

UNOS Bylaws

各小児心臓移植プログラムには以下の外科医と小児科医が必要

Pediatric Primary Heart Surgeonの資格	20 heart transplant < 18 yrs未満 8例以上 < 12 yrs未満 4例以上 American Borad of Thoracic Surgery Congenital Heart
Pediatric Primary Heart Physicianの資格	Care of 20 pts of heart transplant < 18 yrs未満 8例以上 < 12 yrs未満 4例以上 American Board of Pediatrics/ Pediatric Cardiology

上記の基準は、我が国にとって厳しすぎる、徐々に数を増やしていけばよい、との意見であった。

日本の基準として推奨された基準

	外科医の要件	循環器小児科医の要件
Arkansas	10 adults + 8 pediatric transplant, 100 CHD surgery	12 pediatric care
Seattle		12 pediatric care
Morgan Stanley	150 CHD surgery, 1-2 pediatric transplant	12 pediatric care
Montefiore		10 pediatric care

参考資料

- UNOSの移植施設に関する規則
- USAの主な施設の実績

“Pediatric Heart Component” Qualifying Criteria

<p>“Pediatric Primary Heart Surgeon”</p>	<ul style="list-style-type: none"> • Meet current Bylaws requirements for “Primary Heart Surgeon”, and • 8 heart transplants in patients younger than 18 years of age • 4 heart transplants in patients younger than 12 years of age • American Board of Thoracic Surgery Congenital Heart Certification
<p>“Pediatric Primary Heart Physician”</p>	<ul style="list-style-type: none"> • Meet current Bylaws requirements for “Primary Heart Physician”, and • Care for 8 heart transplant patients younger than 18 years of age • Care for 4 heart transplant patients younger than 12 years of age • American Board of Pediatrics: Sub-board of Pediatric Cardiology Certification

OPTN



“Pediatric Lung Component” Qualifying Criteria

<p>“Pediatric Primary Lung Surgeon”</p>	<ul style="list-style-type: none"> • Meet current Bylaws requirements for “Primary Lung Surgeon” • 6 lung transplants in patients younger than 18 years of age <p>OR</p> <ul style="list-style-type: none"> • American Board of Thoracic Surgery Congenital Heart Certification
<p>“Pediatric Primary Lung Physician”</p>	<ul style="list-style-type: none"> • Meet current Bylaws requirements for “Primary Lung Physician” • American Board of Pediatrics certification in pulmonology medicine possessed by the individual who meets the current Bylaws requirements OR another member of the lung transplant team.

OPTN



Pediatric Training and Experience Considerations in the Bylaws – Additional Considerations

- Similar to the current Bylaws pathways, these pediatric-specific requirements would be expected of the clinician over 2-5 years
- Alternative pathway for individuals who do not meet all of the pediatric-specific requirements, yet very experienced
- One individual could fill both, for example, the primary surgeon and the pediatric primary surgeon roles, but it doesn't need to be the same person.

OPTN



Questions?

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OPTN



OPTN/UNOS Pediatric Transplantation Committee
Interim Report for
January 15, 2014
Teleconference

The Pediatric Transplantation Committee's (the Committee's) update at the OPTN/UNOS fall regional meetings focused on its recommendations for pediatric training and experience considerations to be included in the OPTN Bylaws. The Committee met via teleconference on January 15, 2014, to consider the feedback received at the fall regional meetings and potential changes to its recommendations.

The call began with Committee members and UNOS staff recapping questions and comments provided at each regional meeting. With the exception of two regions that didn't express much concern, similar general themes were raised (to varying degrees) at each of the regional meetings. The following issues were recognized as the primary themes of concern:

- Lack of supporting data.
- Recommended requirements will negatively impact pediatric transplant candidates' access.
- Recommended case volumes are too high.
- Transplanting adolescents/larger pediatric patients should not require an approved "pediatric component."

Prior to the call, Committee leadership and UNOS staff discussed possible modifications to the Committee's "pediatric component" key personnel recommendations to accommodate these concerns. After reviewing the regional meeting feedback, the Committee Chair began presenting possible ideas to modify the Committee's recommendations. The first presented idea would eliminate the requirement that the "pediatric key personnel" case volumes are met over a five year period. Including a broad, undefined timeframe to attain the set level of experience would necessitate the addition of to-be-determined requirements that reflect "currency" with pediatric transplantation; e.g., a percentage of the reported cases must have been performed in the past two years. This possible modification is intended to address concerns that the recommended case volumes are too high, and the potential for these Bylaws to impact pediatric candidates' access negatively. Committee members expressed concerns about vast time differences between when one attained their pediatric transplant training/experience and when they may be approved as a "pediatric primary surgeon" or "pediatric primary physician." Committee leadership pointed out that there are no current requirements to check or limit very infrequent involvement with difficult pediatric cases. Additionally, although seemingly intuitive, there is no definitive evidence that infrequently performing these procedures is necessarily problematic. As indicated by the regional meeting feedback, more stringent recommendations will bring more opposition, which likely means the proposal will not pass. The Chair reminded the Committee that it must keep these things in mind and search for an acceptable balance as it develops a proposal.

