OPTN ORGAN PROCUREMENT AND TRANSPLANTATION NETWORK

Meeting Summary

OPTN Membership and Professional Standards Committee (MPSC)
Meeting Summary
February 16-17, 2023
Chicago, Illinois

Zoe Stewart Lewis, M.D., Chair
Scott Lindberg, M.D., Vice Chair

Introduction

The Membership and Professional Standards Committee (MPSC) met in-person in Chicago, Illinois, and via Citrix GoToTraining in both open and closed session on February 16-17, 2023. The following agenda items were discussed during open session of the meeting:

1. Public Comment Presentation: Optimizing Usage of Offer Filters
2. Public Comment Presentation: Establish Member System Access, Security Framework, and Incident Management and Reporting Requirements
3. Public Comment Presentation: Require Confirmatory HLA Typing for Deceased Donors
4. Public Comment Presentation: Continuous Distribution of Kidneys and Pancreata Committee Update
5. OPO Performance Monitoring Project
6. Offer Acceptance Collaborative Update
7. Performance Monitoring Enhancement (PME) Project Update
8. Project to Refine Safety Event Reporting Requirements
9. Educational Initiatives

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

1. Public Comment Presentation: Optimizing Usage of Offer Filters

The OPTN Operations and Safety Committee Vice Chair presented their public comment proposal *Optimizing Usage of Offer Filters* and asked for the MPSC's feedback. This proposal would implement default offer filters, where model-identified filters will automatically be enabled by default instead of kidney programs voluntarily opting-in to enable them. The goal of this proposal is to have offer filters increase the number of transplants by getting organs accepted faster by increasing efficiency in the system.

The Committee was asked the following questions:

- What other educational considerations would be helpful for patients to understand processes related to offer filters?
- Is three months a sufficient re-evaluation period of the offer filters? If not, what timeframe would be most appropriate?
- Are there other automatic exclusions not mentioned that should be considered? Are there additional filter options not mentioned that should be considered?

Summary of discussion:

Members voiced support for the proposal and see it as a natural progression of the MPSC's offer acceptance metric and an opportunity to ensure the optimization of transplantable organs. Members felt this proposal was the first step to eventually mandating offer filters, noting that mandating offer filters now would likely receive pushback from the community. If the offer filters do eventually become mandatory, it is recommended to develop some type of transition period when new personnel joins the transplant program to allow for changes in acceptance practices. A member recommended reviewing the quantity of HIV transplants for potential future inclusion in the offer filters system as the number of these transplants increases.

The MPSC identified educating transplant programs as essential for the successful implementation and utilization of offer filters by the community. Members felt that transplant centers would be more inclined to use the offer filters if they correctly understood the intent of the filters and dispel the assumption that filters would cause transplant programs to miss offers that they may accept.

Members felt this proposal would increase efficiency for both OPOs and transplant programs and reduce the number of offers for organs that the transplant program would never accept while getting harder to place organs to hospitals that will use them more expeditiously. This would also reduce the burden on the MPSC to evaluate instances of OPOs offering organs out of sequence in an attempt to match hard-to-place organs. Alternatively, the filters would allow OPOs to identify hospitals in the match run sequence that will accept and transplant the organ, thus leading to a reduction in discards.

A member recommended developing a report where programs can review the organ offers that were within their filtered criteria but were not accepted and the offers that were filtered off and never seen. Members suggested that this review could allow transplant programs to analyze their acceptance practice every 3-6 months. Having access to this data could allow transplant programs to have a better understanding of their organ acceptance behavior and potentially modify their filter criteria. This data could also serve to develop trust in the offer filters system by showing transplant programs how their offers have shifted since its implementation. However, it would be beneficial to have an offer filter system that learned from hospital practice so that if a program were more aggressive the filters would learn and adjust to this behavior, as opposed to manually modifying the filters on a regular basis.

A member expressed concern that offer filters could negatively impact programs by restricting access to organ offers. The member suggested providing assistance to hospitals with low utilization rates to consider ways to increase utilization, without placing any restrictions on aggressive, high-utilizing programs. Another member wondered if the filters could be used so stringently that only the best offers were received and all were accepted giving the center a misleadingly high offer acceptance rate. Others clarified that the MPSC metrics indicate the offer acceptance ratio which evaluates the offers accepted versus the offers that were expected to be accepted.

Members recommended connecting offer filters to the new MPSC offer acceptance tool so that the MPSC could interpret the metrics with the context of the filters. This could also allow the MPSC to provide guidance to utilize the filters to improve their offer acceptance ratio. Additionally, connecting the two may incentivize transplant programs to use the offer filters more as they see the benefit to their offer acceptance ratio.

2. Public Comment Presentation: Establish Member System Access, Security Framework, and Incident Management and Reporting Requirements

The OPTN Network Operations Oversight Committee (NOOC) Chair presented their public comment proposal and asked for the MPSC's feedback. The NOOC Chair provided a description of the project's

background regarding the increase in healthcare malware and ransomware and the need for increased IT security. The proposal outlines that:

- Security frameworks vary by member
- Individuals are bound by System Terms of Use, but OPTN Member organizations are not
- Updated security is part of the OPTN contract requirements
- The purpose of the proposal is to strengthen the protection of candidate, recipient, and donor data by reducing risk of member security incidents and establishing expectations for member responses in the event of a breach to OPTN computer system or data

Summary of discussion:

A member explained that the MPSC is already seeing increased workload and currently does not have any subject matter experts to review these types of non-compliances, so finding a proper balance would be difficult. They added that if members decline to adhere to these proposed changes there are no adequate intermediaries to deal with them via the MPSC.

Another member added that their initial reaction was that this was not necessary, but after more thought and exposure to the proposal, thought it was a good idea. They wondered if there was a way for members to be exempt from the routine audits if the member consistently exceeds the requirements. The presenter added that having that initial reaction is not unusual, but much of the feedback during public comment has been positive and to the point of being exempt from the audit, the requirements change constantly so the attestation and frameworks would need to be updated accordingly. The presenter acknowledged that there will be a need to find a balance between administrative burden and appropriateness of the requirements.

A member asked if there is a sense of how many members will have issues meeting requirements with their current security system. The presenter noted that honestly the NOOC is not sure of the baseline security frameworks in the community, so the proposed initial readiness phase is critical for this proposal. They added that there may be some beneficial anonymity for smaller programs versus larger members regarding the amount of security threats.

