**Interim Report**
**Pancreas Transplantation Committee**

**November 21, 2008**
**Chicago, IL**

The following is a summary of the Pancreas Transplantation Committee meeting on November 21, 2008 held in Chicago, Illinois.

1. **Update on the Implementation of the Kidney Committee's Proposal to Limit Mandatory Sharing of Zero Mismatch Kidneys**

Aaron Powell, PMP, UNOS Project Office Manager, updated the Committee on the implementation of the Kidney Transplantation Committee's proposal to limit mandatory sharing of zero mismatch kidneys. In September 2008, the Executive Committee voted to give the implementation of this proposal greater priority. The expected implementation date for this proposal is January 21, 2009.

2. **Update from the November 2008 Board of Directors Meeting**

Rainer Gruessner, MD, updated the Committee on the November 2008 Board of Directors meeting. Dr. Gruessner presented the major activities of the Committee to the Board. Dr. Gruessner also shared the trends in pancreas transplant by year. Figure 1 shows that the percentage of pancreata that are not recovered is increasing and the percentage of pancreata transplanted is decreasing.

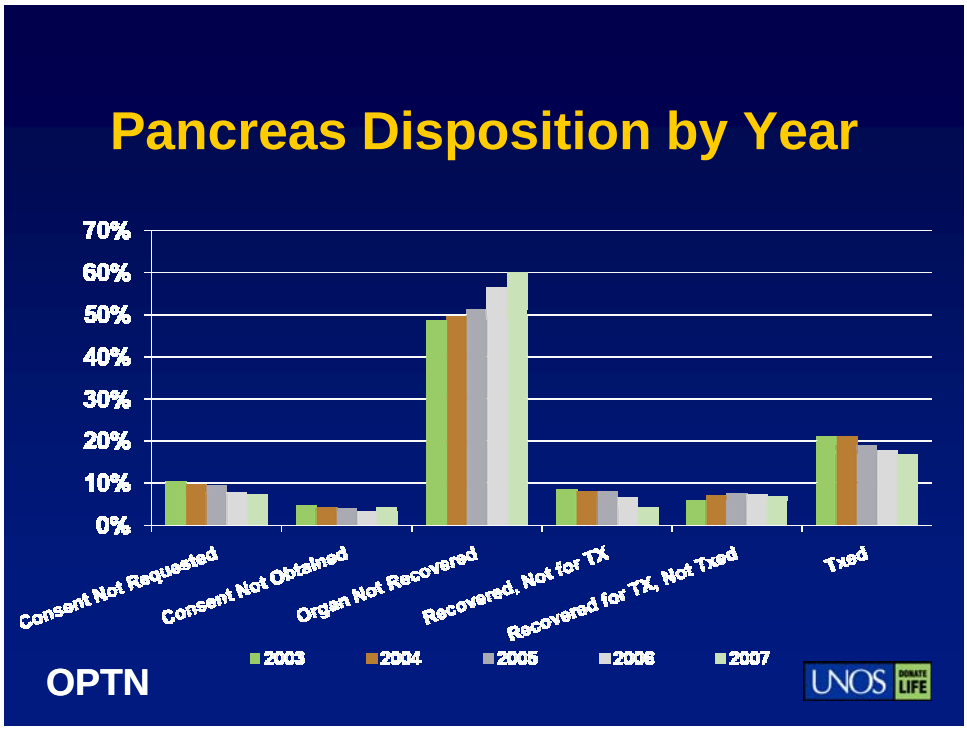



**Figure 1: Pancreas Disposition by Year**

Figure 2 shows that the pancreas discard rate is higher than every other organ and that the pancreas discard rate has increased from 2003 to 2007.

