OPTN Kidney Transplantation Committee Meeting
Meeting Summary
September 15, 2025
Conference Call

Jim Kim, MD, Chair
Arpita Basu, MD, Vice Chair

Introduction

The Kidney Transplantation Committee met via WebEx on September 15, 2025 to discuss the following agenda items:

1. Multi-Organ Transplantation Committee: *Establish a Comprehensive Multi-Organ Allocation Policy 2025*
2. Transplant Coordinators Committee: *Require Patient Notification for Waitlist Status Changes*
3. OPTN Updates

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

1. Multi-Organ Transplantation Committee: *Establish a Comprehensive Multi-Organ Allocation Policy 2025*

The Chair of the OPTN Multi-Organ Transplantation Committee (the OPTN MOT Committee) presented the *Establish a Comprehensive Multi-Organ Allocation Policy 2025* proposal.

Presentation summary:

The *Establish a Comprehensive Multi-Organ Allocation Policy* project has been ongoing; the OPTN MOT Committee developed the multi-organ policy and allocation tables in 2024, and released these tables in a request for feedback for public comment in Winter 2025. Through June of 2025, the OPTN MOT Committee refined the policy proposal, and released the proposal for public comment in August of 2025. The OPTN MOT Committee then plans to send the proposal for consideration by the OPTN Board of Directors in December 2025; implementation timeframes, if approved by the OPTN Board of Directors, are still to be determined.

This proposal aims to promote equity, consistency, transparency, and efficiency. Specifically, this proposal aims to:

- Promote equitable access to transplant among multi- and single-organ candidates
- Direct order of allocation across match runs based on medical urgency, access to transplant, and optimizing organ use
- Standardize allocation processes, multi-organ offers, and order of priority across match runs
- Facilitate stronger monitoring of outcomes, compliance, and allocation out of sequence
- Increase transparency and allows candidates to better understand priority
- Provide a system-generated, donor specific multi-organ allocation plan for most deceased donors
- Update match runs to display which additional organs must/must not be offered
- Direct allocation order for high priority candidate groups and provide flexibility for other offers

Example: A 25 year-old donor with a kidney donor profile index (KDPI) of 10 percent and heart, lungs, pancreas, and two kidneys available for donation:

- 1st Priority: Candidate A, an adult status 2 heart candidate within 500 nautical miles (NM) who meets medical eligibility for a heart-kidney offer
- 2nd Priority: Candidate B, an adult kidney candidate with a calculated panel reactive antibody (CPRA) equal to 100 percent
- 3rd Priority: Candidate C, an adult kidney-pancreas (KP) candidate within 250 NM

In this example, the highly sensitized kidney candidate would have increased access to transplant, receiving priority above the KP candidate.

The proposed policy would make the following key changes to multi-organ allocation policy:

- **Direct allocation order across match runs** for donors and candidates covered by multi-organ allocation tables
- **Standardize the allocation process** for donors and candidates covered by multi-organ allocation tables
- **Direct which additional organs follow the primary organ** on each match run
- Incorporate a **binary "must"/"must not" offer framework for additional organs** for which candidates are registered, removing discretionary "permissible" offers
- **Remove priority for some kidney-multi-organ candidates** with the goal of increasing access to transplant for high-priority single-organ candidates

Currently, pediatric and qualifying adult heart-kidney, liver-kidney, and lung-kidney candidates and all KP candidates are prioritized above all kidney alone candidates. This proposal would remove priority for kidney multi-organ candidates above all kidney-alone candidates. High priority single-organ candidates, such as highly sensitized and pediatric kidney candidate groups are included in the allocation tables, with the goal of increasing access to transplant for these candidates.

