OPTN Heart Transplantation Committee
Meeting Summary
April 20, 2021
Conference Call

Shelley Hall, MD, Chair
Richard Daly, MD, Vice Chair

Introduction

The Committee met via Citrix GoToMeeting teleconference on 04/20/2021 to discuss the following agenda items:

1. Welcome and introductory remarks
2. Policy Oversight Committee Update
3. Request for Feedback: Evaluating Heart Monitoring Report effectiveness
4. Status Extension project
5. Executive Committee Request for Feedback: Remaining Emergency Actions
6. Primary Graft Dysfunction project
7. Open forum for questions and answers; Closing remarks

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

1. Welcome and introductory remarks

Summary of discussion:

The Chair welcomed the members of the OPTN Heart Transplantation Committee, thanked them for their time, and reviewed the agenda.

2. Policy Oversight Committee Update

The Vice Chair gave an update on the activities of the Policy Oversight Committee (POC).

Summary of discussion:

POC is comprised of the Vice Chairs of the policy development committees and is charged with approving projects and ensuring the work is in alignment with broader OPTN goals. The POC also evaluates resourcing, sequencing, and sets priorities.

The Vice Chair gave an overview of current projects and workgroups. A member asked if the initiative to increase offer filters will create more dynamic screening criteria such as height and weight by gender. The Vice Chair responded that the idea is to increase the specificity of screening and commented that the Heart Committee will be invited to provide feedback as the project develops.

3. Request for Feedback: Evaluating Heart Monitoring Report effectiveness

UNOS Research staff invited the members to reflect on the current monitoring reports and consider additional analysis to request in order to review the effectiveness of heart policies post-implementation.

Summary of discussion:

UNOS staff reviewed an overview of outcomes provided in the last 2- year monitoring report on changes to adult heart allocation. She commented that this policy will be monitored for 5 years and shared a list of additional requests from the committee members received during the previous monitoring report presentations.

The Chair commented that the community is concerned about the increase of candidates with intra-aortic balloon pumps (IABP) and decrease of candidates being supported by ventricular assist devices (VADs). She commented that more information relating to outcomes for candidates with IABPs is important. She also recommended evaluating the removal of candidates with left ventricular assist devices (LVADs) from the waiting list due to being too sick or dying.

UNOS staff asked if it would be valuable to identify if the removed LVAD candidates were supported by other devices, how many, and when. The Chair agreed that removal information should be assessed for candidates who had a LVAD at time of removal.

A member commented that it would be good to continue looking at the distance the organ travels as well as tracking what is happening at Interagency Registry for Mechanically Assisted Circulatory Support (INTERMACS). The Chair commented that the distance and sharing analysis will remain on the report and can be supplemented by the information provided in the monitoring report for the removal of donor service areas (DSA) policy modification.

A member commented that it is hard to judge how the allocation system is working because of the number of status exception requests. UNOS staff commented that a larger sample size will allow more in depth analysis.

A member of the public commented that it is important to understand the reasons for requesting an exception and supported monitoring waiting list outcomes for LVAD candidates. UNOS staff commented that reviewing the details of exceptions is labor intensive but the forms can be mined for data.

A member asked if there is any benefit to also review the LVAD candidates who become inactive. UNOS staff commented that inactivation is transitory in that candidates can be inactivated for one or multiple days. There is no reason collected for why they are inactivated as there is when a candidate is removed but UNOS Research staff will consider how to approach reviewing this inactivation data. Members suggested looking at candidates with prolonged inactivation and identifying their previous listing status. The Chair suggested reviewing candidates that have inactivation as their last status. UNOS staff commented that these numbers can be reviewed but raised a concern about inaccurately applying causation for why the candidates were inactivated.

A member raised a concern about the increase in number of candidates approved for and/or transplanted at a status by exception. A member agreed that exception requests need to be addressed more aggressively, specifically for Status 2. Another concern was raised about candidates who are transplanted prior to the determination or approval of a status exception request.

