OPTN/UNOS Pancreas Transplantation Committee
Report to the Board of Directors
November 12-13, 2012
St. Louis, MO

Summary

I. Action Items for Board Consideration

- None

II. Other Significant Items

- The Committee is sponsoring a proposal that requires transplant programs to report each pancreas islet infusion, but no longer submit islet logs to the OPTN Contractor. This proposal has been distributed for public comment, and the Committee anticipates presenting this proposal to the OPTN/UNOS Board of Directors in June 2013 (Item 1, Page 2).

- The Committee discussed functional inactivity issues for pancreas programs (Item 2, Page 6).

- The Committee reviewed pancreas physician and surgeon bylaws (Item 3, Page 7).

- The Committee reviewed updates on its Board-assigned projects (Item 4, Page 7).

- The Committee reviewed public comment proposals, including the proposed policy rewrite effort and proposals released on September 21, 2012 (Item 5, Page 8).

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The following is a summary of the Pancreas Transplantation Committee's (the Committee) meetings that occurred by telephone and Internet on July 30, and in Chicago, Illinois on October 16, 2012.

1. **Proposal to Require Reporting of Every Islet Infusion to the OPTN Contractor within 24 Hours of the Infusion.** The Committee is sponsoring a proposal that requires transplant programs to report each pancreas islet infusion. Programs can do this using existing UNet^{SM} programming that allows the program to easily re-list the candidate for additional infusions. Programs would no longer be required to submit paper islet logs to the OPTN Contractor. This proposal has been distributed for public comment. Below is the summary of the proposal, which, to date, has received favorable feedback from the public and OPTN/UNOS regions:

   Currently, it is not required that islet transplant programs report every islet infusion to the OPTN Contractor. Therefore, it is possible that the OPTN Contractor may be unaware which islet recipients have received infusions, which could have patient safety or disease transmission implications. The goal of this proposal is to require accurate and timely reporting of each islet infusion to the OPTN Contractor, and to update policy and bylaws language to reflect current practice for reporting islet infusions and outcomes information. This proposal:

   1) Requires that islet programs report each islet infusion to the OPTN Contractor within 24 hours of the infusion, while still allowing islet candidates to retain their waiting time through three consecutive islet infusions.
   2) Removes outdated bylaws requirements for submitting islet logs.

   On July 30, 2012, the Committee reviewed the proposed policy and bylaw changes, and voted to submit them for public comment: 13-supported; 0-opposed; and, 0-abstained. The proposed changes do not require programming in UNet℠. The following is the policy and bylaw language changes approved by the Committee for public comment distribution. The Committee anticipates presenting these policy and bylaw changes for the OPTN/UNOS Board of Director's approval in June 2013.

   3.8.7 Islet Allocation Protocol

   [There are no policy changes preceding Policy 3.8.7.2.]

   2.8.7.2 Accrual of Waiting Time~~.~~

   A candidate will begin to accrue islet waiting time when the candidate is registered on the waiting list. Candidates accrue waiting time while registered at an active or inactive status.

   An islet candidate will retain waiting time through three registrations at the registering center, including the waiting time from the previous registrations and any intervening time. After a candidate has received a series of three islet infusions at the registering hospital, waiting time will be reset, and the candidate will retain waiting time through another three

infusions,

~~A candidate is eligible to accrue waiting time:~~

- ~~while listed in an active or inactive status; and~~
- ~~until the candidate has received a maximum of three islet infusions.~~

~~Waiting time will begin when a candidate is placed on Waiting List. Waiting time will end when the candidate is removed from the waiting list. Waiting time will accrue for a candidate until he/she has received a maximum of three islet infusions or the transplant center removes the candidate from the waiting list, whichever is the first to occur. If the candidate is still listed at this time or subsequently added back to the Waiting List, waiting time will start anew.~~

[There are no further changes in Policy 3.8.7.2.There are no changes in Policy 3.8.7.3.]

3.8.7.4 Process for Re-Allocating Islets. If the transplant center determines that the islets are medically unsuitable for the candidate for whom the center accepted the islets, the islets from that pancreas will be reallocated to a medically suitable candidate at a transplant center covered by the same IND, based upon waiting time. The transplant center that accepted the islets on behalf of the original candidate is responsible for documenting:

- to which candidate the center re-allocated the islets, and
- that the center re-allocated the islets to the medically suitable candidate covered by the same IND who had the most waiting time.

