

**OPTN/UNOS Minority Affairs Committee**  
**Report to the Board of Directors**  
**November 8-9, 2010**  
**St. Louis, MO**

**Summary**

**I. Action Item For Board Consideration**

- None

**II. Other Significant Items**

- The committee presents the final results of its *Survey on Referral to Kidney Transplantation* for Board information. The survey attempts to document transplant center practices in tracking and monitoring referrals to kidney transplantation as well as explore barriers to referral and wait listing for different ethnic groups. The committee is developing a methodology to distribute results of the *Survey* to the transplant community to encourage best practices in transplant center monitoring of referrals to kidney transplantation. (Item 4, Page 7)
- The committee is interested in pursuing initiatives to standardize transplant education in dialysis facilities and improve processes for tracking patient referral to transplantation by linking these activities to reimbursement penalties. (Item 4, Page 7- 9)
- The committee is pursuing publication of a manuscript summarizing the results of its *Dialysis Facility Public Comment Opinion Survey*. (Item 3, Page 3)
- The committee is pursuing publication of an article reviewing organ allocation policy addressing minority access to transplantation over the last decade as viewed by the committee. (Item 5, Page 9)

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**Report of the OPTN/UNOS Minority Affairs Committee to the Board of Directors  
November 8-9, 2010  
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**Henry Randall, MD, Chairman  
Silas Norman, MD, Vice-Chairman**

This report includes select items addressed by the Minority Affairs Committee (MAC) during its meetings held on March 23, 2010, and full discussion of items from its meeting on July 20, 2010.

1. Summary of the Meeting of the Board of Directors, June 2010

The committee was provided with a summary of Board actions resulting from the June 21-22, 2010 meeting of the Board of Directors in Richmond, VA. Items of interest and relevance to the committee were highlighted for members.

2. Minority Affairs Committee Report

The committee was referred to the final report prepared for the Board of Directors. The report summarized the November 20, 2009, and March 23, 2010 committee meeting discussions.

3. MAC Public Education and Outreach Initiatives

*Explore Transplant Presentation*

For several years, the committee has been very interested in reaching out to the dialysis patient population to increase their level of knowledge and understanding about kidney transplantation. Two specific outgrowths of this interest were the *Dialysis Facility Public Comment Opinion Survey* as well as involvement in specific initiatives with DaVita Corporation to provide dialysis patients with greater access to transplant-related educational information and resources.

The committee viewed a presentation by Amy Waterman, Ph.D, *Improving Transplant Education in Dialysis Centers to Reduce Health Disparities*, which summarized her research on educating dialysis patients about transplantation (**Exhibit A**).

Dr. Waterman's research showed that a very high proportion of minority patients remain poorly informed about kidney transplantation as the preferred treatment option for ESRD. Her research also revealed that the dialysis staff designated to explain this option to patients are often not well educated on the subject of transplantation. A survey of 254 dialysis centers in ESRD Network 12 revealed the following:

- Although 100% of patients were transplant-eligible, only 55% were told to contact a transplant center.
  - 71% did not have a formal transplant education program.
  - 62% were not satisfied with available transplant education.
  - 62% did not have a designated transplant educator.
  - 59% were not knowledgeable enough to answer patient questions.
  - 51% felt that dialysis center and transplant center communication was poor.
  - Many were unsure of the evaluation or wait list status of their patients.
- Compared to Caucasians, patients of color were more likely to be on dialysis and less likely to be educated about transplant or evaluated for placement on the kidney waiting list.

- Minorities often have a very negative perception about transplantation as well as a great deal of fear about the subject and are more unlikely to consider the option without specific targeted education.

Dr. Waterman presented an overview of her education program “Explore Transplant” which was developed to broach the subject of transplantation to dialysis patients as an exploratory activity rather than an action-oriented concept. The goal of the program was to assess whether improved transplant education in dialysis centers can increase patients’:

- Informed transplant decision-making;
- Discussion about transplant with other family members (potential living donors); and
- Pursuit of transplant.

The program encourages patients to explore transplantation by providing concrete facts about the advantages of transplantation over dialysis and encouraging a discussion between the patient, family members and friends about the benefits transplantation might have for the patient, thus providing the tools for informed decision making for the patient as an individual. Results of the program demonstrate improvements in patient knowledge about transplantation, as well as an increase in patient actions to pursue transplantation.

The presentation was followed by lengthy discussion. Committee members inquired about some of the major barriers to dissemination of transplant information Dr. Waterman identified in her research. Dr. Waterman noted that relevant factors include overworked providers in dialysis facilities who must juggle patient education along with their other clinical and administrative responsibilities. In addition, transplant centers often have difficulty getting transplant materials into dialysis centers for patients. Likewise, dissemination of materials costs money. Finally, there may be very different perceptions from provider to provider as to what constitutes transplant education. Committee members also acknowledged that there is a strong economic disincentive for dialysis companies to ensure that dialysis patients are well educated about the benefits of transplantation. In addition, the referring physicians are not necessarily invested in the patient being more aggressive so the resulting path is dialysis rather than transplantation.

The committee discussed advocating for transplantation as the default therapy for ESRD. It was suggested that part of routine chronic kidney disease (CKD) care should be referral to transplantation rather than dialysis. Though the research shows that patient outcomes and quality of life is better with transplantation, dialysis remains the overall default therapy, whether or not the patient is ultimately referred to transplantation. One member commented that all patients should have the opportunity to be considered for a transplant without being required to be well educated enough to have to request one. As an example, the member noted that patients in need a heart catheter are not asked to wade through all of the available medical information to learn about the benefits of the procedure and then make the choice for themselves. The member noted that transplantation is the only medical field where the ultimate responsibility for receiving the optimal therapy for a disease rests with the patient. He suggested that every patient should be considered for a transplant in lieu of a specific medical reason why the patient would not be a suitable candidate.

The committee also briefly discussed other options that could be pursued. While it is true that dialysis providers and others are incentivized, it was noted that all patients will not be able to receive a transplant. For this reason, it was suggested that the committee also investigate other ways to resolve the problem in addition to improved education. Although the financial issue may be well beyond the purview of the OPTN, there are other aspects of the problem that can be addressed by the committee. One member commented that the transplant center staff should be involved in any

educational initiative developed because they are the most knowledgeable about transplantation. It was remarked that any effort to resolve the problem would require a strong regulatory action.

The committee discussed a path toward a multi-pronged collaborative approach to transplant patient education:

- Patient focused initiatives – Initiatives similar to Dr. Waterman’s educational program.
- Provider focused initiatives - Initiatives requiring collaboration with the professional transplant associations, Kidney Disease Outcomes Quality Initiative (KDOQUI), etc.
- Regulatory initiatives - Collaboration with HRSA and CMS to pursue additional regulation.
- OPTN/UNOS initiatives - Publishing related data and collaborating in all of the both activities.

