Network for Hope

Transforming Lives Through Organ, Tissue, and Eye Donation

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August 27, 2025

The Honorable John Joyce, M.D.
Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
United States House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515-6115

Dear Chairman Joyce:

Thank you again for the opportunity to provide testimony on behalf of Network for Hope, Inc. at the Subcommittee's hearing entitled "Ensuring Patient Safety: Oversight of the U.S. Organ Procurement and Transplant System," conducted on July 22, 2025. Network for Hope, Inc. appreciates the Subcommittee's commitment to this important cause and its continued efforts to rebuild and strengthen the organ donation and transplant system in the United States.

Enclosed with this correspondence please find Network for Hope, Inc.'s Responses to the Additional Questions for the Record.

Should you have any additional questions or seek further information or clarification, please do not hesitate to contact me.

Sincerely,

Barry C. Massa
Chief Executive Officer

Additional Questions for the Record

July 22, 2025 Hearing | "*Ensuring Patient Safety: Oversight of the U.S. Organ Procurement and Transplant System*"

Barry C. Massa | Chief Executive Officer, Network for Hope, Inc.[1]

The Honorable John Joyce, M.D. (R-PA)

1. **Are there ever instances where cases are locked to prevent individuals who work for the OPO from viewing the details of the case after the case is closed?**

   It is NFH's standard policy that electronic donor case records are "locked" from further editing or revising once the required documentation and information has been entered into the case record, all open or assigned tasks within the case record have been completed, and the Compliance Department has completed a final quality assurance review of the case record. "Locking" a case record does *not* prevent an authorized user from viewing the case record for an authorized purpose (*e.g.*, to determine suitability for donation, to conduct quality assurance activities, *etc.*); once that specific authorized purpose is complete, the case record is "re-locked." Accessing a case record without a specific authorized purpose is strictly prohibited, as is sharing or disclosing confidential donor information that is not necessary to fulfill assigned job duties or responsibilities.

   a. **If so, please explain why that happens and how many cases are locked to prevent individuals who work for the OPO from viewing the case.**

      NFH's standard policy to "lock" electronic case records per the above is primarily intended to: (i) maintain and protect patient privacy and confidentiality, (ii) limit any unauthorized access of a case record, (iii) minimize late or unauthorized revisions to a case record, (iv) ensure that case records are only accessed to the extent minimally necessary, and (v) maintain the integrity of the case record as a whole. "Locking" a case record does *not* prevent an authorized user from viewing the case record for an authorized purpose.

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[1] The following terms used herein have the following meanings:

- "KODA" and "KYDA" refer to Kentucky Donor Affiliates, Inc.
- "NFH" refers to Network for Hope, Inc.
- "LCODN" refers to LifeCenter Organ Donor Network.
- "OPO" refers to an organ procurement organization.
- "DCD" refers to donation after circulatory death.
- "OPTN" refers to the Organ Procurement and Transplantation Network.
- "MPSC" refers to the OPTN Membership and Professional Standards Committee.
- The "Index Case" refers to the case involving A. Hoover in October 2021.
- "HRSA" refers to the Health Resources and Services Administration.

2. **Does Network for Hope have protocols, or limitations, that OPOs share with health care providers regarding the use of sedatives and paralytics for an organ donor candidate, including when the patient is assessed, during testing, and in the OR during the wait period?**

   No. Because OPOs (including NFH) do not provide health care to living patients, NFH does not prescribe, order, share, recommend, regulate, or make any requests related to the administration of sedatives or paralytics to any living patient at any time (and therefore does not maintain any protocols or limitations regarding such).

   a. **If so, what does that protocol entail?**

      N/A.

The Honorable Neal P. Dunn, M.D. (R-FL)

1. **How many senior executives (defined as anyone with a management role) from Kentucky Organ Donor Affiliates (KODA) are now employed at Network for Hope? Please list their names, their title at KODA before the merger, and their title at Network for Hope after the merger.**

Name	Title at KODA (pre-merger)	Title at NFH (post-merger)
Angela Watkins	Vice President & Chief Administrative Officer	Executive Vice President & Chief Strategy Officer
Aubree Hoskins	Surgical Preservation Supervisor	Surgical Preservation Manager
Brian Roe	Vice President & Chief Clinical Officer	Executive Vice President & Chief Partnership Officer
Brian Brunley	Central Supply Technician	Materials & Facilities Manager
Carrie Silvers	Clinical Responder Supervisor	Partnership Services Manager
Chris Dickson	Controller	Controller
Donald Miller	Education & Development Manager	Education & Development Manager
Dwayne Jolly	Tissue Services Manager	Director of Tissue Services
Gerald Stone	Accounting Manager	Accounting Manager
Gretchen Starnes	Aftercare Manager	Family Aftercare Manager
Jennifer Daniel	Director of Organ Services	Director of Organ Services
Julie Bergin	President & Chief Executive Officer	President & Chief Operating Officer