4. Status Extension project

The members reviewed the proposed policy changes that are intended to improve consistency in the required extension criteria. These proposed changes were drafted previously by the Heart Committee and the Status Extension Review Subcommittee.

Summary of discussion:

6.1.A.i Veno-Arterial Extracorporeal Membrane Oxygenation (VA ECMO)

The Status Extension Review Subcommittee reviewed policy *6.1.A.i Veno-Arterial Extracorporeal Membrane Oxygenation (VA ECMO)* and determined that no changes were needed.

6.1.A.ii Non-dischargeable, Surgically Implanted, Non-Endovascular Biventricular Support Device

The Status Extension Review Subcommittee reviewed policy *6.1.A.ii Non-dischargeable, Surgically Implanted, Non-Endovascular Biventricular Support Device)* and determined that no changes were needed.

6.1.A.iii Mechanical Circulatory Support Device (MCSD) with Life Threatening Ventricular Arrhythmia (VA)

The Chair shared that the primary proposed change is reducing the timeframe for this policy from 14 days to 7 in order to be consistent with other Status 1 policies. UNOS staff commented that the other suggested change is adding language around downgrading to Status 3 if the extension or initial justification form expires. Currently, when the justification form supporting a candidate's status expires, UNet automatically downgrades the candidate's status to either to either Status 5, if the candidate requires a multi-organ transplant, or Status 6.

The members discussed how a candidate would be auto downgraded to Status 3, as proposed, since there are no current Status 3 criteria these candidates would be eligible for. The transplant program would need to submit a justification form for Status 3. A member commented that since there is no Status 3 for candidates with VA, an exception request would need to be submitted.

The Chair noted that this new Status 3 criterion would be for patients that are stabilized (have not had an arrhythmia in 7 days) and no longer meet the Status 1 criteria but are not ready for outpatient care which would make them eligible for Status 4. The members supported exploring the addition of another criterion in Status 3 for these candidates. The Chair commented that Status 3 is appropriate for these stabilized candidates as the criteria aligns with VAD complications. UNOS staff will bring this recommendation to the Status Extension Review Subcommittee for further discussion.

UNOS staff asked what should qualify for an extension at this criterion. The Chair commented that the candidate should remain hospitalized and continue to meet one of the two eligibility sub criteria. UNOS staff commented that since the candidate will have a new extension form submitted to maintain the status, the language around hospitalization should be “is hospitalized” rather than “remains hospitalized.” The Chair agreed with this language revision.

6.1.B.vi Ventricular Tachycardia (VT) or Ventricular Fibrillation (VF)

It was determined that another justification form will be required rather than provide criteria for an extension since the same information is requested.

6.1.C.v Mechanical Circulatory Support Device (MCSD) with Right Heart Failure

UNOS staff reviewed a previous proposed modification that would increase the time permitted at an extension from 14 to 90 days. There were no comments or questions.

A member asked if there is a policy that states that the candidate will be downgraded if their justification or extension forms expire. UNOS staff responded that this requirement is stated in policy and is also included on the justification forms.

6.1.C.vi Mechanical Circulatory Support Device (MCSD) with Device Infection

UNOS staff asked about keeping the language "recurrent debridement or persistently positive culture" previously proposed as an additional row in *Table 6-1: Evidence of Device Infection*. The members confirmed that this language should be kept.

UNOS staff asked if timeframes should be included to define "recurrent" in order to increase consistency. A member commented that patients typically need multiple debridement procedures.

UNOS staff asked what qualifies as persistently. The Chair commented that if the positive culture is still not eradicated after 14 days, it is a persistent infection. The Vice Chair questioned if the infection has to be the same organism similar to how bacteremia is described in the same table.

A member commented that the only way to ultimately treat these infections is by removing the device. She commented that the wound culture will always be positive. The Vice Chair commented that if the infection needs recurrent debridement, there's a reason. The members agreed to remove the language "or persistently positive culture."