The Committee proceeded to discuss the criticism that its recommendations, and the need for such, lack supporting evidence. Early discussions indicated consensus that requirements need specific numbers of cases so that transplant hospitals are clear on what is required and so the Membership and Professional Standards Committee (MPSC) has clear parameters to evaluate "pediatric program" applications. Committee members reiterated that it is impossible in this situation to find numerical data that distinguish a significant difference for a requirement that reflects the minimum amount of training and experience. For example, the Committee cannot prove that eight pediatric heart transplants is superior to six (or 10) pediatric heart transplants as a minimum level of necessary experience. The Committee does not believe that its recommendations necessarily reflect profound expertise with pediatric transplants; rather, the requirements reflect that the individual has been exposed to pediatric transplantation and the unique considerations that these cases require. Committee members also pointed out the arbitrary case volumes in the current key personnel Bylaws that are routinely accepted today. The Committee did incorporate some logic in its recommendations by making them a consistent percentage (40%) of the current Bylaws' case volume requirements for each organ-specific program.

The Committee also discussed if its recommendations should solely focus on the youngest/smallest pediatric patients. This would have the potential to address concerns that caring for adolescent patients should not require an approved "pediatric component." The Committee generally agreed that excluding adolescent patients neglects crucial, unique matters faced by teenaged transplant patients (psycho-social matters, development issues, etc.) that require special pediatric expertise. The Committee also expressed concerns about defining "pediatric" other than the commonly accepted less than 18 years of age. A Committee member suggested another option of having pediatric program "tiers" to focus on different age groups (or weights) of patients less than 18 years old (e.g., less than 18-13 years, 12-6 years, 5-0 years).

The mention of patient size prompted the Committee to discuss possible Bylaws requirements that consider experience relative to patients' weights and not their ages. Committee members referenced off-line conversations with transplant surgeons that revealed a general acceptance of the quantifiable risks associated with transplanting smaller children, and that transplanting these patients requires unique skills. Focusing on the patients' weights (especially the smallest patients) is reasonable, but those cutoffs could also be criticized as arbitrary. It would be difficult to explain a difference between transplanting a kidney into a 20kg child as compared to a 19kg child.

Conversation returned to possible requirements to demonstrate currency. The Committee first considered the "primary pediatric kidney surgeon" requirements, and a suggestion that half of the pediatric transplants must have been performed over the last five years. Applying this logic to the Committee's recommendations would require a "pediatric primary surgeon" to have completed six kidney transplants in patients younger than 18 years of age in the past five years. Committee members responded with the suggestion of five transplants in patients younger than 18 years of age in the past five years, simplifying the "currency" requirement to an average of one pediatric transplant per year over the past five years.

To evaluate how reasonable this requirement may be, the Committee referenced a data analysis UNOS staff prepared for the call that evaluated the total number of pediatric transplants performed at each program over the past five years (Figures 1-4). Although potential Bylaws will require "pediatric transplant program key personnel" to have a set level of training/experience, not the transplant program, this analysis provides an approximation of which programs may have difficulty meeting any potential requirements. The Chair asked the Committee to consider, as it reviews the data, the possibility of eliminating the recommendations focused on younger/smaller pediatric transplant recipients. This approach would rely on appropriate medical judgment and outcome reviews to influence which programs care for the youngest, most complicated pediatric cases. Proceeding in this fashion may be more supported by the community as it would avoid limiting high volume, successful programs that focus on older pediatric patients.

The Committee first reviewed an assessment of kidney programs that performed at least one pediatric transplant and whether the *program volumes* could meet the Committee's current recommendations