Katherine Mitchell	Organ Services Supervisor	Organ Recovery Manager
Krystne Browning	Human Resources Manager	Human Resources Manager
Kenny Peters	Tissue Recovery Supervisor	Tissue Recovery Manager
Lola Lewis	Partnership Services Manager	Director of Performance Excellence
Matthew Von Hauter	Organ Services Supervisor	Organ Recovery Manager
Melissa South	Family Services Manager	Family Support Manager
Robin Adkins	Senior Human Resources Generalist	Director of Human Resources
Ryan Etienne	Vice President & Chief Financial Officer	Executive Vice President & Chief Financial Officer

2. **At the hearing, you continued to maintain that TJ Hoover's case (known in the HRSA report as "the index case") was unique and refused to acknowledge serious problems. Why, specifically, was TJ Hoover's family not told that he woke up in the catheter lab during organ procurement preparations?**

   NFH acknowledges, as it did at the July 22, 2025 hearing, that the Index Case was difficult and that communication and collaboration between KODA and the hospital could have been vastly improved (among other things).

   According to documents in Mr. Hoover's medical record, after Mr. Hoover's health care provider ordered a cardiac catheterization to assist KODA with evaluating the suitability of Mr. Hoover's heart for potential donation, the health care provider explained that procedure in detail to Mr. Hoover's father. KODA has no direct knowledge of whether, as part of that explanation, Mr. Hoover's family was informed that Mr. Hoover "woke up in the catheter lab" during the administration of the cardiac catheterization. KODA's donor record does not reflect that KODA informed Mr. Hoover's family of Mr. Hoover's "purposeful movement" during the cardiac catheterization, which is information that NFH acknowledges should have been relayed at the time (KODA did speak with Mr. Hoover's family after Mr. Hoover was returned to the ICU, as reflected in the donor record). NFH has since revised its policies, procedures, and practices to facilitate more frequent and clear communication with hospital staff and a potential donor's family regarding any change(s) in a patient's condition that would affect the patient's ability to become a donor.

a. **Do you acknowledge that multiple whistleblowers have stated that after the doctor in the operating room called the treatment of Mr. Hoover "inhumane" and refused to proceed, that KODA leadership tried to find another doctor that would remove Mr. Hoover's organs?**

NFH denies the allegation that KODA leadership "tried to find another doctor that would remove Mr. Hoover's organs."[2]

3. **Did KODA ever report the TJ Hoover case to OPTN's MPSC for review?**

No. When the MPSC contacted KODA about the Index Case in September 2024, KODA cooperated with the inquiry and timely addressed the MPSC's requests for information.

The Honorable Russ Fulcher (R-ID)

1. **The HRSA report noted that 27.9% of KYDA cases involved patients who experienced intoxication from opioids, amphetamines, or cocaine. Opioid abuse remains an ongoing crisis, especially as illicit substances such as fentanyl continue to enter the US. Since opioid use can result in a presentation of lower neurologic scores than the patient actually possesses, how will Network for Hope train its employees to address the dangers of opioid cases?**

NFH, through its Medical Directors and through independent, licensed neurosurgical Advanced Registered Nurse Practitioners (ARNPs), annually trains its organ recovery coordinators on the complete neurological assessment, including, for example, potential changes resulting from a patient's use of illicit drugs before admission, when medications administered by health care providers as part of their provision of patient care may affect the accuracy of a neurological assessment, and other ways in which metabolic issues can potentially cause a neurological assessment to inaccurately reflect the patient's current neurological status. Additionally, NFH trains its staff to notify and review with a patient's health care provider any possible concerns related to a patient's clearance of neurological-influencing drugs shortly after authorization for donation is obtained or confirmed.

The Honorable Erin Houchin (R-IN)

1. **How many total donation by cardiac death (DCD) procurements did Kentucky Organ Donor Affiliates (KYDA), now Network for Hope, complete during the period in which the Health Resources & Services Administration (HRSA) conducted its investigation into the conduct and practices of KYDA?**

[2] NFH believes it is important to note that this allegation is not reflected in, or even supported by, any documentation in the donor record to NFH's knowledge.

