OPTN Kidney Transplantation Committee Meeting
Meeting Summary
August 18, 2025
Conference Call

Jim Kim, MD, Chair
Arpita Basu, MD, Vice Chair

Introduction

The Kidney Transplantation Committee met via WebEx on August 18, 2025 to discuss the following agenda items:

1. Updated Non-Use Data
2. Health Resources and Services Administration (HRSA) Letter on Kidney Expedited Placement

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

1. Updated Non-Use Data

The Committee reviewed the most recently available data on national kidney non-use rates, mean kidney allocation time, and mean cold ischemic time at last offer notification.

Data summary:

All presented data is from January 1, 2016 through June 30, 2025.[1]

Kidney non-use is defined as the proportion of organs recovered from deceased donors for the purpose of transplant (disposition code 5 or 6), but not transplanted (disposition code 5). Non-use has increased from 2016, with initial upward trends beginning in 2019 at less than 20% and increasing up to around 28% in 2025.

Kidney allocation time is defined as the number of hours between first and last electronic offer notification. Mean allocation time of kidneys has increased since 2018, plateauing slightly after the COVID-19 outbreak at around 15 hours, and then increasing more significantly after implementation of circles-based kidney allocation policies. Mean allocation time plateaued again in 2023 at around 18 hours, and began again to increase in 2024. As of June 30, 2025, mean allocation time was 19.69 hours.

Cold time at last offer notification is defined as the number of hours after cross clamp that the last electronic offer notification was made for a donor, regardless of whether the organ was transplanted. Cold time at last offer notification was set to zero if the last offer notification occurred prior to cross-clamp. Last offer notifications more than 48 hours after cross-clamp were assumed erroneous and removed. Mean cold time at last offer notification for kidneys has increased from around 5 hours in 2019, plateauing during the initial COVID-19 emergency at around 6 hours, and increasing up to 7 hours in 2022 and 2023. Mean cold time at last offer notification for kidneys has been steadily and slowly declining since then, to around 6.5 hours in 2025.

[1] SRTR Donation and Transplant System Explorer; https://www.srtr.org/tools/donation-and-transplant-system-explorer/

Summary of discussion:

One member asked for clarification on cold time at last offer notification, and OPTN contractor staff noted that this the cold ischemic time when the OPO stopped offering, either because the organ was accepted or the OPO stopped allocation. OPTN contractor staff explained that in July 2016, cold ischemic time at last notification was lower, at ana average of 5.4 hours cold ischemic time. This offer time increased in 2019, plateaued during the COVID-19 crisis, and then increased after implementation of circles based kidney allocation. OPTN contractor staff noted that cold ischemic time at last offer notification has been declining since July 2022. The member asked if this is for kidneys that were recovered and not transplanted, and OPTN contractor staff clarified that this is for all kidneys recovered. The member asked if this data indicates that kidneys were not-used and allocation stopped at 6 hours of cold ischemic time, and OPTN contractor staff clarified that this data is for mean cold ischemic time at last offer notification, and thus is an average of all the cold ischemic time at last offer notification data. The member noted that this doesn't align with his experience, noting that his program receives a number of offers that are 15 and 20 hours cold. The Chair noted that this could also be due to OPOs sending out electronic notifications as back up offers well before the OPO calls with the primary offer. The Chair agreed, noting that most offers come in several hours colder than indicated by this data. The Chair noted that OPOs will often send out a hundred offers or more in rounds.

2. HRSA Letter on Kidney Expedited Placement

The Chair presented the concerns presented in the Kidney Expedited Placement letter, as well as additional context on previous Committee discussions or clarity on systems operations related to the concerns.