The transplant center must maintain this documentation and submit it upon request.

Islet allocation must abide by all applicable OPTN/UNOS policies, including but not limited to:

- Policy 3.2.1 (Mandatory Listing of Potential Recipients), which states that all candidates who are potential recipients of deceased donor organs must be on the Waiting List,
- Policy 3.2.1.4 (Prohibition for Organ Offers to Non-Members), which stipulates that organ offers cannot be made to non-member centers, and
- Policy 3.2.4 (Match System Access), which requires that organs only be allocated to candidates who appear on a match run~~,~~.
- ~~Policy 6.4.1 (Exportation), which states that the exportation of organs from the United States or its territories is prohibited unless a well-documented and verifiable effort, coordinated through the Organ Center, has failed to find a suitable recipient for that organ on the Waiting List.~~

3.8.7.5 Removal from the Pancreas Islet Waiting List~~.~~

The transplant center must remove the candidate from the waiting list within 24 hours of the candidate receiving each ~~his/her third~~ islet infusion.

OPTN Bylaws, Appendix G

G.4 Requirements for Designated Pancreatic Islet Transplant Programs

All Pancreatic Islet Transplant Programs must meet the following criteria:

1. All of the requirements of a Designated Pancreas Transplant Program as defined in the sections above *or* meet the criteria for an exception as detailed in Section *G.4.E: Programs Not Located at an Approved Pancreas Transplant Program* below.
2. Demonstrate that the required resources and facilities are available as described in the sections that follow.

~~**A. Reporting**~~

~~The Program must submit data to the OPTN Contractor for all donors, potential transplant recipients, and actual transplant recipients using the required forms.~~

~~Pending development of standardized data forms for pancreatic islet transplantation, the Program must maintain patient logs and provide them to the OPTN Contractor every 6 months. The patient logs must be cumulative and must include for each transplant performed:~~

~~1. The patient name~~
~~2. Social security number~~
~~3. Date of birth~~
~~4. Donor ID~~
~~5. Patient status (alive or dead)~~
~~6. Whether the pancreas was allocated for islet or whole organ transplantation~~

~~For each pancreas allocated to the Program for islet transplantation, the Program must report to the OPTN Contractor if the islets were used for transplantation. If the islets were not used in transplantation, the Program must report the reason and disposal method, together with other information requested on the Pancreatic Islet Donor Form.~~

A~~B~~. Transplant Facilities

The Program must document adequate clinical and laboratory facilities for pancreatic islet transplantation as defined by current Food and Drug Administration (FDA) regulations. The Program must also document that the required Investigational New Drug (IND) application is in effect as required by the FDA.

B~~C~~. Expert Medical Personnel

The program must have a collaborative relationship with a physician qualified to perform portal vein cannulation under direction of the transplant surgeon. It is further recommended that the Program have on site or adequate access to:

1. A board-certified endocrinologist
2. A physician, administrator, or technician with experience in compliance with FDA regulations

3. A laboratory-based researcher with experience in pancreatic islet isolation and transplantation

Adequate access is defined as having an agreement with another institution for access to employees with the expertise described above.

C~~D~~. Islet Isolation
Pancreatic islets must be isolated in a facility with an FDA IND application in effect, with documented collaboration between the program and the facility.

D~~E~~. Programs Not Located at an Approved Pancreas Transplant Program
A Program that meets all requirements for a Designated Pancreatic Islet Transplant Program but is not located at a hospital approved as a Designated Pancreas Transplant Program may qualify as a Pancreatic Islet Transplant Program if the following additional criteria are met:

1. The Program demonstrates a documented affiliation with a Designated Pancreas Transplant Program, including on-site admitting privileges for the primary pancreas transplant surgeon and physician.
2. The Program provides protocols documenting its commitment and ability to counsel patients about all their options for the medical treatment of diabetes.
3. The Program demonstrates availability of qualified personnel to address pre-, peri-, and post-operative care issues regardless of the treatment option ultimately selected. An informal discussion with the MPSC is also required.