The proposed policy sets out the process that OPOs must follow for deceased multi-organ donors:

- OPOs must **execute match runs for organs recovered for the purpose of transplantation**
- **Prior to making organ offers to primary potential transplant recipients (PTRs)**, OPOs must **generate a multi-organ allocation plan**
- For deceased donors **not covered** by a multi-organ allocation table or if **all organs have not been accepted** upon completion of the multi-organ allocation table, **OPOs may determine the order in which to make organ offers across match runs**, which is consistent with current policy and practice

The proposed policy requires OPOs to allocate organs from deceased multi-organ donors according to the multi-organ allocation tables. The order of priority is based largely on medical urgency, as well as access to transplant and optimizing organ use. The policy proposal uses the orders of priority developed by organ-specific Committees – it does not propose any changes to orders of priority. The proposal includes 7 multi-organ allocation tables. Different tables are needed because the tables incorporate organ-specific allocation policies that are different based on donor characteristics, such as age and KDPI.

The proposed policy would also direct which organs follow the primary organ on each match run:

Table 1: Organs that Follow the Primary Organ by Match Run

From this match run:	Additional organs that follow the primary organ
Heart or Heart-Lung	All other organs follow on the heart/heart-lung match
Lung	All other organs follow on the lung match
Liver	All other organs follow on the liver match
Intestine	Kidney, pancreas, and covered VCA follow on the intestine match
Kidney	Intestine and covered VCA follow on the kidney match
Pancreas/Kidney-Pancreas	Intestine and covered VCA follow on the Pancreas/Kidney-Pancreas match

Kidneys could be offered from the heart, lung, liver, intestine, and KP match runs. On the kidney match run, intestine and covered vascularized composite allograft (VCA) could follow as part of multi-organ offers.

The proposed policy would incorporate a binary "must"/"must not" offer framework for additional organs for which candidates are registered, removing discretionary "permissible" offers.

Example: A donation after brain death (DBD) donor aged 18-69 with a KDPI 0-34 percent and 5 organs available for donation.

1. Donor has 5 organs available for donation: Heart, Liver, Kidneys, and Pancreas
2. OPO runs relevant match runs: Heart, Liver, Kidney, and Pancreas/KP
3. OPO makes offers according to multi-organ allocation plan
4. Some organs are placed within the multi-organ allocation plan:
    a. Heart and one kidney accepted by a heart candidate who meets medical eligibility criteria for a kidney
    b. Liver is accepted by a liver-alone candidate
5. Organs not yet placed are allocated from organ specific match runs: Pancreas/KP match and/or Kidney match

The proposed system solution includes:

- The user would run relevant match runs and request a system-generated donor-specific multi-organ allocation plan
- The plan would display the order in which the user should make offers across different organ match runs
- The system would determine whether candidates are eligible for a multi-organ offer and match runs would display whether additional organs candidates are registered for must or must not be offered

The OPTN MOT Committee reviewed a significant amount of data in developing this proposal. Some of this included data on covered donors, recipients, match runs, and organ offers:

- 80.91 percent of deceased donor match runs in 2024 would have been covered by multi-organ allocation tables
    - Allocation plan expected to be generated for about 80 percent of deceased donor match runs
- Seven multi-organ donor groups covered by a multi-organ allocation table:
    - DBD donors aged 18-69 with KDPI of 0-34 percent – 55.75 percent of multi-organ recipients
    - DBD donors aged 16-69 with a KDPI of 35-85 percent – 19.29 percent of multi-organ recipients
    - DBD donors aged 11-17 with a KDPI of 0-34 percent – 8.40 percent of multi-organ recipients
    - DCD donors aged 18+ with a KDPI of 0-34 percent – 6.23 percent of multi-organ recipients
    - DCD donors aged 18+ with KDPI of 35-85 percent – 5.40 percent of multi-organ recipients
    - DBD donors aged <11 with a KDPI of 0-34 percent and liver and intestine available – 1.02 percent of multi-organ recipients
    - DBD donors aged <11 with KDPI of 35-85 percent and liver and intestine available – 1.48 percent of multi-organ recipients
- The multi-organ allocation tables cover about 98 percent of donors to multi-organ recipients
- The allocation tables cover about 78 percent of multi-organ recipients who received a transplant from covered donors
- The proportion of recipients covered by an allocation table varies between 62-97 percent depending on the multi-organ combination
- Percent of accepted organs allocated within the proposed multi-organ allocation tables for deceased donors with match runs in 2024 by organ:
    - Heart-lungs were most likely to be accepted within the tables – about 93 percent
    - Kidneys were least likely to be accepted within the tables – about 14 percent
    - Typically 2-3 organs would remain available and OPOs would allocate these organs according to the individual match runs
- Most candidate groups included in the multi-organ allocation tables have 0 median appearances, meaning that, on average, 0 registrations appeared in that classification across historic match runs