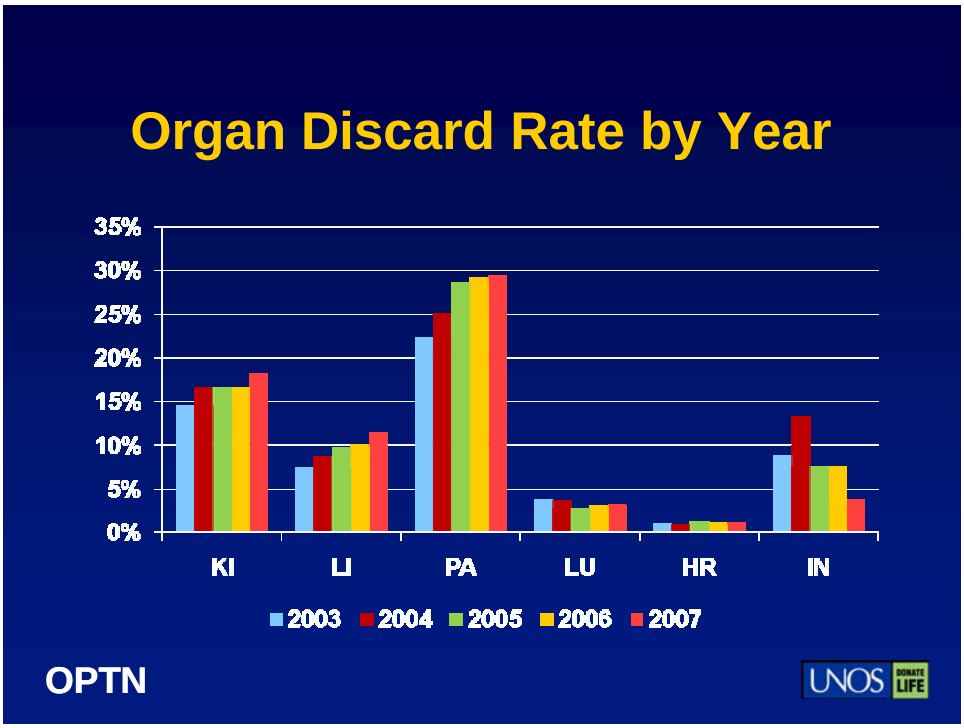



**Figure 2: Organ Discard Rate by Year**

The Committee noted that changes to payback rules and having the kidney follow the pancreas may improve these trends.

### 3. Pancreas Outcomes Review Model Subcommittee Update

The subcommittee has been working with the SRTR to develop an outcomes review model for use by the Membership and Professional Standards Committee (MPSC). Randy Sung, MD, presented the 1-year and 3-year graft failure and patient survival models developed by the SRTR and the Pancreas Outcomes Review Model Subcommittee. Before this review of the pancreas models, the MPSC used an outcomes review model that included only simultaneous pancreas-kidney (SPK) transplants. The subcommittee has recommended that a combined SPK/PAK/PTA model be used so that more pancreas programs can be evaluated by the model. All of the combined models are stratified by transplant type, which allows SPK, PAK, and PTA recipients to have a differing hazard over time. The MPSC only uses the model to evaluate centers that perform ten or more transplants over a 2.5 year period. For each type of model, the combined model is compared to the existing SPK model in the tables below (Tables 1-4).

**Table 1: 1-Year Graft Failure Model**

| | Combined SPK/PAK/PTA Model | SPK-only Model |
|---|---|---|
| **Index of Concordance** | 63% | 58.0% |
| **Covariates** | Deceased donor cause of death, donor age, recipient gender, **recipient age, recipient BMI, recipient PVD, previous pancreas transplant, donor gender, donor height** | Deceased donor cause of death, donor age, recipient gender, *duct management, HLA mismatch* |
| **Interactions** | • Recipient gender and PTA<br>• Donor COD:CVA with PAK | |
| **% of centers that perform less than 10 transplants in a 2.5 year period** | 34.8% | 49.3% |

**Table 2: 3-Year Graft Failure Model**

| | Combined SPK/PAK/PTA Model | SPK-only Model |
|---|---|---|
| **Index of Concordance** | 61% | 57.8% |
| **Covariates** | Donor age, donor gender, recipient age, **recipient PVD, ESRD years (for SPK), previous pancreas transplant, albumin, donor height** | Donor age, donor gender, recipient age, *deceased donor cause of death, HLA mismatch* |
| **Interactions** | • Recipient age and SPK | |
| **% of centers that perform less than 10 transplants in a 2.5 year period** | 34.8% | 49.3% |

**Table 3: 1-Year Patient Survival Model**

| | Combined SPK/PAK/PTA Model | SPK-only Model |
|---|---|---|
| **Index of Concordance** | 73% | 60.4% |
| **Covariates** | Recipient age, years of ESRD treatment, **recipient BMI, duct management, donor age, donor race, pancreas preservation time** | Recipient age, years of ESRD treatment |
| **Interactions** | • Donor age and PAK | |
| **% of centers that perform less than 10 transplants in a 2.5 year period** | 34.8% | 49.3% |

