OPTN Heart Transplantation Committee
Meeting Summary
October 9, 2024
In-Person Meeting Detroit, Michigan

J.D. Menteer, MD, Chair
Hannah Copeland, MD, Vice Chair

Introduction

The OPTN Heart Transplantation Committee met in Detroit, Michigan on 10/09/2024 to discuss the following agenda items:

1. Welcome, introductions, and agenda review
2. Committee work: Finalize and vote on proposed policy language for *Escalation of Status for Time on Left Ventricular Assist Device* project
3. Review of general themes from public comments regarding *Continuous Distribution of Hearts Update, Summer 2024*
4. Committee work: Using operational changes to address exception requests and review board practices
5. Committee work: Discuss Heart priorities and consider future projects
6. Clarify / affirm roles of OPTN contractor, SRTR, and MIT in terms of data analysis, simulation, and optimization supporting the Committee's continuous distribution efforts
7. SRTR presentation describing continuous distribution and OASimulation
8. Committee work: Confirm metrics of success for each CD attribute
9. Introduction of xenotransplantation and hearts
10. Open Forum
11. Closing remarks

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

1. Welcome, introductions, and agenda review

The Chair welcomed the members and provided an overview of the agenda. Members calling in by phone only were reminded to tell OPTN contractor staff their names for attendance purposes. Non-committee members and those without business before the Committee were reminded that they should follow the proceedings using vimeo.com/optn.

2. Committee work: Finalize and vote on proposed policy language for Escalation of Status for Time on Left Ventricular Assist Device project

The objective was to review policy language, answer questions about potential edge cases, and other considerations, as well as potentially vote to approve draft language for inclusion with public comment proposal scheduled for release in January 2025.

The project is intended to address the concern about status 4 candidates with implanted dischargeable LVADs not getting transplanted. Analyses suggest survival rates on the waiting list decrease the longer a device remains implanted. The current proposed solution is to provide additional priority to candidates with dischargeable LVADs based on having a device implanted for six or eight years.

Summary of discussion:

Decision #1: The Committee approved draft policy language for inclusion with a public comment proposal.

Decision #2: The Committee agreed to revise the type of support being referenced in the draft policy and use 'ventricular assist device with systemic circulatory support.'

Decision #3: The Committee agreed that they would likely need to re-vote on the draft policy language at a future Committee meeting.

A member summarized the Committee's work on the project. The individual explained the reasons why this is a problem for the heart community. The issue the Committee is addressing is that adult status 4 candidates with ventricular support devices (VADs) have limited access to transplantation. The Chair added that analyses have shown that survival rates while on the waiting list decrease the longer such a device remains implanted. The Committee member walked through the supporting evidence the Committee used in determining how to solution the issue. OPTN contractor staff shared the proposed policy language with the Committee for review and comment.

Members were reminded that the Committee chose VAD implant date over time registered on the waiting list because there is an equity issue. Because of the long waiting time associated with candidates assigned to adult heart status 4 with a dischargeable LVAD, some heart programs have decided not to add their patients to the OPTN waiting list. At the same time, the Committee recognized that an appropriate time waiting after implant is critical to the success of the proposed policy change. The members acknowledged that if the proposed changes added too many patients to the adult heart status 2 waiting list at one time, it would also increase the waiting time for other patients assigned to status 2. Such an increase in waiting time could be harmful to existing status 2 patients who might experience greater mortalities while waiting. The Committee addressed the issue by agreeing to use the six-year and eight-year timeframes after device implant. The Committee reviewed the previous data analysis of potential patient volume changes by status by time since implant and time registered on the waiting list. The analysis indicates that establishing an eight-year timeframe between device implant date and eligibility for adult heart status 2 results in an increase in patient volume of about one percent. The analysis results also suggest that establishing a six-year timeframe between device implant date and eligibility for adult heart status 3 results in an increase in patient volume of about three percent. The Committee members concurred that the proposed timeframes and patient volume increases are appropriate given the objectives of the proposed policy changes.