The OPTN MOT Committee has reviewed extensive historic data and undertaken a values prioritization exercise to inform the multi-organ allocation tables. During Winter 2025 public comment, some participants requested modelling or additional data to better understand the potential impacts. Policy does not currently direct the order in which OPOs make offers across match runs. Analysis of historic data cannot predict how the proposed policy changes will impact access to transplant, organ non-use, and other areas of concern. Modelling is not currently feasible for multi-organ allocation. Adoption of this proposal and implementation of the system solution would allow for stronger monitoring of outcomes, compliance, and allocation out of sequence in the context of multi-organ allocation.

Post-implementation monitoring will be evaluated for this proposed policy by several key metrics, including:

- Number and proportion of multi-organ and single-organ candidates transplanted pre- vs. post-policy
- Median waiting time to transplant for multi- and single-organ candidates pre-vs. post-policy
- Median time from start of first match run (e.g., electronic notification time) to recovery of donor organs (e.g., cross-clamp time) pre- vs. post-policy

Special attention will be paid to the following groups to assess impacts on access to transplant and organ use and utilization: heart-lung, heart-kidney, multi-visceral, pancreas, and pediatric.

Finally, this proposal would consolidate multi-organ allocation policy and revise several related sections of policy to ensure consistency and coherence. This policy proposal includes a change to OPTN *Policy 8.6.A: Choice of Right vs. Left Donor Kidney.* Specifically, this revision proposes that "if both kidneys from a deceased donor are able to be transplanted, the transplant hospital that received the offer for the potential transplant recipient with higher priority, as determined by *Policy 5.10: Allocation of Organs from Deceased Multi-Organ Donors* or individual organ allocation policies, will get to choose first which of the two kidneys it will receive."

The OPTN MOT Committee seeks feedback on the following:

- Kidney specific issues e.g.
    - Kidney classifications included in the tables and order of priority
    - Proposed changes to Policy 8.6.A: Choice of Right versus Left Donor Kidney
- Do you support the standardized process for multi-organ allocation?
- What challenges do you anticipate if the policy proposal is implemented and how should the OPTN support members to ensure successful implementation and promote compliance?
- Are there specific candidate groups or areas of interest that should be the focus of post-implementation monitoring? The proposed monitoring plan pays special attention to the following groups to assess impacts on access to transplant and organ use and utilization:
    - Heart-lung, Heart-kidney, Multi-visceral, Pancreas, Pediatric

<u>Summary of discussion:</u>

One member remarked that there is subjectivity in the determination of the allocation tables, such as prioritizing a liver candidate above a heart candidate and the heart candidate above another liver candidate. The Chair noted that there was a lot of data reviewed in the development of the tables, and that prioritizing the classifications and determining what's more important is an impossible task. The Chair continued that the overarching theme in determining this prioritization was equity in access, and so the OPTN Multi-Organ Transplantation Committee (OPTN MOT Committee) reviewed a lot of data to see how many potential recipients were in each category and sought public comment to get a sense of the community's priorities. The Chair continued that those discussions were utilized to develop these classifications.

