

**OPTN/UNOS Minority Affairs Committee  
Report to the Board of Directors  
November 12-13, 2012  
Richmond, VA**

**Summary**

**I. Action Items for Board Consideration**

- None

**II. Other Significant Items**

- The Committee continues work toward developing its *Educational Guidelines for Patient Referral to Kidney Transplantation (Item 6, Page 4)*
- The Committee is developing a plan for its Committee project *Survey on Referral to Heart Transplantation (Item 7, Page 5)*
- The Committee is developing a plan for its Committee project *Study of Best Practices in Minority Donor Conversions (Item 7, Page 5)*
- The Committee reviewed data on *Minority Donor Conversion Rates by Ethnicity, and Age, Gender, and Cause of Death (Item 8, Page 6)*
- The Committee continues to review *CPRA Data by Ethnicity (Item 9, Page 8)*
- The Committee reviewed results from the newest kidney allocation computer simulation models (*Item 10, Page #9*).

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**Silas P. Norman, MD, Chairman  
Meelie Debroy, MD, Vice-Chairman**

*This report includes discussions from the Minority Affairs Committee meeting on August 8, 2012.*

1. Report of modifications approved by the Board of Directors June 25-26, 2012

The Minority Affairs Committee was updated on the following Board actions of relevance to the Committee:

- Approval of changes to the UNOS Bylaws to clarify and update laboratory testing requirements.
- Approval of changes to Policy 3.2.1.8 which clarify the requirements for submitting waiting time modification requests.
- Approval of the relocation of items from the UNOS Bylaws into OPTN Policies as part of the OPTN Bylaws Plain Language Rewrite project.
- Approval of changes to the OPTN Bylaws, including Appendices A-K and M.
- Approval of revisions to the policies to clarify and improve variance policies to assist members and staff in compliance, evaluation, uniformity, and reliability of information provided with variance applications.
- Approval of changes to Policies 3.7.3 which include technical edits to policy and the requirement that heart transplant programs record in UNet<sup>SM</sup> changes to a heart transplant candidate's status or criterion within 24 hours.
- Approval of the proposal to include HLA-C in the CPRA calculation, update the HLA frequencies used to calculate CPRA, and add a mandatory field to Waitlist<sup>SM</sup> for reporting of anti HLA antibodies.
- Approval of substantive changes to the OPTN Bylaws addressing reviews, actions, and due process, and reorganization of the changes into Appendix L of the recently approved plain language rewrite of the OPTN Bylaws
- Approval of changes to Policy 3.6 that will offer adult deceased donor livers to all candidates in Status 1A and Status 1B and those with MELD/PELD scores of 15 or higher locally, regionally, and nationally before being offered to candidates with lower MELD/PELD scores.
- Approval of changes to Policy 3.6 that will offer adult deceased donor livers to local and regional candidates with MELD/PELD scores of 35 or higher before being offered to candidates with lower MELD/PELD scores.
- Approval of changes to Policy 6.0 which include technical edits to Policy 6, removal of the audit policy that allows the OPTN to review transplants of organs from deceased donor non-resident aliens if the transplant rate at a given program exceeds 5% annually, new definitions for citizenship categories approved by the Board in June 2011, a policy that allows the OPTN to review listings and transplants of non-US citizens/non-US residents, and a new requirement that the OPTN provide transplant-by-citizenship data to the public.

## 2. Minority Affairs Committee Overview

The Committee was provided with an overview of Committee service for the benefit of its new members. The overview included a brief historical review of the work by the Committee or in collaboration with other Committees regarding development of policies to improve access to transplantation for minorities. The overview also included an outline of member expectations and staff roles, a presentation on the role of data in policy making and the process for submitting Committee and member data requests, as well as a brief overview of the structure purpose and function of the SRTR contractor by the Minnesota Medical Research Foundation (MMRF).

## 3. UNOS Instructional Innovations

The Committee was updated on the structure, purpose, and role of the new educational arm of the OPTN by Angela D. Allen, Ed.D, UNOS Director of Instructional Innovations. The updated consisted of a brief overview of the new Instructional Innovations Department with a description of departmental mission and goals, target population for programs, and examples of instructional approaches, to include:

- Webinars
- Webcasts
- Online Learning Modules
- On Demand Options
- Discussion Boards
- Course Management
- Face-to-Face Experiences
- Resource Documents

The Committee expects to follow the process for utilizing the Instructional Innovations Department for assistance with several of its educational projects.

