OPTN Kidney Transplantation Committee Meeting
Expedited Placement Workgroup
Meeting Summary
May 12, 2025
Conference Call
Chandrasekar Santhanakrishnan, MD, Chair

Introduction

The Expedited Placement Workgroup met via WebEx on May 12, 2025, to discuss the following agenda items:

1. Welcome
2. Update on Donor Continuous Renal Replacement Therapy
3. Data Report: Assess Scope of Proposed Expedited Placement Initiation Criteria
4. Expedited Placement Offer Filters
5. Data Report: Assess Scope of Proposed Expedited Placement Initiation Criteria
6. Discussion: Expedited Placement Offer Filters

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

1. Welcome

Summary of discussion:

No decisions were made.

The Chair welcomed the Workgroup. Today the Workgroup will review the results of previous data requests regarding the scope of proposed expedited placement initiation criteria and offer filters. The Workgroup will also discuss expectations for Organ Procurement Organizations (OPOs) and initiation of expedited placement relative to allocation and recovery timelines. The Workgroup's goal is to finalize an Expedited Placement policy for the summer 2025 public comment period.

2. Update on Donor Continuous Renal Replacement Therapy

The Workgroup agreed to remove "Donor Use of CRRT" from the expedited placement initiation criteria.

OPTN staff provided additional information on the potential inclusion of donor use of continuous renal replacement therapy (CRRT) in the expedited placement initiation criteria. Previously, the Kidney Committee had identified use of CRRT in their "hard to place" definition. However, donor use of CRRT has not yet been implemented into the OPTN Donor Data and Matching System, and that implementation may not be finalized until September 2025, as this data is still pending approval from the Office of Management and Budget (OMB). Due to this, donor use of CRRT is not reflected in any analysis. It is recommended to exclude this criterion from the expedited placement initiation criteria, as the impact of its inclusion cannot be evaluated and understood until that data is collection. Once the OPTN is collecting that data, policymaking Committees could evaluate and determine if donor use of CRRT should be incorporated into the expedited placement initiation criteria or offer filters model.

Summary of discussion:

Workgroup members had no questions or comments.

3. Data Report: Assess Scope of Proposed Expedited Placement Initiation Criteria

No decisions were made.

OPTN contractor staff presented the results of the Workgroup's previously requested data evaluating the scope of the expedited placement initiation criteria.

Data summary:

For the purposes of this analysis, "allocated out of sequence" (AOOS) is defined as any offer having bypass codes 861 (operational – OPO), 862 (donor medical urgency), or 863 (offer not made due to expedited placement attempt) entered before the final acceptance. This definition uses the bypass codes to **estimate** AOOS and is distinctly different from the Membership and Professional Standards Committee's definition of AOOS reviewed for policy violations.

Transplants were determined to meet the initiation criteria if the following was met:

- More than 6 hours of cold ischemic time at placement, or
- At least two of the following:
    - Donor history of hypertension greater than 5 years
    - Donor history of diabetes greater than 5 years
    - Donor age greater than or equal to 60 years
    - Donation after circulatory death (DCD)
    - Biopsy on both kidneys with glomerulosclerosis greater than 10 percent

32.69 percent of transplants in 2024 would have met the proposed expedited placement initiation criteria, compared to 67.31 percent of transplants that did not. The proportion of transplants meeting criteria for expedited placement increased as kidney donor profile index score (KDPI) increased:

- KDPI 0-20 percent: 6.37 percent of transplants met criteria
- KDPI 21-34 percent: 11.87 percent of transplants met criteria
- KDPI 35-50 percent: 21.72 percent of transplants met criteria
- KDPI 51-85 percent: 47.92 percent of transplants met criteria
- KDPI 86-100 percent: 79.35 percent of transplants met criteria

28.56 percent of allocated in-sequence transplants would have met criteria for expedited placement, or 4409 transplants out of 15,436 in-sequence transplants. For transplants allocated in sequence, the majority of transplants that met expedited came from higher KDPI donors, particularly in the KDPI 51-100 percent group:

- KDPI 0-20 percent: 5.15 percent of allocated in sequence transplants met criteria
- KDPI 21-34 percent: 10.92 percent of allocated in sequence transplants met criteria
- KDPI 35-50 percent: 18.69 percent of allocated in sequence transplants met criteria
- KDPI 51-85 percent: 45.21 percent of allocated in sequence transplants met criteria
- KDPI 86-100 percent: 80.03 percent of allocated in sequence transplants met criteria

48.33 percent of AOOS transplants would have met criteria for expedited placement, or 1970 transplants out of 4076 AOOS transplants. For transplants AOOS, slightly increased percentages of lower KDPI transplants would have been eligible.