The Chair of the OPTN MOT Committee agreed, noting there was robust discussion from all members in determining the order of the allocation tables. The Chair of the OPTN MOT Committee shared there was strong representation from Kidney, Kidney-Pancreas, and Pediatric Committees. The Chair of the OPTN MOT Committee explained that the OPTN MOT Committee utilized a values prioritization exercise, in which it became clear that severity of illness, access to transplant, and access to life supporting devices were higher priority than post-transplant survival rates over time. These values drove the decision making in the allocation tables. The Chair of the OPTN MOT Committee continued that individual classifications had to maintain their priority relative to other classifications within their organ allocation schema. For example, kidney prior living donor candidates could not receive more priority in the multi-

organ allocation scheme than 0-ABDR mismatch 100 percent CPRA candidates within 250 nautical miles, because the kidney allocation schema has its specific order. Thus, in order to include the prior living donors in the MOT allocation table, the OPTN MOT Committee had to consider how to prioritize the Kidney classifications above it. The Chair of the OPTN MOT Committee shared that the MOT Committee took a lot of public feedback and OPTN Committee feedback on this.

The Chair reiterated that the sequence of allocation within each organ system is maintained in the MOT allocation order, so that priority doesn't change within organ systems. The Chair added that it was priority amongst the organs that is established in these tables. The OPTN MOT Committee Chair confirmed this.

One member shared that one concerns from the Kidney community at large is that both kidneys from low KDPI donors are going to multi-organ recipients, leaving kidney-alone potential recipients hanging. The member offered that there is some sentiment that one kidney should be maintained for kidney alone patients if the other is transplanted in a multi-organ combination. The member continued that it is problematic when both kidneys go to multi-organ candidates, particularly in instances where the multi-organ recipient has poor outcomes. The member shared that this is a big gripe within the kidney community, and that this has come up at multiple meetings with multiple organizations, such as the American Society for Transplants and KPCOP. The member reiterated that it may be unpopular to have both kidneys utilized in multi-organ transplant.

The OPTN MOT Chair noted that this is one reason the OPTN MOT Committee developed this proposal, to address instances where multi-organ candidates may have been overly prioritized ahead of single organ candidates, including kidney candidates.

The Chair remarked that the first five kidney classifications have bene prioritized above many of the multi-organ candidates in other organ classifications, such as liver multi-organ candidates with median end-stage liver disease (MELD) scores of 37 within 150 nautical miles. In the current state, nearly all multi-organ candidates are prioritized over kidney recipients. Within this proposal, the OPTN MOT Committee proposes prioritizing some high priority kidney candidates higher than many multi-organ candidates.

A member noted that there are some kidney-pancreas (KP) candidates who also have a calculated panel reactive antibody (CPRA) score of 100 percent. The member continued that there is support for those 100 percent CPRA KP candidates should have high priority along with 100 percent CPRA kidney candidates so they can receive appropriate offers. The member noted that this is a small population, but still significant. The Chair of the OPTN MOT Committee agreed, noting that the OPTN Pancreas Transplantation Committee provided similar feedback. The Chair of the MOT Committee added that this would be a change in kidney and pancreas allocation tables that is outside of the scope of the OPTN MOT Committee, which is constrained by current organ-specific allocation order.

The member asked, considering this proposal, what the chances are that both kidneys will still go to multi-organ recipients, instead of one kidney going to a kidney-alone candidate. The Chair of the OPTN MOT Committee shared that, in looking at the data from 2023-2024, the vast majority of the time, after allocating to all candidates in the allocation table, there was at least one kidney available to be offered to the rest of the candidates on the KP or Kidney match run.

One member remarked, in looking at the allocation tables, that some liver, heart, and lung multi-organ candidates are prioritized above kidney-alone candidates. The member reiterated that one kidney should be reserved for kidney-alone recipients, and noted that this proposal does not necessarily ensure this. Another member expressed disagreement, noting that it is arbitrary to split kidneys based on the donor. The other member continued that it may make more sense to understand the pool of kidneys