Presentation summary:

(A) Concerns raised by the OPTN DAC

*Concern: "The cold ischemic time (CIT) of an offer is not knowable in the current system, so the proposed policy would not be auditable." "Currently, technical limitations make it impossible to know definitively what an organ's CIT was when it was first offered out of sequence." "allocation time stamps are '*a moving target…'" *"Unreliability of this variable is especially concerning given that the CIT over 6 hours at time of organ acceptance is sufficient to establish any kidney, regardless of other aspects, as 'hard to place.'"*

The OPTN Donor Data and Matching System calculates and shows cold ischemic time in real time based on the reported time of cross clamp. This system records and logs timestamps when an electronic notification is sent for each sequence; a new response is reported for each sequence, including provisional yes, refusals, and acceptance; a bypass is input for each sequence. Allocation time stamps are not overwritten in the log. Offer filters bypasses are applied automatically at time of offering , as part of the electronic notification process. The Committee supported expedited placement process that utilizes expedited-specific offer filters, which apply bypasses automatically at time of allocation. Currently, OPOs have 30 days to close the donor disposition, including completing all open match runs. This means OPOs allocating out of sequence have 30 days to input bypasses.

Summary of discussion:

The Chair remarked that this concern came from the Kidney Committee's most recent presentation to the OPTN Data Advisory Committee, which was intended to ensure the proposed data elements were collected appropriately.

The Vice Chair added that, since it is the OPO inputting the time of offer acceptance, there is a possibility that the OPO may call and make an offer to a center out of sequence, and that this would not be captured. The Vice Chair noted that the expedited placement pathway would be able to capture all expedited offers. The Chair asked if any members with OPO experience could comment on this. The Chair asked whether the Committee should require that expedited placement offers are sent specifically by electronic notification, to ensure they are timestamped appropriately. The Chair noted that this would allow expedited offers to be accurately timestamped so that simultaneous review could be maintained.

One member expressed support for requiring electronic notification, noting that the letter raises the fact that phone calls are not auditable, and that the premise of expedited placement has been transparency. The member continued that expedited placement is meant to prevent OPOs having a hot list of programs who may consider the organ and making phone calls in the background. The member expressed support for full visibility and auditability, noting that it should be done by the book with electronic notification timestamps.

The Chair agreed, noting that the overarching theme to keep in mind is fairness and transparency. The Chair remarked that these seem to be the points that HRAS wants to get across as the Committee puts forward any policy that affects allocation out of sequence. The Chair continued that many have heard or been in involved in certain hotlists, and noted that this is a workaround programs have made to better serve their patients as offers are being made. The Chair agreed that OPOs have their own set of concerns and want to ensure that organs are placed, and that there are certain programs that may take longer to review or don't necessarily follow all the guidelines, and so are also creating a workaround. The Chair noted that if both OPOs and programs are creating workarounds, that's where the problem with allocation out of sequence comes in and worsens. The Chair remarked that the Committee will need to concern how to address this cycle, and noted that this is where the Kidney Expedited Placement Workgroup came in. The Chair added that the Committee reviewed the policy proposal decided that was the direction they wanted to head in, to create a system that is both fair and transparent to everyone, keeping the patients in mind. The Chair continued that not all organs are appropriate for all candidates on the waitlist. The Chair asked if there were additional thoughts or comments.

One member remarked that it would be good to hear from the OPOs, noting that the OPOs are using the phone call system to get the organ placed as quickly as possible. The member questioned whether the emphasis on electronic notification is going to add a time lag to allocating those organs. The member agreed that the goal of the expedited placement proposal and subgroup was to maintain transparency and equity and having centers have access to those organs. The member recommended hearing from OPOs on whether this slows down placement, but noted that the system ultimately must be approved by the Board, and would need to be auditable and visible. The Chair asked if there were any Committee members with OPO experience, or of patient experience, with thoughts.

A member noted that these concerns are valid, and shared that he takes offer call for his program, and that his program does about 70-80 percent of kidney transplants from open offers. The member remarked that by the time kidneys are being offered aggressively by OPOs, with some OPOs starting as early as 4 hours cold, the kidney likely already has 10-12 hours of cold time. The member remarked that at this point, time is of the essence. The member noted that the work of defining "hard to place" kidneys was put on hold, and noted that finalizing the definition of "hard to place" kidneys will make more sense. The member remarked that the electronic notification requirement should *not* stop the OPOs from making open offer phone calls. The member explained that the coordinator who receives the electronic notification will not evaluate the offer in the same away a surgeon or nephrologist would. The member remarked that there are instances where he receives and acceptances an open offer for an

organ rejected by the coordinators. The member remarked that if the kidney is already rejected by one center, the OPO cannot go ahead and give another offer, so instead, the OPO will make a phone call. The member remarked that there are many nuances here and to make one blanket requirement may lead to more non-use. The member agreed that transparency is important, but that there must be a point at which usage should be emphasized more than equity. The member remarked that the Committee will need to determine where this point is. The Chair remarked that this provides insight, particularly from a center who accepts a lot of open offers.

