

OPTN/UNOS Kidney Transplantation Committee
Report to the Board of Directors,
November 17-18, 2008
St. Louis, MO

Summary

Action Items For Board Consideration

- None

Other Significant Items

- The Committee voted to circulate a concept proposal for public comment to solicit feedback about the use new concepts in an allocation system. (Item 1, Page 3)
- The Committee recommended that the SRTR modify existing covariates in the kidney center specific reports (CSR), eliminate and add covariates to the CSR, and revise the methodology for the kidney CSR. (Item 2, Page 5)
- The Committee is working with the Liver and Intestinal Organ Transplantation Committee to develop listing criteria for liver-kidney transplants. (Item 3, Page 7)
- The Committee considered adding altruistic donors, closed chain donation, and open chain donation to the KPD Pilot Program. (Item 4, Page 10)

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OPTN/UNOS Kidney Transplantation Committee
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Peter G. Stock, MD, PhD, Chair
Kenneth Andreoni, MD, Vice Chair

This report summarizes the work of the Kidney Transplantation Committee during its July 16, 2008 meeting and its August 28, 2008 teleconference.

Abbreviations: Center Specific Reports (CSR) Donor Profile Index (DPI); Dialysis Time (DT); Life Years from Transplant (LYFT); Office of Civil Rights (OCR); Orthotopic Liver Transplantation (OLT); Simultaneous Liver-Kidney Transplantation (SLK)

1. **Kidney Allocation System**

In December 2007, the Committee voted to circulate a concept proposal for public comment to solicit feedback about the use new concepts in an allocation system. During the first quarter of 2008, a subcommittee drafted a document but has not circulated it due to the ongoing review by the Department of Health and Human Services (HHS) Office of Civil Rights (OCR). Due to the magnitude of considered changes to the kidney allocation system, this review is part of the policy development process and should be completed before the Committee issues a formal public comment proposal. The OCR will determine if the concepts under consideration are in line with existing federal regulations including the Age Discrimination Act and Medicare reimbursement rules. Several Committee members as well as Board of Directors members discussed the need for on-going dialogue with the transplant community and general public about the process to develop a new system. They expressed concern that the delay in issuing a public comment proposal may signal to the community that the proposed concepts are inadequate or flawed in some way. To keep the transplant community and general public engaged in the policy development process, the Committee, Board of Directors, and HRSA DOT staff have agreed to release a concept document as a Request for Information (RFI).

Ciara Gould, UNOS policy analyst and liaison to the committee, explained the rationale and process for issuing an RFI. The OPTN public comment process is designed to solicit feedback on policy proposals. Currently, the Committee does not have a formal policy to propose. The concept document drafted by the subcommittee explains the major components for a possible kidney allocation system (i.e., life years from transplant, time on dialysis, and donor profile index), as well as the more minor components (e.g., the A₂/A₂B allocation sequence, and a sliding points scale for sensitization). The concept document does not contain policy language directing the actions of OPTN member institutions. The RFI process is utilized by federal agencies (e.g., National Institutes of Health and the Centers for Disease Control and Prevention) to solicit feedback on concepts and proposed approaches. UNOS will release a concept document through a similar process with a series of questions for consideration by members of the transplant community and general public. The questions and responses will then be discussed in a public forum.

The Committee reviewed the following questions and considered whether to add others to the RFI.

- **Life Years from Transplant (LYFT)**
Please describe any limitations to the use of LYFT in an allocation system. Equally, are there any benefits you see to incorporating LYFT? If so, please concisely describe them.
- **Dialysis Time (DT)**
Please describe any limitations to the use of DT in an allocation system. Alternately, what benefits do you see to incorporating DT? Please concisely describe them
- **Donor Profile Index (DPI)**
Please describe any limitations to the use of DPI in an allocation system. Are there any benefits you see to incorporating DPI? If so, please concisely describe them.
- **Solutions to Limitations**
Please concisely describe specific approaches or concepts that would address any of the above limitations.

Members recommended reversing the limitations and benefits questions. The current ordering of limitations before benefits sets a negative tone for responses. Instituting a page or word limit was strongly recommended. One member suggested that the following question be added: “are the proposed concepts superior to the concepts on which the current system is based (e.g., time since listing, HLA matching, etc).” Some on the Committee were concerned that feedback to the RFI would indicate that the public desires to keep the current system. A Committee member reminded others that the activities of the Committee to research and propose new concepts for kidney allocation were mandated by the Board of Directors. With the known limitations of the current system and the potential for improvement, it is unlikely that the Board would consider continuing the current system if presented with a reasonable proposal for an improved system.

The committee also discussed the need to communicate with the transplant community through established media. The journals Transplantation and The American Journal of Transplantation were recommended as possible sources. A manuscript is currently being developed to describe the Committee’s process and work to date. Additionally, the 2007 OPTN/SRTR annual report contains an article on the LYFT methodology.¹

Finally, the Committee established a subcommittee to design and execute a public forum. The Public Forum Subcommittee will be led by Committee member Marjorie Hunter, JD. Silas Norman, John Hodges, Albin Gritsch, Marla Rodgers, Dorry Segev, Eileen Brewer, Mark Stegall and Steven Rayhill volunteered to serve on this subcommittee.