available and ensure that kidney patients have equity in access and allocation is fair. The initiating member disagreed, noting that the pool of kidneys is not the same, and that many multi-organ recipients are receiving the best, lowest KDPI kidneys. The member continued that these kidneys, when allocated in a multi-organ combination, are not typically going to pediatric candidates, but instead are going to multi-organ candidates who may have lesser outcomes. The other member agreed, but noted that it goes into the pool of kidneys already determined by policy. The other member continued, explaining that it's a heroistic way of splitting it up by each donor. The other member explained that it's that the low KDPI kidneys in an appropriately fair way and the medium and high KDPI kidneys in an appropriately fair way. The other member added that it's arbitrary to say that just because the kidneys are from the same donor that allocation should be split with one kidney allocated only to kidney candidates from that donor. The member remarked the kidney community may not see it as arbitrary, including the pediatric kidney transplant community. The member provided an example of a high CPRA candidate who has been waiting for twenty years; this candidate could be potentially prioritized behind two multi-organ candidates in the proposed system and may not receive another medically appropriate kidney offer for many more years. The member remarked that the problem is larger, and that kidney-alone candidates should A member explained that, in the proposed policy, that candidate still has increased priority. The member responded that this concern could be addressed by increasing the priority for high CPRA kidney alone candidates further on the multi-organ allocation tables, as opposed to the specific donor. The Chair added that this is precisely why this is being proposed, to put all the multi-organ candidates and single kidney candidates in the same pool and prioritize amongst the organs. The Chair continued that the OPTN MOT Committee looked at how many organs are allocated based on this priority. The Chair continued that there are some kidney candidates that will be highly prioritized above multi-organ candidates.

The OPTN MOT Committee Chair provided additional clarification, noting that the classifications included on the multi-organ allocation tables include candidates who are also single-organ candidates. The OPTN MOT Committee Chair noted that the OPTN MOT Committee considered which candidates should be offered to first, and ensuring kidney candidates are appropriately prioritized, but not to the exclusion of multi-organ candidates. The OPTN MOT Committee Chair added that overall, once offers have been made through these classifications, there is frequently one kidney available to be offered on the kidney alone match run. The Chair added that this is not exclusively multi-organ for kidney combinations, but also includes liver multi-organ combinations as well.

One member expressed that there are instances where it may be more appropriate for candidates to receive a safety net kidney than a kidney as part of a multi-organ combination. The member explained that there are liver-kidney and heart-kidney candidates that are more likely to lose that kidney in the first year than a kidney-alone candidate. The member expressed that the organ loss in those instances could be avoided by more widespread use of the safety net kidney policy. The member added that if it is easier to receive a kidney as part of a multi-organ combination and programs opt to do that, this does impact kidney patients negatively. The member added that this may be outside of the scope of this proposal.

The Chair asked for clarification on simultaneous liver-kidney (SLK) eligibility, specifically whether there are instances where a candidate can be listed for an SLK without being eligible. The OPTN MOT Committee Chair remarked that there are specific requirements for SLK eligibility, but these are not necessarily required in order to be listed for a kidney. Another member commented that the requirements to qualify for kidney waiting time are actually stricter than the requirements for SLK eligibility in terms of glomerular filtration rate (GFR) thresholds. The Chair asked if the non-eligible candidates were potentially in a lower classification. OPTN contractor staff clarified that a candidate

may be listed on the kidney waiting list and appear on kidney match runs without that candidate qualifying for waiting time. However, those candidates will have very low priority on those match runs relative to similar candidates accruing waiting time. A member asked for clarification as to whether a candidate with an eGFR of 25 can be listed and receive offers at a low priority, and OPTN contractor staff confirmed this. The member remarked that it must be a rare situation in which a candidate is listed for both a liver and a kidney but does not meet eligibility criteria. The Vice Chair expressed confusion as to how candidates who are not accruing time could receive an offer, and the Chair of the OPTN Transplant Coordinators Committee (OPTN TCC) explained that some non-wait time qualifying candidates receive offers through the 0-ABDR mismatch classification or, in current policy, as part of multi-organ. The OPTN TCC Chair explained that their program will have a heart-kidney candidate who has a GFR above 20 receive multi-organ offers. A member noted that those candidates are not likely to receive a kidney alone offer, because they do not qualify for kidney waiting time. The Vice Chair remarked that there is a different GFR threshold for heart-kidney multi-organ eligibility. The Chair recommended providing more clarity on that.