- KDPI 0-20 percent: 18.84 percent of AOOS transplants met criteria

- KDPI 21-34 percent: 17.39 percent of AOOS transplants met criteria
- KDPI 35-50 percent: 35.55 percent of AOOS transplants met criteria
- KDPI 51-85 percent: 54.88 percent of AOOS transplants met criteria
- KDPI 86-100 percent: 77.94 percent of AOOS transplants met criteria

13.43 percent of transplants that qualified for expedited placement and were allocated in sequence went to recipients within the priority classifications, or 592 transplants. For those transplants allocated in sequence meeting the proposed initiation criteria, the majority of recipients were outside of the priority classifications, except for KDPI 0-10 percent.

- KDPI 0-20 percent: 87.36 percent of transplants allocated in-sequence met the proposed initiation criteria and were allocated to priority classifications, or 152 transplants out of 174 transplants
- KDPI 21-34 percent: 14.06 percent of transplants allocated in-sequence met the proposed initiation criteria and were allocated to priority classifications
- KDPI 35-50 percent: 16.34 percent of transplants allocated in-sequence met the proposed initiation criteria and were allocated to priority classifications
- KDPI 51-85 percent: 10.99 percent of transplants allocated in-sequence met the proposed initiation criteria and were allocated to priority classifications
- KDPI 86-100 percent: 4.82 percent of transplants allocated in-sequence met the proposed initiation criteria and were allocated to priority classifications

The vast majority of transplants that would have met expedited placement criteria went to adult recipients, irrespective of in or out of sequence allocation status.

Among kidneys that would have qualified for expedited placement, a greater proportion of kidneys AOOS went to white, non-Hispanic recipients (40.96 percent) compared with kidneys allocated in sequence (34.63 percent).

In conclusion:

- Approximately one third of all deceased donor kidney-alone transplants in 2024 would have qualified for the proposed expedited placement pathway
- Majority of transplanted kidneys that would have qualified for the expedited placement were KDPI 51 percent or higher
- 28.56 percent of kidneys allocated in sequence and 48.33 percent of kidneys AOOS would have qualified for expedited placement
- Majority of kidneys that would have qualified for expedited placement:
    - Were allocated outside of the priority classifications
    - Were given to an adult recipient
    - Came from higher KDPI donors

<u>Summary of discussion:</u>

The Chair noted that a good portion of AOOS transplants would have qualified for expedited placement, and that this indicates the expedited placement pathway would be impactful for kidneys that may be otherwise allocated out of sequence. The Chair noted that it was expected that the highest KDPI kidneys would qualify for expedited placement. The Chair remarked that it is important for programs to have the opportunity to receive offers for these organs, highlighting that AOOS can be opaque. The Chair continued that expedited placement will give programs a chance to make a deliberate decision about receiving expedited placement offers. The Chair remarked that the data supports the effectiveness of the initiation criteria. Other members agreed.

The Chair asked if the AOOS organs traveled a greater distance, noting the expedited placement pathway may be able to support placing kidneys closer to the recovery hospital and reducing travel time. OPTN contractor staff shared that for transplants allocated in sequence, the median distance was 119 nautical miles (NM), and for AOOS transplants, the median distance was 155 NM. The 75th percentile distance for transplants allocated in sequence was 204 NM and for AOOS transplants was 378 NM. The OPTN contractor staff explained that on average, AOOS kidneys were traveling further.

A member discussed the proportion of waitlist candidates by race, and wondered whether the percentage of patients that were on dialysis but not yet listed would break down in a similar fashion. OPTN contractor staff noted that the OPTN does not have data for patients not on the waitlist.

One member asked if the report includes data on how many kidneys not transplanted would have qualified for expedited placement. OPTN contractor staff explained that the OPTN Kidney Committee reviewed similar data when developing the hard to place definition. OPTN contractor staff continued that kidneys that were not placed would have ultimately met the cold ischemic time criteria for expedited placement.

The Workgroup agreed that the data supports the Workgroup's expedited placement criteria, and indicates the potential impact of an expedited placement system for hard to place kidneys, particularly in providing equity, transparency, and efficiency, and in reducing non-use.

