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Editor’s Letter

How many times have you managed a clinical situation that you’ve never personally seen before? Isn’t the need to make important judgments in the absence of definitive data, or huge clinical experiences the very essence of transplant surgery? Aren’t these moments what make your career intellectually challenging and thrilling? While you will ultimately decide how to proceed and what to advise your patient, communication with other transplant experts can be exceptionally helpful. ASTS and the Communications Committee have been hard at work creating mechanisms to facilitate these important interactions.

Centerspan has been an important forum for expert level, international, 24/7 internet discussions of a wide variety of transplant related issues since 2002. Centerspan will soon be moving to the ASTS website. For those who have already participated in some of these exchanges, and those who have lurked without exposing their presence (including government officials and third party payer executives), the rapid opinions posted offer multiple perspectives, links to published data and, often, voluntarily provided availability of a discussant possessing relevant knowledge for off-line consultation. Importantly, this communication also offers a type of virtual yet precious camaraderie spanning specialties, nationalities, and politics.

The Communications Committee also has other initiatives, such as the Online Clinical Forums. To reach these case discussions, go to the ASTS website (http://www.asts.org), through the Members’ Portal (log in with your user name and password), under Tools (left side of the page), and click on Message Board. Each of the seven categories (Cellular Transplantation, Heart, Kidney, Liver, Lung, Pancreas and Small Bowel) hosts forums on Research Projects and General Discussion topics. Why not be the first to start a forum?

Keep reading Chimera for breaking information on the other new opportunities in development.

The proposal to base kidney allocation on LYFT (life years following transplantation) has been hot and controversial. ASTS members have played major roles in the discussion. Dr. Richard Freeman summarizes the most recent events in the very public debate. The updates on ASTS involvement in past and current Legislative Activities, and in Regulatory and Reimbursement issues should also be included in your required reading.

Some communications are best in person. Apparently, many ASTS members agreed, as attendance at this year’s ASTS Winter Symposium in Marco Island was record-breaking. During the meeting the second Chimera Chronicles, focusing on Great Stories in Transplantation was filmed and will soon be available.

It would be an oversight not to mention the recent accomplishment of the first U.S. face transplant by the Cleveland Clinic team led by Dr. Maria Siemionow. Lay press and media communication about this event was so effective that multiple, simultaneous observers immediately proposed sending a Connecticut woman whose face sustained extensive injury from a chimpanzee’s attack a few weeks later, directly to the face transplant team’s home base!

This type of rapid patient referral for such an experimental transplant, based on knowledgeable consideration of available alternatives, even prior to publication in the medical literature would have seemed unimaginable to Dr. Willem Kolff. This Lasker prize winning surgeon credited with development of both the artificial kidney and artificial heart, has just died at the age of 97 years. He did not conceive of the enormous number of patients his innovations would benefit or of the range of transplantation procedures that would evolve in great part, because of the supportive therapies he developed. This brave and focused inventor with limitless imagination would only have been thrilled by the collaborations of ASTS members in seeking to better the lives of increasing numbers of patients. One must wonder what else he might have accomplished if he had been able to use any or all of these Communications Methods now available at our fingertips. Let us honor him by embracing these new directions in Transplantation, and by choosing to be active participants in ASTS.

Best Regards,
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About the Cover
The cover photo is of a transplanted pancreas allograft, which was part of a simultaneous living donor kidney and deceased donor pancreas transplantation which Dr. Jacqueline A. Lappin has pioneered at Memorial Hermann Hospital-Texas Medical Center. Lappin heads the Pancreas Transplant Program and performed the surgery with Dr. Jose Benito A. Abraham, Clinical Fellow at the Organ Transplantation Program of the University of Texas Health Science Center.

ASTS is grateful to Dr. Abraham for sharing his photo.

If you have a photo that you would like displayed on the cover of the Chimera, please e-mail it along with a brief description to Chantay Parks Moye.
This is the last of my missives for the Chimera as the ASTS president. From this point forward, there are less than 2 months remaining in my term. Fortunately or unfortunately, there is no lame duck time in this presidency.

The Obama administration is going to create opportunities and challenges for the world of transplantation. One of the opportunities will present itself within the monies that have been allocated to the NIH for scientific inquiry. The challenges are going to be evident in the forthcoming changes in the delivery of health care.

As an opportunity, the increased funding may provide for better chances for grant funding. I would hope that members who have had trouble with grant funding in the recent past would renew their efforts to obtain funding. There are also a series of Challenge grants that could have applicability to transplantation (http://grants.nih.gov/grants/guide/rfa-files/RFA-OD-09-003.html#Section1). The timeframe for submitting these challenge grants is quite short with an application due date of April 27th. There may be additional funds available for Comparative Effectiveness Research (CER). Projects receiving these funds will need to meet this definition of CER: “a rigorous evaluation of the impact of different options that are available for treating a given medical condition for a particular set of patients.” Such a study may compare similar treatments, such as competing drugs, or it may analyze very different approaches, such as surgery and drug therapy.”

There are many aspects for transplantation that could be examined using this mechanism such as a comparison of resection versus transplantation for small hepatocellular carcinoma.

The Society needs to prepare itself for the inevitable changes in health care that are appearing on the horizon with the new administration. I, for one, believe that there is the political will to make these changes. This will is going to be strengthened by the massive debt that the country is accumulating and the increasing burden of Medicare on the financially strapped country. I don’t think that the Society alone can have much effect on changing the overall course of this policy development; but, in combination with other, larger organizations, we may be able to keep the ship off the rocks.

What the Society needs to focus on is assuring that the issues specific to transplantation are heard so that we are not drowned in a deluge of rapid changes made to the system. The issues regarding transplantation are frequently unique and our patients, who are gravely ill, but with hope, need to be protected from the currents. To this end, we have had a presence in both the legislative and regulatory processes on Capitol Hill. Peter Thomas, who is our ASTS legislative counsel and lobbyist on the Hill, was invited to take part in the recent health care summit at the White House and is in a good position to alert us to changes in policy that impact our patients. Chair, Dr. Richard Freeman, and other Legislative Committee members have been active in Washington. They participated in their first “Fly-In” of the year April 1st.

What we all need to do is to make our voices heard in the discussions. For example, there are going to be regional forums in a number of states to have broader discussions about health care (http://thecaucus.blogs.nytimes.com/2009/03/06/white-house-plans-regional-health-care-forums/). Our members should participate in these types of forums in order to gain knowledge about the direction of the changes and to assure that our concerns are heard. We should be willing to work with our elected representatives in Washington during what is going to be a drawn out legislative and regulatory process. ASTS has done a lot of work in the past in these areas and we should be well positioned for the future.

Another important set of issues for the Society involve the policy developments by the OPTN. Currently there are 8 policy proposals available for public comment on the OPTN website (http://www.optn.org/policiesAndBylaws/public-Comment/proposals.asp). It is important that our membership be aware of these proposals and submits comments. ASTS will be developing comments and we are interested in your thoughts.

Two of the policy proposals deal with wider sharing of livers for transplantation. These proposals include sharing of Status 1 livers regionally and allocation of livers regionally by MELD/PELD. We expect these proposals to be controversial.
ASTS has been involved with the development of the kidney allocation policy. ASTS representatives formulated a response to the RFI promulgated by UNOS (http://www.asts.org/Tools/Download.aspx?fid=889), and the representatives attended the public forum in St Louis. The concerns with the proposal primarily centered on the use of the metric termed “Life Years From Transplant” (LYFT). This metric was to allow calculation of the benefit of transplantation from both the decreased pre-transplant mortality associated with transplant and the life years gained after transplantation. Some of the issues with LYFT were that it did not do a good job with predicting outcome (relatively poor concordance) and the long time horizons chosen for the metric. Overall, the policy was far too complex. The ASTS has suggested that the UNOS Kidney Committee step back and reassess the goals of allocation. One goal that has relatively good acceptance is not to use kidneys from young donors in patients who are very old. This situation has become more frequent because of the dramatic aging of patients on the waiting list. Because of the greater number of older patients, younger patients cannot compete well as there is little direction in the allocation of kidneys based upon age. Examination of waitlist additions demonstrates that the number of younger patients approximates the number of kidneys from younger donors. ASTS has proposed using kidneys from donors less than 35 years of age in recipients younger than 35, similar to the current policy for patients younger than 18. This is a relatively straightforward method to achieve the goal noted above. The Kidney committee has returned to the drawing board to re-tool the proposal, most likely without the inclusion of LYFT.