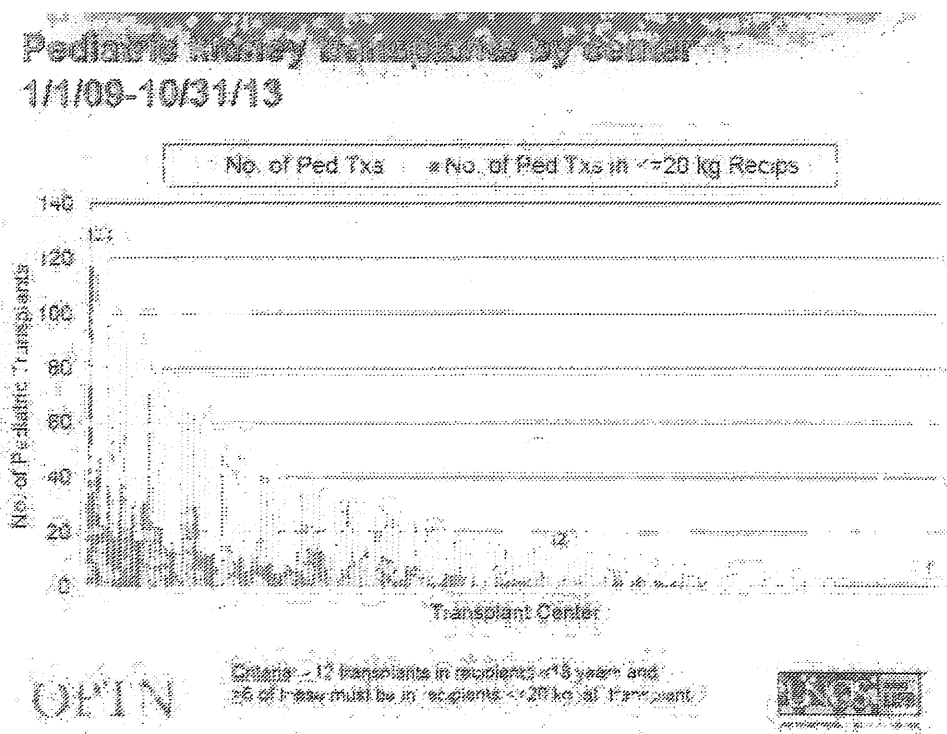


Figure 1: Pediatric kidney transplants by center, 1/1/09- 10/31/13

Figure 1 shows that 150 transplant programs performed at least one pediatric kidney transplant over the five year cohort examined (1/1/09-10/31/13). Of those 150 programs, 83 performed 12 or more pediatric kidney transplants, and 56 of those performed six or more pediatric transplants in recipients that weighed 20 kg or less at transplant. The Committee noted variability across transplant programs, highlighting that programs doing the most kidney transplants in patients that weigh 20 kg or less aren't necessarily the same programs that do the most pediatric patients. This seems to support the notion that appropriate medical judgment and

outcome reviews will influence which programs care for the youngest, most complicated pediatric cases. Accordingly, the Committee was asked if it would be appropriate to remove the requirement that a "pediatric primary kidney surgeon" must have performed at least 6 transplants in patients that weigh 20 kg or less. Committee members asked for clarification on how outcomes are evaluated for programs that do occasional pediatric transplants. The Chair, who is also a member of the MPSC, responded that the MPSC evaluates a program's pediatric and adult transplant outcomes separately. When evaluating a low-volume (currently defined as less than 10 transplants in two and a half years) of pediatric (or adult) outcomes, a single poor outcome flags that program for further review. Even though programs doing occasional pediatric transplants would have their outcomes monitored, some Committee members were still concerned that this would put the youngest/smallest transplant candidates in jeopardy of receiving substandard care. It is accepted that transplanting younger/smaller patients is more challenging, and mistakes in caring for these patients have particularly significant ramifications. In response, the Committee leadership reminded the Committee that this topic has been discussed multiple times over the years, and no solutions have been adopted because consensus has not been reached. The current Bylaws, or even if this Committee's first recommendations were implemented immediately, do not prevent an individual with no pediatric transplant experience from transplanting a kidney into a 15 kg recipient. The Committee must remember that the recommended Bylaws will only address needed requirements for a "primary pediatric surgeon" and a "primary pediatric physician;" the expertise and experience of the program's additional physicians and surgeons will not be addressed by the OPTN. An agreement on a basic pediatric program framework, thereby designating and acknowledging pediatric experience at programs that do pediatric transplants, would drastically improve the current Bylaws, even if it is not the Committee's perfect solution. The Committee agreed to continue contemplating this possibility, and proceeded to review the remaining organ-specific data.