4. Expedited Placement Offer Filters

No decisions were made.

OPTN contractor staff provided an overview of several decisions the Workgroup will need to make.

Presentation summary:

Current offer filters policy includes the following components:

- Model-identified filters are generated based off of a program's transplantation behavior within the most recently available 365 days of data
- The model-identified offer filters are generated if all of the following criteria are met:
    - The program declined all kidney offers on at least 20 donors meeting the filter criteria
    - The program transplanted 0 donors that met the filter criteria, and
    - The kidneys that meet the filter criteria were transplanted elsewhere
- All model-identified offer filters will automatically not apply to candidates with the following criteria at the time of match run:
    - Greater than 90 percent CPRA,
    - 0-ABDR mismatch,
    - In medically urgent status, or
    - Less than 18 years old
- All programs may remove their model-identified filters or modify automatic candidate exclusion criteria of their model identified filters. Any program may create their own program identified filters

The Workgroup will need to determine whether these components will need to be adjusted for the expedited placement workflow.

Summary of discussion:

There were no questions or comments.

5. Data Report: Assess Scope of Proposed Expedited Placement Initiation Criteria

No decisions were made.

OPTN contractor staff presented the results of the expedited placement offer filters data requested by the Workgroup.

Data summary:

The motivation for this data request was to assess different model parameters for the cohort of donors and estimate the potential impact of filters on expedited matches.

- "Donor evidence threshold" – a recommended filter must filter at least this many unique donors in the training cohort
    - Training cohort (1-year or 2-years of offers as the basis of acceptance history)
- Impact of filters on expedited matches includes:
    - Number of programs that have recommended filters for expedited placement
    - Number of programs filtered entirely – including by standard filters
        - Standard filter – an active filter used to bypass offers
    - Characteristics of filtered candidates

Utilizing the 1 year cohort, the number of programs with filters does not change much when going from a donor evidence threshold of 5 to a donor evidence threshold of 25. Utilizing the 1 year cohort, about 191 to 192 programs received filters under these evidence thresholds. The evidence thresholds do affect the total number of filters generated. The number of filters per program varies from 2.2 filters per program to about 3 filters per program, on average, depending on the evidence threshold. This pattern is robust across all programs, pediatric only programs, and mixed programs as well.

Utilizing the 2 year cohort, the overall number of filters are robust to the training cohort, and pediatric only programs have more generated filters compared to the 1 year cohort. This may be due to the pediatric programs having smaller offer volume, as two years of data allows for more filters to meet that evidence threshold. Utilizing the 2 year cohort, the number of programs with generated filters remains around 192-194, and the number of filters per program ranges from 2.6 to 3.7 filters per program for adult programs, on average, depending on the donor evidence threshold.

When evaluating model parameters, lower donor evidence thresholds will generate more filters per program. Pediatric-only programs will be more sensitive to the training cohort.

The potential impact on match runs can be estimated can be estimated in looking at the average number of programs filtered per match. The mean number of programs to final acceptance is about 30. A program is counted as "filtered" if all offers from that match run were bypassed by a filter. Using the 1-year training cohort, the number of programs filtered by standard offer filters is about 3 or 3.1 across the donor evidence thresholds, and the number of programs filtered by expedited placement filters ranges from 5 to 5.5 programs. The number of programs filtered by both filter types is about 9-9.1 across the donor evidence thresholds. The number of programs not filtered by either ranges from 13.3 to 13.8. Using the 2-year training cohort, the number of programs filtered by standard filters ranges from 3.3-3.5 programs, and the number of programs filtered by expedited programs ranges from 4.2-4.6. The number of programs filtered by both filter types ranges from 8.7 to 8.9. The number of programs not filtered by either filter type ranges from 14.3 to 14.6.

The data shows that the expedited placement filters will screen off additional programs not identified by the standard filter, and that's robust across training cohorts and evidence thresholds. The model is

slightly more impacted by the training cohort, but by a small difference, with an average of one additional program filtered.