**Table 4: 3-Year Patient Survival Model**

| | Combined SPK/PAK/PTA Model | SPK-only Model |
|---|---|---|
| **Index of Concordance** | 64% | 60.0% |
| **Covariates** | Recipient age, ESRD years, **recipient BMI, recipient albumin, recipient PVD, recipient primary insurance, donor age, donor gender, CMV mismatch** | Recipient age, ESRD years, *recipient gender* |
| **Interactions** | • Primary insurance and PTA | |
| **% of centers that perform less than 10 transplants in a 2.5 year period** | 34.8% | 49.3% |

The Committee debated whether to recommend that the MPSC use the 1-year combined graft failure and patient survival models in its review of pancreas programs. The Committee was concerned that larger, more aggressive programs would be penalized by these models because they do not take into account all of the potential risk factors. This situation would encourage transplant centers to only transplant low risk candidates with pancreata from low risk donors, which could reduce access to transplantation. The Committee also commented that other groups, such as payers, are using these models, but they may not be aware of the limitations of the models. Additionally, the data that is available for input into these models is limited by what is collected. However, the models developed by the SRTR and the subcommittee are better than the models that were available previously. The Committee concluded that it could not recommend a model with an index of concordance below 66%, which is the index of concordance for the lung and liver 1-year graft failure models. The Committee wanted more time to try to reach a higher index of concordance for the models. The Committee voted to recommend that the MPSC:

1. Recognize only the 1-year pancreas combined patient survival model for the assessment of pancreas programs
2. Defer the use of the 1-year pancreas combined graft failure model at least one year until the index of concordance can reach at least 66%, which is the index of concordance of the liver and lung models, and allow the Committee to re-assess pancreas data collection and quality
3. Post the combined graft failure model instead of the SPK model in the interim. (13-Support, 0-Oppose, 0- Abstain)

This recommendation would give the Committee time to assess pancreas data collection and to attempt the raise the index of concordance.

The Committee also discussed the process for making modifications to the data collection forms. All OPTN forms are reviewed and approved by the Office of Management and Budget (OMB). The current forms expire in March 2010. The time for Committee review is through spring 2009. Then the Ad Hoc Data Management Group will review all recommendations, and the Policy Oversight Committee will send all new data elements out as a single public comment proposal. This proposal will be sent to the Board for approval in March 2010. All recommendations for new data elements should adhere to the Principles of Data Collection and Operational Guidelines. The Committees should identify any important data elements that may be missing and try to clarify anything that may be difficult to understand. The Committees should consider whether forms are the appropriate place for this data. For example, data needed for allocation may fit better into Waitlist[SM] or DonorNet®.

The Pancreas Outcomes Review Model Subcommittee has already identified several potential additional data elements. The subcommittee has developed a unified definition of pancreas graft function and failure (Table 5).

**Table 5: Uniform Definition of Graft Function/Failure for Whole Pancreas and Islet Transplant**

| Description | Grade | Insulin Use (U/kg/day) baseline established prior to transplant | C-peptide | Euglycemia defined as: | | | Comments |
|---|---|---|---|---|---|---|---|
| | | | | Hgb A1c | Fasting plasma glucose[1] | "Casual" plasma glucose[2] | |
| Full graft function | **A** | none | normal range[3] | less than 6.0% | <100 mg/dl | < 160 mg/dl | Full graft function definition requires Hgb A1c ≤6.0%, and (with rare exception), fasting & casual plasma glucose values within the specific limit |
| Substantial graft function | **B** | less than 0.2 U/kg/day | normal range[3] | within normal range for lab | <100 mg/dl | < 160 mg/dl | Substantial graft function definition requires Hgb A1c within the normal range, fasting & casual plasma glucose values within the specific limit |
| | | | | | | | |
| Partial graft function | **C** | less than 50% pre-transplant dose | >0.5 ng/ml | less than 7.0% | <126 mg/dl | < 200 mg/dl | |
| | **D** | more than 50% pre-transplant dose | >0.5 ng/ml | less than 7.0% | <126 mg/dl | < 200 mg/dl | |
| | | | | | | | |
| Graft failure | **E** | C-peptide < 0.5 ng/ml or suboptimal glycemia control defined as any Hgb A1c greater than or equal to 7.0%, or any fasting plasma glucose > than 126, or casual plasma glucose values > than 200 mg/dl | | | | | |