The committee discussed the possibility of Medicare endorsement of standards for providing transplant education. It was suggested that the information could be audited by the government with reimbursement penalties for non-compliance. If the initiative originated with CMS as the funding body, the issue would be more likely to retain long term traction in the community. A member remarked that the dialysis facilities already have bench marking standards for reimbursement through Medicare; however, the OPTN could work with CMS to enforce the standards already in place for tracking referrals and for transplant education. The committee was informed that Arbor Research currently calculates this information for the dialysis facility reports. The data includes the number of patients in the dialysis population who should be suitable transplant candidates by measuring the percentage of patients waitlisted for transplant and the standardized transplant patient ratio. However, it was noted the only risk-adjusted factor included in the data is patient age. A member of the committee remarked that this information may not present a complete picture of the percentage of suitable transplant candidates in dialysis units due to centers cherry picking candidates. Another suggestion was made to require documentation in each dialysis patient’s medical chart indicating either that the person has been evaluated for placement on the waiting list or that the person is not a suitable candidate.

A member of the committee remarked that there is some precedent for provision of transplant education within the Medicare Improvement Providers Patient Act (MIPPA)<sup>1</sup>. In January 2010, MIPPA incentivized private providers to conduct transplant education for CMS reimbursement for CKD 4 Dialysis Options. This is a payment stipulated by CMS for six sessions of transplant education about treatment options for patients diagnosed with Stage IV CKD kidney disease that are referred by a nephrologist for education about:

- Management of co-morbidities;
- Prevention of uremic complications;
- Education about renal replacement therapy and vascular access options to ensure individual’s participation in choice of therapy tailored to meet their specific needs.

The education can be provided by physicians and non-physician providers (nurse practitioners, clinical nurse specialists, physician assistants) and hospital-based dialysis providers in rural areas only. Outpatient dialysis facilities may not provide this service. Payment will be made under the physician fee schedule. The standards for content of CKD education will be determined by CMS after consulting with physicians and other health professionals, health educators, professional organizations and accrediting bodies, kidney patient organizations, dialysis facilities & transplant centers, network organizations and other knowledgeable persons who have not received industry funding from a drug or biological manufacturer or dialysis facility.

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<sup>1</sup> United States, Cong. House. H.R. 6331-2 TITLE I—Medicare Improvements for Patients and Providers Act of 2008, Subtitle C-Part II – Other Payment and Coverage Improvements Sec. 152- Kidney Disease Education and Awareness Provisions

### *Update on Dialysis Facility Public Comment Opinion/Outreach Survey*

The committee was briefly updated on the purpose and results of its *Dialysis Facility Public Comment Opinion Survey* for the benefit of the new members.

For the past several years, the committee expressed concern with regard to the inclusiveness of public comment and the possibility important allocation policy decisions were being made without the input of affected patient populations. In 2004, the Board of Directors approved a survey of dialysis patients to:

- 1.) Collect baseline information on public perception of organ allocation policy, and
- 2.) Assess public knowledge about the opportunity to provide input into the development of these policies through the public comment process.

The results would help the committee gauge the overall level of public understanding of organ allocation policy and awareness of public comment and possibly identify barriers to the process for all participants in transplantation. The committee also hoped that the survey results would help justify further refinement of the public comment process and development of targeted public education and outreach initiatives in this area. The committee completed the survey in July of 2009.

Survey results showed that virtually all respondents, regardless of ethnicity, were aware of the option for transplantation and most had discussed transplantation with their physician. The majority (74%) reported good or fair understanding of transplant allocation policies; however, 84% reported no awareness of the public comment process with African-Americans being significantly more likely to be aware of public comment than Caucasians (22% vs. 5%). Only 2% had ever participated in public comment. Common reasons for non-participation were lack of knowledge of the public comment period, not knowing where to obtain copies of policies, and the belief that physicians were more qualified to make policy decisions. However, 75% of participants indicated interest in expressing their opinion, with African-Americans being more likely to express this interest than Caucasians (85% vs. 63%). Over half of the respondents favored communication by postal mail as most did not have access to email and the Internet.

Overall, survey responses appeared to document limited understanding of organ allocation policies and very limited participation in public comment among dialysis patients. Survey results did not show that African-Americans had less knowledge about public comment than Caucasians; though this was possibly due to the demographic and geographic limitations of the survey. Responses did suggest an overall desire among all dialysis patients to be involved in public comment; however, limitations in access to technology may be hampering their participation in discussions about policy changes.

During previous discussion, the committee debated whether the survey findings demonstrate that inadequate transplant information and education is being provided to dialysis patients. The committee also noted that the challenges with regard to patient education and outreach are multi-factorial and should involve a wide breadth of interventions across multiple communities (patient level, provider level, center level, and UNOS level interventions.)

The committee discussed specific ways to circulate the survey findings in the public domain, including:

- Expanding patient outreach efforts (to patient and public advocacy groups).

- Collaboration with other groups to develop specific interventions or education and training within professional associations ex. dialysis companies, End Stage Renal Disease (ESRD) Networks, National Kidney Foundation (NKF), National Association of Transplant Coordinators Organization (NATCO), Association for Multicultural Affairs in Transplantation (AMAT), American Society for Nephrology (ASN), Health Resources Service Administration (HRSA), Centers for Medicare Services (CMS) etc. as appropriate.
- Further refinement of the OPTN public comment process.

The committee was informed that a manuscript summarizing the results of the survey is being prepared for submission to the American Journal of Transplantation (AJT). The results have also been accepted for a mini oral presentation at the upcoming AMAT meeting.

*Collaboration with the DaVita Corporation regarding Patient Education Efforts*

During the March 23, 2010 meeting, the committee was updated regarding ongoing discussions within UNOS to collaborate with DaVita to provide their dialysis patients with supplemental transplant-related educational information. One of several proposed initiatives will be the publication of a feature entitled “Myth Busters” which will appear in the quarterly *DaVita Lifelines* newsletter. The article will present and refute myths about transplantation and donation commonly heard among dialysis patients. Because the committee has been very interested in finding ways to reach out to this patient population for some time, the committee was encouraged to submit the ideas for these myths which would then be developed into articles authored by staff in the UNOS Communication Department. Committee members forwarded the following myths to be incorporated in the article:

- Patients on dialysis are automatically placed on the waiting list for transplantation.
- Dialysis patients must be on dialysis for at least two years before being listed for transplantation.
- Dialysis patients cannot be organ donors.
- Only immediate family members can donate their organs to another family member.
- Transplantation does not work/is experimental.

The committee requested to be updated as discussions on the project continue.

4. Survey on Referral to Kidney Transplantation

The committee was briefly updated on the purpose and results of the *Survey on Referral to Kidney Transplantation* for the benefit of the new members.