In August 2008, Keith McCullough of the SRTR presented data on the bolus effect in the kidney-pancreas simulated allocation (KPSAM), KAS tool and LYFT scores for living donor transplants. As part of the ongoing effort to evaluate the effect of changes to the kidney allocation system and in

¹ 2007 OPTN / SRTR Annual Report: Transplant Data 1997-2006.
http://www.ustransplant.org/annual_reports/current/. Accessed 21 July 2008.

order to determine the differences in outcomes of living donor (LD) vs. deceased donor (DD) transplants and determine if the use of LYFT with appropriate modifications is appropriate or feasible for pediatric candidates, the Committee requested additional data analyses.

A long term goal of these analyses is to determine expected outcomes accounting for waiting times to transplant are desired. These calculations depend strongly upon the allocation system and development of such calculations would be prioritized in conjunction with potential changes in the allocation system. Information about pediatric outcomes is also of interest, although detailed development of those models has not begun and will be limited by small sample sizes and by the longer lifetimes of these recipients, which requires more reliance upon extrapolation of empirical models.

Specifically, the Committee requested additional analyses on LYFT to show average characteristics of recipients of living donor and deceased donor kidneys. The Committee also requested comparisons of deceased and living donor kidneys according to a donor profile index. To make the information more relevant at a donor service area level, the Committee also requested analyses of time-to-transplant at listing under the current system versus a new system. Finally, the Committee is beginning to investigate the relevancy of a pediatric LYFT calculation.

2. Center Specific Reports Subcommittee

In February 2007, the Membership and Professional Standards Committee (MPSC) requested that the Kidney Committee review the covariates used in the living and deceased donor kidney transplant Center Specific Report (CSR) models. Mark Stegall, MD, presented the three main recommendations of the CSR subcommittee.

Recommendation 1: Modify Existing Covariates

Currently, age and PRA are categorical variables in the CSR models. After reviewing the categories, the Committee raised concerns that the categories are too broad. For example, the donor age category of 50-64 implies that the risk from a 50 year old donor is the same as from a 64 year old donor. However, current allocation policy acknowledges the increased risk of donors >60 years old. The SRTR reported that it is looking into the use of splines to capture non-linear distributions within categories. The Committee recommended that donor and recipient age should be included in the CSR models as continuous variables. The Committee also recommended that *recipient peak PRA* be changed from its current format as a categorical variable, to a continuous variable.

The current CSR models do not include interaction terms. The Committee recommended incorporating interaction terms to address the combined effects of conditions such as diabetes and hypertension with recipient and donor age.

Finally, the Committee requested analyses from the SRTR to determine the predictability of the CSR models. The SRTR described that the index of concordance for the models is approximately 70% meaning that when the outcomes of two recipients are compared, the model predicts which recipient survived longer 70% of the time. Some on the Committee were concerned with this finding given that random chance (e.g., through flipping of a coin) would have an index of concordance of 50%.

The Committee also requested analyses to determine whether there are upper limits where confidence is affected for variables such as donor age and recipient age. The Committee was concerned that the sample sizes for donors >65 may affect the confidence for recipients of these organs. Likewise the number of older recipients, especially when complicated by the interactive terms of diabetes and donor age, may not be adequate for a predictive model.

Recommendation 2: Eliminate or Add Covariates to the CSR

During the development of a new kidney allocation system, the Committee only used data elements that were thought to be objective, clinically relevant, statistically significant, and non-gameable. The Committee employed the same standards when reviewing the CSR covariates.

The Committee recommended eliminating Functional Status because it is not objective. The American Heart Association only uses Functional Status with objective clinical assessment to classify patients with cardiac disease.

The Committee recommended eliminating Recipient Primary Insurance as it is not clinically relevant or statistically significant. Additionally, a candidate's primary insurance may change throughout the course of treatment for recipients as Medicare coverage for immunosuppression expires.

The Committee recommended eliminating deceased donor kidney was pumped because recent SRTR analyses did not show an improvement in outcome for recipients of pumped kidneys.

The Committee recommended adding factors to account for the duration of diabetes and hypertension in deceased donors. The current model only contains dichotomous variables for diabetes and hypertension. The same could be said of recipients as length of exposure to diabetes and hypertension leads to increased risk of mortality and morbidity.

The Committee recommended adding donor biopsy results (%glomerulosclerosis <15%, 15-30%, >30%; if no biopsy then default to <15%), recipient diagnosis of hepatitis C, donor kidney size, and recipient diagnosis of peripheral vascular disease. Recipient PVD and donor kidney size would require additional data collection in UNetsm and may not be feasible at this time.

