

**OPTN Patient Affairs Committee
Meeting Summary
September 15, 2022
Richmond, Virginia**

**Garrett Erdle, MBA, Chair
Molly McCarthy, Vice Chair**

Introduction

The OPTN Patient Affairs Committee (the Committee) met in-person in Richmond, Virginia, and via Citrix GoTo Meeting teleconference on 09/15/2022 to discuss the following agenda items:

1. Welcome and Introductions
2. National Academies of Science, Engineering, and Medicine (NASEM) report recommendations
3. Introduction to Normothermic Regional Perfusion (NRP)
4. Public Comment Presentation: Transparency in Program Selection white paper
5. Scientific Registry for Transplant Recipients (SRTR) Consensus Conference discussion
6. Patient Engagement Workgroup recommendations and Patient Information Letter
7. Public Comment Update
8. Feedback Requested: Monkeypox Patient Resource

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

1. Welcome and Introductions

The Chair welcomed the in-person and virtual members to the fall in-person Committee meeting. The Committee shared their connections to transplant.

2. National Academies of Science, Engineering, and Medicine (NASEM) report recommendations

The Committee reviewed recommendations from the National Academies of Science, Engineering, and Medicine (NASEM) report *Realizing the Promise of Equity in the Organ Transplantation System*.¹

Summary of discussion:

A member asked whether the NASEM report made recommendations on how to encourage transplant programs to accept high risk deceased donor organs. Staff stated that the utilization of offer filters may help organ procurement organizations to place high risk deceased donor organs faster by having transplant programs apply filters which filter out offers from types of organs they have historically never accepted.

The Chair expressed concern that transplant candidates are not informed when they receive an organ offer. The Chair explained that a transplant candidate may be interested in accepting a high Kidney Donor Profile Index (KDPI) kidney, but often is not part of that decision making due to the transplant team not having to inform them of organ offers. The Chair stated that the transplant candidate should be informed of organ offers and be able to consider the cost-benefit of accepting that offer. Staff stated

¹ "Realizing the Promise of Equity in the Organ Transplantation System," National Academies of Science, Engineering, and Medicine, 2022, accessed October 12, 2022, <https://www.nationalacademies.org/our-work/a-fairer-and-more-equitable-cost-effective-and-transparent-system-of-donor-organ-procurement-allocation-and-distribution#sectionPublications>.

that the NASEM report did discuss allocating kidneys based on a survival-benefit score. This would account for the odds of survival with and without a transplant. A member stated that patient education would benefit this situation. The member added that that transplant program staff also need more education on policy changes.

Another member stated that their transplant programs asks transplant candidates whether they would accept a high risk organ offer. The member stated that this is asked during the initial visit and never revisited with the transplant candidate. The member agreed that continual education would enhance the ability to have shared decision making among the transplant candidate and transplant team. Another member emphasized that patients need to be asked whether they are willing to take a risk. The member emphasized that it is the transplant candidate's life that is impacted by these decisions, and the decisions should not be made without input from the transplant candidate. The member stated that transplant programs make decisions based on impacts to metrics and outcomes, which is a problem.

A member stated that they were informed a number of transplant candidates are declining organ offers. The member stated the transplant professional estimated that 25% of organ offers are declined by transplant candidates, against the advice of the transplant professional. The member asked if the system tracks organ offers that were turned down by transplant candidates. Staff will follow-up on the granularity of refusal codes to determine whether the system track organ offer declines made by candidates. The member stated there should be an expedited way to place organs. The member explained that if it is known the organ will not be accepted by transplant candidates at the top of the match run, there should be an expedited process to send out organ offers to those lower on the list that are more likely to accept the offer in order to place the organ faster.

Another member stated if a transplant candidate repeatedly declines organ offers for something they said they were interested in, then their transplant programs flags it and revisits that discussion. The member noted this practice is variable among transplant programs.

A member stated a balanced approach is needed. The member explained that transplant candidates should be educated, informed, and presented options. However, the member stated that the physician is the clinical expert and is responsible for presenting compatible options with the best outcomes. The member stated that transplant programs are concerned with viability, funding, and metrics, which is an issue.

