Part 3: Abdominal Wall VCA - Liver Transplant Program

Table 1: OPTN Staffing Report

OPTN Member Code:	**Name of Hospital:**	
Main Program Phone Number:	**Main Program Fax Number:**	**Hospital URL:** http://www
Toll Free Phone Number for Patients:		**Hospital Number:**

Refer to the staffing audit sent with this application and complete the table below for staff that are not captured on the staffing audit or to update information for current staff, including deleting (DEL) an individual. If you did not receive an audit with this application, complete the entire staffing report. Make sure to use individuals' full, legal names (middle name/initial also included when possible) to prevent duplicate entries within the UNOS Membership Database and UNet. Add additional rows as necessary.

Identify the **transplant program medical and surgical director(s)**.

DEL	**Name**	**Address**	**Phone**	**Fax**	**Email**

Identify the **primary and additional surgeons** who perform transplants for the program.

DEL	**Name**	**Address**	**Phone**	**Fax**	**Email**

Identify **other surgeons** who perform transplants for the program.

DEL	**Name**	**Address**	**Phone**	**Fax**	**Email**

Identify **the primary and additional physicians** (internists) who participate in this transplant program.

DEL	Name	Address	Phone	Fax	Email

Identify **other physicians** (internists) who participate in this transplant program.

DEL	Name	Address	Phone	Fax	Email

Identify the **transplant program administrator(s)/hospital administrative director(s)/manager(s)** who will be involved with this program.
The * denotes the primary transplant administrator.

DEL	Name	Address	Phone	Fax	Email
	*				

Identify the **clinical transplant coordinator(s)** who will be involved with this program.

DEL	Name	Address	Phone	Fax	Email

Identify the **data coordinator(s)** who will be involved in this transplant program. The * denotes the primary data coordinator.

DEL	Name	Address	Phone	Fax	Email
	*				

Identify the **social worker(s)** who will be involved with this program.

DEL	Name	Address	Phone	Fax	Email

Identify the **Independent Living Donor Advocate(s) (ILDA)** who will be involved in the care of living donors.

DEL	Name	Address	Phone	Fax	Email

Identify the **pharmacist(s)** who will be involved with this program.

DEL	Name	Address	Phone	Fax	Email

Identify the **financial counselor(s)** who will be involved with this program.

DEL	Name	Address	Phone	Fax	Email

Identify the **director of anesthesiology** who will be involved with this program.

DEL	Name	Address	Phone	Fax	Email

Identify the anesthesiologist(s) who will be involved with this program.

DEL	Name	Address	Phone	Fax	Email

Identify the **QAPI team member(s)** who will be involved with this program.

DEL	Name	Address	Phone	Fax	Email

Identify **any other transplant staff** who will be involved with this program **.**

DEL	Name	Title	Address	Phone	Fax	Email

Part 3A: Personnel – Transplant Program Director(s)

Identify the surgical and/or medical director(s) of the VCA abdbominal wall transplant program and submit a C.V. for each program director. Briefly describe the leadership responsibilities for each individual.

Name	Date of Appointment	Primary Areas of Responsibility

Part 3B, Section 1: Personnel – Surgical – Primary Abdominal Wall VCA Surgeon

1. Identify the primary abdominal wall VCA transplant surgeon:

Name:

a) Provide the following dates (use MM/DD/YY):

Date of employment at this hospital:
Date assumed role of primary surgeon:

b) Does the surgeon have FULL privileges at this hospital?

Yes	
No	

If the surgeon does **not** currently have full privileges:

Date full privileges to be granted (MM/DD/YY):
Explain the individual's current credentialing status, including any limitations on practice:

c) How much of the surgeon's professional time is spent on site at this hospital?

Percentage of professional time on site:
Number of hours per week:

d) How much of the surgeon's professional time is spent on site at other facilities (hospitals, health care facilities, and medical group practices)?

Facility Name	Type	Location (City, State)	% Professional Time On Site

e) List the surgeon's current board certification(s) below. If board certification is pending, indicate the date the exam has been scheduled. If the surgeon has been recertified, use that date. Provide a copy of certification(s).