Another member brought up that having an OPTN specific Information Security Contact is part of the proposed requirements, but those individuals may not be familiar with OPTN requirements. They asked what training or expectations would be required for these individuals. The presenter explained that the member would be responsible for deciding who the best individuals for this role would be and that it is necessary to have this contact in the event of a security breach. The member asked if these individuals would be responsible for communicating directly with the OPTN Contractor and the presenter confirmed they would be part of the communication process during a security breach. UNOS staff added that the hope is that the OPTN Contractor becomes part of the incidence response plan with this proposal because currently they are contacted much later than they should be.

A member mentioned that the discussion on this proposal during an OPTN Regional Meeting was not received positively since it seemed like an overreach and asked if all Organ Procurement Organizations (OPOs) would be held to the same requirements. The presenter clarified that the proposed requirements would apply to all OPTN members (Transplant Hospitals, OPOs, and Histocompatibility Laboratories) and that in most cases when someone is accessing a system there are requirements in place to ensure security no matter where they are accessing it from. The presenter added that the level of access to the OPTN Computer System is different for various users based on pulling data versus pushing data which has a higher level of vulnerability (pushing out data versus only looking at it).

A member noted hospital based IT staff have already pushed against the use of patient Social Security Numbers for the current verification process in the OPTN Computer System and this may give them another opportunity to advocate against the use of this patient identifying information.

A member struggled with how the MPSC would be pulled into member compliance scenarios if there are not clear policies guiding them. The presenter noted that this is an important question and so is feedback from the MPSC. They added that a process for compliance that is evaluated by the NOOC or referred to the MPSC still needs to be developed and time needs to be spent parsing out the framework of this project, which is one of the major challenges. The member also added an unintended consequence may happen with smaller histocompatibility labs who refuse to participate due to size and resources so those issues would need to be considered and resolved. They also mentioned that Veteran's Affairs affiliated programs may also face challenges with these requirements. The presenter agreed that these are great points noting that there should not be an expectation of consistency across member type and size, but this proposal is trying to mitigate risk by requiring a consistent framework.

Another member mentioned that if there is a final plan with requirements in place, surveys for all member institutions would be imperative, but would be a huge lift across member types. The presenter agreed and added that some systems may be easier than others to change/meet requirements, but some of the smaller members will face challenges as some of these requirements may be brand new to them. The presenter explained that this proposal is not trying to make a MPSC violation issue, but to be more collaborative and impactful without being too expensive.

Next Steps/Follow-up:

Consider impacts to patient safety and a member's ability to comply with OPTN policy if they lose access to the OPTN Computer System during a security event.

3. Public Comment Presentation: Require Confirmatory HLA Typing for Deceased Donors

The Chair of the OPTN Histocompatibility Committee presented their public comment proposal *Require Confirmatory HLA Typing for Deceased Donors* and asked for the MPSC's feedback. The proposal requires labs to perform two HLA typings from deceased donors. The two tests must be performed from two separate samples that were drawn at two different times. The goal of this proposal is to lower the occurrences of the rare instances where HLA test results are incorrect due to assay or laboratory error and the recipient and organ are not compatible.

The MPSC was asked the following questions:

- Consider any MPSC experience you have evaluating the existing relevant policies. What feedback do you have about implementing this proposal in the future?
- Consider any clarification and direction that may be needed for members to resolve discrepant typings. Is it clear what policy needs to be followed to resolve discrepancies?

Summary of discussion:

The MPSC thanks the Histocompatibility Committee for the opportunity to review and comment on the Require Human Leukocyte Antigen (HLA) Confirmatory Typing for Deceased Donors proposal. Members inquired about the outcomes for the 3% of cases with errors, but unfortunately, the data is limited to knowing the errors have occurred and not knowing the consequences. The presenter noted that, currently, discrepancies are taken care of within the labs and do not get reported, which likely leads to an underreporting of these instances. The goal of the policy is to reduce typing errors that occur within the lab to avoid challenges post-transplant.

Members expressed concern about the cost-benefit ratio associated with implementing this policy. Members identified small labs as being particularly disadvantaged by the cost of double testing, while also noting that the benefit of this would be minimal. Members considered that the increase in workload could result in additional errors, delays in transplant, and a potential increase in discards. Members commented that sending both results to the OPO would lead to complications and delays as they are not the experts in interpreting the results, therefore the lab should only send a single final test. Overall, members did not feel confident that duplicative testing would resolve the issues intended by the proposal.

4. Public Comment Presentation: Continuous Distribution of Kidneys and Pancreata Committee Update

The OPTN Kidney Transplantation Committee Vice Chair and UNOS Staff presented the public comment project update for the *Continuous Distribution of Kidneys and Pancreata* asking for the MPSC's feedback. The update included a timeline of where the project is and what has been accomplished so far, including the first round of Scientific Registry of Transplant Recipients (SRTR) Organ Allocation Simulator (OASIM) modeling results which are currently being reviewed by the Kidney and Pancreas Transplantation Committees. The project is also incorporating mathematical optimization provided by Massachusetts Institute of Technology (MIT) to help inform the Committees as they select the weight of each attribute as part of acceptable policy proposal options. The Kidney and Pancreas Committees also have formed Workgroups to consider allocation and continuous distribution components that fall outside the composite allocation score (CAS) including workgroups for establishing review boards, evaluating pancreas medical urgency, and utilization considerations.

UNOS Staff presented the goals of the OPTN Utilization Considerations Workgroup. The Workgroup aims to transition several operational and utilization aspects of kidney allocation to a continuous distribution framework including released organs, facilitated pancreas, dual kidney, and kidney minimum acceptance criteria screening and national offers. This Workgroup also plans to leverage other efficiency efforts, such as the use of predictive analytics, offer filters, the Kidney Minimum Acceptance Criteria (KiMAC), overall minimum acceptance criteria, and proximity efficiency attributes as part of the CAS.

The presentation covered next steps for the project explaining that the Committees and Workgroups will continue working on developing the framework, submit the second round of SRTR OASIM modeling based on the results from the first round, and will continue to update the community on the progress of the project.

Summary of discussion:

A member raised concerns about placement efficiency in the models explaining that Region 6 only has a quarter of the perceived circle because much of it lies in Canada and the ocean also noting issues with circles and population density, which occurs for other regions as well. The member added that they would like for the Kidney Committee to consider circles or proximity based on population density. Another concern the member mentioned was around organ utilization citing logistics for getting an organ from places like Montana to California may lead to increased organ non-utilization. The presenter explained that the results seem to counterbalance each other, but these points are important to consider. The member reiterated that circles based on fixed distances should be reconsidered and the presenter explained that fixed distance is really a way to try and control cold ischemia time, but travel and the ability to get on a flight may affect that. The presenter added that the Committees will continue to evaluate the models.