One area of tremendous success has been the joint venture of ASTS and AST in the development of the American Journal of Transplantation. The growth of the journal has been spectacular. The impact factor of the Journal is now the highest among the transplant journals and is second only to the Annals of Surgery in impact factor among surgical journals. We are all indebted to Dr. Philip Halloran (Phil) who has been the editor since the inception of the journal. Phil has been amazing in his dedication to the journal and the revolutionary success of the Journal is testament to his hard work. Unfortunately, Phil is retiring as editor of the journal. Over the next year the societies will be searching for a new editor. Ideally, this would be someone who could bridge both the basic science and clinical areas as Phil did so well. We hope that there will be strong interest in the editorship position among the community.

At the time of the Congress, new committee members and committee chairs will be appointed. I would hope that those of you who are interested in getting involved have applied for positions on the committees. ASTS also accepted nominations for president-elect, treasurer and three councilors.

In just over a month, my term will be over. It has been a very interesting and rewarding year. As I said in my first letter: “Over the last several years, I have had the opportunity to observe the issues that the ASTS president has to face. The whole process is like tending a garden where the gardener changes each year. There are new urgent issues that need immediate attention but usually can be solved quickly much like weeding. There are other issues that are new and require time to solve and, much like planting a tree, most of these issues take several years to mature to fruition. Some issues require protecting the garden from disease.” We have sowed a lot of seeds during this past year, and there has not been a lot of weeding or pest control necessary. I think the garden is improving but there are huge challenges ahead for us.

John P. Roberts, MD
The ASTS Winter Council and Committee Chair Meeting was held January 14-15, 2009 in Marco Island, FL. Following are select committee news and reports for the meeting.

**Ad Hoc Composite Tissue Allotransplantation (CTA) Committee**

Dr. Linda Cendales thanked the council for establishing the new ad hoc committee and provided background information about CTA and the evolution of the field. Dr. Cendales stated that the ASTS could benefit the progress of CTA as the complexity of CTA mandates that this procedure be driven by surgeons and classified as an organ from a regulatory standpoint. She presented a mission statement focused on education, research and professional development.

**American Board of Surgery**

Dr. Douglas Hanto reported on the proceedings at the recent American Board of Surgery (ABS) retreat. The ABS has reviewed the preliminary results of the Association of Program Directors (APDS) survey of general surgery program directors and residents regarding the resident experience on transplant rotations. There were no huge discrepancies between program director and resident responses to date but the biggest issue appears to be with residents that have to travel to another institution for the rotation. A follow-up survey with a control group is performed in two years to give the curriculum time to be implemented and used by residents. The ABS continues to deliberate the concept of recertification with focused expertise and has identified two areas that ASTS would need to improve before a program could be implemented. To support MOC Part 2, lifelong learning and self-assessment, ASTS would need to develop an ongoing activity that could be assessed such as monthly articles with an annual exam. To support MOC Part 4, evaluation of performance in practice, individuals would need to participate in an outcomes database that was surgeon specific. Dr. Hanto reported that SRTR and OPTN/UNOS data were not acceptable to ABS due to the lack of an audit function and the need to include quality indicators beyond graft survival.

**Awards Committee**

Dr. Ginny Bumgardner reported on behalf of Dr. Humar that the deadline for 2009 research awards had been extended until January 22, 2009 and a summary of the 2009 applications will be presented at the May council meeting. Dr. Bumgardner also reported that ASTS has received several questions from members interested in applying for the ASTS – Astellas David Hume Bridge Award that did not apply to the NIAID but another institute within the NIH. The committee would like to investigate establishing a similar relationship with other institutes so this award could be more encompassing. The council agreed with the committee and encouraged them to work with other institutes.

**Bylaws Committee**

Dr. Stuart Flechner reported the transition to online voting for the quarterly membership ballot has increased member participation. The committee is poised to help in the creation of a surgical associate committee as needed and will propose relevant bylaws changes.

**CME Committee**

Ms. Kim Gifford reported on behalf of Dr. Kinkhabwala that ASTS is due for reaccreditation by the Accreditation Council for Continuing Medical Education (ACCME) this year. The National Office will work with Amedco, the CME consultant, to prepare the application. The interview will occur during the fall. The overwhelming response to the call for comments regarding commercial support of CME activities. Due to the level of feedback, ACCME will continue to discuss the matter and has postponed a decision until late in 2009.

**Communications Committee**

Dr. James Whiting reported that the committee continues to look for new ways to engage the membership through the website and other means of communication. He reported that the December Chimera issue was in circulation and continues to be well received. The committee is working with Tii to add RSS (Real Simple Syndication) feeds to the ASTS website. This will allow people to sign-up to automatically receive website updates based on their areas of interest.

**Critical Care Task Force**

Dr. Dinesh Ranjan reported that the task force is hosting a luncheon symposium at the winter symposium titled “Management of the Wrong Organ for the Wrong Recipient” to complement the winter symposium topic: “The Right Organ for the Right Recipient.” Dr. Ranjan reported that ongoing initiatives include the development of unit objectives for the online curriculum and a transplant critical care manual. Dr. Ranjan presented the draft ASTS white paper on the prerogative of the transplant surgeon in the ICU care of transplant patients. He asked the council and committee chairs to review the document and provide feedback so the paper can be finalized.

**Fellowship Training Committee**

Dr. John Magee presented evaluation data from the fellows’ symposium and thanked the Society for its support of ASTS CME activities. Finally, Ms. Gifford reported that ACCME received an overwhelming response to the call for comments regarding commercial support of CME activities. Due to the level of feedback, ACCME will continue to discuss the matter and has postponed a decision until late in 2009.
the meeting. The committee believes this meeting is of great value to fellows as it covers topics not addressed in clinical training and engages fellows early in their careers. If funding can be secured for the 2010, Dr. Magee proposed the planning committee consist of Drs. Geevarghese, Collins and Fryer. The council discussed the “Quality vs. Quantity” program instituted in 2006 and requested that Dr. Magee present detailed information about this program at the next council meeting along with committee recommendations regarding continuing this program.

**Historian Report**
Dr. Thomas Peters reported that the videos of the first group of Chimera Chronicle honorees are in the final phase of editing. The design and development of the online content is ongoing and ASTS plans to have the first two filming sessions available online by May 2009. Dr. Peters also presented an update on the second taping schedule to take place during the ASTS 9th Annual State of the Art Winter Symposium. He stated that six participants will be filmed for the Chimera Chronicles library (full report page 20).

**Membership Committee**
Dr. Paul Kuo reported that the September 30, 2008 quarter represented the highest number of applications in the history of the ASTS with fifty-five applications approved. Overall, membership increased by 12.4% in 2008 and the current count is 1320. Dr. Kuo reported that the committee continues to develop strategic approaches to increase and broaden membership through mailings, collaboration with NATCO, and the recent initiative to attract nurse practitioners (NP) and physician assistants (PA). NATCO notified its members of the new collaboration in October and approximately 70 NATCO members expressed interest in dual membership with ASTS. The ASTS national office will work with these individual NATCO members to complete the membership process.

**Scientific Studies Committee**
Dr. David Gerber presented data from the DonorNet follow up survey. While the committee is still in the preliminary stages of their analysis, Dr. Gerber noted that there was an increase since the previous survey in the number of surgeons taking the primary calls for organ offers (up 8%), 66% reported their center had an effective plan in place for the implementation of DonorNet, 75% reported no personnel had resigned, 63% considered the information more reliable than the phone-based process (up from 43%) and 47% rated the system as “good” (up from 29%). Dr. Gerber will work with the ASTS national office to sort the data by organ and will provide a final report at the May Council Meeting.