The Committee confirmed that all candidates registered on the waiting list who are supported by a dischargeable LVAD that was implanted at least six years prior are eligible for adult heart status 3. They also confirmed that all candidates registered on the waiting list who are supported by a dischargeable LVAD that was implanted at least eight years prior are eligible for adult heart status 2. A candidate does not have to be assigned to adult heart status 4 to be eligible for either policy.

The Committee discussed the timeframes a candidate can remain assigned at either status 2 or status 3 under either of the policy changes. The members agreed that both an initial assignment of 180 days, as well as an extension of 180 days are appropriate timeframes for both the status 2 and status 3 policies. A member suggested that initial assignment or an extension at either policy should not require recertification. (Currently, OPTN *Policy 6.2.C: Pediatric Heart Status 2 Requirements* does not require recertification.) The member stated that because eligibility is based upon the length of time a candidate has been supported by a VAD, once a candidate meets the timeframe should the transplant program be relieved of submitting new forms? A likely outcome is that programs are going to inadvertently forget to

submit the extension form. Some members agreed. However, others pointed out that transplant programs are also supposed to report updated clinical information on the extension forms and this is the type of information the Committee previously indicated was important for several reasons, including the future development of a candidate risk score. A member also stated that a candidate's clinical condition changes over time. So, for example, the Committee and community would still want to know if a candidate assigned to one of these policies started inotrope therapy sometime following the initial assignment. After considering the option, the Committee decided to use 180 days as the duration for the initial assignment and the extension.

A member raised the concern that the proposed changes seem somewhat inequitable when considering medical urgency. The member said the proposed changes take patients who have been supported by a dischargeable LVAD for at least eight years and who are doing relatively well, and escalates them ahead of patients suffering from complications associated with their dischargeable LVAD. The member added that they suspect that the heart community's response to the proposed changes will be along the lines that the Committee is putting in place a system that prioritizes healthy patients over unwell patients. A patient representative on the Committee supported the expressed concern. They explained that while waiting for a donor heart, their transplant program implanted an intra-aortic balloon pump (IABP) to provide temporary support for cardiogenic shock. The member said their medical urgency reflected how sick they actually were. Whereas, LVAD support may provide adequate support for a much longer period of time and not even require hospitalization. Other members acknowledged the concern but disagreed that the proposed changes are inappropriate. A member said that by removing the disincentives to implanting LVADs, the community might see the use of such devices increase and there may be more patients without complications at five years or later. And if such patients remain healthier during that time, that could stave off the need for temporary mechanical support or even transplant. Which in turn, could lead to the availability of more donor hearts for transplanting at status 2. Another member said that the Committee had wrestled with the significance of essentially permitting someone to obtain status 2 assignment just for time alone. The member continued that it had been a pretty weighty decision and that is why the Committee decided to push that out to eight years. And the Committee tried to balance out the basic acuity and severity of someone as sick as the patient member was while in the hospital versus someone who is stable. The member added that almost a decade of time on an LVAD is a pretty long time to wait given the potential for complications, and as a result the balance of using six and eight years seemed appropriate. Another member expressed their hope that the bulk of the work associated with these policy changes will occur by moving patients from status 4 to status 3. A member added that it will be very important for the public comment document to clearly explain that the six- and eight-year timeframes will eventually be replaced with five- and seven-year timeframes, and that the Committee acknowledges the policy cannot jump to five- and seven-years which is why the changes are being done strategically and safely so no harm is done.

Committee members had questions about how the "step-down" component will be captured in policy. OPTN contractor staff explained that the proposed draft policy established the six- and eight-year transition periods the Committee identified as the initial modification. Contractor staff also explained that the draft policy established the five- and seven-year transition periods the Committee identified. Contractor staff said that after consultation with the policy drafter, the most appropriate way to effectuate the "step-down" component would be through the OPTN Board resolution language, rather than in the draft policy language.