**Pediatric liver transplants by center
1/1/09-10/31/13**

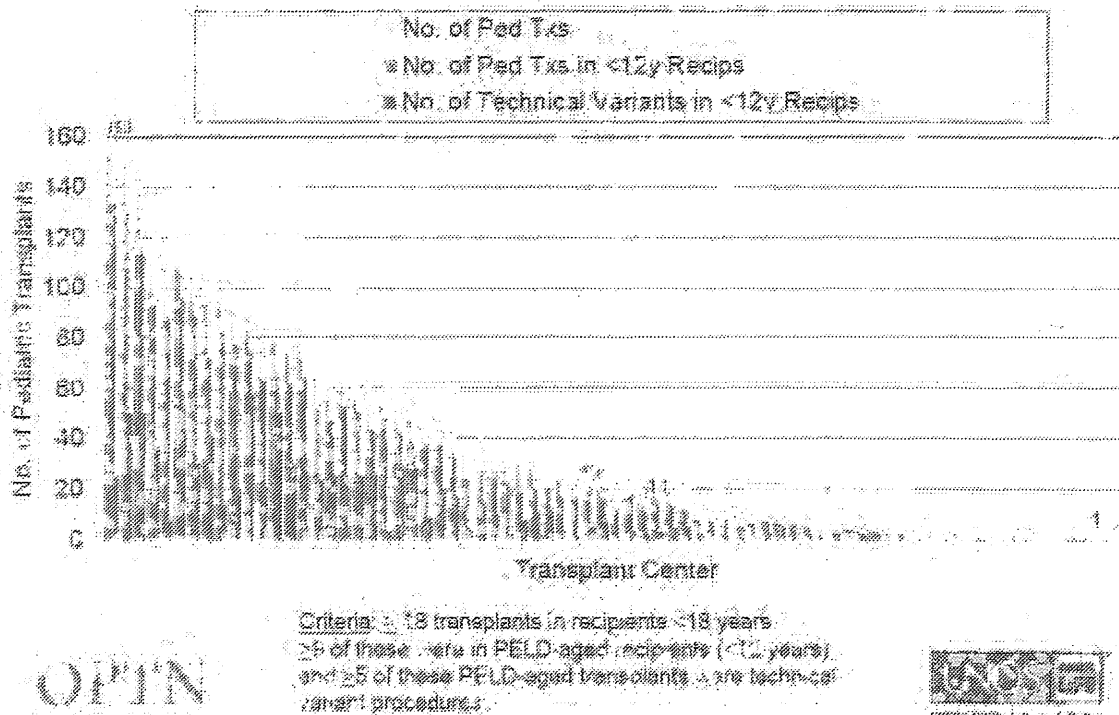


Figure 2: Pediatric liver transplants by center, 1/1/09- 10/31/13

Using the same cohort, the data displayed in Figure 2 show that 75 programs performed at least one pediatric liver transplant. Of these programs, 40 performed 18 or more pediatric liver transplants, 43 programs performed nine or more transplants in patients younger than 12 years old, and 36 programs performed five or more technical variant liver transplants in patients younger than 12 years old. This analysis yielded 32 transplant programs that met all three criteria. Again, the Committee noted program variation. The busiest pediatric liver program did relatively few technical variant transplants. In general, the technical variant requirement seems like it may be the most limiting. With these data, the Committee suggested that the technical variant requirement could inappropriately penalize those programs that are exposed to a high number of pediatric donors, and thus do not need to perform as many technical variant procedures. The Committee also highlighted that a program's number of liver transplants done in patients less than 12 years old is closely related to the program's total number of pediatric liver transplants. Committee members explained this observation by the fact that a majority of liver transplants are performed in pediatric patients younger than five years of age. Considering this parallel and the number of programs that may have difficulty qualifying with the technical variant requirement, should the Committee eliminate the requirements that a "pediatric primary liver surgeons" must perform nine or more transplants in patients less than 12, at least five of which must be technical variant procedures? Considering the close relationship, the Committee also considered if it should recommend only a number of transplants in patients younger than 12 years. Ultimately, participants agreed that the requirement should only focus on the number

of transplants performed in patients younger than 18 years. This would avoid potentially redefining “pediatric” and would accommodate those programs that occasionally transplant livers into teenagers.

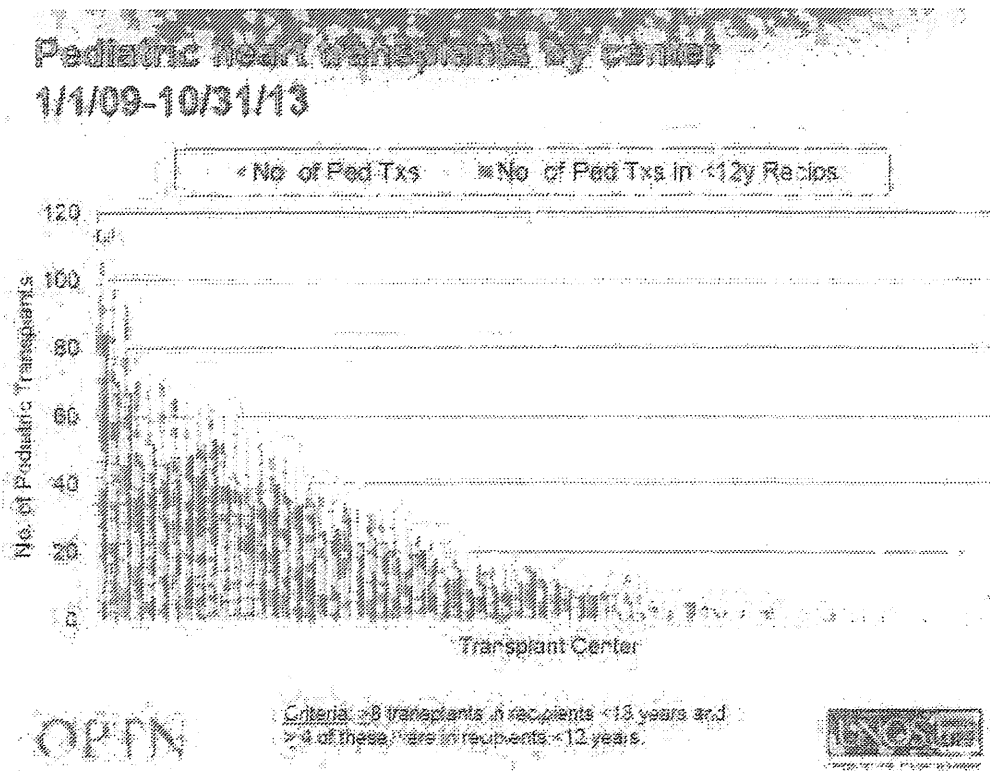


Figure 3: Pediatric heart transplants by center, 1/1/09- 10/31/13

Using the same cohort, the data show 74 programs performed at least one pediatric heart transplant (Figure 3). Of those, 45 programs performed 8 or more pediatric heart transplants and 46 programs performed four or more transplants in patients younger than 12. This analysis showed a total of 43 heart programs that meet the Committee’s recommended *case volume* requirements for a “primary pediatric heart surgeon.” Similar to liver, a significant number of pediatric heart transplants are performed in the youngest/smallest pediatric patients. As such, a program’s volume of heart transplants in patients younger than 12 years seems to be very closely related to the total number of pediatric heart transplants performed. To simplify, and address the concerns of those programs that want to transplant adolescents and not get involved with the youngest/smallest pediatric patients, it seems reasonable to remove all proposed requirements for “pediatric heart programs” with the exception of requiring eight or more pediatric heart transplants. This approach also addresses some concerns that were expressed regarding the inclusion of specific certifications.