**Standards Committee**
Dr. David Mulligan reported that the committee had successfully completed the recommendations on standards for organ procurement and recommendations for guidelines for DCD organ procurement and transplantation. Dr. Mulligan submitted both documents to UNOS/OPTN. Dr. Mulligan then presented revised recommendations for the definition of a transplant surgeon. The council decided that the current experience criteria are too broad. The committee will remove the currency criteria and develop alternate pathways that do not endanger senior members. Finally, Dr. Mulligan presented two new committee initiatives, drafting recommendations for combined liver and kidney transplantation and standards for evaluating and using donors with infection/transmission risks. At the suggestion of the council, the committee will examine the use of kidneys for transplant where the donor has renal cell carcinoma.

**Vanguard Committee**
Dr. Randall Sung provided an update on the 2009 Winter Symposium program and associated events. Dr. Sung reported that of the 124 abstracts submitted, 15 were accepted for oral presentation, 9 for mini-oral presentation, 74 for poster presentation for an overall acceptance rate of 79%. Dr. Sung also highlighted the special features including the Chimera Chronicles lecture featuring Dr. William Pfaff, career development symposium, standards committee presymposium, business practice seminar, critical care luncheon symposium, FMG task force event and two satellite symposia (full report page 16).

Dr. Sung announced the 2010 winter symposium will be titled “The Cutting Edge of Transplant Surgery” and scheduled for January 15-17, 2010 at the Marriott Harbor Beach in Ft. Lauderdale, FL. The 2010 pre-meeting is titled “Clinical Research in Transplantation.”

A full listing of all ASTS committees and their mission can be found at www.asts.org/Society.
The 111th Congress commenced early this year to give the new Obama Administration an early start in tackling the fiscal woes of the nation. Democrats now hold a substantial majority in both houses of Congress and this reality will likely impede the minority party’s ability to slow or kill legislation, especially in the House. Despite this enhanced Democratic control, the 2008 elections failed to seat 60 Democrats, thereby requiring bipartisanship to ensure passage of legislation in the Senate. This also means the minority party will keep a powerful negotiating tool to achieve its legislative objectives.

The Obama Administration has hit the ground running by tackling a number of campaign pledges including the expansion of health insurance coverage for children, passing an omnibus spending bill to fund federal programs and agencies through the rest of the fiscal year. In addition, an economic recovery package that will provide relief to states and funding for infrastructure projects that are designed to stimulate the economy and spur job growth through increased federal spending. In early March, the President fulfilled another campaign promise by lifting the federal ban on stem cell research. Depending on which side of the political spectrum one sits, these expenditures are either vital to re-start the economy while tackling difficult health care problems, or they represent a huge and unnecessary shift of debt onto future generations.

Key components of the ARRA include a $10 billion increase for NIH research funding, $1.1 billion for comparative effectiveness research to examine the clinical and cost effectiveness of particular treatments, and a $19 billion investment in Health Information Technology (HIT) through Medicare and Medicaid. This last provision will significantly boost the amount of resources available to capitalize the electronic medical records platform, providing incentives (including out-year penalties for non-compliance) for physicians and hospitals to adopt HIT within the next decade.

Other provisions include a nearly $90 billion boost for state Medicaid programs, an extension to COBRA insurance coverage for employees who lose their jobs during the recession, and a repeal of the 3% withholding tax on Medicare payments to health care providers.

The early Congressional start allowed for a behind-closed-doors conference on the remaining 2009 spending bills. On February 25, the House passed a $410 billion FY 2009 omnibus spending bill, finishing up the work that could not be resolved by the last Congress. The bill currently funds a number of agencies including the Department of Health & Human Services at 2008 levels under a continuing resolution (CR). At the time of this writing, both the House and Senate were set to extend the CR for an additional week to allow the Senate time to consider and pass a final bill.

The bill provides about $152 billion to labor, health & human services and education programs, nearly a $6 billion increase over 2008. Under the current omnibus package, HHS receives a 4% increase which the Bush Administration had proposed cutting in 2009.

**Health Resources and Services Administration (HRSA):** Within the $7.25 billion for HRSA, the Division of Transplantation, the agency that oversees and funds the organ allocation system in this country, receives about $24 million, which is nearly $1.5 million over the 2008 funding level. ASTS and others actively sought this additional funding in the transplant community. It is the first time new federal dollars has been appropriated to fund the programs under the Organ Donation and Recovery Improvement Act.

**National Institutes of Health (NIH):** The bill also provides just over $30 billion for NIH, over $1 billion more than the budget request. After accounting for this increase and the additional temporary funding in the recent stimulus legislation, NIH will have $11 billion over their existing budget to spend over the next two years. Before this infusion, funding for NIH projects had been critically low and now NIH will be able to fund almost 10,600 new research grants.

The National Institute of Diabetes, Digestive and Kidney Diseases is provided $1.76 billion in funding, almost $60 million more than in 2008.
The National Heart, Lung, and Blood Institute is provided just over $3 billion, an increase of $79 million in funding.

The National Institute of Allergy and Infectious Diseases is provided $4.4 billion, an increase of $138.8 million in funding.

**PRESIDENT OBAMA’S FY 2010 BUDGET**

On Thursday, February 26, in preliminary budget documents (a full proposal will be released in April), President Obama released a summary of his $3.55 trillion FY 2010 federal budget. The budget was termed “honest” by Administration officials because it eliminated budget devices used by previous administrations to disguise the magnitude of federal outlays, in particular, war spending. This proposal contains a number of big-ticket spending items as well as tax increases on top income brackets, both of which quickly came under fire in Congress and in the news media. The White House asserted that it had closely reviewed the budget and found $2.2 trillion in savings over ten years to help pay for many of its new initiatives.

As is the case every year, however, the President’s proposal is just the first step in a lengthy budget process and it is not a law but a non-binding resolution that frames consideration of the many appropriations bills that fund the agencies and programs of the federal government. In years past, Congress has not adopted many of the President’s proposals in the budget process.

**Health Care Reform:** As in other areas, the Administration’s budget does not contain many specifics about the President’s plan to overhaul health care. However, the Administration did outline eight principles for a healthcare overhaul, including: reduce the cost of premiums and protect families from bankruptcy as a result of health bills; invest in prevention; reduce waste and inefficiencies; put the nation on a path to universal coverage; make health plans portable; allow Americans to keep employer-based plans; improve safety; and make the plan pay for itself.

**Health Care Reform Reserve Fund:** The President’s budget proposes to create a $634 billion “reserve fund” over the next decade to finance expanded health insurance coverage and other health care investments. The reserve fund is likely a little more than half the cost of health care reform that is expected to eventually provide universal health care coverage. Congress will be expected to find additional savings to make up the difference.

The reserve fund would be paid for through tax increases on high income Americans and Medicare cuts. Approximately half of the fund would be generated by increasing taxes on couples earning more than $250,000 a year and individuals earning more than $200,000 a year. Cuts in subsidies to Medicare managed care plans and changing the Medicare Advantage program so that plans bid to provide Medicare benefits and the program pays based on the average bid are expected to yield $175 billion in savings over 10 years.

**Other Health Reform Funding:** Other sources of funding include savings from “bundling” payments for hospitals and post-acute care services ($17.8 billion)—a very controversial proposal that some say is unworkable—reducing hospital payments for patients who are readmitted to the acute care hospital ($8.4 billion), linking a portion of Medicare payments to the quality of care delivered as hospitals ($12 billion), increased Medicaid drug rebates ($19.6 billion), and increased Part D drug premiums for higher income beneficiaries ($8.1 billion), amongst other cuts. In addition, the budget calls for unspecified restrictions on physician owned hospitals and incentives for physicians to administer flu vaccinations (both with negligible savings and with no policy explanation).

The new budget would also create a regulatory pathway to allow the Food and Drug Administration to approve generic or follow-on versions of biotechnology drugs. The budget documents state that the Administration will support FDA’s efforts to allow Americans to buy safe and effective drugs from other countries (“drug reimportation”). Other savings would come from streamlining certain programs, such as linking Medicare physician payments to the quality of care provided.

**Fixing the Physician Fee Schedule:** The budget proposal includes $329.6 billion over the next 10 years to fix the Medicare physician fee schedule problem. If adopted by Congress, this would effectively eliminate the enormous deficit and scheduled Medicare physician payment cuts of 40% that result from the Sustainable Growth Rate “SGR” formula over the next seven years. While the full impact is hard to gauge, such a large financial commitment would seem to meet the AMA’s desire for a realistic budget baseline to solve this problem and assumes Congress will continue to protect against further SGR cuts. In addition, the Administration would support comprehensive, fiscally responsible, reforms to the SGR payment formula and moving to a system of better incentives for high-quality care rather than simply more care.

