OPTN Executive Committee
Meeting Minutes
June 7, 2020
Teleconference

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Introduction

The Executive Committee (EC) met via teleconference on June 7, 2020 to discuss the following agenda items:

1. COVID-19 Update
2. New Projects Recommended for Approval
3. OPTN Policy Clarification
4. Regional Study Project Update
5. Board Committee Elections Bylaws
6. 2021-2014 Strategic Planning Process

The following is a summary of the Executive Committee's discussions.

1. COVID-19 Update

The OPTN Executive Director presented a review of the organ donation and transplant data over the last 12 weeks compared with data from the past year.

Data summary:

The transplant community data for the past 12 weeks were reviewed. While COVID-19 has created quite a challenge, data seems to indicate that trends are moving positively and beginning to recover. The number of deceased donors significantly decreased in March, but has since rebounded and is almost back on track. By comparison, other countries experienced more challenges and significantly decreased numbers in transplants due to COVID-19. The fact that U.S. transplant center staff were able to quickly adjust to the challenges of finding tests and equipment, for example, and stop the descent in donors at that point, is a testament to the determination and professionalism of the transplant community. Geographically, some areas were hit much harder than other areas. Data from OPTN regions previously used for external reporting showed timing and steepness were different for different regions; however, eventually most parts of the community went through a decrease at some point, followed by a rebound.

There has been a slight change in the donors that were accepted for transplant. Centers perhaps were being more selective about the timing of a transplant and whether donors should be brought into the hospital, but that turned out to be more candidate-specific than donor-specific in the long run, with more emphasis on slightly younger donors.

Donor KDPI calculations during COVID-19 compared to 2019 show slightly more use of low donor KDPI and slightly less use of high donor KDPI. There is a slight decrease of the hardest-to-use organs, but given the magnitude of the COVID change, the numbers are still remarkably similar to each other.

DCD donation slightly decreased, but numbers are small enough to easily see a big change in a short time. The number of DCD donors is below the 2019 average, which shows the transplant community is being more selective, but the change is not dramatic.

Data on all organ types for deceased donor transplants shows similar patterns of decreased numbers and then a move back towards a more typical number the closer it gets to today. Percentage decreases are larger for kidneys, indicating some were considered less urgent, while transplants for other organs proceeded. Data on all organ types for living donor transplants were similar. Living donation nearly stopped in March. Centers showed concern for recipients and donors, and considered whether bringing them into the hospital environment was appropriate. Again, in May 2020, the numbers nearly returned to the high level they were at prior to COVID-19.

Cumulatively, numbers of deceased donor transplants were stronger at the beginning of 2020 compared to 2019, slowing to less than that of 2019 only due to COVID-19. The strong start to the year and the dedication of the transplant community during the pandemic led to almost exactly as many transplants early June 2020, as early June 2019.

To be discussed further at the Board of Directors' meeting in June will be the registration number, which has dropped significantly, but has started to rebound a little, though not in the same way the other numbers have. Therefore, a conservative budget will likely be approved in June, as the registration numbers are being tracked. Currently, the revenue for OPTN is about $3 million less than expected.

In the last couple of months, the Executive Committee approved a number of emergency actions.

a) Updates to candidate data during 2020 COVID-19 emergency

   Policy changes allow candidate data and labs active in the system prior to COVID-19 to be used in case labs could not be updated.

b) Applications for modifications of kidney waiting time

   Changes were made to allow for the ability to apply for kidney waiting time.

c) Relax data submission requirements

d) Incorporation of COVID-19 testing in DonorNet

   Testing fields were incorporated into DonorNet to improve communication between OPOs and centers regarding COVID-19 testing.

UNOS Research staff presented a summary of the monitoring reports on the COVID-19 emergency policy and IT modifications.

<u>Policy updates</u>

- Updates to candidate lab data were made to allow old lab values to be used to maintain waitlist status. Consistently week over week, usage of this update was about 5% for liver candidates, 8% to 10% for adult lung, and very low for adult heart and pediatric lung.
- Modifications were made for wait time initiation for non-dialysis kidney candidates by creatinine clearance/GFR of <20 in policy. Registrations in general have decreased, but the proportion of additions qualifying for waiting time not by dialysis have remained fairly stable at 30% to 35%. Policy change allows for wait time modification request forms to be backdated to the COVID-19 era. About 60% of the forms submitted in May were related to COVID; therefore, the backlog is being worked through.
- Updates regarding relaxation of data submission requirements included that forms expected between 3/13/20 and the end of September would move into amnesty status every night, and

would not need to be filled out until post-COVID-19. As expected, the percent of TRFs, LDFs, and post-transplant malignancy forms in amnesty status have grown, and graph failures and patient deaths are still being reported in a timely manner.