The Committee recommended that the current variable donor meets expanded donor criteria (ECD) be replaced by donor profile index (DPI).

Recommendation 3: Revise Methodology

The Committee recommended revisions to the methodology to improve the CSR models. Primarily, the Committee recommended that any missing data be defaulted to the value that gives the best expected outcome. Currently, there is a disincentive for reporting all data, especially data that may result in a lower expected outcome.

The Committee will continue to review the methodology and dialogue with the SRTR. There is still strong sentiment that the most fair evaluation models are going to need to exclude groups with little information until a greater experience with those groups can be collected. The Committee also favors replacing the current expanded criteria donor (ECD) designation in the model with a donor profile index (DPI) since DPI provides more granular information about kidney quality than the dichotomous ECD variable.

One member remarked that inclusion of waitlist mortality in the model was inappropriate since transplant centers are not fully involved in the care of transplant candidates, only transplant recipients. Some on the Committee requested that the current CSR models be suspended pending revisions to the methodology. Gregory Fant, HRSA liaison to the Committee, reminded the Committee that the CSRs are a requirement in the SRTR contract so while discussion of the methodology is encouraged, the SRTR contractor is obligated to provide this information at this time.

The Committee thanked the subcommittee for its work and voted to send the above recommendations to the MPSC (17 in favor, 0 opposed, 0 abstentions). In the memo, the Committee will ask the MPSC to provide additional instructions for further review.

3. **Liver-Kidney Allocation**

Todd Pesavento, MD, presented the work of the Liver-Kidney Allocation Subcommittee (**Exhibit A**). This subcommittee is a joint venture between the Liver-Intestinal Organ Transplantation Committee and the Kidney Transplantation Committee. The intent of the policy in development is to identify candidates who are not likely to regain kidney function after orthotopic liver transplant and to provide these candidates priority for liver-kidney allocation. The proposal includes listing requirements for simultaneous liver-kidney (SLK) candidates as well as listing requirements for liver recipients in continued renal failure (as a safety net provision).

The demand for liver-kidney transplantation has increased from 2.2% of all orthotopic liver transplants (OLT) in 1988 to 7.1% in 2007 (Figure 1). The total number of deceased donor kidneys used in SLK transplantation has increased from 38 to 439 during the time period.