**Pediatric lung transplants by center
1/1/09-10/31/13**

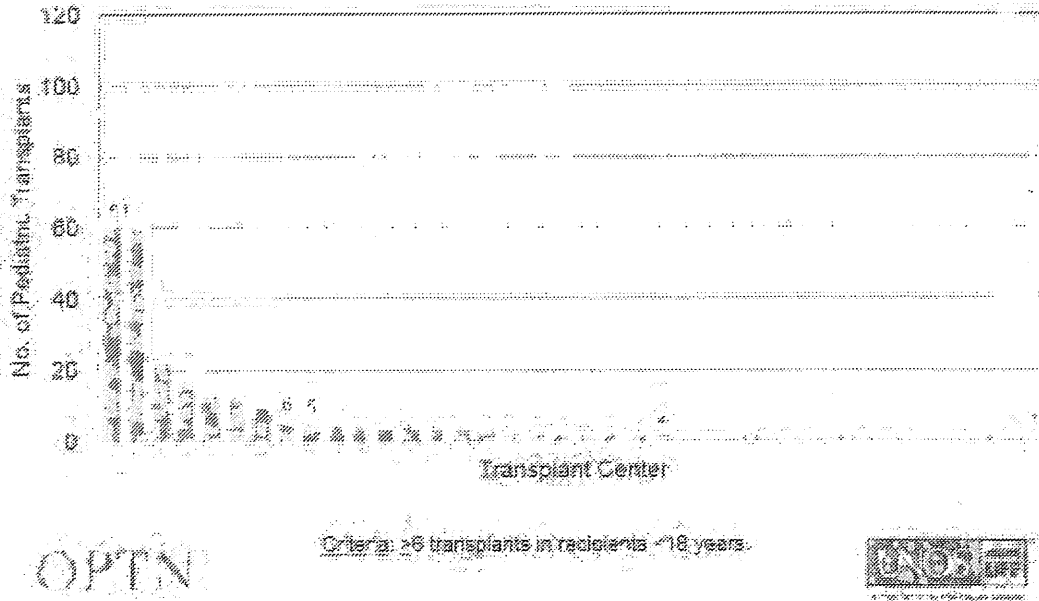


Figure 4: Pediatric lung transplants by center, 1/1/09- 10/31/13

Using the same cohort, a total of 38 centers performed at least one pediatric lung transplant, eight of which did six or more pediatric transplants. The Committee thought that if the certification requirements would be removed for “pediatric primary heart surgeon,” then similar certification requirements should be removed for the “pediatric primary lung surgeon.” The Committee’s pulmonologist was unable to join the call, and the Chair agreed to reach out to him for additional input on the “pediatric lung program” requirements.

To conclude the call, the Committee agreed that Committee leadership and UNOS staff will draft a new set of recommendations based on the discussions had during this call. The new draft will be distributed to the Committee and another teleconference will be scheduled to discuss and refine these recommendations.

Participants:

Pediatric Transplantation Committee

Heung Bae Kim, MD (Committee Chair)

Eileen Brewer, MD (Vice-Chair)

