

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

Summary

Action Items for Board Consideration

- The Board of Directors is asked to approve modification to Policy 3.3.7 (Center Acceptance of Organs from Living Donors) (Item 1, Page 3)

Other Significant Items

- Status of Living Donor Follow-up (Item 2, Page 6)

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

Matthew Cooper, MD, Chairman
Connie Davis, MD, Vice Chair

The following report is a summary of the OPTN/UNOS Living Donor Committee's deliberations and discussions during its full Committee meetings held on May 12, 2008, and October 6, 2008, and Live Meeting on December 18, 2007.

1. Proposal to improve the safety of living donation by restricting the acceptance and transplant of living donor organs to OPTN member institutions (Proposed Addition to Policy 3.3.7, Center Acceptance of Organs from Living Donors) (**Exhibit A**)

Living donation is unique in its potential for both harm and benefit to the volunteer donor. For this reason, the OPTN is committed to developing and maintaining system-wide standards that provide the best possible care and the least potential harm for living donors. Living donors recovered at non-OPTN member facilities may not be afforded the same protections provided at OPTN member institutions. Consequently, the Committee proposes that living donor organs must be recovered at OPTN member institutions.

In a statement published in the Federal Register on June 16, 2006, HRSA determined that OPTN policies addressing issues of donor safety and equitable allocation of living donor organs will have the same enforceability as deceased donor policies under the OPTN Final Rule. The Federal Register notice expresses that the emphasis of living donor guidelines and policies, should be "to promote the safety and efficacy of living donor transplantation for the donor and recipient."

The bylaws establish membership criteria for deceased donor transplantation programs as well as for transplant programs that perform living donor transplants, and help standardize quality level among transplant programs. In September 2007, the OPTN/ UNOS Board approved new bylaws for member transplant centers that operate kidney and/or liver programs involving living donor transplants.

Under existing bylaws, transplant centers:

- must develop, and once developed must comply with written protocols to address all phases of the living donation process.
- must document that they performed all phases of the living donation process according to the center's protocol.
- must provide an Independent Donor Advocate who is responsible to:

- (a) promote the best interests of the potential living donor;
 - (b) advocate the rights of the potential living donor; and
 - (c) assist the potential donor in obtaining and understanding information regarding the:
 - (i) consent process;
 - (ii) evaluation process;
 - (iii) surgical procedure; and
 - (iv) benefit and need for follow-up.
- must develop, and once developed, must comply with written protocols for the medical evaluation of the potential living donors that must include, but are not limited to, the following elements:
 - (a) a thorough medical evaluation by a physician and/or surgeon experienced in living donation to assess and minimize risks to the potential donor post-donation, which shall include a screen for any evidence of occult renal and infectious disease and medical co-morbidities, which may cause renal disease;
 - (b) a psychosocial evaluation of the potential living donor by a psychiatrist, psychologist, or social worker with experience in transplantation (criteria defined in Appendix B, Attachment I) to determine decision making capacity, screen for any pre-existing psychiatric illness, and evaluate any potential coercion;
 - (c) screening for evidence of transmissible diseases such as cancers and infections; and
 - (d) anatomic assessment of the suitability of the organ for transplant purposes.
 - must develop, and once developed, must comply with written protocols for the Informed Consent for the Donor Evaluation Process, which include, at a minimum, the following elements:
 - (a) discussion of the potential risks of the procedure including the medical, psychological, and financial risks associated with being a living donor;
 - (b) assurance that all communication between the potential donor and the transplant center will remain confidential;
 - (c) discussion of the potential donor's right to opt out at any time during the donation process;
 - (d) discussion that the medical evaluation or donation may impact the potential donor's ability to obtain health, life, and disability insurance

Committee members reviewed Living Donor Registration (LDR) forms and noted that 22 living donors donated their organ at non-OPTN member hospitals during the last five years. At the time of this review, none of these cases involved a pediatric recipient or a standalone pediatric hospital. The Committee was concerned that these donors, in such circumstances are not afforded the same protections provided at OPTN member institutions. In response, the

Committee proposed that living donors' organs only be recovered within OPTN member institutions.

