OPTN

Thank you to everyone who attended the Region 8 Summer 2025 meeting. Your participation is critical to the OPTN policy development process.

Regional meeting presentations and materials

Public comment closes October 1st! Submit your comments

The sentiment and comments will be shared with the sponsoring committees and posted to the OPTN website.

Non-Discussion Agenda

Modify Guidance for Pediatric Heart Exception Requests to Address Temporary Mechanical Circulatory Support Equipment Shortage

Heart Transplantation Committee

Sentiment: 2 strongly support, 7 support, 9 neutral/abstain, 0 oppose, 0 strongly oppose

- **Comments**: This was not discussed during the meeting, but attendees were able to submit comments with their sentiment. An attendee stated that this policy offers an important bridge to allow standardized guidance for change in listing acuity for patients that do not have access to lifesaving MCS devices. It will be important to maintain consistent follow-up with industry partners regarding availability of device equipment to remove this policy change when it is no longer appropriate.

2025 Histocompatibility HLA Table Update

Histocompatibility Committee

Sentiment: 4 strongly support, 11 support, 3 neutral/abstain, 0 oppose, 0 strongly oppose

- **Comments**: None

Discussion Agenda

Require West Nile Virus Seasonal Testing for All Donors

Ad Hoc Disease Transmission Advisory Committee

Sentiment: 1 strongly support, 12 support, 2 neutral/abstain, 4 oppose, 0 strongly oppose

- **Comments**: Attendees raised concerns that the seven-day testing window for living donors is too short and may result in donors undergoing multiple lab draws. It was recommended aligning this requirement with the existing 28-day serology testing window to reduce burden and ensure consistency across required testing. Questions were raised about whether the shortened timeframe is necessary nationwide or only in certain regions, and how international travel might affect applicability. Concerns were also expressed about the turnaround time for test results and the additional costs that may be incurred, with suggestions to coordinate all living donor testing to minimize duplication. Participants noted that there is currently no specific treatment or

prophylaxis for West Nile Virus, making prevention difficult. This led to questions about whether NAT testing is the most appropriate method given its 28-day turnaround time and what steps can be taken to reduce the risk of transplant recipients acquiring West Nile Virus in endemic areas after surgery.

Update and Improve Efficiency in Living Donor Data Collection

Living Donor Committee

Sentiment: 1 strongly support, 12 support, 5 neutral/abstain, 1 oppose, 0 strongly oppose

- **Comments**: An attendee questioned whether the SRTR should be explicitly identified as the responsible party, noting that while SRTR is contracted through HRSA under NOTA, the contract could change, and tasks would transfer with it. There was agreement that the data could provide valuable insight into living donation, but transplant centers emphasized the administrative burden it would place on staff. There was a suggestion for extending the reporting timeframe from 90 days to one year, while other attendees supported maintaining a 90-day turnaround if tied either to the date of transplant center denial or the donor's decision to withdraw. Concerns were raised about the length and complexity of the proposed non-donor form, with requests to streamline it before implementation. Attendees also questioned the definition of "non-donation," whether it applied to donors who declined, were declined, or who remained in paired exchange beyond 90 days. There was concern that nuanced reasons for declining donors might not be adequately captured. Additional questions were raised about what specific demographic, clinical, and decision-making data would be collected, and how data from non-donors would be used to inform understanding of barriers to living donation and long-term donor outcomes. Attendees noted financial barriers for donors, including complications with insurance coverage, evaluation costs, and lack of financial protection for complications after donation. There was support for shifting long-term follow-up responsibility after one year to SRTR along with SRTR contacting donors directly. While the burden of data collection remained a central concern, some noted that improved understanding of barriers could ultimately encourage more living donors.