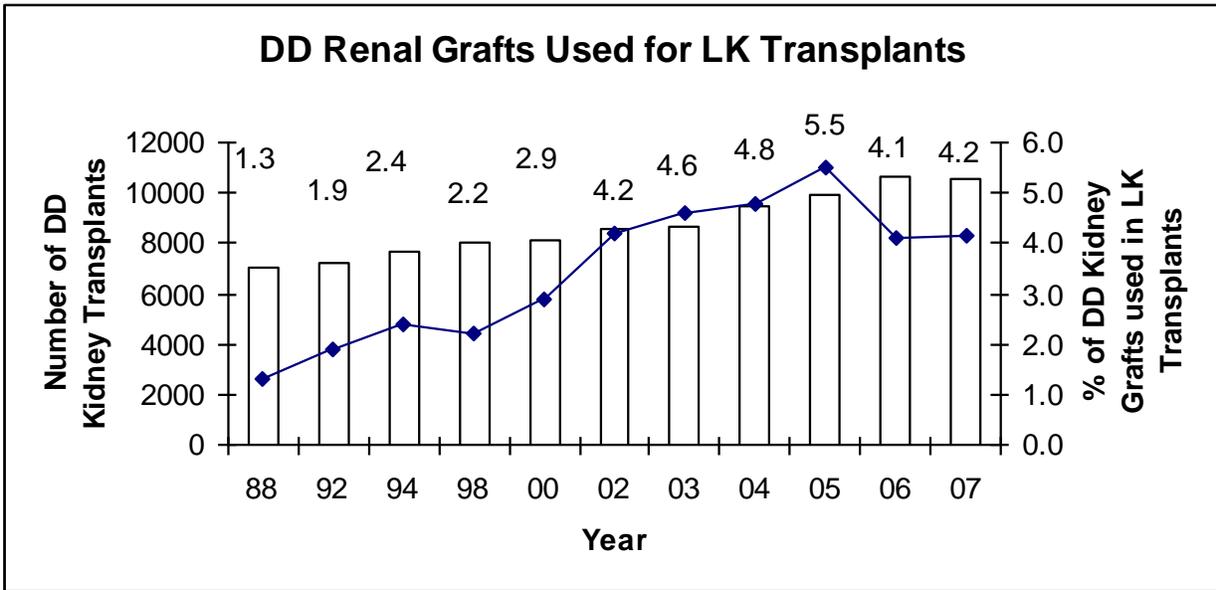


Figure 1: Deceased Donor Renal Grafts Used for Liver-Kidney Transplants

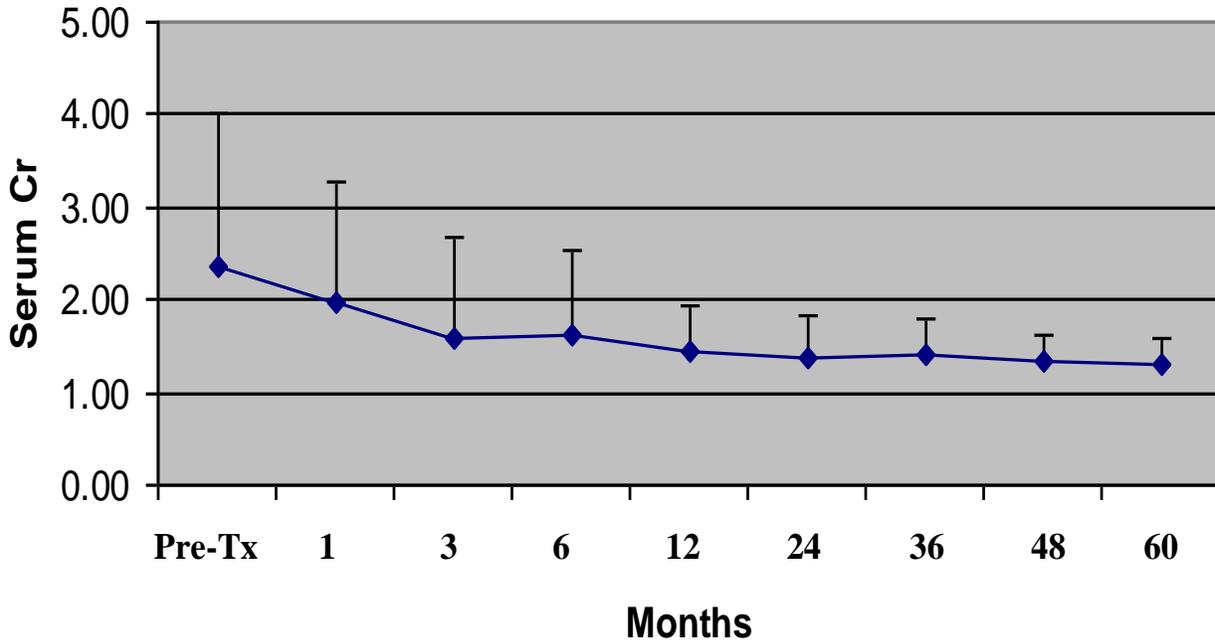


Figure 2: Renal function after Orthotopic Liver Transplant (OLT)

Candidates for SLK would fall into one of three categories: chronic renal failure, sustained acute renal failure, or metabolic disease. The criteria for each of these categories is provided in Table 1. Requirements for candidates who need a kidney after liver transplant are outlined in Table 2.

		Dialysis Required?	Time Duration	Documentation Requirement
A. Chronic Renal Failure	1	Yes	None	Documentation of the date of initiation of dialysis and the cause of ESRD (CMS Form 2728)
	2	No	None	[GFR \leq 30 ml/min by MDRD6 OR Direct measurement (iothalamate or iohexol)] AND proteinuria (> 3gms protein per day with 24 hour protein measurement or Urine Protein/Creatinine ratio >3.0)
B. Sustained Acute Renal Failure	1	Yes	\geq 6 weeks	Documentation of dialysis at least 2 times per week
	2	No	\geq 6 weeks	GFR \leq 25 ml/min by MDRD6, iothalamate, or iohexol (test results reported every seven days)
	3	Yes	\geq 6 weeks	Combination of B1 and B2 documentation for at least 6 weeks
C. Metabolic Disease	1	No	None	Documentation from a nephrologist specifying the reason for kidney transplant

Table 1: Listing Requirements for Simultaneous Liver-Kidney (SLK) Transplantation

		Dialysis Required pre-Liver Transplant	Time Duration	Documentation Requirement
D. Liver Recipients who did not qualify for SLK initially	1	Yes	\geq 2 weeks	Documentation of dialysis pre-liver transplant
	2	No	\geq 4 weeks	Documentation of intrinsic kidney disease pre-liver transplant and GFR between 30 and 40 ml/min for at least 4 weeks pre-liver transplant
	3	Yes	\geq 4 weeks	Combination of D1 and D2 documentation for at least 4 weeks

Table 2: Requirements for Liver Recipients who did not qualify for SLK initially who remain in renal failure post liver-transplant

A member of the Committee remarked that the methodology for calculating glomerular filtration rate (GFR) was only applicable to adult candidates. The data analyses only included candidates older than 11 years. The Committee agreed to study pediatric candidates and possibly adjust the criteria for these candidates to continue to provide access to SLK transplantation.

Another member remarked that that the criteria for kidney-after liver transplant may be too broad since many liver recipients experience renal failure immediately after transplant and then recover. Dr. Pesavento responded by pointing out that the requirement of 90 days post liver transplant should limit the kidney allocation priority to those liver recipients who are unlikely to regain renal function with their native kidneys (Figure 2).

