

**OPTN/UNOS Pediatric Transplantation Committee
Meeting Minutes
April 21, 2017
Chicago, IL**

**William Mahle, M.D., Chair
George Mazariegos, M.D., Vice Chair**

Introduction

The Pediatric Transplantation Committee met in Chicago, IL on April 24, 2017 to discuss the following agenda items:

1. Policy Oversight Committee Update
2. Guidance on Explaining Risk Related to Use of Increased Risk Donor Organs When Considering Organ Offers
3. Revisions to Pediatric Emergency Membership Exception Pathway
4. Tracking Pediatric Outcomes
5. Update on Data Requests
6. Project Brainstorming
7. State of Pediatric Lung Transplantation
8. Committee Member Recognition

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

1. Policy Oversight Committee Update

The Vice Chair provided an overview of recent POC actions from the last two months.

Summary of discussion:

The POC serves three central roles for the OPTN. These include:

1. New project consideration
2. Readiness for public comment
3. Annual review of project portfolio

With the above mentioned roles in mind, the POC recently reviewed and approved nine new projects in January and February 2017 (Pediatric Committee's project in italics):

Project	Goal Assignment
Education To Reduce Unnecessary Discard of Kidneys with Small RCC Found Pre-Transplant (DTAC)	#1 (Increase number of transplants)
Assessment of Transplant Programs Conducting A2/A2B Deceased Donor Kidney Transplants to Blood Type B Recipients (MAC)	#2 (Equity in access to transplants)
Expediting Organ Placement (OPO Committee)	#1 (Increase number of transplants)
<i>Tracking Pediatric Transplant Outcomes Following Transition to Adult Transplant Programs (Pediatric Committee)</i>	<i>#3 (Improve outcomes)</i>
Guidance on Optimizing VCA Recovery from Deceased Donors (VCA Committee)	#1 (Increase number of transplants)
Pancreas Program Functional Inactivity (Pancreas Committee)	#3 (Improve outcomes)

Project	Goal Assignment
Lung allocation score (LAS) Refinements and clean-up (Thoracic Committee)	#3 (Improve outcomes)
Modification of the Lung TRF to include CLAD (Thoracic Committee)	#3 (Improve outcomes)
White Paper Addressing the Escalation of Treatment for the Purpose of Advancing a Patient's Status on the Waitlist (Ethics Committee)	#2 (Provide equity in access)

The Vice Chair also profiled the resource allocation across the OPTN strategic goals, and the distribution of all OPTN committee projects for each strategic goal. The POC will be reviewing the entire project portfolio in July 2017 to assess for degree of progress. With no discussion on this update, the Vice Chair segued to the next agenda item.

Next steps:

-The Vice Chair will continue to serve as a representative to the POC and keep the Committee informed of discussions.

2. Guidance on Explaining Risk Related to Use of Increased Risk Donor Organs When Considering Organ Offers

The Chair of the OPTN/UNOS Ad-Hoc Disease Transmission Advisory Committee (DTAC) shared a presentation on a guidance document out for public comment. This guidance is a collaborative project involving the American Society for Transplantation (AST), the American Society for Transplant Surgeons (ASTS), and the North American Transplant Coordinators Organization (NATCO).

Summary of discussion:

In July 2013, the U.S. Public Health Service (PHS) published new guidelines for reducing HIV, HBV, and HCV transmission through organ transplantation. OPTN data shows that increased risk donors has gone up substantially over time. Some transplant programs are reluctant to use organs from deceased donors that meet increased risk criteria due to perceptions that it may translate to poor recipient or graft survival. With this information in mind, the transplant community had requested assistance how to best explain relative risk of disease transmission involving increased risk organ donors to potential organ recipients.

The speaker described the collaborative development that took place during the summer and fall of 2016. DTAC and representatives of the AST, ASTS, and NATCO created a guidance document for transplant providers and Organ Procurement Organizations (OPOs). The hope is by educating providers, they will be better informed to counsel patients during transplant evaluations as well as consider risk when receiving organ offers. The guidance includes:

- Executive Summary with speaking points for transplant program staff
- Graphic renderings to describe the risk of disease transmission compared to the risk of death from other causes
- Risk of declining an organ from a donor that met PHS guidelines for increased risk of HIV, HBV and HCV infection versus remaining on the waiting list
- Consequences of transmission of HIV, HBV, and HCV
- Risk of acquiring HCV on hemodialysis
- Limitations of current screening technology

Following the presentation, the Vice Chair opened the floor for discussions. The Committee discussed several elements, including the:

- Need for content noting the benefits of transplantation with an increased risk donor organ versus continuing to remain on the Waitlist,
- Potential to add data describing risk of HIV, HBV, or HCV transmission, versus risk of death on the Waitlist with organ-specific elements, e.g.: a specified MELD score.
- Availability of point-of-service apps to support discussions with the medical team,
- Challenges of accessing HCV treatment for different age recipients less than 18 years old,
- Variability in risk associated with each behavior and how this information impacts clinical decision-making, candidate specific considerations (time waiting, high sensitization, etc...), and
- The need for pediatric specific content in the guidance.