Another member added that Region 1 encounters the same issues with the circles and also supported the need to rethink if circles are the right approach, especially when considering the corners of the

country since it may really disadvantage some patients. The member continued with support for a uniform system throughout the entire U.S. that is compatible with OPOs who function very differently. The member explained that there has to be an understanding of when things are not working as an equitable system and how it may be changed to be more equitable. The presenter explained that other attributes (aside from placement efficiency) and the weighting of those in the CAS move away from those hard boundaries. The presenter added that the first iteration of continuous distribution for kidneys and pancreata will not fix everything, but will give the community a framework to build upon which is why community feedback is important.

A member mentioned that they hope that the second iteration will take MIT's mathematical optimizations into consideration and from the MPSC's standpoint, they want to reduce the number of allocations out of sequence. They noted that we cannot predict acceptance behavior, but wondered if continuous distribution will help with out of sequence allocations if the proximity related attributes are not weighted correctly. Another member added that there needs to be allocation out of sequence allocation and expedited placement considerations because those offers are being placed with a small percent of programs. They acknowledged that this is a small percent of all offers being placed with a small percent of programs, so predicting that behavior would be difficult, but advocated for giving OPOs more freedom to place organs so they are transplanted.

A member noted that in addition to distance, time of day has a huge impact, explaining that organs sit in a box overnight because baggage handling is closed at the airport. They added that hearts, lungs, and livers are mainly flying via chartered flights, but that is not the case for kidneys, which is why distance cannot be considered the same way.

Another member felt that the project so far is not working in favor of hard to place kidneys and explained that in their Region, the ability to get kidneys to a hub in order to distribute them is difficult, which adds more cold ischemic time to these already hard to place kidneys so distance considerations will definitely have an impact.

A member added that in general, a majority of kidney transplant programs will not change the number of transplants they are performing, but there will be a chance the types of organs they are accepting does change. The member cited New York is an example, and they may stop taking hard to place kidneys since they are now receiving better quality offers. The presenter explained that the goal of continuous distribution is to remove the hard boundaries that are in place and find out how factors should be weighted when moving to this better process of allocation and that some of the concerns being raised about travel and time of allocation efficiency are more systems issues. They continued by saying that if we can efficiently allocate organs to hospitals that will use them, we can reduce overall non-utilization and that predictive analytics will be very difficult initially, but hopes the new framework will help the community move toward that.

Another member noted that if performance outcomes with very different program behavior from before continuous distribution implementation and after are looked at, how would the MPSC interpret that data to know that programs are being appropriately flagged even though their practices may have changed. SRTR Staff explained that if there is a policy change during a cohort period, the expected model should capture how behaviors are changing across the country and would take that into consideration, so it can be done.

<u>Next Steps/Follow-up:</u>

Provide additional feedback to the OPTN Kidney Transplantation and Pancreas Transplantation Committees regarding the need to address expedited placement of kidneys as well as the rise of

allocations out of sequence. The MPSC concluded that identifying specific criteria for kidneys that would benefit expedited placement and a specific expedited allocation algorithm for OPOs to follow would be of tremendous benefit to the community to have a uniform practice pattern.

5. OPO Performance Monitoring Project

During its October meeting, the Committee decided to pursue a project to evaluate current OPO performance monitoring. Staff presented information to support the Committee's consideration of the goal and scope of this project. Information was provided on the shared oversight of OPOs by Centers for Medicare and Medicaid Services (CMS) and the OPTN, OPTN authority with regard to OPOs under the OPTN Final Rule and the OPTN contract, and relevant references to OPO performance monitoring in the 2021 - 2024 OPTN Strategic Plan. Staff also described the recommendations made by the OPTN Ad Hoc Systems Performance Committee in its June 2019 report to the OPTN Board of Directors, and current OPTN OPO performance monitoring, which evaluates OPO performance based only on organ yield for donors with at least one organ transplanted. In addition, staff noted that OPTN allocation monitoring arguably also evaluates OPO performance. Staff noted that the Committee had delayed evaluating revisions to its OPO performance monitoring while CMS was developing its new OPO outcomes measures. CMS has now finalized two outcome measures, donation rate and transplant rate, which became effective August 1, 2022. Staff reviewed the principles the Committee had used to evaluate potential metrics for transplant programs while developing the Enhance Transplant Program Performance Monitoring proposal approved by the OPTN Board of Directors in December 2021. Staff proposed the following questions to spur consideration and discussion of the project goal and scope:

- Should the same principles the MPSC used to select transplant program performance metrics be used for the OPO performance monitoring/metric project?
- Should new metrics be developed that align with the MPSC principles used for determining the transplant program metrics or should the focus be on providing support to OPOs to meet CMS performance outcomes measures?
- Should OPO performance monitoring be focused on the allocation phase, including considerations related to allocation monitoring?

Ultimately the Committee must weigh the benefit that might be gained from making changes to an existing metric or creating a new metric that better suits the performance monitoring needs of the OPTN versus the increased burden on members presented by lack of metric alignment between oversight organizations.

The Director of the Scientific Registry of Transplant Recipients (SRTR) presented an overview of the OPO performance monitoring landscape. The Director illustrated the role of the OPO in the transplant system using a chart developed for the SRTR consensus conference that maps out each participant in the system and the interactions of those participants. There is a line specifically for OPOs that includes "stops" for potential donor, authorization to donate, organ offered to center, organ recovered and splits to either organ not used or family after care. He described the process points for OPOs including in-hospital deaths, potential donors, authorizations, organ recovery, and transplants, noting the two broad metric points, which are potential donor to donor conversion which connects potential donor to organ recovery; and donor to transplant conversion, which connects organ recovery to transplant. The second of these is the current MPSC focus in its OPO performance monitoring. The Director used a circle diagram to further describe the OPO process including rings from total population, total deaths, potential donors, authorized potential donors, donors and transplants. He also used a diagram of system metrics and program/OPO metrics produced for use by the Committee during the Transplant Program

Performance Monitoring Enhancement project to highlight potential metrics for review of OPO performance, noting that the deceased donor yield metric currently used by the MPSC and a death to donor conversion metric. The deceased donor yield metric is included as a system performance metric and the death to donor conversion metric is an OPO performance metric that is under the control of the OPO. The Director explained that the deceased donor yield metric is included as a system metric because he believes that the deceased donor yield metric is influenced by programs' waitlist management and offer acceptance practices in addition to death to donor conversion. He also notes that allocation policy which is not under the control of the OPO affects the deceased donor yield metric. He noted there is a lot that contributes to the deceased donor yield that is not under the control of the OPO, thereby making it a systems metric rather than an OPO metric. He posits that the fact that it is a systems metric does not mean that it is an invalid metric but if one is trying to isolate the performance of the OPO, it is his opinion that focus should be on the metrics that are within the control of the OPO.