OPTN Bylaws
Article I: Membership
1.2 Transplant Hospital Members

D. Registration Fees
Transplant hospital members are responsible for the payment of an OPTN Registration Fee for each transplant candidate ~~listed~~ registered by that member on the waiting list database maintained by the OPTN Contractor. The OPTN Registration Fee is proposed by the Board of Directors and determined by the Secretary of HHS.

An additional registration fee will be due for a transplant candidate if:

- A candidate is given an inactive status or removed from the waiting list without receiving a transplant and is not placed back on the list within the 90-day grace period.
- A recipient has received a transplant but is put back on the waiting list for another transplant. However, no additional registration fee will be due for an islet candidate who is removed and, if the option to re-register is offered during the removal process, immediately re-registered for an islet infusion.
- A candidate is transferred to a transplant hospital *outside* the original OPO Donation Service Area. A new registration fee must be paid by the receiving hospital.

- The potential recipient is listed at multiple transplant hospitals. A registration fee must be paid by each transplant hospital that places the candidate on the waiting list.

Members who ~~list~~ register candidates needing more than one organ (for example, kidney and pancreas) are only charged one registration fee.

2. **Functional Inactivity for Pancreas Programs.** The Committee continued its discussion on pancreas program functional inactivity. Current recommendations required two pancreas transplants every six months to maintain active program status. The Committee raised concerns that this may not be appropriate. A suggestion had been made to the Membership and Professional Standards Committee (MPSC) that one transplant every three months may be more attainable and appropriate as a standard. A Committee member suggested that the transplant rate may be a more effective way to look at this. The median number of transplants by individual transplant centers is suspected to be approximately four per year, with large volume centers transplanting ten or more a year. Based upon this, a suggestion was made to offer new programs a grace period in reaching such thresholds. A new program would need time to build its waiting list and notify candidates. Committee members also recognized that some centers are not actively pursuing pancreas transplant. It was recommended that those with extremely low volume programs, presumably with less skill and experience due to lower numbers, refer candidates to new or higher volume centers that are serious about pursuing pancreas transplant numbers.

   It was suggested that transplant rates may be the most telling way to measure for inactivity. How fast are candidates being transplanted and removed from the waiting list? The Committee would like to request data to include with this recommendation. How many centers would be affected by low volume? This number should not include multi-visceral candidates. Committee members agreed that there is little value in maintaining programs that only complete one or two pancreas transplants per year, though the issue of geographic availability must also be considered.

   The Committee agreed that it might be wise to await the completion of Chrysalis programming before implementing such changes to the inactivity definition, but they would like to pursue this issue after reviewing the data. A member also noted that it is critical to communicate openly with candidates to make them aware of their options, including programs with higher transplant numbers.

   The Committee requested a response from the MPSC regarding its memo (**Exhibit B**) related to this issue. Data were requested for the Committee to review the relationship between center-specific transplant rates and average annual volume.

   - Relationship between a pancreas transplant center's volume and rate of transplant (e.g. percentage of waitlist candidates transplanted during a fixed time span), overall and for each type of pancreas transplant.
   - The number of pancreas transplant centers that perform 10 or fewer transplants in a 2.5 year window.

   This information will be provided at an upcoming meeting to determine whether there are high volume but low transplant rate centers and vice-versa. Members agreed that there must be accountability in this area, and the data will make the creation of these related bylaws more credible.

3. **Review of Pancreas Primary Physician and Surgeon Bylaws.** The Board of Directors requested that the Committee review the recent rewrite of bylaws related to pancreas programs. Staff briefly summarized the rewritten language describing these requirements. Committee members questioned the range of time (two to five years) for gaining procurement experience, with a minimum of two years. This was put into place to prevent those seeking exposure from going to a high volume program for a short period of time to gain experience in a specific area. A member asked why procurement matters in this instance. The Committee was asked to look at the kidney surgeon requirement bylaws, as this language was drafted to correlate with other organ requirements.

