

OPTN/UNOS Liver and Intestinal Organ Transplantation Committee
Report to the Board of Directors
November 12-13, 2012
St, Louis, MO

Summary

I. Action Items for Board Consideration

- The Board is asked to approve changes to Policy 3.6.4.4 (F) (Extensions of HCC Exception Applications) that would allow transplant programs to voluntarily place candidates with stable or well-treated hepatocellular carcinoma (HCC) in inactive status without losing accumulated exception points (Item 1, Page 2).

II. Other Significant Items

- The Committee requests to review the rewritten policies pertaining to liver and intestinal transplantation and provide potential edits prior to submission to the Board (Item 2, Page 4).
- The Committee is examining ways to modify the priority assigned to candidates with exceptions for HCC. A questionnaire was circulated in October 2012 to obtain community feedback prior to developing a policy proposal (Item 3, Page 4).
- The Committee plans to circulate a proposal for public comment in the spring of 2013 that would add serum sodium to the Model for End-stage Liver Disease (MELD) score (Item 4, Page 6).
- The Committee is considering a possible MELD exception for recipients of livers from donation after cardiac death (DCD) donors who develop biliary strictures post-transplant (Item 4, Page 7).
- The Committee has been reviewing data related to the utilization of deceased donor livers to help formulate a transparent process for expedited liver placement that will enhance utilization and decrease discards (Item 5, Page 8)
- The Committee discussed a project being conducted by the Scientific Registry of Transplant Recipients (SRTR) contractor that uses principles-based optimization to design alternative regions for liver allocation (Item 7, Page.10)

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Kim M. Olthoff, M.D., Chair
David C. Mulligan, M.D., Vice Chair

This report presents the OPTN/UNOS Liver and Intestinal Organ Transplantation Committee's (Liver Committee) deliberations during its September 5, 2012 meeting and July 23, 2012, conference call.

I. Action Items for Board Consideration

1. Post Public Consideration of the "Proposal to Allow Transplant Centers to Place Liver Candidates with Exceptions for Hepatocellular Carcinoma (HCC) on 'HCC Hold' Without Loss of Accumulated Exception Score. Under the current policy, candidates listed with an exception for HCC continue to receive increases in priority every three months regardless of whether the HCC tumors have shown progression. Thus, candidates with small tumors that do not demonstrate progression such as an increase in size, rising AFP, or development of new lesions continue to receive higher and higher MELD scores even though their risk of dropout from the waiting list (i.e., death or becoming unsuitable for transplant) is low. These candidates continue to receive offers as their MELD score increases, despite the fact that the transplant center may not be ready to transplant the candidate yet, causing inefficiency in organ placement. The Committee proposed modifications to the current policy that would allow transplant programs to voluntarily place well-compensated candidates with stable or well-treated HCC in inactive status without losing accumulated exception points. This proposal was circulated for public comment from March 16, 2012, through June 25, 2012. During the September 2012 meeting, the Committee reviewed the comments submitted on this proposal. Of the 62 individual responses, 29 (46.8%) were in support, 10 (16.1%) were opposed, and 23 (37.1%) had no opinion. Of those with an opinion, 74.4% were in support. Nine regions were in support, while Regions 5 and 10 supported with amendments. The American Society of Transplantation (AST) was opposed, and the American Society of Transplant Surgeons (ASTS) was in support. The Patient Affairs and Transplant Administrators Committees were in support. In general, comments in opposition included concerns that:

- Candidates would come out of inactive status with high MELD scores and appear on the top of the waiting list;
- This would become mandatory policy; and
- The option would not be used by many centers.

