

**OPTN/UNOS Minority Affairs Committee
Summary**

Action Items for Board Consideration

- None

Other Significant Items

- The Committee continues its review of computer modeling simulations used to integrate Life Years From Transplant (LYFT) into the national system of deceased donor kidney allocation. During its most recent review, the committee focused upon eliminating geographic boundaries as an approach to help correct some of the inequities in the kidney allocation system. (Item 4, Page 4)
- The committee continues its review of data on access to transplantation. (Item 5, Page 5)
- The Committee has finalized the survey instrument for the Board approved Survey on Public Comment Opinion and Outreach. Survey questionnaires have been coded and translated into English and Spanish versions. The questionnaires will be submitted for IRB approval and approval by the local dialysis companies. (Item 7, Page 7)
- The committee provided comment on the four living donor proposals. (Item 12, Page 9)

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Report of the OPTN/UNOS Minority Affairs Committee to the Board of Directors

**Los Angeles, California
September 17-18, 2007**

**Pang-Yen Fan, MD, Chairman
Henry Randall, MD, Vice-Chairman**

The following report contains Committee deliberations and recommendations on matters considered during its meeting on July 13, 2007.

1. Progress Toward HHS Donor-Related Program Goals. Dr. Wida Cherikh, PhD, presented the Committee with maps showing progress toward meeting the program goals by donor service area (DSA) (**EXHIBIT A**). Overall, the data show that the number of combined donation by cardiac death (DCD) and non-DCD organs continues to increase, but fell short of the program goals for 2005-2006. For non-DCD donors, the goal has been reached and exceeded for the 2004-2006 time period; however, the goal has not been reached for DCD donors (648 as compared to 793).

Dr. Cherikh also reported on the change in deceased donor organs in the United States by DSA. Overall, of the 58 DSA's, 23 (40%) showed a decrease, 13 (22%) showed no increase or an increase less than 10%, and 22 (38%), showed an increase of 10% or more. The change in non-DCD donors across DSA from 2005-2006 showed 24 (41%) had a decrease, 14 (24%) had a no increase or less than 10% increase and 20 (34%) showed an increase of 10% or more. For DCD donors by DSA, 27 (49%) experienced an increase of 42% or more, 28 DSA's showed an increase of 10% or more and 9 DSA's, showed an increase of less than 10%. Fourteen DSA's showed a decrease.

For organs transplanted per non-DCD donor (SCD and ECD combined) in 2006 by DSA, data shows that the majority of DSA's are transplanting an average or 3 or more organs per donor, which is lower than the goal of 3.44. However, for organs transplanted per SCD donor in 2006, the majority of DSA's have reached the goal of 3.44. Organs transplanted per DCD donors shows that DSA's fell short of reaching the goals in 2006 (2.11 actual versus the goal of 2.33).

Dr. Cherikh noted that since the goals are set for the entire country and are not established by DSA, it may be unrealistic to expect every DSA to perform at the same level since DSA's may have different potential. Furthermore, until patient level data for eligible deaths is collected, it is not possible to incorporate each DSA's donor potential when evaluating the goals by DSA. A member of the Committee suggested that it may be helpful to incorporate the population size for each DSA in the report.

2. Summary of the June 25, 2007 Board of Directors Meeting. Dr. Carlton Young, immediate past Chairman of the Committee, provided members with a summary of the Minority Affairs Committee report delivered to the OPTN/UNOS Board of Directors at its June meeting. The Committee was informed that the Board was updated as to the status of the Committee's deliberations in three areas: Kidney Allocation Review, the Public Comment Survey, Access to Transplantation, and findings from the OPTN Consensus Conference on Increasing Input into OPTN Matters.

The primary concern expressed to the Board was recent computer simulation modeling data showing that under the proposed new kidney allocation system, minorities will not experience a significant increase in allocation of available kidneys. The Committee will continue to work with the SRTR to develop a goals statement that will include appropriate benchmarks the Committee agrees are acceptable for moving forward with a new system that is more beneficial for minority candidates. The difficult challenge ahead will be in determining a benchmark that will provide enough of a benefit for minority candidates without a significant negative impact on organ utility.

