OPTN Board of Directors Meeting Summary

Meeting Information: Agenda and Attendees

Friday, August 1, 2025 | 1:00–2:30 p.m. ET | Location of Event: Zoom

The following are meeting minutes from the OPTN Board of Directors meeting, which took place on **August 1, 2025, 1:00–2:30 p.m. ET**.

Agenda

- Welcome
- OPTN Board Operating Committees
    - Executive Committee
    - Finance Committee
    - Network Operations Oversight Committee
    - Nominating Committee
- Policy Oversight Committee Proposals
    - 2025 Histocompatibility Human Leukocyte Antigen (HLA) Table Update
    - Update and Improve Efficiency in Living Donor Data Collection
    - Modify Guidance for Pediatric Heart Exception Requests to Address Temporary Mechanical Circulatory Support Equipment Storage
    - Require West Nile Virus Seasonal Testing for all Donors
    - Establish Comprehensive Mult-Organ Allocation Policy
    - Requires Patient Notification for Waitlist Status Changes
- Updated Timeline
- INVEST Insurance Coverage
- Announcements
- Adjourn

Attendees

Attendee Name(s)	Affiliation
John Magee (President), Shelley Hall (Vice President), William (Bill) Ryan (Vice President of Patient Donor Affairs), Alan Reed (Treasurer), Justin Wilkerson (Secretary), George Bayliss, Vincent Casingal, James Cason, Kenneth Chavin, Ari Cohen, Andrew Courtwright, Nahel Elias, Samantha Endicott, Gitthaline Gagne, Joshua Gossett, John Hodges, Darren Lahrman, Kevin Lee, Joseph Magliocca, Gina Marie-Barletta, Dan Meyer, Annette Needham, Peter Nicastro, Robert (Cody) Reynolds, Austin Schenk, John Sperzel, Mark Wakefield, Kymberly Watt	OPTN Board of Directors

Attendee Name(s)	Affiliation
Brianna Doby, Mesmin Germain, Stephanie Grosser, Amy Harbaugh, Raymond Lynch, Joni Mills, Arjun Naik, Nolan Simon	HRSA Representatives
Christine Jones, Rachel Shapiro, Vanessa Amankwaa, Thomas Barker, George Barnette, Melanie Bartlett, Shayonna Cato, Tamika Cowans, Tennille Daniels, Jadyn Dunning, Karen Edwards, Emily Elstad, Samuel Hoff, Surakshya Karki, Tessa Kieffer, Anthony LaBarrie Mona Kilany, Mary Lavelle, Andrew London, Markus Louis, Taylor Melanson, Eliana Saltares, Christina Sledge, Zulma Solis, Lee Thompson, Kristen Welker-Hood	OPTN Board Support Staff
Kelley Hitchman, Erika Lease, John Lunz, Jondavid Menteer, Rachel Miller, Jacqueline O'Keefe, Stephanie Pouch, Jennifer Prinz, Lisa Stocks	OPTN Committee Representatives
Lindsay Larkin, Lauren Mauk, Sara Rose Wells	OPTN Operations Contractor Staff

Meeting Summary

Welcome and Announcements

After reaching quorum, the OPTN Board President ("President") welcomed attendees and began the meeting. The President thanked the Board of Directors ("Board") for their continued engagement during multiple Board meetings since the start of their tenure in July 2025.

OPTN Board Operating Committees

The Board President shared the OPTN Board Operating Committee rosters for the following committees:

- Executive Committee
  - President (Chair): John C. Magee
  - Vice President: Shelley Hall
  - VP of Patient and Donor Affairs: Bill Ryan
  - Treasurer: Alan Reed
  - Secretary: Justin Wilkerson
  - Minority Transplant Professional Representative: Nahel Elias
  - Transplant Coordinator Representative: Annette Needham
  - Histocompatibility Lab Representative: Cathi Murphey
  - Public Representative: Jen Benson
  - OPO Representative: Samantha Endicott
  - At Large Representative: George Bayliss

The 11-person Executive Committee will begin meeting within the next few weeks and will continue their meeting series at a monthly cadence.

