OPTN Lung Transplantation Committee
Meeting Summary
November 13, 2025
Conference Call

Matthew Hartwig, MD, Chair
Dennis Lyu, MD, Vice Chair

Introduction

The OPTN Lung Transplantation Committee (the Committee) met via teleconference on 11/13/2025 to discuss the following agenda items:

1. Update: 11/7 OPTN Board of Directors Meeting
2. Discuss policy proposal and supporting evidence

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

1. Update: 11/7 OPTN Board of Directors Meeting

The Chair reported that the OPTN Board of Directors (BOD) was presented with a snapshot of the data reviewed by the Committee on 10/30/25 and the following proposed plan of action:

1. Continue using simulation modeling to identify a policy that reduces transplant programs at the top of the match as a surrogate marker of logistical complexity, while not increasing patient deaths on the waitlist
2. Because Allocation Out Of Sequence (AOOS) is multifactorial and multiorgan in nature, leverage the work of the AOOS Working Group for an OPTN-wide strategy to reduce non-compliant out of sequence allocation
3. Push forward the stalled implementation of previously approved Committee initiatives to reduce logistical complexity
4. Short-term PDSA of increasing placement efficiency points to decrease expected travel distance of organs

The BOD asked the Committee to submit a policy proposal for their consideration at the meeting scheduled for November 20, 2025.

Summary of discussion:

No decisions were made.

An attendee recommended omitting references to the AOOS working group and earlier committee initiatives from the action plan, noting that these elements are unlikely to contribute to a viable solution.

2. Discuss policy proposal and supporting evidence

The Committee examined the data and several alternatives before providing simulation recommendations.

Data summary:

Distribution of lung transplant programs within a given radius of donor hospitals

The Committee reviewed data showing the number and proportion of lung transplant programs located within increasing nautical mile (NM) distances between donor and transplant hospitals increases. On median, over 60% of lung transplant programs are located within 1,000 NM of the donor hospital.

Simulation analysis: Impact of changing efficiency weight on unique transplant programs at the top of the match

The Committee reviewed simulation analysis of how adjusting efficiency weights affected the number of unique transplant centers among the top 10, 25, and 50 Potential Transplant Recipients (PTRs) in the match run. Results showed a modest decrease in the metric as the weight increased. The Committee reviewed a figure simulating several policies, showing that as weight on efficiency increases, median travel distance decreases, with transplants averaging 100 NM closer from donor to recipient. Another figure showed that higher efficiency weights in policies could lead to increased waitlist mortality.

Summary of discussion:

> Decision #1: The Committee requested additional simulation analysis, prioritizing assessment of alternate efficiency rating scale #1 at various placement efficiency weights between 10-20%.

During the discussion on the distribution of lung transplant programs within a given radius of donor hospitals, the Chair noted the most recent data from the Scientific Registry of Transplant Recipients (SRTR) Explorer showed that the median distance traveled in 500 NM, with a mean travel distance of 600 - 650 NM. They continued that the analysis presented to the Committee today showed that reducing the distance between the door hospital and transplant hospital from 500 to 400 NM could result in the reduction of the number centers on the match, therefore decreasing the logistical complexity. The Immediate Past Chair asked if these data were broken out by donation after brain death (DBD) and donation after circulatory death (DCD) donors, noting that these two distinct donor types may need different rating scales. OPTN Contractor staff replied that they could obtain this data and follow up.

During the discussion on simulation analysis regarding the impact of changing efficiency weight on unique transplant programs at the top of the match, the Chair clarified that the proposed increase in efficiency points was achieved by proportionally reallocating points from other attributes. The rating scales themselves remained constant throughout this analysis.

When discussing the third figure, which indicated that policies with more weight on placement efficiency might increase waitlist mortality, the Chair restated the Committee's position from earlier meetings that they would not endorse any policy that raised waitlist mortality among lung candidates.

An attendee suggested reallocating points from the post-transplant outcomes score to efficiency, noting this would likely not affect pre-transplant mortality. A representative from HRSA explained that the purpose of this policy change is to ensure compliance with the National Organ Transplantation Act (NOTA). Once the policy is compliant, continuous distribution will enable timely adjustments to address emerging areas of increased need. An attendee noted that substantially increasing the weight assigned to the efficiency attribute would only raise waitlist mortality per 100 years by two per 100 listing years. A Committee member questioned whether it was feasible to model if any proposed changes would lead to higher compliance, noting that previous data indicates certain members of the transplant community are more regularly involved in AOOS. In response, an attendee explained that modeling non-compliance is not viable because it involves unpredictable human behavior. The Committee member then suggested that, rather than revising the policy, the OPTN might be better off prioritizing enforcement of the

existing policy from a compliance standpoint. The attendee suggested that increased involvement from the Membership and Professional Standard Committee (MPSC) regarding AOOS may be a viable strategy. Additionally, a representative from HRSA noted that the Committee is examining temporal and spatial factors associated with non-compliance, as compliance rates declined following the implementation of continuous distribution. They continued that this trend indicates a need to develop a new policy that facilitates improved member compliance.