The Vice Chair stated that their transplant programs did not have conversations with them about acceptable risk criteria. The Vice Chair expressed concern that doctors are making decisions on transplant candidate's lives based on competing priorities (i.e. funding and assessments). The Vice Chair expressed concern for transplant candidates who do not speak English, have low literacy levels, or lack insurance. A member responded that some of this concern is the issue of metrics and the structure that is in place which holds organ procurement organizations (OPOs) and transplant programs accountable. The member suggested that national standards may need to be revisited. The member explained that the metrics that penalize transplant programs for poor outcomes may be too stringent. SRTR staff stated that the metrics are risk adjusted for the quality of the offer. SRTR staff added that more education about risk adjustment for transplant programs may be necessary.

A member noted that there does not seem to be a mechanism in place for donor families to report their experiences with OPOs.

Next steps:

OPTN committees will continue discussing and prioritizing project ideas from the NASEM report.

3. Introduction to Normothermic Regional Perfusion (NRP)

The Chair of the Ethics Committee presented an introduction on Normothermic Regional Perfusion (NRP). The Ethics Committee is currently discussing NRP and seeking feedback from patient and donor family representatives.

Summary of discussion:

A member participating in the NRP Workgroup meeting outlined several considerations that the NRP Workgroup is discussing:

- How much information to include in the consent process?
- How much information should be presented to the deceased donor family?
- Should the information be more focused at the time of donation, and provide more information afterwards when there is more time for education?
- Should there be levels of information provided depending on wants of the deceased donor family?
- Should specifics about the NRP process be included in the authorization form?

The member participating in the NRP Workgroup noted that European doctors who have been utilizing NRP for a longer period of time have joined the NRP Workgroup meetings. The member participating in the NRP Workgroup stated that the European doctors shared that the European transplant community is very accepting of the utility aspect of NRP.

The member participating in the NRP Workgroup stated that an individual's decision to be an organ donor should be honored regardless. The member emphasized that the separation of the medical teams is extremely important and necessary. The member explained there should be no overlap between the medical teams working to save an individual's life and the medical teams working to recover organs.

The member participating in the NRP Workgroup stated that NRP will likely increase utility. The member stated that increasing utility of organs and post-transplant outcomes are key.

A member stated that they have heard OPOs needing to "fight" to get the necessary testing completed in order to have the organs recovered for transplantation. The member stated that more education is needed for donor hospitals that are not transplant centers to ensure they are supporting transplantation.

Another member stated that donation after cardiac death (DCD) is a harder concept than donation after brain death (DBD). The member added that when NRP gets added on top of DCD, it becomes even more complex. The member stated that negative representation of transplant in the media also causes public mistrust and aids in misunderstanding of the standard that the transplant community seeks. The member stated that DCD is an emerging area that is hard for the public to wrap their minds around, and more education and positive stories are needed.

A member asked if NRP is used for all organs. Another member confirmed that NRP is being used or explored for all organs.

The Chair asked if the definition of DCD is standard. A member responded that the definition of DCD is standard, but the level of risk that transplant programs are willing to accept varies. The Chair asked if that means transplant programs vary in determining the timeframe to begin NRP.

Next steps:

The Committee will provide additional feedback to the NRP Workgroup on a future meeting.

4. Public Comment Review: Transparency in Program Selection white paper

The Committee provided feedback on the OPTN Ethics Committee white paper, *Transparency in Program Selection*.

Summary of discussion:

A member stated that there has been a general push for more transparency in all types of health systems. The member noted U.S. World News and Reports as a consumer based resource which ranks various health systems in order to allow individuals to make decisions about their individualized care. The member noted that a complicating factor in the transplant system is information and data that aid in decision making versus metrics. The member emphasized that individuals should be knowledgeable of programmatic elements to aid in their selection of transplant programs. The member stated that information should be available to allow transplant candidates to determine which transplant program would be best for their individual health. Another member responded that if ratings such as those in U.S. World News and Reports were created, it would be necessary to ensure transparency about the specific details included in the rating to understand why transplant programs are ranked a certain way.

A member stated that while outcomes metrics and transplant rate volumes are important, transplant candidates will initially want to know whether the transplant program closest to them will accept them.