Certification Type	Certificate Effective Date (MM/DD/YY)	Certificate Valid Through Date (MM/DD/YY)	Certification Number

f) Check the applicable pathway through which the surgeon will be proposed. Refer to the OPTN Bylaws for the necessary qualifications and more specific descriptions of the required supporting documents.

Membership Criteria	
Two Year Transplant Fellowship	
Clinical Experience	
Full (Intestine only)	
Conditional (Intestine only)	

g) Transplant Experience (Post Fellowship)/Training (Fellowship): List the name(s) of the transplant hospital(s), applicable dates, program director name(s), and the number of transplants and procurements performed by the surgeon at each transplant hospital.

Training and Experience	ASTS Approved Programs? Y/N	Date (MM/DD/YY)		Transplant Hospital	Program Director	# LI Transplants as Primary	# LI Transplants as 1st Assistant	# of LI Procurements as Primary or 1st Assistant
		Start	End					
Fellowship Training								
Experience Post - Fellowship								

h) Describe in detail the proposed primary surgeon's level of involvement in **this** transplant program as well as **prior** training and experience.

	Describe Level of Involvement in This Transplant Program	**Describe Prior Training/Experience**
Pre-Operative Patient Management (Patients With End Stage Liver Disease)		
Recipient Selection		
Donor Selection		
Histocompatibility and Tissue Typing		
Transplant Surgery		
Post-Operative Care and Continuing Inpatient Care		
Use of Immunosuppressive Therapy		
Differential Diagnosis of Liver Dysfunction in the Allograft Recipient		
Histologic Interpretation of Allograft Biopsies		
Interpretation of Ancillary Tests for Liver Dysfunction		
Long Term Outpatient Care		
Living Donor Transplantation (if applicable)		
Pediatric (if applicable)		
Coverage of Multiple Transplant Hospitals (if applicable)		
Additional Information:		

Table 2: Primary Abdominal Wall VCA Surgeon - Transplant Log (Sample)

Complete a separate form for each transplant hospital.

Organ:	
Name of proposed primary abdominal wall VCA surgeon:	
Name of hospital where transplants were performed:	
Date range of surgeon's appointment/training: MM/DD/YY to MM/DD/YY	

List cases in date order. Add rows as needed. Patient ID should not be name or Social Security Number.

#	Date of Transplant	Medical Record/ OPTN Patient ID #	Primary Surgeon	1st Assistant
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Director's Signature	**Date**
Print Name	

Table 3: Primary Abdominal Wall VCA Surgeon - Procurement Log (Sample)

Organ:	
Name of proposed primary abdominal wall VCA surgeon:	
Name of hospital where surgeon was employed when procurements were performed:	
Date range of surgeon's appointment/training: MM/DD/YY to MM/DD/YY	

List cases in date order. Add rows as needed. Patient ID should not be name or Social Security Number.

#	Date of Procurement	Donor ID Number	Comments (LD/CAD/Multi-organ)
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Director's Signature	**Date**
Print Name	

Part 3B: Section 2- Personnel, Additional Abdominal Wall VCA Surgeon(s)

Complete this section of the application to describe surgeons involved in the program that are not designated as primary, but are credentialed by the transplant hospital to provide transplant services and independently manage the care of transplant patients, including performing the transplant operations and organ procurement procedures. **Duplicate this section as needed.**

1. Identify the additional abdominal wall VCA transplant surgeon:

Name:

a) Provide the following dates (use MM/DD/YY):

Date of employment at this hospital:

b) Does the surgeon have FULL privileges at this hospital? (check one)

Yes	
No	

If the surgeon does **not** currently have full privileges:

Date full privileges to be granted (MM/DD/YY):
Explain the individual's current credentialing status, including any limitations on practice:

c) How much of the surgeon's professional time is spent on site at this hospital?