The speaker shared that other OPTN committees have similarly requested pediatric specific content, as well as data on known donor-derived disease transmission cases. DTAC was committed to adding such content following public comment. The Committee also asked if educational materials could contain a reference table delineating risk to aid “middle of the night” discussions. The speaker responded that DTAC was very receptive to this suggestion and would work with UNOS staff to integrate this idea into supporting information.

At the conclusion of the discussion, the Pediatric Committee unanimously supported the proposal.

Next steps:

-UNOS staff will draft a response from the Pediatric Committee based on the conversations held at the meeting. The response will be posted on the OPTN following approval by leadership.

3. Revisions to Pediatric Emergency Membership Exception Pathway

The Committee considered draft language that was developed by members of a working group from the OPTN/UNOS Membership and Professional Standards and Pediatric Committees. This language will amend the emergency membership exception pathway for adult heart and liver transplant programs that wish to register a candidate less than 18 years old.

Summary of discussion:

UNOS staff summarized the progress to date of the working group through April 2017. The working group shared an update to the OPTN/UNOS Thoracic Committee in March 2017 with overall favorable feedback. One question was asked; what of the scenario of a pediatric patient receiving a ventricular assist device (VAD) that was only approved for adults? A small number of questions were also asked that relate to the larger bylaws proposal approved by the Board in December 2015. Favorable feedback was also received from the Vice Chair of the OPTN/UNOS Liver and Intestine Committee. They did comment that it would be very helpful to adult transplant programs if a programmed feature in Waitlist could include the contact information for an approved pediatric component for consultation. Members of the Committee felt it was reasonable to locate contact information for pediatric transplant programs. Further, this suggestion would be difficult to program.

The Chair asked the Committee to discuss the elements of the heart transplant program emergency membership exception. One member commented, when this proposal was first conceived, critical care transport of a pediatric patient on extra-corporeal membrane oxygenator (ECMO) was not widely available. The passage of time has allowed for greater access to transport teams with ECMO expertise and this is now within the standard of care. As a result of this change in practice, it did not seem prudent to include ECMO in the heart membership

exception pathway. He commented that this element was discussed at the Extracorporeal Life Support Organization (ELSO) Steering Committee. The opinion of ELSO was that including ECMO as a criteria for an emergency exception was not sensible. The speaker continued by citing the poor transplant outcomes that are associated with candidates on veno-arterial ECMO as compared to a VAD. Thus, it makes more sense to transport a pediatric patient to a pediatric transplant program for the appropriate VAD therapy. Another Committee member verbalized support for this change, affirming the national availability of transport services for patients on ECMO. Further, it was important to consider this language and not have requirements in place that would be outdated in the near-future. A third Committee verbalized support for this approach. He commented, the expansion of ECMO therapy in the last five years has resulted in more adult hospitals becoming familiar with the technology and the ability to transfer patients on ECMO. At the conclusion of the discussion, the President of ELSO [also a Pediatric Transplantation Committee member] offered the assistance of his organization in future discussions.

One member shared concerns that the requirement for a consultation with an approved pediatric transplant program could allow for potential abuse. He shared that an adult program could feasibly contact *any* pediatric program, rather than contact a specific pediatric program that had the capability to treat the condition at hand. The examples he shared included contacting a low volume center versus a high volume center. The Vice Chair responded that the required consult with a pediatric transplant program is intended to confirm the clinical decision making that transfer is not advised and the patient was in such extremis that they would be best served by the care at the adult hospital.

One member inquired about the transplant outcome data. Specifically, which hospital would the outcome data be reflected, the transplanting adult hospital or the consulting pediatric hospital? UNOS staff responded that any transplant outcomes are reflected on the program that performed the transplant procedure. The member then commented this transplant outcome (and the potential for a poor outcome) may compel the adult transplant program to transfer the patient. The ELSO President responded that ECMO outcomes are actually split between hospitals that have contact with the patient on ECMO.