Over the past several years, the committee has sought to examine the factors leading to lower referral rates and delayed placement on the kidney waitlist for minority patients. The subcommittee reviewed data which showed large geographic differences in access to the kidney transplant waiting list and once listed, to a kidney transplant. The committee also previously reviewed data from the CMS Medical Evidence 2728 Form (Certification of End Stage Renal Disease) (**Exhibit B**) which was revised in recent years to add a question asking whether or not patients have been informed about their transplant options. A very high percentage of African-Americans are reported as having been informed about renal transplantation by the time they begin dialysis. Thus, there is an unexplained discordance between the high rates with which African-Americans are reportedly informed of transplant options and the low rates of referral for transplant evaluation. Committee members noted that although CMS mandates that all patients be assessed for referral for transplant evaluation and

informed about transplant options, there are no requirements or standards as to how providers should do perform these actions.<sup>2</sup>

In November of 2009, the committee viewed preliminary results of the survey which showed that many centers actively monitor the number of patients referred for evaluation, but few attempt to identify eligible patients who are not referred. Further, relatively few have an established process for stimulating referrals. The most common outreach initiative identified in the survey was communication with the referring nephrologist in the form of a follow-up letter, phone call or similar interaction.

Highlights of the survey include the following:

- 50% of respondents were surgical directors, and 32% were medical directors.
- The majority of respondents were from Regions 4, 5, and 11.
- 92% of respondents actively monitor patient referrals.
- Less than 50% monitor the percentage of eligible patients referred.
- The most frequently used methods for determining eligibility for transplant are transplant physician review and nephrologists' review.
- Over 50% of respondents take some form of action if eligible patients are not referred, such as letters to the nephrologist.
- The majority of patients are referred in < 6 months of dialysis or 1 – 2 years of dialysis (~ 23% each).
- Medical co-morbidities, other reasons, and patient unaware of transplant opportunity are the majority of reasons for delayed referral.
- 65% of respondents receive >150 referrals a year.
- On average over 50% respondents estimated that 75% -100% of referrals come in for evaluation.
- On average 50% of the kidney wait list for a center are Caucasian, 29% are African American, and 20% are Hispanic.
- Ethnic distribution of referrals is similar to ethnic distribution of patients on the wait list.
- Transplant centers use letters, brochures, and presentations to physicians and dialysis staff to enhance referrals.

The committee discussed the final survey results during its July 20, 2010 meeting and focused on published research and anecdotal evidence shared by members suggesting that referral physicians may not be well-informed or up to date with regard to medical practice for ESRD patients, including emphasizing preemptive transplantation and more liberal definitions of an appropriate transplant patient. Since many referring physicians do not follow the field closely, it was suggested that efforts to provide current information about patient eligibility and outcomes could be essential for increasing minority access to transplantation.

During the MAC subcommittee meeting on June 25, 2010 and again during the full committee meeting on July 20, 2010, the committee discussed ways to engage the referring physicians and their national societies to address the problem and help raise awareness among practitioners about appropriate and timely referral. This was suggested as a more practical and effective approach than seeking remediation through OPTN policy. The committee also discussed addressing the issue more directly through action taken by the Department of Health and Human Services (DHHS) or CMS

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<sup>2</sup>Amy D. Waterman PhD, et. al, "Improving Transplant Education in the Dialysis Setting: The 'Explore Transplant' Initiative" *Dialysis & Transplantation* 20452 (June 2010): 236-241.

addressing standards for dialysis patient education and requirements for referring physicians on behalf of their ESRD patients.

Following the discussion, the committee recommended the following future actions:

1. Collaborating with other OPTN/UNOS committees (Kidney Transplantation and Living Donor Committees, etc.) and all potential OPTN professional partners including ASN, Renal Physicians Association (RPA), NKF, KDOQI, primary care organizations such as the American Medical Association (AMA), the National Medical Association (NMA), and other organizations and individuals, in developing specific recommendations/guidelines for transplant education and referral for shared distribution among members. The committee will work with these groups in an attempt to influence medical practice and dispel myths regarding the type of patient who could be referred as a suitable transplant candidate through the use of publications, a consensus statement, and educational interventions, etc.
2. Developing a white paper or journal article summarizing the results of the kidney and liver referral surveys in conjunction with the above activity or as a separate activity.
3. Partnering with CMS through the Advisory Committee on Organ Transplantation (ACOT) to encourage the development of standards for education of dialysis patients by linking the standards to reimbursement penalties for both inadequate education failure and failure to refer dialysis patients for transplant evaluation as an incentive to encourage compliance by both dialysis facilities and nephrologists.
  - The standards should include/communicate the idea that referral to transplant is the default/expected action from dialysis providers (in the absence of specific exclusions).
  - The standards should also include specific language/expectations outlining what "informed of transplant options" should entail for dialysis providers to show compliance with CMS.
  - These standards can also be built on the existing CKD 4 reimbursement structure for more specificity.
  - The existing CMS referral measures should be strengthened with standardization and consistency in application of the measures as well as appropriate monitoring processes.

The committee discussed the need to combine the work of the dialysis survey and kidney referral survey subcommittees into one global outreach subcommittee which would develop and implement the above initiatives. Finally, the committee was informed that the results of the kidney referral survey will be presented at the upcoming AMAT meeting and later developed into a journal article.

#### 5. MAC Review Article

The committee was updated on plans to pursue publication of an article addressing access to transplantation from the historical perspective of the MAC. The article will discuss the concepts of equity and utility and the inherent tradeoffs that must be made in developing kidney allocation policy aimed at increasing minority access to transplantation. The article will incorporate the experience implementing the policy proposal removing HLA B points from the national system of kidney allocation to illustrate these principles.

The committee was informed that preliminary historical information has been compiled and is in the process of being reviewed. The committee will actively begin the process of writing the article upon completion of the dialysis survey manuscript.

## 6. Committee Service Overview

The committee viewed a brief presentation summarizing the roles and responsibilities associated with membership on the Minority Affairs Committee.

## 7. Overview of OPTN Data Requests

The committee viewed a brief presentation summarizing the OPTN committee data request process, outlining the responsibilities of members for data submission, and explaining the events that trigger data collection (either through forms or through other mechanisms).

## 8. SRTR Overview

The committee viewed a brief presentation summarizing the role of the SRTR in providing inferential data and simulation modeling to the Minority Affairs Committee.

## 9. OPTN/UNOS Strategic Planning

The committee was updated on OPTN/UNOS efforts to prioritize committee activities and help define the strategic direction for the committees and the Board in the coming years. The OPTN/UNOS is also developing a process to use the Executive Committee of the Board to assist in prioritizing committee activities rather than the full Board.

## 10. Update on North Carolina Pilot Program Decreasing time for Referral to Wait Listing

The committee was updated on the pilot project initiated by the North Carolina Baptist Hospital, which successfully reduced the time between the referral and wait listing stage of the transplant evaluation process. Their total pre-transplant cycle was reduced 46% (from 286 to 150 days). Gloria Hairston, Transplant Financial Manager and former MAC member, presented the information to the committee.

The Abdominal Organ Pre-transplant Team at Wake Forest University Baptist Medical Center conducted a retreat to identify and reduce primary delays in the Referral to Wait-listing process. Cycle time for 199 candidates was reviewed. The cycle begins when the nephrologist/dialysis center's referral form is received and entered into the database and ends with the patient selection wait listing presentation and a disposition of either "active", "inactive", or "declined." Four process steps were identified, with a review of the processes causing the most delays (1 and 4).