Using a diagram of system and program/OPO performance metrics, he described the current focus of the OPTN and CMS. The OPTN focuses on transplants per donor with its deceased donor yield metric, while CMS focuses on the death to donor conversion through its metrics measuring donors and transplants per potential donor. The Director thinks CMS has the right target for OPO performance but the metrics developed missed the mark in some ways and could be improved upon. The OPTN definition of a "donor" is a donor for which at least one organ was procured for transplant, while CMS defines a donor as a donor for which at least one organ was transplanted. By using this definition of a donor, he believes that the CMS metrics are a system metric since it requires a program to transplant the organ. The CMS definition also includes pancreata that are placed for research.

The Director described the CMS metrics. The CMS donation rate measures donors per potential donor. The CMS transplant rate measures the transplants per potential donor. The potential donor denominator for both metrics is defined as the number of inpatient deaths within the DSA among patients 75 and younger with a primary cause of death that is consistent with organ donation. Death that is consistent with organ donation means all deaths from the state death certificates contained in the CDC death certificate data with a primary cause of death listed as certain International Classification of Diseases, tenth revision (ICD-10-CM) codes for ischemic heart disease, cerebrovascular disease and external causes of death. For the donation rate, a donor is a deceased individual from whom at least one vascularized organ is transplanted and also includes deceased individuals from whom a pancreas is procured and used for research or islet cell transplantation. The Centers for Disease Control and Prevention (CDC) data does not include information as to whether a patient was ever ventilated during the hospital stay. The donation rate has no risk adjustment. Each OPO is placed in one of three tiers for each of the measures. Tier 1 includes OPOs that are not significantly below the 75th percentile of the rates from the prior year. Tier 2 is not significantly below the median rate from the prior year. Tier 3 is significantly below the median rate form the prior year. The Director provided information on which OPOs fall within the three tiers for the donation rate in the most recent 2020 data released by CMS, 30 OPOs fall within the first tier, 14 are in tier 2, and 14 are in tier 3. For the transplant rate, the numerator is the number of organs transplanted from donors in the DSA including organs transplanted into patients on the OPTN waiting list as part of research. The transplant rate is risk adjusted for age. In the most recent released transplant rate data for 2020, there are 22 OPOs in tier 1, 14 in tier 2, and 22 in tier 3 for the transplant rate. CMS uses the lower of the donation rate or transplant rate as the final tier for recertification purposes at the 4-year recertification cycle. Tier 1 OPOs would be recertified. Tier 2 OPOs would have an opportunity to compete for the DSA. Tier 3 OPOs would be decertified. In the 2020 CMS data, 20 OPOs are in tier 1, 16 are in tier 2, and 22 are in tier 3.

The Director then went through what data the OPTN has available in its current data capture, noting other sources of data not within the OPTN dataset. Total deaths and in-hospital deaths are not collected by the OPTN but are available from the CDC. Referrals are available in the OPTN dataset aggregated monthly. Referrals are aggregated so the OPTN does not have data on individual referrals. Potential donors is not collected. Finally, imminent and eligible deaths with information about the individual patients is captured, and authorizations are only captured for imminent and eligible deaths.

The Director reviewed what the SRTR reports currently, eligible death donation rate and deceased donor organ yield. The eligible donation rate measures the number of donors meeting the eligible death criteria out of the eligible deaths reported by OPOs to the OPTN. The eligible death definition excludes all potential donation after circulatory death (DCD) donors. The SRTR Review Committee recently voted to remove the eligible death donation rates from the SRTR reports. The deceased donor organ yield measures the organs transplanted from donors based on the OPTN definitions, which is a donor with at least one organ recovered for transplant.

The Director opined that an OPO metric should focus on the portion of the process that is most under the control of the OPO, which is converting potential donors to actual donors, noting that he believes we could improve on the definitions of "potential donor" and "donor." He suggested that the steps to develop a metric should proceed in the following order: pursue the best denominator by determining what is a potential donor, pursue the best numerator by determining what is success, pursue the best metric by determining how we compare OPOs, and finally, determining how we define OPOs that are "failing." The flagging rule should be discussed separately from what is the best metric to evaluate OPO performance.

The Director noted that the SRTR conducted a pilot in Region 8 in 2018 and 2019 in collaboration with the Association of Organ Procurement Organizations (AOPO). For that pilot, the group developed a definition of potential donor to include in-hospital deaths in patients under the age of 76 that were ventilated during the terminal hospitalization and that do not have absolute contraindications to transplant, noting contraindications could be defined further. He noted that OPOs capture in their systems whether a patient was ventilated, but if an administrative data source was used, there are ICD-10 Diagnosis Codes, CPT Codes, and ICD-10-PCS Codes that could be used to identify or verify ventilated deaths. He also suggested it is important to develop a standardized capture of cause of death. He provided a list of causes of death and an example of guidance that could be provided for the cause of death categorization which was used in the Region 8 pilot. For the measurement of success, the Director noted several options that include use of "donor" consistent with the OPTN definition, an authorized potential donor, any authorized potential donor where there was a match run generated or any authorized potential donor where at least one organ offer was made. The current CMS donor definition is an authorized potential donor where at least 1 organ transplanted or a pancreas submitted for research. The current OPTN donor definition is an authorized potential donor where at least 1 organ was procured for the purpose of transplant. The Director provided data for two OPOs that demonstrated the difference in the number of donors under the CMS definition and the OPTN definition. Under the OPTN definition of a donor, 6.5% and 7.5% more donors at the example OPOs were counted.

The Director reviewed a flow diagram created as part of the Region 8 pilot that documents the death to donation process that could be used to provide more standardization in the OPO electronic medical records. He noted that for each step, reasons were provided for each "no" in the flow diagram. The Director reviewed a draft data capture form for in-hospital death notification that was created using the flow diagram.

Finally, the Director provided an overview of construction of a metric including risk adjustment for things that vary across OPOs, are associated with the likelihood of being a donor, and are not "caused" by the OPO. He provided examples of age, sex, cause/mechanism/circumstances of death, hospital unit and three characteristics that are more controversial, which include race/ethnicity, social determinants of health based on place of residence, and comorbidities. He provided data collected during the Region 8 pilot on various potential adjusters. The Director then provided his thoughts and opinions on flagging rules including that the flagging rules should be considered separately from the metric itself, should be constructed to meet the goal of the regulatory body, and should compare OPOs to each other in the current evaluation period rather than a historic standard as the CMS metrics do.

