

OPTN/UNOS TRANSPLANT COORDINATORS COMMITTEE

SUMMARY

I. Organ Availability Issues

Action Items for Board Consideration

- None

Other Significant Items

- A joint subcommittee was formed to discuss the potential for reallocation of organs in the event that a DCD donor progresses to brain death and to identify the practices that would allow the most transplants to be performed in this situation. The subcommittee will include representatives of the organ specific committees, Patient Affairs, OPO, Organ Availability Committees and any other interested Committee. (Item 1, page 1)

II. Patient Access Issues

Action Items for Board Consideration

- None

Other Significant Items

- None

III. Other Issues

Action Items for Board Consideration

Other Significant Items

- Regarding the new proposed electronic system for placement of organs, the Committee fully supports any system that will enhance and expedite organ placement, supports the goal of this proposed change, and recognizes that this system will move forward. However, due to many concerns discussed, the Committee recommends that pilot programs be conducted prior to widespread implementation and that the plans for development and implementation of this system be made available to the community now. (Item 2(16), page 5)

**REPORT OF THE OPTN/UNOS TRANSPLANT COORDINATORS COMMITTEE
TO THE BOARD OF DIRECTORS**

**November 17 - 18, 2005
Reston, VA**

**Barbara Nuesse RN, BSN, CCTC, CPTC, Chair
Cheryl Edwards RN, MSN, CCRN, CPTC, Vice-chair**

The following report summarizes the OPTN/UNOS Transplant Coordinators Committee's deliberations and recommendations on matters considered during its meeting on September 23, 2005.

I. Organ Availability Issues

1. **Organ Availability/Allocation Issues When DCD Donors Progress to Brain Death.** Following the last meeting, the Committee requested input from various OPTN/UNOS committees regarding the process of allocation when a DCD donor progresses to brain death prior to being transported to the operating room for recovery of organs. The Committee questions whether another match should be generated to reallocate the organs, in particular the liver and thoracic organs, when that patient progresses to brain death. This question was raised as the number of DCD donors continues to increase and there are more patients who progress to brain death after the match run has been completed. Members recognize that centers may refuse the DCD organ for a particular patient, but may be more agreeable to an organ from a donor declared dead by neurological criteria. The intention of the Committee in this discussion is to maximize the number of organs transplanted from every donor.

The Committee received a large number of responses, primarily from the OPTN/UNOS Thoracic Committee. Some respondents did not feel that the organ should be reallocated if it had already been allocated to a patient. However, others opined that the need to maximize the number of organs for transplant should supersede any inconvenience that it may cause to transplant teams or patients. The Committee agreed that information changes throughout the placement process, and patients need to be informed and prepared for any changes in allocation. Renal allocation might not be affected; however, the liver, lung and hearts may be allocated differently.

Some argued that once an organ is allocated to a candidate, it is too traumatic for the candidate and too inconvenient for a transplant team to change the allocation. However, it is known that DCD donors are always tentative because 20% do not progress to asystole within the designated time frame. Therefore, all physicians and patients should be aware that DCD donor allocation may be tentative as well and report this to patients.

Motion: That a joint subcommittee be formed comprising representatives of the organ specific committees, Patient Affairs, OPO, Organ Availability Committees and any other interested Committees, in order to discuss the potential for reallocation of organs when a DCD donor progresses to brain death and to identify the practices that would allow the most transplants to be performed in this situation. Donor Family wishes should always be a major consideration in these instances.

The motion was passed by a vote of 14-0-0.

II. Patient Access Issues

None

III. Other Issues

2. Public Comment Proposals Distributed for Public Comment, April 20, 2005

1. *Proposed Modification to OPTN/UNOS Policy 3.5.10 (Preservation Mode of Shared Kidneys). (Kidney and Pancreas Transplantation Committee)* The proposal would remove a requirement in policy that appears to no longer be needed. Members agreed that there is some difficulty involved when experimental preservation or changes in preservation techniques affect the sharing of organs and an, and has, resulted in the loss of organs. It was noted, that when a different preservation mode is utilized, and the transplant center does not keep the organ for the intended recipient, there may be problems with placement at another center. This problem may be eliminated if the DSA can get tissue typing results returned in a more expedient way. The Committee also recognizes that if a center accepts a kidney, that center has the right to change the preservation mode.