- Process 1: Referral to education cycle causes significant delays in succeeding processes.
- Process 4: Evaluation, testing to wait listing cycle directly is affected by information gathered during the referral to education cycle.

The total cycle time was determined to be 287 days or 9.6 months. This was compared to other transplant center cycle times of 4-6 months. In order to enhance clinical quality and patient satisfaction, the team determined that a reduction in cycle time was necessary. The team identified opportunities for improvement with a focus on the following areas:

- Incomplete referral forms
- Delays in obtaining referral packets/demographic information
- Patient cancellations/no shows lead to multiple reschedules
- Back log/volume load (financial coordinators understaffed, surgeon visit and clinic space issues)
- Incomplete or unclear orders from physicians

The following improvements were implemented during the pilot project:

- Transplant clinic space/availability enhanced due to new location, offering additional patient visits;
- Radiology department offered at clinic location;
- Education visit scheduled immediately after receipt of the referral form from the nephrologist / and dialysis centers;
- Retreat was held to identify improvement initiatives;
- Additional staff assistance with scheduling the back-log of pre-transplant clinical visits and evaluation testing;
- Increased number of patients presented at pre-selection committee meeting;
- Decrease in cycle time by 46% (5 months)
- Social work evaluation completed on the same day as the surgeon visit.
- Psychosocial evaluations completed and electronically documented within one week of completion and available prior to presentation;
- 46% reduction in Pre-transplant cycle time;
- Evaluation testing for patients who travel greater than one hour, or who have transportation issues is scheduled the same day of surgeon visit whenever possible to minimize the need for additional trips.
- Implemented the following changes to financial approval process
  - Medicare/Medicaid simultaneously approved at time of verification.
  - Private insurance prior approval; pre-certification

#### Comparative Cycle Time

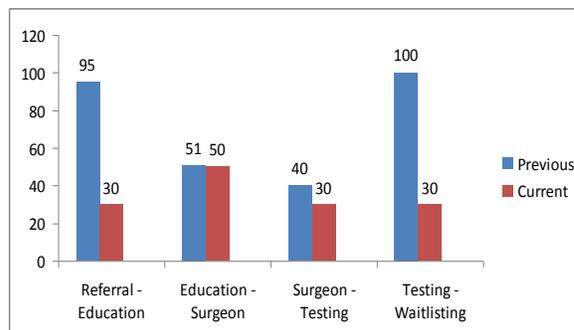


Figure 1

The committee briefly discussed the results. A member inquired about the major impetus for the change. It was responded that a number of factors inspired the examination and resulting changes, including a growing transplant population and subsequent growing waiting list, as well as additions to the transplant team. It was remarked that the major factor responsible for the decreased cycle time was the move of the transplant clinic off-campus to another facility with more space and availability for scheduling clinics. A member also inquired about outreach of the transplant centers to the dialysis facilities. It was responded that the decision was an interdepartmental decision rather than an outgrowth of outreach considerations; however, the center does employ a pre-transplant team program assistant who visits the dialysis facility every month with a list of patients on the waiting list. The role of the program assistant is to examine the medical charts to see if there are any patients who can be referred on to transplantation.

## 11. MAC Outcomes Article

The committee was referred to a manuscript on minority transplant outcomes as an example of recent committee activity. The paper is entitled, *Access and Outcomes among Minority Transplant Patients, 1999-2008, with a Focus on Determinants of Kidney Graft Survival* and recently appeared in the April 2010 issue of the American Journal of Transplantation (AJT) State of Transplantation series.

The article was authored by former and current MAC members and chairs and attempted to examine determinants of graft survival outcomes to try to correct for discrepancies in outcomes among various ethnic groups. The study examined both patient and transplant center characteristics. The study found that some of the differences observed can be explained by the patient and center characteristics; however some others remain unexplained, especially for African-American patients.

## 12. Ongoing Review of CPRA

The MAC was updated on data resulting from monitoring of the second phase of the CPRA policy implemented in UNet<sup>SM</sup> on October 1, 2009. Under this policy, highly sensitized candidates are assigned 4 extra points based on Calculated PRA (CPRA) value of 80% or greater. Prior to October 1, 2009 these points were assigned based on candidate's PRA value of 80% or greater.

Note: CPRA is the percentage of donors expected to have one or more of the unacceptable antigens indicated for the candidate.

The committee requested to be updated on the following:

- Percentage of kidney programs that listed unacceptable antigens and the numbers of unacceptable antigens listed for different allocation PRA/CPRA groups (0, 1-20, 21-79, 80+) on 03/31/2008 and 03/31/2010.
- CPRA distribution for kidney registrations on the list on 03/31/2010 and allocation PRA distribution for kidney registrations on the list on 06/30/01, 06/30/02 and 03/31/2009, stratified by ethnicity.

Dr. Wida Cherikh, PhD, presented the information to the committee (**Exhibit C**). Waiting list data for kidney registrations prior to October 1, 2009 were analyzed based on allocation PRA; while waiting list data for kidney registrations after October 1, 2009 was analyzed based on CPRA. A patient waiting at more than one center would have multiple registrations. CPRA defaults to zero if no unacceptable antigens are entered. The committee was informed that comparison of sensitization data at different time periods should be interpreted with caution because of the changes in typing methods and techniques through the years and the change from PRA to CPRA for allocation.

The analyses show that after the policy implementation on October 1, 2009 the following occurred:

- On 03/31/2009, 11 (4%) out of 257 programs did not list unacceptable antigens for any of their kidney candidates. Most of these programs (8/11) had less than 10 kidney candidates listed at that time.
- On 03/31/2010, 10 (4%) out of 255 programs did not report any unacceptable antigens. Only three of these programs had more than 10 kidney candidates listed at that time.
- There was an increase in the number of unacceptable antigens reported on the waiting list and a substantial decrease in the number of kidney refusals due to positive crossmatch.
- The number of low sensitized registrations (PRA/CPRA of 20% or less) decreased and the number of very highly sensitized (PRA/CPRA 97%+) registrations increased.

- The overall transplant rate seemed to have decreased for registrations with 1-20% sensitization level, remained the same for patients with 21-79% sensitization level, and increased for patients with 80%+ sensitization level.

A member advised the committee that some of the 0% PRA patients are actually sensitized. In the new system, unacceptable antigens that have a frequency of less than 1% default to zero. She also noted that the CPRA does not take into account antibody to HLA C, HLA DQ, or HLA DP. Histocompatibility labs are finding a fair number of patients with antibodies to those loci and who cannot truly be classified as unsensitized.

