System) and APM programs and implications for transplant. Task Force has attended ACS meetings and CMS webinars re the MACRA rule, to help inform our efforts.
- Presentation and updates to UNOS BOD re MACRA implications for transplant and potential opportunities for UNOS to support transplant providers (CPIA tools, advocacy for SRTR approval).
- MACRA questions included in compensation survey to help inform Task Force efforts (Individual vs GPRO reporting? PQRS reporting?).
- Member education
    - 2016 ASTS/Kellogg LDP: keynote dinner talk on MACRA
    - 2017 ASTS Winter Meeting: MACRA presentations during the Business Practice Seminar
    - March 2017 ASTS Webinar on MACRA

Outline of the Committee's Top Priorities: ***(3 min)***

Priority	Anticipated Completion Date	Budgeted Initiative?	Related Attachments?
MACRA primer for members (written materials on what to do for MIPS)	Late 2017	NA	NA
ACS/Harvard/Brandeis APM project (see top of page re Council input)	Ongoing (in-person meeting 2017)	NA (no cost now; incremental costs possible)	NA

Continued…

Continue to study and react to emerging MACRA regulations for the MIPS and APM programs (partner with ACS, AMA and others)	Ongoing	NA	NA
Monitor the impact of the Comprehensive ESRD Care (CEC) ACO-like initiative on referrals for transplant evaluations by End Stage Renal Disease Comprehensive Care Organizations (ESCOs)	Ongoing	NA	NA

Are you satisfied with the level of engagement from the committee? If not, what would help better engage the other committee members?

The Task Force members have given thoughtful consideration to the new MACRA regulations and have helped to craft our response. They have also provided insightful feedback regarding the ACS APM project. In order to best address the increasing plethora of regulations pertaining to quality and pay reform, eventually, ASTS might benefit from additional paid-for, in-house, transplant-focused expertise (to complement Powers efforts).

Future Ideas for Consideration (if applicable):

- SRTR approval for MACRA pay-for-value programs (follow up meeting with CMS)
- Develop Patient Reported Outcomes (PRO) tool to meet MACRA requirements
- Develop transplant-relevant PQRS measures (if required as MACRA evolves)

ASTS Bi-Annual Committee Report

Committee Name: AMA Liaison
Chair/Co-Chair: Tom Peters / Stuart Greenstein
Staff Liaison: Diane Mossholder
Council Liaison: Entire Council

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Please Indicate any Committee Initiatives Needing Formal Council Vote or Feedback:

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- Example one:
- Example one

Review of Recent Committee Accomplishments (if applicable):

- Example Accomplishment one: ASTS seat in the AMA House of Delegates begins 10 June, 2017
- Example Accomplishment two:

Outline of the Committee's Top Priorities:

Priority	Anticipated Completion Date	Budgeted Initiative?	Related Attachments?

Are you satisfied with the level of engagement from the committee? If not, what would help better engage the other committee members?

Yes

Future Ideas for Consideration (if applicable):

All pertinent policy issues to take to the AMA