The Chair noted that phone calls may be faster, and asked if there is a system in which the timestamp could be recorded. The Chair noted that the offer has to be made electronically regardless, and if a phone call is made, then it should be a bypass code input for those patients and centers that did not receive the offer. The Chair asked OPTN Contractor staff for confirmation, and clarified that this would be to describe how the system works currently, without expedited placement. The Chair noted that with expedited placement, it should be a second set of bypass codes from offer filters, such that the candidate and program that would be willing to accept is identified and placed more quickly. The Chair also noted that expedited placement would give the opportunity to candidates who are higher on the list or at another program who may not necessarily have gotten the open offer call.

OPTN contractor staff explained that the offer filters will apply bypasses automatically to those candidates that are not expected to accept the offer based on prior program acceptance history or based on the standard offer filters the program has in place. The system has an electronic notification functionality to send out the initial offers, and it's the follow up that is more complicated, where OPOs are making phone calls to make the primary offer. OPTN contractor staff continued that there are currently additional notification buttons in the system to notify as primary or notify as back up, and this functionality could be something the Committee considers as a requirement so that the primary offer is automatically logged in the system. The OPTN Contractor staff explained that these offers would then be made by the system sending out an automated call message to notify the patient has received a primary offer. The Chair noted that this is something that could be presented to the Data Advisory Committee as well.

One member commented that there are some high volume centers that will not review an offer until they've received a call, despite receiving an electronic notification, including being notified as primary or backup. The Chair remarked that it slows the system down when centers won't look at the donor in great detail until they have been made a primary offer. The Chair continued that part of the proposal was to have a secondary set of bypass filters so that that specific candidates would not receive the offer. The Chair continued that this is specifically for "hard to place" kidneys, not donors who are young and have perfect creatinine levels.

Presentation summary:

Concern: "The hard to place criteria are too general and will include kidneys that do not require expedited placement." "'Hypertension of more than 5 years and a [donation after circulatory death]… is too broad.'"

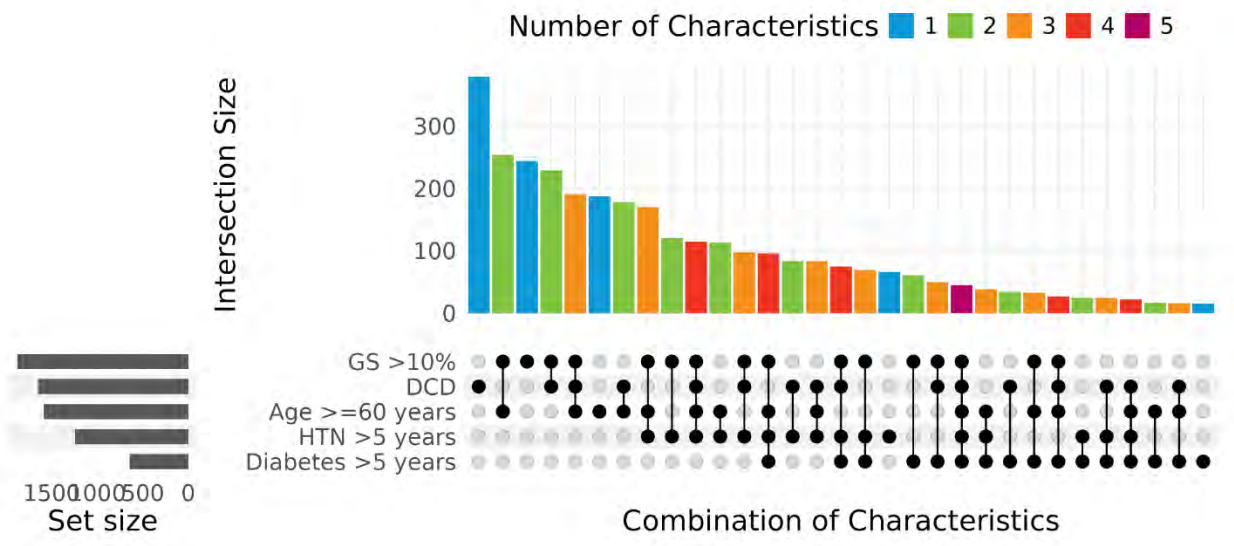
The Committee and Workgroup reviewed multiple data requests, and both groups discussed whether to require 2 or 3 criteria to be met for initiation. At the Committee's December meeting, "the Chair noted… that the characteristics identified by the Committee in combination offer a data driven definition that can be shared with the community for feedback."[2] In January, "the Workgroup recommended modifying