The Director's concluding thoughts include that metrics that best isolate the role of the OPO should be targeted and to arrive at the best metric of OPO performance, agreement is needed on:

- Denominator: what is a potential donor?
- Numerator: what is success? Is it an authorized potential donor, a donor for which a match run was created, a donor or a transplant?
- Metric: what should or can we risk adjust for?

Summary of discussion:
One Committee member noted given how flawed the CMS outcome measures are, OPOs are still being evaluated on those measures so should an MPSC metric align with CMS to avoid adding complexity for OPOs. The Director responded that, in his opinion, given the shortcomings in CMS metrics based on the data it has available to them, if the Committee believes that it could develop a better metric, we should explore that option. It has become increasingly important for the OPTN and the SRTR to describe how our system is doing and have that oversight. Noting that we could potentially tell the story of how our system is functioning in a better way.

Another Committee member agreed with the Director's assessment of the denominator but asked how one balances the utilization part of the metric with the efficiency of the system. Efficiency can sometimes go unchecked, so when does maximizing utilization affect efficiency resulting in the non-utilization of an organ because of cold ischemia time. The Director restated the question noting that the more OPOs are pushing boundaries to get more and more donors, the more it is flooding the offer system, which may be potentially causing inefficiencies in the system resulting in organs not being used. As noted in the Kidney/Pancreas (KP) continuous distribution modeling discussion earlier, incorporating efficiency into allocation policy is a focus. For this project, the focus should be on what we call success at the OPO level. If an OPO is successful, they are identifying donors, getting authorization for donors, and proceeding to actual donation. If the OPO is performing at a high level, then we need to work on system efficiency separately. Another SRTR representative noted that, as in transplant performance, no single metric is going to capture everything you want to measure. There will need to be multiple metrics if we want to capture efficiency such as time from referral to OR, but that is more a system metric not dependent just on the OPO but on interactions between the OPO and transplant programs. None of those systems metrics should be used to monitor performance of individual members. If the Committee adopts a different metric than CMS, OPOs will be evaluated differently by the two entities, but he suggests that OPTN members should be held accountable for an accurate and precise metric that is evaluating a process that the member has control over. CMS' metrics do not meet that standard in addition to the lack of risk adjustment.

A Committee member noted that he was still uncertain about the interaction between CMS and the OPTN asking whether these two entities are totally independent and whether it will matter what the OPTN does or is the hope that if the OPTN sets more sensible criteria, it may potentially influence what CMS will do? The Chair responded that the OPTN is independent from CMS and the hope would be that CMS would consider a better measure if developed by the OPTN. The Committee member then suggested that there are two things we are trying to achieve. One is to try to identify OPOs that are functioning at the bottom and try to help them identify areas for improvement like we do for transplant programs. For a broader group that may be performing lower than the average but are not in that group of outliers, the OPOs probably know better than we do how they could improve so the OPTN would notify them that improvement is needed.

Another Committee member noted that the medical community can already see that we need to do something different because heart transplants have plateaued. He also recognized the pressure that OPOs are under with the new CMS outcome measures and creation of a different metric by the OPTN might add to that pressure, but we definitely need to help increase transplants.

A Committee member suggested that a critical component will be getting the definitions right. Whatever we set as the standard should support the goal of increasing donation. Some of the current metrics can be manipulated. He noted that data in some reviews have found that 10-15% of "transplants" for some OPOs are actually research pancreata and that is not the goal. The goal is to get as many patients as possible transplanted and off the waiting list. He stated that he liked the SRTR Director's evaluation of donor potential and noted that Howard Nathan has published something similar not that long ago. He further noted that the OPTN needs to look at what OPOs can impact, and after that the Committee can look at a system goal that will help OPOs and transplant hospitals work together. In determining metrics, the Committee should focus on how we can increase donation and he opined that the current OPTN and CMS metrics do not support that goal. He further noted that there has been a lot of conversation about potential bias in self-reported OPO data but OPOs have a massive amount of data that the OPTN can access and that data should not be ignored entirely. He noted that much of the data used for transplant program metrics is self-reported data so he would not want the Committee to take the position that no OPO data could be used for a metric. The SRTR Director stated that he has seen the amazing amount of data that OPOs have and it is important to explore whether and how that could be useful to the OPTN. If the data is not submitted to the OPTN now, how can we collect that data and learn from it? Some OPOs may have different processes and definitions even if using the same data elements, so we need to reach consensus on the definitions. Self-reported data exists for both transplant hospitals and OPOs, and if that is a concern, is there a way we could audit or verify the data?

Another Committee member suggested that the Committee should not implement another flawed metric like the CMS metrics. The Committee needs to evaluate data sources and collect data from the OPOs as the SRTR Director showed in the flow diagram in order to have access to the data the Committee will need, not surrogate numbers that do not reflect what needs to be evaluated.

Finally, a Committee member suggested that OPO metrics will need to be linked in some way to acceptance rates in the area noting that OPOs are recovering more marginal DCD donors that should be accounted for. He also expressed support for an efficiency and system metric.

Staff noted that based on comments made, the Committee supports looking at potential data collection and development of a metric that better reflects OPO performance and not focus on or align with CMS.

The Chair suggested that the MPSC should not move forward on this by itself. We should gather input from the OPTN Organ Procurement Organization (OPO) Committee, Association of Organ Procurement Organizations (AOPO) and others. Staff stated one of the next steps is to determine which committees the MPSC will collaborate with and how it will collaborate. Board leadership and others would like this project to move forward quickly to have some resolution and communication with the community based on acknowledgment of the need for work on this issue. Staff expect that, as with the transplant program performance monitoring project, there were be frequent subcommittee meetings and discussion of this project at each Committee meeting. If there are additional things committee members would like staff to be thinking about or additional information staff should collect, please let them know through communication between meetings or at meetings. Staff also anticipates some type of pre-public comment updates on what the Committee is doing on this project. A Committee member noted that a strong representative of the OPO community will be needed to lead this work group and discussion as was done during the transplant program performance monitoring enhancement project.

6. Offer Acceptance Collaborative Update

The Committee received an update on the Offer Acceptance Collaborative Improvement project, including information about the kickoff conference. The committee was reminded of the purpose and aim of the project as well as the composition of the cohort (83 transplant programs with a mixture of kidney, liver, heart, and lung programs as well as both adult and pediatric programs). The project timeline was provided and it was noted that the participants are currently in the active engagement phase (February – July 2023) of the effort.