Recommended expedited placement filter criteria:

- Model parameters: 1 year training cohort with 20-donor evidence threshold
    - These are the same model parameters used for generating "standard" model filters
    - Fewer filters overall for pediatric programs, which may be easier to manage
- Should include standard filters when filtering expedited placement matches
    - These filters still filtered programs that would not have been identified by expedited placement filters only

Summary of discussion:

The Chair noted that standard filters rule out some programs based on some of the "hard to place" criteria already. OPTN contractor staff explained that using standard filters in addition to expedited placement filters would result in an additional 3 programs filtered off, on average. Some of the criteria in the standard filters applies to the donors that meet the expedited placement criteria.

The Chair noted that using both standard and expedited placement filters would be most effective in improving efficiency, explaining that the data supports this. The Chair continued that this will ensure offers are effectively made to programs that are interested.

Members expressed support for the recommended model parameters, noting they align with the spirit of the proposal and will support more successful placement.

The Workgroup agreed with the recommended offer filter model parameters for expedited placement offer filters, specifically using the 1-year training cohort and 20 donor evidence threshold. The Workgroup also agreed to maintain standard filters while in expedited placement allocation.

6. Discussion: Expedited Placement Offer Filters

The Workgroup discussed automatic exclusions, changing acceptance behavior, and initiation of expedited placement.

The Workgroup decided that the following candidates are automatically excluded from expedited placement offer filters, meaning they will not be bypassed by expedited placement:

- **Greater than 90 percent CPRA**
- **0-ABDR mismatch**
- **In medically urgent status, or**
- **Less than 18 years old**

The Workgroup decided that expeditated placement offer filters will be mandatory.

The Workgroup supported allowing OPOs to initiate expedited placement prior to recovery, with additional discussion on timeframes.

The Workgroup decided that OPOs should have discretion on when to initiate expedited placement once criteria has been met.

Automatic Exclusions:

The following candidates are automatically excluded from standard model-identified filters:

- Greater than 90 percent calculated panel reactive antibody (CPRA)

- 0-ABDR mismatch
- In medically urgent status, or
- Less than 18 years old

The analysis shown incorporated these automatic exclusions.

The Chair expressed support for maintaining the same automatic exclusions from expedited placement offer filters.

One member asked what the rationale is for excluding medically urgent patients, as opposed to letting the center decide whether to consider expedited placement. OPTN contractor staff explained that these automatic exclusions for standard filters were selected to ensure that candidates that were hard to match or high urgency continued to receive offers, noting these are very specific candidate population. This ensures medically urgent candidates still receive the offer. It was noted that these candidates will largely be captured by the priority classifications, and will have received the offer prior to the OPO initiating expedited placement. However, for those candidates still meeting this criteria not in priority classifications, the automatic exclusion ensures that candidate will still receive the offer. Those candidates not in priority classifications but meeting the automatic exclusion criteria include:

- CPRA 90-98 percent
- Pediatric candidates outside of the 250 NM circle

The program could still use other tools available to not see these offers for these candidates. The member agreed that this makes sense, and supported the listed automatic exceptions.

One member remarked that education and communication will be important to ensure programs understand what is meant by "automatic exclusion."

The Workgroup supported ensuring that the following candidates are automatically excluded from expedited placement offer filters, meaning they will not be bypassed by expedited placement:

- Greater than 90 percent CPRA
- 0-ABDR mismatch
- In medically urgent status, or
- Less than 18 years old.

<u>Changing acceptance behavior:</u>

Previously, the Workgroup supported mandating expedited placement offer filters, such that programs cannot turn off the expedited placement filtering. Programs would have expedited placement filters generated by the model, refreshed every 6 months, and applied. Public comment feedback requested providing pathways for transplant programs to change behavior and start accepting these offers. Particular consideration is given for smaller transplant programs, programs hiring new transplant surgeons who may be more aggressive, or instances where programs may be equipped with additional resources to better consider the offers.

OPTN contractor staff asked if programs should have the option to remove or modify expedited placement filters, making the filters less stringent if they wanted to modify their acceptance behavior.

The Chair clarified that programs will still have standard offer filters as recommended by the offer filters model, as well as the expedited placement filters. The Chair supported mandating kidney expedited placement offer filters across the board, noting that consistency in application is important and that programs have leeway in the standard offer filters to expand the pool of offers they are interested in receiving. The Chair remarked that there may need to be a pathway for programs to modify those filters

based on changes within the program, such as hiring a new surgeon, and that the Workgroup should discuss how frequently the program could modify those filters. The Chair supported mandating the filters. Another member agreed, and noted that programs will be able to modify their organ acceptance history through non-expedited offers. The member continued that the way programs utilize local donors will allow them to modify their behavior such that they can receive more aggressive expedited offers. The member noted that, in order for the expedited placement pathway to be effective, there needs to be confidence that the programs are likely to accept the offers, and the filter helps to ensure that. The member added that, if the filters are not enforced, expedited offers will be sent to programs who may theoretically want to accept the organ, but won't actually accept it, thus reducing the efficiency of the expedited placement system.