Percentage of professional time on site:
Number of hours per week:

d) How much of the surgeon's professional time is spent on site at other facilities (hospitals, health care facilities, and medical group practices)?

Facility Name	Type	Location (City, State)	% Professional Time On Site

e) List the surgeon's current board certification(s) below. If board certification is pending, indicate the date the exam has been scheduled. If the surgeon has been recertified, use that date. Provide a copy of the certification(s).

Board Certification Type	Certification Effective Date/ Recertification Date (MM/DD/YY)	Certification Valid Through Date (MM/DD/YY)	Certificate Number

Part 3C: Section 1 – Medical Personnel, Primary Abdominal Wall VCA Physician

1. Identify the primary abdominal wall VCA transplant physician:

Name:

Check which membership criteria the primary VCA physician will use to qualify. Next steps are within the criteria box selected.

Membership Criteria	Check One
(1) Currently designated as the primary transplant surgeon or primary transplant physician at an active solid organ transplant program. o Which solid organ transplant program? _____ o Proceed to Table 8, Certificate of Investigation.	
(2) Meets the requirements of a primary transplant surgeon or primary transplant physician in the OPTN Bylaws. o Which solid organ transplant program? _____ o Complete the rest of the application.	
(3) Meets the requirements found in Appendix J.2. Fellowship Hospital: _____ Dates: _____ Fellowship Program Director: _____ Medical or Surgical Specialty: _____ o Complete 1a) – e) below.	

a) Provide the following dates (use MM/DD/YY):

Date of employment at this hospital:
Date assumed role of primary physician:

b) Does the physician have FULL privileges at this hospital? (check one)

Yes	
No	

If the physician does **not** currently have full privileges:

Date full privileges to be granted (MM/DD/YY):
Explain the physician's current credentialing status, including any limitations on practice:

c) How much of the physician's professional time is spent on site at this hospital?

Percentage of professional time on site:

Number of hours per week:

d) How much of the physician's professional time is spent on site at other facilities (hospitals, health care facilities, and medical group practices)?

Facility Name	Type	Location (City, State)	% Professional Time On Site

e) List the physician's current board certification(s) below. If board certification is pending, indicate the date the exam has been scheduled. If the physician has been recertified, use that date. Provide a copy of the certifications(s). If the physician does not have current American or Canadian board certification, provide letters of recommendation requesting this exception and provide the plan for continuing education as described in the OPTN Bylaws.

Board Certification Type	Certification Effective Date/ Recertification Date (MM/DD/YY)	Certification Valid Through Date (MM/DD/YY)	Certificate Number

Answer if qualifying by the primary intestine physician requirements: If the physician is not a pediatric gastroenterologist and the program serves predominately pediatric patients, please identify a pediatric gastroenterologist who will be involved in the care of transplant recipients. Provide C.V.

Name	Board Certification	% Professional Time on Site

f) Check the applicable pathway(s) through which the VCA transplant physician will be proposed. Refer to Appendices E-I in the OPTN Bylaws for the necessary qualifications and more specific descriptions of the required supporting documents.

Membership Criteria	Check one
Residency Pathway	
Transplant Fellowship Pathway	
Combined Pediatric Training and Experience Pathway	
Clinical Experience Pathway	
Full (Intestine only)	

Conditional (Intestine only)	

g) Transplant Experience (Post Fellowship) and Training (Fellowship): List the name(s) of the transplant hospital(s), applicable dates, and program director name(s) from either fellowship training or experience post fellowship. If a surgeon is being proposed to serve as the primary physician, also document the number of transplants and procurements performed. If a physician, document the number of patients that were provided substantive patient care (pre-, peri- and post-operatively from the time of transplant).