The Committee acknowledges that potential living donors may prefer to specify that their organ donation occur at a non-OPTN member institution. However, the Committee, currently composed of 1/3 living donors, strongly supported requiring that living organ donation should only occur at OPTN member institutions in order to best protect living donors. The Committee questioned what would occur if a living donor experienced complications or died after donating their organ at a non-OPTN member institution. In such a scenario, UNOS would not be able to investigate the circumstances contributing to this adverse donor outcome.

The Committee discussed the possible development of a new OPTN/UNOS membership category for institutions interested in performing living donor organ recoveries, if those institutions were subject to OPTN/UNOS bylaws and policies for the care, evaluation, and follow-up of living donors, but did not include it as an element of this policy proposal.

A proposal to require transplant centers that perform living donor transplants to only accept and transplant living donor organs recovered at OPTN member institutions was released for public comment on June 30, 2008.

After this proposal was released for public comment, a transplant center contacted UNOS to report it had preformed a living donor recovery at a non-OPTN center for transplant to a pediatric recipient at a standalone pediatric center. After further inquiry, UNOS determined that this same pediatric center had recovered a total of four living donors at a non-OPTN center for transplant to pediatric recipients at their facility. This center had failed to report these cases as having occurred at a non-OPTN center (ZZZZ-non-OPTN center) on the Living Donor Registration forms submitted to UNOS; consequently UNOS had no record of these donors. Based on a review of available data reported to UNOS, these were the only four cases involving a living donor recovery at a non-OPTN center for transplant to pediatric recipients in the past five years.

Overall public comment supported requiring OPTN member hospitals to only accept and transplant living donor organs recovered at other OPTN member institutions. A summary of the public comment and the Committee's responses are included in the briefing paper. **(Exhibit B)**

During the Committee's meeting on October 6, 2008, the public comment responses were reviewed. Based on that review, the Committee agreed to slightly modify the proposal language to read OPTN member hospitals because some OPO's now have operating rooms and could conceivably begin living donor organ recovery.

The Committee also considered comments from some regions suggesting the establishment of a new category of OPTN membership for hospitals performing living donor organ recovery before implementation of this policy. Based on available data reported to UNOS, implementation of this policy would affect only one program. The Committee opined that implementation of this policy would improve the safety of living organ donation and opposed modifying or delaying implementation of this policy proposal for a single center. The Committee approved the amended proposal language: Committee vote: 25-1-0.

*****RESOLVED, that the modifications to Policy 3.3.7, (Center Acceptance of Organs from Living Donors) set forth below is hereby approved, effective pending distribution of notice:**

3.3.7 Center Acceptance and Transplant of Organs from Living Donors. Transplant centers that perform living donor transplants must only accept and transplant living donor organs recovered at OPTN member ~~institutions~~ transplant hospitals.²

2. Status of Living Donor Follow-up

A current goal assigned to the Committee is to improve living donor follow-up and consider if it should be a performance metric of living donor transplant programs.

The Committee continues to be concerned with the number of living donors designated as “lost to follow-up” on Living Donor Follow (LDF) forms. During a review of such forms the Committee noted that many forms were incomplete, contained suspicious data, and listed many living donors as “lost to follow up.” The Committee discussed methods to improve living donor data submission, and identified several potential changes to the Living Donor Registration (LDR) form and LDF as an important first step in improving overall living donor data collection.