One member asked, is there anything built into this proposal to require periodic review of the criteria? UNOS staff responded that post-implementation monitoring is a consideration for all committee proposals. As a result, the Committee has discretion to describe this monitoring plan in the Public Comment Document and Board Briefing Paper. However, these monitoring plans are not included in bylaw proposal language. UNOS staff can provide reports on the use of this pathway to the Committee as needed. If the Committee felt this pathway was no longer needed in the future, the Committee could put forth a proposal to strike the pathway.

UNOS staff thanked the Committee for their robust discussion on the proposal and discussed strategies for approaching public comment. They recommended that the ECMO criteria and VADS remain in the proposal for public comment. If the public comment reflects that these therapies should be removed, the language can be easily struck. Thus, the member burden would then decrease. If the Committee removed the language *before* public comment and later needed to add it back, it would be considered a substantive change. This would translate to an expansion of the proposal and an increase in member burden. As a result, a second round of public comment would be required.

The Vice Chair then segued to a discussion on the emergency membership exception pathway for liver transplant programs. He mentioned that feedback was received from the Vice Chair of the Liver and Intestine Committee. He acknowledged this element of the proposal is a bit simpler than the heart elements. Members with liver transplant expertise felt this pathway was

reasonable. One member asked, do we have a sense of how often this pathway would be used? The Vice Chair responded that the data was examined and the vast majority of transplants in candidates less than 18 years old are performed at pediatric transplant programs. Thus, the frequency this pathway may be used is anticipated to be low.

At the conclusion of the discussion, the Vice Chair asked the Committee if the proposal was ready for public comment. A motion was made and seconded to approve the bylaw language as presented to the Committee, and recommend to the POC to solicit for public comment. The Committee approved the motion (Yes – 15, No – 0, Abstain – 0).

UNOS staff spoke briefly on the role of outreach in public comment solicitation. A list of potential stakeholder groups was reviewed with the Committee. Members will be asked to communicate to these groups to make them aware of the public comment period in July 2017.

At the conclusion of the discussion, UNOS staff thanked the Committee for their hard work on this proposal and for the solution-oriented approach throughout the process.

Next steps:

-UNOS staff will prepare public comment materials and submit to Committee leadership for review. If approved by the POC and Executive Committees, public comment will be sought from July 31, 2017 to October 2, 2017.

-UNOS staff reminded committee members that a presentation at the regional meetings may be possible. More updates will follow in the coming weeks.

-The Committee will consider public comment during their in-person meeting in October 2017.

-The target for this proposal continues to be the December 2017 Board meeting.

4. Tracking Pediatric Outcomes

The Chair of the Transition Subcommittee provided an update on recent discussions to the Committee.

Summary of discussion:

The goal of this project is to decrease the incidence of lost to follow-up designation for pediatric recipients after transition to adult care. By doing so, the OPTN will have more complete data on pediatric transplant outcomes. Thereafter, the Committee and the OPTN will be able to assess the impact of transition on transplant outcomes.

Previous discussions with the Committee noted high lost to follow-up for liver and kidney recipients transitioning to adult care. The Subcommittee met by conference call most recently on March 21, 2017. The Subcommittee recognized there are three common types of transition scenarios that may present from a pediatric transplant program:

- to an adult transplant program within the same institution
- to an unaffiliated adult transplant program
- to an outside provider that is not affiliated with any transplant programs

One of the items discussed on the conference call was a method to identify effective practices for low lost to follow-up rates. The intent of this survey is to rate these effective practices for low lost to follow-up rates at high, medium, and low volume transplant centers. UNOS staff then profiled for the Committee some other OPTN committees that may be interested in collaboration during the development of this guidance (Kidney, Liver, Transplant Administrators, Minority Affairs, and Transplant Coordinators Committees). The Committee then reviewed a timeline for the project, including the identified targets for public comment and Board consideration in 2018.

During the discussions, the Subcommittee acknowledged the lost to follow-up problem is not unique to pediatric transplant recipients. However, the focus of this project is on addressing problems associated with transition from pediatric medical care to adult medical care.