A member asked if the draft policy language could be changed to reference 'LVAD / RVAD in the systemic ventricle,' rather than just referring to LVAD? The member said that there are some transposition patients who have a VAD in their right ventricle and they would not qualify under the

proposed language. Another member suggested just referring to the 'systemic ventricle,' in order to avoid the use of left and right. OPTN contractor staff expressed some concern that such a change would expand the scope of the project and could create inconsistencies with other OPTN policy sections that reference the same type of support. Another member asked that the term 'FDA-approved' device be replaced with "qualifying dischargeable LVAD." The Committee agreed to amend the draft policy to replace the references to left ventricular assist devices with "systemic circulatory support." The Committee voted to approve the draft policy with the understanding that the revisions agreed to during the meeting would be shared with the Committee and they may be asked to re-vote on revised language at a future meeting.

Next steps:

OPTN contractor staff will make changes to the proposed policy language based on the Committee's discussions and share the revised version with leadership and the Committee members. The Committee may be asked to re-vote at a future meeting.

3. Review of general themes from public comments regarding Continuous Distribution of Hearts Update, Summer 2024

OPTN contractor staff shared a document with the members containing all of the public comments received about the CD of Hearts Update, Summer 2024. Contractor staff also presented the general themes and some sub-themes from public comment with the Committee.

Summary of discussion:

No decisions were made as part of this agenda item.

The objective for this agenda item was to share the public comment feedback received concerning the Committee's CD Update and to provide members with the opportunity to discuss any topics based on the feedback. The CD Update asked the community whether they agreed with the general prioritization of the attributes based on the VPE results. More specifically, the community was asked whether they agreed with the relatively low prioritization of the proximity efficiency attribute. The community was also asked how the Committee should consider the use of perfusion technology when developing the continuous distribution allocation framework. Finally, the CD Update document asked whether additional information needs to be provided that would help the public understand the concepts related to continuous distribution, with the intention being to help solicit feedback from patients, patient families, donor families.

The public comment document received a total of 67 responses. However, because all comments provided as part of a regional meeting are summarized into a single response, a total of 34 comments appear on the OPTN website. Transplant programs accounted for 29 of the 67 comments, while stakeholder organizations, like ISHLT, AST, and ASTS accounted for seven comments. Four comments were received from individuals who identified themselves as patients.

Commenters generally agreed with the overall attribute priority reflected by the VPE results. However, commenters shared several caveats with their general agreement. Some comments raised concerns about the impact prioritizing living donor candidates will have on pediatric candidates. Other respondents expressed concerns about the costs and equity implications of that could occur in relation to the proximity efficiency attribute, as well as how the rapidly evolving use of perfusion technology may impact the attribute in the future. At least two commenters wanted the Committee to be aware that inefficiencies and delays in the allocation process can negatively impact donor families and their grieving

process by delaying access to their loved one, and that the Committee should look to limit such delays when developing the heart CD allocation framework.

In terms of general themes, multiple respondents stressed the importance of ensuring that pediatric candidates are appropriately prioritized within the new allocation framework. Pediatric priority received the second highest prioritization based on the VPE results. Nonetheless, some concerns were raised that the VPE result's high prioritization for prior living donors would negatively impact pediatric prioritization. For example, commenters pointed out that pediatric candidates are inappropriate choices to become living donors. Moreover, that means there is a category of prioritization that pediatric candidates are barred from accessing. Commenters also stated that pediatric candidates will be greatly impacted by the fact that there is no post-transplant survival attribute in the composite allocation score. The commenters said that pediatric candidates' scores would benefit a great deal from the longevity after transplant.

Regarding prior living donors, the community had mixed feedback as to whether the VPE results' high prioritization was appropriate. A couple of comments supported the high priority identified in the VPE results, but there were probably more responses disagreeing with the high prioritization. Some commenters questioned whether it should be included as an attribute at all. A Committee member asked which categories of respondents submitted feedback about the prior living donor prioritization. OPTN contractor staff responded that one of the two supportive responses was from the OPTN Living Donor Committee and that the other was from a prior living donor.