**Definitions**

1. No caloric intake for at least 8 hours
2. Plasma glucose any time of day without regard to time since last meal
3. Can be considered "normal" if it is above the laboratory's reference range (often the case in pancreas allograft recipients)

In order to be able to use this definition, several new data elements (c-peptide, HbA1c, fasting plasma glucose, and casual plasma glucose) would need to be added. Additionally, the subcommittee has recommended that coronary artery disease be uncoupled from angina on the pancreas forms. Because this subcommittee is already familiar with the data, the Committee charged the Pancreas Outcomes Review Model Subcommittee with reviewing the pancreas data collection forms and bringing recommendations to the full Committee in the spring.

### 4. Pancreas DRI/DPI Subcommittee Update

David Axelrod, MD, MBA, updated the Committee on the work of the Pancreas DRI/DPI Subcommittee. This subcommittee is working with the SRTR to develop a pancreas donor risk index (DRI). DRI is a measure of organ quality that is computed using a weighted function of several relevant donor and transplant characteristics. Donor Percentile Index (DPI) is developed by using the DRI to rank organs from highest to lowest quality and then assigning each organ a percentile based on where they rank

according to other organs in the sample. This is how the kidney DRI is incorporated into the kidney allocation score (KAS). The DRI can be used to inform clinical decisions, to assess pancreas utilization, and in allocation. The SRTR has created a 1-year pancreas graft failure model with an index of concordance of 66%. The model includes donor age, donor gender, donor race, donor BMI, donor height, donor cause of death being CVA or stroke, DCD status, serum creatinine greater than 2.5 mg/dl, and pancreas preservation time as covariates. The model controls for the recipient characteristics of age, race, BMI, albumin, duct management, peripheral vascular disease, PRA, private primary payment, and previous pancreas transplant. The subcommittee created a reference donor whose DRI is equal to 1. The reference donor is male, is 25 years old, is not black, is not asian, has a BMI of 25kg/$m^2$, is 170 centimeters tall, did not die of CVA/ Stroke, has a pancreas preservation time of 12 hours, is not a DCD donor, and does not have a serum creatinine greater than 2.5 mg/dl. The model shows that there is a difference in graft failure outcomes for recipients who receive pancreata from donors that have a low versus a high DRI. The impact of donor quality is greater for PAK and PTA than for SPK. Additionally, there is more graft loss after 60 days for PAK and PTA than for SPK. There is substantial overlap in the range of DRIs generally used in PTA, PAK, and SPK transplants. However, center aggressiveness as represented by the center's median pancreas DRI varies by center. Centers are more conservative for pancreas alone transplants than for SPKs. Centers that perform more than 40 transplants do have a statistically significantly higher median DRI than centers that perform fewer pancreas transplants. There is also variation in the median DRI and range of DRI used by region. The Committee decided to send this data to the Kidney Transplantation Committee to show why high quality pancreata are important for pancreas candidates.

## 5. Pancreas Review Subcommittee Update

Dixon Kaufman, MD, PhD, presented a review of the data evaluated by the Pancreas Review Subcommittee. The purpose of collecting this data was to investigate changes to pancreas allocation that would be necessary in light of the Kidney Committee's decision to have the kidney follow the pancreas in KAS, to consider the effects of combining the PA and SPK lists, to develop listing criteria for kidney-pancreas transplants, to investigate the use of net benefit in pancreas allocation, and to determine the effect any changes to pancreas allocation might have on pediatric kidney transplantation.

*Combining the PA and SPK Lists*

The Committee noted several advantages to combining the SPK and PA waiting lists:

- A single list for all pancreas candidates is easy to use
- Candidates for all types of pancreas transplants have an equal opportunity to receive offers for high quality pancreata
- Increased national consistency in pancreas allocation
- Does not discourage living donation
- Returns some high quality kidneys to the kidney allocation system

However, combining the SPK and PA lists would result in fewer SPK transplants (approximately 70-80 fewer SPK transplants).