The Chair considered the proposed changes regarding choice of left or right kidney, noting that currently priority is given to the most highly prioritized candidate. The OPTN MOT Committee Chair agreed, noting this proposal aims to codify this practice into policy. The OPTN MOT Committee Chair asked if the OPTN Kidney Transplantation Committee would recommend additional language to modify how choice of left and right kidney is determined. The Chair explained that some of the debate came up with respect to choice between a pediatric recipient and a more highly prioritized multi-organ recipient. The Chair expanded on this example, noting that the multi-organ candidate could have choice, even in an instance where the pediatric candidate may need a specific laterality due to anatomical concerns. The Chair asked if that should be given priority, or if that should be carried out in conversation between accepting centers.

A representative from the Scientific Registry of Transplant Recipients considered the question of laterality choice with respect to pediatric recipients. The SRTR representative explained that it's not the right or the left that is key as much as the single artery, explaining that transplanting a kidney into an infant with limited room to place the artery, having more than one artery is problematic. The SRTR recommended that this be considered in terms of how laterality choice is determined.

2. Transplant Coordinators Committee: *Require Patient Notification for Waitlist Status Changes*

The Chair of the OPTN TCC presented the *Require Patient Notification for Waitlist Status Changes* proposal, and the Committee provided feedback.

Presentation summary:

The purpose of this proposal is to:

- Add transparency and empower patients to work with their transplant team to ensure their listing status is accurate
    - Alert patients who are moved to active from inactive status, or inactive from active status
- Standardize patient notification requirements related to waitlist status changes
    - While many programs currently notify their patients of status changes, it has not been an OPTN Policy requirement

This proposal would establish that transplant programs would be responsible for communicating to candidates whenever their waitlist status has changed from inactive to active or active to inactive.

Programs have 10 business days from the status change to send this notification to the candidate. The current proposal requires written notification, which is consistent with other notification requirements.

Patients may not be aware of their inactivity on the waitlist. This proposal empowers patients to work with their transplant team to ensure their listing status is accurate. This proposal also provides transparency for patients on their status. Depending on the organ type, the candidate may not be accruing wait time while inactive. Candidates assigned to an inactive status while on the waiting list are ineligible from receiving organ offers during allocation.

This proposal requires that:

- Transplant programs will need to notify candidates within 10 business days of a waiting list status change
- Programs without a status change notification system in place may need to update procedures
- Program-wide notification of this change and training for staff may be needed

The OPTN TCC seeks the following feedback:

- Is written notification is necessary, or would documentation of notifications, including conversations, be sufficient?
- Is this notification change feasible, or are there concerns about the level of burden?
    - What education or guidance would be helpful for programs to support the implementation of this proposal?
- Do patients & patient families and caregivers support notifying candidates when their waiting list status changes?
    - Any additional information to include in the patient notification, other than waiting list status?
    - What education or guidance would be helpful for patients & patient families and caregivers?
    - Any additional tools, such as patient portal, that would be helpful to engage patients in the future?

Summary of discussion:

The Chair asked for clarification on whether current policy includes requirements for how and when programs communicate with patients about wait list status, and if this proposal just aims to provide standardization. The OPTN TCC Chair explained that current policy requires programs to notify patients when they are listed or delisted, but there is no OPTN Policy relating to patient notification when made inactive or active. The OPTN TCC Chair explained that the OPTN TCC has received a lot of input from patients and the Patient Affairs Committee that patients do not always know they are inactive. The OPTN TCC Chair provided an example of a listed candidate who was wounded; if that patient does not know they were inactivated as a result of their wound, they may not be as aggressive to ensure their program is notified and status updated when their wound is healed.