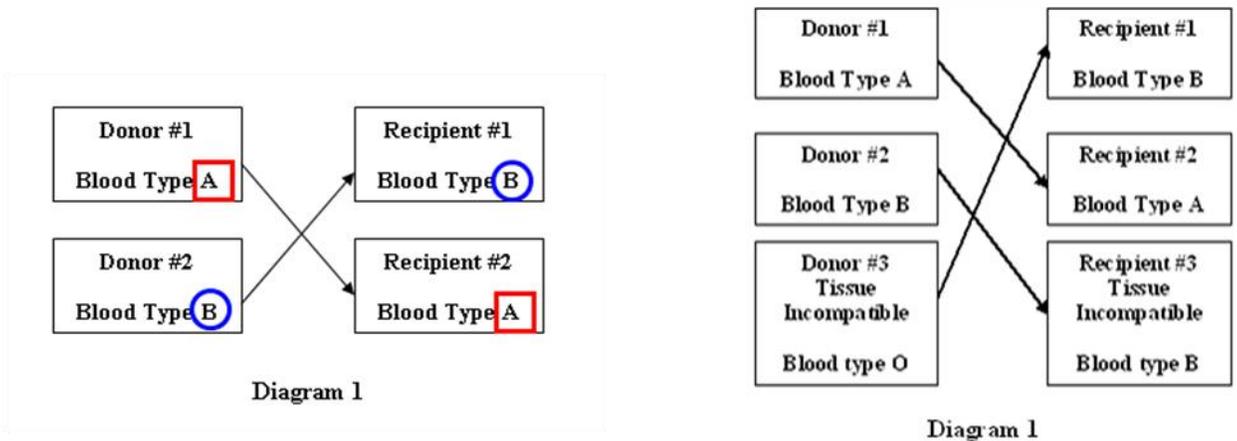
The Committee also discussed ways to collect information to evaluate a possible policy change. Possible approaches include a conglomeration for centers to join to amass laboratory data. Following transplant, the Committee also recommends the following data elements to be collected at discharge, 6 months, and 12 months: serum creatinine, albumin, BUN, and dialysis (start and stop dates).

Following review, the Committee determined that this policy proposal should be sent for public comment jointly by the Kidney Transplantation Committee and the Liver and Intestinal Organ Committee (17 in favor, 0 opposed, 0 abstentions).

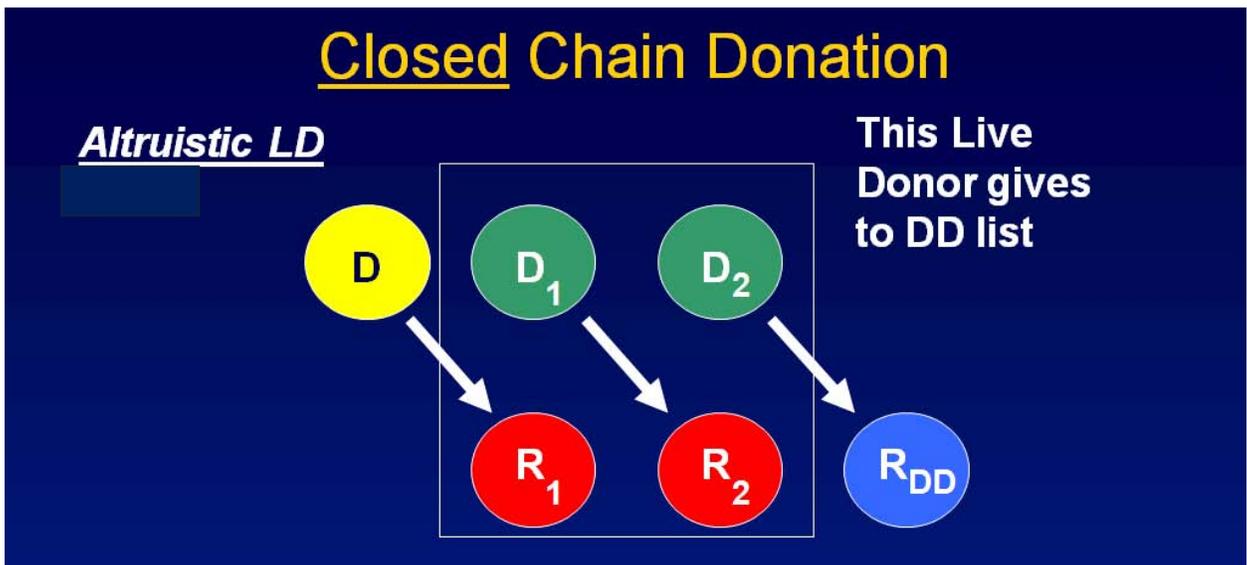
4. **Kidney Paired Donation**

Ken Andreoni, MD, Chair of the Kidney Paired Donation (KPD) Working Group updated the Committee on recent progress to develop a national KPD system (**Exhibit B**). In June 2008, the Board of Directors approved a national KPD pilot program. This program will allow transplant centers with living kidney donor programs to elect to participate. As approved, the pilot program would allow for two and three-way matches of donor and recipient pairs (Figure 3).