UNOS staff asked if not providing more information for what qualifies as "recurrent" will be clear to coordinators. Another UNOS staff mentioned that transplant programs have questions about this status including eligible timeframes for when a debridement occurred (e.g., a transplant program may want to use a debridement that occurred 2 years prior). The members suggested adding a six-month timeframe to limit these types of instances.

A member asked about patients managed with suppressive oral antibiotics, agreeing that IV antibiotics should take priority. The Vice Chair commented that if they are suppressing a bad infection and treating with debridement, Status 3 is appropriate. A member noted that a bad infection requires VAD removal. The Vice Chair commented that the hope is to get a transplant before being forced to exchange the VAD.

A member asked about using language around surface or deep infections to help clarify. The Vice Chair pointed out the driveline and pump pocket descriptions.

A member commented that they do not support including a timeframe for "recurrent debridement" because it is not enforceable and may increase exceptions. A member noted that the criterion for positive bacterial or fungal cultures from the driveline exit site is required to have been collected within the last 14 days, whereas the other criteria in the table do not have timeframes which is inconsistent. A member raised a concern about programs submitting exception requests using 3-month old data if a timeframe is required. He noted that it is up to the program to use discretion about what infections qualify for Status 3 and when you give them more rules such as requiring antibiotics to qualify, programs will put their patients on antibiotics.

Members ultimately agreed that "recurrent debridement" will not include a required timeframe (e.g., debridement occurred within last six months) and will be valid up to 90 days.

6.1.C.iv Mechanical Circulatory Support Device (MCSD) with Pump Thrombosis

The Chair commented that the proposed revisions are intended to update the policy to reflect a more current understanding of thrombosis. She commented that, similar to the other policies discussed, if the extension requirements are the same as the requirements for the initial justification, it does not need to be reiterated.

A member questioned the criterion of mean arterial pressure (MAP) under 90. The Chair commented that this was included to indicate that the candidate's blood pressure is being controlled. This is consistent with the definition of Aortic Insufficiency (AI) provided in *Policy 6.1.C.vii*.

UNOS staff commented that the proposed revisions lengthen the time at this status from 14 to 30 days and allow for the program to maintain extensions for 90 days, rather than 14.

Potential data needs or analyses

UNOS staff asked if there are any data needs or analysis that would support the proposed policy modifications. Members were invited to submit requests for data or share relevant journal articles.

Demonstration of heart justification form functionality

UNOS staff provided a demonstration of how the current justification forms work and what is required in order to extend at specific statuses. Mock ups of proposed changes were also shared.

6.1.B.vi Ventricular Tachycardia (VT) or Ventricular Fibrillation (VF)

The Chair commented that requiring the user to indicate the patient is hospitalized and still meeting criteria is preferred. She commented that collecting medication types and dosages may be unnecessary and asked the members for their thoughts. She noted that if the program has an audit, this information would be available in their charts. The members agreed that this detailed information does not need to be collected.

6.1.C.iv Mechanical Circulatory Support Device (MCSD) with Pump Thrombosis

The Chair commented that some device complications do not require hospitalization. UNOS staff commented that hospitalization is required in order to extend at this status. A member suggested adding three options for indicating hospitalization: admitted to the hospital; not admitted to the hospital; and not admitted to the hospital, requesting exception.

6.1.C.vi Mechanical Circulatory Support Device (MCSD) with Device Infection

The Chair noted that hospitalization is not required for this status. She confirmed that hospitalization should not be required to extend.

The mockup of the extension form requires the user to indicate that the candidate continues to meet criteria. The Chair commented that medication type and dosing does not need to be collected.

6.1.C.v Mechanical Circulatory Support Device (MCSD) with Right Heart Failure

UNOS staff asked the members if there should be validation on the extension form for the date of inotrope initiation fields. The Chair questioned if the date of initiation needs to be collected since this information should have already been submitted with the initial justification form. UNOS staff commented that collecting inotrope information on the extension allows the user to provide more recent information if the patient's inotropes or dosing has changed since the initial form was submitted.