3. Update on Kidney Allocation Policy Development. Alan Leichtman, MD of the SRTR, provided the Committee with an overview of the Scientific Registry of Transplant Recipients (SRTR) contract, including the organization of the SRTR, its role and responsibilities relative to the OPTN, positions represented in the SRTR, research methodology, information flow, and its role in the development of allocation policy. The Committee was also provided with a summary of the current national kidney allocation algorithm.
4. Integrating a Measure of Life Years From Transplant (LYFT) into Deceased Donor Kidney Allocation. Dr. Leichtman provided the Committee with a summary of the background of the concepts proposed to integrate LYFT into the national system of deceased donor kidney allocation. He also provided the latest results of the SRTR Kidney Pancreas Simulated Allocation Model (KPSAM) computer presented to the Kidney Committee and the OPTN Board of Directors (**EXHIBIT B**). The KPSAM simulations compare the current kidney allocation system using 2003 data to possible alternative systems which maximize some element of LYFT. LYFT is the estimated difference in candidate survival with a transplant minus their estimated survival without a transplant. The following KPSAM runs were conducted to test alternative allocation systems utilizing LYFT: (see Table 1 below)

Transplant Percentages Total Kidney Alone										
Percentage of Waitlist	Run 1: Current Allocation System	Run 3: LYFT	Run 7: KP/KI Interleave	Run 9: OMM share only PRA 80+, A2->B, no paybacks	Run 15: LYFT w/o HLA A, B	Run 17: LYFT DM only, w/o HLA A, B	Run 18a: Cont. DPI	Run 18b: Cont. DPI ²	Run 21 DPI Quintiles	Run 22: Cont. Age Matching
Recipient African-American	33.2 (0.3)	31.3 (0.3)	32.9 (0.1)	33.4 (0.2)	34.3 (0.2)	34.5 (0.7)	35.7 (0.7)	35.9	32.6 (0.4)	34.3 (0.9)
Recipient Hispanic	13.3 (0.2)	14.2 (0.4)	14.6 0.3()	14.7 (0.2)	14.8 (0.2)	14.6 (0.1)	13.8 (0.1)	14.6	14 (0.1)	14.6 (0.2)
Recipient Caucasian	47 (0.1)	47.8 (0.9)	45.2 (0.2)	44.5 (0.6)	43.5 (0.7)	43.1 (0.5)	43.7 (0.5)	42.3	46 (0.5)	44.2 (0.6)
Recipient Other/Missing Race/Ethnicity	6.5 (0.1)	6.7 (0.1)	7.3 (0.3)	7.4 (0.2)	7.4 (0.2)	7.8 (0.2)	7 (0.1)	7.2	7.3 (0.2)	7 (0.2)

Table 1

Under the current system, 33.2% of deceased donor kidneys would be allocated to African Americans. Substituting LYFT for the current system and using the parameters of the tested alternative allocation systems such as removing HLA A and B matching, removing certain diagnoses, allocating kidneys using continuous donor profile index (DPI) and age matching, and adding waiting time, increases allocation to African Americans by only a small percentage. The largest increase was shown with the addition of waiting time and continuous DPI (Run 18b), which increased allocation by 2.7% (33.2% to 35.9%). While a system using DPI quintiles (which divides candidates and donors into five equal categories of DPI) decreased allocation to African Americans slightly from 33.2% to 32.6%. It was remarked that this small increase, over time, would help redress the inequity in transplant rates between African American and Caucasian candidates. However, the increase is not substantial enough to fundamentally change the relationship between the number of African Americans candidates on the waiting list and allocation to this population.

The Committee reiterated discussions from prior meetings identifying geography as a significant barrier to transplantation for African American candidates. In some areas of the country, the supply of available organs matches the number of people waiting to be transplanted. These areas tend to be predominantly White and so candidates with very low LYFT scores would receive an organ. In other areas, primarily large cities with a heavy concentration of minorities, there are more people listed than the number of available organs so candidates with lower LYFT scores would not be transplanted. Dr. Leichtman reported that a quick modeling run of the rules without allocation boundaries showed that geography is the single most important factor in achieving more equitable transplant rates. Further, the geography issue is one that affects not only minority

patients but Caucasian patients living in densely populated areas. Because all of the different allocation systems being modeled are being applied to current geographic boundaries, the Committee discussed the need for additional accommodations in order to lessen the significance of geography on allocation. Data has shown that the various proposed changes in the kidney allocation system would not demonstrate a marked improvement in transplant rates for African Americans; however, eliminating geographic boundaries may be an acceptable and justified approach to help correct some of the inequities in the current allocation system.