   Members noted that multi-visceral requirements are troubling, in that a program must be approved to transplant pancreas in order to complete multi-visceral transplant, even though they may not transplant isolated pancreata. This is specifically an issue for pediatric transplant centers. Members agreed that an alternate pathway is critical here for qualification as a primary surgeon in this scenario. Members discussed whether pancreas could be transplanted for technical reasons, to complete the multi-visceral transplant and not for function (non-therapeutic transplant). A recommendation was made to discuss this issue with the Pediatric and Liver and Intestinal Organ Transplantation Committees to determine the best way to approach this area of concern without making bylaw requirements overly complex or cumbersome. A Committee member asked if there were any adult programs completing multi-visceral transplant without an active pancreas program. This question will be pursued. Members agreed that there may be benefit in providing an option to list candidates in need of a pancreas for technical reasons in order to complete multi-visceral transplant, noting that this would be a new complexity in policy. The bylaws and policies will need to be carefully reviewed regarding the use of pancreas for technical reasons.

   There is also concern regarding the islets bylaws and their requirements.

   Committee members reviewed and discussed this information. While some specific changes were recommended at the meeting, the Chair proposed the formation of a pediatric subgroup as well as an islet subgroup to consider these specific sections more carefully. It is unclear on whether a surgeon certified for pancreas surgery is needed to have an islet program.

4. **Committee Project Progress Reports.** The Committee completed a review of various efforts underway as assigned by the Board of Directors.

   Pancreas Outcomes Review. The Committee received an overview of work completed by its Pancreas Outcomes Review Subcommittee. This group convened by teleconference on August 22, 2012 (**Exhibit C**).

   Pancreas Graft Failure. Committee members discussed concerns regarding the need to develop a uniform definition of pancreas graft failure. They agreed that an objective method is needed for evaluating failure. This definition will allow for verification when applied and reviewed upon audit. It was noted that some recipients do well post transplant, but may still become Type II diabetics. If a recipient requires insulin temporarily, does this indicate a failed transplant? Committee members also noted that a direct comparison with islet definitions would be helpful if possible. It was suggested that Collaborative Islet Transplant Registry (CITR) data may be a resource for developing such definitions.

A Committee member noted that looking at the qualifications for a pancreas transplant may be helpful in determining a definition for pancreas failure. If a recipient meets relisting qualification, should this then be classified as graft failure? It was noted that graft failure reporting on the program specific reports could be concerning for these reasons. After discussion, the Committee suggested that the Board of Directors or Executive Committee draft a letter to the Health Resources and Services Administration (HRSA) and Scientific Registry of Transplant Recipients (SRTR) regarding its concerns about graft failure being used without good data to define the term in a clear and measurable way.

Facilitated Pancreas Allocation. The Committee continued preliminary discussion on improving facilitated pancreas allocation and updating the policy language to align with the way organs are allocated to help increase placement and transplantation of pancreata. Facilitated pancreas allocation is not addressed in the new allocation system, and members questioned whether it is still necessary. The number of pancreata offered using this system is small. Members discussed the need to review revised policy language, and determine whether facilitated allocation should be struck completely or reinvigorated. A subcommittee was put together to consider this issue and bring suggestions back to the full committee. This group will request information from Center for Medicare and Medicaid Services (CMS) to determine the issue of intent. Members agreed that the pancreas should be evaluated at the point of recovery, not after a period of organ offers.

Best practices for Isolated Pancreas Recovery with an Isolated Intestine. Members discussed whether recovery of isolated intestine may trump recovery of the pancreas during donor recovery. The Committee reviewed a recent manuscript related to this topic that included single center and national data. The OPO representative on the Committee will work to disseminate this information through the OPO community with the intent of increasing the number of recoverable pancreata. This would benefit OPOs by increasing placement rates as well as increasing the number of organ offers related to pancreas alone or simultaneous kidney-pancreas transplant for pancreas programs.

Characteristics of Improved Pancreas after Kidney (PAK) Outcomes. The Committee plans to develop a manuscript based upon its work in this area. Volunteers were requested to complete this project, and an additional year of data was requested to include more recent transplant numbers. There was concern that this may involve added committee work not specifically assigned by the Board of Directors.

5. Review of Policies and Bylaws Issues for Public Comment. The Committee reviewed public comment proposals released in July and September 2012.

   The Committee discussed the proposed plain language rewrite of the policies, released for public comment on July 2, 2012, during its July 30, 2012, conference call (**Exhibit D**). The Committee specifically reviewed which version of the pancreas policies are displayed in the rewrite. (In November 2010, the Board of Directors approved a new pancreas allocation system, but this system has not been programmed.) Additionally, the current pancreas allocation system contains several national variances and the Committee expressed a desire for the variances to be displayed with the current policy language. UNOS staff responded that the proposed rewrite structure will contain a format to include the variances, but that they were not being converted into policy language at this time.