The Committee recommended adding one new data element to the LDF form and three new data elements to the LDR form, which would document important information, including:

- New options for living donor status on the LDF will be:
 - (1) Living: Donor seen at transplant center;
 - (2) Living: Donor status updated by phone or email correspondence between transplant center and donor;
 - (3) Living: Donor status updated by other health care facility;
 - (4) Living: Donor status updated by transplant recipient
 - (5) Living: Donor contacted, declined follow up with transplant center;
 - (6) Dead;
 - (7) Lost: No attempt to contact donor; and
 - (8) Lost: Unable to contact donor (document)

If item 8 (Lost: Unable to contact donor) is selected, the transplant center will be asked to document their efforts to contact the donor.

- Changes to the LDR form will provide:
 - (1) the date of and the living donor’s status during the most recent contact between the donor and the recipient transplant center; and
 - (2) whether living donor organ recovery and transplant of that organ occurred at the same center.

Proposed changes to the LDF and LDR were in accordance with the Principles of Data Collection and operational statements for data collection approved by the Board in December 2006. Increased and improved living donor follow up will provide valuable information on the peri-operative experience and short-term health and safety implications for living donors. Center compliance in submission of LDR and LDF forms is especially important since no alternate source of data exists.

The OPTN/UNOS Board of Directors approved changes to the LDR and LDF forms in June, 2007 for implementation pending OMB approval of revision to the forms. Center reporting utilizing these the new forms went into effect on March 31, 2008.

The Committee sponsored new Bylaws which required transplant centers to disclose they are required, at a minimum, to submit LDF forms addressing the health information of each living donor at 6 months, one-year, and two-year post donation. Under these Bylaws, transplant center must have written protocols with a plan to collect information about each donor. The Board approved these Bylaws during its September 2007 meeting.

On July 22, 2008, the Living Donor Committee Chair gave a presentation to the Membership and Professional Standards Committee (MPSC) on the current status of living donor follow-up (**Exhibit C**). That presentation explained that the Committee's review of LDF forms revealed a large number of programs reported their donors as "lost to follow-up" when it is uncertain if realistic measures were taken to contact donors in this effort. Additionally, this Committee's review found that completing a single data element on the form enabled a center to meet requirements for completion of the form. However, submitting forms with such inadequate information, is of limited value in our desire to collect data on short term follow-up after surgery and in counseling those individuals who seek our knowledge as to the risks of donation on their long term health.

The Living Donor Committee believes the problem of categorizing living donors as "lost to follow-up" must be addressed especially in this important period in transplantation when the public and the media seek data on the safety of living donation. Often, untoward outcomes are reported without sufficient advice from the transplant community. Without accurate and comprehensive living donor follow-up data, it will not be possible to answer questions and quell concerns. The presentation concluded with a request to the MPSC to:

- Determine a minimum threshold for categorizing living donors as "lost to follow-up" on LDF forms;
- Ensure 6 month, one -year and two- year LDF forms are submitted at appropriate times; and
- Commit to annual review of LD follow-up.

The MPSC agreed to study the issue through the formation of a joint workgroup with the Living Donor Committee. The MPSC Living Donor Workgroup on Data Submission Issues met for its first conference call on September 30, 2008. Some initial strategies under consideration include:

- Demonstrate that 1-2 year follow data is valuable
- Developing reports on short-term problems encountered by living donors
- Reporting each programs percentage of living donor categorized as "lost to follow-up"
- Educating living donors on the importance of participating in follow-up

One of the Committee's goals for the past two years has been to evaluate available UNOS living donor data and establish performance metrics for living donor transplant programs. This work was assigned to a subcommittee of the Living Donor Committee. That subcommittee began to address this work by comparing the variables on the LDR and LDF forms that could be considered to monitor change in living donor health from donation to follow-up. Unfortunately, the Subcommittee has been unable to develop metrics for the evaluation of living donor programs because the data submitted on LDF forms was too inconsistent for comparison and analysis

3. **Living Donation Position Statements**

A current goal assigned to the Committee is to work with the Ethics Committee to develop living donation policy or position statements. In response, the Committee sent a letter to the Chair of the Ethics Committee asking that Committee develop position statement for:

- The level of treatment and follow up given to living donors; and
- The health status of recipients in kidney paired exchanges

In regards to the *treatment and follow up of living donors*, the LD Committee recommends that the Ethics Committee provide a statement reflecting the position that the transplant center recovering an organ from a living donor organ should not deny or limit care for a living donor who experiences complications related to the act of donation. Furthermore, the care should be offered regardless of the time since donation, and/or the donor's ability to pay.