## 4. Plain Language Rewrite of OPTN Policies

The Committee was provided with an overview of the purpose of the project, rationale for its development, and highlights of the specific improvements offered by the rewrite of policies distributed for public comment. Leigh Kades, MS, Policy Editor at UNOS, provided the overview. Like the bylaws rewrite, the intent of the work is to reorganize the policies in a more clear and logical manner and rewrite them in plain language. The Committee was reminded that feedback on the effort is being collected via an alternative public comment solicitation consisting of a targeted survey on the OPTN web site. Following the presentation, the Committee expressed its approval of the project and its intent, but declined to submit a formal statement or comment; however, members were encouraged to review the document and provide feedback using the survey tool by August 31<sup>st</sup>.

## 5. OPTN Strategic Planning Update

The Committee was updated on the new key goals for the OPTN developed by the Board as well as the process for review and prioritization of Committee activities for alignment with approved goals and performance indicators. Meelie Debroy, MD, vice chairman of

the Committee also described the role of the POC and the Executive Committee in the process as well as how the Committee projects were tied into the key goals. The six key goals of the OPTN include:

1. Increase the number of transplants;
2. Increase access to transplants;
3. Improve survival for patients with end stage organ failure;
4. Promote transplant patient safety;
5. Promote living donor safety; and
6. Promote the efficient management of the OPTN.

#### 6. Educational Guidelines on Appropriate Patient Referral to Kidney Transplantation

Data reviewed by the Committee has shown that minority patients experience significant delays in referral, wait listing, and eventual transplantation as compared to their white counterparts. Furthermore, many patients who are appropriate for transplantation are never referred for transplant or are referred late in their disease progression. To better focus its work, the Committee formed a Joint *Subcommittee on Education and Awareness of Transplant Options*. The purpose of the subcommittee was to develop an educational initiative aimed at improving patient referral to transplantation by helping to raise awareness among physicians, practitioners and their national societies about appropriate and timely patient referral to kidney transplantation. The overall goal of the initiative is to provide an opportunity for every medically eligible patient to be referred for transplant evaluation.

Key elements of the guidelines include:

- The default pathway for CKD and ESRD patients should be transplant referral
- Preemptive transplant is the goal and can only be achieved with “early” referral
- Education about transplant has to begin long before ESRD (Stage 3-4 CKD) to be most effective

The Committee was updated on the status of the project which is nearing completion. The Committee was informed that the draft guidelines document has been approved by the Subcommittee and full Committee. A joint subcommittee consisting of several other OPTN Committees and professional transplant organizations reviewed the document for major missing topic areas. The group discussed development of a dissemination plan involving stakeholder groups for collaboration and consensus building. Further, an informal teleconference call meeting was held with the National Association of Transplant Coordinators (NATCO) leadership to discuss ways that NATCO could help support the project and disseminate information to its constituents. This could include development of a survey targeted to specific NATCO member populations. The Committee was informed that the path forward for finalizing the document is a review cycle to include input from CMS, the American Society of Transplantation/American Society of Transplant Surgeons (AST/ASTS), American Nephrology Nurses Association (ANNA), American Physician Assistants Association (APPA), then UNOS leadership, and the Health Resources Services Administration (HRSA). The Committee hopes to complete the project over the next 12 months.

## 7. Committee Project Update

The Committee was presented with a general outline and revised plan for completing its outstanding projects, which include two new approved projects\* and several manuscripts. The approved Committee projects include the following:

- Educational Guidelines for Patient Referral to Kidney Transplantation
- Perceptions of the Organ Procurement and Transplantation Network/United Network for Organ Sharing (OPTN/UNOS) Public Comment Period Among Dialysis Patients
- Referral to Kidney and Liver Transplantation: The Transplant Program's Perspectives
- Addressing Issues of Equity and Utility to Enhance Access to Transplant: A Historical Perspective of Kidney Allocation Policy from the Minority Affairs Committee
- Minority Donor Conversion Education Project\*
- Survey on Referral to Thoracic (Heart) Transplantation\*