   The Committee completed review of the six policy proposals released for public comment on September 21, 2012, during its meeting on October 16, 2012.

1) Proposal to Substantially Revise the National Kidney Allocation System *(Kidney Transplantation Committee)*

The Vice Chair of the sponsoring committee presented the proposal for consideration. Committee members were encouraged by the Chair to consider the proposal as a whole and also the potential impact on simultaneous kidney-pancreas transplant and overall organ supply as they reviewed the presentation.

After review of the presentation, Committee members raised concerns regarding waiting time under the proposed allocation schema. The Kidney Committee did note that waiting times could actually be longer in the new system for some patients.

Life years gained from current allocation system as compared to dialysis was also discussed. The Chair noted that the proposed system is expected to incrementally increase the amount of life years gained through available organ supply by 5-10%.

Graft survival data for three, five, and ten years was requested. Currently, survival is only depicted for two years post-transplant. A Committee member noted that this longer term follow up might give better insight for selecting cut offs. This was noted as important for all kidneys. The presenter noted that the cut offs can be adjusted within the proposed system as new data comes in. The movement of cut offs can be easily adjusted as needed without disrupting the allocation system. This was considered as the proposed system was designed. Quality of kidney and "quality" of recipient was also noted as variable, and difficult to predict long term. The Committee noted that there should be more explanation of the power of the graft survival slides as related to the risk adjustment.

A member noted that that the prior living donors category has two groups of candidates ahead of it. Is this seen as an area of concern? This observation has been previously noted and data do not appear to disadvantage this population, including those donors who had an organ recovered but not transplanted.

Diabetes was also noted to be non-objective, and could potentially be used for gaming the proposed system because it is self-reported information. The presenter suggested that this may be an area where auditing will be needed. Transplant professionals do not apply this appropriately at listing when other co-morbidities such as hypertension or obesity are involved.

Zero antigen mismatch allocation was also noted reduce opportunities for multi-organ transplant if there were two multi-organ candidates (e.g, a simultaneous kidney-pancreas and a combined liver-kidney) appearing on the list. A Committee member questioned whether a zero antigen mismatch candidate's need was greater and should trump this scenario. The presenter stated that he would take this back to the sponsoring committee for consideration. Glomerular filtration rate **(**GFR**)** was noted as another element that could potentially be used to game the system. It was noted that an acceptable method of testing must be used and back dating for GFR under 20 is not allowed.

A Committee member asked about geographic sharing. Does the proposed system break down geographic boundaries? Can small programs remain viable in this new

schema with the removal of variances? The Committee urged that this be considered carefully. A Committee member asked if sharing could be broken down by donor age or Kidney Donor Profile Index (KDPI). A Committee member opined that kidneys from younger donors might be more likely to be shared.

Overall, the Committee asked that the following elements be considered by the sponsoring committee:

- A request to look at extended life years by KPD
- A request to look at potential interaction between donor risk and recipient risk. What is KDPI at one, three, and five years for best recipients, median recipients. and highest risk recipients?
- From an outcomes-based standpoint, expanded criteria donor kidneys (i.e., those with KDPI over 85%) should be considered differently in order to encourage the use of these kidneys and avoid discard.

Committee members suggested that if a recipient qualifies for pancreas criteria and has had a successful pancreas transplant, then they be classified as diabetic when listed for a kidney. This group of patients still has a higher than average mortality rate. The question was raised as to whether there should be two different definitions for diabetes-related listings when listing for kidney after pancreas transplant.

A member opined that the new system may create too much complexity for a relatively small gain in overall life years. Additionally, in terms of kidney sharing, the proposal eliminates many kidney variances, some of which promote sharing over larger geographic areas than proposed. The Committee recommended that the proposal could be strengthened by providing better data about potential functioning of kidneys from donors with higher KDPI scores (e.g., 1, 3, and 5 expected survival curves for candidates with relatively high, median, and low EPTS scores). With this information, clinicians and patients could make more informed decisions about which types of kidneys to accept, thereby potentially improving utilization. Finally, the Committee recommended that additional attention be paid to the consent process for kidneys based on KDPI. Currently, programs are required to obtain consent from candidates who agree to accept ECD kidneys. Under the proposed system, programs would be required to obtain consent from all candidates based on the maximum KDPI score they would be willing to accept. This change represents a shift away from current practice and needs to be better understood by the transplant community.