It was suggested that a system could be implemented where for candidates above a certain high LYFT score, kidneys would be shared more broadly before being allocated to local candidates with lower LYFT scores, as with the MELD Share 15 system. The Committee also discussed other alternative systems, including a national waiting list, restrictions on wait listing of candidates, and the institution of super regions. It was also noted that the Policy Oversight Committee has been charged to report to the Board with a plan to understand the effects of geography in order to make policy changes that would mitigate its effects. One member of the Committee recommended the need to accommodate high PRA patients, who would not receive many opportunities for transplant under the proposed system. It was responded that the Kidney Transplantation Committee is considering nationalizing the sensitized list to allow greater opportunities for high PRA patients to get transplanted. It was also suggested that when the Committee examined data attempting to explain the 15-17% lower transplantation rate for African Americans as compared to Caucasians, the analysis may not have adequately corrected for the geography factor. It was determined that the SRTR would continue to provide KPSAM data outputs by ethnicity when possible and model the effect of allocation without boundaries as final kidney allocation models are finalized.

5. Access to Kidney Transplantation. During the July meeting, Valarie Ashby, MS, of the SRTR, provided the Committee with updated data examining deceased donor kidney transplant rates among different ethnic groups for OPO's with various length waiting times, accounting for elimination in HLA B points in the kidney allocation system that occurred in 2003. **(EXHIBIT C)**. The Committee has reviewed data in this area for the past year in an attempt to explain a lower transplant rate for African Americans than for all other ethnicities, despite various adjustments. A previous analysis showed that transplant rates for this group lag across the board in short, medium, and long waiting time OPOs. The Committee requested that the updated analysis provide more descriptive detail and present the data using more granular waiting time categories. The analysis included 43,637 kidney registrants on the waiting list on 12/31/99 and 180,268 kidney registrants entering the list between 2000-2006. The quintile of waiting time to transplant for the OPO of each registration was <500 days; 500 to 750 days; 750 to 1000 days; 1000-1500 days; or >1500 days.

Results show that among all patients on the waitlist from 2000-2006, there was a 9.5% increase in the deceased donor transplant rate between the period before and after the change in the BDR policy, perhaps due to the Organ Donation Breakthrough Collaborative. Overall, the transplant rate increased about 4% and 6% for Caucasians and Hispanics respectively, while the increase was more than 20% for all other ethnicities. Additionally, the increase in the transplant rates varied by ethnicity within each OPO waiting time quintile. Among new patients added to the kidney transplant waitlist from 2000-2005, Caucasians are overrepresented in short waiting time OPOs, are listed earlier than all other ethnicities, and have higher rates of inactive time. Older patients also had higher rates of inactive time. The percentage of Caucasians receiving a deceased donor transplant declined after the policy change (from 58% to 48%) but now reflects the percentage of Caucasians newly added to the waitlist (47%). There were similar results in the crude transplant rate and in the adjusted rates.

As demonstrated in previous analyses, data continues to show that African Americans have adjusted deceased donor transplant rates that are lower than those of all other ethnicities (see Table 2 below). The deficit for African Americans was 25% before the policy change and 16% after the change, as compared to Caucasians. This deficit is most pronounced in OPOs that have long waiting times (>750 days). Among OPOs that have very short waiting times (<500 days) African Americans and Native Americans have lower adjusted deceased donor transplant rates than Caucasians, Hispanics, and Asians.

Relative Rate of Deceased Donor Transplantation by Ethnicity and OPO Waiting Time Category among New Kidney Waitlist, 2000-2006						
ETHNICITY	All RR	<500 days RR	500-750 Days RR	750-1000 Days RR	1000-1500 Days RR	>1500 Days RR
Caucasian	1.00 (REF)	1.00 (REF)	1.00 (REF)	1.00 (REF)	1.00 (REF)	1.00 (REF)
Hispanic	0.95*	1.06 (ns)	0.94	0.93 (ns)	0.98 (ns)	0.97 (ns)
African American	0.81*	0.93 (ns)	0.87*	0.81*	0.79*	0.77*
Asian	1.00 (ns)	1.23*	0.93 (ns)	1.05 (ns)	1.09 (ns)	1.03 (ns)
Native American	0.95 (ns)	0.73*	0.99 (ns)	0.94 (ns)	0.98 (ns)	1.05 (ns)

Table 2

* *Adjustments*

In the other 4 quintiles of OPO waiting times that are 500 days or more, African Americans have lower adjusted deceased donor transplant rates than do Caucasians, Native Americans, Hispanics, and Asians. Overall, the time period after the change in HLA BDR policy showed higher deceased donor transplantation rates for non-Caucasians, especially Asians, than before the policy change. An exception to this occurs in the short waiting time OPOs where Native Americans had lower adjusted deceased donor transplant rates after the policy change. Also, inactive status did not account for the deficit in the deceased donor transplant rate for African Americans.