The Chair remarked that there is no policy that dictates a requirement for programs to communicate changing a candidate's status from status 7 inactive to active or vice versa. The OPTN TCC Chair confirmed. The OPTN TCC Chair remarked that many transplants have a program-specific policy to do so, but it is not currently codified in OPTN Policy and not all programs have a policy to notify candidates when made inactive.

The Chair shared that this requirement makes sense and seems justified to ensure patients know their status. The Chair added that a patient portal would be easier. The OPTN TCC Chair agreed that a patient

portal would be easier, but it would require significantly more resources and that it made more sense to establish the policy first, and then work on next steps.

One member expressed that the written policy should allow programs to notify via patient portals and/or phone communication. The member explained that sometimes programs send letters, and patients do not always see them, or have moved, or have another interfering circumstance. The member added that there should be an option for programs to call and document the call or else send a notification via the portal, and ensure that the patient has seen the notification in the portal.

The member noted that some transplant centers in hurricane-prone places will need to inactivate all candidates for a day or two, because all systems to allow kidneys to be accepted and transported are down. The member added that there should be a grace period for which candidates are inactive that the program does not need to write a letter, particularly if the candidate is made active again by the time the letter is sent. The OPTN TCC Chair thanked the member and remarked that this feedback has been received before. The OPTN TCC Chair continued that the OPTN TCC is considering establishing the requirement for notification if the candidate is active for 5 or 10 days or more. The TCC Chair shared an example of a heart patient who is hospitalized at the program and spikes a temperature, it may make sense to inactivate the candidate for a very brief period of time.

One member agreed, noting that policy language should be agnostic to the notification mechanism, allowing programs to determine the best mechanism for notifying candidates. The member explained that these mechanisms change over time and there should just be a requirement for documentation of notification. The OPTN TCC Chair noted that this feedback has also been received frequently, particularly as programs are using patient portals. The OPTN TCC Chair shared that their program still sends a letter, with the information to allow the patient to contact the OPTN. The OPTN TCC Chair remarked that this is important and gives patients someone to talk to outside of the transplant program. The OPTN TCC Chair remarked that if that's something that's needed, then the written requirement may need to be maintained, but how that written information is sent could still be up for program determination. The OPTN TCC Chair shared that less than 20 percent of patients at their program use the patient portal, and that their program still relies heavily on paper and written notification.

The Chair agreed that it is not necessary to be overly prescriptive in how notification is sent, noting that it is up to the center to document the notification itself. The Chair remarked that this could be in the post-implementation monitoring, noting that programs will need to maintain documentation regardless if the programs are going to be audited on this.

3. OPTN Updates

The Chair provided brief updates on the OPTN Board's Allocation Out of Sequence Workgroup.

The Chair explained that the Allocation Out of Sequence Workgroup has started meeting, and is dividing work into three subgroups: defining offers, expedited placement, and compliance. The Expedited Placement subgroup is going to work on policy related to what the Committee worked on and will be discussing the Committee's policy proposal as well.

Summary of discussion:

An SRTR representative asked if there were any updates on the status of the Continuous Distribution project. The Chair explained that all Continuous Distribution projects are on hold for now until the Allocation Out of Sequence Workgroups have rolled out their work. The Chair added there are no real updates on when Continuous Distribution will be picked up.

Upcoming Meetings

- October 20, 2025

Attendance

- **Committee Members**
  - Jim Kim
  - Arpita Basu
  - Leigh Ann Burgess
  - Eloise Salmon
  - Jesse Cox
  - John Lunz
  - Patrick Gee
  - Christine Hwang
  - C.S. Krishnan
  - Curtis Warfield
  - Prince Anand
  - Kristen Adams
  - Marc Melcher
  - Patrick Gee
- **HRSA Representatives**
  - Sarah Laskey
- **SRTR Staff**
  - Jon Miller
  - Bryn Thompson
  - Peter Stock
- **UNOS Staff**
  - Kayla Temple
  - Kaitlin Swanner
  - Sarah Roache
  - Jaime Panko
- **Other Attendees**
  - Lisa Stocks
  - Christine Brenner