**Cancer:** The budget also calls for the doubling of funding for cancer research, primarily through the National Institutes of Health. It also accelerates the adoption of electronic health records, and would create a nurse home visitation program within the Department of Health and Human Services (HHS).
CMS Considers Transplant Center Appeals Based on “Mitigating Factors”

Transplant centers that have been denied certification for failure to meet the new certification standards can seek review based on “mitigating factors.” This review focuses on considerations outside of the survey criteria, which may justify failure to meet a particular condition. This review is conducted by the CMS central office, in order to assure that a consistent standard is applied throughout the country. By contrast, the reviews conducted by the survey agencies, under the supervision of the CMS Regional Offices, focuses on whether a center’s plan of correction adequately addresses the deficiencies cited as the result of the survey.

As of February 1, 2009, CMS reports that it completed action on mitigating factors requests from 21 transplant center programs. Nine of the requests (43%) were approved. Seven of the nine were related to patient or graft outcomes, all seven of those programs were able to demonstrate substantial program improvements that had been implemented, and institutionalized, significant evidence of improved outcomes subsequent to the changes, and projected compliance with outcomes requirements based on current outcomes. An effective QAPI program and a thorough root cause analysis were also cited by CMS as important in reaching a positive decision.

ASTS to Review Impact of New Liver and Heart DRGs on Transplant Centers

This is the second year of the new MS-DRGs for heart and liver transplants. Beginning in FY 2008, CMS implemented a new DRG system that included two separate DRGs (one for high complexity cases and another for low complexity cases) for liver transplants and for heart transplants. ASTS had urged CMS not to implement the tiered DRG structure on the grounds that it would have a disruptive impact on transplant center financial operations because of the significant disparity in payments between the low and high complexity procedures. CMS did not agree, stating that it had insufficient data under the new MS-DRG system to justify any changes. Now that the new DRGs have been in place for over a year, ASTS intends to collect and analyze transplant center Medicare data to assess the actual impact of the DRGs on transplant centers. If the data confirms ASTS’s belief that this contributes to financial instability due to widely fluctuating payment amounts from year to year, ASTS will take this data to CMS in a renewed effort to change policy.

Costs of Pancreata Acquired for Islet Cell Transplants

The confluence of a number of CMS policies has resulted in a significant cost increase in the standard organ acquisition charge (SAC) for pancreata acquired for use in conjunction with islet transplants. This cost increase has contributed to a significant reduction in islet cell transplant research. In December 2008, ASTS spearheaded a meeting with CMS to discuss the problems created by CMS policies in this arena. At the meeting, ASTS was advised that CMS has taken the position that the agency is statutorily required to apply the same cost reporting principles to islets as it does to whole organs. For this reason, it is anticipated that this issue likely will not be resolved without considerable additional effort by ASTS and others dedicated to islet cell transplantation research. At this time, ASTS is putting together a plan to convince the agency to reverse its current position. It is possible, if not likely, that the plan will require legislative outreach.

CMS Outlines Its Vision for Implementing “Value Driven” Healthcare

CMS recently posted its “roadmap” for implementing “value driven” healthcare in the Medicare Program. This document focuses on the steps involved in implementing a “Value-Based Purchasing” (VBP) approach to Medicare payment. A careful reading of this document, posted at http://www.cms.hhs.gov/QualityInitiativesGenInfo/downloads/VBPRoadmap_OEA_1-16_508.pdf provides a glimpse of the types of reforms that are likely to be considered in the context of health care reform over the coming year.

Adoption of a VBP system for compensating physicians is likely to be accelerated when CMS submits to Congress a report required by Section 131(d) of the Medicare Improvements for Patients and Providers Act (MIPPA), a statute that requires the Secretary to develop a plan to transition to a VBP program for Medicare payment for professional services. No later than May 1, 2010 CMS is required to submit a Report to Congress containing the plan with recommendations for legislation and administrative action. To meet this statutory requirement, CMS has formed an internal workgroup, which will be evaluating the implications of a number of demonstration projects that have been ongoing.

While VBP is beginning with efforts to incorporate incentives for quality reporting and performance into the current payment system, it is clear that CMS envisions VBP as an approach that would ultimately result in completely new payment mechanisms that presumably would replace the current Physician Fee Schedule in many cases. These payment systems would be structured to include shared savings models between CMS and providers. To support these new payment systems, CMS would need to consider appropriate modifica-
tions to the physician self-referral rules so that hospitals and other institutional providers could reward physicians for improving quality and efficiency in their local healthcare delivery settings. As an example, CMS could develop units of payment that are based on broad bundles of hospital and physician services which eventually could even include entire episodes of care. Physicians and hospitals could then decide how best to provide these services in a more efficient manner on a patient-by-patient basis, and could allocate the payment among themselves in a way that allowed each to share in the savings.

This model is already being tested in the current CMS Acute Care Episode (ACE) demonstration. In this demonstration, announced in January, 2009, five hospitals in the South Central states will participate in a project in which they are paid global fees for cardiac and/or orthopedic procedures. Meaning that they will be paid a single fee for the hospital facility fee and for all of the physician fees, including the surgeon, any consulting physicians, radiologists, anesthesiologists, and other physicians/practitioners included in the care of the patient. Also, the participating hospitals and physicians will be permitted to use gainsharing to improve incentives for collaboration. Quality will be measured through a series of reported process and outcome measures, including several that focus on surgical infections such as selection and administration of antibiotics and deep sternal wound infection rate.

Another important demonstration project noted in the “Roadmap” is the Premier Hospital Quality Incentive Demonstration, which includes approximately 250 hospitals in 38 states in collaboration with Premier, Inc., which operates a large quality measurement and improvement operation. That demonstration started in October 2003, and has documented substantial improvements in the quality of inpatient care. The demonstration is measuring and providing bonus incentives for improving quality of care in five clinical areas: acute myocardial infarction (AMI), pneumonia, heart failure, CABG, and hip and knee replacement.

In addition, transplant surgeons ultimately may be affected by the results of the Medicare Hospital Gain-sharing Demonstration, authorized by Section 5007 of the Deficit Reduction Act. This provision requires the Secretary of Health and Human Services to establish a gainsharing demonstration program to test and evaluate arrangements between hospitals and physicians designed to improve the quality and efficiency of care provided to beneficiaries. The demonstration allows hospitals to provide gainsharing payments to physicians that represent a share of the savings incurred as a result of collaborative efforts to improve overall quality and efficiency. In the absence of this DRA authority, gainsharing is restricted by the civil monetary penalty law, which prohibits hospitals from rewarding physicians for reducing services to patients, even if such reductions are limited to duplicative services or otherwise represent improvements in quality.

ASTS will be monitoring movement both at CMS and on the Hill related to VBP initiatives, and will keep ASTS posted on new developments in future issues of Chimera.

By Diane Millman, Esq. and Rebecca Burke, Esq.
Powers, Pyles, Sutter & Verville, PC

Legislative Update
Continued from page 9

The increased spending and the proposed elimination of major tax cuts drew immediate opposition to the Obama Administration’s budget outline from not just mainstream Republicans, but also Republican and Democratic moderates as well as the many groups facing cuts in his budget. Whether Congress will be able to answer the Obama proposals with equally ambitious legislation at a time where there are other huge problems facing the nation is an open question at the moment. But, whatever the shortcomings of the new budget proposal, the onus will be on critics and lawmakers to propose and pass alternatives.

ASTS and others interested in organ donation and transplantation-related policies will continue to support legislation left undone from the last Congress while tackling new issues such as health care and Medicare reform. These priorities include increased federal funding of organ donation and transplantation programs, the removal of financial disincentives for organ donation, an extension of Medicare immunosuppressive drug coverage, and organ donor registry legislation.