There were multiple comments addressing proximity efficiency and perfusion technology, and how closely intertwined the two matters are. Based on the responses, it seemed that comments mentioning the costs associated with acquiring and using perfusion technology, as well as the increasing costs around travel, that such comments were less likely to support the low prioritization found in the VPE results. There was a lot of concern expressed that the costs associated with traveling and perfusion technology will create or further exacerbate a 'have and have not' situation among transplant programs. And, that such a divide could eventually result in the 'have not' programs being driven out of transplantation. On the other hand, if a commenter did not address cost in their response, then there was general support for the low prioritization of the proximity efficiency attribute. Such feedback focused on the benefits associated with being able to travel farther to get donor hearts that may not have been even procured in the past. As a result, those respondents indicated it would be appropriate to give low priority to an attribute restricting extended travel distances beyond 500 nautical miles.

Several comments identified the importance of equity in determining attribute prioritization, both to the placement efficiency and the perfusion technology impact on programs in the long run. It also came up in terms of how the changes would potentially impact different patient populations. For example, some feedback encouraged the Committee to revisit the way medical urgency is defined as well as post-transplant outcomes. Finally, there were at least two comments that stated that donor families are very interested in actions that will improve allocation efficiency because it helps to validate the difficult decisions such families face. In addition, greater efficiency would reduce the time that donor families spend grieving the loss of a loved one. AOPO's comment mentioned the increased case time related to donor procurement and how that impacts donor families.

The Committee members did not have questions or provide additional feedback.

Next steps:

The Committee members were encouraged to review the public comment analysis document and provide questions or comments to Committee leadership and/or OPTN contractor staff. In terms of next steps, the OPTN Board will receive an update about all of the CD allocation work currently underway as

part of their December 2024 meeting. It was stated that it is unlikely that another public comment document would be submitted as part of the January-March 2025 cycle.

4. Committee work: Using operational changes to address exception requests and review board practices

The Committee discussed concerns about the use of exceptions for assigning pediatric heart candidates to appropriate statuses. The Committee also considered several options for improving the current use of exceptions for pediatric candidates. Additionally, the Committee member discussed whether the options might also benefit the current use of exception requests on behalf of adult heart candidates.

Summary of discussion:

> Decision 1: The Committee agreed to explore the option of creating the position of National Heart Review Board for Pediatrics Chair. The position would serve as a liaison to the regional review board members, similarly to the chairs of the Lung and Liver review boards.

The Committee considered several options for potentially improving the use of exceptions requests for pediatric candidates. The options included, but were not limited to, creating the position of Chair of the National Heart Review Board (NHRB) for Pediatrics, and developing a guidance document identifying the hemodynamic and other clinical information transplant programs are expected to provide as part of an exception request.

There was agreement among the members that it would be beneficial to create a NRHB for Pediatrics Chair, which would serve in an advisory capacity to the regional review board members. OPTN contractor staff indicated that the OPTN Lung and Liver committees already have similar positions within their review board frameworks. Contractor staff said that creating such a position for the NHRB for Pediatrics will require revisions to the Operational Guidelines. Staff said they would find out more information as to whether revising the Guidelines will require submission of a public comment document.

There was less agreement among members that developing a guidance document would lead to improvements in the use of exceptions for pediatric candidates. The guidance document the Committee created to assist transplant programs with submitting exceptions for status 2 assignment has been less effective than the Committee thought it would be at the time of its implementation.

Other options were also discussed. The members agreed that there needs to be better communication and feedback among the regional review board members and the Committee to ensure that exception requests receive the appropriate decision-making. This includes ensuring that transplant programs are fully aware of what information they are expected to provide, as well as the consequences of not providing the expected information.

Committee members also discussed whether the current retrospective review of exceptions requests should be replaced with a prospective review to improve the current use of exceptions. They also discussed whether creating a panel or group to perform quality improvement activities could be a solution. The members considered creation of a group who would randomly review exception request cases and their associated decisions. The group would provide real-time feedback to the regional review boards about their findings. While the Committee showed some interest in the option, they were also aware that it could impact the confidentiality associated with the regional reviewers.

Next steps:

OPTN contractor staff will find out more information about whether public comment is required to make changes to the NHRB for Pediatrics Operational Guidelines. Contractor staff will also explore whether an entity, like a quality improvement body, is permissible given the confidentiality associated with reviewing such requests.

5. Committee work: Discuss Heart priorities and consider future projects

The Committee was unable to discuss this topic due to timing. This will be discussed at a later time.