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Betsy Gans

Jory Parker

Chad Waller, MS

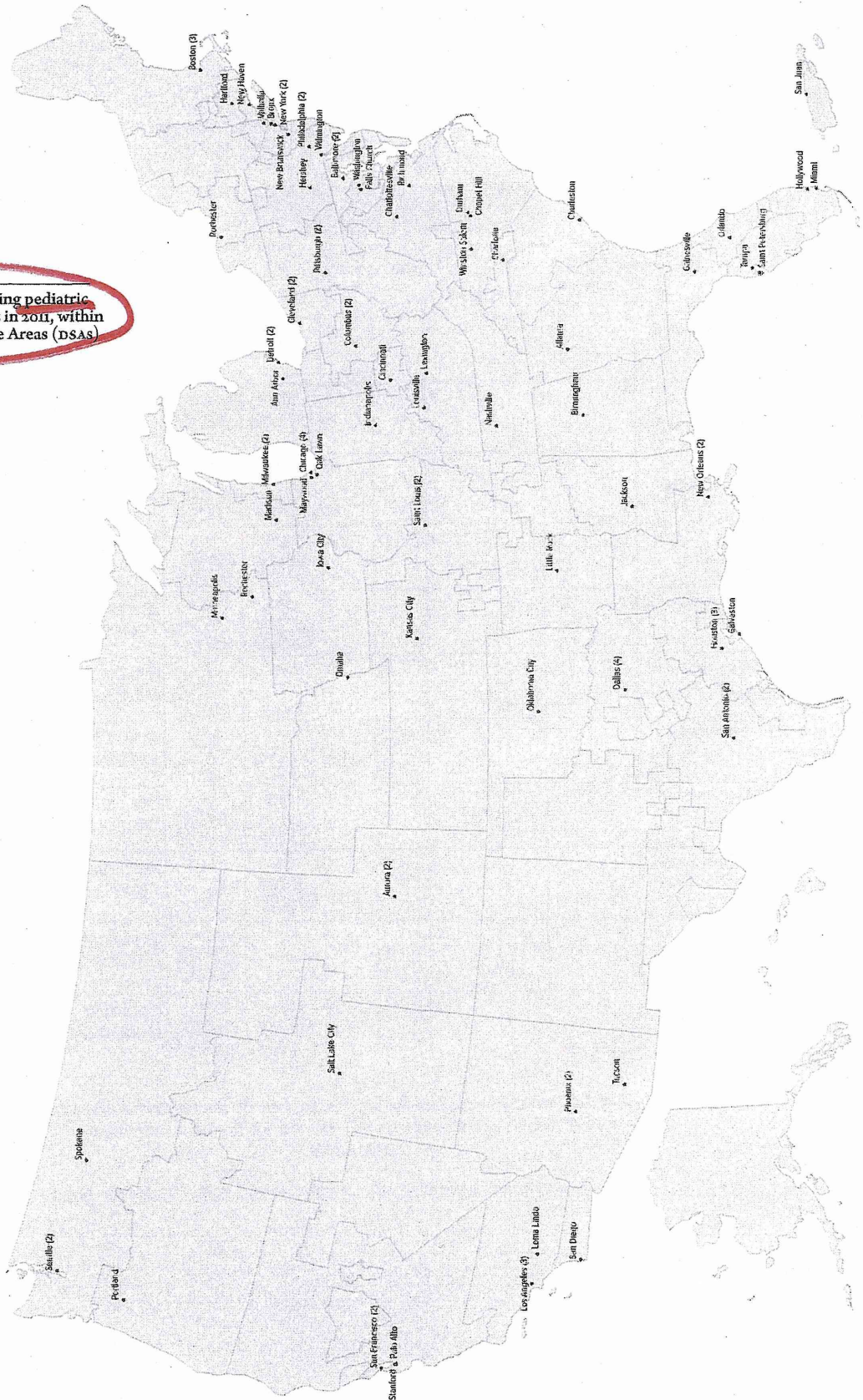
Trevi Wilson, RN

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Susan Leppke, MPH

Jodi Smith, MD

HR 8.2 Centers performing pediatric heart transplants in 2011, within Donation Service Areas (DSAs)





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			Donor Type		Recipient Age		Patient Survival Rate - One Year		
			Living	Deceased	18 & Over	Under 18	18 & Over	Under 18	
OH	Children's Hospital Medical Center, Cincinnati, OH	12		9	0	9	Not Applicable	100%	New Format Traditional Format
PA	Children's Hospital of Pittsburgh of UPMC, Pittsburgh, PA	4		9	1	8	100%	100%	New Format Traditional Format
PA	Children's Hospital of Philadelphia, Philadelphia, PA	13		10	0	10	100%	93%	New Format Traditional Format
SC	Medical University of South Carolina, Charleston, SC	15		24	19	5	100%	80%	New Format Traditional Format
TN	Vanderbilt University Medical Center, Nashville, TN	38		36	29	7	100%	96%	New Format Traditional Format
TX	Children's Medical Center of Dallas, Dallas, TX	30		9	0	9	100%	89%	New Format Traditional Format
TX	Texas Children's Hospital, Houston, TX	21		15	5	10	100%	97%	New Format Traditional Format
UT	Primary Children's Medical Center, Salt Lake City, UT	4		6	0	6	100%	88%	New Format Traditional Format
VA	University of Virginia Health Sciences Center, Charlottesville, VA	20		15	13	2	82%	100%	New Format Traditional Format
WA	Children's Hospital & Regional Medical Center, Seattle, WA	8		10	1	9	Not Applicable	92%	New Format Traditional Format
WI	Children's Hospital of Wisconsin, Milwaukee, WI	19		13	0	13	100%	91%	New Format Traditional Format

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			Living	Deceased	18 & Over	Under 18	18 & Over	Under 18	
MN	University of Minnesota Medical Center, Fairview, Minneapolis, MN	62		23	15	8	93% <small>AS EXPECTED</small>	73% <small>AS EXPECTED</small>	New Format Traditional Format
MO	Cardinal Glennon Children's Hospital, St. Louis, MO	0		2	0	2	Not Applicable	100% <small>AS EXPECTED</small>	New Format Traditional Format
MO	St. Louis Children's Hospital, St Louis, MO	16		18	0	18	100% <small>AS EXPECTED</small>	87% <small>AS EXPECTED</small>	New Format Traditional Format
MS	University of Mississippi Medical Center, Jackson, MS	23		13	10	3	76% <small>LOWER THAN EXPECTED</small>	Not Applicable	New Format Traditional Format
NC	Carolinas Medical Center, Charlotte, NC	11		18	16	2	96% <small>AS EXPECTED</small>	100% <small>AS EXPECTED</small>	New Format Traditional Format
NC	Duke University Hospital, Durham, NC	65		60	52	8	93% <small>AS EXPECTED</small>	83% <small>AS EXPECTED</small>	New Format Traditional Format
NC	University of North Carolina Hospitals, Chapel Hill, NC	19		19	16	3	86% <small>AS EXPECTED</small>	100% <small>AS EXPECTED</small>	New Format Traditional Format
NY	NY Presbyterian Hospital/Columbia Univ. Medical Center, New York, NY	173		77	54	23	89% <small>AS EXPECTED</small>	91% <small>AS EXPECTED</small>	New Format Traditional Format
NY	Montefiore Medical Center, Bronx, NY	23		29	20	9	97% <small>AS EXPECTED</small>	100% <small>AS EXPECTED</small>	New Format Traditional Format
NY	Mount Sinai Medical Center, New York, NY	34		29	27	2	85% <small>AS EXPECTED</small>	70% <small>LOWER THAN EXPECTED</small>	New Format Traditional Format
OH	The Cleveland Clinic Foundation, Cleveland, OH	101		55	53	2	96% <small>HIGHER THAN EXPECTED</small>	100% <small>AS EXPECTED</small>	New Format Traditional Format