By Peter Thomas, Esq.
Legislative Counsel, and
Adam Chrisney, Legislative Director
Powers, Pyles, Sutter & Verville, PC

Visit the ASTS website for additional advocacy efforts at www.asts.org/Advocacy
from the 2008 Declaration of Istanbul regarding transplant tourism and organ trafficking. In other action, the Board endorsed a statement proposed by the OPTN/UNOS Ethics Committee that living donation from prisoners may be ethical in certain circumstances, such as to a family member.

An executive summary of Board actions will be posted as soon as they are available on the OPTN web site in the following location: http://www.optn.org/ members/executivesummary.asp. A notice of policy changes resulting from the Board meeting will also be distributed via broadcast e-mail to contacts including transplant program directors and transplant administrators.

OPTN/UNOS Board Officers and Regional Councillors for 2009 Term
OPTN/UNOS members recently elected officers and Board members to fill vacancies for the 2009 term. The new officers and members will begin their terms after the conclusion of the OPTN/UNOS Board of Directors meeting on June 23. The officers for the 2009 term are as follows:

- President – James J. Wynn, M.D., Medical College of Georgia
- Vice President/President Elect – Charles E. Alexander, RN, M.S.N., M.B.A., CPTC, Living Legacy Foundation of Maryland
- Vice President of Patient and Donor Affairs – M. Jill McMaster, M.A., CAPT USNR (Ret.)
- Immediate Past President – Robert S.D. Higgins, M.D., M.S.H.A., Rush University Medical Center
- Secretary – Mitchell L. Henry, M.D., Ohio State University Medical Center
- Treasurer – Art L. Thomson, M.A., Cleveland Clinic Foundation

The OPTN UNOS Regional Councillors serve two-year terms. Including those recently elected and those continuing service, Councillors for the 2009 term will be as follows:

- Region 1 – Paul E. Morrissey, M.D., Rhode Island Hospital
- Region 2 – Lynt B. Johnson, M.D., Georgetown University Medical Center
- Region 3 – George E. Loss, Jr., M.D., Ph.D., Ochsner Foundation Hospital
- Region 4 – John A. Goss, M.D., Methodist Hospital, Houston
- Region 5 – Chris E. Freise, M.D., FACS, UC San Francisco Medical Center
- Region 6 – Jorge D. Reyes, M.D., University of Washington Medical Center
- Region 7 – John R. Lake, M.D., University of Minnesota Medical Center
- Region 8 – Michael D. Voigt, M.B., Ch.B, University of Iowa Hospital and Clinics
- Region 9 – Patricia A. Sheiner, M.D., Westchester Medical Center
- Region 10 – Lynn Driver, CPTC, Indiana Organ Procurement Organization
- Region 11 – Carl L. Berg, M.D., University of Virginia Health Sciences Center

For a list of all members newly elected to the OPTN/UNOS Board, visit the OPTN web site: http://www.optn.org/news/newsDetail.asp?id=1218.

By Joel Newman
Assistant Director of Communications
UNOS
Five years ago, the Organ Procurement and Transplantation Network (OPTN) charged its Kidney Transplant Committee to perform a complete review of kidney allocation policy. This process resulted in the issuance of a Request for Information (RFI) from UNOS in August of 2008 (The full text of this document can be found at www.optn.org.) The RFI described a new Kidney allocation score (KAS) that would be calculated at the time of an organ offer using parameters for donor risk, time on dialysis and life years gained from transplant (LYFT). Although many found merit in using dialysis time and incorporating a continuous scale for donor risk assessment, there was considerably more concern directed at the proposed use of LYFT to rank patients on the list. The ASTS formed a task force and developed a comprehensive response to the UNOS/OPTN request (http://www.asts.org/Advocacy/Regulatory04.aspx). Subsequently, members of the ASTS task force presented the Society’s viewpoint at the public Forum held in St. Louis on January 26, 2009.

**Three Main Criticisms Raised in the ASTS Response**

1) The underlying demand for kidney transplantation, and therefore the foundation for kidney allocation, is driven by different motivations than exist for liver or lung transplants where allocation policy is heavily weighted toward mortality risk. In contrast to these other transplant types, candidates for kidney transplantation do not have immediate short-term mortality risks because of the availability of dialysis. Their motivation for seeking a kidney transplant is much more driven by the immediate gains in quality of life that a kidney transplant can offer. Therefore, allocation policy based on LYFT, where long term survival estimates are used to distinguish between high and low priority patients on the list, does not have much relevance and does not offer adequate consideration for the more looming quality of life decisions patients face while on dialysis.

2) The KAS proposal was a donor driven system that would have significantly limited patients’ autonomy. Under the proposal, the risk profile of the donor would determine how much weight dialysis time and LYFT were given in the final KAS. This means that the system would determine the quality of kidney being offered to individual patients and if the candidate refused a given offer, it would be unlikely that a better offer would ever come along since a given candidate’s LYFT would decrease as the candidate ages. Moreover, since there would be no way to predict what type of donor would be offered, there would be no way to predict which waiting candidates were most likely to be offered the next organ. Because of this, transplant centers would have much more difficulty managing their lists and would not be able to offer any realistic estimate of waiting time for their patients.

3) Another major concern with calculating LYFT is that the models used for estimating pre and post-transplant survival did not meet the usual standards for mathematical model predictive accuracy. The whole process highlighted that the OPTN/SRTR data do not discriminate well among various important risk covariates such as cardiovascular disease, severity of diabetes, and some would argue, race.

Ultimately, the ASTS and others opined that the LYFT-based KAS proposal was much too complicated and too opaque to be implemented for kidney allocation policy.

**Alternative Approaches**

The ASTS suggested that one option for directly allocating kidneys with long projected function times to recipients with long projected life spans could be to require that deceased donor kidneys from donors less than 35 years old be preferentially offered to candidates less than 35 years old. Even though this is an arbitrary approach, this simple modification would be consistent with the existing, also arbitrary, policy that mandates kidneys from donors less than 35 years of age be preferentially allocated to pediatric candidates who are equally arbitrarily defined as less than 18 years of age at the time of listing. Geographic differences could also be addressed by allowing regional sharing for kidneys from donors less than 35 that are allocated to candidates less than 35 years old. Importantly, this would be a very simple, easy to understand, system.

This change might reduce the demand for living donor transplantation as was seen when the pediatric policy was activated. Modifications could be made so that some period of waiting was required for the less than 35-year-old candidate before they achieve the priority for the less than 35-year-old donor kidney analogous to the pediatric waiting time policy in effect now.

Another, not necessarily mutually exclusive, change could be to require that all candidates indicate what range of donor risk (DPI) he or she is willing to accept. By allowing patients to designate the DPI they are willing to accept before a donor organ is offered, the system becomes a patient-based system. Some critics have voiced concern that under such a system, candidates might all designate broad ranges of donor risk that they are willing to accept. This is precisely why kidney allocation is different. Many candidates are more concerned about their quality of life and being given the opportunity for any kidney with reasonable risk characteristics rather than getting the one with the best match to their own projected lifetimes. If they are well informed in making such a decision (another ad-
The advantage of this proposal is that it would, out of necessity, require that candidates are well informed about the spectrum of donor quality that could be offered to them, system should prevent this. To address concerns that some candidates with very limited survival times might choose to designate broad ranges of donor types and thereby open the possibility for receiving a long functioning kidney, we could just require that candidates greater than a certain age cannot designate accepting kidneys with the lowest DPI. This type of patient driven system may not achieve an overall increase in life-years from transplant, but it will preserve patient autonomy and individual justice, and would require much less reorganization and reeducation.

Change always engenders fear. Whatever changes in kidney allocation policy are put forward, open, and frequent communication, presentation and publication in peer-reviewed venues and careful planning for transition can go a long way to allay these fears. The American Society of Transplant Surgeons’ membership interacts with kidney transplant candidates face to face everyday and are direct messengers to patients for explaining allocation policy for every type of deceased donor transplant. We are pleased to be ongoing, active participants in future policy development.