After discussion, the Committee did not vote to support the proposal as written, but was in support of the proposal with the caveats outlined in the discussion above (15 in favor, 0 against, 2 abstentions).

Members asked that the Kidney Transplantation Committee carefully consider feedback provided by this Committee, based upon its strong concerns. If the concerns cannot be addressed, the Committee wishes to rescind its support for the proposal.

2) Proposal to Require Reporting of Every Islet Infusion to the OPTN Contractor within Twenty-Four Hours of the Infusion *(Pancreas Allocation Committee)*

The Committee sponsored this proposal, and awaits feedback from committees, regions, and the general public.

3) Proposal to Remove the OPTN Bylaw for Combined Heart-Lung Transplant Program Designation *(Thoracic Organ Transplantation Committee and Membership and Professional Standards Committee)*

Upon review, the Committee determined that it had no comment regarding this issue.

4) Proposal to Change the Composition of the OPTN Finance Committee *(Finance Committee)*

Upon review, the Committee voted in support of this proposal (17 in favor, 0 opposed, 0 abstentions).

5) Proposal to Change the OPTN/UNOS Bylaws to Better Define Notification Requirements for Periods of Functional Inactivity *(Membership and Professional Standards Committee)*

Upon review, a Committee member questioned the definition of a "potential candidate." It was noted as an illogical term to be used for this purpose. Referred patients should not be included and require a letter unless they appear on the specific program's waiting list. The Committee is supportive of being transparent in sending letters to its candidates on the waiting list to notify them of an inactive status. Members agreed that this is important. However, the "potential candidate" phrase was thought to be unclear and poorly defined, putting potential burden on a center to reach out to any patient even referred to the transplant program prior to listing.

The Committee believes that terminology regarding program wait list inactivity needs clarification as well to more plainly state that this is related to an organ-specific program and not a specific patient's inactivity.

Additionally, a Committee member suggested that standardized communication should be provided for centers to use to meet this requirement. Currently, the proposal includes elements that must be included, but not a form letter. A Committee member also questioned whether this letter should include the name of referral centers that may be alternative options for candidates facing long term inactivation. The presenter noted that this is not a required element in the current proposal. Committee members suggested that a standardized form letter should be provided, with a field to be personalized with the transplant center name and pertinent organ-specific program information.

The Committee voted unanimously to oppose the proposal as written (0 for, 17 opposed, 0 abstentions). The Committee appreciated the spirit of the proposal, recognized the transparency needed in this scenario, and supported the concept, but believed that the terms "potential candidate" and "program waitlist inactivity" needs clarification for this proposal to be effective and auditable. The Committee felt strongly that this proposal must be re-worked before going to the Board for consideration.

6) Proposal to Modify the Imminent and Eligible Neurological Death Data Reporting Definitions *(OPO Committee)*

The Committee reviewed this proposal, and appreciated the sponsoring committee's efforts to make these definitions more precise. After discussion, the committee voted unanimously in support of this proposal (17 in favor, 0 opposed, 0 abstentions).

6. **Policy Oversight Committee (POC) Update.** The Committee's Vice Chair provided an overview on discussions from the October 10, 2012, POC meeting. Topics covered included: substantive rewrite of Policies 9 and 10, changes to the policy rewrite project timeline, multi-organ allocation, and addressing geographic disparity in access to organ transplant. The Outcomes Subcommittee will work to address concerns related to geographic disparity.

7. **Welcoming New Committee Members.** The Chair welcomed new Committee members who began terms on July 1, 2012.