Another member stated that patients do not know what they do not know. The member added that patients are sick, which makes transparency an even more important factor. The member noted that the Final Rule stated that the OPTN and SRTR shall provide the Secretary and data that the Secretary requires. The member added their interpretation of federal regulations makes them believe that the OPTN is collecting more data than they are providing to the SRTR.² The member suggested that the OPTN should share more data with the SRTR. The member stated that regulations also mention social workers and nutritionists, but does not state that the social worker has to be qualified nor does it define the qualifications for a qualified social worker.³ Additionally, the member added that the regulations do not dictate how many social workers or nutritionists are needed in a transplant program. The member stated that the regulations permit transplant programs to develop criteria that best fit the needs for their patients and gives the transplant programs flexibility to change the criteria. The member stated that the regulations state that transplant programs are not required to use existing patient selection criteria as long as their patient selection criteria are fair and nondiscriminatory. The member stated that the regulations state that transplant programs are free to develop their criteria based on the medical judgement of their transplant team, but they are not required to give the criteria to the patient unless the patient asks. The member noted that this is an issue because the patient does not know what they do not know, so they do not know to ask. The member expressed concern with the requirements in the regulations. The member reviewed insurance company websites and stated that insurance companies have dictated requirements to transplant programs that are not in the regulations. The member explained these insurance company requirements begin with overall function of the patient by understanding underlying illnesses and need for proposed treatment, history of adherence and compliance, barriers to compliance, quality of relationships, presence of supportive caregiver, social

² OPTN data are published on the OPTN website at <https://optn.transplant.hrsa.gov/data/>. More information about the data that the OPTN provides to SRTR is available at <https://srtr.org/about-the-data/the-srtr-database/>.

³ The OPTN Final Rule includes a requirement for most transplant programs to “[Make] available psychiatric and social support services for transplant candidates, transplant recipients, and their families” (42 CFR §121.9(a)(2)(viii)) but does not require nutrition counseling. The Centers for Medicare and Medicaid Services (CMS) Final Rule for Medicare Program; Hospital Conditions of Participation: Requirements for Approval and Re-Approval of Transplant Centers to Perform Organ Transplants includes requirements for nutrition services and qualified social workers: <https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/Downloads/trancenterreg2007.pdf>. Many of the requirements described in this section refer to CMS regulations rather than the OPTN Final Rule.

history including educational level and employment history, housing and living situation including reliable transportation to attend medical visits, socioeconomic status including funding to pay for immunosuppressive medication post-transplant, current and past history of alcohol and substance abuse, current and past psychiatric history including baseline cognitive status, and coping skills (example from United Healthcare). The member expressed concern that insurance companies are dictating where individuals are able to receive care and what will be paid for. The member noted that in addition to the insurance company criteria, the transplant program will have additional criteria. The member added that there is stigma and it is getting exacerbated through insurance company requirements. The member stated that insurance companies and transplant programs do not inform patients of their ability to multi-list. The member expressed deep concern that insurance companies are dictating the ability for individuals to be transplanted. The member stated that they know an individual in need of a lung transplant who is having trouble identifying a caregiver so now the insurance company is not helping which furthers discrimination. The member stated that the transplant program is going to do what the payer says whether that's Medicare or a private insurance company.

Members noted that transplant recipients may face challenges with insurance coverage for medications needed post-transplant.

The Chair stated that transplant programs should provide profiles to transplant candidates so that the patients to have a baseline understanding of the transplant program and the care provided before investing time in evaluation. The Chair suggested that transplant programs present information about transplant recipients that were successfully transplanted at that transplant program. The Chair stated this affords transplant candidates the opportunity to understand where they could receive healthcare that aligns with their needs. The Chair stated that candidates are not provided enough information at this point in time, so it is not necessary to worry about the unintended consequences of providing more information because transplant candidates need more transparent information provided to them. The Chair stated that individuals are likely making decisions not based on enough information. A member agreed and stated that they would prefer to be confused by too much information rather than having to make a decision based on not enough information.

The member suggested that transplant programs should publish their specific list of ten to fifteen general exclusions to being listed for transplant. The member stated that in addition to posting their general exclusions, transplant programs should further breakdown organ-specific exclusion criteria, the most common contraindications. The member explained that it may not be necessary for the transplant program to list very granular exclusion criteria. The member added that individuals have had to crowdsource information which can lead them to inaccurate information. The member stated that rather than reverting to crowdsourcing information via social media, transplant programs should be transparent in their contraindications to transplantation.