Another member inquired about progress made in the Histocompatibility community toward the ability to perform virtual crossmatching. The member was interested in whether there was information on 1.) patients predicted to have a positive cross match but who were negative when tested and 2.) patients listed with unacceptable antigens who were not tested because of the assumption of a positive crossmatch, but who would have been negative and able to be transplanted if actually tested. The histocompatibility representative on the committee responded that virtual crossmatching is not yet possible. Further, if a center listed unacceptable antigens, then the patient will be screened off of the match run for donors with those antigens. Another member commented that the scenarios proposed are able to be answered with paired donation but not deceased donation because of the limited time available to perform the crossmatches.

The committee also briefly discussed testing standardization in histocompatibility labs. The data show that the histocompatibility community is good at excluding positive crossmatches; however, it is not as good at predicting absolute negative crossmatches due to the instability of the various factors affecting the final crossmatch. For example, differences in personnel, reagents, etc. may all play a role in the testing results. A member inquired about standard histocompatibility procedures performed in labs. It was responded that most centers are using complement dependent cytotoxicity and flow cytometry with viable cells for crossmatching. Unacceptable antigens are predominantly being determined by solid phase assay: either luminex or enzyme linked. It was noted that standard values are still difficult to establish across the board due to the variability of instrument sensitivity in labs. However, the non-standardization allows centers the freedom to decide for themselves the level of risk of a positive crossmatch they want to exclude immediately with their patients as a result of not entering every single unacceptable antigen. Another member commented that is important to determine who defines the risk as non-standardization in testing also may result in centers leaving a patient on dialysis that could have been transplanted.

It was remarked that the Thoracic Organ Transplantation Committee (Thoracic Committee) is in discussion with the Histocompatibility Committee about the collection of additional HLA information for Thoracic organs. The proposed policy will be distributed for public comment during the next cycle. A member commented that the policy might present a huge problem if CPRA is open to mismatch with DQ and some of the more significant antigens for Thoracic organs, as there is not always enough time to perform a prospective cross match with heart and lung organs. It was responded that the Thoracic Committee has asked to continue using the old PRA in addition to CPRA so that they are able to examine both methods for comparison purposes.

The committee was informed that the Histocompatibility Committee is planning to review a year's worth of data at their next meeting in January or February of 2011. The Histocompatibility Committee also is exploring the possibility of a sliding scale for CPRA points and has requested data on transplant and offer rates by sensitization group. The data will be presented in 5% increments to examine and compare the increment categories to explore the type sliding scale which is able to be implemented (Ex. 80-85% with 95%, etc.) The Histocompatibility Committee plans to review this information during its upcoming meeting in October. The MAC requested to be able to view the

same information for its November meeting and to also examine the twelve month CPRA data when it is available, to determine if there are any minority implications.

### 13. Update on Development of a New Kidney Allocation Concepts

The committee was updated on the progress of the Kidney Transplantation Committee (Kidney Committee) in developing a new kidney allocation concept. The update was provided by Ciara Samana, MS, liaison to the Kidney Committee (**Exhibit D**).

The primary goals for the system are to:

- Better match graft longevity and recipient longevity within biological reason and acceptable levels of accessibility to:
  - Decrease return to wait list
  - Minimize loss of potential graft function
- Improve system efficiency and organ utilization
- Make comprehensive data better available to patients and transplant programs
- Address differences in accessibility for populations described in the National Organ Transplant Act

The allocation of deceased donor kidneys under the proposed system was summarized for the committee. The system proposes to use a combination of age matching and survival matching for deceased donor kidneys. The system would utilize a Kidney Donor Profile Index (KDPI) to better characterize donor kidneys and provide additional clinical information for patients and providers to consider during the transplant evaluation and organ offer process. Under the new system, the top 20% of kidneys would be allocated using the Kidney Donor Profile Index (KDPI) to the top 20% estimated recipient post-transplant survival. The majority of donor kidneys (80%) would be allocated to candidates who are within 15 years of the donor.

KDPI is a formula that summarizes the risk of graft failure following kidney transplant by combining a variety of donor factors into a single number. Unlike the current system which classifies kidneys into two discrete categories: expanded criteria donor (ECD) or standard criteria donor (SCD), KDPI represents a continuous score awarded to kidneys based on donor quality. Before a donor organ is offered through an Organ Procurement Organization (OPO), the specific donor information is entered into the computer system. This information will be used to generate the KDPI score. If the score is  $\leq 20\%$  (kidneys with the predicted longest function), the donor kidney would first be offered to local candidates who have at least the 20% longest estimated post-transplant survival before being offered to all other candidates. If the KDPI score is  $> 20\%$ , the kidney would first be offered to candidates who are between 15 years older and 15 years younger than the donor before being offered to all other candidates. When a candidate is listed for a kidney transplant, the information entered during the listing process will be used to determine the candidate's estimated post-transplant survival. KDPI can be used to help people better understand the potential longevity of a certain kidney in a certain donor.

Whether a candidate is in the first allocation group (20% Allocation Group) or in the second allocation group (80% Allocation Group) depends on the specific medical characteristics of the donor kidney and the medical characteristics of the candidate that has been entered into the computer. For example, if a donor kidney becomes available with a KDPI score of 60%, it will be allocated first to candidates within 15 years older or younger than the donor. A candidate's priority would change based on the donor's age in relationship to the candidate's age. However, a donor kidney with a KPDI score of  $\leq 10\%$  will be first allocated to candidates with an estimated post-transplant score of  $\leq 20\%$  regardless of donor age (see Figures 2 and 3).

The order in which candidates are ranked on the waiting list of candidates within each of the allocation groups is based on the current national kidney allocation rules with the following exceptions: waiting time is calculated as either time on dialysis or time since listing with a GFR $\leq$ 20ml/min, whichever is longer. When determining the age brackets to be used for kidney allocation, the Kidney Committee considered three different age groupings. These included recipients aged within +/-10 years, +/-15 years, and +/-20 years of the donor's age. The +/-10 years system resulted in fewer donors available to candidates in their mid to late 30's, while the +/-20 years system resulted in a substantial increase in donors available to these candidates. The +/-15 years system was advantageous because the donor distribution is substantially younger than the candidate population. Further, the +/-15 years allocation represented a compromise system allowing broader distribution of donor organs across the spectrum of candidates.

