OPTN Transplant Coordinators Committee
Meeting Summary
Sept 18, 2025
Conference Call

Christine Brenner, RN, BSN, CPTC, CCTC, Chair

Heather Bastardi, RN, MSN, CPNP, Vice Chair

Introduction

The Transplant Coordinators Committee ("the Committee", "TCC") met via Webex on 09/18/25 to discuss the following agenda items:

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

1. Presentation - Update and Improve Efficiency in Living Donor Data Collection
2. Presentation - Guidance for Pediatric Heart Exception Requests
3. Presentation - Establish Comprehensive Multi-Organ Allocation Policy

1. Presentation - Update and Improve Efficiency in Living Donor Data Collection

The Committee did not make any decisions.

Summary of Presentation:

The Chair of the Living Donor Committee ("Chair") presented the Living Donor Data Collection project.

Summary of Discussion:

A Committee member stated that transplant nurses from their program were in favor of removing the two-year data collection follow-up because they have a lot of issues contacting the donors at the two-year mark. They stated this is especially prevalent in Region 6 where states such as Alaska, Montana, and Idaho are spread out and have higher concentrations of remote, rural patients. The Chair agreed that removing the two-year requirement is helpful, and that the current completion rate for the two-year data nationally is around 68%. The Chair also stated that the SRTR has plans to expand that even further and continue follow-up over the long term.

A member asked if the project includes informing families and patients around data collection, or if there has been any discussion of a need for education around data being shared with SRTR. The Chair responded that the SRTR is classified as a public health authority, and therefore, gathers data similarly to the OPTN and does not need informed consent.

A member asked if the SRTR would continue collecting data long-term. The Chair stated that in the short-term, they will gather data on the barriers for those potential donors who do not donate. In the long-term, they will be able to continue maintain long term follow up indefinitely with living donors and even the potential living donors. The Chair also mentioned that the rate of living donation has not changed "over many years." He continued that the SRTR is able to look at outcomes through long-term endpoints such as survival dialysis, even if a person doesn't voluntarily do surveys with them. He also added that living donors are healthier than the general population, given that they have gone through initial evaluations.

2. Presentation – Guidance for Pediatric Heart Exception Requests

The Committee did not make any decisions.

Summary of Presentation:

The Chair of the Heart Committee ("Chair") presented the *Guidance for Pediatric Heart Exception Requests* project.

Summary of Discussion:

A member thanked the Heart Committee for their work and stated their own program has used this guidance to help 1A pediatric patients get exception requests approved. The member suggested that the Heart Committee evaluate the shortage by looking at the waitlist for the Berlin heart devices. The Chair responded that they hope this guidance has provided access to devices for patients who otherwise would have been in 1A status anyway. The Chair recognized that patients that have dilated cardiomyopathy that are on inotropes have been put into the 1A category, which is something that the Committee attempted to avoid previously in the allocation system for pediatrics. They continued that more pediatric patients may now be in the 1A status, which may cause longer waiting time.

A member asked why the Heart Committee was not interested in how the impact is felt by the transplant centers. The Chair responded that the Committee is interested, but that impact is hard to quantify. The Chair continued that they have data currently being pulled about the number of 1A exceptions being sought by dilated cardiomyopathy patients over 10 kilograms on the pediatric list. They also said they are looking at if exception numbers are going up out of proportion to the number of exceptions being sought for other indications. The Chair added that it is hard to judge by the individual center because different centers have access to different VADS and different VADS strategies, such as non-FDA approved Abbott VADs.

The Chair mentioned the Heart Committee is aware that waitlist mortality for patients at status 1A by exception is lower than the than the waitlist mortality for patients that meet 1A status criteria. However, he said it is hard to find all of the exception requests that are related specifically to this guidance document change. The Chair stated that the Heart Committee is seeking advice from people that are putting in these exceptions and from the NHRB (the National Heart Review Board) regarding their experience with these exceptions as they come through.

The Chair said that they've received a variety of feedback. He mentioned that some people feel that some think programs are overusing the new guidance to get all their dilated cardiomyopathy patients up to 1A status, while others are glad for the straightforward guidance.

A member asked if the perspective of the patient and the candidate were being considered. The Chair responded that the OPTN Public Comment would be the best way to get this feedback.

3. Presentation - Establish Comprehensive Multi-Organ Allocation Policy

The Committee did not make any decisions.

Summary of Presentation:

Support staff for the Multi-Organ Transplantation Committee presented their new project - *Establish Comprehensive Multi-Organ Allocation Policy*.

Summary of Discussion:

A member asked if a patient with simultaneous Pancreas-Kidney listing would be eligible for the priority of a high KDPI with 85% sensitization. The speaker responded that if the candidate described wishes to receive a kidney from a donor with greater than 85%, they would still be able to receive that. She continued that for donors not covered by the plans, OPOs would allocate as they currently do by working through each of the individual match runs.

A member asked if the tables are relevant to pediatric donors, and the Chair stated that there are 3 donor tables listed in the policy for pediatrics, including one for adolescent donors with low KDPI, and two for pediatric donors less than 11 years old with livers and intestine available with varying KDPIs. The speaker said the latter two categories are important for multivisceral pediatrics.

A member asked if it would be helpful for centers to view the allocation plan. The speaker responded that it may be difficult for readers to understand.

A member stated that they have had difficulty in certain placement situations, such as where a heart that was sequence one rank one was then given to the lung recipient who took both a heart and lung. The speaker agreed that they have heard similar feedback around increased transparency for transplant centers who are seeking to understand single-organ candidate priorities relative to multi-organ candidates.

A member said that sample scenarios would be helpful for coordinators to explain multi-organ allocation to patients and for transplant programs to develop a deep understanding of the policy.

Next meeting:

10/16/25

Attendance

- **Committee Members**
  - Kati Robinson
  - Amy Olsen
  - Courtney Risley
  - Gertrude Okelezo
  - Kenny Laferriere
  - Karl Neumann
  - Whitney Holland
  - Brandy Baldwin
  - Eve Cabatan
  - Christine Brenner
  - Katherine Meneses
  - Heather Bastardi
- **UNOS Staff**
  - Jamie Panko
  - Sarah Roache
  - Eric Messick
- **Other Attendees**
  - JD Menteer
  - Stevan Gonzalez