The Vice Chair stated that some transplant programs will decline individuals if they do not have regular checkups with dentists. The Vice Chair elaborated that this presents an opportunity for bias. The Vice Chair suggested that transplant programs should agree to a minimum standard of evaluation. The Vice Chair stated that then an individual may be evaluated at one transplant program and then take their evaluation results to another transplant program without having to be reevaluated due to the agreed upon minimum standard of evaluation. The Vice Chair said that this "baseball card summary" could be used by transplant programs to pre-approve individuals. The Vice Chair explained that this would reduce the burden on individuals to understand which transplant program may accept them as well as insurance coverage of multiple evaluations.

The Committee agreed that greater transparency is to the benefit of the transplant candidates. The Committee noted that there may be a threshold of too much information provided to transplant

candidates. A member added that in addition to greater transparency, collaboration in understanding information is needed. The member explained that clinical support is still needed for some individuals to process the information and correctly incorporate it into their decision making. Another member agreed that patients and transplant teams need to be having discussions.

The Vice Chair stated that it is important to consider what information is given at what point in the transplant journey. The Vice Chair explained that the information that a candidate needs to know depends on where an individual is in the transplant process. The Vice Chair stated they are receptive to information via personas. The Vice Chair explained that being able to relate to another individual at that specific place in the transplant journey is beneficial. The Vice Chair added that the subway analogy developed by the SRTR⁴ could be used as a tool to disseminate certain information at certain points in the transplant process. The Vice Chair explained that the subway analogy helps visualize the different stages of the transplant process, and transplant candidates need different information at various times in this process. The Vice Chair stated that it should not be assumed when an individual is ready to intake information. The Vice Chair stated that information should be delivered through the journey, through personas, so that people can say what they want, when they want, when they are ready to actually do something with it. The Vice Chair stated that the notion that transplant candidates do not understand information needs to end.

A member stated that transplant programs should publish their strategic objectives. The member stated that a transplant program may be focused on increasing their living liver donor program. The member explained that if this strategic goal was published, then a transplant candidate that is seeking living liver donation would be aligned with that transplant program. The member stated that publishing strategic objectives may be the initial step, then a subsequent step may be the transplant program publishing profiles of individuals that were successfully transplanted. The member added that the transplant program can have contact information for individuals in the region to talk about their transplant experience. The Vice Chair agreed that geographic representation is important. The member agreed and stated that the OPTN should dictate that.

A member suggested that profiles should be created, similar to those in U.S. News and World Reports, for transplant programs that shows baseline inclusion criteria. The member suggested the transplant programs should have a one pager baseline in order to understand which transplant candidates they would accept. The member added that more specific information could be included too for those individuals that are able and ready to intake more information.

Another member stated that each transplant program should have criteria on their website in addition to insurance companies and Medicare publishing their additional criteria.

A member stated that individuals will find the information they are seeking no matter what. The member explained that everything is searchable online and individuals may end up with the wrong information and make decisions based on this misinformation. The member stated that transplant programs should have more peer-to-peer mentoring. The member added that publishing personas of successful transplants is also beneficial as mentioned previously. Another member noted that their transplant experience did not meet a typical persona. The member noted that due to his experience, personas may not be as beneficial as transplant programs publishing their exclusion criteria.

SRTR staff noted that there has been feedback from the transplant community that increased transparency may drive risk aversion by transplant programs. SRTR staff stated that this concern may be

⁴ Scientific Registry of Transplant Recipients, *2022 Consensus Conference Workbook*. Transplant system, page 8. Available at https://www.srtr.org/media/1568/cc-workbook_final_2.pdf.

guided due to lack of understanding of risk adjustment. SRTR staff noted that even if the information is not presented as a metric, insurance companies may use the information to limit access to transplant. SRTR staff added that patients also may become risk averse with increased transparency due to the common theme of individuals not knowing what they do not know. SRTR staff noted that these concerns can be overcome and the concerns do not necessitate that transplant programs should not be transparent. SRTR staff added that transplant programs will likely say that they do not have specific exclusion criteria, and that acceptance of an individual for transplant is patient-specific. SRTR staff gave an example that an individual may have a high BMI but is otherwise healthy, which is a different situation than if an individual has a high BMI with cardiovascular disease.

The Chair suggested that data should be analyzed to understand whether the populations that are listed at a transplant program are comparable to the population that is transplanted at that transplant program. SRTR staff stated that the Committee is able to suggest metrics that transplant programs are held accountable to.

A member stated that currently there is no broad, consistent transparent information. The member stated the Committee should determine the starting point for transparent information before diving into transparent granular information.