By Richard B. Freeman, Jr., MD
Vice Chair for Research
Department of Surgery
Professor of Surgery
Tufts Medical Center

ASTS Welcomes New Staff

ASTS Welcomes
Serge Shahabian
Manager, Business Development and Policy Initiatives

Serge Shahabian is an accomplished marketing professional with a wide variety of experience in all facets of business planning, market research, competitor analysis, promotions, market strategy, cycle time reduction, request for proposals and business development. Mr. Shahabian comes to us from The U.S. Chamber of Commerce, the world’s largest business federation, where he spent the last three years directing the research and analysis team in support of multiple sales channels. Previously, he held the position of a Market researcher at Computer Systems Center, Inc. (CSCI), a provider of innovative business and product solutions to the Federal Government, where he developed strategic business plan for commercialization of in-house computer software. Mr. Shahabian has Bachelor of Science in Marketing from the Pennsylvania State University Smeal College of Business.

Serge’s primary role will be to work with the ASTS Business Practice Advisory and help grow revenue-generating initiatives for the Society. In addition, he serves as staff liaison for legislative, regulatory and reimbursement committees/projects.

ASTS Compensation Report

Have you taken the opportunity to download the ASTS comprehensive compensation study for transplant surgeons practicing within the United States?

This fifty-page report allows ASTS members to compare their salary and benefits with their peers at the staff surgeon and program director level. The data is aggregated by region, practice type, personal and center volume and primary practice in order to provide the most comprehensive data. For ASTS members in leadership positions (Division Chief, Transplant Center Director or Institute Director/Chief) a Leadership Report is also available. This seventy-page document expands on the base report to include compensation data for the leadership levels. To receive the Leadership Report, send a letter on institutional letterhead confirming your leadership status to the ASTS National Office.

Distributing this report to non-members is prohibited. Interested parties should contact the ASTS National Office for access to the report.
Is your transplant center participating? Why not? There is no better time!

The NLDAC provides up to $6,000 for eligible living donors and their companions to travel to the transplant center for the evaluation, surgical and medical follow-up trips.

As of March 2009
• 120 (approximately 50%) Transplant Centers have filed a NLDAC application
• 86% of applications are approved
• 415 applications have been approved for funding
• $2,900 is the average amount approved per donor
• 189 donors have completed their donor surgery using NLDAC funding

Did you know?
• NLDAC can assist with travel to or from U.S. Territories such as Guam and PuertoRico
• NLDAC has budgeted 1.3 million dollars for donor travel in 2009
• NLDAC staff are available to train transplant center staff how to file an application
• NLDAC is a funded by a DoT grant awarded to ASTS and the U of Michigan

Donors Appreciate the Assistance!

Being an out of state donor, I really thought it would be a hardship. The NLDAC made it such an effortless decision. I truly believe if people knew about what you offer, more living donors would come forward. Thank you for all your support.

Katherine - Cleveland Clinic Foundation

Thank you for the financial assistance. We wouldn't have been able to proceed with the transplant without the support. Your assistance made it possible for our family members to be together during times of need.

Nalee - Medical College of Georgia Hospital

National Living Donor Assistance Center
2461 S. Clark Street Suite 640 Arlington, VA 22202 Ph 703-414-1600 Fax 703-414-7874
nldac@livingdonorassistance.org www.livingdonorassistance.org
This is my favorite meeting...this meeting allows you to meet people in the inner circle without the distraction, as when attending larger meetings in big downtown cities. This meeting provides close discussion on immediate issues.

– Hoonbae Jeon, MD, University of Kentucky Medical Center-Chandler

The Program Planning Committee of American Society of Transplant Surgeons convened another triumphant symposium focusing on the complex concept of matching donors to recipients. This CME event engages multidisciplinary education planned for and by the entire transplant team and is designed to address performance-based gaps in learning with a commitment to quality improvement. Each year the Planning Committee does an exceptional job at addressing the educational objectives of the symposium through a keynote address, debates, oral abstract presentations, poster presentations, video presentations and other special events.

The educational goals were for participants to 1) develop an understanding of how donor and recipient matching may affect outcomes, 2) learn a variety of practices employed in matching donors to recipients, 3) understand the ethical principles which affect the selection of recipients for high-risk donors, and 4) become conversant with the issues surrounding the use of organ allocation policy to match donors and recipients.

When we surveyed attendees on their symposium experience, this is what they had to say.

[The Winter Symposium] is an excellent venue for young surgeons to rub elbows with icons in transplant surgery...with contemporaries changing the course of transplantation over the next generation. One of the main highlights of the meeting is the ability to watch the heavy weights debate the ethically charged issues at this juncture in transplantation.

– Burnett “Beau” Kelly, MD, Vanderbilt University Medical Center

This meeting is an excellent learning resource. It's always interesting to learn about someone else’s perspective on transplantation techniques. The meeting encourages participation and time for feedback and discussion. In addition, the symposium is a great opportunity to meet up-coming leaders and to network with other transplant surgeons.

– Dinesh Ranjan, MD, University of Kentucky Medical Center

This is my first time attending the academic conference after becoming an attending. I wanted to see how the ASTS works and broaden my insight into the Society.

– Dong-Sik Kim, MD, University Hospital of Cincinnati

Attendance

2009...the highest registrants in Symposium history!

<table>
<thead>
<tr>
<th>2009</th>
<th>2008</th>
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<tr>
<td>344 ASTS Attendees</td>
<td>306 ASTS Attendees</td>
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<td>110 NATCO</td>
<td>112 NATCO</td>
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<td>454 attendees Total</td>
<td>418 attendees</td>
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10 Exhibits
8 Additional Events
2 Satellite Symposia

Save The Date

ASTS 10th Annual State of the Art Winter Symposium

January 15-17, 2010

New Location!
Marriott Harbor Beach
Fort Lauderdale, FL
Why Do We Need Them and How Do We Maintain Them?
The intent of the Pre-Symposium was to provoke dialog among the transplant community concerning what types of standards are required and/or needed in organ transplantation. The purpose of the ASTS Standards on Organ Transplantation Committee is to develop high standards for organ procurement, transplantation, and patient care, and to educate the membership about existing or new regulations, standards and policies under development. In recent years, the controversy surrounding standards has amplified concerning performance and practice. The Standards committee thought it beneficial to bring together subject matter and develop a clear understanding of where transplantation stands by way of standards and future goals.

Transplant Center Models: From Design to Practice
Focusing on their mission, The ASTS Business Practice Committee used a series of presentations to help participants develop an understanding of transplant center models, payer and inter-provider relationships, and define key issues in total integration and partial integration models. In addition, the surgeon compensation process and comparative data were presented.

Practical Approach To Grant Writing
Defining and promoting training and the career-long education of members is important to ASTS. The Career Development Seminar addressed a critical aspect of transplantation science and medicine essential in securing funding and advancing academic careers. Junior members rarely receive the adequate training needed to submit a competitive application. During the seminar, attendees gained insight on how to develop a fundable grant through a systematic approach and information about available funding mechanisms from representatives of leading funding agencies. Special thanks to the ASTS Vanguard Committee for their insight.

Wrong Organ for the Wrong Patient, Critical Management Options
Dr. Dinesh Ranjan heads up the ASTS Critical Care Task Force. Dr. Ranjan and other committee members put together a Critical Care Luncheon Symposium designed to fulfill the need for specialized critical care in transplantation. Transplant critical care looks at end stage organ disease, anesthetic and ICU management, and remote postoperative management. The symposium specifically addresses optimization of medical management of elderly kidney transplant recipients with cardiac disease receiving ECD kidneys, along with identifying key strategies in transplant recipients with compromised organ function such as allograft pancreatitis or small-for-size liver transplantation. Lastly, the symposium addressed how to define and diagnose portopulmonary hypertension in patients undergoing liver transplantation and develop in depth knowledge of appropriate treatment modalities during the perioperative phase.

Opportunity Knocks
Luck or great planning paid off for prospective transplant fellows. Those in attendance at the Winter Symposium got an integral opportunity to interact with current ASTS Abdominal Fellowship Training Program Directors and to obtain information about applying for and participating in an ASTS Accredited Fellowship Training Program. Members of the ASTS Fellowship Training Committee felt it important to reach out to upcoming surgeons, help direct their careers and convey the importance of interacting with other colleagues.

Advancing Transplantation Science and Medicine
ASTS recognizes outstanding abstracts submitted each year through oral presentations, posters, and videos. Thank you to everyone that submitted an abstract.