Pancreas Transplantation Committee	July 30, 2012 Teleconference and Live Meeting	
Name	**Position**	**Attendance**
David A. Axelrod, MD, MBA	Chairperson	By phone
Jonathan A. Fridell, MD	Vice-Chairperson	By phone
Sayeed K. Malek, MD	Region 1 Representative	By phone
James W. Lim, MD	Region 2 Representative	By phone
Joseph F. Magliocca, MD	Region 3 Representative	
John P. Duffy, MD	Region 4 Representative	
Jonathan S. Fisher, MD, FACS	Region 5 Representative	By phone
Nelson B. Goes, MD	Region 6 Representative	By phone
Jon S. Odorico, MD	Region 7 Representative	
Michael C. Morris, MD	Region 8 Representative	By phone
Bernd Schroppel, MD	Region 9 Representative	By phone
Edmund Q. Sanchez, MD	Region 10 Representative	By phone
Douglas A. Hale, MD	Region 11 Representative	
Lisa Chronis, RN	At Large Member	
Chris Curran, CTBS, CTOP	At Large Member	
Monica Grafals, MD	At Large Member	
Gloria T. Hairston, BS	At Large Member	By phone
Albert J. Hwa, PhD	At Large Member	By phone
Joan Kelly, RN, CCTC, BS	At Large Member	By phone
Dixon B. Kaufman, MD, PhD	At Large Member	
Jason Wellen, MD	At Large Member	By phone
Jim Bowman, MD	Ex Officio – HRSA (Non-Voting)	
Ba Lin	Ex Officio – HRSA (Non-Voting)	By phone
Monica Lin	Ex Officio – HRSA (Non-Voting)	
Sally Gustafson	SRTR	By phone
Susan Leppke	SRTR	By phone
Nicholas Salkowski	SRTR	By phone
James Alcorn	UNOS Staff	By phone
Bob Carrico	UNOS Staff	By phone
Vipra Ghimire	UNOS Staff – Liaison	By phone
Leigh Kades	UNOS Staff	By phone
Elizabeth Miller	UNOS Staff	By phone
Elizabeth Sleeman	UNOS Staff	By phone
Jennifer Wainright	UNOS Staff	By phone

Pancreas Transplantation Committee	October 16, 2012 Meeting in Chicago, Illinois	
Name	**Position**	**Attendance**
David A. Axelrod, MD, MBA	Chairperson	X
Jonathan A. Fridell, MD	Vice-Chairperson	X
Sayeed K. Malek, MD	Region 1 Representative	X
James W. Lim, MD	Region 2 Representative	By phone
Joseph F. Magliocca, MD	Region 3 Representative	X
John P. Duffy, MD	Region 4 Representative	X
Jonathan S. Fisher, MD, FACS	Region 5 Representative	X
Nelson B. Goes, MD	Region 6 Representative	X
Jon S. Odorico, MD	Region 7 Representative	X
Michael C. Morris, MD	Region 8 Representative	X
Bernd Schroppel, MD	Region 9 Representative	
Edmund Q. Sanchez, MD	Region 10 Representative	X
Douglas A. Hale, MD	Region 11 Representative	X
Lisa Chronis, RN	At Large Member	X
Chris Curran, CTBS, CTOP	At Large Member	X
Monica Grafals, MD	At Large Member	X
Gloria T. Hairston, BS	At Large Member	X
Albert J. Hwa, PhD	At Large Member	X
Joan Kelly, RN, CCTC, BS	At Large Member	X
Dixon B. Kaufman, MD, PhD	At Large Member	X
Jason Wellen, MD	At Large Member	X
Jim Bowman, MD	Ex Officio – HRSA (Non-Voting)	By phone
Ba Lin	Ex Officio – HRSA (Non-Voting)	By phone
Monica Lin	Ex Officio – HRSA (Non-Voting)	By phone
Karen Near, MD	Ex Officio – HRSA (Non-Voting)	X
Sally Gustafson	SRTR	X
Raja Kandaswamy	SRTR	X
Bertam Kasiske	SRTR	By phone
Susan Leppke	SRTR	By phone
Nicholas Salkowski	SRTR	
Jon Snyder	SRTR	By phone
James Alcorn	UNOS Staff	By phone
Bob Carrico	UNOS Staff	X
Kerrie Cobb	UNOS Staff	By phone
Vipra Ghimire	UNOS Staff – Liaison	X
Leigh Kades	UNOS Staff	By phone
Jason Livingston	UNOS Staff	By phone
Elizabeth Miller	UNOS Staff	By phone
Heather Neil	UNOS Staff	By phone
Ciara Samana	UNOS Staff	By phone
Jennifer Wainright	UNOS Staff	X