The Workgroup supported mandating expedited placement offer filters.

Initiating expedited placement:

The Workgroup has previously discussed the criteria for initiating expedited placement, particularly such that the donor has to meet at least two clinical criteria from the list, or accrued six hours of cold ischemic time without at least one kidney being placed. The Workgroup also discussed required reporting of post-recovery information, such as anatomy and biopsy. OPTN contractor staff asked if the OPO should be able to proceed to expedited placement as soon as they have completed offers through the priority classification for donors that meet the clinical criteria, but for whom the post-recovery information is not yet available. Specifically, should OPOs be able to go to expedited placement prior to recovery for donors meeting the clinical criteria.

The Chair remarked that there is likely a good amount of allocation occurring pre-procurement.

OPTN Contractor staff shared that there is a median of only 1 candidate in each priority classification and 0 candidates for KDPI 35-85 percent kidneys. The Chair noted that per the data, most of the expedited placement kidneys are coming from KDPI 35 and above.

One member shared that most OPOs are allocating kidneys typically 24 hours prior to recovery in order to secure interest. The member continued that, unless there are time constraints from instability or time constraints, there are match runs well ahead of recovery. The member added that post-recovery information can typically be obtained within 3 or 4 hours. Another member shared that in some cases, biopsy time can be up to 7 hours post recovery.

A member commented that it could help with placement to be more aggressive prior to recovery in some cases, particularly if there is a low likelihood those kidneys will be utilized. The Chair remarked that having a mechanism in place where OPOs are able to initiate expedited placement if the kidney meets criteria and there is a high likelihood of difficulty in placement. The Chair remarked that the data supports that some refusal decisions could at least be made prior to procurement based on the characteristics of the donor. The Chair expressed support for granting OPOs the capability to initiate expedited placement prior to recovery, but noted that success will hinge on programs adequately reviewing the offer and making timely decisions.

OPTN contractor staff highlighted that, for the OPO to shift to expedited placement prior to recovery, the donor would need to meet two of the following criteria:

- History of hypertension greater than 5 years
- History of diabetes greater than 5 years
- Age greater than or equal to 60 years
- Donation after circulatory death

The benefit of pre-recovery initiation is the additional filtering applied, which can improve efficiency early in allocation. The downside is that programs may be interested, but won't be able to make a final decision until this information is available, and so the OPO may still have a number of provisional yes response that do not become acceptances. OPTN contractor staff asked the Workgroup if it is better for the OPO to wait until all the information can be provided, or if it is helpful to initiate expedited placement earlier.

One member remarked that accepting surgeons will need the post-recovery data in order to make a final decision. The member noted that introducing a post-recovery expedited placement process will be a big change to the current system, and that it may be worthwhile to add pre-recovery expedited placement as a later iteration. The Chair agreed, noting that this would not require programs to accept prior to recovery, but would at least allow OPOs to increase efficiency in early allocation by initiating expedited placement filters.

A member noted that the framework for allocation will include a standard pathway, an expedited placement pathway, and in extreme cases, the non-standard, non-expedited aggressive placement. The member remarked that the third pathway would require follow up with the OPO through standard processes.

The Workgroup noted support for starting expedited placement once recovery begins, which is still earlier than the 6 hour cold ischemic time threshold.

One member remarked that initiating expedited placement prior to recovery would be a big change for their OPO, but that there are certain cases, such as DCD donors over 70 years old, where there is such a low likelihood of placement that expedited pathways may be crucial and useful prior to recovery. The member continued that their OPO may utilize pre-recovery expedited placement depending on the donor characteristics, although ultimately the OPO's goal is to align as closely with the match run as possible. The member explained that pre-recovery, cold ischemic time is not necessarily accruing and there is more time to determine which programs are truly interested. Another member agreed that it is likely going to be rare for OPOs to initiate expedited placement prior to recovery.