A member commented that removing the date of initiation fields on the extension would not compromise the requirements set in policy. The members considered if the candidate would still qualify for the status if they switch inotropes. The Chair commented that the candidate should be eligible if they are on inotropes to support their right ventricle, noting that the inotrope type may change if the patient experiences side effects. The members agreed to remove the date of initiation fields from the extension form.

Hospitalization requirements for status assignments by standard criteria and by exceptions

The members discussed hospitalization requirements for initial justification for Statuses 2 and 3 as well as the hospitalization requirements for requesting an exception at these statuses.

For exceptions, the Chair suggested having programs complete the most appropriate justification form for their candidate and include a narrative about why the candidate does not quite meet the eligibility criteria but is still at the same medical urgency. This would be instead of only submitting an exception form for a status in general.

A member raised a concern about removing the hospitalization requirement for exceptions. She commented that narrow criteria needs to be established for outpatient Status 3 candidates by exception. She commented that she does not recommend allowing any candidates at Status 1 or 2 by exception to be outpatient. A member commented that improving technologies may permit Status 2 candidates to receive outpatient care or care at extended stay clinical settings. A member noted that *Policy 6.1.B.ii Total Artificial Heart (TAH), BiVAD, Right Ventricular Assist Device (RVAD), or Ventricular Assist Device (VAD) for Single Ventricle Patients* does not require the candidate to be hospitalized.

The members discussed that further clarifications to Status 2 criteria may need to be addressed through a separate project. The Chair questioned if a workgroup would need to be formed. UNOS staff commented that a new project form will be developed.

Consideration of potentially disadvantaged groups and transition procedures

UNOS staff shared that transition procedures are required to be developed if policy changes will disadvantage groups of patients. The members were asked to consider the impact of any modifications to extension requirements (e.g., if hospitalization requirements are changed). This will be discussed further at future subcommittee meetings.

Next steps:

UNOS staff will update the proposed policy revisions based on the discussion. UNOS staff will create a new project form for reevaluating Status 2 criteria and will present the initial project idea to the full committee at the May meeting.

5. Executive Committee Request for Feedback: Remaining Emergency Actions

Policy 1.4.F: Updates to Candidate Data during the 2020 COVID-19 Emergency allows a transplant program to submit a candidate's most recently reported clinical data if a candidate is unable to access testing needed to maintain their urgency status. The Executive Committee is requesting feedback from the Heart Committee to determine if this policy is still needed or can expire.

Summary of discussion:

UNOS staff shared that only 5 candidates have used *Policy 1.4.F* since made effective in March 2020, and no candidates have used the policy so far in 2021. The members were asked if there are there any logistical barriers to obtaining labs for heart candidates due to COVID-19 and whether they would recommend to repeal this policy action. Members agreed that this policy should be repealed. The Chair commented that their transplant program is operating as normal at this point in time. A SRTR representative raised a concern that the need for maintaining this policy may vary by location and encouraged advance notification to members to allow for adequate preparation prior to repealing. Members agreed that 90 days of notice would be adequate.

6. Primary Graft Dysfunction project

UNOS staff gave an overview of the Primary Graft Dysfunction (PGD) project and shared that it was generally supported by the community during the request for feedback.

Summary of discussion:

Finalize timing of data collection

The Chair commented that the most common recommendation received during the request for feedback included collecting data at 24 hours post-transplant to align with the definition of PGD provided by the International Society of Heart and Lung Transplantation (ISHLT) consensus statement. The most popular second time point was 72 hours. The Chair reminded the members that the want for additional data needs to be balanced with the amount of effort required to collect and enter the data. In addition, the Data Advisory Committee previously recommended only collecting data at two time points.