Another member stated that the Committee needs to consider that organs are a scarce resource and there are individuals who may never qualify for transplant. The member stated that the transplant system needs to work towards ensuring that organs are transplanted to the individuals most in need that have the best possible outcomes.

A member stated that individuals should be able to search for which transplant program would accept someone with their medical condition for transplant prior to having to go through the evaluation. Another member added that ensuring transparency requires consideration for populations who may not have easy access to the internet. SRTR staff stated that ensuring transparent information and data is available for access on a cellphone is very important.

The Chair asked if a uniform evaluation standard would lower the barrier for individuals to pursue transplant. The Chair stated that this uniform evaluation standard would allow an individual to be evaluated at one transplant program and take the evaluation results to other transplant programs that may accept the individual without having to go through the evaluation again. Another member stated that transplant programs are going to want to perform their own testing due to variations in testing practices and technology. The Vice Chair suggested that a "baseball card" of information could be agreed upon, then individuals could send that "baseball card" to transplant programs to get pre-approval or immediate dismissal. Another member shared their experience of trying to send their lab results to various transplant programs. The member shared that the transplant programs would tell them they would not accept labs from an outside source.

A member stated that the profiles may be helpful for some but most transplant experiences are so different that it may not be as beneficial as a list of general exclusion criteria within a transplant program.

Another member expressed interest in understanding the differences between populations who have access to multiple transplant programs compared to individuals in more marginalized populations who only have access to one transplant program. The member stated that individuals with access to one transplant program may not benefit from increased transparency. SRTR staff stated some research has been done regarding that concern and often individuals have more than one option for transplant programs.

The Chair asked whether there is more data available to share with the patient population that would not scare individuals away from transplant but aid more in transparent transplant program selection. SRTR staff stated that the majority of the data has been available for a very long time but has been included in technical reports. SRTR staff explained that the data has not changed but the way it is presented for broader interpretation has shifted. SRTR staff stated that more education regarding risk adjustment is needed in order to help counter reactive risk aversion. SRTR staff stated that getting a transplant is usually more important than where the transplant is performed.

A member suggested that information could be organized by patient characteristics. Another member stated that the OPTN should provide basic information on exclusion criteria at all transplant programs. The member suggested that the OPTN contractor may create an algorithm to help publish this information for patients. The Chair asked whether the OPTN contractor should be the independent arbitrator of data versus requiring transplant programs to publish this information. Another member stated a disclaimer mentioning that there are many different transplant scenarios may be needed.

A member stated that providers also need access to transparent information to best help their patients. Another member agreed and stated a searchable application would be great.

Another member stated that information on post-transplant outcomes after five years is needed. The member stated that transparent information needs to be considered in the context of caregivers as well. The member explained that transplant candidates are often very sick, so it may be the caregiver that will be needing to search and digest information on behalf of the transplant candidate. A member agreed and emphasized that referring providers also need this information because the individuals already have an established relationship with the providers. Another member stated the general education on end organ failure for primary care physicians is needed.

A member stated that there needs to be equal responsibility on the primary care physician and the patients to collaborate together in reviewing the data to make the best health care decisions. SRTR staff stated that transplant is a specialized field so the tools that are created to aid patient decision making are the same tools that will be utilized by primary care providers. The Vice Chair suggested that outreach to primary care providers may be needed. Another member agreed and added that transplant programs needs to do more satellite care and outreach.

Next steps:

The Committee's feedback will be summarized and submitted to the OPTN Ethics Committee for consideration. The Committee will continue to discuss next steps regarding increasing transparent information for the patient population.

5. Scientific Registry for Transplant Recipients (SRTR) Consensus Conference discussion

Several Committee members attended SRTR's Task 5 consensus conference.

Summary of discussion:

SRTR staff provided a brief overview of the Task 5 initiative and the consensus conference, noting that it was the SRTR's first big effort towards patient engagement, and discussed next steps, including publishing articles on topics discussed at the conference. SRTR staff said they are writing an article about not using the term "discard," which is currently defined as organs recovered but not transplanted, and they will be requesting feedback from patient and donor affairs representatives on what term to use instead. The Vice Chair suggested that the focus could instead be on turning those discards into successful transplants, and requested to review the 155 recommendations from the consensus

conference. SRTR staff requested that the Committee send any feedback they have regarding the consensus conference.

Next steps:

The Committee will continue to discuss areas of interest from the SRTR's Task 5 Consensus Conference.