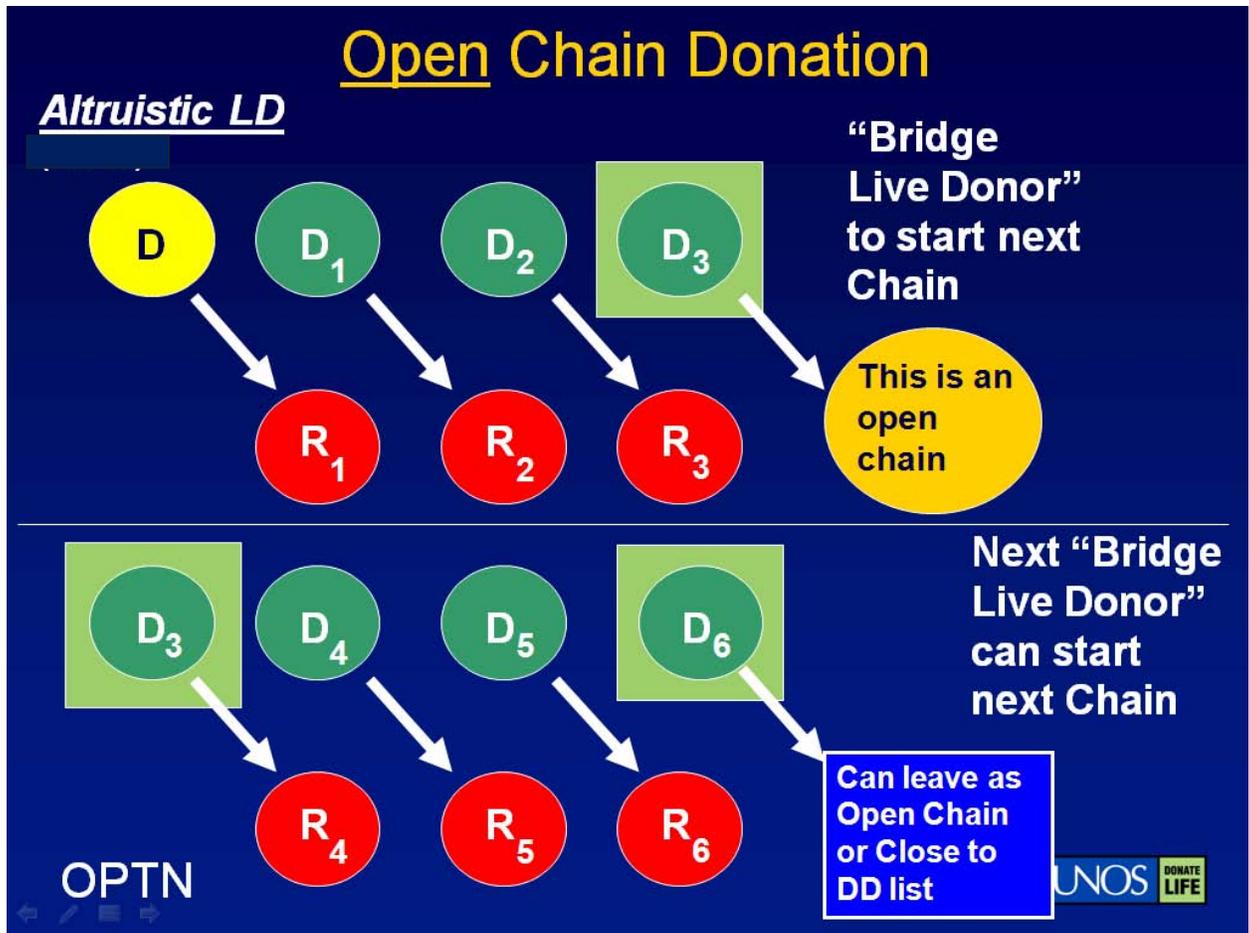
Figure 3: Two and Three-way Matching of Donor and Recipient Pairs



Many KPD experts agree that additional features, such as open and closed chains, would greatly increase the number of possible matches (and subsequently transplants) achievable by a KPD system. Dr. Andreoni explained these two approaches to the Committee. With a closed chain, an altruistic donor gives to a KPD recipient (R1). The paired donor (D1) then gives to the next recipient (R2). The second donor (D2) then closes the chain by donating to the deceased donor list. Some expressed concern that because these transplants do not take place simultaneously, increasing the likelihood that some potential donors may back out before donating their kidney. Dr. Andreoni explained that this is possible and that the longer the time period between the recipient receiving a kidney and the donor giving to the next recipient in the chain, the higher the likelihood of failure. However, the advantage of this approach is that the recipient always receives a kidney before his or her donor is required to donate. With two and three way matching, even with simultaneous procedures, the possibility that one donor is unable to donate due to medical issues discovered during nephrectomy exists, meaning that one recipient could potentially lose their donor. With closed chains, the donor in the donor-recipient pair only donates after his or her recipient receives a transplant. The final donor in the chain will then donate to the deceased donor list within 3 months of his or her intended recipient's transplant.