The Committee discussed its two recently approved Committee projects, the *Minority Donor Conversion Education Project* and the *Survey on Referral to Thoracic (Heart) Transplantation*. The Committee is reviewing data on minority donor conversions in an attempt to improve consent rates among minorities and identify a focused educational initiative involving the OPO community. The Committee is also proposing development of a survey of heart transplant programs as a way to document whether or not the delays which exist for referral to kidney and liver transplantation, also exist for heart transplantation. Committee discussion recently revisited concerns expressed previously about possible delays in minority access to heart transplantation. Members noted that a survey of transplant centers seemed to be the logical next step for the Committee in its work attempting to identify and address overall barriers to referral. The Committee is hoping to learn whether or not transplant centers are able to gauge if they are reaching all of the eligible heart transplant candidates from the population of patients with heart failure. The challenge in this area is identifying a captured population of patients with heart failure (denominator) in order to address this question. The Committee plans to assign this to a subcommittee consisting of heart physicians and surgeons to reexamine previous Committee heart data analyses and make recommendations on how to locate or develop a dataset of patients with heart failure to document the existence of a disparity in heart referrals.

The Committee discussed development of a new process and timeline for completing several new manuscripts and other manuscripts in various stages of completion. These manuscripts represent work that the Committee has completed with the intention of publishing results. These include the Minority Affairs Committee A2/A2B National Variance Manuscript, Dialysis Facility Survey Manuscript, Kidney and Liver Referral Survey Manuscript, and MAC Comprehensive Review Article. The new process will include designation of a Committee member leader to initiate the writing of the paper and facilitate Committee member and staff writing assignments and deadlines. Several Committee members volunteered to assist in writing and other Committee members were encouraged to contact UNOS staff to express interest in contributing to one of the manuscripts.

## 8. Minority Donor Conversion Rates by Ethnicity, and Age, Gender, and Cause of Death

The Committee reviewed data on minority donor conversion rates by ethnicity, age, gender, and cause of death requested at the March 13<sup>th</sup> meeting. The Committee has historically been interested in examining donor conversion rates for different ethnic groups to gauge progress in this area. Since this information has become available, the Committee has previously reviewed data on regional variation in donor conversion rates among different ethnic groups. With the review, the Committee hopes to bring more granularity to the subject of discerning donor potential by ethnicity and geography, and further refine OPO performance measures by identifying all of the possible variables which may prevent an eligible donor from progressing to an actual donation.

Wida Cherikh, PhD., presented the analysis to the Committee (**Exhibit A**). In the analysis, the eligible donor conversion rate is defined as the percentage of eligible deaths that became actual donors. The donor conversion rate was calculated by ethnicity and by age, gender, and cause of death. The conversion rate was calculated as the number of actual donors divided by the number of actual deaths.

The data show the following:

- The eligible donor conversion rate was the highest for multiracial ethnic group and the lowest for American Indians/Alaskan Natives with the following ethnic breakdown:
  - Multiracial: 84%
  - White: 79%
  - Hispanic: 67%
  - Black: 56%
  - Asian: 49%
  - Native Hawaiian/Other Pacific Islander: 47%
  - American Indian/Alaskan Native: 41%
- Among different ethnic groups, the eligible donor conversion rate was the highest in the 18-34 age group and the lowest for the 65+ age group, with the exception of Hispanics who had similar conversion rate in the 0-17 and 18-34 age groups and Native Hawaiians/other Pacific Islanders who had the second highest conversion rate in the 65+ age group.
- Among different ethnic groups, the eligible donor conversion rate was higher in males than females, with the exception of Native Hawaiians/Other Pacific Islanders.
- Although the eligible donor conversion rate by cause of death varied among different ethnic groups, the overall eligible donor conversion rate was highest in donors with head trauma cause of death, followed by anoxia, CNS tumor, cerebrovascular/stroke, and other causes of death.

It was noted that previous data analysis showed demographic differences across regions; however, limited information in the current data collection does not enable further examination on why there is a variation in donor conversion rates across ethnicities.

Following review of the data, the Committee discussed challenges with regard to conversions in general. The transplant donation rate for African Americans is much higher than whites and currently African Americans are donating at a rate that exceeds their representation in the population. These improvements with regard to minority donation are not well publicized because the percentage of ESRD disease in the African American population is significant and there is a critical need for minority donation to continue to increase. A member also noted that there was need to develop different culturally competent approaches for dealing with foreign born versus native born ethnic populations for those who approach families.