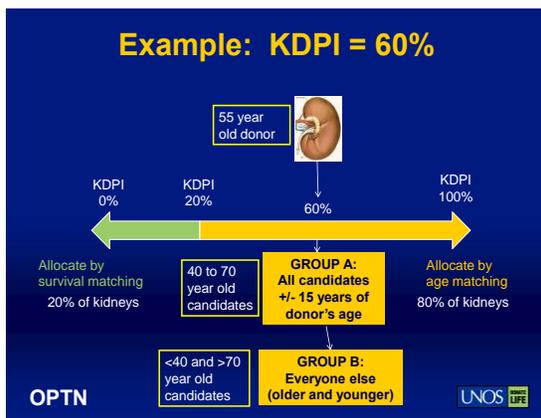


Figure 2

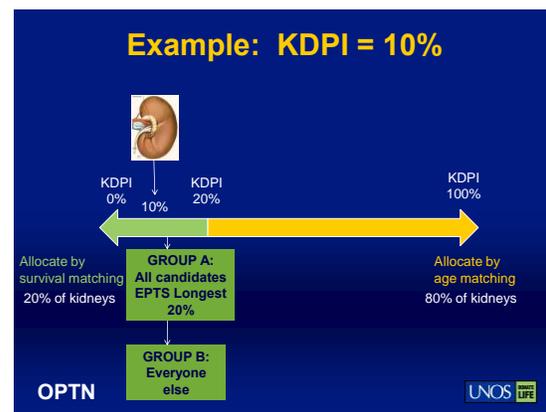


Figure 3

Results of the simulations by candidate characteristics were briefly summarized for the committee. Overall, no major changes were observed in the proportion of kidneys allocated to candidates by race/ethnicity, ABO blood type, or degree of HLA mismatch, as compared to the current system. The most substantial changes observed were in the proportion of transplants by primary diagnosis (diabetes mellitus) and recipient age (with a decrease in transplants to patients over age 50). However, the proposed system does improve the age correlation between the donor and recipient which was a concern expressed in public feedback. The committee was also informed that waiting time will begin when the patient's dialysis time has begun (with the initiation of dialysis) and not when the patient is placed on the waiting list. The system also incorporates the Minority Affairs Committee A2/A2B Alternative System. The committee was informed that these two factors alone resulted in increased allocation to minority candidates; however when the factors incorporating utility are layered on top of the system, the net benefit to minorities is diminished.

The committee was informed that the KDPI calculation was approved by the Board of Directors at its June meeting. As a result, KDPI will be displayed in DonorNet<sup>®</sup> within the next year and a half so that whenever an organ becomes available clinicians can see the KDPI displayed along with the organ offer. Preceding the availability of KDPI in DonorNet<sup>®</sup>, a KDPI calculator will be added to the OPTN website along with patient educational materials. A pocket-sized version of an I-Phone application including the KDPI calculator will also be made available.

Following the presentation, a committee member inquired about the pathway of a patient who understands the system and chooses to refuse a kidney with a KDPI of a certain value. Would this patient be forced to reenter the donor pool? It was responded that the committee is currently examining ways to incorporate patient efficiency and patient choice into the system. The patient

education materials and the calculator on the web will be available to assist patients in making decisions about acceptance criteria in advance of receiving an offer. Also, there will be no penalty for refusal of an organ. The committee was also updated on plans to distribute a second concept proposal document which will present the concepts to be used in the proposed kidney allocation system for public review and feedback. The Kidney Committee is awaiting communication from HRSA before releasing the concept document. The communication plan will include webinars for patients, professionals, and the media. The Kidney Committee will consider feedback on the concepts before crafting a policy proposal.

#### 14. Kidney Paired Donation Pilot Project (KPD-PP) Update

The committee was briefly updated on the status of the Kidney Paired Donation Pilot Project (KPDPP) (**Exhibit E**).

In June of 2008, the Board approved a national KPD pilot program to be administered by the OPTN. KPD is a program which assists donor/recipient pairs who are incompatible or poorly matched with each other in finding another donor/recipient pair(s) with whom they can exchange kidneys. The matching program can enable more favorable compatibility between two donor/recipient pairs in order to allow a successful transplant to occur.

The purpose of the pilot project is to test KPD on a national scale. The system will utilize UNet<sup>SM</sup> as the mechanism for integrating the national system. Advancement of the KPDPP system from a pilot project to a non-pilot system will be based upon policy development related to KPD.

There are currently three phases of implementation:

- Phase 1 -Operational guidelines and contracts (This phase has been completed.)
- Phase 2-Interim policy (Adaptation of operational guidelines to allow sanctions and adverse actions.)
- Phase 3-Permanent policy (Will occur at the end of the pilot project. Depending on the results of the pilot it may eventually apply to all KPD programs.)

The interim policy development process includes the following groups:

- KPD Work Group (Consists of a drafting group which includes representation from many committees and existing KPD systems).
- Committee Sponsor Review:
  - Kidney Committee
  - Living Donor Committee
  - Patient Affairs Committee

The KPD Work Group Subcommittees include:

- Donor Chains Subcommittee- finalizing the proposal on whether to include non-directed donors and donor chains in the KPDPP.
- Interim Policy Subcommittee- converting the KPDPP Operational Guidelines into interim policy for KPD.
- Financial Subcommittee- addressing financial and administrative barriers to KPD including reimbursement, payer relations, and contracts.

The committee was also informed that an additional MAC member recently joined the KPD work group as a member.

## 15. Issues Regarding Geographic Variation

### *Access to Liver Transplantation*

*On-going Evaluation of Region 8 “Share 29” Liver Policy: Analysis of characteristics of Candidates and Recipients, Waiting List Death Rates, Number of Transplants and Post Transplant survival, Stratified by MELD/PELD Scores by Ethnicity, Before and After Share 29 Implementation.*

Various data reviewed by the committee over time have shown higher MELD/PELD scores for minorities at wait listing and a lower overall wait listing rate for minorities. Further, the results show a fairly consistent wait listing rate for all groups, except a significant reduction is shown for the African-American group. The committee has been interested in trying to gain a better understanding of the reasons for the variability in the MELD/PELD scores and exception points and in bringing some uniformity to the system. The questions the committee has attempted to address are:

- 1.) What is driving the variability for these patients?
- 2.) Is the problem limited access to the waiting list or are patients being referred late in the process?

The committee requested data on the following:

- Wait list death rates by candidate ethnicity;
- Distribution of deceased donor transplants by MELD/PELD (M/P) score and recipient ethnicity;
- Basic demographics and characteristics of transplant recipients; and
- Kaplan-Meier survival by recipient ethnicity before and after Share 29 implementation.

The committee reviewed updated results. Dr. Wida Cherikh, Ph.D presented the information to the committee (**Exhibit F**). The data show that:

- There did not seem to be any reduction in death rates per 100 patient years after Share 29 implementation, overall and for MELD/PELD 29+;
- Median MELD/PELD at transplant was comparable before and after Share 29 across ethnic groups;
- There were higher number and percentage of transplants done in M/P 29+ after Share 29; and
- Across ethnic groups, graft and patient survival rates within 1 year of transplant were similar for transplants done before and after Share 29.

The committee briefly discussed the purpose and goal of the Share 29 policy. A member commented that the policy did not expand access to organs as intended. The committee also inquired about possible comparator locations. Members were interested in the context in which the Share 29 assessment was being conducted. In the non-Share 29 regions was the proportion of MELD patients who received a transplant equivalent? Did Region 8 have a disproportionate number of a certain MELD score? It was explained that the primary objective of Share 29 was to reduce wait list mortality in Region 8. The purpose of the experiment was to compare Region 8 with itself before the policy was implemented. Further, there is no other comparative region because there is no other sharing occurring at that level.