6. Patient Engagement Workgroup recommendations and Patient Information Letter

The OPTN Executive Committee has requested that the Committee update the OPTN Patient Information Letter⁵ to inform patients about opportunities to volunteer with the OPTN at the time of registration on the waiting list for transplant. This letter is required to be included during specified patient notifications per *Policy 3.5: Patient Notification*.

Summary of discussion:

Several members commented that they do not remember receiving this letter. The Chair suggested the Committee consider when the appropriate time to give transplant candidates this letter.

A member asked for the primary objective of the patient information letter. Staff stated that part of the objective is to inform transplant candidates of the patient services line which is an OPTN contract requirement. Another member suggested that pre-transplant patients are the population that may benefit from knowing about the patient services line. The member added that there is an opportunity to inform the transplant community of this letter and the information provided.

Next steps:

The Committee will review and update the patient information letter.

7. Public comment update

The Committee was reminded that public comment is open until September 28, 2022. The Committee was encouraged to review the items out for public comment and provide any feedback they may have.

8. Feedback Requested: Monkeypox Patient Resource

The Committee was asked to provide feedback on a patient resource for Monkeypox.

Summary of discussion:

A member asked whether a similar resource exists for COVID-19. It was noted that there is COVID-19 information available on the OPTN website.⁶ Another member emphasized that the OPTN needs to take more affirmative efforts regarding COVID-19. Several members agreed they felt lost during the COVID-19 pandemic and were not provided the support they needed from their transplant programs. Members noted that they continue to feel lost.

A member stated that the OPTN should have more purview and action over standardizing post-transplant care. The member stated that transplant recipients are seeking advice from non-medical professionals because medical professionals are not provided the necessary support.

Another member suggested the OPTN COVID webpage should have a link to the COVID therapeutic dashboard. A member emphasized that more collaboration is needed within the transplant community.

⁵ Patient Information Letter, OPTN, accessed October 11, 2022, https://optn.transplant.hrsa.gov/media/2921/optn_patient_info_letter.pdf.

⁶ "COVID-19," OPTN, accessed October 12, 2022, <https://optn.transplant.hrsa.gov/covid-19/>.

Another member stated transplant programs need to agree on COVID-19 recommendations for transplant candidates and transplant recipients. A member stated that opinions among staff at a single transplant program regarding COVID-19 recommendations will vary, so it is difficult to have a national consensus.

The Vice Chair stated that there should be foundational connective elements that drive some national uniformity among transplant programs. A member responded that OPTN should have policy to dictate post-transplant communication standards. Another member suggested that recommendations could be provided to transplant programs on how to treat individuals on immunosuppressive medications. Another member added that recommendations and guidelines should be made with the caveat that every patient is different.

Another member suggested that evidence-based recommendations for transplant recipients regarding COVID-19 could be made by analyzing available data. The member stated that once the evidence-based recommendations are determined, transplant recipients could bring those recommendations to their transplant program in order to receive a response and direction.

Next steps:

The Committee was asked to provide feedback on the monkeypox resource by September 22nd. The feedback will be shared with the Disease Transmission Advisory Committee.

Upcoming Meetings

- October 18, 2022 (teleconference)
- November 15, 2022 (teleconference)
- December 20, 2022 (teleconference)

Attendance

- **Committee Members**
 - Anita Patel
 - Calvin Henry
 - Dana Hong
 - Eric Tanis
 - Garrett Erdle
 - Julie Spear
 - Justin Wilkerson
 - Kenny Laferriere
 - Kristen Ramsay
 - Lorrinda Gray-Davis
 - Molly McCarthy
 - Sejal Patel
 - Steven Weitzen
- **HRSA Representatives**
 - Jim Bowman
 - Mesmin Germain
- **SRTR Staff**
 - Allyson Hart
 - Katie Audette
- **UNOS Staff**
 - Alex Carmack
 - Delaney Niles
 - James Alcorn
 - Kaitlin Swanner
 - Kim Uccellini
 - Krissy Laurie
 - Kristina Hogan
 - Laura Schmitt
 - Maureen McBride
 - Meghan McDermott
 - Morgan Jupe
 - Rebecca Murdock
 - Roger Brown
 - Sam Settimio
 - Stryker-Ann Vosteen
 - Susan Tlusty
- **Other Attendees**
 - Keren Ladin