6. Clarify / affirm roles of OPTN contractor, SRTR, and MIT in terms of data analysis, simulation, and optimization supporting the Committee's continuous distribution efforts

OPTN Contractor Staff:

- Work with Committee to identify and perform data analyses to guide future decision-making

MIT:

- Build Heart Optimizer tool
- Use Committee inputs to identify 'optimized policy' options designed to efficiently and effectively achieve desired outcomes
- Assist Committee in iteratively working towards optimized policy options and attribute weightings

SRTR:

- Build Organ Allocation Simulation (Thoracic OASim) for modeling
- Use Committee inputs to model impacts of proposed policy changes on allocation outcomes

Summary of discussion:

No decisions were made as part of this agenda item.

A member inquired whether MIT has a representative on the committee. OPTN contractor staff informed the members that there are currently no representatives, but someone from MIT may become more involved as the Committee's work progresses. Another member mentioned that the Committee is working on various scenarios and weightings, which will be utilized by MIT in the initial optimizer and considered by SRTR. This member emphasized that the Committee's approach to weighing attributes is critical, as it will help prevent over- or under weighing any factor. For instance, if distance is given a lower weight, it could result in organs being transported across the country. OPTN contractor staff noted that placement efficiency serves as a good example. In such cases, the optimizer can reflect how the Committee would approach the situation initially. Through their work, MIT can quickly simulate and review options, then collaborate with SRTR to model a more focused selection. SRTR contractor staff added that while they haven't raised this point in previous discussions, they will compile a detailed list of research questions that the Committee is interested in exploring.

Next steps:

None were discussed.

7. SRTR presentation describing continuous distribution and OASimulation

SRTR contractor staff presented an introduction to their organ allocation simulation, referred to as OASim. The OASim addresses all aspects of organ allocation, including candidates, donors, and allocation rules.

Summary of discussion:

No decisions were made as part of this agenda item.

The Chair inquired whether, in the event of a delay, there would be documentation available for SRTR to gather the Committee's insights. This would allow for early input, perhaps through a standard document. SRTR contractor staff clarified that while there isn't a standard document, there is a standard approach to soliciting this information. The primary concern lies within the research questions and how to accurately represent them in the modeling process. A useful reference would be the research questions from other OPTN committees. The analysis plan submitted in response to the OPTN Kidney-Pancreas data request contains more detailed insights into how to map these research questions. Another member asked if historical data would be used in the simulation, especially if predicting behavioral changes proves unfeasible. SRTR contractor staff responded that they specifically avoid modeling behavior changes in this context. A member then questioned whether the simulation varies listing practices. SRTR contractor staff indicated that acceptance modeling does incorporate variations between centers, but they also strive to create models that maintain consistency across centers. A key aspect of the diagram shared involved comparing these models against one another. It was emphasized that part of the input cohort—patients at a specific center—might be sicker or older, and that the simulation will be conditional on the candidates and donors included.

A member asked how SRTR determines which models to use. SRTR contractor staff responded that they work to translate the questions into figures, tables, and simulated results to see if they adequately address the inquiries. A range of sub-models is built to simulate a historical scenario using these models, which aids in determining what works best based on related figures. This process is why they cannot specify in advance which model will ultimately be chosen. If multiple models are considered, they will run current policy through them to assess whether the results align closely with existing outcomes. Another member inquired about how the SRTR would model post-transplant survival and the data sources for this. SRTR contractor staff indicated that a model would be fitted to national heart recipient data to develop a post-transplant survival specific to this request. The simulation could gather this information without using it for allocation purposes. The same member asked how this information would be calculated. SRTR contractor staff explained that the modeling process involves variable selection to identify good predictors. The Chair mentioned that the Committee plans to include new fields when developing the CD system, emphasizing the importance of enhancing diagnostic fields, particularly in pediatrics, to differentiate between waiting list mortality and post-transplant survival. SRTR contractor staff suggested that the new system would need to be in place for some time before specific elements could be accurately inputted.

Next steps:

None were discussed.