The first concern stemmed from a misunderstanding of the proposal. This proposal would actually prevent candidates from accruing additional points while inactive, something that can occur currently if centers submit the required paperwork every three months during periods of inactivation. If the Committee determined that this should become mandatory, any policy change would require a separate proposal that would be circulated for public comment. Finally, several large centers have indicated that they would use this option if it was available. The briefing paper, which includes the Committee's responses to comments received, is included in **Exhibit A**. The Committee submits the following resolution for consideration by the Board of Directors:

***** RESOLVED, that Policy 3.6.4.4 (F) (Extensions of HCC Exception Applications) shall be amended as set forth below, effective pending notification and programming in UNetSM.**

**3.6.4.4 Liver Transplant Candidates with Hepatocellular Carcinoma (HCC).
A. – E. (no change)**

F. Extensions of HCC Exception Applications. Candidates will receive additional MELD/PELD points equivalent to a 10 percentage point increase in candidate mortality to be assigned every 3 months until these candidates receive a transplant or are determined to be unsuitable for transplantation based on progression of their HCC. To receive the additional points at 3-month intervals, the transplant program must re-submit an HCC MELD/PELD score exception application with an updated narrative every three months. Continued documentation of the tumor via repeat CT or MRI is required every three months for the candidate to receive the additional 10 percentage point increase in mortality points while waiting. Invasive studies such as biopsies or ablative procedures and repeated chest CTs are not required after the initial upgrade request is approved to maintain the candidate's HCC priority scores.

The following options are available while a candidate with an approved HCC Exception application is in inactive status:

- The center may choose to submit an extension application every 3 months, as described above; the candidate will receive a MELD/PELD score equivalent to a 10 percentage point increase in candidate mortality following each approved extension.
- The center may keep the candidate in inactive status for any length of time, without submission of an extension application every 3 months. However, prior to reactivation, an extension application must be submitted. Once the extension application is approved, the candidate will be listed with the candidate's previously approved exception score prior to inactivation (i.e., without loss of the accumulated MELD/PELD exception score) upon re-activation.

If the number of tumors that can be documented at the time of extension is less than upon initial application or prior extension, the type of ablative therapy must be specified on the extension application. Candidates whose tumors have been ablated after previously meeting the criteria for additional MELD/PELD points (OPTN Class 5T) will continue to receive additional MELD/PELD points (equivalent to a 10 percentage point increase in candidate mortality) every 3 months without RRB review, even if the estimated size of residual viable tumor falls below stage T2 criteria.

For candidates whose tumors have been resected since the initial HCC application or prior extension, the extension application must receive prospective review by the applicable RRB.

G. – I. (no change)

Committee Vote: 22 in favor, 0 opposed, and 0 abstentions.

The Resource and Impact Statement for this proposal is provided in **Exhibit B**.

II. Other Significant Items

2. Policy Rewrite Project. The Committee discussed the plain-language rewrite of the OPTN policies that was circulated for public comment in July 2012. In several places, parts of the policies were omitted, or the new wording changed the intent of the original policy. For example, for Status 1A candidates with fulminant hepatic failure, the statement that “absence of pre-existing liver disease is critical to the diagnosis” was removed, but this is required on the Status 1A justification form and is an important component of the policy. Some of the changes identified will require the clinical expertise of the Committee to determine if the meaning has been changed. One decision that caused concern is the removal of examples, which are helpful for the centers and auditors when determining compliance with policies. If these examples cannot reside in policy, then there must be some way for them to be easily cross-referenced. Committee members will review the issues identified and provide recommendations to UNOS staff. Committee members asked to review the final version before it is submitted for final consideration, and approved the following motion by a vote of 22 in favor, 0 opposed, and 0 abstentions:

Motion: that the Liver and Intestinal Organ Transplantation Committee must be allowed to review the rewritten policies pertaining to liver and intestinal transplantation and provide potential edits prior to submission to the Board.

3. HCC Working Group Report. The Committee reviewed the recent history of policy development for candidates with HCC. A consensus conference held in November 2008 generated several recommendations for policy, including revised imaging criteria, an on-line explant pathology form, changes to the priority for HCC exceptions, and policies for downstaged HCC, HCC beyond the Milan criteria, and those treated with loco-regional

therapies. New imaging criteria were approved by the Board in November 2011, and the pathology form was implemented in UNetSM in April 2012.