- Finance Committee
  - Treasurer (Chair): Alan Reed
  - At Large Representatives (7): Ari Cohen; Vincent Casingal; Ryan Davies; Josh Gossett; John Hodges; Peter Nicastro; Justin Wilkerson

The Finance committee will help the Board understand its incoming revenue and expenditures; along with strategic planning to ensure the Board prioritizes policy projects in a responsible manner.

- Nominating Committee
  - President: John C. Magee
  - Vice President (Chair): Shelley Hall
  - VP of Patient and Donor Affairs: Bill Ryan
  - Minority Transplant Professional Representative: Nahel Elias
  - Transplant Coordinator Representative: Annette Needham
  - Histocompatibility Lab Representative: Cathi Murphey
  - Patient and Donor Affairs Representatives (3): John Sperzel; Cody Reynolds; Candie Gagne
  - At Large Representatives (4): Vincent Casingal, Josh Gossett, Meelie DebRoy, Kymberly Watt

The Nominating Committee will work to fill any vacancies on the Board if or when they arise.

- Network Operations Oversight Committee (NOOC)
  - At Large Representatives (5): Shelley Hall; Mark Wakefield; Josh Gossett; Darren Lahrman; Bill Ryan

Policy Oversight Committee Proposals

Two Policy Oversight Committee (POC) representatives provided an overview of six policy proposals that the POC approved on 7/24.

2025 Histocompatibility HLA Table Update

The *2025 Histocompatibility HLA Table Update* proposal, sponsored by the Histocompatibility Committee, proposes updates to OPTN Policy 4.11: *Reference Tables of HLA Antigen Values and Split Equivalences*. This update aligns with the primary strategic plan goal: *Optimizing Organ Use.* The POC supported the proposal's release for public comment based on review criteria and expedited implementation per Policy E.8 *Expedited Actions*.

The POC's final vote to recommend approval was: 12 Yes, 0 No, 0 Abstain.

A Board member asked about the level of urgency for this proposal, and specifically, if it will significantly impact patient care right now. The Vice Chair of the Histocompatibility Committee stated that the proposed project could potentially change a patient's status in allocation, and therefore, would have a great impact on patients. The Vice Chair shared that HLA is complex, and it is a regulatory requirement to routinely and regularly update this information as technology and information changes. The Vice Chair noted that the process is manual and requires HLA directors to catch that an offer is unacceptable as they are doing virtual cross matches or consultations. If an offer is unacceptable for an involved DP group, it would automatically block that offer, making the process more efficient.

Update and Improve Efficiency in Living Donor Data Collection

The *Update and Improve Efficiency in Living Donor Data Collection* proposal, sponsored by the Living Donor Committee (LDC), proposes the incorporation of data on potential donors who do not donate into data collection, and the long-term follow up responsibilities to the Scientific Registry of Transplant Recipients (SRTR). This policy aligns with the primary strategic plan goal: *Enhance OPTN Efficiency.* The POC supported the proposal's release for public comment based on review criteria and provided considerable feedback.

The POC's final vote to recommend approval was: 12 Yes, 0 No, 0 Abstain.

A Board member asked if this project could be used to train data over several years to identify trends and to understand why living donors could not donate. The Vice Chair of the LDC confirmed this use would be an aspect of the project. She explained that the two data collection aspects of the proposal are: (1) long-term donor follow-up for those who donate beyond the two years that the committee collaborates with SRTR; and (2) obtaining information on people who are evaluated by transplant centers to be a donor, but did not donate for various reasons. She stated that the two data collection aspects will provide insight into the barriers of donation (e.g., trends for why people did not donate). She shared that the long-term subsequent follow-up would be voluntary; however, the committee has discussed engagement methods to encourage transplant centers to educate potential non-donors about the importance of participating in the voluntary data collection. She stated that the estimated success rate is predicted to be 50-60% but may increase. One Board member expressed concern about the quality of data once the two-year mandatory data collection period ends and it becomes voluntary. The Vice Chair stated that the LDC discussed that concern and explained that the reason for switching from mandatory to voluntary data collection after two years is to balance the burden of data collection for transplant centers.