Year	Number of DCD Donors[3]
2021	54
2022	66
2023	113
2024	138

The Honorable Frank Pallone, Jr. (D-NJ)

1. **Has Network for Hope made any changes to policies or personnel that would require a patient case like the 2021 index case in Kentucky be handled differently than the way it is portrayed in HRSA's report? If so, please describe those changes.**

   Yes. Since learning of the allegations related to the Index Case in September 2024, NFH has implemented a number of operational, personnel, and policy changes, including, but not limited to, the following:

   - Requiring that NFH staff observe the hospital care team's neurologic assessments at least every 12 hours throughout the case. If an NFH staff member observes any change that would indicate improvement in the patient's condition (*e.g.,* a rise in the GCS to >/=7), they are required to contact NFH's Administrator on Call and Medical Director to reassess donor suitability.

   - Enhancing DCD policies, procedures, and trainings to, for example: (a) clarify when the Medical Director should be contacted to obtain determination (and redetermination, as needed) of a patient's medical suitability and how it should be documented in the electronic donor record; (b) better detail the roles and responsibilities of OPOs in the DCD process; (c) outline the process for huddling, discussing, and addressing with hospital staff any concerns or observations raised by anyone involved in the case (*e.g.,* NFH staff, hospital staff, a family member, recovery team staff, or a third-party contractor) regarding a patient's condition, including any reflexes, signs of improvement, or appearance of experiencing pain. If the concerns are resolved and the health care provider's plan of care for the patient and the family's decision to withdraw life sustaining treatment remains the same, the plan for donation may proceed. If a change in the patient's care plan is initiated by the family or healthcare team that does not

[3] This represents the number of donors from whom at least one organ was recovered during the DCD process.

include the withdrawal of life sustaining treatment, NFH will not pursue donation.

- Revising DCD "Hard Stops" to require that NFH staff review a potential donor's initial neurological assessment and any reassessment(s) with NFH's Administrator on Call, in consultation with the Medical Director, at the start of the case, prior to allocation, and prior to the operating room, to evaluate medical suitability.

- Strengthening personnel, including hiring additional Medical Directors, clinical recovery staff, and hospital services coordinators. In addition, NFH has expanded its executive leadership team to allow for more focused oversight, and it has implemented cross-functional quality improvement teams.

- Instituting weekly debriefs to review and discuss all DCD cases.

- Developing and implementing additional guidance related to DCD cases, including, for example, an RN DCD Checklist, a DCD Protocol Checklist, and DCD Guidelines for Attending Physicians

- Improving relationships with hospital partners by, for example: (a) developing educational training modules for hospital staff, (b) hiring additional staff to engage with hospitals for DCD education and case follow-ups, and (c) enhancing overall collaboration and communication.

- Enhancing staff education, training, and evaluation.

Additionally, NFH has fully implemented all the changes and corrective actions required by the HRSA-approved Corrective Action Plan, which include, for example, conducting huddles with the patient's health care team, conducting just in time education for anyone involved in the case at the time of withdrawal of life sustaining care, and ongoing reinforcement of stakeholders' ability to pause donation if concerns are raised regarding the possibility of the patient experiencing pain or potential improvement in status.

2. **As you understand current OPTN guidelines for organ procurement organizations (OPO), when does an OPO have a responsibility to terminate a planned procurement if a patient's condition changes and indicates that they may no longer be an appropriate candidate for donation?**

   To date, the OPTN has not issued any formal guidelines that dictate when an OPO has a "responsibility to terminate a planned procurement if a patient's condition changes" in a way that would indicate that they "may no longer be an appropriate candidate for

donation."[4] However, the OPTN and HRSA have provided guidance specific to NFH through the development and approval of the HRSA-approved Corrective Action Plan. As noted above, the HRSA-approved Corrective Action Plan requires, among other elements, additional and more frequent neurological assessments, elevation of a patient's neurological improvements to the Administrator on Call and the Medical Director for donor suitability reassessment, consideration of a stakeholder-requested "pause" in the donation process if concerns are raised, and increased training and communication for both NFH and hospital staff.

[4] OPTN Policy 2.15 ("Requirements for Controlled Donation after Circulatory Death (DCD) Protocols"), which took effect on August 1, 2025, provides general, broad guidance on DCD protocols, DCD donor evaluation, and organ recovery in DCD cases.