Additionally and as a separate question, the LD Committee asks the Ethics Committee to support a mechanism to provide healthcare for the donor's lifetime after donation, to include coverage for preventative and maintenance healthcare.

With respect to the issue of the *health status of recipients in paired exchanges*, the LD Committee asked for the development of a position statement from the Ethics Committee addressing if kidney paired exchanges should be equipoise in the selection of donor recipient pairs for living donor exchange transplants. The LD Committee supports the principle of comparable benefit to donor and recipient pairs in paired exchange transplantation.

After the June 2008 Board of Directors meeting, the Ethics Committee asked this Committee to provide feedback on its position statement on prisoners serving as living donors. The Committee provided the following responses:

- a. The LD Committee is concerned about the vulnerability of prisoners as living donors.
- b. Stating living donation is permissible under certain circumstances may be too vague. Could the position statement include examples of such circumstances, or suggest procedures for reviewing individual cases?
- c. The LD Committee agrees that non-directed donation is not ethically permissible for prisoners.

- d. The LD Committee agrees that there may be added risk for prisoners following living donation for not receiving optimal care without a means of recourse.
- e. Could the position statement be changed to read that an independent donor advocate *must* be utilized in the consent and medical evaluation of any potential incarcerated living donor (as specified in the OPTN/UNOS Bylaws).

4. **Two Separate ABO Tests for Living Donors**

At its October 6, 2008, meeting, the Committee discussed a recent transplant of an ABO incompatible Living Donor kidney. In this case, the donor was ABO typed as A2. The recipient was ABO O. This is an allowable “A2” into “O” kidney transplant. However, the transplanted kidney showed immediate signs of “accelerated” rejection. After repeat typing and cross matching, the donor was actually ABO A1 with a weakly positive crossmatch with the kidney recipient’s serum.

The Committee questioned why there would be less stringent requirements for living donors than deceased donors. The Committee supports and will develop a policy proposal to require repeat ABO testing for living donors.

5. **Review and Responses to Public Comment Items**

The Committee reviewed two public comment proposals from the Membership and Professional Standard Committee during its October 6, 2008, meeting. The following is a description of the Committee’s review and recommendations for each proposal:

Proposal to modify the bylaws pertaining to conditional approval status for liver transplant programs that perform living donor transplants Bylaw affected: Attachment I, Appendix B, Section D, (4) Liver Transplant Programs that Perform Living Donor Liver Transplants of the OPTN/UNOS Bylaws

The Living Donor Committee supports this proposal as a necessary step to help protect living liver donors. Transplant programs that do not fully satisfy the criteria for full program approval by the end of the conditional approval period should not be performing living donor transplants. However, members of the Committee did recommend that the MPSC seek feedback from the transplant community and consider modifying the current physician requirements for living liver program certification.

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 Bylaw affected: Appendix B, Section II, C of the OPTN/UNOS Bylaws

The Living Donor Committee conditionally supports this proposal. Committee members understood functional inactivity was based on the annual number of transplants, not transplants only occurring the previous three months. Programs might not transplant during a three-month period due to lack of organs, but have a large number of annual transplants.

The Committee reviewed a public comment proposal from the Executive Committee during its May 12, 2008 meeting. The following is a description of the Committee's review and response to the proposal:

Proposal to Require Transplant Centers to Inform Potential Recipients about Known High Risk Donor Behavior

The Committee supports informing transplant candidates if their potential deceased donor has a history of high risk behavior, but also opined that donor risk should be based on state of the art risk assessment rather than outdated CDC criteria. The Committee was unanimous in recommending revision of CDC high-risk criteria.