8. Committee work: Confirm metrics of success for each CD attribute

The objective of this agenda item is to have the Committee confirm proposed “optimization metrics of success.” Optimization metrics are used by MIT in testing validity of optimization results. Optimization metrics are not used to determine whether policy changes eventually produced the intended result.

Summary of discussion:

No decisions were made as part of this agenda item.

A member expressed concerns that the focus on mortality does not align with the priority it should receive. They discussed the policy level and various attributes associated with waitlist mortality while considering the development of a rating scale. The question was raised about how many points should be assigned to this system. Another member clarified that when assessing mortality, the timeframe considered is within twelve months, not afterward. Regarding blood type considerations, members discussed the possibility of increasing transplant rates for candidates with blood type O. They also suggested evaluating the impact of allocating points based on blood type compatibility. Additionally, there is potential to examine data concerning highly sensitized candidates with blood type O.

The Chair then asked whether the incidence of death should be stratified by quintiles of medical urgency. A member added that if they shift to qualification for medical urgency based on status criteria, it might be more beneficial to analyze this using individual criteria. SRTR contractor staff noted that the optimization metrics desired might either minimize, maximize, or constrain certain factors. If stratification is employed, it usually serves as an equity metric. Overall, the Committee aims to prevent patient deaths before transplantation. If there are many low-urgency patients, the cumulative incidence will be low, while a high number of status 1, ECMO patients on the list could result in a high cumulative incidence. There were uncertainties regarding whether they were assigning the proper weight to waiting list mortality when considering total mortality. Another member raised multiple questions for the Committee to address—specifically about weighting and the assignment of criteria to certain attributes. When developing the rating scale, it may be beneficial to consider the individual mortality rates by criteria. In this context, they are looking to understand the overall effect. The Chair confirmed that simplifying this and leaving it cumulative would be sufficient. SRTR contractor staff expressed agreement, stating uncertainty in how a stratified metric could be conceptualized. It was deemed important for everyone to know that the Committee is interested in analyzing waiting list mortality based on specific criteria.

The Chair asked if the incidence of death should be stratified by quintile of medical urgency. Another member advised that if they moved to qualifications for medical urgency based on current criteria it would be more useful to analyze that based on the individual criteria. SRTR contractor staff advised that based off the optimization metrics its best to either minimize, maximize, or constrain it. If one stratifies it's usually an equity metric. A member replied that if they have a lot of low urgency patients then the cumulative incidence will be low and will have a lot of ECMO patients on the lists. Another member advised that they should investigate what is the appropriate weight and the other item to investigate is the assignment of the criteria to that attribute. Regarding the designing of the rating scale, it's best to investigate the individual mortality rates by criteria.

Regarding blood type, members advised that the overall goal is to prioritize blood type O candidates while maintaining overall system effectiveness. Specifically, focusing on addressing blood type O disadvantages. One member suggested that the Committee minimize the difference in transplant rates between blood type O candidates and all other blood types. Another member suggested monitoring overall waitlist mortality to ensure optimization doesn't negatively impact outcomes. The Chair asked what the term transplant rate means to which SRTR contractor staff advised that in the simulation it would be the number of transplants divided by total person time waiting during the simulation. Another member asked if they were looking at the number of offers in terms of liver metrics. SRTR staff advised that the transplant rate is a combination of biological compatibility, how much access the system allows,

and the offer acceptance practices. Members considered the need to consider compound disadvantages (for instance, being both type O and highly sensitized). ABOi patients' likely group with their blood type in the model per members.

Members spoke about the community's support for maximizing pediatric transplants. Members advised that they need to monitor impact on small pediatric patients (suggested size groupings: <10kg and 10-20kg). Size matching wasn't included as an attribute in the current version of heart CD but could be considered as part of the next version. Members confirmed that pediatric numbers are small enough that prioritizing them would not significantly impact others. A member proposed waiting time score: index of time × urgency. Members identified that prioritizing longer-waiting patients, average waiting time to transplant might increase. Which would need to be balanced with waiting time with medical urgency.

Regarding proximity efficiency, members identified that the current initial travel distance of 500NM sharing is working well and there should be a focus on preventing coast-to-coast organ travel. They want to protect access for rural areas.