[2] Meeting Summary for December 16, 2024, OPTN Kidney Transplantation Committee

the definition to require the donor to meet two rather than three of the clinical criteria for use as initiation criteria. The Workgroup also recommended using a cold ischemic time threshold of six hours as initiation criteria."[3]

The Committee also reviewed **Figure 1**. The Chair noted that the Committee found it was broad when considering the different combinations.[4]

Figure 1: Combinations of "Hard to Place" Characteristics for Deceased Kidney Donors Recovered but Not Transplanted in 2023



In 2023, 1019 donors (7.2 percent) would have met criteria by both DCD and hypertension greater than 5 years. Non-use rates from these donors was 56.1 percent.

The Committee also reviewed additional data to determine whether to utilize two or three characteristics in combination to define an organ as "hard to place:"

- In 2023, 23.1 percent of donors had 2 or more clinical characteristics.
- In 2023, 8.3 percent of donors had 3 or more clinical characteristics
- The non-use rate increased as the number of clinical criteria met by the donors increased:
    - In 2023, the overall non-use rate was 27.9 percent
    - In 2023, among the donor population that met at least two criteria, the non-use rate was 63.9 percent
    - In 2023, among the donor population that met at least three criteria, the non-use rate was 78.8 percent
- 17.6 percent of transplanted kidneys had at least 6 hours of cold time prior to placement
    - 82.4 percent of transplanted kidneys were placed prior to 6 hours of cold ischemic time

The Chair noted that the Workgroup and Committee ultimately went with two criteria, in order to not be overly prescriptive.

[3] Meeting Summary for January 13, 2025, OPTN Kidney Expedited Placement Workgroup
[4] Meeting Summary for December 16, 2024, OPTN Kidney Transplantation Committee

The Workgroup evaluated data on the impact of initiation criteria on allocation out of sequence:[5]

- 32.69 percent of transplants in 2024 would have met the proposed expedited placement criteria
- 48.33 percent of transplants allocated out of sequence (AOOS) would have met criteria for expedited placement
    - Note: HRSA endorsed a new OPTN operational and analytical definition of AOOS as of June 6, 2025. Previous OPTN analyses may not reflect this new definition of AOOS.

The Committee requested and reviewed public comment feedback on the "hard to place" definition in development, and aimed to request additional feedback on the Expedited Placement Initiation Criteria in public comment.

Concern: "The proposal does not address challenges in the practical implementation of notifications that may cause a substantial burden or present significant inefficiencies for transplant centers." "Impact should be quantified, assessed, and mitigation strategies considered before moving the policy forward."

The Chair remarked that, considering managing offer volume, the Workgroup looked at an extensive literature review. This literature review found that "expedited placement pathways must ensure effective offering, such that offers are made to candidates who are more likely to accept them."[6] The Chair explained that expedited placement is trying to match donors to the candidates that would benefit from these offers.