The Committee also discussed possible educational or best practice initiatives among OPOs that could be developed into a Committee project. The Committee discussed how to best frame the approach to the project. Committee members noted that sometimes attempts at donation are often very high but many donors are eliminated beforehand for various reasons. Most OPOs are required to collect information on their conversion rates for reporting to the Centers for Medicaid Services (CMS). Previous Committee discussion highlighted that fact that CMS outcome measures for conversions are not adjusted for different demographic characteristics by geographic region. However, problems identified by the Committee as affecting conversion rates are numerous and may vary depending on donor quality, transplant hospital policies, state laws, and geographic issues (ex. demographic and cultural characteristics, etc.)

The Committee discussed the need to better define and understand the reasons for eligible deaths being declined as donors. The educational initiative developed should document all of the variables involved in why donation does not progress in order to identify OPO best practices that have been successful in addressing those issues. This means obtaining access to patient level data. It was noted that this information is not available from UNOS because it is not required to be reported by OPOs. Only organ donors who have been converted to an actual donor are included in DonorNet®. It was suggested that the new OPO performance metrics analyze individual patients based on comorbidities and other patient characteristics, etc. The Committee may be able to determine the type of organ the donor would yield, compare it to what the OPO actually does, in order to tie it back to the database and at least identify donors who are minorities. Any information from UNOS would be piecemeal and would not have the same quality from OPO to OPO. The Committee discussed obtaining OPO information for Committee review. It was noted that although some of information on variables affecting conversion rates may be collected by individual OPO's it is not available across the board for comparison purposes. If available, the information may be anecdotal at best.

The Committee discussed potential collaborations with other groups in developing the project. Specific feedback from the POC and the Board has been that there are groups already collecting the data and who are better equipped to do this work. An effective partnership could help the Committee better define the scope of the problem and develop the specific initiative to address it. The Committee discussed partnering with other entities to include the OPO community, the Alliance/National Learning Congress(NLC) Collaborative, Donate Life America(DLA), who each have done considerable work in the area of donor designations, and AMAT etc. to collect, organize, and study best practice information in order to better focus its work. The Committee also discussed contacting individual OPO's in Michigan and NY as well as organizations such as the Minority Organ

Tissue and Transplant Education Project (MOTTEP), and the New York Organ Donor Network (NYODN) who regularly report their donor conversation rates. It was also suggested that the Regional Administrators at UNOS may have a good perspective on what is being done regionally.

The Committee had previously discussed development of a national survey to capture OPO practices designed to improve donor conversions. The Committee built upon the previous discussion with the idea of a potential partnership with the NLC/Donor Alliance in development of a National Consensus Conference on Donor Conversions. The Committee determined that it should first attempt to identify the relevant issues to be addressed within the project to determine the specific focus of the Consensus Conference. For the next meeting, the Committee discussed identifying a broad compilation of information on donor conversions from multiple sources (to include OPOs) for comparison and then presentation to the Committee. It was recommended that the compilation include data from at least five OPO's for comparison purposes and to ensure an accurate representation. Following review of the data, Committee discussion, and then investigation of the process for convening a national consensus conference on the issue, the Committee will plan a path forward.

9. Review of CPRA for Deceased Donor Kidney Allocation: 30 Month Data

CPRA measures a candidate's overall immune sensitivity to potential donor antigens by calculating how many potential donors would be considered incompatible for a given candidate based on the patient's known HLA specific antibodies. The use of CPRA was adopted in October 2009 and is intended to provide a more consistent and accurate definition of sensitization and improve the efficiency of organ allocation by reducing the risk of antibody rejection in a candidate. The Committee continues to review CPRA in concert with the Histocompatibility Committee to determine if it has increased transplant rates to sensitized patients, particularly minority candidates. The Committee has been updated with an on-going analysis to monitor the policy by comparing CPRA and PRA, especially regarding transplant rates in different sensitization categories by ethnicity.

Wida Cherikh, PhD presented data that was prepared for the Histocompatibility Committee meeting on August 6-7, 2012, entitled *Evaluation of Modification to OPTN Policy on Using CPRA for Deceased Donor Kidney Allocation: 30 Month Data (Exhibit B)*. In this analysis, sensitization level was categorized into 0%, 1-20%, 21-79%, 80-89%, 90-95%, or 96%+.