During discussion it was noted that the analysis included zero mismatched (OMM) transplants. For the next meeting, the Committee requested to examine an analysis of time to OMM transplant and time to first non-OMM offer by ethnicity, accounting for the elimination of HLA B points in the kidney allocation system that occurred in 2003, and including the ethnic distribution of the OMM transplants.

Ms. Ashby presented an additional data update requested by the Committee examining adjusted rates of waiting list for different states, overall and by ethnicity, before and after the elimination of points for HLA B matching in kidney allocation (**EXHIBIT D**). The analysis included 482,163 patients under the age of 70 beginning ESRD between 1998-2005 with follow-up until 12/31/2006. The number and percentage of patients new to ESRD from 1998-2005 were calculated by state. The ethnic distribution was also calculated overall and for each state. The analysis showed that among patients starting ESRD from 1998-2005, African Americans, Caucasian Hispanics, and Native Americans have adjusted kidney waitlist rates that are lower than Non-Caucasian Hispanics, Asians and Other ethnicities. African Americans have the highest wait listing deficit amongst all of the other non-Caucasian ethnicities (37%), as compared to non-Caucasian Hispanics. Whereas Asian Americans have a 16% higher wait listing rate than non-Caucasian Hispanics. There were higher rates of wait listing for Caucasians, Hispanics, African Americans, and Asians after the policy change than before the policy change. Wait listing rates across states ranged from 52% lower than the national average to 66% higher. Between 1998 and 2006, the average 3 year increase in the wait listing rate was 6%. However, this increase was not uniform across the United States or among ethnicities.

The data presented was ordered according to the concentration of African Americans in the state, with the states having the highest concentration of African Americans listed at the top. During its discussion, the Committee noted that many of the states shown with wait listing rates that were 25% higher than the national average, were not the states one would assume had a high concentration of African Americans (For example, ND, MT, SD, ME, OR). It was also noted that the locality with the highest concentration of African Americans (DC) also had the lowest wait listing rate than any other state in the country. Additionally, in both Pennsylvania and Massachusetts there is a high African American population and high wait listing rates. This data suggests that the difference in wait listing rates for African Americans experienced by practically every state cannot be explained entirely by their geographic location and representation in the country.

6. Living Donation Issues. This data was not presented to the Committee due to time limitations.

7. Update on Minority Affairs Committee Public Comment Opinion Survey. The Committee was updated on the background and progress on the national survey to collect baseline data on the views of the general public regarding its awareness and understanding of the public comment process and transplantation in general. The Committee was informed that the survey questionnaire has been finalized and arrangements are underway for coding of the questionnaire as well as submitting the survey for IRB approval and approval by the dialysis centers.
8. CPRA: Calculated Probability of a Positive Crossmatch and Impact on African American Renal Patients. Steven Geier, Ph.D., presented an overview of CPRA, a Board approved policy modification that will change the way sensitized patients are defined and receive priority in kidney allocation (**EXHIBIT E**). The system will determine the sensitization level of a patient based on unacceptable HLA antigens and award the sensitization points based on the patient's probability of a positive crossmatch. The current policy awards 4 points to patients with a PRA \geq 80%; however, HLA labs use different technologies with different levels of sensitization to characterize patient HLA antibodies, allowing patients who are not truly highly sensitized to receive the additional priority points. The implementation of CPRA is hoped to provide a more accurate and consistent measure of sensitization, reduce the number of organs going to unintended patients, benefit minorities who are sensitized to common donor antigens, and allow highly sensitized patients defined as those with a calculated PRA of 80% or higher to be eligible to receive 4 points of additional priority. The policy modification will also reduce the gameability of the current system.
9. Allocation of Deceased Donor Organs Based on HLA Antibody Specificities of Potential Recipients. Ronald Kerman, Ph.D, presented the Committee with data from a retrospective study recently presented at the American Transplant Congress showing that the presence of donor specific antibody (DSA) may not be a contraindication to transplantation (**EXHIBIT F**). Newer and more sensitive laboratory testing technologies are more accurate at predicting donor specific antibodies and antigens identified in the population which are deemed more likely to be reactive with certain groups. When these antigens are entered into the system for calculating CPRA, candidates with these antigens will be screened from the match list. The data are relevant to the Minority Affairs Committee because a large number of patients with DSA and negative crossmatch were minorities and women.