In April, a member commented that "proposed expedited offer filters could reduce the number of offers transplant programs receive, improving efficiency" and that "using both standard and expedited placement filters will be most effective in improving efficiency."[7] In May, it was noted that "The Workgroup agreed that OPOs should send expedited offer notifications in limited rounds for simultaneous review by transplant programs."[8] The Workgroup further supported allowing programs to opt candidates in and out of receiving expedited placement offers, further supporting offer volume management.[9]

The Committee reviewed data on the impact of expedited placement offer filters:

- Expedited placement offer filters are expected to filter an additional 32.1 percent of offers, compared to 27 percent of offers filtered by standard offer filters alone
- With both expedited and standard offer filters in use, an expedited match run would be expected to have 59.1 percent of offers filtered
- Offer filters data demonstrated that expedited placement specific offer filters did not disproportionately bypass candidates based on candidate age, sensitization, race and ethnicity, or sex

Summary of discussion:

The Chair remarked that the Workgroup has discussed these stated concerns in relation to the expedited placement bypass filters proposed in this project. The Chair continued that DAC was presented an overview of the proposal and how it would work, but was not necessarily presented the proposal in full detail, and so the DAC comments are not based on the entire proposal. The Chair asked

[5] Meeting Summary for May 12, 2025, OPTN Kidney Expedited Placement Workgroup
[6] *Update on Kidney Continuous Distribution, Summer 2024,* OPTN Kidney Transplantation Committee, July 2024.
[7] Meeting Summary for April 21, 2025, OPTN Kidney Transplantation Committee
[8] Meeting Summary for May 12, 2025, OPTN Kidney Expedited Placement Workgroup
[9] Meeting Summary for May 15, 2025, OPTN Kidney Expedited Placement Workgroup

the Committee if there were any comments related to concerns raised about managing offer volumes, noting that smaller programs may need to more seriously consider how to manage expedited placement offers.

One member remarked that the expedited placement specific offer filters concept was generated when the Workgroup considered the most efficient way to make these offers, including how to determine which programs should receive these offers and giving programs the autonomy to determine whether they want to receive expedited offers. The member noted that this allows programs to opt in to expedited offers, rather than having OPOs allocate out of sequence utilizing a "hot list" of programs who typically accept these offers. The member continued, adding that this allows programs to decide their own capacity to receive and consider expedited placement offers.

The member addressed the comment regarding broadness of initiation criteria, noting that it was intentional to include 6 hours of cold ischemic time as an initiation criterion separate from the clinical criteria. The member explained that if the kidney is 6 hours cold and still being allocated, that organ is by definition hard to place regardless of the characteristics. The member continued that the cold ischemic time threshold was based on data, noting an inflection point at 6 hours at which there is a steep drop in the likelihood of placement. The member continued that cold ischemic time factored into the initiation criteria significantly because the data supported it. The member added that the Workgroup also considered how many clinical characteristics should be considered hard to place, and decided to utilize two characteristics, as the data shows that the non-use rate for those organs was almost 64 percent. The member noted disagreement with the statement that the criteria are too broad, noting that some broadness is intentional to account for anatomic damage or abnormalities that may make an organ difficult for most centers to accept. The member expressed hope that the Committee does not decide to revise criteria again, noting that this initiation criteria was developed with a lot of thought over several month.

The Chair remarked that the Workgroup and the Committee spent a lot of time reviewing and evaluating the data. The Chair noted that this was something the Committee wanted to ask about the initiation criteria in public comment. The Chair remarked that it is important for the Committee to address these comments in order to move the proposal forward for public comment, including discussing it with the Board and have HRSA review it.

Presentation summary:

Concern: "There is a lack of clarity regarding which patients may safely receive EPP kidneys, which raises concerns about centers' ability to apply EPP filters effectively." "HRSA believes that clarification on which patients would benefit from these hard-to-place kidneys is necessary to increase transparency, support healthcare providers, and prioritize patient outcomes."

The Workgroup and the Committee ultimately leaned towards supporting informed, shared decision making and clinical autonomy for care teams. In March of 2025, members of the Kidney Expedited Placement Workgroup "advised against creating a prescriptive candidate identification or consent policy within expedited placement, pointing to the variability of organ offers and existing guidelines and protocols transplant programs follow when consenting a patient for an organ offer."[10]

The Committee supported education requirements allowing patients to understand relative risks and thus their own risk tolerances. The proposal required programs to document and provide information to each kidney candidate regarding potential outcomes associated with accepting kidneys of varying KDPI,

[10] Meeting Summary for March 24, 2025, OPTN Kidney Expedited Placement Workgroup

compared to potential outcomes associated with extended time on dialysis or time waiting for transplant. In October, 2024, a member from the Kidney Committee noted that "patient education in understanding the risk-benefit ratio ahead of time would help the transplant center better understand a patient's transplant goals and interest in accepting a high KDPI kidney."[11]

The Workgroup supported candidate-specific opt-in/out, noting this allows programs to identify which candidates are appropriate and willing to accept these offers.