The Working Group has been examining ways to modify the priority assigned to candidates with exceptions for HCC. As shown in Figure 1, dropout rates are generally much lower for candidates with HCC exceptions, but it is variable across regions. In regions with higher MELD scores (and longer waiting times) at transplant, tumor patients tended to have more similar wait list dropout rates to non-HCC patients, which may be due to those with unfavorable tumor biology dropping off the list. A high percentage of patients are transplanted with HCC exceptions, but the percentage also varies across regions.

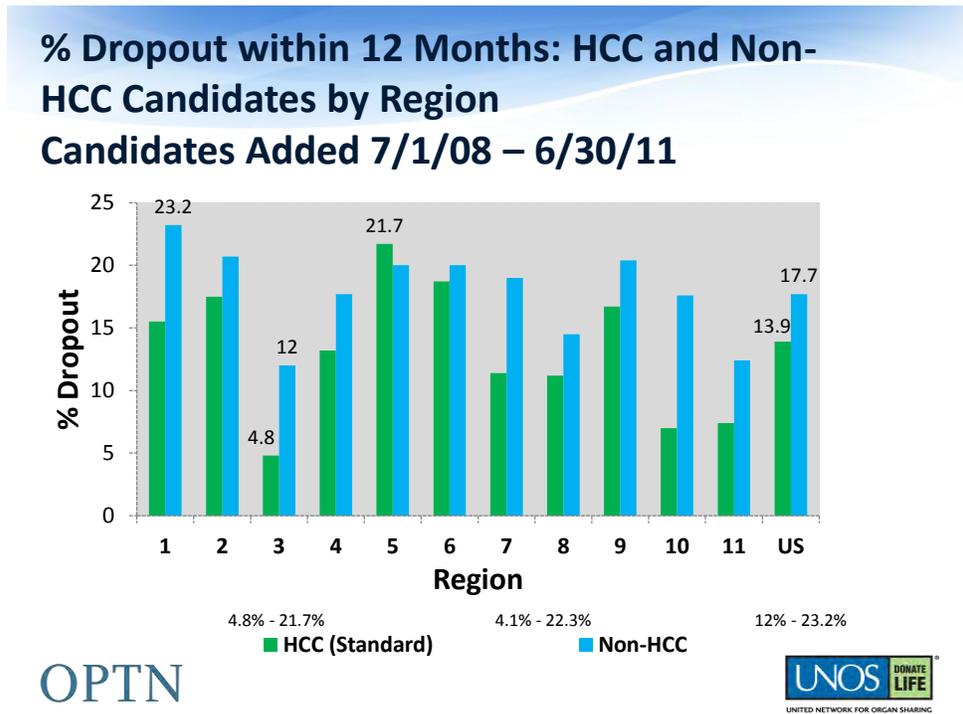


Figure 1

The Working Group requested modeling of several alternative policies, including lowering the initial score assigned for HCC exceptions, placing a cap on the score that can be reached upon extension, or requiring some waiting period before exception scores could take effect.

Lowering the initial score would address the issue of HCC exceptions having too much priority, simply by decreasing it from the start. Deferring the score for some period would build in time to observe the biology of the tumor prior to transplantation. Candidates could still receive offers based on the calculated MELD score while the HCC score is pending. The idea of capping the score stemmed from the observation that the high HCC exception scores are driving the rising MELD scores across all regions, but does not address the problem of dissimilar wait list dropout rates. Depending on the score selected, a cap may not affect areas of the country that transplant candidates at low MELD scores. To account

for this variation in the MELD score at transplant across the country, the working group asked the SRTR to modeling of an HCC exception score based on median MELD score at transplant in each region. Although the 2008 consensus conference participants also recommended a continuous HCC score that would include MELD, tumor size, tumor number, and AFP, the Committee decided against modeling this option at this time due to concerns over the potentially negative impact on outcomes and the lack of robust data to properly weight the factors.

When modeled alone and in combination, there are 12 different algorithms, plus the current policy (**Exhibit C**). The SRTR anticipated having results available for presentation in mid- to late October 2012. The Committee reviewed a questionnaire designed by the HCC Working Group regarding these possible proposals. The Committee agreed that it would be helpful to gauge the community’s support prior to circulating a proposal for public comment.