It was remarked that the results show an increase in the number of transplants with malignant neoplasm diagnosis, though the study excluded both tumor upgrades and MELD exceptions. A

member suggested that one reason could be that the tumor patients continually receive upgrades every three months. If an organ is offered to the region and the only patient available is a tumor patient, the organ will stay in the region and be used locally and not shared. It was commented that Region 4 turned down the proposal previously distributed by the Liver and Intestinal Organ Transplantation Committee (Liver Committee) because it appeared to incentivize lower performing OPOs.

A member of the committee commented that the region was considering abolishing the Share 29 pilot project; though it would need Board approval to do this. The member was not aware if the liver committee was aware of the sentiments of the region with regard to abolishing the variance. It was noted that the Liver Committee will need to follow up with the region as it is monitoring the data. It was also remarked that the organ bank in Region 8 is a net exporter of organs. There may be repercussions if the centers no longer have access to this unlimited resource for organs. It was suggested that the region should collect data over the next three years to examine what happens comparatively.

#### 16. Draft Liver Referral Survey

Various data reviewed by the committee over time have shown higher MELD/PELD scores for minorities at wait listing and a lower overall wait listing rate for minorities. Further, the results show a fairly consistent wait listing rate for all groups, except a significant reduction is shown for the African American group. The committee has been developing an online *Survey on Referral to Liver Transplantation* to explore barriers to liver referral and wait listing for different ethnic groups. The survey is in the final stages of development and was modeled after the *Survey on Referral to Kidney Transplantation*. The initial online survey questionnaire will target transplant centers. Another more specific questionnaire will target hepatologists and gastroenterologists through newsletters and websites of professional organizations and other communication vehicles.

The committee has been interested in trying to gain a better understanding of the reasons for the variability in the MELD/PELD scores and exception points and in bringing some uniformity to the system. The questions the Committee has attempted to address are:

- 1.) What is driving the variability for these patients?
- 2.) Is the problem limited access to the waiting list or are patients being referred late in the process?

During its meeting on November 20, 2009, the committee conducted a review of the draft questionnaire developed by the subcommittee. Following brief discussion, it was determined that additional refinements to questionnaire were needed before the survey was distributed. The Liver Referral Subcommittee made additional modifications to the survey questionnaire and reviewed the changes during the full committee meeting. A separate meeting of the Kidney Referral Subcommittee revealed the need to revise several of the survey questions, based on possible misinterpretation of the intent of the questions demonstrated by the raw survey data from the Kidney Referral Survey.

The committee reviewed the changes during the July 21, 2010 meeting and crafted a tentative timeline for distribution. The proposed timeline included distribution in late August, follow up reminders every four weeks with a final reminder in another two weeks, after which the survey would be closed. It was recommended that the revised questionnaire be distributed to the subcommittee a final time before distribution.

## 17. Liver Allocation Forum

The committee was updated regarding the public forum on liver distribution held on April 12, 2010, in Atlanta, GA. The purpose of the forum was to gain a greater understanding among all stakeholder groups about hopes and concerns associated with liver allocation and distribution, and to open up discussions about policies regarding liver allocation/distribution concepts that do and do not resonate with the community. It is also hoped that the discussions will reveal desired directions for further work on the subject.

During the forum, the following sentiments were revealed:

- MELD score not “broken”;
- Changes to distribution should be made in small incremental steps;
- The community is split on many issues;
- There are strong feelings about geographic inequities caused by using the DSA and regions for distribution;
- There were many comments about OPO effectiveness and single-center OPOs;
- There was support for some tiered sharing, Share 15 National, and the “risk equivalent threshold” (RET) concepts;
- There was not much support for concentric circles;
- There was strong support for increased utilization, decreased discards, and/or expedited placement of livers;
- The committee must collaborate with OPO Committee and community; and
- The committee needs clear goals and objectives.

The forum was followed by development of a Liver Allocation & Distribution Subcommittee to evaluate proposals/concepts discussed at the forum and formation of a Subcommittee on Liver Utilization. The subcommittee will examine the following:

- Processes for expedited placement of livers;
- Increased utilization of organs and organ discards.

## 18. Request from Tennessee Transplant Society (TTS) to Study Statewide Alternative Allocation System (AAS)

The committee considered a request from the Tennessee Transplant Society to conduct computer simulation modeling comparing the current national system with the TTS Alternative Allocation System which awards additional priority to patients with good CREG and BDR matching as well as high PRA patients. The request is being made to determine if the AAS is creating a disparity in waiting times for sensitized candidates within the local area. There is disagreement within the region regarding whether or not the variance should be continued and so the region is requesting additional information to help make this decision. Some of this data would include:

- Distribution in various minority groups
- Distribution of high PRA versus low PRA
- How the data compares with the nation?

The committee was informed that in August, the Kidney Committee will undertake a review of all of the alternative systems currently in place for kidney allocation with an eye toward dissolving all variances. This will occur along with the implementation of the new Kidney Allocation System (KAS) to allow some time to develop a baseline and establish how the system is operating before

introducing alternate allocation models. After brief discussion it was determined that data from the TTS alternative system had previously been provided by UNOS in response to a member's data request. Committee staff requested that Dr. Grandas prepare a draft of the data request and forward to Dr. Cherikh as a member data request.

#### 19. Living Donation Issues

The committee was updated on the status of the manuscript *Prior Living Kidney Donors Who Subsequently Developed End Stage Renal Failure*. The manuscript is in the final stage of completion and is hoped to be submitted for publication in the Fall of 2010.

#### 20. Discussion of Public Comment Proposals Distributed on March 5, 2010 and March 19, 2010

*Committee discussion of these public comment items was incorporated within the June 2010 MAC Report to the Board of Directors and is also being included here due to Board consideration of the proposed items.*

*Proposed Modifications to Data Elements on Tiedi<sup>®</sup> Forms* - In March 2010, a MAC Data Forms Subcommittee reviewed the details of the OMB forms revision changes and presented its comments and recommendations to the group during the full committee meeting. Committee feedback consisted of the following overall themes:

- Many data items are being proposed for addition, but their utility is questionable.
- There is a need to better define and clarify some of the proposed additions.
- Certain fields may not be appropriate to be collected by the OPTN, especially if being used primarily for research purposes.
- Travel for additional tests may be difficult for minorities who live in remote regions, and this may delay the wait listing of these patients.
- The additional testing required will increase costs to patients and may negatively impact minorities.
- The proposed data additions will significantly increase staffing resources and will be an additional burden to members.

*Summary of Discussion of Liver Proposals* - The committee discussed the four liver proposals as a unit and provided the following feedback to the Liver Transplantation Committee:

The Minority Affairs Committee supports the concept of split liver transplantation but has significant concerns regarding adequate protection of the index patient. The committee recommends that split liver transplantation should be performed only if the index patient is size unsuitable for a whole organ transplant. The committee also supports the concept that the institution performing the split should retain the second portion of the liver for transplantation of a candidate on its own waiting list.

Further, if the proposal is approved, the committee wishes to examine data before and after implementation of the ALU showing the impact on minorities from the patient safety perspective.