- The policy change included extending the time allowed for centers to submit graph failure and patient deaths from 14 days to 30 days. Data on median days from the time of the event to the validation of the form were presented. Even with the expanded timeframe for reporting, there has actually been a decrease in the days between the event and the validation of the form, which might be attributed to increased communication between centers and transplant recipients.

Guidance

Guidance was given in early April to maintain waiting times for inactive candidates. Donor age acceptance criteria would be set to a particular value, so that candidates that are unlikely to receive organ offers could remain active and accrue waiting time. Most heart, lung, and liver registrations moved from inactive status to active status in early April, which means the community read the guidance and reacted accordingly.

System changes

- The three COVID-related refusal reasons are candidate-related, donor-related, and OPO and transplant center/hospital operational-related reasons. COVID-19-related reasons accounted for 40%-60% of match refusals for all organs except intestine, which was lower. However, numbers of COVID-19-related refusals is decreasing perhaps due to relaxation of COVID restrictions.
- There has been a decrease recently in COVID-related refusal reasons across all organs. The percent of all waiting list removals for COVID-19-related deaths shows kidney had the highest total count of deaths, but a lower proportion than lung, kidney, pancreas. Also in the report, on the post-transplant side, most of the COVID-19 reported deaths were for kidney recipients reaching as high as 50 in one week late in March. The data shows a little bit of a tapering, but more data is expected to see if that number persists or not, since centers have twice as long to enter deaths in the system.

These changes were taken under the Executive Committee's authority to make an emergency action in an effort to comply with a change in a law or regulation due to an emergency public health issue/patient safety issues. The full report is available to the Committee so the members can review it and submit any questions.

The timeline for public comment was presented. Expiration dates for emergency actions cannot be more than a year away, so the 3/17/20 actions were approved through March 2021, and the one 4/3/30 action was approved through September 2020, which could be extended up to a year in the future, but not beyond that without going through regular public comment and through the Board of Directors. The policy changes will go out for public comment for at least 30 days, no more than 6 months after approval, even if it is intended to allow them to expire or if it is decided at a future meeting to have them revoked. A Board meeting is scheduled for 6/8/20. Public comment for all the policies and proposals for this cycle is scheduled to begin on 8/4/20 and end 10/1/20. With the 6-month requirement, it was assumed that the actions would be sent to the regular public comment cycle, but feedback would not be completed until October, after the regional meetings, including virtual meetings. The Committee therefore has the option to obtain public comment sooner than August. It could be up on the website in a few days, as long as it lasts 30 days.

There is an OPTN site in collaboration with societies, joint webinar, and others about clinical practices, available data, and treatments. The collaborative OPTN site is available to all members and is about operational practices, bringing patients in and out of the hospital setting, and reopening office space that may have been closed temporarily, for example. There are separate threads set up for trading ideas. The July MPSC is going to be virtual. All the spring committee meetings, as well as the last three regional meetings, were virtual. There is nothing scheduled in-person for the next 10 weeks. The next scheduled in-person meetings are the first regional meetings in late August, and those are being evaluated for the possibility of in-person meetings, as things are changing fast. Members can opt to postpone site surveys or have them conducted virtually. Many members are teleworking and some staff are occasionally working on site, along with facility maintenance. There has been little to no interruption of day-to-day functions.

Summary of discussion:

The EC has the option to repeal the emergency actions or leave them in place at this time. One committee member felt it best to leave the emergency actions in place due to the great uncertainty of COVID-19. Another member agreed.

The Committee Chair also agreed with letting things continue for now. Looking at the data, it does not look like people are abusing the emergency actions in any way, so that is not a concern.

It was clarified that because the emergency actions are in place, the Committee does not have to act to leave them.

Regarding emergency actions going out for public comment, one Committee member felt the only reason for a faster public comment would be if there controversy around the decisions the EC made to try to protect patients and enable the transplant centers and OPOs to do their best job possible to continue to transplant. The data so far seem to indicate the policy changes have been supported and effective. No issues have been brought up by the community regarding the changes. Therefore, allowing the changes to go to fall public comment should be sufficient.