Dr. Kerman's presentation focused on three distinct questions for determining the importance of donor specific antibodies in successful recipient outcomes following transplant:

- What is the antibody specificity?
- How much antibody is present?
- Does the antibody bind to the target cell?

A few considerations that must be taken into account when allocating organs based on HLA antibody specificities of potential recipients is epitope reactivity and whether or not the antibody epitope specificity is the same as the donor antigen epitope. Antibodies react against epitopes and antibody binding can only be determined by performing a crossmatch. Antibody binding leads to cell destruction which will result in death. Positive antibody that is present but does not bind or positive antibody with a low titer will result in cell survival.

HLA Ab, Specificity, Titer and FCXM

	HLA Ab			FCXM		24 mo. Graft Survival
	NDS	Non-DS	Titer	(+)	(-)	
1. 15*	+	+	≥256	(+)		0%
2. 44	+	+	≤16		(-)	91%
3. 10	+	+	≤16	(+)		60%
4. 22	0	+	≥256		(-)	86%
5. 23	0	+	≥256	(+)		74%
6. 35	0	+	≤16		(-)	89%
7. 30	0	+	≤16	(+)		74%
8. 96	0	0	-		(-)	95%
9. 25	0	0	-	(+)		76%

2-yr GS of 91% for (-) vs 72% for (+) FCXM P<0.001

Table 3

A study performed at the University of Texas Medical School, retrospectively evaluated the serum of 300 recipients using negative flow cytometry crossmatch technology with the following results (see Table 3 above). Patients with positive donor specific HLA antibody and high titer ≥256 with positive crossmatch lost their grafts in 30 days or less. Patients with donor specific antibody, low titer and negative crossmatch had a 91% graft survival at 2 years. Patients with positive donor specific HLA antibody, low titer, but positive crossmatch had 60% graft survival at 2 years. Patients with no donor specific HLA antibody, but antibodies directed at other HLA antigens, high titer and negative crossmatch experienced 86% graft survival at 2 years. Similarly, patients with the same characteristics but a positive crossmatch, experienced 74% graft survival at two years and patients with low titer and negative crossmatch experienced 89% graft survival. Patients with the same characteristics but positive crossmatch experienced 74% graft survival. A group of patients with no detected HLA antibody at all, but with negative crossmatch showed 95% graft survival. Another group of patients with no detected HLA antibody but a positive crossmatch showed 76% graft survival. 67% of the patients with positive donor specific HLA antibody and low titer were minorities.

The data suggest that recipients with donor specific antibodies and positive flow crossmatch are at high risk for rejection and early graft loss. However, for recipients with low titer donor specific or non donor specific antibodies but a negative flow crossmatch, there was no higher incidence of delayed graft function, no difference in renal function, and no significant impact on graft survival for the recipients with positive DSA compared with those who lacked DSA. At two years, patients who have a negative crossmatch versus a positive crossmatch have a highly significant graft survival difference. This demonstrates that antibody specificity, while relevant, is not necessarily a contraindication to transplantation, unless something in the serum binds to the donor target cell. If the patients in the study had not been transplanted due to the presence of DSA, many would have been disadvantaged, including a large number of minority patients. Therefore, this information should not be used to avoid performing a crossmatch.

Dr. Kerman's presentation was followed by discussion from the Committee. Members voiced support for implementation of CPRA. A member of the Committee responded to the impression that CPRA would be used to avoid crossmatching patients. It was noted that the system is intended only to eliminate the number of unintended crossmatches that are positive. Further, CPRA will correct for the gameability of the system due to the lack of standardization across laboratories. Additionally, with CPRA there is no requirement to enter unacceptable antigens unless to the center wants the patient to receive the additional points. The committee agreed that there are varying degrees of unacceptable antigens and crossmatch should still be performed. The introduction of CPRA is an attempt to improve the system, even with the flaws demonstrated by the data. This area is a work in progress and CPRA is only the first step in standardizing the system. It will not cure all the problems in the system or benefit every patient.