4. MELD Enhancements Subcommittee Report. The Subcommittee has been working on two potential policy changes:
 - Modifications to the MELD score; and
 - A standard exception for recipients of livers from donation after cardiac death (DCD) donors that develop biliary cast syndrome and need retransplant.

The Subcommittee will also continue to review data on MELD exceptions and develop improved guidelines for RRB review and granting of exceptions, especially in light of the “Share 15 National” policy approved in June 2012.

MELD-Na Proposal

The MELD score has been in use for over 10 years without modification. Over the last year, the Committee has been working with the SRTR to consider changes to the MELD score, including adding serum sodium (MELD-Na), and refitting the coefficients and the upper and lower cut-points for bilirubin, INR, and creatinine using recent data (‘refit MELD’), as well as combinations of the two approaches (Table 1).

Table 1. Definitions of Proposed MELD Equations

Name	Description
MELD	Current
MELD-Na	Current MELD + Sodium (Na) added
Refit MELD	Coefficients and upper/lower cutoffs for bilirubin, INR and creatinine updated with recent data
Refit MELD-Na-1	Refit MELD (above) + Na added
Refit MELD-Na-2	Coefficients and upper/lower cutoffs for bilirubin, INR, creatinine and sodium updated

Most recently, the Committee asked that the SRTR provide demographic data on the types of candidates transplanted under each scenario using the Liver Simulation Allocation Model LSAM (**Exhibit D**). LSAM analyses suggested that recipient age, gender, and race distributions would not be dramatically different under the different MELD equations. When compared to the current MELD score, all other equations modeled resulted in slightly more patients transplanted with alcoholic liver disease (18.1-19.1% vs. 17.7%) and fewer patients with malignancy (10.5 -11.9% vs. 12.8%), but these were very small differences. Under the Refit MELD or MELD-Na system, liver transplant recipients were more likely to have higher bilirubin, higher INR, and lower sodium levels, but these differences were also very small. There were fewer recipients with high creatinine levels under the current MELD system than other MELD equation models.

The Committee discussed the advantages of using the various models. Using the refit MELD models might necessitate changing the sharing thresholds, which would not be ideal as the Share 15 National and Share 35 Regional were recently approved by the Board. MELD-Na would not require this, and was similar in terms of the reduction in overall deaths to the refit MELD-Na-1. Also, as sodium is a surrogate for ascites, the need for exceptions for ascites might diminish. The Committee was reminded that when modeled with LSAM, MELD-Na reduced total deaths (pre- and post-transplant) by about 50 per year, with very good discrimination as shown by the C-statistic (Table 2). The Committee approved a motion to circulate a proposal for MELD-Na for public comment by a vote of 22 in favor, 0 opposed, and 0 abstentions. The Subcommittee will determine the details for when sodium should be obtained (e.g., at time of listing or using same schedule as other MELD laboratory values).

Table 2. Summary Statistics for MELD Equations

	MELD	MELD-Na	Refit MELD	Refit MELDNa 1	Refit MELDNa 2
Discrimination					
C-Statistic	0.868	0.877	0.872	0.88	0.879
Calibration					
SSE	304	264	188	109	98
LSAM					
Pretransplant Deaths	Ref	-66	-27	-57	-47
Total Deaths	Ref	-52	-26	-61	-44

Exception for Recipients of DCDs

The Subcommittee was charged with developing a proposal for a standardized MELD exception for recipients of DCD livers who develop biliary strictures and need retransplant, perhaps similar to the exception provided for recipients who develop hepatic artery thrombosis (HAT) after 7 days. The HAT exception provides an incentive to utilize these donors by providing a safety net if the candidate requires retransplantation. The Subcommittee reviewed analyses of the trends in utilization of DCD donors and donation