One Committee member noted that recent meetings had included talk about a decrease in lung AOOS and asked if related data could be reviewed. A representative from HRSA indicated that the data was currently undergoing validation, and OPTN Contractor staff confirmed that their records showed a decrease in lung AOOS for September.

The Committee reviewed the existing placement efficiency rating scales and discussed options for considering changes to the rating scales as well as the attribute weights. While reviewing a slide that compared the Composite Allocation Score (CAS) based on medical urgency and efficiency, one member expressed concern that patients nearing hospitalization and at high risk of deterioration might be placed at a disadvantage. An attendee inquired whether there was data available showing how pre-transplant mortality was distributed across the population at any given time. OPTN Contractor staff did not have this data, but referenced the Lung Continuous Distribution Two-Year Monitoring Report, noting that more urgent candidates typically travel longer distances. An attendee commented that this is logical, as sicker patients should be prioritized and placed higher on the list; thus, out-of-sequence allocations for them may be less common, though other factors can influence results. The Chair added that the system generally works as designed, as critically ill patients receive offers from a wider area, while lungs travel shorter distances for recipients whose conditions are less severe.

The Committee discussed potential options to simulate:

- Efficiency rating scale
    - #1 (drop to 50% of the efficiency points between 400 NM and 1,000 NM)
    - #2 (drop to 25% of the efficiency points between 400 NM and 1,000 NM)
    - #3 (extended drive zone to 100 NM with drop to 25% if the efficiency points between 400 – 1,000 NM)
- Medical urgency rating scale
    - Current rating scale (base 25 nonlinear curve)
    - Shallower rating scale (base 10 nonlinear curve)
    - Linear rating scale (straight line)
- Vary placement efficiency weights between 10-20%

The Immediate Past Chair explained that their large, centrally located center flies for nearly all lung procurements because opportunities for local donors are limited. They continued that it is important to consider the potential effects of modifying the rating scale on remote centers, as centers in rural locations will likely require frequent air travel.

The Vice Chair noted that the Committee has seen how powerful rating scale changes can be, since the 2023 blood type change altered the blood type rating scale but not the overall attribute weights. The Vice Chair summarized that the Committee could adjust not only the efficiency weight but also the curves. For example, currently every potential transplant recipient within 1000 NM receives about 70% of the points, but an alternate rating scale could concentrate those points within the first 400 NM, making the efficiency score much more focused, while scores for those farther away decrease significantly. The Vice Chair expressed concern that rating scale changes could shift the allocation

system back towards the previous circle-based model by further increasing the proportion of efficiency points in the overall score.

One member expressed interest in viewing simulations for efficiency rating scale option 1, suggesting it would minimize impact on rural programs while still reducing the number of programs appearing at the top of the match run. A HRSA representative noted that while pursuing a compliant policy could impact projected waitlist mortality, the Committee could also consider adjusting the medical urgency rating scale or scheduling a rapid reassessment within the first two months after the policy is implemented, as a way of balancing that impact. A member inquired whether it is possible to make projections regarding the impact of these changes on rural or remote programs, for example, based on factors such as population density. Researchers performing the simulation analysis explained that they track every transplant in the simulation along with its corresponding center, but do not have transplant centers labeled as urban or rural. Adding this feature would require time to define each center's classification.

The Chair summarized the Committee's request for further simulation analysis of the three alternate efficiency rating scales, prioritizing efficiency rating scale #1 at various placement efficiency weight between 10-20%. The analysis will use the current medical urgency rating scale and will not include simulations of alternate medical urgency rating scales due to the short timeframe for analysis.

Next steps:

The Committee will reconvene on Monday, November 17, 5-6pm ET to review the analysis and work towards finalizing a policy that can be submitted to the BOD ahead of their November 20th meeting.

Upcoming Meetings

- November 17, 2025, 5-6pm ET
- December 11, 2025, 5-6pm ET

Attendance

- **Committee Members**
  - Matthew Hartwig
  - Marie Budev
  - Dennis Lyu
  - Ernesta Melicoff-Portillo
  - Jody Kieler
  - Joseph Tusa
  - David Erasmus
  - Wayne Tsuang
  - Siddartha Kapnadak
  - Heather Strah
  - Jordan Hoffman
  - Brian Keller
- **HRSA Representatives**
  - Raymond Lynch
  - Sarah Laskey
- **SRTR Staff**
  - Maryam Valapour
  - Katie Siegert
- **UNOS Staff**
  - Kaitlin Swanner
  - Keighly Bradbrook
  - Susan Tlusty
  - Kelley Poff
  - Rebecca Murdock
- **Other Attendees**
  - John Magee
  - Doug Fesler
  - Peter Nicastro
  - Thomas Athey
  - Shelley Hall
  - Justin Wilkerson
  - Elijah Pivo