*SPK Listing Criteria*

The Committee discussed the need for SPK listing criteria to allow only candidates who really need both a kidney and a pancreas to be listed for SPK. The Committee discovered that the pancreas transplant community is appropriately listing candidates for SPK in the current system. Very few PA candidates later decide they also want or need a kidney after initially being listed just for PA (51 candidates in 2006 and 40 in 2007). In 2006, only 16 kidney-pancreas candidates who were on the SPK list in 2006 received

a kidney-only transplant, indicating that transplant centers are not listing candidates for a SPK when they only want the kidney. Additionally, few Type 2 diabetic candidates over the age of 45 receive SPK transplants. Out of 318 SPK recipients in 2006 who were older than 45 years old, 38 had Type 2 diabetes (as opposed to 221 who had Type 1 diabetes, 56 who had diabetes type unknown, and 3 who did not have diabetes). Approximately 2% of SPK candidates have never had a creatinine clearance less than 20 **and** are not yet on dialysis. The Committee noted that these data show that the pancreas transplant community is being a responsible steward of scarce resources. The Committee plans to continue its investigation of SPK listing criteria. The Committee noted that instituting listing criteria for when the kidney follows the pancreas based on these data likely would have little impact on what types of pancreas candidates are transplanted.

*Pancreas Transplantation Demographics and Net Benefit*

Kathryn Meyer, MS, reviewed waitlist death rates and net benefit for SPK and kidney-alone recipients. Both diabetic SPK and diabetic KI candidates had shorter waitlist lifespan than non-diabetic KI candidates for all age groups. Diabetic SPK and diabetic KI candidates had similar waitlist lifespan for all age groups. However, diabetic SPK recipients have a longer lifespan post-transplant and greater LYFT than diabetic KI recipients.

The Committee assessed whether there were any differences in donor and recipient characteristics by transplant type (SPK, PAK, PTA). The Committee did not note any significant differences. The Committee also compared SPK and kidney-alone waitlist and transplant rates by age group. There is a higher percentage of 18-49 year old candidates on the SPK waitlist than on the KI waitlist and a higher percentage of 18-49 year old SPK recipients than KI recipients. SPK patient survival, pancreas graft survival, and kidney graft survival are similar for the 18-49 age group and the 50-60 age group, but outcomes are worse for the greater than 60 age group.

The Committee also compared waitlist, transplant, and donor data for DSAs that gave absolute priority to SPK candidates over PA and KI candidates versus DSAs that did not give absolute priority for SPKs. The median donor age was 24 years old in DSAs with absolute SPK priority versus 22 years old in other DSAs. In DSAs with absolute SPK priority, there is a higher percentage of candidates in the 50-60 age group (26.2% vs. 21.7% in other DSAs). However, there is a smaller percentage of SPK transplants for recipients in the 50-60 age group in DSAs with absolute SPK priority (17.2% vs. 19.7% in other DSAs).

*SPK, Pediatric KI, and Multi-Organ Transplants*

The Committee analyzed how many kidneys are transplanted into multi-organ recipients. In 2005, 2006, and 2007, kidney-alone recipients account for the majority of all kidney transplants (88.11%), followed by kidney-pancreas (7.85%) and kidney-liver (3.47%). Whereas the trend in the number of kidney-pancreas has decreased from 8.28% in 2005 to 7.41% in 2007, the trend in the number of kidney-liver transplants has increased from 3.12% in 2005 to 3.87% in 2007. For donors under the age of 35, both kidneys from a donor were transplanted into adult multi-organ recipients in only 2.3% of donors in the post-Share 35 period.

The Committee recommended that this data be published and be sent to the Kidney Transplantation Committee.