The Committee is very concerned that the policy could be applied to living donors. The Committee acknowledges that OPO's are seldom involved in living donation, and that current language may imply that it applies to deceased donors. However, other Committees and some regions also questioned if the policy would apply to living donors. Living donor confidentiality is of paramount importance to the Committee. As the policy is currently stated, a potential living donor might not be offered an opportunity to opt out of the donation process, rather than have his or her high risk status disclosed. The Living Donor Committee recommends revising this policy to specify that it only apply to deceased organ donors.

The Committee recommended the following modifications for consideration by the Executive Committee to clarify that the policy only applies to deceased donors. 18-1-0

*** RESOLVED, that the modification to Policy 4.1.1 (Communication of Donor History), set forth below, is hereby approved, effective pending distribution of notice. 4.0 Acquired Immune Deficiency Syndrome (AIDS), Human Pituitary Derived Growth Hormone (HPDGH) and Reporting of Potential Recipient Diseases of Medical Conditions, Including Malignancies, of Donor Origin

4.1 [No Changes]

4.1.1 Communication of Donor History. The Host OPO will obtain a history on each potential deceased donor in an attempt to determine whether the potential donor is in a "high risk" group, as defined by the Centers for Disease Control and Prevention (CDC). If the donor meets the criteria below, the Host OPO must communicate this information regarding donor history to all institutions receiving organs from the donor. [No Further Changes]

The Executive Committee did not support this policy modification. The Committee discussed the Executive Committee's response during its October 6, 2008 meeting and agreed to prepare a policy proposal for public comment to clarify that this policy does not apply to living donors.

6. **Modification of the Patient Notification Bylaws to include Living Donors**

As one of its annual goals, the Living Donor Committee was asked to revise the patient notification bylaws to include living donors, thus providing living donors with the same information and protections given to candidates on the national transplant waiting list.

In response, the Committee proposed a policy change under which transplant centers would provide written notification to living organ donors within ten business days following their donation date to include: the telephone number that is available for living donors to report concerns or grievances through the OPTN; disclosure that the recipient transplant center is required to submit Living Donor Follow-up (LDF) forms to the OPTN for a minimum of two years; and the plan for obtaining living donor data for completion of follow-up forms.

The proposal was released for public comment on February 8, 2008. Overall, public comment supported the concept of providing living donors with the phone number available to report grievances to the OPTN, but revealed opposition to providing the notification ten days after donation. Instead, most public comment responses recommended providing the notification during the consent process for living donors.

The Living Donor Committee met on May 12, 2008, to review responses to public comment. Based on that review, the Committee agreed to change the proposal to require centers to provide the phone number that is available for reporting grievances to the OPTN to potential living donors during the consent process. Under this timeline for notification, the Committee recommended moving this requirement to the consent section of the living donor Bylaws. Committee vote: 18-0-0.

The proposal was considered and unanimously approved OPTN/UNOS Board during its June 2008 meeting.

Proposal to Change the OPTN/UNOS Bylaws to Require Written Notification (or Disclosures) to Living Donors from the Recipient Transplant Programs (Proposed Modifications to Appendix-B, Section II, (F) "Patient Notification" of the OPTN Bylaws and Appendix B, Attachment I, XIII, D (13) of the UNOS Bylaws)

Designated Transplant Program Criteria

XIII. Transplant Programs.

A.-D. 2) b. (iii). [No Change]

(iv) Informed Consent: Kidney transplant programs that perform living donor kidney transplants must develop, and once developed, must comply with written protocols for the Informed Consent for the Donor Evaluation Process and for the Donor Nephrectomy, which include, at a minimum, the following elements:

- (1) discussion of the potential risks of the procedure including the medical, psychological, and financial risks associated with being a living donor;
- (2) assurance that all communication between the potential donor and the transplant center will remain confidential;

- (3) discussion of the potential donor's right to opt out at any time during the donation process;
- (4) discussion that the medical evaluation or donation may impact the potential donor's ability to obtain health, life, and disability insurance; and
- (5) disclosure by the transplant center that it is required, at a minimum, to submit Living Donor Follow-up forms addressing the health information on each living donor at 6 months, one-year, and two-years post donation. The protocol must include a plan to collect the information about each donor.