- "Programs generally have an idea of which candidates on their lists who may be an appropriate match for a kidney from a medically complex donor"[12]
- "Patient willingness plays a critical role"[13]
- "Many patients are not appropriate candidates for expedited placement offers, and it may be helpful to have a way to differentiate on the Waitlist"[14]
- "[candidate opt-in] would ensure expedited offers are made to patients who are appropriate matches"[15]

The Workgroup also sought feedback from the OPTN Patient Affairs Committee on the proposed education requirements; "the Chair supported the effort to standardize practices across transplant programs."[16]

Summary of discussion:

The Chair remarked that a lot of this is based on center experience, and that there is additionally literature to support candidate-organ matching. The Chair added that this point may require simple clarification. The Chair added that part of the removal of the KDPI consent was due to the limited nture of KDPI, and encouraging broader discussion with patients about the type of offers that they could receive. The Chair added that it may be necessary to clarify the clinical criteria, noting that an organ allocated out of sequence may result in a higher ranked, similarly appropriate candidate may be bypassed. The Chair continued that following the current allocation pattern and offering every organ to every candidate one by one, with the time required to do so, would limit the number of transplants that occur. When considering hard to place kidneys, the Chair asked the Committee how to develop a system in which the specific donor could be offered to candidates that are good matches for those donor organs.

One member remarked that going too far into detail to describe the precise kind of candidate to receive "hard to place" organs could be problematic. The member commented that by the time the organ is being offered with an open offer, then it should fall on the transplant program to ensure the kidney is given to an appropriate recipient. The member continued that trying to rabbit hole into specifics will create a lot of problems given the specifics of donor organs and of candidates. The member continued that it could become a hassle for programs to follow stringent guidelines. The member added that their program accepts a lot of open offers, and struggles to determine the best recipient for the organ. The member expressed support for not developing guidelines on which candidates should accept these organs, instead leaving it to the clinical discretion of the accepting center.

[11] Meeting Summary for October 8, 2024, OPTN Kidney Transplantation Committee
[12] Meeting Summary for August 5, 2024, OPTN Kidney Expedited Placement Workgroup.
[13] Meeting Summary for May 15, 2025, OPTN Kidney Expedited Placement Workgroup.
[14] *Ibid.*
[15] *Ibid.*
[16] Meeting Summary for April 15, 2025, OPTN Patient Affairs Committee.

The Chair agreed, noting there is no "magic formula" or specific set of characteristics; instead this is a lot of clinical decision making, which is informed by comfort level, training, experience. The Chair continued that there is a lot of literature that supports the clinical decisions made by the transplant community, and that is part of the point that needs to be clarified.

The Vice Chair remarked that the organ offer is being made to a patient, and not a transplant center, and so that degree of autonomy associated with an open offer is not necessarily part of the expedited placement process. The Vice Chair continued that the program will need to identify and input provisional yes responses for specific patients. The Vice Chair recounted a comment from HRSA, noting that the representative had shared an instance where an OPO was utilizing open offers significantly, and upon switching to in-sequence allocation, found that following the routine priority list allowed them to minimize organ non-use. The Vice Chair continued that the practice is going to be that OPOs stop making open offers and instead utilize a definitive and transparent expedited placement pathway. A HRSA representative confirmed that there was an OPO who utilized a lot of AOOS and early this spring shifted to compliance with the order of allocation and saw a decreased non-use rate. The Chair noted that the data has shown that as allocation has increased, the rate of non-use has increased, and that may not necessarily correlate but does demonstrate a trend.