*Simulated Allocation Modeling*

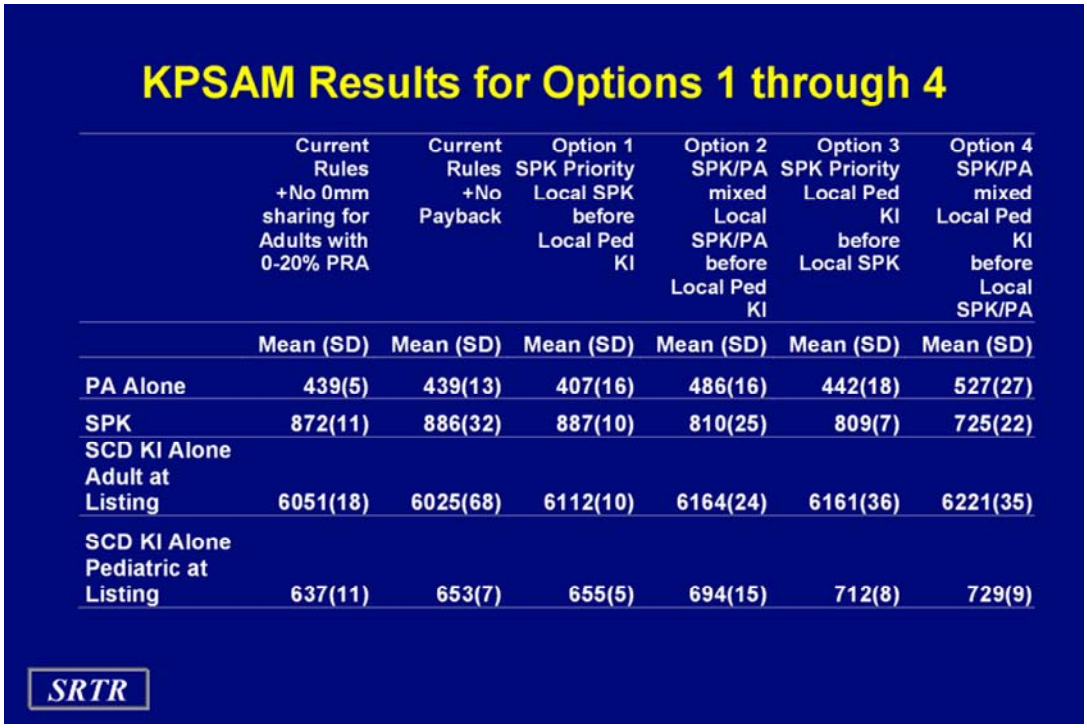
Kathryn Meyer presented the results from simulated allocation modeling requested by the Pancreas Review Subcommittee. At its April meeting, the subcommittee has made several modeling requests of the SRTR, comparing combinations of:

- SPK priority over PA vs. a combined SPK/PA list based on waiting time
- Local SPK priority over local Peds KI vs. local Peds KI priority over local SPK

The subcommittee requested that the SRTR model four allocation options:

- Option 1: Local SPK priority over local Pediatric KI; SPK priority over PA
- Option 2: Local SPK priority over local Pediatric KI; SPK and PA combined into one list
- Option 3: Local Pediatric KI priority over local SPK; SPK priority over PA
- Option 4: Local Pediatric KI priority over local SPK; SPK and PA combined into one list

The simulations assumed that there is no zero mismatch sharing for adult kidney candidates with a PRA of 0 to 20% and that there are no paybacks. Figure 3 shows the number of pancreas-alone, kidney-pancreas, pediatric kidney, and adult kidney transplants that would occur under each option.




| | Current Rules +No 0mm sharing for Adults with 0-20% PRA | Current Rules +No Payback | Option 1 SPK Priority Local SPK before Local Ped KI | Option 2 SPK/PA mixed Local SPK/PA before Local Ped KI | Option 3 SPK Priority Local Ped KI before Local SPK | Option 4 SPK/PA mixed Local Ped KI before Local SPK/PA |
|---|---|---|---|---|---|---|
| | Mean (SD) | Mean (SD) | Mean (SD) | Mean (SD) | Mean (SD) | Mean (SD) |
| PA Alone | 439(5) | 439(13) | 407(16) | 486(16) | 442(18) | 527(27) |
| SPK | 872(11) | 886(32) | 887(10) | 810(25) | 809(7) | 725(22) |
| SCD KI Alone Adult at Listing | 6051(18) | 6025(68) | 6112(10) | 6164(24) | 6161(36) | 6221(35) |
| SCD KI Alone Pediatric at Listing | 637(11) | 653(7) | 655(5) | 694(15) | 712(8) | 729(9) |

**Figure 3: KPSAM Results**

The results show that combining the SPK and PA lists increases PA transplants and decreases SPK transplants. All options results in more pediatric KI transplants and more adult KI transplants than the current system. The Committee suggested that it would be helpful to assess outcomes other than number of transplants, such as mean waiting time. The Committee requested that the Pancreas Review Subcommittee meet to define the goals of the allocation change and to request further simulations.