The proposed policy change was approved by a vote 13-0-0 with the understanding that experimental protocols and changes in preservation modes need to be communicated *appropriately*.

2. *Proposed Modification to OPTN/UNOS Policy 3.4.6.1 (Application Process for Alternative Organ Distribution or Allocation Systems). (Executive and Kidney and Pancreas Transplantation Committee)* The Committee discussed this proposal and understands that this change will expand the type of policies required to be submitted for input through public comment. The aim is increased sharing of information and opinions about proposed policies.

Following a brief discussion, the proposed policy change was approved by a vote of 12-0-1.

3. *Proposal to Integrate Modified Pediatric Kidney Allocation Priority into Committee-Sponsored Alternative System for Intended Candidate Priority. (Kidney Pancreas Transplantation Committee)* The proposal modifies an existing alternative allocation system approved by the Board of Directors for use by OPOs and transplant centers that wish to use it to address recent modifications in kidney allocation policy for assigning priority to children. There was some disagreement among Committee members regarding the placement of paybacks in the allocation scheme. However, members agreed that the local waiting list of pediatric candidates should be listed ahead of the payback in the scheme. Members agreed that paybacks on donors >35 should remain unchanged.

After lengthy discussion, the Committee approved the proposed change by a vote of 10-1-2

4. *Proposed Modification to OPTN/UNOS Policies Assigning Priority in Kidney Allocation to Children and Exempting Donation after Cardiac Death (DCD) (Kidney and Pancreas Transplantation Committee)* The Committee discussed this proposal that would modify the priority among pediatric candidates for allocating zero antigen mismatched DCD kidneys from donors less than 35 years old at the regional and national levels. This change revises existing policy assigning priority in kidney allocation for children to address the unintended complexity in the computer implementation of a related policy. The Committee agreed that this change will provide a greater priority for children and that zero antigen mismatched pediatric patients should receive additional points based on age and local, regional location.

The Committee approved the proposed policy change by a vote of 12-0-0.

5. *Proposed Modifications to the Liver Regional Review Board (RRB) Operational Guidelines. (Liver and Intestinal Organ Transplantation Committee)* The Committee discussed this proposed modification and agrees that it will better define the composition of the Review Board and the specific responsibilities of Review Board chairs and members. The Committee understands that the intent of these proposed changes is to improve the efficiency of the exceptional case request process. The Committee understands the importance and necessity of all RRB members being responsive and agrees with the proposed change that provides for removal of non-responsive review board members. The proposed changes appear to clarify and strengthen the RRB activity. The Committee also discussed the possibility of requiring a clinical transplant coordinator to review cases and provide input to the RRB.

The Committee approved the proposed change by a vote of 12-0-1.

6. *Proposed Modifications to Policy 3.6.4.1 (Adult Candidate Status). (Liver and Intestinal Organ Transplantation Committee)* The Committee understands that this proposed policy change would eliminate the requirement of the MELD/PELD system threshold of a CTP score of 7 for listing and that the entry of CTP data in to UNetSM would be required only at time of removal from the waiting list, not at other intermediate time points, which will reduce the data entry burden on transplant centers. The Committee agreed that this change will be particularly helpful to coordinators who are responsible for entering the data by eliminating unnecessary data entry.

The Committee approved the change with a vote of 12-0-1.

7. *Proposed Modifications Policy 3.7.6.3 (Candidate Variables in UNetSM) and to Least Beneficial Values for Lung Variable Data Collected by Heart Catheterization (Thoracic Organ Transplantation Committee)* The proposal would require normal pulmonary pressure values to be used by default in the calculation of Lung Allocation Scores where actual values are not provided. Previously, when pulmonary artery systolic pressure (PA systolic), pulmonary artery mean pressure (PA mean), or pulmonary capillary wedge pressure (PCW) was missing; the value for the variable that contributed the least to the overall Lung Allocation Score would be used by default. By using normal pulmonary pressures instead of the least beneficial values, the purpose of the proposal is: 1) candidates with normal pulmonary pressures would not be penalized for not performing a heart catheterization when there is no evidence to indicate that pulmonary pressures are abnormal; and 2) to reduce the burden on the Lung Review Board from responding to many repetitive requests for normal pulmonary pressure values.

The Committee discussed the cost benefit as well as the benefits of preventing candidates from undergoing a procedure that is not essential. This modification will address the issue that presently certain candidates are being disadvantaged and will definitely be a benefit to candidates.