Members supported collecting data at 24 and 72 hours post-transplant. A member commented that if the patient's chest remains open, the timing may be delayed. The Chair questioned if they would be able to accommodate a second set of times for open chest patients and reminded the members that this data will be collected on all heart recipients.

A member asked when this data will be entered. The Chair responded that the data would be entered within 30 days of transplant. UNOS staff shared that the data would be entered on the Transplant Recipient Registration (TRR). The member suggested that for patients who are identified as having PGD, there could be an additional follow up to learn how long they were in the Intensive Care Unit (ICU). The Chair suggested collecting data at 24 hours and 72 hours post-transplant as well as a final follow up. A member raised a concern that requiring data as a final follow up may be too vague if a specific time point is not provided. The Chair acknowledged that the final follow-up could be dropped from the proposal if opposed in public comment.

The members discussed the value of collecting this data on all candidates. The Vice Chair commented that collecting data on all heart recipients will allow identification of mild PGD as well as cases of PGD that the patient's program may not have identified.

The members agreed on the time points of 24 and 72 hours post-transplant. The subcommittee will continue to discuss whether there should be a third time point. A member asked if the values reported will be the worst at 24 hours and 72 hours post-transplant. The Chair commented that the time points for data collection need further discussion with the Subcommittee to finalize.

Finalize post-transplant data elements for collection

Members reviewed the data elements that went out to public comment and discussed recommendations provided during the request for feedback.

PGD: yes/no

The Chair shared that there was mixed support about including the question "PGD: yes/no." Comments were received that this question is too subjective and needs clear definition. A member commented that severe PGD can be defined by whether mechanical support is needed post-transplant but moderate PGD is harder to identify with a limited dataset and will require the program to indicate the diagnosis. He suggested changing the question to "PGD: yes-severe/yes-moderate/no." A member agreed with this recommendation.

A member commented that it will be helpful to know if the program believes there is PGD, how they react, and what treatment is provided.

The Chair commented that this data element will be kept in the proposal. The Subcommittee will create clear definitions and continue to discuss if adding a drop down to indicate severe or moderation PGD will be discussed further. A member raised a concern about the additional burden for a coordinator related to selecting moderate or severe if not clearly defined.

Left Ventricular (LV) Dysfunction: yes/no

The members were asked to consider whether or not to keep this data element. A member commented that it would be better to collect a number or range noting that sometimes that the transesophageal echocardiography (TEE) is not accurate but the collected value could fall within a range. The Chair asked if this data element needs to be collected if ejection fraction (EF) is also being collected. A member commented that EF is good data and questioned how relevant it is to try to define right sided or left sided PGD. He raised a concern about some patients not having Swan-Ganz catheters in place which would limit data collection.

Members supported removing this data element since EF is also being collected.

Right Ventricular (RV) Dysfunction: yes/no

The Chair shared that the feedback received requested this data element be clearly defined and suggested allowing the user to indicate if the right ventricular dysfunction is mild, moderate, or severe. The members discussed whether to keep or remove this data element.

A member asked how difficult it would be to stratify moderate or severe RV dysfunction retrospectively. The Chair commented that this depends on the hemodynamic data collected and the time points of collection.

A member commented that the ISHLT consensus definition supports identifying isolated RV dysfunction and provides hemodynamic criteria. A member commented that RV dysfunction will need to be clearly defined and distinguishable from pulmonary hypertension.

The members agreed to keep this data element but further refine as “RV Dysfunction Alone: yes/no” and develop a clear definition.

Left Ventricular Ejection Fraction (LVEF)

A member commented that their program only performs echocardiograms on patients immediately following transplant, typically within 24 hours, and does not perform echocardiograms on patients in first three days post-transplant. She raised a concern about missing data if values are not collected on all patients at the determined time points. The Chair commented that patients doing well will not have EF collected. A member commented that echocardiograms are performed at discharge. The Chair suggested collecting EF at 72 hours or at discharge.