after brain death (BDD) donors for liver transplants; recipient characteristics of DCD vs. BDD transplants; the frequency of listing for re-transplantation following transplantation with DCD vs. BDD; and outcomes for recipients of DCDs (**Exhibit E**). The data showed that, for the years 2004-2011, fewer than five percent of transplants were performed using a DCD donor (fewer than 300 per year), and that DCDs were used least often in Region 4 (1.2%) and most often in Region 7 (8.6%). DCD livers were more often used in recipients with MELD scores less than 15 and are rarely used in pediatric recipients. There were no significant differences in the demographic characteristics of DCD recipients. While recipients of DCD donors relisted within 2 years of transplant at more than twice the rate of BDD liver recipients, the rates of relisting for DCD recipients have dropped slightly when stratified by era of transplant (2004-2007 vs. 2008-2011). Committee members suggested that the analyses be restricted to data from the later era, as patterns of utilization of DCDs have changed over time.

The Committee reviewed analyses of comparative outcomes of DCD vs. BDD transplants, overall and by region, as well as the predictors of death and graft failure following transplantation with DCD (**Exhibit F**). Recipients of DCDs had lower rates of graft and patient survival at one year than did recipients of BDDs, and these rates were statistically significant. There was no difference in the hazard ratio between the unadjusted and adjusted analyses, suggesting that recipients of DCDs have a higher risk ratio independent of other factors. There did not seem to be a correlation between the average MELD score at transplant and the use of DCDs by region, or between the utilization rate and the graft failure rate by region. The hazard ratios for graft failure and death for recipients of DCDs vs. BDDs are different among regions ($p < 0.0001$). Factors associated with a higher risk of graft failure between DCDs and BDDs include recipients of previous liver transplants, those with a primary diagnosis of metabolic liver disease or HCV, and those who were on life support or dialysis prior to transplant.

The Committee requested the outcomes for recipients of DCDs who are later retransplanted, which will help determine whether additional priority should be given to these patients. Committee members also asked if there is a benefit to candidates from getting a DCD donor transplant versus waiting for a BDD donor; this has been published in a paper written by researchers at Northwestern University. The Committee was polled to determine whether to continue to develop a proposal for a standard exception score for candidates relisted after a DCD transplant, and the majority indicated support. The Subcommittee will continue to review additional data and the transplant literature as it develops a potential policy proposal.

5. Liver Utilization Working Group Report. This Working Group has been charged to formulate a transparent process for expedited liver placement that will enhance utilization and decrease discards. To address this charge, this working group has been reviewing data related to the utilization of livers. The working group began by studying the characteristics of livers that were shared nationally, those placed out of sequence, and those discarded (**Exhibit G**). More recently, the group had requested that the OPTN develop a “donor profile” for expedited placement, i.e., subsets of donor livers that are more likely to be shared

outside the local area. Numerous factors were included in the initial analysis. This yielded a profile based on the donor age, whether a biopsy was performed, split versus whole liver, hepatitis B and C serologies, and alanine transaminase (ALT or SGPT) levels. Of adult donor livers recovered and transplanted between July 1, 2008 and June 30, 2011 (n=14,601¹), 1194 donors (8%) fit the donor profile. Donors meeting at least one of the criteria in this profile were shared 48% of the time vs. 21% for those that did not, with an odds ratio (OR) of 3.5 [CI 3.10 - 3.95]. During this three-year period, 341 donors fitting the profile were discarded.

The Working Group discussed potential mechanisms for expedited placement of livers that fit a pre-determined profile, once finalized. Working group members were concerned about the number of discarded livers, as well as the lack of transparency associated with organs that are placed in an expedited manner. The working group had discussed several concepts for improvement or best practices, some of which may fall outside of the purview of the Committee or the OPTN, such as:

- Livers should be procured by someone more experienced than a fellow;
- Donors likely to be turned down locally should be identified prior to cross-clamp, as cold ischemia time is a large contributor to discard;
- The center that accepts the organ should be held accountable if they decline the organ at the time of procurement (unless there is some clear issue with the donor such as a tumor);
- Biopsies should be done prior to cross-clamp so that another center can be notified if the center turns it down;
- DonorNet[®] should allow “blast offers” for these donors, by MELD score (versus OPOs making calls to a few centers); and
- An expedited placement list could be structured such that centers that routinely turn down these livers could lose the ability to get these offers until they demonstrate a willingness to accept them.