The proposed policy change was approved by a vote of 13-0-0.

8. *Proposed Serial Collection of Blood Gas Analysis Data on Candidates Registered for Lung Transplantation (Thoracic Organ Transplantation Committee)* This proposal would require that serial blood gas analysis data of PaCO₂, PaO₂, and pH be collected at six-month intervals on all lung transplant candidates age 12 and up. The Committee understands that the purpose of the proposal is to collect data from candidates that may be a significant indicator of waitlist urgency and post-transplant survival.

As this proposed change would strictly monitor blood gases to assist in future evaluation and research, some members questioned whether this policy change should be introduced and researched on a smaller scale as opposed to making it a national requirement. Others clarified that when the new allocation policy was introduced, members recognized the need to continuously study, monitor and modify the allocation scheme based on these data. Members agreed that this change would assist in that goal and provide information to indicate waitlist and post transplant mortality.

The proposed change was approved by a vote of 13-0-0.

9. *Proposed Modifications to Heart Status 1A Justification Forms in UNetSM. (Thoracic Organ Transplantation Committee)* The Committee discussed the intent of the proposal to modify the Status 1A(b) section of the 1A justification forms in UNetSM to collect the type of right ventricular assist device (RVAD), left ventricular assist device (LVAD), or Total Artificial Heart as it pertains to device infection and also collect the implant date for each device. The proposal would also modify the form to collect device infection locations (pocket, driveline, or other) for each of the device types implanted, and the onset date for all device infections. The proposed modifications would also make the narrative a required field for listing candidates at Status 1A(b). The proposal would also modify the Status 1A(e) section of the form to collect the type of brain natriuretic peptide (BNP) test used (if BNP data is provided) and add "paced rhythm" to the possible responses for heart rhythm. The purpose of the proposal is to collect additional data on heart candidates listed at Status 1A.

This proposed change would alter those data that are currently being collected and provide vital information on heart candidates. Members discussed the impact of this change on those individuals who enter the data and agreed that this change would not place an undue burden on them.

The Committee approved the proposed policy change by a vote of 13-0-0.

10. *Proposed Modifications to Policy 3.7.3 (Adult Patient Status) (Thoracic Organ Transplantation Committee)* The proposal would eliminate the requirement for heart candidates listed at Status 1A(b) to be admitted to the listing transplant center. The purpose of the proposal is to allow the treating physicians the option to treat these candidates on an outpatient basis if the physician feels that it is in the candidate's best interest. In addition, the proposal provides that the clinical narrative would become a required field on the Status 1A justification form when the center uses criteria (b) in order to provide detailed information to the Regional Review Boards that review 1A(b) listings.

With new technology available, many heart candidates no longer need to be in the hospital when on an assist device. Since they can be treated at home for device related complication such as infection or a malfunction LVAD, and due to cost constraints, this change allows candidates to remain at home and still be listed at an elevated status. The Committee agreed that it is of great benefit to have some candidates, when appropriate, cared for at home while waiting and support this proposed change.

The Committee approved the proposed policy change by a vote of 13-0-1.

11. *Collection of Supplemental Oxygen Use as a Percentage and Conversion to Liters per Minute (Thoracic Organ Transplantation Committee)* The proposal will allow a modification to UNetsm for the collection of supplemental oxygen use as a percentage and for the conversion of percent to liters per minute (L/min.) for calculating the Lung Allocation Scores (LAS). As the current unit of collection of supplemental oxygen is in L/min, this proposal is intended to respond to concerns from member centers that, due to variations in oxygen delivery methods, they are not able to enter their candidates' supplemental oxygen use in L/min. The proposed modifications are intended to collect additional data that may prove useful to the future development of the lung allocation system.

The Committee agreed that standardizing the conversion from percent to liters per minute will be helpful for patient evaluation and provide valuable data that is needed to evaluate and enhance the lung allocation system.

The Committee approved the proposed policy change by a vote of 14-0-0.

12. *Proposed Modifications to the OPTN/UNOS Histocompatibility Lab Standards: Appendix B-Attachment 1 (Histocompatibility Committee)* The proposed changes to the Bylaws are intended to update the current OPTN/UNOS Standards for Histocompatibility Testing. The Committee did not discuss this proposed policy change.