A member of the Committee inquired whether or not the study examined whether there was a higher rate of positive flow crossmatch for minority patients. For some time the Committee has attempted to explain why minority patients fared less well after transplantation than Caucasian patients. It was responded that African Americans were crossmatch positive a minimum of two times more often than Caucasians. This is possibly due to African American patients having been exposed to Caucasian blood during transfusion resulting in the production of antibodies. Another possible cause is that African Americans may be higher immuno-reactive genetically.

10. Introduction to the Minority Affairs Committee. During the July meeting, Deanna Parker provided the Committee with a brief introduction to the Minority Affairs Committee for the benefit of its new members, including member responsibilities, committee priorities, and current activities.

11. Public Comment Document Distributed June 15, 2007.

1. Request for Incorporating CPRA into an Existing Alternative System for Kidneys (Histocompatibility Committee)

The Committee determined that any additional priority given to sensitized patients could only be helpful to minority candidates. After brief discussion, the Committee voted unanimously to approve the proposal.

Committee vote 16, 0, 0.

2. Proposed Modifications to OPTN/UNOS Policy 4.0 (Acquired Immune Deficiency Syndrome (AIDS), Human Pituitary Derived Growth (HPDGH), and Reporting of Potential Recipient Diseases or Medical Conditions, including Malignancies, of Donor Origin) (Operations Committee)

The Committee determined that there was no minority impact requiring comment from the Committee.

3. Proposed Modifications to OPTN/UNOS Policy 7.4 Submission of Organ-Specific Transplant Recipient Follow-up Forms. (Operations Committee)

The Committee determined that there was no minority impact requiring comment from the Committee.

4. Proposed Modifications to OPTN/UNOS Policy 3.5.9 (Minimum Information/Tissue for Kidney Offer) (Organ Availability Committee)

The Committee determined that there was no minority impact requiring comment from the Committee.

12. Update on Public Comment Document Distributed July 13, 2007

1. Proposed Modifications to OPTN/UNOS Bylaws, Appendix B, Attachment I, Section XIII, C (2) Kidney Transplant Programs that Perform Living Donor Kidney Transplantation (Membership and Professional Standards and Living Donor Committees)

The Minority Affairs Committee met via conference call on August 3, 2007, to discuss the proposals. All four living donor proposals were reviewed and discussed as a unit.

The Committee supports the principles and intent behind the proposals submitted by the Membership and Professional Standards (MPSC) and Living Donor Committees. However, it believes that the guidelines, as written, are overly prescriptive and detailed and appear to mandate specific elements of a protocol, without allowing enough flexibility in medical decision making for individual patients, cases, etc. Although the proposals are presented as guidelines, there is also concern that they could be used as a model against which all programs would be measured. The Committee believes that the principles

of good practices should be reflected in the guidelines, rather than mandated functions of procedures and staff.

The Committee is very supportive of the concept of the independent donor advocate (IDA), provided there is flexibility in how the position and team is defined. The Committee recognizes the difficulty in assembling an IDA team which would be totally independent of the donation process; however, the committee agrees that programs should have at least one team member who is relatively independent of the process at that level. The Committee also supports centers assisting donors with obtaining medical and disability insurance, as the donation procedure could potentially impact the donor's ability to obtain future employment and insurance.

The Committee did not formally vote on the proposals.

2. Proposed Modifications to OPTN/UNOS Bylaws, Appendix B, Attachment I, Section XIII, C (4) Liver Transplant Programs that Perform Living Donor Liver Transplants (Membership and Professional Standards and Living Donor Committees)

The Minority Affairs Committee met via conference call on August 3, 2007, to discuss the proposals. All four living donor proposals were reviewed and discussed as a unit.

The Committee supports the principles and intent behind the proposals submitted by the Membership and Professional Standards (MPSC) and Living Donor Committees. However, it believes that the guidelines, as written, are overly prescriptive and detailed and appear to mandate specific elements of a protocol, without allowing enough flexibility in medical decision making for individual patients, cases, etc. Although the proposals are presented as guidelines, there is also concern that they could be used as a model against which all programs would be measured. The Committee believes that the principles of good practices should be reflected in the guidelines, rather than mandated functions of procedures and staff.

The Committee is very supportive of the concept of the independent donor advocate (IDA), provided there is flexibility in how the position and team is defined. The Committee recognizes the difficulty in assembling an IDA team which would be totally independent of the donation process, however, the committee agrees that programs should have at least one team member who is relatively independent of the process at that level. The Committee also supports centers assisting donors with obtaining medical and disability insurance, as the donation procedure could potentially impact the donor's ability to obtain future employment and insurance.