Project engagement began with a kickoff conference on January 31 and February 1, 2023 in Orlando, Florida. Seventy-eight of the 83 programs attended in person, with over 150 participants in attendance. The conference included plenary and breakout sessions with a mixture of education and interaction. Virtual sessions were offered to those participants unable to attend in person as well as any member interested in joining. Over 400 people attended the virtual sessions on the first day and over 300 on the second day. The Committee was informed that the virtual sessions were recorded and would be posted in UNOS Connect for anyone to view.

A status update on collaborative engagement activities including collaborative calls, individual coaching and support, and interaction on the private project site (resources and discussions) was provided. Next steps of the effort were also shared. These steps include continual evaluation of project offerings and assessment of community education opportunities as well as the provision of webinars.

No questions were asked regarding the kickoff conference or the collaborative improvement project overall.

7. Performance Monitoring Enhancement (PME) Project Update

The Committee received an update from the Performance Monitoring Enhancement Subcommittee Chair on the number of programs identified or that would have been identified if the two pre-transplant metrics were in place in the January 2023 SRTR reports. The Chair noted that there are 714 transplant programs and with four metrics the possibility of 2,856 flags. Based on the current data, there are a total of 105 flags for 86 individual active programs. Eleven programs were flagged for more than metric including three kidney programs, three liver programs and five heart programs. In addition, five of the flagged liver programs and three of the flagged kidney programs are now either withdrawn or inactive. Data showed the following flags for each organ:

Table 1: Number of flags by organ and metric.

Organ	90-day graft survival	1-year conditional graft survival	Offer Acceptance	Pre-transplant mortality	Total
Heart	8	8	7	9	32
Kidney	12	8	16	1	37
Liver	7	0	11	6	24
Lung	4	2	2	3	11
Pancreas	1	0	0	0	1
Total	32	18	36	19	105

The total numbers comprise 18.4% of heart programs, 13.4% of kidney programs, 12.6% of liver programs, 15.2% of lung programs, and less than 1% of pancreas programs. The Chair then reviewed the number of adult flags for January 2023 and the previous cycle in July 2022 as well as the number of pediatric flags for those 2 cycles. Finally, he reviewed the number of flags for offer acceptance over the last three SRTR report cycles. There were a total of 31 flags for offer acceptance in January 2022, 34 in July 2022 and 36 in January 2023. Finally, the chair reviewed the incidence of program flags for offer acceptance over the three cycles:

- 54 programs were flagged in at least one cycle with 2 programs with flags for both adult and pediatric offer acceptance
- 17 programs were flagged in all 3 cycles
- 6 programs in January 2022 only
- 5 programs in July 2022 only
- 11 programs in January 2023 only
- 7 programs in January and July 2022 but not January 2023
- 6 programs in July 2022 and January 2023 but not January 2022
- 2 programs in January 2022 and July 2023 but not July 2022

Adult and pediatric components are counted separately in this data. This data gives the Committee information on the incidence of programs being flagged over multiple cycles and how programs may move in and out of being flagged over the 3 cycles or an 18-month time frame. There is more movement of flags due to amount of offers and the shorter 1 year cohort as opposed to the post-transplant outcomes metrics that have a longer 2.5 year cohort.

Summary of discussion:

A Committee member expressed concern about the COVID carve out that the SRTR uses in producing these reports noting that the use of this carve-out produces inaccurate data that will cause some programs to be identified that would not be if transplants during the carve out were included. The Subcommittee Chair noted that the Committee has discussed continued use of the COVID carve out previously and for purposes of the review, programs identified have the opportunity to provide information on the effects of COVID on their program. The SRTR Director explained that the SRTR worked with their Review Committee who made the recommendation to include the carve-out in the public reports. The SRTR presented the change to the MPSC at that time and the MPSC did not object to the SRTR implementing the COVID carve-out. The Chair asked whether the SRTR could publicly report both sets of data. The SRTR Director stated that the option was presented to the SRTR Review Committee and SRTR Patient Affairs Committee and both recommended against that option. Both

committees felt that having two sets of data publicly reported would cause confusion. A staff member responded that the MPSC has also requested the data without the carve-out to provide reviewers when programs indicate they would not have been identified for outcomes if not for the carve-out. The MPSC has received information periodically from the SRTR on the effect of the COVID carve-out. The MPSC's approach has been that the MPSC can ask the SRTR for any data it needs for purposes of performance monitoring but the MPSC does not have the authority to tell the SRTR what to report publicly since they have their own review process and contract that makes those determinations.

Staff then reviewed the draft initial questionnaire for offer acceptance that was developed based on recommendations from the Subcommittee.

Summary of discussion:

A Committee member asked if she could provide additional feedback prior to the Committee finalizing the questionnaire as she believes the questionnaire can be trimmed down. Staff indicated that we could send it out to the Committee for additional feedback before a final vote is taken by the Committee. Another Committee member suggested that most of the questions revolve around clinical decision making and the environment in which those decisions are made. He proposed that the institutional commitment becomes less important and should be moved towards the end of the questionnaire. The quality initiatives and questions regarding clinical decision making should be moved towards the beginning of the questionnaire.

8. Project to Refine Safety Event Reporting Requirements

Staff provided an overview of the potential new project to be sponsored by the MPSC (the Committee). This project would revise and re-evaluate required reporting of specific patient safety events to align with the "Wakefield Criteria"[1] and other events as deemed appropriate by the Committee.

The purpose of this project is to align required reporting in OPTN policy with the current OPTN contract requirement, which requires staff to notify MPSC leadership and HRSA of certain patient safety events within a specified timeframe (the "Wakefield Criteria"). Since some of these events aren't currently required to be reported by OPTN members, the MPSC doesn't know the prevalence of these events. By adding this requirement to policy, the MPSC would gain a better understanding of how often these events occur and could provide guidance to the community on how to limit risks to transplant recipient and living donor safety.

The proposal is to add the "Wakefield Criteria", and additional concerning patient safety events, into OPTN Policy 18.5 *(Reporting of Living Donor Events)*. This project would also streamline the reporting process through the Improving Patient Safety Portal (the Portal) by removing duplicative fields.

The Committee reviewed the project form and the preliminary draft language for familiarity with which policies would be revised as part of this project.

The Committee was asked the following questions:

- Does the MPSC have any concerns or suggested edits to the project form and/or draft policy language?

[1] Wakefield, Mary K., Administrator, Department of Health and Human Services; Letter to Jack Lake, M.D., President, Organ Procurement and Transplantation Network, August 5, 2011.

    - Consult Operations and Safety Committee and Living Donor Committee?
    - Near Miss definition
    - Reporting timeframe for members
- Aside from the "Wakefield Criteria", are there other patient safety events that the MPSC would like to require to be reported?
    - ABO typing and/or subtyping discrepancies?
- Concerns with the Portal field removals?