The Committee Chair stated for consistency and lack of confusion, that since the 4/3/20 emergency actions expire before the end of fall public comment, it might be best to have them extended to coincide with the other actions' expirations of March 2021. It was confirmed that the expiration could be extended, as long as it is not further than a year from approval in emergency status. The actions will be reviewed at every EC meeting as long as they are active.

One Committee member agreed with staying the course on the timeline to increase engagement with the rest of the community. People are in different phases of recovery from COVID-19, so trying to get public comment sooner runs the risk of not being able to engage a fuller audience. Another Committee member supported staying on the timeline since the future is unclear and since other activities are occurring in many cities across the country, which might result in a backlash of COVID-19.

An additional comment was that looking at the COVID-19 responses, just focusing on pediatrics, it looks like there has been come recovery, but then a drop on the deceased donor transplant side. This could be a follow-up item if there are any thoughts as to why that is. It seems like recovery has not been as beneficial in pediatrics. In addition, there has been tight collaboration within some of the pediatric societies on COVID-19. Heart groups are currently conducting joint meetings, the last being 2 days ago, where they discussed that the recovery option did not work out for them because of their unique circumstances. In addition, they felt the impact of VADs for pediatrics has not been quite as severe as anticipated because VADs are beneficial in terms of deferring transplants.

Another question from the same Committee member was whether working remotely was going to be a permanent change in culture at UNOS. The OPTN Executive Director did confirm that UNOS has improved technologies, so some of what is being done now could be carried forward. Remote meetings are easier to conduct and the interactivity of those meetings should work better in the future. Some departments are looking at whether they could conduct full-time telework.

One Committee member commented that the EC encouraged the transplant community to use the local donor procurement teams to recover organs for transplant centers that are a great distance from donor hospitals. It was inquired whether there is any information regarding the number of donors being recovered by local procurement teams, as well as a comparison of historic and pre-COVID data related to recovery for individual organs. It was clarified that these data are not reported to OPTN and are therefore not in the system. Anecdotally it sounds like there has been more local recovery and this could be a project for the future to gather hard data.

The POC Chair agreed that New England OPOs have experienced more local recovery and increased coordination of organs being imported into New England from other areas. This is seen more with livers and less so with hearts and lungs. There is a workgroup that is looking at local recovery that was established through the POC prior to the pandemic. It will be reported to the Board that there needs to be a better way to measure local recoveries and collect the data to find the ideal scenario for practice and what changes need to be made for each specific organ. It seems there is a lot more collaboration of centers, including liver transplants, and people are recovering more often than before.

Next steps:

There was consensus to allow the emergency actions to proceed to public comment according to the current timeline.

2. New Projects Recommended for Approval

The Chair of the Policy and Oversight Committee (POC) presented the three new project proposals: Pediatric Heart Guidance, Updating the Median MELD, and Sorting within Live Allocation Classification. All three new projects were recommended by the POC to go forward.

Data Summary:

The first new project is a pediatric heart guidance coming out of the Thoracic committee. Very straightforward, relating to the creation of the National Pediatric Heart Review Board. The goal of this project is to provide better guidance for the Pediatric Review Board reviewers to ensure some consistency. The analysis was supportive of this, and with alignment with other related projects that were happening, it passed quickly.

The first Liver Committee project relates to updating the median MELD at transplant (MMaT). The concern that the Liver Committee wanted to address in this new project was the fact that allocation draws the circle relative to the donor hospital where the organ becomes available, whereas the exception scores that are being used, use circles around the transplant hospital, resulting in discrepancies that need to be addressed and resolved. The vote was to move this forward.

The second Liver Committee project is being called Sorting within Liver Allocation Classification. It is about reprioritization of liver candidates that have exceptions. The project will address two concerns, one relating to the ranking of candidates with exceptions, and the other relating to whether there needs to be some reprioritization because of the way the exceptions were calculated, possibly resulting in some unfairness. The POC had a relatively robust discussion regarding this proposal because of the limited details about the project. The POC needs to determine if the projects coordinate with other

work that is happening, if should they should be prioritized in terms of resources, and in terms of timing and sequencing of the project with other work that is going on, either for that committee or more broadly for all of the committees. Discussion and concerns were raised that the work on the project might be premature, given the fact that the implementation of acuity circles is relatively new and that some Liver Committee concerns might level out with a little bit more time under the new acuity model.