The Vice Chair thanked the Subcommittee Chair for her update and opened the floor for questions. Members discussed:

- Strong support for this project, and members were pleased with the progress to-date.
- Value of looking at data on transplant recipients that are followed by a transplant program outside the region where they were originally transplanted. Further, there may be value looking at international transplant recipients. There may be value in identifying what percentage of lost to follow-up are a long distance from their following transplant program.
- Issue of resources may come into play for “high performing” transplant programs versus “low performing” transplant program. The Subcommittee Chair thanked the member for this insightful comment. The current project pertains to guidance, and thus is not a requirement for transplant hospitals. She acknowledged that a *policy* change is one way to compel OPTN member transplant hospitals to secure resources. However, a transition from guidance-to-policy is not foreseen for this project.
- The need for the survey to assess for changes in insurance status. One member indicated his institution cares for many out-of-state patients from a state with no Medicare funding. Thus, his institution has limited ability to provide follow-up care beyond a certain time frame.

Next steps:

-The next conference call for the Subcommittee will be May 23, 2017

-Updates will be provided to the Committee in the months ahead

5. Update on Data Requests

UNOS staff shared an update on two data requests submitted by the Committee:

- Update on living donor information
- Outcomes for recipients lost to follow-up

Summary of discussion:

The Committee previously submitted data requests to the OPTN to support on-going project discussions.

Request # 1 – Linkage Results among Kidney, Liver, and Heart Recipients Lost to Follow-up

In October 2016, the Committee reviewed a data report prepared by UNOS staff. Based on the discussion, the Committee requested additional data:

- Returned to the waiting list at another center
- Returned to chronic maintenance dialysis as reported in CMS database (for kidney)
- Had a death date in the OPTN or verified from external sources

Staff from the UNOS Research Department shared the latest data report, noting:

- Heart
 - Few recipients relisted at another center
 - Between 10% and 20% of pediatric recipients died, 16% aged 18-25 died

- Kidney
 - Proportion of recipients aged 12-25 who were relisted was twice the proportion of recipients aged 26+
 - Proportion of recipients aged 12-25 who returned to dialysis was larger than the proportion of adults 26+
- Liver
 - Larger proportion of recipients aged 12-25 were relisted than other ages
 - Larger proportion of recipients aged 12-25 died than recipients aged 0-11

UNOS staff reported that other concerns were identified, including the majority of all recipients could not be linked to OPTN data or external sources, regardless of organ; younger recipients were more likely to be unaccounted for.

The Vice Chair thanked UNOS staff for the presentation and opened the floor for discussion on this component of the presentation. Members understood there were challenges with this analysis due to unaccounted recipients in each organ type reported. The assumption is that the recipients are alive if they are not reported as deceased, relisted for transplant, or on dialysis (kidney recipients). Further, because of the small numbers of pediatric transplants performed, the raw numbers of lost to follow-up will correspondingly be small. One member felt that under the assumption that the “unaccounted” recipients are alive, the kidney cohort of 12-17 year old recipients shows a higher rate of death, dialysis, and relisting; thus this cohort is doing worse. Another member clarified that the numbers of deceased kidney recipients was likely lower due to the possibility to institute dialysis as a treatment for failure of the transplanted kidney. This appeared to show evidence of a problem. Members felt this data was informative and will discuss further. They asked for UNOS to examine ways to censor recipients from outside the U.S., as well as those recipients without Social Security Numbers.

UNOS staff thanked the Committee for the diligent discussion on the topic. They suggested that some of this analysis and related discussion pertains to the on-going project by the Transition Subcommittee.

Request # 2 – Donor and Recipient Characteristics for Living Donor Kidney and Liver Transplants from 2000-2016

In March 2016, the Committee reviewed a data report prepared by UNOS staff. Based on the discussion, the Committee requested additional data:

- Tabulate living donor kidney and liver transplants by transplant year and select recipient characteristics
- Tabulate living donor kidney and liver transplants by region
- Tabulate living donor kidney and liver transplants in pediatric recipients from blood related parents by transplant year and recipient age group
- Tabulate select demographic and socio-economic data of the living donors as collected on the Living Donor Registration (LDR) records by year

Staff from the UNOS Research Department shared the latest data report, noting:

- Kidney
 - Larger proportion transplants done for recipients 55+, decrease for all other ages
 - Slight increase in Hispanic living donor kidney transplant recipients
 - Decrease in biological parent living donors to pediatrics
 - Majority of living donors aged 35-54, very few 55+
 - Increase in living donors with BMI between 26-35

- Liver
 - Decrease living donor liver transplants for pediatric recipients, increase for recipients 55+
 - Pediatric recipients more likely to be Black or Hispanic than adults
 - Pediatric recipients more likely to have repeat transplant
 - Decrease in biological parent living donors to pediatrics, biggest change for recipients aged 0-5
 - Increase in living donors with BMI between 23-25 increased

UNOS staff reminded the Committee that additional content on the data request is pending and will be presented on a future conference call or meeting.