A member recommended that the Workgroup develop guidance for OPOs, to support consistency in OPO behavior in initiating expedited placement. The Chair responded that in practice, most of the expedited placement allocation will take place post-recovery, as the post-recovery information required to finalize offer acceptance won't be available. The Chair added that there may still be cases where pre-recovery expedited placement is useful, though they are rare, and agreed that it may be helpful to develop guidance. One member agreed that it is difficult to definitively accept an offer prior to recovery, but there may still be cases prior to 6 hours of cold ischemic time, or when the biopsy information is delayed, and earlier initiation of expedited placement may be appropriate. The member expressed support for reducing the amount of allocation time, noting how much time is involved in transporting organs.

The Workgroup agreed that public comment feedback may be important to determine whether policy should allow OPOs to initiate pre-recovery expedited placement.

One member asked if the OPOs should offer biopsy waivers and allocate the kidneys ahead of biopsy results. Another member remarked that this could result in OPOs sending out kidneys, only to have them refused and require reallocation. A member remarked that this is where demonstrated track records of accepting and utilizing medically complex kidneys is important. The member continued that these programs will make good faith efforts to utilize the kidneys unless they are truly non-transplantable. Another member agreed.

It was confirmed that it is the OPOs who decide when to start expedited placement once the cold ischemic threshold is hit post recovery or if the criteria is met prior to recovery.

A member asked if there was any data available on how many donors are accepted without post-recovery information, noting that the program will likely need this information to finalize acceptance. The member continued, however, that OPOs should still be able to make expedited offers prior to recovery. Another member remarked that it rarely, if ever, happens that a program accepts an organ without post-recovery information, particularly as programs typically must determine laterality.

OPTN contractor staff asked if the Workgroup supports OPOs starting expedited placement for donors meeting clinical criteria prior to all the post-recovery information becoming available, but there is interest in refining the time frame around which the OPO shift to expedited placement for these donors.

One member remarked that OPOs should not be limited from making expedited placement offers, at least to initiate offer early. The member continued that this information could be tracked going forward to see how effective pre-recovery expedited placement is, and that this data can guide future decisions. The member remarked that at the end of the day, it is still the surgeons at the transplant program making that decision. Another member agreed that expedited offers could be done pre-recovery based on the donor characteristics, but it must be done knowing that transplant programs should not be expected to make a decision until the post-recovery information is available. Another member agreed.

A member explained that the expedited placement pathway will still result in a greater number of offers with a more narrow window of decision making. The member asked if, pre-recovery, the timeframe would still be one hour for programs to determine acceptance. OPTN contractor staff remarked that the pre-recovery timeframes would not require acceptance without the provision of post-recovery information. The member remarked that the only challenge would be receiving favorable biopsy results, and the OPO had already triggered expedited placement. OPTN contractor staff explained that OPOs would be able to rollback expedited placement offer filters in the case that acceptance within simultaneous evaluation was not achieved but the OPO believes the kidney could still be placed, the OPO could choose to rollback to sequence standard allocation.

OPTN contractor staff noted that more open ended policy will allow OPOs more discretion to make expedited placement offers in the way that they best think will result in timely acceptance. OPOs could choose to wait until the post-recovery information is available before initiating expedited placement for donors meeting clinical criteria. OPTN contractor staff asked the Workgroup whether this OPO discretion should be incorporated into the expedited placement policy.

The Workgroup agreed that OPOs should have discretion on when to initiate expedited placement once criteria has been met.

Upcoming Meeting(s)

- May 15, 2025, 3:00 ET

Attendance

- **Workgroup Members**
  - C.S. Krishnan
  - Jillian Wojtowicz
  - Jami Gleason
  - George Suratt
  - Leigh Ann Burgess

    - Kristen Adams
    - Peter Stock
    - Tania Houle
    - Carrie Thiessen
    - Jim Kim
    - Oluwafisayo Adebiyi
    - Micah Davis
    - Anja DiCesaro
    - Jason Rolls
- **HRSA Representatives**
    - Sarah Laskey
- **SRTR Staff**
    - Jon Miller
    - Bryn Thompson
- **UNOS Staff**
    - Kaitlin Swanner
    - Carly Rhyne
    - Thomas Dolan
    - Cass McCharen
    - Sarah Booker
    - Keighly Bradbrook
    - Carlos Martinez
    - Amelia Devereaux
    - Kayla Temple
    - Carly Layman
    - Rebecca Fitz Marino
    - Ross Walton
    - Houlder Hudgins