The Chair remarked that allocation out of sequence inherently bypasses candidates that could potentially be transplanted, and that every candidate should have an opportunity to be matched. The Chair added that some of that is going to be clinical decision making based on the center that the candidate is listed at. The Chair added that the Committee is not necessarily saying there is one candidate that the organ offer should be made to, but that there are multiple candidates just like any match run, and the offer is made to all the candidates and the program determines acceptance down the sequence. The Chair continued that part of the way the expedited placement filters were to work was to bypass certain candidates from that original match run that programs did not think would benefit from receiving a "hard to place" kidney. The Chair emphasized the clinical and shared decision making with the candidates.

The Chair remarked that the Committee did receive feedback from the OPTN Patient Affairs Committee on the proposed education requirements, and noted that was an important piece of the policy proposal, to ensure patients understood the different types of offers rather than just the KDPI discussion.

Presentation summary:

Concern: "There is a significant risk that this proposal (and any expedited placement proposal) prioritizes maximizing transplants and minimizing non-use at the expense of medium and long-term patient outcomes." "DAC members emphasized the need to center longer-term patient outcomes as a measure of success instead of just non-use rates."

Summary of discussion:

The Chair remarked that the Committee is likely in agreement that the community needs to focus on longer term patient outcomes, but until the data is analyzed, there will not be an answer to this.

One member commented that bringing in outcomes to validate policies developed to decrease non-use rates is dramatically opposite. The member continued that this policy aims to encourage use of medically complex organs, but cannot in the same time ask programs to monitor and improve longer term patient outcomes. The member agreed that obviously, programs want to ensure long term patient outcomes, but that it is important to be careful with how high the bar is set. The member explained that requiring programs to have a certain percentage of one, three, or even five year outcomes could have a chilling effect on centers accepting expedited placement offers. The member continued that pushing

decreased non-use while maintaining great outcomes is tough, and there needs to be give somewhere. The member added that SRTR may need to give risk adjustment to higher KDPI kidneys, and potentially to organs accepted through expedited placement, to ensure programs are able to remain within regulatory bounds of outcomes. The member continued that this could be some buffer that centers can create to be able to accept these organs, because there is too much non-use. The member added that one reason for the proposal was to decrease non-use and get these kidneys to the centers willing to use them; but by the same token, you can't say continue to jump higher and higher to maintain outcome expectations. The member expressed support for this discussion, noting misalignment, particularly because accepting medically complex organs means there may be primary non-function and lower graft outcomes in the longer term. The member urged HRSA to speak with regulatory bodies who develop outcome measures to create carve outs for expedited placement organs. The member added that a lot of this is out of the purview of the OPTN Kidney Committee. The member continued that, if expedited placement is going to be a success and centers are going to opt in to transplant these organs, then there needs to be a carve out for these organs, and that has been done before. The member concluded that, in the immediate term, the recommendation to continue meeting long term outcome expectations is a blanket statement.

The Chair agreed, and noted that this gives the Committee an opportunity to have that discussion, noting that this is a whole separate topic outside of the Committee's scope. The Chair agreed there is a disconnect in looking at improving outcomes while increasing use of medically complex donors.

The Chair asked Committee members to share feedback, especially as they speak with OPO colleagues. The Chair continued that OPOs are oftentimes set by different metrics, and have different angles, just to understand the other side. The Chair requested that Committee members send additional comments by email.

Upcoming Meetings

- September 15, 2025

Attendance

- **Committee Members**
  - Jim Kim
  - Arpita Basu
  - Aparna Sharma
  - C.S. Krishnan
  - Christine Hwang
  - Curtis Warfield
  - Eloise Salmon
  - John Lunz
  - Kristen Adams
  - Patrick Gee
  - Prince Anand
  - Reza Saidi
  - Toni L. Bowling
- **HRSA Representatives**
  - Annie Tor
  - Ray Lynch
  - Sarah Laskey
- **SRTR Staff**
  - Bryn Thompson
  - Jon Miller
- **UNOS Staff**
  - Kayla Temple
  - Kaitlin Swanner
  - Asma Ali
  - Cole Fox
  - Houlder Hudgins
  - Sarah Booker
  - Thomas Dolan