The results showed the following:

- In the first 15 months after policy implementation -
  - Transplant rates significantly decreased for non sensitized (CPRA 0%) and low sensitized (CPRA 1-20%) groups and for very broadly sensitized patients (CPRA 96%+), but transplant rates significantly increased for the 21-79%, 80-89% and 90-95% CPRA groups
- In the second 15 months after policy implementation -
  - Transplant rates for the 21-79%, 80-89% and 90-95% CPRA groups remained significantly higher compared to 15 months prior to CPRA implementation

- Transplant rate increased for the 96%+ CPRA group, but remained significantly lower
- During the two 15-month periods after policy implementation -
  - The percentage of very broadly sensitized registrations (PRA/CPRA 96%+) continued to increase for all ethnicity groups
  - The number and percentage of very broadly sensitized registrations (PRA/CPRA 96%+) were the highest among Blacks

The Committee will await the next update and continue to review CPRA data in concert with the Histocompatibility Committee.

10. Update on Development of a New Kidney Allocation System (KAS)

The basic framework for the new KAS system proposed by the Kidney Committee is a two-tiered system which prioritizes the top 20% of kidneys estimated with the longest graft function according to the Kidney Donor Profile Index (KDPI), to candidates estimated to have the highest estimated post transplant survival (EPTS). The remaining 80 percent of transplant candidates would be allocated kidneys using an allocation point scale based upon an expanded definition of waiting time, a combined local plus regional list, and new categories for highly sensitized candidates.

During the meeting, the Committee viewed results from the newest computer modeling simulations upon which the soon to be distributed new Kidney Allocation System proposal is based. Dr. Ajay Israni of the SRTR presented the analysis to the Committee (**Exhibit C**). The Committee was provided with an overview of the simulations comparing the current kidney allocation rules (N1) to the simulation results which are incorporated into the new proposed Kidney Allocation System (N4). (Figure 1)

Average for 10 iterations	N1	N4
Number of candidates (on waitlist at start or joining during run)	122,669	122,669
Average number of primary transplant recipients (KI+KP)	11,531 (11,463-11,586)	11,365 (11,324-11,409)
Average median lifespan post-transplant (min, max of runs: primary KI+KP)	11.82 (11.75 - 11.85)	12.73 (12.65-12.79)
Average median graft years of life (min, max of runs: primary KI+KP)	8.82 (8.80-8.84)	9.10 (9.08-9.12)

Average median extra life-years for tx recipient versus waitlist candidate (min, max of runs: primary KI+KP)	5.01 (4.99-5.03)	5.27 (5.24-5.29)
Average median LYFT per transplant (min, max of runs: primary KI+KP)	5.70 (5.68-5.72)	5.97 (5.95-6.0)

Figure 1

Highlights of the comparison between Run N1 and Run N4 showed that Run N4 resulted in the following:

- Increase in percent of transplants for ABO Blood Group B candidates
- Slight increase in percent of transplants for African American and Hispanic Candidates (1% each)
- Decrease in percent of 0-HLA mismatched transplants
- Increase in percent of transplants for candidates aged 18-49
- Slight decrease in percent of 0% CPRA transplants
- Increase in percent of transplants for 99-100% CPRA candidates
- With sliding scale CPRA, 99-100% CPRA candidates have the greatest possibility of getting a transplant with a slight decline in percent of transplants for patients with 80-98% CPRA

Following the presentation, the Committee discussed the simulation results. Concern was expressed by a Committee member that pediatric candidates would be severely disadvantaged in the proposed allocation scenario. Pediatric candidates currently receive local priority for donors under 35; however, they still wait behind highly sensitized candidates who also have access to kidneys from donors 35 or older. It was proposed that since more offers would now be going out to highly sensitized candidates, this would delay the process for offers to pediatric candidates (possibly 24-36 hours or more) who are already disadvantaged in the system. The member noted that Region 4 had requested a proposed variance that was turned down because the new policy proposal was under development. For donors under 35, the variance would allocate one kidney to a highly sensitized candidate and the other kidney to a pediatric candidate. Alternately, another member responded that the number of offers to the patients in the 99-100% CPRA category is very low and that many highly sensitized candidates are minorities. These patients may receive one offer every 10 years or so; however, pediatric candidates will likely get another chance at an offer in a few months. Additionally, it was noted that the Pediatric Committee is currently developing a pilot program for regional sharing for pediatric candidates with CPRA of 80% and above. It was noted that it may be prudent; however, to examine the situation with regard to adult patients in the over 80% CPRA category.