Require Patient Notification for Waitlist Status Changes

Transplant Coordinators Committee

Sentiment: 1 strongly support, 11 support, 1 neutral/abstain, 6 oppose, 0 strongly oppose

- **Comments**: Several attendees noted support for patient notification but favored phone calls or patient portal messages over mailed letters, citing short inactive periods and the risk of confusion from delays or out-of-order delivery. Some attendees noted that inactivation may last only hours or a few days, and requiring written notification in such cases would create unnecessary burden. Others went further, expressing opposition to requiring any notification at all for inactivations lasting fewer than 10 days. There was support for ensuring patients are informed not only of status changes but also of the reasons behind them. Attendees emphasized the importance of transparency and fairness, with some highlighting that timely communication allows patients to address issues that led to inactivation. At the same time, several expressed concern about the administrative burden on transplant center staff if written notification within 10 days were required for every change, particularly when multiple changes occur in a short time. It was recommended that phone or portal communication, with proper

documentation in the electronic medical record, should satisfy notification requirements. This approach would both reduce workload and better reflect real-time care decisions. Attendees agreed that standardized guidance on the content of patient notifications would be useful but argued that centers should have flexibility in choosing the communication method. Some also raised questions about how compliance would be monitored if notifications were verbal or electronic.

Establish Comprehensive Multi-Organ Allocation Policy

Ad Hoc Multi-Organ Transplantation Committee

Sentiment: 4 strongly support, 10 support, 4 neutral/abstain, 1 oppose, 0 strongly oppose

- **Comments**: An attendee noted a lack of visibility in current kidney match runs, where kidneys are often allocated to multi-visceral candidates without appearing on the match run, and requested greater transparency in the OPTN computer system at the time offers are made. There was also concern about the complexity of the proposal, drawing parallels to challenges in lung continuous distribution and cautioning against potential programming errors. Questions were also raised about the "must/must not" designations, with some suggesting they could cause confusion. Process considerations were a recurring theme, with suggestions that abdominal organ match runs be run first, though attendees acknowledged this might slow allocation overall. While the standardized approach across OPOs was welcomed, several emphasized that allocation changes often create unintended ripple effects across the system that cannot be fully modeled in advance. Some attendees stressed the importance of focusing on high-priority single-organ candidates and cautioned that subgroups such as Fontan patients requiring heart-liver or heart-kidney transplants are not adequately accounted for in the current framework. Post-implementation analysis was seen as necessary to assess potential unintended consequences for these at-risk populations. Pediatric representation was a focus, with strong support expressed for prioritizing pediatric candidates over some multi-organ combinations. Attendees noted that pediatric patients face longer wait times and reduced transplant rates compared to previous years, particularly for kidney transplants, where suitable high-quality organs are often allocated to multi-organ recipients instead. Prioritization for pediatric candidates would improve equity and long-term outcomes. Attendees recognized the importance of standardizing multi-organ allocation and acknowledged the substantial effort behind the proposal, but they cautioned that the changes add complexity, could increase inefficiencies in allocation time, and may leave important subgroups at risk without further refinement and careful monitoring after implementation.

Updates

Councillor Update

- **Comments**: None

OPTN Patient Affairs Committee Update

- **Comments**: Attendees acknowledged appreciation for service on the Patient Affairs Committee, emphasized the importance of improving clinical care and communication with patients and families, and recognized the value of representation on the committee. Gratitude was also expressed for honesty and willingness to share perspectives.

OPTN Executive Update

- **Comments**: Attendees asked about vendor selection, fee increases, and OPTN communications. No timeline is set for vendor selection, which will likely occur in stages. Fee increases are primarily due to legacy costs and reduced reserves, with only part of the OPTN budget supported by fees; HRSA contributes additional resources outside the OPTN budget. On communications, leadership emphasized a cautious, non-confrontational approach, aiming to represent donors, patients, and the OPTN as a whole while respecting the unique responsibility of engaging with Congress and the public.

HRSA OPTN Modernization Update

- **Comments**: Attendees provided feedback to HRSA's Division of Transplantation during this session.