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			Living	Deceased	18 & Over	Under 18	18 & Over	Under 18	
FL	Shands Hospital at The University of Florida, Gainesville, FL	59		31	20	11	93%	90%	New Format Traditional Format
GA	Children's Healthcare of Atlanta at Egleston, Atlanta, GA	2		17	1	16	Not Applicable	94%	New Format Traditional Format
IL	Children's Memorial Hospital, Chicago, IL	6		13	0	13	100%	90%	New Format Traditional Format
IL	University of Chicago Medical Center, Chicago, IL	41		25	23	2	83%	100%	New Format Traditional Format
IN	Indiana University Health, Indianapolis, IN	10		22	19	3	91%	100%	New Format Traditional Format
LA	Ochsner Foundation Hospital, New Orleans, LA	38		25	23	2	98%	100%	New Format Traditional Format
MA	Children's Hospital, Boston, MA	11		11	0	11	0%	96%	New Format Traditional Format
MD	Johns Hopkins Hospital, Baltimore, MD	36		16	10	6	76%	94%	New Format Traditional Format
MI	Children's Hospital of Michigan, Detroit, MI	3		3	1	2	100%	75%	New Format Traditional Format
MI	University of Michigan Medical Center, Ann Arbor, MI	50		33	29	4	89%	100%	New Format Traditional Format
MN	Saint Marys Hospital (Mayo Clinic), Rochester, MN	83		29	24	5	96%	100%	New Format Traditional Format

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			Living	Deceased	18 & Over	Under 18	18 & Over	Under 18	
AR	Arkansas Children's Hospital, Little Rock, AR	6		31	0	31	100% <small>AS EXPECTED</small>	84% <small>AS EXPECTED</small>	New Format Traditional Format
AZ	Phoenix Children's Hospital, Phoenix, AZ	2		2	0	2	Not Applicable	Not Applicable	New Format Traditional Format
AZ	St Josephs Hospital and Medical Center, Phoenix, AZ	0		4	0	4	Not Applicable	100% <small>AS EXPECTED</small>	New Format Traditional Format
CA	Childrens Hospital Los Angeles, Los Angeles, CA	4		3	0	3	Not Applicable	100% <small>AS EXPECTED</small>	New Format Traditional Format
CA	Loma Linda University Medical Center, Loma Linda, CA	14		24	10	14	94% <small>AS EXPECTED</small>	88% <small>AS EXPECTED</small>	New Format Traditional Format
CA	Lucile Salter Packard Childrens Hospital at Stanford, Palo Alto, CA	6		13	1	12	100% <small>AS EXPECTED</small>	90% <small>AS EXPECTED</small>	New Format Traditional Format
CA	University of California at Los Angeles Medical Center, Los Angeles, CA	66		52	35	17	94% <small>AS EXPECTED</small>	84% <small>AS EXPECTED</small>	New Format Traditional Format
CO	The Children's Hospital, Aurora, CO	4		16	2	14	100% <small>AS EXPECTED</small>	95% <small>AS EXPECTED</small>	New Format Traditional Format
DE	Alfred I DuPont Hospital for Children, Wilmington, DE	1		7	0	7	Not Applicable	100% <small>AS EXPECTED</small>	New Format Traditional Format
FL	All Children's Hospital, St. Petersburg, FL	0		6	0	6	Not Applicable	100% <small>AS EXPECTED</small>	New Format Traditional Format
FL	Joe DiMaggio Children's Hospital, Hollywood, FL	2		3	0	3	Not Applicable	100% <small>AS EXPECTED</small>	New Format Traditional Format

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Compare US Hospitals with Heart Transplant Centers