The members discussed collecting EF as ranges. A member commented that they would want to compare the values at the different time points to determine severity. A member suggested collecting LVEF closer to the time of surgery and then again at discharge rather than 72 hours.

The members decided to keep this data element, further consider how to collect ranges to reduce the need for typing, and further discuss timing. The modality for collection will be TEE and transthoracic echocardiogram (TTE).

A member recommended considering whether ranges or discrete values would be consistent with importing data by API.

A member asked how missing values would be reported, such as in the case of death. The Chair commented that once the list is finalized, the Subcommittee will need to determine how to accommodate missing values.

Right Atrial Pressure (RAP)

Community feedback recommended the use of ranges for collecting RAP. The members supported the collection of hemodynamics. A member suggested collecting at 24 hours, plus or minus 4 hours, and offer ranges. A member commented that RAP information is important.

The mode for collection would be an invasive catheter. Members commented that RAP is one of the only pressures collected for pediatric patients.

Pulmonary Artery Systolic and Diastolic Pressures (PAS/PAD)

Similar to collecting RAP, this data element would be collected via invasive catheter near determined time points (plus or minus a few hours), and will be reported as ranges.

A member raised a concern about challenges associated with, if it is determined that the worst value in a time range should be reported, identifying the worst value as well as determining if this value is accurate because of issues related to values that are auto populated from electronic medical records. Members acknowledged that member education will be important to ensure accurate data submission.

Cardiac Output (CO)

The community recommended making this data element simple and recommended creating ranges. The Chair questioned if cardiac index should be reported since it is more aligned with PGD definitions. A member commented that if cardiac output is being collected with the intention of being able to calculate cardiac index (CI), discrete values rather than ranges will need to be reported.

A member supported changing this data element to CI. A member commented that CI could be collected as ranges. A member opposed changing this to CI since the values tell less of a story for moderately obese patients. The Vice Chair supported changing to CI since it is part of the PGD definition. He commented that CO can always be calculated from other values collected, including body surface area (BSA). Calculation cannot occur if a range is collected, rather than discrete value.

The Subcommittee will discuss whether to collect CI or CO and in what format.

Device: yes/no

The members and community feedback supported keeping this data element.

Device: right, left, or biventricular

This data element was supported by the community. A member supported the feedback to add date and time of implant. A member commented that there needs to be a section to indicate open chest. The Vice Chair questioned how extracorporeal membrane oxygenation (ECMO) could be captured.

Device type

A member commented that there is a device question that is required when removing a candidate from the waitlist. UNOS staff verified that this question only collects device information prior to transplant.

The members discussed the order of the device questions. A member commented that other forms collect device type first followed by which ventricle the device supports. The members discussed whether it is necessary to collect implant location if the type is captured. A member raised a concern about the types of devices changing as technology advances. Members suggested simplifying the list to

RVAD, LVAD, VA ECMO, veno-venous ECMO (VV ECMO), and/or IABP, allowing members to multi-select. Members would select RVAD and LVAD to indicate use of biventricular assist devices (BiVAD).

Consider inotrope information for collection

Collecting inotrope information received moderate support from the community. There was a concern about burden and a suggestion to also collect dosing information on Flolan and nitric oxide (NO). A member commented that inotrope information needs to be collected and suggested making the data entry easier by providing ranges. A member agreed with collecting NO information. The Chair commented that NO is commonly used within 24 hours of transplant but if the patient is still on NO or Flolan at 72 hours, there is a problem. NO and Flolan are used to avoid graft dysfunction and the need for an RVAD.

A member questioned how this data would be used and another member commented that inotrope information is needed to diagnose PGD using the ISHLT consensus definition.

A member suggested collecting at 72 hours. Prior to 72, there may be institutional variability in providing inotropic support immediately post-transplant. The Vice Chair commented that if the patient is on ECMO at 72 hours, they may have already been weaned from inotropes. He suggested collecting highest dose and time of highest dose. A member commented that if collecting highest value, it should be collected once the patient is out of operating room where they have received pressors.