Committee members discussed the importance of timely access to biopsies, such as pre-procurement biopsies (or “bedside biopsies”), which are not always available at some hospitals 24 hours a day. The Committee was reminded that the biopsy resources approved by the Board in June 2012 are available on the OPTN website.

Some of the concepts discussed may require modifications to DonorNet[®] to allow more combinations for acceptance criteria (e.g., DCD and age) and also increase the number of offers that go out at one time for specific donors after being turned down locally. It was reported that Region 9 is using a centralized import system via a grant from HRSA. One OPO serves as the regional importer, and the match list is re-run when an organ is imported. There are guidelines for how long the center can take to identify a recipient for that donor. Pictures are taken of the liver, and the offers are transmitted to 5 surgeons at once. It was

¹ Excluding donors procured in Region 9 (as Region 9 already shares all livers within the region), Hawaii, and Puerto Rico (due to their geographic circumstances)

noted that this is something that cannot be done through DonorNet[®] currently. Data from this project can be provided to the Committee as it is available. This working group will need to work with the OPO and Operations Committee as it develops proposals related to biopsies, placement, and DonorNet[®] issues.

6. Analysis of the Impact of Status 1 Sharing. As part of its duty to monitor the impact of policy changes, the Committee reviewed the waiting list outcomes (deceased donor transplant, death, other removal) for those listed in Status 1 prior to and following implementation of the Regional share for Status 1 candidates on December 15, 2010 (**Exhibit H**). The rates were computed using a competing risks methodology. Overall, there were 41 fewer Status 1 transplants in the post-policy era. There were 53 fewer adults but 12 more pediatric candidates in Status 1 (6 Status 1A and 6 Status 1B). There were more non-White Status 1A recipients in the post-era. The ethnic distribution for Status 1Bs was similar in both eras. The overall death rate in Status 1 was lower after policy implementation, with a slightly lower Status 1A death rate and a much lower Status 1B death rate. It was noted that the drop in Status 1 listings may be attributed to the change in the Status 1 review process implemented in late 2010.
7. Update on the Redistricting Regional Boundaries Project. Following a presentation at the American Transplant Congress in 2010, the Health Resources and Services Administration (HRSA) asked the SRTR to pursue a project focused on reducing geographic disparities in liver distribution. The SRTR is using principles-based optimization to design alternative regions for liver allocation. The details have been provided to the Committee during prior meetings. The Committee has been asked to determine the principles of allocation to be used, such as reducing disparities in the MELD score at transplant or reducing waitlist deaths. The current model regroups existing DSAs into novel regions/units using an integer programming model, and assigns each DSA to exactly one new “region.” The program includes constraints to ensure that the level of the MELD score at which any region exhausts its supply of livers is similar across regions, while trying to minimize organ travel times. The Committee reviewed two sample maps generated to illustrate the concepts. The Committee was asked to comment on a potential directive to “Consider...changes to liver allocation, with the goal of improving geographic fairness as measured by center-level variance of median MELD at transplant (or other variable), provided that predicted waitlist deaths are no greater than in the current system, and provided that worst-case transport times within the contiguous United States are never longer than 8 hours.”

One member commented that this is the most important project discussed thus far, as artificial lines dividing patients do not make sense; another noted that the current system does not follow the OPTN Final Rule and disadvantages socioeconomically deprived patients who cannot afford to travel to other areas for a transplant. Others noted that some of the discrepancies may be driven by factors outside the OPTN’s control, such as insurance coverage, different rates of liver disease/donors, etc. As there are no standards or contraindications for listing, waiting list mortality is not simply a product of access to the list or to donor organs once listed. Committee members discussed whether equalizing the

MELD score at transplant is the right measure, as opposed to waiting list death rates. This will be an ongoing discussion between the Committee and the SRTR.