Special Acknowledgements
ASTS recognizes the contributions of the Program Planning Committee, Exhibitors, Corporate Supporters, Corporate Sponsors, Moderators, and Presenters who helped make this educational opportunity a success.
Thank you!

ASTS Program Planning Committee
Program Chair, Randall S. Sung, MD
Senior Advisor, Dixon B. Kaufman, MD, PhD
Peter L. Abt, MD
Dev M. Desai, MD, PhD
Catherine Garvey, RN, BA, CCTC
Dorry L. Segev, MD
Thomas Waddell, MD, PhD

Webcasts of Presentations Can Be Found at www.asts.org / Research & Education
2009 Francis Moore Excellence in Mentorship in the Field of Transplantation Surgery Award

Congratulations to Dr. Arthur J. Matas, University of Minnesota and Dr. Robert L. Jenkins, Lahey Clinic, recipients of the 2009 Mentorship Award. The Vanguard Committee created the award to distinguish exceptional efforts of established surgeons for their mentorship, leadership, and stewardship of fellows and junior faculty. The award cultivates admirable mentorship and acknowledges the time and effort required to advance the careers of new investigators and clinicians. The award was presented during the annual Vanguard Committee Reception. This is a nomination-based award.

Dr. Arthur Matas has been more than a mentor for me. He is an example of compassion, commitment to education and research, integrity and leadership: an example, which goes beyond the training and stays for life. Unique of Dr. Matas, are his silences. You learn more from what he does not say than from what he does say. No words can define his efforts for continuous improvement and advancement of the people working with him.

– Massimo Asolati, MD, Dallas VA Medical Center

I first came to know Dr. Jenkins over 6 years ago when I was a general surgery resident rotating through the liver transplant service. Since then he has had a tremendous impact on the development and refinement of my surgical decision-making as well as my surgical technique. Dr. Jenkins simplifies every step and teaches how to operate with efficiency. In the operating room, he is patient and allows the fellows or residents to find their way through the case with his guidance.

– Khashayar Vakili, MD, Lahey Clinic

Dr. John S. Najarian, Professor of Surgery, Regents Professor Emeritus, University of Minnesota was the keynote speaker for the awards ceremony. Dr. Najarian, considered a mentor and pioneer in the field, formed one of the world’s largest transplant programs, which has now performed more than 7,000 kidney transplants; more than 2,500 pancreas transplants; and hundreds of heart, liver, lung, islet, bowel, and combined transplants. Under his leadership, the Minnesota program pioneered innovative and difficult types of transplants; achieved unequalled success with diabetic, pediatric, and older patients; and made major research, clinical, and educational contributions to the field of surgery. Dr. Najarian is a member of a long list of surgical societies and has received numerous honors for outstanding achievements in transplantation nationally and internationally. Dr. John Najarian was the 1999 recipient of the ASTS-Roche Pioneer Award. One of his greatest honors is the 2004 Medawar Prize. Dr. Najarian became a Medawar Laureate for his monumental contributions to immunobiology, experimental transplantation, and clinical transplantation. The Prize is widely deemed the world’s most prestigious award for outstanding achievement in organ transplantation (University of Minnesota, Biographical Sketch, 2008).

2009 ASTS Vanguard Prize

Andrew M. Cameron, MD, PhD, Johns Hopkins Medical Institute and Reza F. Saidi, MD, Massachusetts General Hospital are the 2009 ASTS Vanguard Prize recipients. The Vanguard Prize recognizes and honors ASTS junior members for their efforts in basic and clinical research. The award identifies the best clinical and basic research manuscripts from young investigators in the previous year. The awards were presented during Winter Symposium. Congratulations to both recipients for outstanding publications.
Symposium Highlights

[Images of various scenes from the symposium, including presentations, discussions, and social events.]
ASTS History Corner

The Chimera Chronicles: Great Stories in Transplant Surgery

Everybody always talks about the good things and how well things are and how good results are and I think the current generation of transplant surgeons needs to know that these good results were built from a fire of disappointment; from years of struggling and failures at multiple centers and whose leaders because of their perseverance, and I will repeat that, because of their perseverance and belief in the discipline, put those failures behind them and kept moving forward.

– James Cerilli, MD, Retired Transplant Surgeon

In 2008, ASTS began recording living legacies in transplantation. ASTS currently has over 75 members of the Society designated as “senior” status. While many of them have retired, it is important that their contributions are remembered, recorded, to serve as an inspiration to the new generation of surgeons, physicians, and transplant personnel.

The second Chimera Chronicles filming took place during the ASTS 9th Annual State of the Art Winter Symposium. The stories they told were amazing. You can view them on the ASTS website late spring. The website will also display a photo library.

The recordings will become an annual event, to take place during the ASTS Winter Symposium.

In Memoriam Andrew Novick, MD

ASTS would like to recognize one of its long time members, Dr. Andrew Novick, a renowned Urologist and Chairman of the Glickman Urological and Kidney Institute at the Cleveland Clinic. He was an ASTS member since 1977. ASTS was established in 1974. Novick passed away Saturday, Oct. 18, 2008 from complications of lymphoma. Novick joined the staff of the Cleveland Clinic in 1977 and was appointed Chairman of the Urology Department in 1985, which was later named the Glickman Urological and Kidney Institute. Under Dr. Novick’s leadership, the Institute has grown from seven to 74 full-time faculty. The Institute also includes 40 residents and fellows, and seven basic research laboratories. It is currently the largest and most subspecialized urology program in the world. In the 1980’s, Novick pioneered nephron-sparing surgery (partial nephrectomy) for the treatment of kidney cancer. He also pioneered extracorporeal or “bench” kidney surgery for the repair of complex kidney disorders. To date, doctors at the Glickman Urological and Kidney Institute at Cleveland Clinic have performed more than 3,000 open partial nephrectomies, most of which were performed by Dr. Novick, giving the Institute the largest experience in the world. In addition to his surgical accomplishments, Dr. Novick discovered a correlation between chronic kidney disease and atherosclerotic renal artery disease. Dr. Novick also devoted significant effort to the understanding and management of end stage renal disease through renal transplantation, and to preserving renal function through reconstructive surgery.
American Transplant Congress 09

Save the Date
May 30 - June 3, 2009
Boston, MA

Visit us online at www.atcmeeting.org
Mark Your Calendar!

ASTS Events at ATC

Friday, May 29, 2009
  Council Meeting – Executive Session  
  Council & Committee Chair Meeting

Saturday, May 30, 2009
  Council & Committee Chair Meeting  
  Council Meeting – Executive Session  
  Foundation Board of Directors Meeting

Sunday, May 31, 2009
  8:30 – 10:30 AM:  
    Joint Plenary & ASTS Awards Ceremony  
    Hynes Convention Center, General Session Room  
    ASTS Award Presentations will begin at 9:15 AM

Tuesday, June 2, 2009
  8:30 – 10:30 AM:  
    Joint Plenary & ASTS Awards Ceremony  
    Hynes Convention Center, General Session Room  
    ASTS Award Presentations will begin at 9:15 AM

  11:00 – 11:30 AM:  
    ASTS Presidential Address  
    Hynes Convention Center, General Session Room

  12:15 – 12:30 PM:  
    ASTS Pioneer Award Presentation  
    Hynes Convention Center, General Session Room

  5:30 – 6:30 PM:  
    ASTS Business Meeting  
    Hynes Convention Center, Room 313

  6:30 – 6:45 PM:  
    Corporate Recognition Ceremony  
    Hynes Convention Center, Room 313

  7:00 – 8:00 PM:  
    ASTS Members Reception  
    Hynes Convention Center, Room 313
Objective
The objective of the curriculum is to define the key areas of knowledge necessary for mastery of the field of transplantation surgery and to provide an educational guide for trainees as they progress through their fellowship and will serve as a dynamic reference for all ASTS members.

Watch for updates online at www.asts.org!
Creating Award Winning Educational Videos for the Transplant Community

Living Kidney Donation: What You Need to Know

Kidney Transplantation: A Guide for Patients and their Families

Ask About Spanish Versions

www.astros.org
Abdominal Transplant Surgery Fellowship Match

Match Program The American Society of Transplant Surgeons (ASTS) is the sponsoring organization for the Abdominal Transplant Surgery Fellowship Match conducted via the National Resident Matching Program (NRMP). Visit www.asts.org and www.nrmp.org for detailed information concerning the Match.