Summary of discussion:

Living Donor Reporting Requirements

A member asked for clarification on the timeframe for living donor event reporting. It was clarified that it is currently a 72-hour requirement in policy, but the OPTN Living Donor Committee would be consulted on whether they would like to make any changes since they established the living donor reporting requirements. Staff also noted that the "Wakefield Letter" requires that the OPTN reports living donor events within 24 hours, but currently members have 72 hours to report. Staff explained that the timeframe for members to report the other "Wakefield Criteria" is up to the Committee to determine, but staff suggested 24 hours due to some of the events being very concerning (i.e., transplant into the wrong recipient).

A member asked if the OPTN Living Donor Committee will also consider changing the two-year requirement for reporting living donor deaths, making it mirror the "Wakefield Criteria" of no time limit. Staff explained that the OPTN Living Donor Committee decided that there are certain events that must be reported within two years and be reported through the Portal. Every living donor death still must be reported on the living donor follow-up forms in TIEDI, but if a living donor death occurs greater than two years after donation it doesn't have to be reported through the Portal so that the Committee can review it.

Revisions to the Patient Safety Portal (PSP)

Staff noted that the field removals in the Portal would be subject to OMB approval and could be submitted with the current OMB change package prior to this project going out for OPTN Public Comment. The Committee needs to provide formal approval of these removals and was asked if they were supportive of the proposed changes to the Portal.

A member also suggested revising the OPTN Disease Transmission Advisory Committee (DTAC) forms, since they are extremely painful to fill out.

Wakefield Criteria in Policy

A member asked if the Committee is making a distinction between the "Wakefield Criteria" near miss and the aborted living donor transplant. Staff explained that the near miss and aborted living donor transplants would stay separate since the living donor section already has separate timelines and requirements; however, the Committee can mirror the near miss requirement off the aborted living donor transplant requirement.

Overall Discussion

A member voiced support for moving forward with this project and mentioned that it may be worthwhile to work with HRSA to see if there are any revisions that need to be made to the Wakefield Letter. There are events in the letter that need to be reported within the 24-hour period but requiring members to report some of the never events in that timeframe may bog down the system and lead to a lot of inefficiencies with monitoring for compliance. Most of the time hospitals have their own policies

regarding never events. The member also stated that they agreed with the removals from the Portal. Staff explained that if the Committee feels it's more appropriate for staff to continue notifying MPSC leadership and HRSA when they become aware of a never event occurring then they can, but it doesn't have to translate into a required report by members.

A member noted concern with the near-miss definition since it is an extremely generic term being defined very narrowly, and if the term is used anywhere else in policy that definition isn't going to hold. The member suggested altering the definition to make it clear that it only applies to this specific area of policy. The member supported the proposed removals in the Portal and supported sending this project to the OPTN Policy Oversight Committee (POC).

Another member voiced concern over using language such as "when the hospital becomes aware" because it takes time for members to make sure that they have all the facts and suggested it should be "within 24 hours of the hospital becoming aware" since it gives members time to assess the situation and talk to people who might have been involved in the event.

UNOS Staff asked for feedback on how to best define near-miss and never event. Staff explained that there is a final verification in the process for hospitals to make sure they have the right organ for the right patient and asked if the Committee considers it a near miss if it gets all the way to that point and then it's caught. Staff mentioned that, presumably, there might not be any other time to report it between when that final verification takes place and when the procedure starts.

The Committee approved a motion to support sending this project to POC for review and the proposed removals from the Portal by a vote of 34 Yes; 1 No; 0 Abstentions

Next Steps:

This project will be reviewed by POC in March 2023 and the Committee will continue discussions/ finalizing the policy language. This project should be distributed for public comment in August 2023.

9. Educational Initiatives

The MPSC is tasked with identifying opportunities to improve the system, whether through educational efforts (e.g., presentations, webinars, and articles), programming improvements, or policy changes. The MPSC has historically referred issues directly to policy-making committees for action, if needed. Going forward, the MPSC will report all potential policy issues to the Policy Oversight Committee (POC), while continuing to also send the referral to the appropriate policy making committee. With this change, the POC can incorporate the issue into the portfolio of committee work as appropriate. This process will require a longer MPSC discussion of topics to allow prioritization of the recommendations to committees and the POC. Staff reviewed important factors to include in an MPSC discussion such as a description of the problem and MPSC suggestions for potential ways to address it. The Committee may also want to include an idea of the frequency and severity of the issue, whether the issue fits within an OPTN Strategic Plan Goal or POC Strategic Policy Priority, the potential patient impact including evaluation of that impact on vulnerable populations, and any applicable data.

At this time, the MPSC has submitted the following project forms for consideration:

- Centralize Reporting of Stored Extra Vessels
- Vessel Storage time period definition and storage of HCV+ vessels
- Pronouncement of DCD Donor Death
- Patient Safety Contact Notification Process
- Organ Labelling Clarification
- Requirements for Communicating Post-Transplant Disease

- Requirement for Photographs of Donor Organs

In addition, the Committee heard updates on a few ongoing projects that have not been referred to the POC. The OPO Committee already had a work group looking at simultaneous organ acceptance and conflicting organ placement policies, and two MPSC members will participate on that groups. An MPSC referral concerning streamlining donor assessment and evaluation procedures and communication of updated donor and recipient information aligns with an existing OPTN Operations and Safety Committee project for automated donor test result reporting, which is slated to start in April 2023. The OPTN Ad Hoc Disease Transmission Advisory Committee is working on testing guidance addressing whether HIV Organ Policy Equity (HOPE) Act requirements apply to any donor with at least one positive HIV test result, or only a clinical determination based on all available tests. The MPSC also received an update on communication with the OPTN Pediatric Transplantation Committee about the use of liver and heart pediatric emergency exception pathways. The Pediatric Transplantation Committee appreciated the MPSC's information about the current use of the pathways, but will not be pursuing a change to the requirements at this time based on the work needed to revise the bylaw or to design a new mechanism to review the cases in more real time, since there is a small number of cases that has been decreasing over time.

The Committee received updates on two projects designed to increase transparency and educate the community.