Next steps:

None were discussed.

9. Introduction of xenotransplantation and hearts

The Chair provided background information that the OPTN Ethics Committee is developing an ethical analysis of xenotransplantation. The project concept was recently presented to the Executive Committee who identified initial areas for exploration as part of the analysis. This was also presented at the Policy Oversight Committee who had concerns about language used in the white paper description, particularly comparisons between xenotransplantation participants and living donors. The Policy Oversight Committee suggested modifying the language to avoid misconceptions and to broaden the discussion to include the impact of medical innovations on the waitlist, rather than solely focusing on xenotransplantation; one member proposed changing the title to reflect the broader focus on medical innovation.

Summary of discussion:

No decisions were made as part of this agenda item.

The Chair advised that patients shouldn't be choosing xenotransplantation over a LVAD, there are two anecdotal experiences. The Chair continued to say that how xenotransplantation is used in special populations is not the Heart Committees purview but figuring out how they fall into the allocation system is.

Next steps:

None were discussed.

10. Open Forum

There were no requests to speak during this part of the meeting.

11. Closing remarks

No closing remarks were discussed.

Upcoming Meetings (ET)

- ~~July 2, 2024 from 4:00 to 5:30 pm~~
- ~~July 16, 2024 from 5:00 to 6:00 pm~~
- ~~August 7, 2024 from 4:00 to 5:00 pm~~
- ~~August 20, 2024 from 5:00 to 6:00 pm~~
- ~~September 4, 2024 from 4:00 to 5:00 pm~~
- ~~September 17, 2024 from 5:00 to 6:00 pm~~
- ~~October 2, 2024 from 4:00 to 5:00 pm~~ – Cancelled
- ~~October 9, 2024 from 8:00 am to 3:00 pm (In-person meeting, Detroit, MI)~~
- October 15, 2024 from 5:00 to 6:00 pm
- November 6, 2024 from 4:00 to 5:00 pm
- November 19, 2024 from 5:00 to 6:00 pm
- December 4, 2024 from 4:00 to 5:00 pm
- December 17, 2024 from 5:00 to 6:00 pm
- January 1, 2025 from 4:00 to 5:00 pm
- January 21, 2025 from 5:00 to 6:00 pm
- February 5, 2025 from 4:00 to 5:00 pm
- February 18, 2025 from 5:00 to 6:00 pm
- March 5, 2025 from 4:00 to 5:00 pm
- March 18, 2025 from 5:00 to 6:00 pm
- April 2, 2025 from 4:00 to 5:00 pm
- April 15, 2025 from 5:00 to 6:00 pm
- May 7, 2025 from 4:00 to 5:00 pm
- May 20, 2025 from 5:00 to 6:00 pm
- June 4, 2025 from 4:00 to 5:00 pm
- June 17, 2025 from 5:00 to 6:00 pm

Attendance

- **Committee Members**
  - J.D. Menteer (Chair)
  - Hannah Copeland (Vice Chair)
  - Denise Abbey (Visting Board member)
  - Tamas Alexy
  - Maria Avila
  - Kim Baltierra
  - Jennifer Cowger
  - Kevin Daly
  - Rocky Daly
  - Jill Gelow
  - Tim Gong
  - Eman Hamad
  - Earl Lovell
  - Cindy Martin
  - Amanda Nathan
  - John Nigro
  - Jason Smith
  - David Sutcliffe
  - Martha Tankersley
  - Dmitry Yaranov
- **HRSA Representatives**
  - Arjun Naik
  - Kala Rochelle
  - Marilyn Levi
- **SRTR Staff**
  - Yoon Son Ahn
  - Avery Cook
  - Grace Lyden
  - Tim Weaver
- **UNOS Staff**
  - Viktoria Filatova
  - Kelsi Lindblad
  - Alina Martinez
  - Eric Messick
  - Laura Schmitt
  - Holly Sobczak
  - Kaitlin Swanner
  - Susan Tlusty
  - Kimberly Uccellini
  - Sara Rose Wells
- **Other Attendees**
  -