Application Process The application process is independent from the Match and unique to individual institutions. Transplant Fellowship Programs use their individual application and interview process to evaluate potential transplant fellowship candidates for their programs. For a list of ASTS accredited Abdominal Fellowship Training Programs visit www.asts.org.

Registering for the Match Transplant Fellowship Programs and Applicants must register for the Match. More information about the Abdominal Transplant Surgery Fellowship Match & other programs focused on advancing surgical care in transplantation can be found on the ASTS website, www.asts.org.

Schedule for Match Conducted in 2009, Appointment Year 2010
January 14, 2009
Match Registration Opens
April 15, 2009
Rank Order List Entry Opens
May 29, 2009
Program Quota Change
June 10, 2009
Rank Order List Closes Certification
June 24, 2009
Match Day

ASTS
American Society of Transplant Surgeons
ASTS Business Practice Advisory
What Every Transplant Surgeon Must Know

KNOW YOUR WORTH!
ASTS conducted a comprehensive compensation survey; now the most comprehensive report in the nation. The fifty-page report allows individuals to evaluate their salary and benefits with their peers at the staff surgeon and program director level.

How Healthy Is Your Transplant Program?
Mock Medicare Services - ASTS has assembled a team of transplant professionals and regulatory experts who are standing by, ready to review your program’s policies and procedures, evaluate compliance through on-site chart review, conduct personal interviews and debriefing, and present programs with a written report of potential deficiencies.

Keeping Up With National Trends!
The mission of the Business Practice Advisory is to assist ASTS members in understanding the business aspect of transplantation and to help them keep up with national trends in transplant practice management. The committee does this through seminars offered during the ASTS annual Winter Symposium.

Job Board
ASTS provides a Job Board as a benefit to its members. This is an abbreviated listing of the job postings currently available on the ASTS website. If you would like to submit a listing, please contact Chantay Parks Moye at chantay.parks@asts.org or 703.414.7870 ext. 101 for submission guidelines and fee requirements.

Children’s Hospital Boston: Administrative Programs
Please contact:
Please refer to AutoReqID: 19017BR
Website: www.childrenshospital.jobs

New York City: Kidney Transplant Surgeon Search
Please contact:
Lois Sacks
Director of Physician Recruitment
Yvonne Wallace, Senior Researcher
Phone: 914-251-1000 x117 or x120
Fax: 914-251-1055
Email: LSacks@ppasearch.com
YWallace@ppasearch.com
Website: www.ppasearch.com

Southern Illinois University School of Medicine: Transplant Surgeon
Please contact:
Edward Alfrey, M.D.,
Department of Surgery
P. O. Box 19638
Springfield, IL 62794-9638
Provide names of three references.
Email: ealfrey@siumed.edu

University Hospitals, Case Medical Center: Surgical Director of Liver Transplantation
Please contact:
James A. Schulak, MD
Chief, Division of Transplantation and Hepatobiliary Surgery
Director, UHCMC Transplant Institute
11100 Euclid Avenue
Cleveland, Ohio 44106
Phone: 216-844-0307
Fax: 216-844-5398
Email: james.schulak@uhhospitals.org

University of Colorado Anschutz Medical Center: Director of Research
Please contact:
www.jobsatcu.com/applicants/Central/quickFind=57380.
Benefits package: http://www.cu.edu/jobs/

University of Utah: Transplant Surgeon
Please contact:
John B. Sorensen, M.D.
Chief, Section of Transplantation
University of Utah Health Sciences Center
Room 3B110 SOM

Salt Lake City, UT 84132
Phone: 801-585-2816
E-mail: John.sorensen@hsc.utah.edu

University of Virginia Department of Surgery: Abdominal Transplant Surgeon
Please contact:
Diana Houchens
Department of Surgery
E-mail: dmh@virginia.edu

Westchester Medical Center: Director, Intra-Abdominal Transplant Surgery
Please contact:
Brian Joyce, Senior Associate
Korn Ferry International
695 East Main Street
Stamford, CT 06901
Phone: 203-406-8799
Fax: 203-327-2044
E-mail: brian.joyce@kornferry.com
Website: http://www.wcmc.com
Corporate Support

The American Society of Transplant Surgeons would like to thank the following companies for their generous support of the ASTS in 2009

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Founder Circle

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Sponsor Circle

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Associate Circle

![United Health Foundation](image)
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(New contributions since Winter 2009 in bold)

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Log on to www.asts.org/Society-Foundation to learn about the Foundation of the ASTS, its projects and to make a contribution.
## Calendar

The ASTS is pleased to coordinate with other professional organizations in order to maintain a relevant events calendar. If your organization would like to list an event, please contact Chantay Parks Moye at 703.414.7870 ext. 101 or chantayparks@earthlink.net.

### April 2009
- **March-May 2009**
  - **Live Regional Meeting Series**
  - **How Do We Prolong Graft Function and Improve Cardiovascular Event-Free Survival in the Kidney Transplant Recipient?**
  - See website for location, date, and times [www.sceptercme.com/kidneytransplant](http://www.sceptercme.com/kidneytransplant)

### April 18-21, 2009
- **5th Congress of the International Pediatric Transplant Association (IPTA)**
  - Istanbul, Turkey
  - Askeri Museum
  - Email: [http://www.iptaonline.org/5thcongress](http://www.iptaonline.org/5thcongress)

### May 2009
- **March-May 2009**
  - **Live Regional Meeting Series**
  - **How Do We Prolong Graft Function and Improve Cardiovascular Event-Free Survival in the Kidney Transplant Recipient?**
  - See website for location, date, and times [www.sceptercme.com/kidneytransplant](http://www.sceptercme.com/kidneytransplant)

### May 20, 2009
- **ASTS 3rd Annual Transplant Fellowship Training Meeting**
  - Chicago, O’Hare Hilton
  - Chicago, IL

### May 30-June 3, 2009
- **American Transplant Congress**
  - Boston, MA

### June 2009
- **June 19-23, 2009**
  - **Introductory Education Course for the New Transplant & Procurement Professional**
  - Tempe Mission Palms Hotel and Conference Center
  - Tempe, AZ
  - Phone: 913-895-4612
  - Email: natcoinfo@goAMP.com
  - Website: [www.natco1.org](http://www.natco1.org)

### August 2009
- **August 2-5, 2009**
  - **NATCO’s 34th Annual Meeting**
  - River Rock Hotel
  - Las Vegas, NV
  - Phone: 913-895-4612
  - Email: natcoinfo@goAMP.com
  - Website: [www.natco1.org](http://www.natco1.org)

- **August 30-September 2, 2009**
  - **14th Congress of the European Society for Organ Transplantation (ESOT)**
  - Paris, France
  - Website: [www.esot.org](http://www.esot.org)

### September 2009
- **September 11-12, 2009**
  - **9th Meeting of the International Society of Hand and Composite Tissue Allotransplantation**
  - Valencia, Spain
  - Director: Dr. Pedro Cavadas
  - Website: [www.ctavalencia2009.com](http://www.ctavalencia2009.com)
  - E-mail: info@ctavalencia2009.com

### September 23-26, 2009
- **Transplant Immunosuppression: Today’s Issues**
  - Radisson University Hotel
  - Minneapolis, MN
  - [http://www.cmecourses.umn.edu](http://www.cmecourses.umn.edu)

### February 2010
- **February 4-7, 2010**
  - **9th International Conference on New Trends in Immunosuppression and Immunotherapy**
  - Kenes International
  - Prague
  - Website: [www.kenes.com](http://www.kenes.com)

### May 2010
- **May 1-May 5, 2010**
  - **American Transplant Congress**
  - San Diego, CA

## Plan Ahead

### ASTS 10th Annual State of the Art Winter Symposium
- **January 15-17, 2010**
- Marriott Harbor Beach, Fort Lauderdale, FL

Stay current with ASTS by visiting the ASTS website at [www.asts.org](http://www.asts.org).

There you can learn more about who we are, what we do, why we care, and how you can get involved.
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