Normothermic Regional Perfusion (NRP) Workgroup: Meeting Summary

Meeting Information: Agenda and Attendees

Tuesday, January 27, 2026 | 2:00–3:00 p.m. ET | Location of Event: Teams

The following are meeting minutes from the Normothermic Regional Perfusion (NRP) Workgroup meeting, which took place on **January 27, 2026, 2:00–3:00 p.m. ET**.

Agenda

- Welcome
- Discussion and Review of Drafted Policy Elements
  - Neuromonitoring
  - Surgical Procedures and Standards
  - Authorization and Consent & Donor Patient Safety Reporting
- Next Steps and Adjourn

Attendees

Attendee Name(s)	Affiliation
PJ Geraghty, John Magee, Bill Ryan, Bob Truog, Brendan Parent, David Foley, Joseph Turek, Kris Croome, Lara Schaheen, Lori Markham, Rachel Beekman, Sarah Koohmaraie, Steve Weitzen	NRP Workgroup
Ray Lynch, Annie Tor	HRSA
Christine Jones, Rachel Shapiro, Doug Fesler, Amy Lin, Rebecca Fritz, Sophie To, Taylor Melanson, Tennille Daniels, Zulma Solis	OPTN Board Support

Meeting Summary

NRP Workgroup Chair PJ Geraghty opened the meeting by briefly reviewing the agenda.

Discussion and Review of Drafted Policy Elements

The workgroup chair noted that the Board Support team would display the draft policy elements document during the meeting and capture edits directly in the shared Box file so that updates reflected the group's real-time discussion.

Neuromonitoring

The group reviewed the work of the neuromonitoring subgroup and discussed whether continuous neuromonitoring should be required or otherwise addressed in NRP policy.

- Members noted that, after examining available modalities and the small number of published studies, no current neuromonitoring modality is sufficiently feasible, validated, or actionable to warrant inclusion in mandatory policy language.
- Several participants raised concerns that omitting neuromonitoring entirely could invite criticism, particularly from stakeholders who argue that the absence of monitoring fails to address uncertainty about potential cerebral perfusion or brain activity. In response, members emphasized the distinction between research findings and real-time clinical monitoring, noting that existing studies are limited, conducted in highly controlled settings, and lack validated thresholds that would support clinical decision-making.
- There was broad agreement that neuromonitoring could create false reassurance rather than improve patient safety, since no clear clinical response exists if monitoring suggests possible brain activity. Practical challenges—including staffing, expertise (e.g., epileptologist availability), and inconsistent interpretation—were cited as further barriers.
- The group agreed that these issues should be addressed comprehensively in the background document, including (1) review of existing studies, (2) explanation of technical limitations, and (3) rationale for excluding neuromonitoring from policy requirements. The group also supported continued research—particularly electroencephalogram (EEG)-based approaches in centers with appropriate expertise—but not as a condition of practice.

Surgical Procedures and Standards

The group reviewed proposed policy elements related to surgical techniques for NRP, including vessel transection, drainage requirements, and documentation.

- There was agreement that atmospheric drainage and single-clamp approaches are acceptable, provided all three head vessels are transected cephalad to the clamp.
- A significant focus was placed on documentation requirements, particularly the need to capture date and time of transection of each vessel. Participants emphasized that if documentation is required by policy, Organ Procurement and Transplantation Network (OPTN) systems must include clearly defined data fields to support compliance and auditability.
- The group also discussed huddle requirements, agreeing that a pre-departure huddle is appropriate when multiple recovery teams are involved, while an on-site huddle with organ procurement organization (OPO) staff and operating room teams is always required. Members emphasized that these huddles should ensure shared understanding of key elements, including hospital-specific Donation after Circulatory Death (DCD)/NRP policies, relevant withdrawal timeframes, and expectations regarding the duration of team presence.

Third-Party Recovery Teams and Accountability

The group addressed challenges related to third-party recovery teams, including communication failures, professionalism concerns, and unclear accountability.

- While contractual indemnification may limit legal liability for transplant centers, participants agreed that professional and OPTN accountability should remain with the transplant center that engages the third-party service.
- There was strong support for clarifying that (1) third-party recovery teams act as agents of the transplant center and (2) transplant centers are responsible for ensuring appropriate vetting and competency, adherence to professional standards, and effective communication with OPOs and donor hospitals.
- Members also noted that, in practice, it can be difficult to address misconduct when third-party teams are not clearly accountable within the existing OPTN framework, which can leave OPOs without a clear mechanism to resolve concerns that arise in the operating room.

Modality Disputes (Thoracoabdominal NRP [TA-NRP] vs. Abdominal NRP)

The group discussed conflicts between heart and lung teams regarding NRP modality selection.

- The workgroup chair reviewed a proposed framework that aligns modality decision-making with multi-organ allocation priority, using candidate status to determine which organ team's preference prevails.
- The group acknowledged that the referenced allocation framework is not yet final but viewed it as a reasonable interim approach that promotes consistency and transparency. Members agreed that donor hospital limitations and informed family consent must always take precedence.
- The group also discussed less common scenarios, such as TA-NRP requests when only abdominal organs are being recovered. The group emphasized that, in such cases, the procuring team should defer to the donor hospital's comfort and policy.

Next Steps

The workgroup chair encouraged members to review the draft document in advance of the next meeting—scheduled for February 2, 2026, 1:00–2:00pm ET—and provide edits and accompanying rationale statements to support continued refinement of outstanding policy elements.

Action Items

- **Board Support:** Distribute post-meeting materials (agenda, meeting summary, and recording) for workgroup members.
- **Board Support:** Prepare and display the updated draft policy elements document for the next workgroup meeting.
- **Workgroup Members:** Refine draft policy elements language, document all changes in the shared working file on Box, and prepare to address remaining elements at the next meeting.