(6) the telephone number that is available for living donors to report concerns of grievances through the OPTN

[No further changes]

(3) Liver Transplantation – [No changes]

(4) Live Donor Liver Transplant Programs that Perform Living Donor Liver Transplants.

a.-b. (iii) [No changes]

- (iv) Informed Consent: Liver transplant programs that perform living donor liver transplants must develop, and once developed, must comply with written protocols for the Informed Consent for the Donor Evaluation Process and for the Donor Hepatectomy, which include, at a minimum, the following elements:
 - (1) discussion of the potential risks of the procedure including the medical, psychological, and financial risks associated with being a living donor;
 - (2) assurance that all communication between the potential donor and the transplant center will remain confidential;
 - (3) discussion of the potential donor's right to opt out at any time during the donation process;
 - (4) discussion that the medical evaluation or donation may impact the potential donor's ability to obtain health, life, and disability insurance; and
 - (5) disclosure by the transplant center that it is required, at a minimum, to submit Living Donor Follow-up forms addressing the health information on of each living donor at 6 months, one-year, and two-years post

donation. The protocol must include a plan to collect the information about each donor.

(6) the telephone number that is available for living donors to report concerns of grievances through the OPTN

[No further changes]

7. **Guidance for the Medical Evaluation of Living Kidney Donors**

The OPTN/UNOS Ad Hoc Living Donor Committee was formed in 2002 and identified “establishing minimum criteria for donor work-up” as a priority for its future work. This Committee developed a set of minimal guidelines for potential living kidney transplant recipient and donor evaluations, which included provisions for an independent donor team, psychiatric and social screening, and appropriate medical, radiologic, and anesthesia evaluation. Those guidelines are available on the OPTN.

In January 2007, the OPTN/UNOS President sent a letter to all transplant programs that perform live donor transplants requesting copies of their informed consent, medical evaluation, and living donor follow-up protocols. The letter explained that federal regulation now required the Organ Procurement and Transplantation Network (OPTN) to develop policies for the equitable allocation of living donor organs. The Living Donor Committee planned to use these protocols to make recommendations to the OPTN/UNOS Board of Directors regarding new living donor guidelines. These recommendations are intended to ensure that individual institutions’ living donor evaluation protocols consistently meet the needs and interests of potential living donors. Additionally, institutions may choose to compare their protocol against this set of recommendations that reflect the consensus of expertise among medical professionals involved in living donor transplantation.

Committee Members reviewed and assessed all submitted protocols. Their evaluation revealed wide variation in the medical evaluation of potential living kidney donors. Some centers did not have written guidelines for the medical evaluation of a living donor. Additionally, the Committee reviewed recommendations from the American Society of Transplantation (AST) and the Report of the Amsterdam Forum on the Care of the Live Kidney Donor; completed an extensive literature review; and completed a focused survey of 16 large transplant centers in the development of these guidelines.

Based on the information reviewed, the Committee developed a set of recommendations for the medical evaluation of living kidney donors. At its June 2007, meeting, the Committee approved sending the Guidelines for the Medical Evaluation of Living Kidney Donors for public comment. The Guidelines for the Medical Evaluation of Living Kidney Donors were released for a 30-day public comment beginning on July 13, 2007.

The Living Donor Committee met by Live Meeting on August 14, 2007, to review public comment and to consider proposed modifications to the proposed Medical Evaluation Guidelines. Based on the comments received, the Committee agreed to make the guidelines less prescriptive, and agreed to refer to the proposal as “recommendations” rather than “guidelines.” Final proposal language was drafted for consideration by the Board.