Dr. Andreoni also explained open chains which are also started by altruistic donors. However, unlike closed chains, the last living kidney donor becomes the start or “bridge” donor for the next chain. The Committee decided that if the next chain cannot be started within 3 months, then the last living kidney donor would donate to the deceased donor list, thereby closing the chain. The Committee also decided to allow for up to 3 transplants within a chain. The KPD Work Group will develop a proposal for public comment to be circulated in late 2008 regarding open and closed chain options within the KPD pilot program.



5. **Proposal to verify that foreign agencies importing organs to the United States, or receiving organs exported from the United States, are legitimate and test organs for transplant safety.**

Christie Thomas, MD, presented a policy proposal by the Ad Hoc International Relations Committee. The intent of the proposal is to clarify and strengthen existing policy language on importing and exporting deceased donor organs to and from the US. Specifically, this proposal would address the clinical (laboratory) safety of imported organs, the application of ethical practices in recovering deceased donor organs imported for transplant, and the application of ethical practices in distributing organs exported from the US. Finally, the proposal would strengthen the legitimacy of the foreign organization engaged in importing an organ to an OPTN member or receiving an organ exported from an OPTN member. A member of the Committee asked if this proposal was in response to an adverse situation. In fact, this proposal is a proactive action taken by the Ad Hoc International Relations Committee to strengthen existing policies. One other member remarked that legitimizing a foreign institution is difficult to do, but that this proposal seemed to be a good initial step. The Committee voted to approve the proposal with a vote of 10 in favor, 0 opposed, 0 abstentions.

6. **Proposal to improve the safety of living donation by restricting the acceptance and transplant of living donor organs to OPTN member institutions**

Steve Rayhill, MD, presented a proposal from the Living Donor Committee to restrict recovery of living donors to OPTN member institutions. Living donors recovered at non-OPTN member facilities may not be afforded the same protections provided at OPTN member institutions. Consequently, the Living Donor Committee proposes that living donor organs must be recovered at OPTN member institutions. The Kidney Transplantation Committee discussed this proposal at length. Some members were concerned that this proposal would inconvenience living donors, especially those in rural areas who may not have access to an OPTN member center. Other members remarked that some inconvenience may be warranted if the living donor's safety is improved. One member was concerned of the impact that this policy may have on pediatric transplant programs. These programs are often affiliated with an adult transplant program, though, and so recovery tends to take place at an OPTN member center. The Committee suggested a new membership category to recognize recovery centers that do not transplant organs. After discussion, the proposal was approved with a vote of 10 in favor, 0 opposed, 0 abstentions.

7. **Proposal to change the OPTN/UNOS Bylaws to better define functional inactivity, voluntary inactive membership transplant program status, relinquishment of designated transplant program status, and termination of designated transplant program status**

David Klassen, MD, presented a proposal from the Membership and Professional Standards Committee (MPSC) to better define functional inactivity, voluntary inactive membership transplant program status, relinquishment of designated transplant program status, and termination of designated transplant program status. All active candidates have to be transferred within 60 days to fulfill the proposed policy requirements. The MPSC specifically asks if the time periods (60 days) for waiting list transfers are considered achievable.

The Committee discussed this question at length and had some additional questions. First, it was unclear whether the time period of sixty days meant that all candidates at the closing center had to be active on another center's waiting list. Centers have different acceptance criteria for transplant candidates and some candidates may require additional testing. If the closing center has a lot of candidates on its waiting list, other centers in the donor service area may be unable to absorb the volume.

The Committee was also concerned about the notification requirements for centers that choose to go into inactive status voluntarily. Some on the Committee suggested that a center could inactivate, notify its candidates early in the process and then remain inactive without further communication to its candidates for up to a year. The Committee requests that there be specific guidelines describing how notification should take place in these circumstances to ensure that candidates are not left uninformed for long periods of time.

8. Allocation of Kidneys to Pediatric Candidates

The Committee briefly discussed a request from the Pediatric Transplantation Committee regarding allocation to highly sensitized pediatric candidates. In a recent review of data following the implementation of the current policy to preferentially allocation kidneys from donors younger than 35 years of age to pediatric candidates (i.e., the Share 35 Policy), the Pediatric Committee identified an opportunity for improvement. The data indicated that, in general, post Share 35, the transplant rate increased for all except those highly sensitized candidates aged 0-5 and 6-10. The overall transplant rate for candidates with 80% or greater sensitization is much lower than for the other candidates. In general, pediatric candidates have benefited from Share 35, but some highly sensitized candidates have been potentially harmed. This indicates that the Share 35 concept is sound, but sensitized pediatric candidates who now have no priority above adults are not being helped. If the allocation algorithm is revised to make offers to sensitized children before adults, this should be expected to have a positive effect.