*Proposal to Develop an Efficient, Uniform Pancreas Allocation System* - After reviewing the data presented in the proposal, the committee determined that there would be no net change in the distribution of pancreata among ethnic groups. The committee did not identify a minority impact or other reason why the proposal should not proceed; however it declined a formal vote.

*Proposal to Modify OPO and Transplant Center Requirements for Screening, Communicating and Reporting All Potential or Confirmed Donor-Related Disease and Malignancy Transmission Events* - After brief presentation of the proposal, the committee determined that there was no minority impact and declined a formal vote. However, the committee noted that it supports appropriate reporting of information on all infectious diseases.

*Proposal to Update HLA Equivalency Tables* – Following the presentation, the committee discussed the possibility that minorities could be disadvantaged in OPO's unable to split antigens, though data was unavailable to prove this has occurred. The broader the antigen is defined the lower the likelihood of receiving organ offers. Therefore, the committee believes that the proposal may have a beneficial impact on organ offers in areas with a high minority population, as minorities are more heterogeneous with regard to HLA.

*Proposal to Require that Deceased donor HLA typing Be performed by DNA Methods and Identify Additional Antigens for Kidney, Kidney-Pancreas, and Pancreas Islet Offers* - After brief discussion, the committee determined that it supports the Histocompatibility Committee in its efforts to standardize HLA typing and clean up reporting of split antigen HLA typing. The committee is also very interested in examining the data following implementation to review for minority impacts.

*Proposal for the Placement of Non-Directed Living Donor Kidneys* - The committee discussed the potential of the proposal to increase inappropriate bypassing of patients on the list versus the societal responsibility to the altruistic donor to make best use of the organ. The committee also expressed concern about whether minorities would be more likely to be listed at centers that do not have the infrastructure or resources to attract altruistic donors.

After brief discussion the MAC determined that it supported the policy proposal as written.

*Proposal to Require Reporting of Non-Utilized and Redirected Living Donor Organs* - After brief discussion, the committee did not identify a minority impact with the proposal and voted to support the proposal as written.

**ATTENDANCE FOR THE MARCH 23, 2010  
OPTN/UNOS MINORITY AFFAIRS COMMITTEE MEETING**

<b>Committee Members</b>	<b>Position</b>	<b>In Attendance</b>
Henry B. Randall, MD	Chair	Yes
Silas P. Norman, MD	Vice-Chair	Yes
Sayeed K. Malek, MD	Region 1 Representative	Yes
Kenny Boyd, EMT-P, CPTC	Region 2 Representative	No
Rosaline Rhoden, MPH	Region 3 Representative	Yes
Ronald H. Kerman, PhD	Region 4 Representative	Yes
R. Kelvin Satcher, MBA, CPTC	Region 5 Representative	Yes
AJ Johnson	Region 6 Representative	No
Beth Plahn, RN, BA, MHA	Region 7 Representative	Yes
Ioana Dumitru, MD	Region 8 Representative	Yes
Joselito Nuqui	Region 9 Representative	Yes
Remonia A. Chapman	Region 10 Representative	Yes
David G. Jacobs, MD	Region 11 Representative	No
L. Ebony Boulware, MD	At-Large	Yes
Oscar H. Grandas, MD	At-Large	No

Camille Hill –Blue, PA-C	At-Large	Yes
Eddie Island, MD	At-Large	Yes
Terri Rihner, MSW, LCSW	At-Large	Yes
M. Christina Smith, MD	At-Large	Yes
Rachel C. Thomas, MBA, BSN, RN, CNN	At Large	No
Roberta Wagner, RN	At-Large	No
Carlton J. Young, MD	At-Large	Yes
Bobby A. Howard	Visiting Board Member	No
Pang-Yen Fan, MD	Ex-Officio	Yes
Mesmin Germain, MBA, MPH	Ex-Officio, HRSA	Yes
Richard Laeng, MPH	Ex-Officio, HRSA	No
<b>UNOS Staff</b>		
Deanna L. Parker, MPA	Committee Liaison/Policy Analyst	Yes
Charlotte Carroll, MS	Research Biostatistician	No
Wida Cherikh, PhD	Sr. Research Biostatistician	Yes
Stacy J. Burson, MS	Business Analyst	Yes(Phone)
<b>Arbor Research Staff</b>		
Valarie Ashby, MS	SRTR Analytic Staff	Yes

Pandu Rao, MD	SRTR Analytic Staff	Yes
Alan B. Leichtman, MD	SRTR Principal Biostatistician	No
Keith McCollum, MS	SRTR Analytic Staff	Yes
<b>Guests</b>		

**ATTENDANCE FOR THE JULY 20, 2010  
OPTN/UNOS MINORITY AFFAIRS COMMITTEE MEETING**

<b>Committee Members</b>	<b>Position</b>	<b>In Attendance</b>
Henry B. Randall, MD	Chair	Yes
Silas P. Norman, MD	Vice-Chair	Yes
Sayeed K. Malek, MD	Region 1 Representative	Yes
Stacey H. Brann, MD	Region 2 Representative	Yes
Rosaline Rhoden, MPH	Region 3 Representative	Yes
Sherilynn A. Gordon Burroughs, MD	Region 4 Representative	Yes
Ricardo Elizondo, RN, CPTC	Region 5 Representative	No
Stephen A. Kula, Ph.D, NHA	Region 6 Representative	No
Bruce A. King, MSW	Region 7 Representative	Yes
Ioana Dumitru, MD	Region 8 Representative	Yes
Lani V. Jones, PhD, MSW	Region 9 Representative	Yes
Remonia A. Chapman	Region 10 Representative	No
David G. Jacobs, MD	Region 11 Representative	Yes (on phone)
L. Ebony Boulware, MD	At-Large	Yes

Oscar H. Grandas, MD	At-Large	Yes
Camille Hill –Blue, PA-C	At-Large	Yes
Eddie Island, MD	At-Large	Yes
Meelie A. DebRoy, MD	At-Large	Yes
M. Christina Smith, MD	At-Large	Yes
Maria R. Lepe, MD	At Large	Yes
Karen A. Sullivan, Ph.D	At-Large	Yes
Pang-Yen Fan, MD	At-Large	Yes
Bobby A. Howard	Visiting Board Member	Yes
Mesmin Germain, MBA, MPH	Ex-Officio, HRSA	Yes
Richard Laeng, MPH	Ex-Officio, HRSA	No
<b>UNOS Staff</b>		
Deanna L. Parker, MPA	Committee Liaison/Policy Analyst	Yes
Wida Cherikh, PhD	Sr. Research Biostatistician	Yes
Stacy J. Burson, MS	Business Analyst	Yes(Phone)
<b>Arbor Research Staff</b>		

Valarie Ashby, MS	SRTR Analytic Staff	Yes
Natalie Lueth, MS	SRTR Analytic Staff	Yes
Alan B. Leichtman, MD	SRTR Principal Biostatistician	Yes
<b>Guests</b>		
None		