- The Living Donor Event MPSC work group reviewed data on kidney living donor deaths within 2 years of donation from 2007 (when reporting became a requirement) through 2019. The group categorized the deaths by cause of death and limited a more detailed review to those categories that have a potential relation to donation such as complications during the kidney recovery procedure, medical issues, suicide or potential suicide, or overdose. The group created case summaries, is reviewing a draft article, and the topic was accepted for the Transplant Management Forum.
- The Patient Safety Project is designed to share information with the transplant community to heighten awareness of safety, promote effective practices and prevent future occurrences. Staff presented preliminary information on this group's work at the Transplant Quality Institutes (TQI) meeting last October, sharing project goals and data based on events reported through the PSP. The group has reviewed historical cases, provided feedback on patient safety educational opportunities, effective practices, and methods of distribution. The work group reviewed cases based on patient safety topics such as Pre-Transplant Verification, Organ Preservation and Transportation, Testing and Reporting, Transcription Errors, and Vessel Storage and Usage. Work group members shared their feedback and insights, noting any process inefficiencies, case outcomes, significant clinical or operational observations and effective practices. The group is drafting case scenarios, and will determine the best way to share these with the community.

The Committee will also have the opportunity to engage with the community through a presentation at the Transplant Management Forum (TMF) 2023. The MPSC will participate in a session titled "*The Improving Patient Safety Portal and the OPTN Membership and Professional Standards Committee (MPSC): How you can report, what other members are reporting, and what the MPSC wants you to know*." Staff asked the Committee to provide suggestions for content to include and to indicate whether they were interested in presenting. Committee members provided suggestions of the following topics for potential inclusion in the TMF presentation:

- Clarification for infectious disease events, including what actually needs to be reported (expected vs. unexpected results).

- Encouraging members to report near misses as the community can learn from near misses as well as actual events.

The MPSC received information about an upcoming implementation of a tool for program evaluation of post-transplant outcomes to assist members in assessing their data. UNOS Research staff created a dashboard tool that will help programs identify characteristics that contribute to post-transplant outcomes, which will be made available to all programs through the OPTN computer system approximately this summer. This tool will include data on hazard ratios, allowing programs to toggle donor type and age group as appropriate and examine any subgroup.

Lastly, the Committee heard about a new process to provide email communications to the community on important topics. The MPSC's report to the OPTN Board of Directors in December proposed an email communication to the community providing reminders based on topics the committee discussed. This is designed to provide increased transparency and the potential for immediate notification of issues. After the December Board meeting, the first email was sent to the community. The MPSC will continue to provide this wide-ranging education after each multi-day MPSC meeting, as it has the potential for more real-time communication than a case study or publication. The Committee can still provide more details or effective practices for the same issues in a longer format. Staff asked the MPSC to provide any topics that may require education or clarification, and any topics from this meeting that might be appropriate for an email communication.

Summary of discussion:

A committee member suggested including some kind of effective practices or tips for responses when asked for information by the MPSC. The MPSC Chair suggested perhaps including information on storage of prohibited vessels or information on workflows for accepting Hepatitis C positive organs and vessels. Confirming insurance approvals, informed consent at the time of transplant, or other factors. Another committee member suggested education on organ packaging and labeling. Other committee members recommended education on how the community can deal with different pre-transplant requirements for COVID-19 testing, or educating on communication during normothermic regional perfusion recoveries while the community works on guidelines.

Upcoming Meetings

- March 20, 2023, 3-5pm, ET (Virtual)
- April 24, 2023, 3-5pm, ET (Virtual)
- May 4, 2023, Chicago
- May 22, 2023, 3-5pm, ET (Virtual)
- June 21, 2023, 3-5pm, ET (Virtual)
- July 25-27, 2023, Detroit

Attendance

- **Committee Members**
  - Maher Baz
  - Alan Betensley
  - Emily Blumberg
  - Timothy Bunchman
  - Anil Chandraker

- Todd Dardas*
- Robert Fontana
- Reginald Gohh
- Barbara Gordon
- Lafaine Grant
- Robert Harland
- Kyle Herber
- Victoria Hunter
- Christopher Jones
- Andrew Kao
- Peter Kennealey
- Catherine Kling
- Michael Kwan
- Dianne LaPointe Rudow
- Carolyn Light
- Scott Lindberg
- Melinda Locklear
- Gabriel Maine
- Amit Mathur
- Kenneth McCurry
- Nancy Metzler
- Dan Meyer
- Bhargav Mistry
- Regina Palke*
- Michael Pham
- Elizabeth Rand
- Sara Rasmussen*
- Pooja Singh
- Jason Smith
- Zoe Stewart Lewis
- Laura Stillion
- Sean Van Slyck
- J. David Vega
- Candy Wells

- **HRSA Representatives**
  - Jim Bowman*
  - Shannon Dunne*
  - Marilyn Levi*
  - Arjun Naik*
- **SRTR Staff**
  - Ryutaro Hirose*
  - Jonathan Miller*
  - Jon Snyder*
  - Bryn Thompson*
  - David Zaun*
- **UNOS Staff**
  - Anne Ailor*

- Kristine Althaus*
- Sally Aungier
- Dawn Beasley*
- Matt Belton
- Dawn Bitler*
- Tory Boffo*
- Kate Breitbeil*
- Rebecca Brookman
- Tyrone Brown
- Austin Chapple*
- Aileen Corrigan-Nunez*
- Tommie Dawson*
- Robyn DiSalvo*
- Nadine Drumn
- Demi Emmanouil*
- Katie Favaro*
- Liz Friddell*
- Jasmine Gaines*
- Rebecca Goff*
- Sheran Goodman*
- Shavon Goodwyn*
- Lauren Guerra*
- Asia Harden*
- Chelsea Haynes*
- Terri Helfrich*
- Courtney Jett*
- Margaret Kearns*
- Lindsey Larkin*
- Krissy Laurie
- Trung Le*
- Ann-Marie Leary
- Jason Livingston
- Carlos Martinez*
- Anne McPherson*
- Sandy Miller
- Amy Minkler*
- Steven Moore*
- Rene Morgan*
- Sara Moriarty*
- Rebecca Murdock*
- Alan Nicholas*
- Delaney Nilles
- Jacqui O'Keefe
- Beth Overacre*
- Rob Patterson*
- Michelle Rabold*
- Liz Robbins Callahan*
- Mohamed Roshanali*

- Logan Saxer*
- Laura Schmitt*
- Kay Scheranek
- Sharon Shepherd
- DeeDee Simmons*
- Kayla Temple*
- Stephon Thelwell
- Melissa Tisdale*
- Jennifer Wainright*
- Marta Waris*
- Betsy Warnick
- Joann White*
- Trevi Wilson*
- Claudia Woisard
- Emily Womble*
- Karen Wooten
- Amanda Young*

- **Other Attendees**
  - Edward Hollinger
  - Jim Kim
  - Kimberly Koontz
  - John Lunz

* Attended virtually