The members discussed how to collect inotrope information in a way that shows escalation or de-escalation and limits the impact of institutional variability in inotrope administration post-transplant. Inotrope dosing may vary drastically in a matter of hours. A member suggested collecting inotrope information at 7 days. If the patient is on inotropes at this point, it would indicate the presence of PGD similar to if device support is required.

The Chair commented that requesting highest values would require more work for the person tasked with reporting as they would have to scan charts to identify the appropriate value. She commented that it may be easier to report values at specific time points, plus or minus a few hours.

UNOS staff asked about how missing data could be handled. The Chair commented that the further out from transplant the patient is, the less information will be available but that hemodynamics will always be available at 24 hours. Although at 72 hours, the patient may no longer have a Swan-Ganz catheter.

The Subcommittee will discuss how to best collect inotrope information and continue to consider adding NO and Flolan.

Potential procurement data elements under consideration

The community did not have a lot of opinions about collecting information on whether the procurement was completed by a local or transplant program team.

Members agree that warm ischemia information is important but complicated to define.

There was community interest in collecting information on donation after cardiac death (DCD) donors, ex vivo, and use of perfusion devices. The Chair asked if determining the specific data elements on these topics should be considered under a separate project. UNOS staff confirmed that information is already captured on whether the donor was DCD. UNOS staff also confirmed that the Operations and Safety Committee is working on a data collection project that intends to collect transportation and perfusion device data for all organs. UNOS staff confirmed that the Deceased Donor Registration (DDR) form has a field that indicates whether the donor heart was perfused.

Another recommendation included collecting information on the volume and types of transfusions the recipient received in the operating room. Members agreed that this is an important factor of PGD. A concern was raised about access and ease of reporting this information. The Chair requested that volume and type of transfusion be added as a potential data element.

UNOS staff asked if transpulmonary pressure gradient (TPG) needs to be collected. The Chair confirmed this can be calculated using existing fields.

Next steps:

The Subcommittee will continue discussions to finalize the data elements to be included in the proposal going to public comment in August.

7. Open forum for questions and answers; Closing remarks

Summary of discussion:

The Chair shared that Status 2 extensions need to be addressed by the committee in the future. UNOS staff commented that adding timeframes to policies that require programs to submit more current information may promote a reduction in those eligible for Status 2. A member commented that other countries that use high urgency allocation systems, such as Canada, require a peer review of cases that are presented by the requestor in order to assign priority. There was a concern raised that the way the review boards are structured now may be inadvertently causing more exceptions. A member suggested meeting with regional review board members to discuss some of these issues and gather their feedback.

Upcoming Meeting

- May 18, 2021

Attendance

- **Committee Members**
  - Adam Schneider
  - Arun Krishnamoorthy
  - Cindy Martin
  - David Baran
  - Donna Mancini
  - Greg Ewald
  - Hannah Copeland
  - J.D. Menteer
  - Jonah Odim
  - Jose Garcia
  - Kelly Newlin
  - Laura DePiero
  - Michael Kwan
  - Mike McMullan
  - Rachel White
  - Rocky Daly
  - Shelley Hall
- **HRSA Representatives**
  - Adriana Martinez
  - Jim Bowman
  - Marilyn Levi
- **SRTR Staff**
  - Katie Audette
  - Melissa Skeans
  - Monica Colvin
  - Yoon Son Ahn
- **UNOS Staff**
  - Chris Reilly
  - Eric Messick
  - Janis Rosenberg
  - Julia Chipko
  - Keighly Bradbrook
  - Leah Slife
  - Sara Rose Wells
  - Sarah Konigsburg
  - Susan Tlusty
- **Other Attendees**
  - Amrut Ambardekar
  - Jennifer Carapellucci
  - Mary Smith
  - Nader Moazami
  - Samantha Taylor
  - Tariq Ahmad