The Vice Chair thanked UNOS staff for the presentation and opened the floor for discussion on this component of the presentation. Members thanked UNOS staff for the substantial analysis. They suggested the following enhancements to the analysis:

- Separate the living liver donor data by type of procedure performed (right lobe, left lobe, or left lateral segment).
- Separate initial versus re-transplant procedures.

The Committee acknowledged that there is a gap in the data that the OPTN does not collect. This gap is the health of potential living donors that are presenting at transplant programs. The general sense is that potential donors are increasing, but the numbers of living donor transplants are decreasing. Representatives of the Scientific Registry for Transplant Recipients (SRTR) responded that a pilot project is in development that could shed light on this discussion. They are working with approximately 15 transplant programs to gather data on all potential living donors that present for evaluations. The Committee felt this information would be very compelling in future discussion on the topic.

UNOS staff reminded the Committee that there is no active Subcommittee on this topic. Following the subsequent discussion on future projects ideas, the Committee will need to prioritize what the future scope of work will include.

Next steps:

-UNOS staff will update the Committee on the remaining elements of Donor and Recipient Characteristics for Living Donor Kidney and Liver Transplants at a future call or meeting.

6. Project Brainstorming

UNOS staff facilitated a review of existing project ideas and new project brainstorming.

Summary of discussion:

UNOS staff began the discussion by reviewing the current catalog of Committee projects. The projects and current status appears below:

- Revise Pediatric Emergency Membership Exception – Evidence Gathering
 - Draft language approved by the Committee (see update above).
- Reduce Pediatric Liver Waiting List Mortality – On hold
 - This project is on-hold pending the availability of resources to move forward.
- Tracking Pediatric Transplant Outcomes Following Transition to Adult Transplant Programs – Evidence Gathering
 - See update above.

Five additional projects were suggested in an earlier brainstorming session:

- Promote Living Donation – Idea
 - The OPTN/UNOS Living Donor Committee has a project in-flight to Remove Disincentives to Living Donation. The Committee reviewed this document in February 2017 and provided feedback.
- Encourage the Use of Increased Risk Donor Organs – Idea
 - The OPTN/UNOS Ad-hoc Disease Transmission Advisory Committee (DTAC) has a guidance document out for public comment on increased risk donor organs. This document will be considered by the Board in June 2017.
- Living Donation to Pediatric Candidates – Idea
 - Ongoing discussions.
- Clinical Criteria for Pediatric Liver/Kidney Transplantation – Idea
 - Clinical criteria for adult transplant candidates in need of simultaneous liver-kidney transplant were approved in June 2016. Clinical criteria for pediatric candidates in need of a simultaneous liver-kidney transplant may be needed. Contributors had suggested to add content to the Pediatric Liver Exception Guidance. However it was decided to be outside the scope of the project and would cause delays.
- Transplant Outcomes in Pediatric Congenital Heart Disease
 - No active discussions to-date.

The Committee was asked to form breakout groups by transplant specialty and consider any project ideas for future work. In doing so, the breakout groups would be asked to report on 1) the problem to be addressed, 2) Strategic Goal alignment, and 3) a potential high-level solution.

Following a lengthy breakout session, representatives shared the following new project ideas:

- Assess for Disadvantaged Patients in the Current Heart Allocation System
 - Members felt there was an opportunity to explore the impact of the current heart allocation system on single ventricle patients, and non-adolescent pediatric patients. There are limited support options for these patients and there is concern that these patients are underserved. There is also some concern that highly sensitized patients in these groups are disadvantaged. They also raised the question if sensitization or PRA should play a role in allocation. Should variables be built in to an exception process?
- Reduce Incidence of Suicide Among Transplant Recipients
 - Should there be changes how candidates are managed, or could individuals at high risk for para-suicide/suicide be targeted for outreach or exclusionary criteria. Members of the Committee felt this project would be impactful across all organ types. Similar discussions are ongoing in other healthcare groups outside the OPTN. One member posed the question, is non-adherence secondary to risk-taking behavior or depression? Another member commented that international data noted that the incidence of depression at 10 years post-transplant is approximately 40%. As discussion develops on this it may be prudent to engage child psychology experts.
- Prioritize Pediatric Kidney Candidates
 - Pediatric kidney candidates appear after high PRA and multi-organ candidates. The concern is that pediatric candidates are not being transplanted. Members acknowledged the challenging organ availability for high PRA candidates. Need to look at data from years before (this was a real issue for Region 5). Members

also felt that multi-organ candidates are reducing transplant opportunities for pediatric candidates in need of isolated kidney transplants.