The Committee did not formally vote on the proposals.

3. Guidelines for the Medical Evaluation of Living Kidney Donors (Living Donor Committee)

The Minority Affairs Committee met via conference call on August 3, 2007, to discuss the proposals. All four living donor proposals were reviewed and discussed as a unit.

The Committee supports the principles and intent behind the proposals submitted by the Membership and Professional Standards (MPSC) and Living Donor Committees. However, it believes that the guidelines, as written, are overly prescriptive and detailed and appear to mandate specific elements of a protocol, without allowing enough flexibility in medical decision making for individual patients, cases, etc. Although the proposals are presented as guidelines, there is also concern that they could be used as a model against which all programs would be measured. The Committee believes that the principles of good practices should be reflected in the guidelines, rather than mandated functions of procedures and staff.

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Committee agrees that programs should have at least one team member who is relatively independent of the process at that level. The Committee also supports centers assisting donors with obtaining medical and disability insurance, as the donation procedure could potentially impact the donor's ability to obtain future employment and insurance.

The Committee did not formally vote on the proposals.

4. Guidelines for the Consent of Living Donors (Living Donor Committee)

The Minority Affairs Committee met via conference call on August 3, 2007, to discuss the proposals. All four living donor proposals were reviewed and discussed as a unit.

The Committee supports the principles and intent behind the proposals submitted by the Membership and Professional Standards (MPSC) and Living Donor Committees. However, it believes that the guidelines, as written, are overly prescriptive and detailed and appear to mandate specific elements of a protocol, without allowing enough flexibility in medical decision making for individual patients, cases, etc. Although the proposals are presented as guidelines, there is also concern that they could be used as a model against which all programs would be measured. The Committee believes that the principles of good practices should be reflected in the guidelines, rather than mandated functions of procedures and staff.

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The Committee did not formally vote on the proposals.

Minority Affairs Committee

Meeting Attendance July 13, 2007

MINORITY AFFAIRS COMMITTEE	MONTH	JULY
	DAY	13
	FORMAT (select)	In-Person
NAME	POSITION	
Pang-Yen Fan, MD	Chair	X
Henry B. Randall, MD	Vice Chair	X
Diego G. Martinez	Regional Rep.	X
Meelie A. DeRoy, MD	Regional Rep.	X
Gaetano Ciancio, MD, FACS	Regional Rep.	X
Alejandro Mejia, MD	Regional Rep.	X
Okechukwu N. Ojogho, MD	Regional Rep.	
Ali s. Olyaei, PharmD	Regional Rep.	
Maurice E. Goodwin, ORT/NREMT	Regional Rep.	X
Andrew C. Kao, MD	Regional Rep.	X
Joselito Nuqui	Regional Rep.	
Silas P. Norman, MD	Regional Rep.	X
Gloria T. Hairston, EMT-D, CNA	Regional Rep.	X
Bonita Balkcom Guilford	At Large	
L. Ebony Boulware, MD	At Large	
Bradley H. Collins, MD	At Large	
Steven S. Geier, PhD, ABHI Diplomat	At Large	X
Judith V. Joseph, RN, BSN, CCTC	At Large	X
Michele M. Snyders, MSW	At Large	X
Helen G. Spicer, RN	At Large	X
H. Gareth Tobler, MD	At Large	X
Jerry Butler	BOD - Liaison	X
Carlton J. Young, MD	Ex. Officio	X

Minority Affairs Committee

Meeting Attendance July 13, 2007

Renee Dupee, Esq.	Ex Officio	X
Gregory Fant, PhD	Ex Officio	
Valarie Ashby	SRTR Liaison	X
Alan B. Leichtman, MD	SRTR Liaison	X
Sangeetha Mahadevan	SRTR Liaison	
Katherine Pearson	SRTR Liaison	
Randall S. Sung, MD	SRTR Liaison	
Deanna L. Parker, MPA	Committee Liaison	X
Wida S. Cherikh, PhD	Support Staff	X
Dielita J. McKnight	Support Staff	X
Emmanuel Anum, MD	Support Staff	X



Number of Committee Members Attending	24
Total Number of Committee Members	34
Percentage of Committee Attending	71%

Meeting Format	0
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