Another member commented that the earlier KAS simulations showed more transplants to minority candidates, particularly African Americans, as compared to the current simulation run. He noted that the numbers demonstrated in N4 were essentially flat. The member acknowledged that there appeared to be some incremental improvement for African American candidates but was unsure of the extent of the significance of the

improvement to these candidates. The Committee had hoped the new system would at least minimally address the level of disparity in access for African American candidates under the current system. The SRTR explained that if the range of simulation runs is examined, there is a trend toward improvement in all categories. If this range is multiplied by 11,000 deceased donor transplants, the middle range could be quite large. The Committee acknowledged that the Final Rule provides that special consideration be given to pediatric, sensitized, and minority candidates and so all of these populations need to be evaluated under the new system.

The Committee also briefly discussed the medical rationale for the 20% cut-off in allocation of kidneys under the proposed system following comments by a Committee member. It was noted that although the 20% cut-off was not made based upon medical criteria, it was based upon the need to increase the amount of survival that would occur in the system and was a compromise plan developed for the benefit of the transplant community. Further, although a sensitivity analysis of the 20% was not performed by the Kidney Committee, previous simulation runs have explored other numeric combinations. The results show that as simulations move closer to a pure net benefit allocation system more life years are gained; when additional factors are added into the system, life years are lost. What is being presented by the Kidney Committee is an attempt to provide for more utility in the system, but on a continuum.

Finally, the Committee discussed specific concerns about the proposal expressed by the Histocompatibility Committee during its recent meeting, introducing the possibility that the 20% cut-off would disadvantage retransplant patients. It was noted that the percentage of OMM transplants decreased in Run N4 and the Histocompatibility Committee expressed interest in examining whether the decrease is occurring because the OMM patients are no longer in the highly sensitized group or because of retransplants. It was reported that the Histocompatibility Committee is hoping to examine additional data on the number of OMM transplants by sensitization level and retransplant under Runs N1 and N4 before the scheduled Kidney Committee meeting on August 27<sup>th</sup>. Following brief discussion, a Committee member noted that retransplants are a very small group (about 10.7% to 12% of all transplants) and that some in the community might disagree with the point being made by the Histocompatibility Committee. The Committee looks forward to the proposal being distributed for public comment for further discussion.

**ATTENDANCE FOR THE AUGUST 8, 2012  
OPTN/UNOS MINORITY AFFAIRS COMMITTEE MEETING**

<b>Committee Members</b>	<b>Position</b>	<b>In Attendance</b>
Silas P. Norman, MD	Chair	Yes
Meelie A. Debroy, MD	Vice-Chair	Yes
Amy Tien, MD	Region 1 Representative	No
Sylvia E. Rosas, MD	Region 2 Representative	Yes
Yma Waugh, MBA	Region 3 Representative	Yes
Terrie L. Boyd, RN, MSN, CCM	Region 4 Representative	No
Dorothy Rocha, MSW, LCSW	Region 5 Representative	Yes
Nidyanandh Vavidel, MD	Region 6 Representative	Yes
Patty S. Rees, RN, BSN, CCTC	Region 7 Representative	Yes
Antonio Sanchez, MD	Region 8 Representative	Yes
Karen A. Gans, RN	Region 9 Representative	Yes
Asif A. Sharfuddin, MD	Region 10 Representative	Yes
Kelly C. McCants, MD	Region 11 Representative	Yes
Remonia A. Chapman, MD	At-Large	Yes
Pang-Yen Fan, MD	At-Large	Yes
Mohamed A. Hassan, MD	At-Large	Yes
Julie Houp	At-Large	No
Bruce A. King, MSW	At-Large	Yes
Rosaline Rhoden, MPH	At-Large	Yes
M. Christina Smith, MD	At Large	No
Winfred W. Williams, MD	At-Large	Yes
Jerry McCauley, MD	At-Large	Yes

Mesmin Germain, MBA, MPH	Ex-Officio, HRSA	(Phone)
Chinyere Amafule	Ex-Officio, HRSA	Yes
<b>UNOS Staff</b>		
Deanna L. Parker, MPA	Committee Liaison/Policy Analyst	Yes
Wida Cherikh, PhD	Sr. Research Biostatistician	Yes
<b>Guests/Visitors</b>		
Lee Goodman	UNOS	Yes
Angela Allen, Ed. D	UNOS	Yes
Franki Chabalewski, MS	UNOS	Yes
	HRSA	
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Laura Sigmon, MS	UNOS	(Phone)
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