- Separation of Pediatric Kidney Outcome Data From Adult Outcome Data
 - Pediatric transplants that are performed under the umbrella of an adult transplant program are difficult to examine. The SRTR reports do not separate this data. If the outcomes were separated, it would be easier to understand recipient and graft survival.
- Increasing split liver transplant when the index program is an adult program
 - Adult program are not incentivized to share the remaining segment. Regional variance efforts in the past did not go very far. There is the need for data to show the problem (outcomes of right tri-segment transplants in adult recipients – including high MELD candidates). Members were interested in learning more about any risk adjustment for programs accepting liver segments. The breakout group acknowledge this is linked to issue of high mortality in young liver candidates. This effort has been tried before and was met with resistance from the adult community. There is some feeling that small stature adults could benefit from this. Future data to consider may be graft and recipient outcomes for segmental transplants.

Next steps:

-UNOS staff will catalog these new ideas. A discussion/survey on the priority of these projects will take place on a future call.

7. State of Pediatric Lung Transplantation

A representative from the Thoracic Committee shared an update on the state of pediatric lung transplantation in the U.S.

Summary of discussion:

Marc Schechter, M.D. was invited to present to the Committee on the state of pediatric lung transplant. Dr. Schechter provided an overview of the current lung transplant activity, noting:

- the relatively flat case volume during the last 10 years
- the continued trend in the last five years that the bulk of pediatric transplant registrations are in candidates 11-17 years old
- described the demographics of pediatric candidates on the pediatric Waitlist
- decline in Waitlist mortality for all pediatric candidates in the last five years

Dr. Schechter noted that in no new pediatric lung transplant programs and three new adult lung transplant programs have opened since January 1, 2015. He noted that ex-vivo lung perfusion (EVLP) would likely play a role in pediatric lung transplantation in the future. However, there is no published data on its use. There are also limitations due to cost, volume of experience, and risk aversion of teams.

Dr. Schechter briefly spoke about the new pediatric lung allocation policy changes that were effective on March 30, 2017. These include:

- Broader sharing of lungs
- ABOi listing option: Titers must be reported every 30 days:
 - < 1 at time of the match: Priority 1, no titer threshold
 - > 1 at time of match: Priority 1, registered before 2, isohemagglutinin titers less than or equal to 1:16

The Vice Chair thanked Dr. Schechter for the informative update.

Next steps:

-The Committee is available to collaborate with the Thoracic Committee on any future discussions.

8. Committee Member Recognition

The Vice Chair recognized the following out-going Committee members for their contributions:

- Manuel Rodriguez, M.D.
- Kyle Soltys, M.D.
- Gregory Abrahamian, M.D.
- Shikha Sundaram, M.D.
- Evelyn Hsu, M.D.
- Sharon Bartosh, M.D.
- Thomas Nakagawa, M.D.
- Eileen Brewer, M.D.
- David McMullan, M.D.

With no further business to discuss, the meeting was adjourned.

Upcoming Meeting

- May 23, 2017 2:00-3:00 PM Eastern (Transition Subcommittee conference call)
- June 21, 2017 4:00-5:00 PM Eastern (Full Committee conference call)

Attendance

- **Committee Members**
 - George Mazariegos, M.D. – Vice Chair
 - Manuel I. Rodriguez, M.D.
 - Kyle Soltys, M.D.
 - Stephen Gray, M.D.
 - Kristin Mekeel, M.D.
 - Evelyn Hsu, M.D.
 - Sharon Bartosh, M.D.
 - Shikha Sundaram, M.D.
 - Kishore Iyer, M.B.B.S
 - Andrew Savage, M.D.
 - Margaret Knight, CRNP
 - David (Mike) McMullan, M.D.
 - Melissa McQueen
 - Eileen Brewer, M.D.
 - Dean Kim, M.D.
- **HRSA Representatives**
 - James Bowman, M.D.
 - Joyce Hagar
- **SRTR Staff**
 - Jessica Zeglin
- **OPTN/UNOS Staff**
 - Christopher Wholley, M.S.A.
 - Leah Slife
 - James Alcorn, J.D.
 - Wida Cherikh, Ph.D.
 - Kimberli Combs
 - Susan Tlusty
 - Elizabeth Miller, J.D.
 - Charles Bradshaw
- **Other Attendees**
 - Kimberly Harbur
 - Cameron Wolfe, M.D.