The Vice Chair stated that there is a process in place for donors who are approved for donation but do not donate because the recipient was too ill, and then later opted to become a non-directed donor.

The Vice Chair informed the Board that the data collection will include patients who were excluded from donating for several reasons including medical, psychosocial, or financial reasons, or did not donate due to recipient reasons or consent. The Vice Chair shared that the LDC spent a significant amount of time discussing the definition of a potential donor, and at what point data collection begins for that subgroup of donors who were evaluated but did not donate. With assistance from SRTR, the Data Advisory Committee (DAC), and other committees, the LDC decided to define a potential donor as an individual who has had at least one in-person visit to a transplant center as a part of their living donor evaluation.

The Vice Chair shared that the LDC spent a significant amount of time discussing with the DAC how this proposed project will interact with electronic medical records (EMR). The DAC informed the LDC of the differences between mappable versus non-mappable data, and objective EMR downloaded data versus non-downloaded data. The current form used to collect data from potential donors includes about half EMR discreet data and half manually collected data. The LDC and DAC discussed creating clear pathways and guidelines for centers, including providing the centers with examples of EMR template that can be used in nephrology, surgery, or social work notes that would help make data collection easier.

A Board member asked if there was any discussion of the cost of increasing data collection over the next ten years. The Vice Chair stated that most of the cost discussion was focused on the first few years of data collection. However, she anticipated that cost will not be a long-term barrier.

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

The *Modify Guidance for Pediatric Heart Exception Requests to Address Temporary Mechanical Circulatory Support Equipment Shortage* proposal, sponsored by the Heart Transplantation Committee, proposes an update to the Heart Review Board Guidance to add descriptions of the circumstances and clinical factors under which the National Heart Review Board for Pediatrics should consider granting pediatric status 1A exception requests to address a shortage of ventricular assist devices for the pediatric population. This policy aligns with the primary strategic plan goal: *Aligns with Other Important Initiatives*. The POC supported the proposal's release for public comment based on review criteria and provided considerable feedback.

The POC's final vote to recommend approval was: 12 Yes, 0 No, 0 Abstain.

A Board member asked how long this issue is expected the last for the pediatric population, noting that it sounds like a temporary supply chain issue. The Chair of the Heart Transplantation Committee stated that he contacted several key people who were involved in the equipment shortage and advocated for the policy change, and he is awaiting their responses. The Chair stated that his impression is that there have been minor improvements in some of the supply chain issues.

Require West Nile Virus Seasonal Testing for Donors

The *Require West Nile Virus (WNV) Seasonal Testing for Donors* proposal, sponsored by the Disease Transmission Advisory Committee (DTAC), proposes updates to OPTN Policy 2.9: *Required Deceased Donor Infectious Disease Testing* and 14.4: *Medical Evaluation Requirements for Living Donors*. These updates would require all organ procurement organizations (OPOs) and living donor recovery hospitals to test potential donors for WNV seasonally, between July 1st and October 31st. This policy aligns with the primary strategic plan goal: *Aligns with Other Important Initiatives*. The POC supported the proposal's release for public comment based on review criteria. The POC recommended the DTAC add actual numbers of deaths from WNV in lieu of percentages and add an additional community question that asks whether the proposed requirement for seasonal testing provides adequate coverage for all OPOs based on regional seasonal WNV occurrences.

The POC's final vote to recommend approval was: 12 Yes, 0 No, 0 Abstain.

A Board member asked whether there is information on characteristics of donors that were implicated in the unknown cause of the death cases or if the cases consisted of a different cause of death, but were incidentally WNV positive. The Board member also asked if there is an option for a more targeted screening recommendation. The Chair of the DTAC stated that in cases of documented WNV transmission, the donors with WMV were not symptomatic in the way that would be expected in the setting of an acute WNV infection. The Chair added that the DTAC is proposing a more seasonal approach considering that many of the cases were identified upon retrospective review or testing.