Training and Experience	**Date** (MM/DD/YY)		**Transplant Hospital**	**Program Director**	**# Transplants as Primary or 1st Assist (Surgeon)**	**# Procured as Primary or 1st Assist (Surgeon)**	**# Patients Followed (Physician)**		
	Start	**End**					**Pre**	**Peri**	**Post**
Fellowship Training									
Experience Post Fellowship									

h) Training/Experience: List how the physician fulfills the criteria for participating as an observer of procurements and transplants. For procurements, the physician must have observed the evaluation, donation process, and management of the donors. **This table is only applicable if you are applying as a primary transplant physician.**

Date From - To (MM/DD/YY)	**Transplant Hospital**	**# of Procurements Observed**	**# of Transplants Observed**

i) Describe in detail the proposed primary physician's level of involvement in **this** transplant program as well as **prior** training and experience **under All Organs. Then also complete the organ specific section for which you are applying through (heart, lung, kidney, liver, pancreas, or intestine).**

Describe Level of Involvement in This Transplant Program		**Describe Prior Training/Experience**
All Organs		
Donor Selection		
Recipient Selection		
Transplant Surgery (surgeon only)		
Pre-operative management/care of patients with acute, chronic disease or end stage organ failure		
Long term outpatient follow-up care		
Immunosuppressive therapy including side effects of drugs and complications of immunosuppressive		
Histological interpretation and grading of allograft biopsies for rejection		
Fluid and electrolyte management (peds only)		
Effects of transplantation and immunosuppressive agents on growth and development (peds only)		
Manifestation of rejection in the pediatric patient (peds only)		

Heart, Lung		
Use of mechanical circulatory support devices/ cardiopulmonary bypass		
Pre-operative hemodynamic/ ventilator care		
Post-operative hemodynamic/ ventilator care		
Kidney, Liver, Pancreas, Intestine		
Differential diagnosis of organ dysfunction in the allograft recipient		
Histocompatibility and tissue typing		
Interpretation of ancillary tests for organ dysfunction		

Table 4: Primary Abdominal Wall VCA Physician - Transplant Log

(Sample)

Only complete this table if applying as the primary VCA transplant physician by qualifying as a primary transplant surgeon.

Organ:	
Name of proposed primary surgeon:	
Name of hospital where transplants were performed:	
Date range of surgeon's appointment/training: MM/DD/YY to MM/DD/YY	

List cases in date order. Add rows as needed. Patient ID should not be name or Social Security Number.

#	Date of Transplant	Medical Record/ OPTN ID #	Primary Surgeon	1st Assistant
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Director's Signature	**Date**
Print Name	

Table 5: Primary Abdominal Wall VCA Physician – Procurement Log

(Sample)

Only complete this table if applying as the primary VCA transplant physician by qualifying as a primary transplant surgeon.

Organ:	
Name of proposed primary surgeon:	

List cases in date order. Add rows as needed. Patient ID should not be name or Social Security Number.

#	Date of Procurement	Donor ID Number	Comments (LD/CAD/Multi-Organ)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
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Director's Signature	**Date**
Print Name	

Table 6: Primary Abdominal Wall VCA Physician - Recipient Log

(Sample)

Only complete this table if applying as the primary VCA transplant physician by qualifying as a primary transplant physician.

Organ:	
Name of proposed primary physician:	
Name of hospital where transplants were performed:	
Date range of physician's appointment/training: MM/DD/YY to MM/DD/YY	

List cases in date order. Add rows as needed. Patient ID should not be name or Social Security Number.

#	Date of Transplant	Medical Record/OPTN ID #	Pre-Operative	Peri-Operative	Post-Operative	Comments
1						
2						
3						
4						
5						
6						
7						
8						
9						
1						

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12						
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Director's Signature	**Date**
Print Name	

Table 7: Primary Abdominal Wall VCA Physician – Observation Log
(Sample)

Only complete this table if applying as the primary VCA transplant physician by qualifying as a primary transplant physician.

Organ:	
Name of proposed primary physician:	

In the tables below, document the physician's participation as an observer in transplants and procurements. For procurements, the physician must have observed the evaluation, donation process, and management of the donors.

List cases in date order. Add rows as needed. Patient ID should not be name or Social Security Number.