13. *Proposed Modification to OPTN/UNOS Policy 3.5.11.3 (Panel Reactive Antibody) (Histocompatibility Committee)* This proposal is intended to increase the fairness of allocation point assignments on the kidney Waiting List. It proposes a way to monitor compliance with Policy 3.5.11.3 that states that for a Kidney Waiting List patient to receive 4 allocation points for being highly sensitized (having a Panel Reactive Antibody (PRA) of 80% or greater), one or more unacceptable HLA antigens must be specified on the Waiting List. The Histocompatibility Committee believes that the greatest potential for violating this policy resides with programs that consistently transplant unusually high percentages of high-PRA patients. Therefore, they proposed that kidney transplant programs that transplant a higher-than-expected percentage of high-PRA Waiting List candidates receive letters of inquiry from the UNOS Department of Evaluation and Quality. Such letters would ask for an explanation of how the program is able to achieve this outcome. Programs with valid strategies would be invited to have them shared with the transplant community. Programs without valid strategies may be subsequently reviewed for potential policy violation.

The Committee discussed the proposed change and agreed that that this change will identify those centers that have greater than 2 standard deviations in order to determine if there is a false high PRA. The Committee did not feel that the PRA can be manipulated and that this policy would help to identify best practices, a major goal of the Collaborative. The Committee agrees that investigators in these cases have a strong knowledge base in histocompatibility.

The Committee approved the proposed policy change by a vote of 13-0-1.

14. *Proposed Best Practice Guidelines for OPTN/UNOS Histocompatibility Laboratories (Histocompatibility Committee)* Technological advances now permit a level of evaluation of histocompatibility between recipients and donors that surpasses that achievable with older techniques. The guidelines reflect the consensus of the OPTN/UNOS Histocompatibility Committee regarding practices that should be standard. Implementation of these guidelines is vital to ensure expedient placement of donor organs and to minimize organ wastage.

The Committee agreed that they do not have the expertise to address the best practice guidelines and therefore, did not comment.

15. *Proposed Modifications to OPTN Bylaws, Appendix A, Section 1.04A, 1.01A Nature of Membership/Designated Transplant Program Status (Membership and Professional Standards Committee)* The Committee discussed the intent of this proposal to provide an alternate pathway for facilities to be approved for pancreas transplantation in cases where the pancreas is transplanted as part of a multi-visceral block.

The Committee agrees that this modification provides the opportunity for a facility to include the pancreas in a multi-visceral block and clearly is of benefit to candidates post-operatively. Members also recognize that this situation will most likely occur infrequently.

The proposed change was approved by a vote of 14-0-0.

16. *Proposed New OPTN/UNOS Policy 3.4.6 (Receiving and Responding to Organ Offers) and Proposed Modifications to OPTN/UNOS Policy 7.5 (Submission of Donor Information) (Operations Committee)* The Committee discussed the intent of this policy proposal that would require organ procurement organizations have the ability to provide donor information required for organ placement to the UNetSM an electronic data format so that multiple simultaneous organ offers can be made to potential recipient centers. Donor information would be required in UNetSM prior to organ allocation. When organ offers are made by organ procurement organizations, transplant centers must be able to accept organ offer notifications in an electronic manner compatible with the at least one of the options that will be provided in the UNetSM. Additionally, transplant centers must have the capability to view organ offers and respond to these offers in an electronic data format (e.g., via Internet access) through the UNetSM. The intent of these policy proposals is to prepare organ procurement organizations and transplant centers for the implementation of a system for simultaneous, electronic organ offers and responses beginning January 1, 2007. It is anticipated that this national electronic organ allocation system will improve the speed, efficiency and accuracy of the current organ placement process.

The Committee understands that the Operations Committee has submitted these proposals for consideration far in advance of implementation with the desire that all organ procurement organizations and transplant centers begin preparations for the January 1, 2007, target date for implementation.

The Committee endorses the concept of the proposal and, from an organ placement perspective, recognizes that this system may provide a consistent means of communicating information and decrease the amount of time necessary for placement. However, the Committee also had numerous concerns. There are significant gaps between OPOs in technological capabilities that are not recognized and there are no implementation guidelines for this change provided in this document. Since the proposal strives to establish minimal technology requirements, members questioned what those requirements are and why they are not listed. Although the proposal discusses the need to conduct pilot and demonstration projects, concerns were

voiced regarding the timeline and whether those projects could be completed prior to the January 1, 2007 deadline.