In December 2007, the Kidney Transplantation Committee discussed whether to address these findings with a policy proposal. Since a proposal for an entirely new allocation system was expected to be released within a few months, and since this issue is addressed within that proposal, the Committee determined that a separate proposal was not necessary. Due to delays in releasing the new allocation system proposal, the Committee decided to revisit its decision. The Committee voted to form a joint subcommittee with the Pediatric Committee to further investigate the possibility for a policy proposal addressing allocation to highly sensitized children. Eileen Brewer, MD, will lead the subcommittee with Silas Norman, MD, Albin Gritsch, MD, and Peter Stock, MD, participating from the Kidney Transplantation Committee. Dr. Brewer will report a path forward at the Committee's next meeting.

9. Orientation sessions

In July, new and returning Committee members heard orientation sessions presented by members of the UNOS Information Technology Department and the Policy, Membership, and Regional Administration Department (PMR). Paula Bryant, Director of Information Management Systems and Aaron Powell, Project Office Manager, presented Policy Implementation Technology Considerations (**Exhibit C**). Karl McCleary, PhD, Director of PMR, presented OPTN/UNOS Policy Development Framework and Process: Strengthening Evidence-Based Health Policy Capabilities to Improve Transplantation (**Exhibit D**).

Following the presentations, Committee members discussed the implications that the current backlog in IT development is having on the policy passed by the Board of Directors in June 2008 to eliminate mandatory sharing of zero-antigen mismatched kidneys for unsensitized adults. The Committee recommended that UNOS institute some form of IT governance to prioritize projects. Perhaps a group made up of Committee representatives could provide assistance. Jill McMaster, the Board of Directors Liaison, reassured the Committee that the Board is aware of and will discuss the circumstances during its September 2008 meeting.

One Committee member asked how IT projects are assigned priority and expressed concern that projects to improve patient safety may not be expedited appropriately. UNOS staff explained that projects related to patient safety and disease transmission are given priority over changes to allocation policy. Another Committee member wanted to know why UNOS was expanding its scope of work from focusing on allocation to regulation and evaluation. Mary D. Ellison, UNOS Assistant Executive Director for Federal Affairs, explained that UNOS was acting appropriately given that the current contract and the Final Rule require activity in these areas.

**Attendance at the July 16, 2008
meeting of the
OPTN/UNOS Kidney Transplantation Committee
Chicago, IL**

Member	Position	Attended
Peter Stock MD, PhD	Chair	x
Kenneth Andreoni MD	Vice Chair	x
Dicken Ko MD	Regional Rep.	
David Klassen MD	Regional Rep.	x
Denise Alveranga MD, FACP, FASN	Regional Rep.	x
Charles Van Buren MD	Regional Rep.	x
H. Albin Gritsch MD	Regional Rep.	x
Stephen Rayhill MD	Regional Rep.	x
John Friedewald MD	Regional Rep.	
Christie Thomas MBBS	Regional Rep.	x
Devon John MD	Regional Rep.	x
Todd Pesavento MD	Regional Rep.	x
Oscar Grandas MD	Regional Rep.	x
Eileen Brewer MD	At Large	x
J. Michael Cecka PhD	At Large	x
Randall Heyn-Lamb RN, BSN, CPTC	At Large	phone
Marjorie Hunter Esq	At Large	x
Patricia Niles RN, BS, CPTC	At Large	
Silas Norman MD	At Large	x
Janis Orłowski MD	At Large	phone
Marla Rodgers MBA	At Large	x
Dorry Segev M.D.	At Large	x
Trent Tipple M.D.	At Large	x
Sean Van Slyck BA, CPTC	At Large	x
Winfred Williams MD	At Large	
Dolph Chianchiano JD, MPA	BOD - Liaison	phone
John Hodges M.A.	BOD - Liaison	x
Marla Jill McMaster MA, CAPT-USNR(Ret)	BOD - Liaison	x
Gregory Fant PhD	Ex. Officio	x
Mark Stegall MD	Ex. Officio	x
James Burdick MD	Ex Officio	
Christopher McLaughlin	Ex Officio	
Elizabeth Ortiz-Rios MD, MPH	Ex Officio	
Alan Leichtman MD	SRTR Liaison	x
Keith McCullough	SRTR Liaison	x

Robert Wolfe Ph.D.	SRTR Liaison	
Ciara Gould MSPH	Committee Liaison	x
Wida Cherikh Ph.D	Support Staff	x
Karl J. McCleary, PhD	Support Staff	x
Mary D. Ellison, PhD, MHSA	Support Staff	x
Paula Bryant	Support Staff	x
Aaron Powell	Support Staff	x
Anne Pashcke	Support Staff	x
Maureen McBride Ph.D.	Support Staff	phone
Dielita McKnight	Support Staff	phone