In addition, the Liver Committee is expected to start work on the continuous distribution framework early next year, which may not coincide with the time and resources it would take for this new project. The continuous distribution framework may have more flexibility to address the very same issues that the POC is identifying, at least with respect to the second project about prioritization, as it will be able to adjust in a more dynamic way than the classification work that is available now.

The Liver Committee did receive the POC's feedback. Some of the new project summaries were revised to be clearer and more specific. The POC did pass both of the Liver Committee's new projects and recommends to the Executive Committee that they move forward. The Liver Committee is aware that shortly they will be working on the continuous distribution, but felt that these changes were needed more immediately.

Summary of discussion:

One Committee member commented on the Updating the MMaT Calculation project. He previously discussed with the Liver Subcommittee Chair their work looking at exception points. Their concerns are that patients are being awarded exception for hepatocellular carcinoma tumors in the liver, for example, which is the same risk based on the disease for those patients, regardless of where they live. The whole purpose was to try to create equity in distribution. The idea is that because of the 250 nm circle around the donor hospital, one area could potentially have patients with the same disease with conflicting exception scores in different areas all within that circle. There are four areas of the country where this happens most frequently, and the idea is to create fairness and normalize that by picking a number, whether it be the mean or the highest or the lowest number, and just make all the patients with that same disease exception have the same score within that 250 nm circle. The Liver Subcommittee has been asked to come up with a proposal to do that and that is the intent of it being looked at more expeditiously.

In addition, the Liver Committee's Sorting within Liver Allocation Classifications Project has to do with the wait time at a particular exception MELD, depending on when the time changed. The Updating MMaT Calculation Project has to do with the process of what to do when awarded an exception in a different 250 nm circle around the donor hospital compared to the transplant center to the complex issue. The new allocation system created a 1- to 2-point disparity in neighboring areas, which may or may not level itself out. The project is only for the time and resources for the Liver Committee to come up with a possible solution to the complex issue, but it is also possible that they will conclude that a policy proposal is not needed at this time, there is a better fix for the issue, as well as roll it into their work with continuous distribution. Further, more data may become available that could change the current path forward on the project. The EC Chair stated that the community supports having OPTN look at this issue and would seem to support the project is important to consider.

A motion was made and seconded for the Executive Committee to approve the all three new projects recommended by the POC as a bloc vote.

Results were as follows: 100% yes; 0% no; 0% abstained.

3. OPTN Policy Clarification

The policy clarification in regard to the HOPE Act was presented by the UNOS Director of Policy and Community Relations.

Data summary:

The HOPE Act, which was enacted by Congress in 2013, authorized the OPTN to create a new variant that allows HIV+ organs to be recovered and transplanted into HIV+ recipients. The first variant of the HOPE Act, which was implemented in late 2015, was for kidney and livers only. A year ago, at last June's meeting, the Board approved the expansion of the HOPE Act to include other organs in addition to kidneys and livers. The work for that implementation has happened since then, and the revised variance was actually implemented on May 21st. The situation is that the day it was implemented, when the new master policy book was posted, it was noted that there was an error, in that kidneys and livers were still in one of the many parts of the policy that were revised. After doing some root cause analysis, it was found that it was a version control issue, and that the action in June in 2019, the Board did not actually approve a strikethrough. It was one of the several sections in policy 55C, which relates to released organs and rerunning match runs. In one sentence a strikethrough was left out, and therefore, technically the approved policy is incorrect, because the Board never took affirmative action to remove the kidney and liver. That is the request today. Paragraph 2 of policy 55C should have had a strikethrough of the kidney and liver at the June board meeting. The administrative error was noticed when the new policy book was posted on May 21st. Official action is requested by the Executive Committee to approve the strikethrough, so the approved and implemented policy book can be consistent, and consistent with the intent of the Board when they approved that additional variance.

Summary of discussion:

No questions were posed.

A motion was made and seconded for the Executive Committee to approve resolution of the administrative errors needing correction.

Results were as follows: 100% yes; 0% no; 0% abstained.

4. Regional Study Project Update.

An update was provided by the UNOS Director of Policy and Community Relations on the Regional Study Project, which looks at the governance and effectiveness of regions and the use of regions.