### 6. Kidney Allocation Score (KAS) Request for Information (RFI)

Peter Stock, MD, PhD, reviewed the major concepts in the KAS RFI with the Committee. The purpose of the RFI is to request input on concepts for possible incorporation into the allocation system for deceased donor kidneys. The proposed new kidney allocation system is based on three major concepts: ranking candidates based upon objective medical criteria (LYFT), replacing SCD/ECD with DPI, and changing from time since listing to time on dialysis (DT). These components are combined into a kidney allocation score. The proposed system will also maintain priority for pediatric candidates and

prior living donors, include a sliding scale priority for sensitized candidates, eliminate absolute priority for 0-ABDR mismatch to unsensitized candidates, eliminate the kidney payback system, change SPK allocation, and incorporate the $A_2/A_2B$ Committee-sponsored alternative allocation system nationally. The objectives of the proposed system are to improve outcomes of recipients of deceased donor kidneys through improved matching of graft/recipient projected survival and to improve access for biologically disadvantaged kidney transplant candidates (highly sensitized, blood group B, minority candidates). The KAS calculation is based on candidate life years from transplant (LYFT), candidate dialysis years (DT), donor profile index (DPI), and candidate sensitization level. LYFT is defined as the difference between a candidate's median projected lifespan post-transplant minus his projected median waitlist survival without a transplant. The time without a transplant is adjusted for quality of life. The DPI is a continuous measure which provides more clinical information than the current ECD/SCD categories about a donor's kidneys. More information should improve clinical decision making.

*Projected Results*

African-Americans will receive approximately 5% more kidneys under the proposed system. Distribution by blood type is similar between the current and proposed system, with a slight increase for B candidates in the proposed system. Candidates with glomular nephritis and hypertension will receive more kidneys under the proposed system, whereas candidates with diabetes over the age of 50 will receive fewer kidneys. Moderately sensitized candidates (PRA 20-79%) and younger candidates will receive a larger percentage of kidneys under the proposed system. In the proposed system, the average post-transplant lifetime increases from 11.8 years in the current system to 13.1 years. Average graft lifetime increases from 8 years in the current system to 8.2 years in the proposed system. Average extra years of life increases from 5.3 years in the current system to 5.7 years in the proposed system.

Committee members expressed concern that the proposed system disadvantages older candidates with diabetes. The Committee supported the proposed changes to SPK allocation because the changes are advantageous for pancreas candidates.

### 7. Memo from the OPO Committee Regarding Establishing Priorities for Multi-Organ Allocation

The OPO Committee has been receiving questions regarding priority for multi-organ transplants. The OPO Committee voted to recommend that each organ specific committee and the Pediatric Committee prioritize multi-organ versus individual organ allocation and establish very specific guidance as to the priority for allocation of organs in a multi-organ transplant situation. The OPO Committee would like updates on the other committees' progress in this area. The Pancreas Transplantation Committee decided to send the OPO Committee the multi-organ priority that the Committee has considered for the modeling changes to pancreas allocation. In this scheme, kidney-pancreas transplants would follow other types of multi-organ transplants.

### 8. Memo from the OPO Committee Regarding the Definition of Multi-System Organ Failure

The OPO Committee is currently grappling with inconsistent data collection from OPOs regarding imminent and eligible (I & E) deaths. One of the concerns they have identified is the inconsistent manner in which multi-system organ failure (MSOF) is being interpreted and its effect on I & E data collection. The OPO Committee asked if there are specific criteria that the Pancreas Transplantation Committee would propose, if met, classify a pancreas as having failed or if the Committee has a definition for "organ failure" with respect to the pancreas. The Committee decided to send the OPO Committee the definition of pancreas graft failure and function developed by the Pancreas Outcomes Review Model Subcommittee.

## 9. Islet Consensus Conference

The Committee discussed having an islet consensus conference in spring 2009 to include the islet transplantation community, representatives from HRSA, CMS, FDA, NIH, JDRF, URN, AOPO, and others. The preferred location would be Washington, DC so that government officials might be able to attend. The agenda would include a review of the current allocation policies and an update from CITR on outcomes. The Committee must find outside funding in order to be able to hold this consensus conference. The first step in the process is for the Committee to write up the purpose of the conference and explain how it is within the purview of the OPTN. Rainer Gruessner, MD, Dixon Kaufman, MD, PhD, Marlon Levy, MD, and Horatio Rilo, MD, volunteered to work on this justification.