8. Overview of RRB Processes. During the July conference call, the Committee received a brief introduction to Regional Review Board (RRB) processes and the duties of the regional representatives as RRB chairs. The RRBs approve requests for MELD/PELD exceptions. The criteria for exceptions are described in several policies: 3.6.4.5 (Liver Candidates with Exceptional Cases) and subsections 3.6.5.1-3.6.5.6, 3.6.4.3 (Pediatric Liver Transplant Candidates with Metabolic Diseases), 3.6.4.4 (Liver Transplant Candidates with Hepatocellular Carcinoma (HCC)), and 3.6.4.1 (Adult Candidate Status) for candidates with hepatic artery thrombosis. The RRBs are also governed by the RRB Operational Guidelines; this document includes the rules for transplant center representation and alternate voters, as well as the responsibilities of RRB chairs and members in terms of voting procedures and timeliness of voting. The guidelines were last approved by Board in 2009.

Per the policies and the guidelines, applications for “standard” MELD exceptions (those outlined in Policies 3.6.4.5.1-3.6.4.5.5) are reviewed by the RRB chair. The criteria and scores are outlined in policy, and centers are expected to use the templates provided to them to ensure that the required information is included in the clinical narrative. This is an interim ‘non-programming’ solution until these can be programmed as automatic exceptions in UNetSM. The RRB Chair is expected to approve the application if the criteria are met. Applications are sent to entire RRB if the criteria are not met. All other exceptions are sent to the RRBs for a vote. Several regions have developed agreements for approval of specific diagnoses, which is acceptable per policy.

Standard HCC applications (those that meet all criteria and are automatically approved by UNetSM) are assigned initial and extension scores on a percentage mortality risk (15%, 25%, 35%, etc) and the assigned scores are fixed at each extension (22, 25, 28, 29, etc). All other exception applications, including those HCC applications that meet criteria but have missed a deadline, begin with a requested score, and the percentage mortality is “back-calculated” with each extension. This calculation results in different score for second extension (27 versus 28), so centers must ask the RRB for a score of 28 in order to stay on the same track as standard HCCs. To change this would require complete reprogramming of exceptions. The Committee reviewed an example of the calculation that leads to this difference in scores. It is important for RRB members to understand this issue, as it has led to many requests to the RRBs.

The Committee discussed other areas of concern that have been expressed related to MELD/PELD exceptions, in particular, the very high number of non-standard MELD exceptions. This will be reviewed by the MELD enhancement working group to see if there are ways to standardize some of the differences in exception practices across regions.

The Committee was reminded that Status 1 listings that do not meet criteria are reviewed by the Status 1 Review Subcommittee on behalf of the Liver/Intestine Committee. These are retrospective reviews, although members may request a prospective review.

9. RRB Streamlining Project. The Committee received a brief overview of this project, which began with a request from then-UNOS President, John Lake, M.D., in March 2012. As a result of two projects that UNOS staff had been working on in parallel, the Policy Rewrite Project and the Chrysalis programming project, it became clear that making the Regional Review Boards more consistent in their processes could save substantial programming costs, as well as make the policies clearer and easier for the public, practitioners, and staff to understand. A subcommittee was formed consisting of representatives from the Liver and Intestinal Organ Transplantation and Thoracic Organ Transplantation Committees. The Subcommittee has several times by conference call and proposed ideas for change to the system. In July 2012, the Subcommittee was asked to limit the scope in order to focus on decisions required to allow the Chrysalis programming to proceed. These included:

- How and when to count alternate votes;
- Voting: defining tie breakers, quorum, and majority;
- The effect of a negative vote by a review board; and
- Extensions of exceptions.

The other issues will be pursued later. For the Liver RRBs, the required changes were limited to the RRB Operational Guidelines, essentially putting in writing what is already being done in practice. The policies should be unchanged. The modifications to the Liver RRB Guidelines were approved by the Executive Committee in August 2012 to facilitate streamlined programming on Chrysalis (**Exhibit I**).