Data summary:

This project has been previously discussed; an update was provided. This Regional Study Project stems from the newest OPTN contract to do an objective review of the current regional process, which includes everything regions and the use of regions in the OPTN structure guide. The contract requires use of a third party of technical experts that have experience in systems and operations design. There are several other requirements within the contract, one of which is presenting an update to the Executive Committee, which would be done regardless. It is also required that a dedicated website be maintained. There is no predetermined outcome, but it is an opportunity to look at the governance and operational effectiveness of regions and the use of regions to optimize them. Regions have been in place for a long time, so it is a good time to see what could be done better and what could be changed, but there is no requirement to change the regions. It is an evaluation and analysis project. At a high level, the process is to hire a third-party vendor and make sure the process is transparent and engaging for the Board, Committees, OPTN membership, and general public. The Board is to approve any changes, and this would include any changes to policy bylaws as required.

An important milestone was achieved about a week ago, which was first to approve the plan. Officially, the project has launched. The next step in the timing is to launch the dedicated webpage. HRSA has provided feedback on the contents of that webpage and it is expected that within the next week approval will be received. Then the webpage will be posted as a source for information going forward.

Shortly thereafter, the next major milestone will be to issue a request for community input. This is really not public comment, as a required public comment for policy proposal, but is a more informal ask for upfront feedback around what works well with regions, what does not work well with regions, what risks should the vendor and the board consider as this project moves forward, any other suggestions, as well as the best way is to keep the community up-to-date on this project. A draft was submitted to HRSA request for community input. As soon as the website is launched and approval is obtained, that will be going up. An update will be provided at the upcoming meeting, as well as through electronic communications when that is up, and how it's going. That will close around the end of July, that's in the plan right now. We will compile the feedback, and the plan is to just post summary comments that are received out back to the community, so the community can see the types of comments that are coming in. That information will be used to craft a formal request for proposals, issue that, and then select a vendor. The longer-term timeline was provided, which could change with different scenarios or situations dictate. Options and recommendations will go to the Board a year from now, and then a final approval after a public comment period, of any changes. It will be voted on by the Board next December.

Some highlights and talking points were noted, including assessment of the configuration and composition of regions; optimized representation in policy development; optimized representation in governance; improved member communications and meetings; proactively design an approach to foster growth in the donation and transplant community; and consider new and different ways to use regions.

Once the project is launched, there may be questions at upcoming regional meetings. There are three key talking points. It is required, and an objective third party that has experience in operations and operational design will be engaged. The Board of Directors will approve any changes. Communication will be frequent and thorough. Committee members may submit any feedback or questions.

Summary of discussion:

One Committee member asked about the importance of feedback and transparency. Once the vendor is hired and the process is established, the community will answer the call for comments. A real-time response is needed for comments that may be inaccurate due to possible circulating misinformation. It was responded that the request for community input has been drafted in a way that submission of contact information is optional to prevent barriers to entry. If contact information is available, outreach will be provided to help with understanding. The comments will be closely assessed, and if there seems to be a misunderstanding in any part of the community, they will be converted into language and verbiage to post on the website, which will be a dynamic and organic website used to respond. Community members can be pointed to the website for more accurate information.

The Committee Chair stated the project is an evaluation. The comments will be unknown. This was a contract deliverable that was part of the new contract and will go forward. It will help determine that whatever is being used for governance of the system is truly doing the best that it can with all of the changes that have been occurring over the past several years. Communication with the community is important and has to be clear in terms of what the purposes are, without any presumed outcomes.

5. OPTN Election Bylaws

UNOS staff presented a question that came through during Board committee elections and asked for the EC to consider whether it could be a potential amendment to the bylaws.

Data Summary:

During the Executive Committee election process, a Board member who had received their ballot asked why category-based voting is done for the Executive Committee, as it seems to perpetuate the idea that Board positions are representative of a constituency, rather than fiduciaries of the whole. The question was provided to the Executive Director, Immediate Past President, Vice President and President to discuss, and the recommendation was to bring the question to the Executive Committee for further discussion to see if it should be addressed in the bylaws.

UNOS staff presented background information on the rules governing the EC's composition and selection. The Final Rule stipulates that the EC must be elected as well as its composition, but it does not mandate category-based voting. OPTN Bylaw section 4.3 reiterates those requirements but goes further by saying that those Executive Committee members who are not members virtue of their office will be elected by a vote of Directors from the category they represent. For example, Directors representing OPOs will elect the individual who will serve as the OPO representative on the Executive Committee.