A document entitled Recommendations for the Medical Evaluation of Living Kidney Donor was presented to the OPTN/UNOS Board during its September 18, 2007, meeting in Los Angeles. During that meeting, the Living Donor Committee Chair agreed that the document could be renamed a Resource Document rather than Recommendations. After extensive discussion and lack of consensus, the Board agreed to table this proposal until its next meeting in February 2008. In the interim, this Committee was charged to seek additional input from stakeholders including but not limited to the AST and ASTS. Within days after the Board meeting, OPTN/UNOS President, Tim Pruett, MD., sent notification to the AST and ASTS requesting each organization to provide specific comments to the Living Donor Committee, which could be considered at the Committee's upcoming meeting in October.

At its October meeting, the Committee reviewed all comments received to date and further revised the resource document in preparation for re-release for public comment. The Resource Document was sent for a special 30-day public comment period on November 12, 2007

The Living Donor Committee met by Live Meeting in December 18, 2007, to review public comments and made modifications to the proposed Resource Document. During that meeting, the Committee agreed to offer the professional transplant societies an additional opportunity to provide feedback during a conference call to be scheduled at some future date. The Committee charged a small subset of its members to review any future public comment, and to prepare a final version of the Resource Document for the next Board of Directors meeting.

The AST and ASTS participated in a Live Meeting to review this proposal on a January 4, 2008. A final version of the proposal was prepared after that meeting and follows and presented at the OPTN/UNOS Board of Director Meeting on February 21, 2007.

On February 7, 2008, UNOS received a letter from HRSA recommending that the OPTN Board of Directors not approve the document in its current form and provided an Addendum which listed 16 specific concerns with the document. In response to the HRSA request, the Committee withdrew the proposal from the list of items for consideration by the Board. However, the resource was discussed during the Board meeting, which included the review of a draft "professional" version of the resource developed by the LD Committee Chair. The Board recommended that two versions of the resource be developed to include a professional version and separate public version and would be entitled Guidance for the Development of Program-Specific Living Kidney Donor Medical Evaluation Protocols in the future. The Board requested the resource be further modified and returned to the Board before or at its next meeting.

On May 7, 2008, HRSA provided comments on the Resource which included adding an expiration date to the resource to ensure it remained updated and adding information explaining important of living donor follow-up. The Living Donor Committee discussed the final draft of this resource at its meeting on May 12, 2008, and restated that the goal of this resource is to make sure that as much as medically possible the living donor is safe and is educated about their risk. Although not perfect to all Committee members, the majority agreed that it is a good resource based on common transplant center practice, data from transplant literature and from standards of evaluation for kidney evaluations used by nephrologists. The Committee plans to review the document at least annually and it will be revised as new data becomes available. **(Exhibit D)**

The Committee recommended sending this resource to the Board of Directors. 16-1-0

The OPTN/UNOS Executive Committee met by conference call on June 6, 2008, and voted to approve the resource which is now available on the UNOS and OPTN websites.

A current year goal for the Committee is to further refine this resource and to develop a version of the resource appropriate for the lay public. During its October 6, 2008, meeting, Committee

members were asked to review the current draft of the public version of this resource and to submit any comments in writing within one week. After final revisions, this resource will be submitted to the Executive Committee for approval.