Transplants Observed

#	Date of Transplant	Medical Record/ OPTN ID #	Living Donor or Deceased	Recipient Age	Hospital
1					
2					
3					
4					
5					

Procurements Observed

#	Date of Procurement	Medical Record/ OPTN ID #	Living Donor or Deceased
1			
2			
3			
4			
5			

Part 3C: Section 2 – Personnel, Additional Abdominal Wall Physician(s)

Complete this section of the application to describe physicians involved in the program that are not designated as primary, but are credentialed by the transplant hospital to provide transplant services and be able to independently manage the care of transplant patients. Duplicate this section as needed.

1. Identify the additional abdominal wall VCA transplant physician:

Name:

a) Provide the following dates (use MM/DD/YY):

Date of employment at this hospital:

b) Does the physician have FULL privileges at this hospital? (check one)

Yes	
No	

If the physician does **not** currently have full privileges:

Date full privileges to be granted (MM/DD/YY):
Explain the individual's current credentialing status, including any limitations on practice:

c) How much of the physician's professional time is spent on site at this hospital?

Percentage of professional time on site:
Number of hours per week:

d) How much of the physician's professional time is spent on site at other facilities (hospitals, health care facilities, and medical group practices)?

Facility Name	**Type**	**Location** (City, State)	**% Professional Time On Site**

e) List the physician's current board certification(s) below. If board certification is pending, indicate the date the exam has been scheduled. If the physician has been recertified, use that date. Provide a copy of the certification(s).

Board Certification	**Certification**	**Certification**	**Certificate**

Type	**Effective Date/ Recertification Date** (MM/DD/YY)	**Valid Through Date** (MM/DD/YY)	**Number**

Table 8: Certificate of Investigation

1. List all transplant surgeons and physicians currently involved in the program.

   a) This hospital has conducted its own peer review of all surgeons and physicians listed below to ensure compliance with applicable OPTN Bylaws. Insert rows as needed.

Names of Surgeons

Names of Physicians

   b) If prior transgressions were identified has the hospital developed a plan to ensure that the improper conduct is not continued?

Yes	
No	
Not Applicable	

   c) If yes, what steps are being taken to correct the prior improper conduct or to ensure the improper conduct is not repeated in this program? Provide a copy of the plan.

I certify that this review was performed for each named surgeon and physician according to the hospital's peer review procedures.

Signature of Primary Surgeon	**Date**
Print Name	
Signature of Primary Physician	**Date**
Print Name	

Table 9: Program Coverage Plan

Provide a copy of the current Program Coverage Plan and answer the questions below. The program coverage plan must be signed by either the:

a. OPTN/UNOS Representative;
b. Program Director(s); or
c. Primary Surgeon and the Primary Physician.

	Yes	**No**
Is this a single surgeon program?		
Is this a single physician program?		
If single surgeon or single physician, submit a copy of the patient notice or the protocol for providing patient notification.		
Does this transplant program have transplant surgeon(s) and physician(s) available 365 days a year, 24 hours a day, 7 days a week to provide program coverage?		
If the answer to the above question is "No," an explanation must be provided that justifies why the current level of coverage should be acceptable to the MPSC. Please use the additional information section below.		
Transplant programs shall provide patients with a written summary of the Program Coverage Plan at the time of listing and when there are any substantial changes in program or personnel. Has this program developed a plan for notification?		
Is a surgeon/physician available and able to be on the hospital premises to address urgent patient issues?		
Is a transplant surgeon readily available in a timely manner to facilitate organ acceptance, procurement, and implantation?		
A transplant surgeon or transplant physician may not be on call simultaneously for two transplant programs more than 30 miles apart unless circumstances have been reviewed and approved by the MPSC. Is this program requesting an exemption?		
If yes, provide explanation:		
Unless exempted by the MPSC for specific causal reasons, the primary transplant surgeon/primary transplant physician cannot be designated as the primary surgeon/primary transplant physician at more than one transplant hospital unless there are additional transplant surgeons/transplant physicians at each of those facilities. Is this program requesting an exemption?		
If yes, provide explanation:		
Additional Information:		