EC membership information over the past two years was reviewed. Staff note that, anecdotally, they notice some confusion among Board members about how selection works for the Executive Committee, especially those that are not able to vote due to not being a member of an elected category. Those that participate in elections see only what is applicable to them and no other elections happening at the same time. Class elections are independent and siloed from one another. Further, in effect, the Histocompatibility (HC) and the Transplant Coordinator (TC) representatives are generally automatic placements as there are rarely are there more than two of each on the Board at any time. The 50% MD requirement means there is often no election for an added OPO representative depending on the makeup of the officers and the HC representative's credentials. There is less intention behind placement on the Executive Committee as is common on other boards, which may be an item for discussion. The composition and practice of elections are Final Rule requirements, so are not in question, but the rest of the items in the bylaws may be amended if the EC so desired.

Summary of discussion:

There are requirements as to who has to be on the Executive Committee. It is currently stated in the bylaws that the voting occurs by class. The specific initial question is whether that is something worthy of consideration for a bylaw change.

The POC Chair was the one who posed the initial question, as one who has spent much time working with board governance in the nonprofit world. The EC is intended to function as the fiduciary in between Board meetings or in circumstances where faster action might be required. It is strange that an election for the EC is siloed in the way it is, since requirements of Board members who serve as EC members are the same, regardless of background.

There was agreement from one Committee member that it seems an antiquated way to seat in Executive Committee. This should be sent out for a broader review in the spirit of looking at all governance across the board.

One question was regarding how the bylaws language was introduced to start with. Part of studying the issue further would be to see if there is a reason for this form of voting. Further policy research is needed; it is possible that this practice pre-dates the OPTN Bylaws.

Another member commented that it is possible that a particular constituency may have more knowledge of the suitability of the candidates for the board, which might not be known to the entire Board, but that may have changed now, as more information on qualifications is made available prior to the elections each year.

Next steps:

A formal vote is not needed to proceed with the bylaws review; the Executive Committee agreed this warrants further review. UNOS staff will do further research and propose options for amendments related specifically amending or eliminating the practice of category-based voting. The EC will limit the scope of this inquiry to the review of category based voting to the EC, but may offer suggestions for items that may be appropriate for review in the forthcoming OPTN regional study.

6. 2021-2024 Strategic Planning Process

The OPTN Executive Director presented an update and preview of the 2021-2024 Strategic Planning Process that will be presented at tomorrow's Board meeting.

Data summary:

In light of tomorrow's meeting being a virtual one, staff have similarly developed a process aimed at replicating the early strategic planning conversations that would ordinarily begin in person this week. As was previously discussed, strategic plan development is a 1-year process resulting in an adoptable plan at the June 2021 board meeting.

As a review, the Executive Committee affirmed that the next iteration of the OPTN strategic plan will be based on the five current goals: increasing the number of transplants; providing equity in access; improving outcomes for waitlisted patients, living donors and recipients; promoting safety for living donors and transplant recipients; and promoting efficiency in donation and transplants.

Staff have developed six work groups made up of about a dozen people each, including current and incoming Board members and Committee Chairs. Each group will be assigned a collaborative SharePoint sites that includes each of the current goals and their initiatives prepopulated. Each idea will have its own thread and can be followed, "liked," and commented on. An invitation email will be sent out that includes directions to access these sites. At some point between now and the 6/29/20 Board meeting, each group will have a call to discuss the items they put on the SharePoint site, and identifying initiatives that should be kept, amended, removed or added. Each of those groups will have an opportunity to present back to the full Board at the 6/29/20 Board meeting.

After the meeting, all the ideas will be reviewed, and the ideas with the most traction will be looked at in more detail. The decision will be made whether the ideas can be funded through an OPTN contract and if there is any history that makes it more or less likely to be a successful item for the Strategic Plan. Over the course of the period between Board meetings, the POC will look at those recommendations. The POC is comprised of Vice Chairs, and so involves all the Committees in the process, which will be important in selecting the work to be done. The EC will combine that information and propose a draft to the Board of Directors in December to review. The Board will decide if the draft is ready for public comment, which will be February or March of 2021. It will be discussed in Regional meetings. In April, feedback from public comment will be reviewed and ultimately, it will be adopted in June 2021.

It is important for the EC members to be prepared to provide input in a virtual format, since they will be unable to be at tables together this time around.

Next steps:

Any further questions or comments may be submitted to Board leadership or the OPTN Executive Director.

The EC Chair concluded by presenting the members of the 2020-2021 Executive Committee. Congratulations were offered to the new members. Farewell and appreciation was expressed for those that contributed to the OPTN over the past several years, particularly the Executive Committee.