The Chair confirmed that the Nucleic Acid Testing (NAT) was similar to other NAT that is already performed. The DTAC does not anticipate significant delays or turnaround time for NAT. The Chair informed the Board that there were two recent surveys of OPOs that were published, including one in 2021 by Nicole Theodoropoulos which had a response rate of 81% of. In that survey, 40% of the OPOs that responded reported that they were testing for WNV and 94% of those responded that they were testing year-round. In a more recent survey, which included 63% of OPOs, 31% indicated that they test all donors, and about 25% reported that they tested some donors based on various triggers.

A Board member inquired about data on the rate of organ non-use related to positive WNV cases; the Chair shared that the DTAC does not currently have that data. She shared that this proposal was focused on the cases of transmission that occur because of the lack of testing and without the donor having obvious clinical indicators. The DTAC spent a significant amount of time discussing balancing the risk of disease transmission and the risk of organ non-use.

A Board member asked if geography could be added to the proposal because transmission rates vary in different areas of the country. The Chair of the DTAC stated that the committee reviewed WNV activity from all states and it is not limited to certain areas of the country. However, rates of WNV vary each year; therefore, the committee determined that it would be best to proceed with nationwide data review.

In response to a Board member's question, the Chair of the DTAC confirmed that there does not appear to be a predilection for disease transmission based on the organ that is transplanted. She shared that of the clusters evaluated, at least 11 clusters had an attack rate above 80%, with encephalitis occurring in over 75%, and death occurring in almost 50% of implicated transmissions.

Establish Comprehensive Multi-Organ Allocation Policy

The *Establish Comprehensive Multi-Organ Allocation Policy* proposal, sponsored by the Ad Hoc Multi-Organ Transplantation Committee (MOT), proposes standardizing the order of priority across different organ match runs by inserting multi-organ allocation tables into policy. This update aligns with the primary strategic plan goal: *Optimizing Organ Use.* The POC supported the proposal's release for public comment based on review criteria and acknowledged that it is an important, well-developed proposal to address a complicated issue. The POC did have concerns for the lack of ability to pre-model the potential impacts of a complex algorithm. However, the committee performed deep retrospective data analysis to the best of its ability, and noted that post-implementation monitoring will be critical.

The POC's final vote to recommend approval was: 12 Yes, 0 No, 0 Abstain.

A Board member asked if there is a reason to approve this policy for public comment if the Board cannot implement continuous distribution and before Allocation Out of Sequence (AOOS) has been addressed. The Board member stated that AOOS changes may have an impact on this policy. A member of the MOT committee responded that the policy would need continual updating as each organ changes to continuous distribution, but it also may help AOOS because it will create an order that will not burden the OPOs. The Board member also noted that this policy proposal is the most budget heavy of the proposals. Another MOT representative stated that the committee's work aligned with the continuous distribution work. He also stated that the Board has said that, during public comment, OPOs should have a significant voice in this work so system and policy align.

A Board member stated that there is a lot of value in collecting public comment and input on this topic, but it does not necessarily mean that the Board would be voting to implement it. The Chair of the MOT shared that the MOT started the multi reallocation process because of identified inequities, particularly for the pediatric population and the kidney-pancreas population.

The MOT did consider if it should pause its work until continuous distribution is complete; however, the MOT created interactive tables that can serve in lieu of a policy document and can be easily adjusted when continuous distribution is implemented for different organs.

Require Patient Notifications for Waitlist Status Changes

The *Require Patient Notifications for Waitlist Status Changes* proposal, sponsored by Transplant Coordinators Committee (TCC), proposes an update to OPTN Policy 3.5: *Patient Notification* to add a requirement for notification related to patient activation and inactivation. This policy aligns with the primary strategic plan goal: *Increase Opportunities for Transplant*. The POC supported the proposal's release for public comment based on review criteria and provided considerable feedback. The POC's feedback stated that the proposal is an important project and has the potential for large benefit for patients. The POC stated that the proposal aligns with patient-centered care principles and supports transparency, trust, and shared decision-making.