10. Joint Societies Working Group for Living Donor Liver Policies. The Living Donor Committee is developing policies for medical evaluation, informed consent, and follow-up of living liver donors similar to those developed for kidney donors. A Joint Societies Working Group (ASTS, AST, and the National Association of Transplant Coordinators) is developing recommendations to be submitted to the Living Donor Committee in early 2013.

11. National Share for Liver-Intestine Candidates. The Board approved a proposal for national sharing for liver-intestine candidates in November 2011. When the proposal was circulated for public comment, the text suggested that it would only apply to candidates with short gut syndrome (SGS), but the document also included a question asking “Would you support the proposal if patients with portomesenteric thrombosis were included?” The actual policy language in the proposal included no diagnostic restrictions. Very few comments were received, with one region commenting that there should be no restrictions. Based on this, the policy went to the board with no diagnostic restrictions. There was some concern that some members would feel that the policy approved differed from the one that was proposed in that one respect. Committee members noted that the important factor for these very ill candidates is not their diagnoses, but the fact that they have intestinal failure. Further, policies for broader sharing for liver-only candidates have no such restrictions.

12. Liver Alternative Allocation System (AAS) Removal. The Committee was informed that the Region 8, Ohio, and Tennessee AASs are scheduled to be de-programmed at the end of 2012.

Attendance, September 5, 2012 and July 23, 2012

		Sept. 5	July 23
Kim Olthoff, M.D.	Chair	X	X
David C. Mulligan, M.D.	Vice Chair	X	
Adel Bozorgzadeh, M.D.	Regional Rep. Region 1	X	X
Andrew Cameron, M.D.	Regional Rep. Region 2		
George Loss, M.D.	Regional Rep. Region 3	X	X
Mark R. Ghobrial, M.D., Ph.D.	Regional Rep. Region 4	X	
Johnny C. Hong, M.D.	Regional Rep. Region 5	X	X
Susan Orloff, M.D.	Regional Rep. Region 6	X	X
David C. Cronin, II, M.D., Ph.D.	Regional Rep. Region 7	X	
Michael D. Voigt, MB, Ch.B.	Regional Rep. Region 8	X	
Milan Kinkhabwala, M.D.	Regional Rep. Region 9	X	
Atsushi Yoshida, M.D.	Regional Rep. Region 10	X	
Kenneth Chavin, M.D.	Regional Rep. Region 11	X	X
Fredric D. Gordon, M.D.	At Large	X	X
Burnett S. Kelly Jr., M.D.	At Large	X	X
Leona Kim-Schluger, M.D.	At Large	X	X
Nancy Knudsen, M.D.	At Large	By telephone	
Manuel Rodriguez-Davalos, M.D.	At Large	X	X
Kirti Shetty, M.D.	At Large	X	
Mike Wachs, M.D.	At Large	X	X
Simon P. Horslen, M.B., Ch.B.	At Large	X	X
Thomas Starr	At Large	X	X
Fredric G. Regenstein, M.D.	At Large	X	
Srinath Chinnakotla, M.D., M.Ch.	At Large	X	
Ryutaro Hirose, M.D.	At Large	X	X
Ken Murphy, J.D.	Board Liaison	X	
Ba Lin, Ph.D.	HRSA, <i>ex officio</i>	X	X
Monica Lin, Ph.D.	HRSA, <i>ex officio</i>	X	X
James Bowman, M.D.	HRSA, <i>ex officio</i>	X	
Karen Near, M.D.	HRSA, <i>ex officio</i>	X	
Peter Stock, M.D.	SRTR	X	X
Jiannong Liu, M.S.	SRTR	X	
Ajay Israni, M.D.	SRTR		X
Kimberly Neiman, M.S.	SRTR		X
Ann Harper	UNOS, Committee Liaison	X	X
Erick Edwards, Ph.D.	UNOS, Research Support Staff	X	X
Cheryl Hall	UNOS, Business Analyst		X
Susan Duerksen, R.N., M.S.N.	UNOS, Site Surveyor		X
James Alcorn, J.D.	UNOS, Policy Director		X
Liz Robbins, J.D.	UNOS, Policy Analyst		X
Aaron McKoy	UNOS, RRB Supervisor		X