Members had a lengthy discussion regarding their concerns surrounding the impact that this change would have on agencies and coordinators. These concerns included the current technological status of hospitals, cost, funding sources, OPO and hospital participation, and the extra workload associated with its implementation. The Committee agreed that the proposed deadline is ambitious and questioned whether or not DSA agencies will be able to meet that deadline.

Of greatest concern, is the current lack of technology and internet access within hospitals and the concomitant requirement in this proposal that everyone must have the electronic capability to exchange information from any location. As such, the Committee questioned how every coordinator will have the capability to access the internet while in the hospital. Several members described their experiences with laptops in hospitals and indicated that they cannot access the internet from within the hospitals and their inability to access the internet. If required to do so, they would have to leave the hospital in order to access it.

Second, the Committee questioned who would be responsible for funding this change. This proposal does not illustrate who will pay for the change and recognized it as an unfunded mandate. Members discussed the previous failure and expense of Expedite and want to ensure that it does not reoccur. Finally, additional questions were posed regarding this system and UNetsm and whether or not these systems will communicate with each other in order to eliminate duplicating data entry. Situations were also discussed such as, when a physician asks for specific information, will that information need to be entered into the system and sent to all parties involved.

The Committee is in full support of any system that will enhance and expedite organ placement, supports the goal of this proposed change, and recognizes that this system will move forward. However, in light of the concerns listed above, the Committee recommends that pilot programs be conducted prior to widespread implementation and that the plans for development and implementation of this system be made available to the community now. This response to the Operations Committee was confirmed by a vote of 13-0-1.

17. *Proposed Modifications to OPTN/UNOS Policy 2.6 (Initiating Organ Procurement and Placement), 3.1 (Organ Distribution) (Operations Committee)* The Committee agreed that this proposed policy modifications would eliminate the antiquated policy that requires the Host OPO to notify the UNOS Organ Center of the blood type for every kidney donor, and updates policy definitions to reflect current practice and conform with definitions of the OPTN Final Rule. The intent of these policy modifications is to maintain policies that reflect current practice and conform to the Final Rule.

After discussion, the Committee approved the proposed policy change by a vote of 14-0-0.

18. *Proposed Modifications to OPTN/UNOS Policy 2.2 (Evaluation of Potential Donors) (Pediatric Transplantation Committee)* This proposal adds Epstein-Barr virus (EBV) testing to the required standard panel of tests for all potential donors.

The Committee voiced concerns regarding the potential delay of accepting an organ while waiting for EBV testing results. Members noted that it can take from 8 hours to more than 3 days to get results and questioned whether this requirement is helpful as the organ most frequently will be transplanted prior to the results being seen. This change is intended to help protect immunosuppressed recipients from potential post-transplant lymphoproliferative disorder (PTLD). If results are secured in a timely manner, testing should decrease the severity and frequency of PTLD in immunosuppressed EBV negative recipients that receive EBV positive donor organs.

Members noted that it seems more appropriate for transplant centers to request the needed blood sample, and run the test if they so desire. Centers generally do not decline or accept organs based on EBV results. However, these results are routinely used to guide post transplant treatment of the recipient. The

Committee questioned whether EBV testing should be required as not every center routinely uses the test results as a determining factor as to whether or not an organ is acceptable. The Committee recommended that a tube of blood (pretransfusion when possible) be provided to the center upon request. The test result need not be available at the time when an organ is accepted nor will it influence the acceptance. Organ placement and acceptance should not be hindered or delayed by the lack of test results.

The Committee did not approve the proposed policy by a vote of 2-9-3.

As an alternative, the following change to Policy 2.2 (Evaluation of Potential Donors) was recommended: Upon request, the OPO will provide a donor blood sample for EBV testing (~~blue top tube~~) to each transplant program receiving the organ(s).

3. **Report of the OPTN/UNOS Data Advisory Committee.** Randall C. Heyn-Lamb RN, CPTC, provided a report on the Data Advisory Committee (DAC) activities and described the Transplant Coordinators Committee's participation. Clinical coordinators on the Committee are encouraged to participate in the DAC subcommittee. Prior to the next conference call, members should assess other centers in individual DSAs to identify who is responsible for post operative data collection, how it is being collected, what type of time and resources are being allocated, and, finally, if the data collected are valuable. Data has been shown to be of particular value in pediatric care.
4. **Donor Families and Recipient Communication.** The Committee reviewed the *NKF National Communication Guidelines*. The Committee did not agree with various parts of the guidelines such as the necessity to seal letters. Some members advocate for screening the communications as they have experienced inappropriate communications in the past. Members did agree that OPOs should be ready to assist in the communication and that information should be passed and that communication should occur in a timely manner. Some OPOs withhold letters from recipients for a year period before sending it to the donor family.