LIVING DONOR COMMITTEE		
	MONTH	OCTOBER '08
	DAY	6
	FORMAT (select)	In Person
NAME	COMMITTEE POSITION	
Matthew Cooper MD	Chair	x
Connie Davis MD	Vice Chair	x
Stefan Tullius MD, PhD	Regional Rep.	x
Burckhardt Ringe MD	Regional Rep.	x
Winston Hewitt MD	Regional Rep.	on phone
Nicolas Jabbour MD	Regional Rep.	x
Suzanne Fitzpatrick	Regional Rep.	x
Regina Klein RN, CCTC	Regional Rep.	x
Kay Catherine Kosberg RN	Regional Rep.	x
Warren Kortz MD	Regional Rep.	x
Dianne LaPointe Rudow Dr NP, CCTC	Regional Rep.	x
Shawn Pelletier M.D.	Regional Rep.	x
Sharon Alcorn RN	Regional Rep.	x
Mark Barr MD	At Large	x
Suzanne Lane Conrad RN, MS	At Large	x
Anne Courcier	At Large	x
Mary Amanda Dew Ph.D.	At Large	x
Oliver Hale	At Large	x
Andrew Klein MD, MBA	At Large	x
Mary Mason MSW	At Large	x
Alicia Munoz	At Large	
Stephanie Musselman DPT	At Large	x
Miguel Pineda	At Large	x
Agrippa Williams	At Large	x
Jane Zill LICSW	At Large	x
Michelle Desler M.S.	BOD - Liaison	x
Pam Gillette MPH, RN	Transplant Admin Committee Rep	x
Robert Brown Jr., MD, MPH	Ex. Officio	x
Mesmin Germain MBA, MPH	Ex Officio	
Bernard Kozlovsky MD, MS	Ex Officio	x
Valarie Ashby	SRTR Liaison	
John Magee MD	SRTR Liaison	on phone

John Wolfe	SRTR	
Lee Bolton	Committee Liaison	x
Jennifer Wainright Ph.D.	Support Staff	x
Mary Ellison, Ph.D.	UNOS Project Officer	x

LIVING DONOR COMMITTEE	Date	OCTOBER '07	JUNE '08
	DAY	20	4
	FORMAT	In Person	In Person
NAME	POSITION		
Robert Brown Jr., MD, MPH	Chair	x	x
Andrew Klein	Vice Chair		x
Michael Wachs MD	Vice Chair		
Jeffrey Stoff MD	Regional Rep.		x
Matthew Cooper MD	Regional Rep.	x	x
Gazi Zibari MD	Regional Rep.	x	x
Greg Abrahamian M.D.	Regional Rep.	x	x
Mark Barr MD	Regional Rep.	By Phone	By Phone
Connie Davis MD	Regional Rep.	x	x
Blanche Chavers MD	Regional Rep.	x	x
Michael Wachs MD	Regional Rep.		
Adel Bozorgzadeh MD, FACS	Regional Rep.	x	By Phone
John Powelson MD	Regional Rep.		
Anthony Reese MDiv.	Regional Rep.	x	x
Anne Courcier	At Large	Joined after 10/20	x
Stuart Greenstein MD	At Large		x
Jennifer Hinkis-Siegel RN, BSN, CCTC	At Large	x	x
Mary Mason MSW	At Large		x
Nicholas Nissen MD	At Large	x	x
Gayle Rowe	At Large		x
Cassandra Smith-Fields RN, MBA, MSN	At Large	x	x
Angela Tagliaferri	At Large	x	x
Jane Zill LICSW	At Large	joined after 10/20	x

Dolph Chianchiano	BOD - Liaison		x
Tom Falsey	BOD - Liaison	x	
Margaret Schaeffer RN	BOD - Liaison	x	x
Mesmin Germain MBA, MPH	Ex Officio		
Bernard Kozlovsky MD, MS	Ex Officio		x
Ginny McBride RN, MPH, CPTC	Ex Officio	x	
Elizabeth Ortiz-Rios MD, MPH	Ex Officio		
Valerie Ashby	SRTR Liaison		
Laura Christensen M.S.	SRTR Liaison		
John Magee MD	SRTR Liaison		
Sangeetha Mahadevan	SRTR Liaison		
Lee Bolton	Committee Liaison	x	x
Darcy Davies	Support Staff	x	
Jennifer Wainright	Support Staff		x