WASH, VAMC, PRCC, OHCH, NEUN, KYKC, IAIV, ALUA

State	Hospital	As of 12/31/2011 Number of Candidates	Transplant (1/1/11 - 12/31/11)				After Transplant (1/1/09 - 6/30/11)		View Report
			Donor Type		Recipient Age		Patient Survival Rate - One Year		
			Living	Deceased	18 & Over	Under 18	18 & Over	Under 18	
AL	University of Alabama Hospital, Birmingham, AL	23		32	22	10	94% <small>AS EXPECTED</small>	100% <small>AS EXPECTED</small>	New Format Traditional Format
IA	University of Iowa Hospitals and Clinics, Iowa City, IA	13		16	15	1	85% <small>AS EXPECTED</small>	100% <small>AS EXPECTED</small>	New Format Traditional Format
KY	Kosair Childrens Hospital, Louisville, KY	0		1	0	1	Not Applicable	50% <small>AS EXPECTED</small>	New Format Traditional Format
NE	The Nebraska Medical Center, Omaha, NE	14		17	16	1	88% <small>AS EXPECTED</small>	100% <small>AS EXPECTED</small>	New Format Traditional Format
OH	Nationwide Children's Hospital, Columbus, OH	3		1	0	1	100% <small>AS EXPECTED</small>	86% <small>AS EXPECTED</small>	New Format Traditional Format
PR	Cardiovascular Center of Puerto Rico and the Caribbean, San Juan, PR	1		6	5	1	93% <small>AS EXPECTED</small>	100% <small>AS EXPECTED</small>	New Format Traditional Format
VA	Medical College of Virginia Hospitals, Richmond, VA	35		19	18	1	84% <small>AS EXPECTED</small>	Not Applicable	New Format Traditional Format
WA	Sacred Heart Medical Center, Spokane, WA	17		10	9	1	88% <small>AS EXPECTED</small>	Not Applicable	New Format Traditional Format

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- [Transplant Program Reports](#)
- [Methodology](#)
- [Risk-Adjustment Models \(Transplant Programs\)](#)
- [Risk-Adjustment Models \(OPO\)](#)
- [Transplant Report Timeline](#)
- [OPO Report Timeline](#)
- [Past Notices](#)
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Appendix H: Membership and Personnel Requirements for Heart Transplant Programs

This appendix describes the information and documentation transplant hospitals must provide when:

- Submitting a completed membership application to apply for approval as a designated heart transplant program.
- Completing a Personnel Change Application for a change in key personnel at a designated heart transplant program.

This appendix does not include the general membership requirements that all transplant programs must meet, which are described in *Appendix D: Membership Requirements for Transplant Hospitals and Transplant Programs* of these Bylaws.

For more information on the application and review process, see *Appendix A: Membership Application and Review* of these Bylaws.

H.1 Program Director, Primary Transplant Surgeon, and Primary Transplant Physician

A heart transplant program must identify at least one designated staff member to act as the transplant program director. The director must be a physician or surgeon who is a member of the transplant hospital staff.

The program must also identify a qualified primary transplant surgeon and primary transplant physician, as described below. The primary surgeon and physician, along with the program director, must submit a detailed program Coverage Plan to the OPTN Contractor. For detailed information about the Program Coverage Plan, see *Section D.5.B. Surgeon and Physician Coverage (Program Coverage Plan)* of these Bylaws.

H.2 Primary Heart Transplant Surgeon Requirements

A designated heart transplant program must have a primary surgeon who meets *all* the following requirements:

1. The surgeon must have an M.D., D.O., or equivalent degree from another country, with a current license to practice medicine in the hospital's state or jurisdiction.
2. The surgeon must be accepted onto the hospital's medical staff, and be on site at this hospital.

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3. The surgeon must have documentation from the hospital credentialing committee that it has verified the surgeon's state license, board certification, training, and transplant continuing medical education, and that the surgeon is currently a member in good standing of the hospital's medical staff.
4. The surgeon must have current certification by the American Board of Thoracic Surgery or its foreign equivalent. In the case of a surgeon who has just completed training and whose board certification in thoracic surgery is pending, the Membership and Professional Standards Committee (MPSC) may grant conditional approval for 24 months to allow time for the surgeon to complete board certification, with the possibility of renewal for one additional 24-month period.

In addition, the primary transplant surgeon must have completed at least one of the training or experience pathways listed below:

- The formal cardiothoracic surgery residency pathway, as described in *Section H.2.A. Cardiothoracic Surgery Residency Pathway* below.
- The 12-month heart transplant fellowship pathway, as described in *Section H.2.B. Twelve-month Heart Transplant Fellowship Pathway* below.
- The heart transplant program clinical experience pathway, as described in *Section H.2.C. Clinical Experience Pathway* below.

A. Cardiothoracic Surgery Residency Pathway

Surgeons can meet the training requirements for primary heart transplant surgeon by completing a cardiothoracic surgery residency if *all* the following conditions are met:

1. The surgeon performed at least 20 heart or heart/lung transplants as primary surgeon or first assistant during the cardiothoracic surgery residency. These transplants must be documented in a log that includes the date of transplant, role of the surgeon in the procedure, and medical record number or other unique identifier that can be verified by the OPTN Contractor. This log must be signed by the director of the training program.
2. The surgeon performed at least 10 heart or heart/lung procurements as primary surgeon or first assistant under the supervision of a qualified heart transplant surgeon during the cardiothoracic surgery residency. These procedures must be documented in a log that includes the date of procurement, location of the donor, and Donor ID. This log must be signed by the director of the training program.
3. The surgeon has maintained a current working knowledge of all aspects of heart transplantation, defined as a direct involvement in heart transplant patient care within the last 2 years. This includes performing the transplant operation, donor selection, use of mechanical assist devices, recipient