## 10. Public Comment Proposals

### a. Proposal to increase the safety of allocations to candidates who do not appear on the match run- Membership and Professional Standards Committee

The revision to Policy 3.1 will incorporate the definition of a directed donation into OPTN policy. The revision to Policy 3.2.4 will require the transplant center to:

- determine why the candidate does not appear on the organ match run for the donor, and
- verify that the donor organ is safe and appropriate for the candidate by comparing donor information and candidate information available in UNet$^{SM}$ before the transplant.

The revision to Policy 3.9.3 will clarify that when multiple organs are allocated to a single recipient, the term "on **a** match run" means that the recipient must appear on the heart, lung, or liver match run. This clarification does not alter the organ allocation sequence defined by organ allocation policy.

The Committee was concerned about the impact this proposal could have on islet allocation. The Committee supported this proposal for whole organs, but it had concerns about the proposal being applied to islets. The Committee believes that this policy would open a loophole that would allow centers to transplant islet candidates who are not on the match run and cite the reason that it prevented islet wastage. The Committee thought that the proposal could open the door for islet transplants not being reported to UNOS because there are currently no islet follow-up forms. The Committee believes that recipients of islet transplants should always appear on the match run. The Committee voted to support the MPSC's proposal for whole organs but not for islets. (11-Support, 0-Oppose, 0- Abstain)

### b. Proposal to clarify, reorganize and update OPO policies to align with current practices- OPO Committee

The proposed modifications clarify the policy requirements, eliminate redundancy and align policy with current OPO practices. The changes reorganize the content, eliminate repeated laboratory tests, and update terminology. The proposed policy modifications should clarify policy and reduce OPO confusion in order to reduce the OPO's risk of non-compliance and enhance patient safety.

The Committee voted to support the OPO Committee's proposal. (10- Support, 0- Oppose, 0- Abstain)

## 11. Feedback on Pancreas Public Comments Proposals and Path Forward

Elizabeth Sleeman, MHA, updated the Committee on responses to the two Pancreas Transplantation Committee proposals out for public comment. So far, the majority of the individual responses have been

supportive of both proposals. The Committee will have a conference call in January to review feedback to these proposals and to vote on whether to send these proposals to the Board in March.

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University of Arizona
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Elizabeth F. Sleeman, MHA
UNOS Staff/Policy Analyst
804-782-4616

| PANCREAS COMMITTEE | | JULY 1, 2008 - DECEMBER 31, 2008 |
|---|---|---|
| | MONTH | NOVEMBER |
| | DAY | 21 |
| | FORMAT (select) | In Person |
| **NAME** | **COMMITTEE POSITION** | |
| Rainer W. Gruessner MD | Chair | X |
| Dixon Kaufman MD, PhD | Vice Chair | X |
| David Axelrod MD, MBA | Regional Rep. | X |
| Peter Abt MD | Regional Rep. | X |
| George Burke III, MD, FACS | Regional Rep. | |
| Marlon Levy MD | Regional Rep. | X |
| Ron Taubman | Regional Rep. | |
| Christian Kuhr MD | Regional Rep. | X |
| Joseph Leventhal MD,PhD | Regional Rep. | |
| Ahmad Abdulkarim MD, PhD | Regional Rep. | X |
| Sandip Kapur MD | Regional Rep. | X (by phone) |
| Venkatesh Krishnamurthi MD | Regional Rep. | X (by phone) |
| Dinesh Ranjan MD | Regional Rep. | X |
| Mary Beth Drangstveit RN | At Large | X |
| David Harlan MD | At Large | |
| Albert Hwa PhD | At Large | |
| Khalid Khwaja MD | At Large | X |
| Christopher Marsh MD | At Large | |
| Patricia Niles RN, BS, CPTC | At Large | X |
| Horatio Rilo MD | At Large | X |
| Meg Rogers | At Large | X |
| Paul Volek MPH | At Large | X |
| Peter Stock MD, PhD | Ex. Officio | X |
| Elizabeth Ortiz-Rios MD, MPH | Ex Officio | X |
| Kathryn Meyer MS | SRTR Liaison | X |
| Randall Sung MD | SRTR Liaison | X |
| Elizabeth Sleeman MHA | Committee Liaison | X |
| Jason Chicirda | Support Staff | X (by phone) |
| Jennifer Wainright Ph.D. | Support Staff | X |
| Aaron Powell, PMP | Support Staff | X |
| Ciara Samana, MSPH | Support Staff | X |