The POC's final vote to recommend approval was: 12 Yes, 0 No, 0 Abstain.

A Board member asked if there had been any consideration of including the reason a patient has been made temporarily unavailable so that they know what is needed to become available. The Chair of the POC stated that she will take this feedback back to the TCC. However, transplant centers must provide patients with a reason for declining them. She stated that she believes that the decline notification would prompt patients to reach out to their transplant center to ask what needs to be done to be reactivated. She informed the Board that one of the questions in the public comment proposal asks whether notifications should delivered in writing or delivered verbally.

In response to a question from a Board member, the POC Chair stated that there is currently no distinction between forms of communication for notifications for inpatients versus outpatients; The POC Chair stated that she will provide the Board member's feedback to the TCC.

Update Timeline

The Board Support Contractor provided an overview of the updated public comment period timeline. The Board plans to vote on the policy project proposals at the 8/21 Board meeting. The six policy project proposals that were presented during this meeting exceed the available funding for project implementation in the FY26 budget. The public comment period will now open on 8/27; subsequently, the four regional meetings scheduled in August will be rescheduled to September. The public comment period will officially close on 10/1, and voting on policy implementation will occur during the biannual, in-person Board meeting in December ("December Board meeting").

INVEST Insurance Coverage

A representative from the Board Support Contractor shared that INVEST previously carried $5 million of insurance, and it covered Directors & Officers/Employment Practices Liability (D&O/EPL) coverage. As of 7/23, the Board carries $10 million in D&O/EPL insurance and $10 million in Errors and Omissions (E&O) coverage, which includes $2 million in Cyber Liability and $750,000 in Bodily Injury Coverage.

The newly bound D&O/ELP insurance policy protects INVEST from lawsuits and claims related to its management and operations, as well as financial losses related to employment-related claims (despite the volunteer capacity of the Board Directors). The newly bound E&O/Cyber Liability coverage protects INVEST from financial losses (e.g., based on leaked data) related to mistakes or negligence during the performance of professional services, as well as losses related to cyber events affecting OPTN data, such as business interruptions. The Bodily Injury/Property Damage protects INVEST from injury-related claims due to policy decisions. The Board Support Contractor reminded the Board that the bound coverage applied not only to Board Directors, but to all INVEST volunteers including standing committees, ad hoc committees, and workgroups.

A legal representative from the Board Support Contractor explained that while it is not possible to prevent anyone from filing a lawsuit, the legal counsel can ensure certain measures are in place to mitigate the risk of Board Directors being held liable. A Board Director acting in official capacity, in good faith, with due care, and in best interest of INVEST/OPTN is typically shielded from liability under: (1) state law; and (2) INVEST insurance policies. A Board Director engaging in willful misconduct or gross negligence, breaching fiduciary duties or care and loyalty, or self-dealing may be held personally liable for actions in certain circumstances.

The legal representative informed the Board of other protections under State law including:

- Delaware’s Volunteer Immunity Statute, which establishes non-profit “volunteers” protected from lawsuits related to acts within scope of role
    - Traditionally applied in the context of volunteers at a charitable event, but “volunteer” is technically defined to include “director … engaged in an activity without compensation”
    - Courts have applied protections to members of non-profit Board (e.g., *Gilliland v. St. Joseph’s*, 2006 Del. Super. LEXIS 11)
- Delaware law permits non-profits to indemnify Directors against liabilities incurred in official capacity
    - Article 8 of INVEST’s Bylaws includes indemnification provision
- Delaware law permits non-profits to purchase insurance to protect Directors against liabilities incurred in official capacity

If a Board Director is sued, they should notify the legal counsel as soon as possible so that they can draft the appropriate response and craft a defense.

Closing Remarks

The Board President thanked the Board of Directors for their engagement, and adjourned the meeting.