Although the Committee agrees that practice guidelines should be followed, they also understand that the process is cumbersome. There needs to be a collaborative effort to streamline professional standards of practice and develop strong guidelines. Members would like to identify current practice and research, and discuss this issue with others.

The Committee suggested that a subcommittee comprising representatives of the OPO, Patient Affairs and any other interested committee, meet by conference call in an attempt to identify the guidelines that should be used.

5. **MatchingDonors.com.** The Committee reviewed a letter that was sent to numerous transplant professionals from matchingdonors.com. The Committee discussed the stated goals and the organization's promise to patients. It was apparent that those patients who cannot afford the cost of this matching system are automatically being disadvantaged. One member reported that a potential altruistic donor that she was aware of was contacted by numerous potential transplant recipients from this system.

The Committee vehemently opposes this practice because there is too much opportunity for deceptive practice and undermines equitable organ allocation as only those that can afford it can register. This bypasses the "sickest first" concept and provides organs only to those that have sufficient means to remain listed. This system also hurts the public trust in that the perception is that the wealthy can list while others cannot. Without strict national oversight, this practice could encourage organ trafficking and selling of organs. The Committee agreed that when patients ask about this system, they should be encouraged to access the OPTN or UNOS website for more information regarding allocation.

6. **Placement of Small Bowel/Intestine.** Members noted the frequent refusal of small bowel/intestines from healthy organ donors. Some OPO members report that, if the pancreas is allocated, the intestine cannot be placed; and that some centers will not accept the pancreas if the intestine is allocated.

Some members discussed the need for more narrowed listing criteria. Due to the excessive time it takes to place these organs, it should be a goal that organs can be placed within 5 phone calls. If this is not possible, then it may be indicative of poor listing criteria. The current system causes significant unnecessary delays in placement of these organs. To expedite allocation, it is recommended that transplant centers utilize

realistic minimal listing criteria for these organs that will not create a wide variety of organs be offered when they are bound to be refused.

The Committee will review the next Organ Donation Breakthrough Collaborative's activities that might address this issue. A subcommittee should be formed to review centers' activities regarding this issue.

7. Regional Review Boards Representation. The Committee discussed the potential of having transplant coordinator representation on the regional review boards and agrees that it would be beneficial to provide a transplant coordinator perspective. Having organ specific clinical coordinators serve on each of the regional review boards can contribute information relative to issues such as quality of life, and provide an unbiased view of the situation. The Committee will investigate this possibility and discuss it at the next meeting.
8. 2006 Meeting Dates. The Committee will meet on April 28, 2006.

UNOS Transplant Coordinators Committee

April 20-21, 2005

Chicago, IL

Committee Members Attending

Barbara Nuesse RN, CCTC
Cheryl A. Edwards RN, MSN, CCRN, CPTC
Scott Demczyszyn NREMT-P, CPTC
Michael Thibault, RN, BSN, CPTC
Nevin Ball, BBA
Randall C. Heyn-Lamb RN, BSN, CPTC
Rae Sullivan
Allen Davis RN, BSN, CPTC
Ann M. Roman MS, ANP-CS
Kim Fox RN, BSN, CCTC
Gary W. Burris RN, CPTC
Jenny Hoover RN, CPTC
Neal Evans RN, CPTC
Sally Keck RN, MS, CCTC
Amy Shorin-Silverstein JD
Nancy Carothers, RN (By Conference Call)

Chair
Vice Chair and Region 1 Representative
Region 2 Representative
Region 3 Representative
Region 4 Representative
Region 5 Representative
Region 6 Representative
Region 8 Representative
Region 9 Representative
Region 10 Representative
Region 11 Representative
At-Large Member
At-Large Member
At-Large Member
At-Large Member
Ex-Officio

Committee Members Unable to Attend

Lynette Fix, RN, BA, CCTC
Marian O'Rourke RN, CCTC

Region 7 Representative
At-Large Member

UNOS Staff Attending

Franki Chabalewski, RN, MS, UNOS Professional Services Coordinator