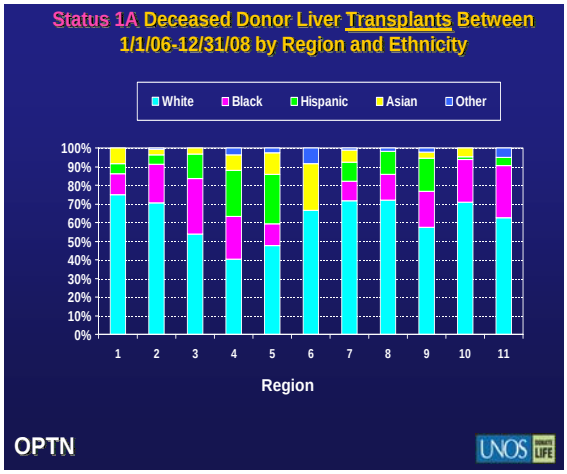
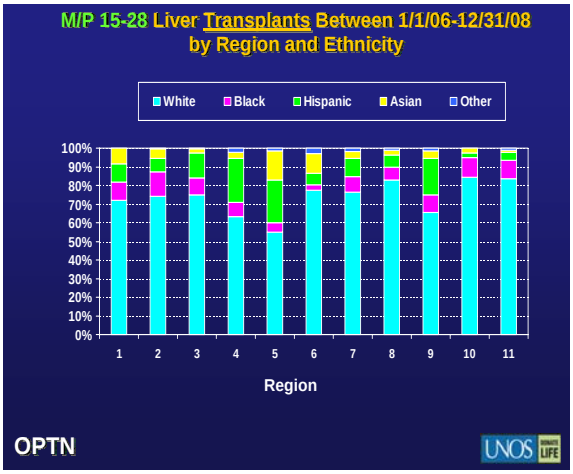


(Figure 1)



(Figure 2)

In summary:

- MELD/PELD scores at listing are variable across ethnicity.
- MELD/PELD scores at listing are less variable across region.
- Some regions are more diverse than others.
  - Regions 4 and 5 most diverse.
  - Regions 1, 6, 8, 10, and 11 are at least 80% white.
- MELD/PELD scores at transplant and ethnicity of liver transplant recipients are also variable across regions.
- Death rates are consistent across ethnicity alone and status alone.
  - More variable across regions for registrations in status 1A.
- Transplant rates are variable across regions for all status levels.

The Committee discussed the results. The data continues to indicate potential differences in access to the liver waiting list by ethnicity and by ethnicity within regions. A member commented on a situation currently being reported in the media where a candidate shopped around for the region that would offer him the most MELD exception points with the shortest waiting time. The patient had the resources to visit each transplant center, was listed at the center that offered him the most MELD exception points, and was transplanted. The issue focused upon in the media was possible questionable medical practices and policies permitting the situation.

Another member of the Committee inquired whether this should be an issue for the Liver Committee rather than a minority issue, since the situation did not demonstrate minority variation in impacts. It was responded that in areas where there is more ethnic diversity, there is tremendous variability in MELD/PELD scores at listing, particularly for pediatric candidates. The Committee is charged with trying to gain a better understanding of the reasons for the variability in the MELD/PELD scores and exception points and to bring some uniformity to the system. The question for the Committee to address is what is driving this variability for these patients? Is the problem limited access to the waiting list or are patients being referred late in the process?

For the November 2010 meeting, the Committee requested to review data on liver waiting list death rates and transplant rates, number of additions and number of transplants in different regions by MELD/PELD score, ethnicity, and age group (pediatric vs. adult), with and without exceptions.

Access to Liver Transplantation

During the July meeting, the Committee was provided with an updated analysis on *Access to the Liver Waiting List*. The Committee requested an updated estimate using more recent data, showing access to the liver transplant waiting list among all patients with liver disease. Amit K. Mathur, MD, MS of the SRTR, presented the data to the Committee (**Exhibit F**).

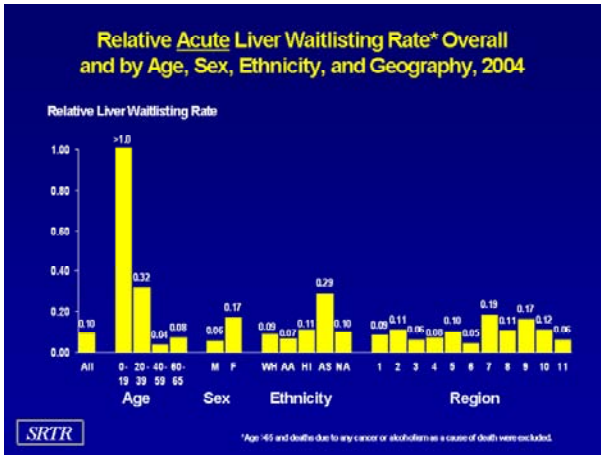
The analysis examined the population that dies of causes related to liver failure using national mortality data from the National Center for Health Statistics (NCHS) for patients 65 and younger to identify deaths in 2004 resulting from liver disease. Mr. Mathur reported that over the last ten years, liver transplantation has remained relatively stable. This steady state includes the number of new patients added to the liver waiting list, the number of deaths on the waiting list, and the number of patients transplanted. The SRTR analytical approach relied on an equilibrium assumption that the number of new cases and the transplant rate would remain constant over time. Bias could be introduced into the calculation if the number of waitlisted patients were to change substantially over time.

It is difficult to determine estimates of access to liver transplantation because there is no national comprehensive registry of the potentially transplantable liver disease population as there is with the dialysis patient population. Therefore, the analysis mapped the ICD-9 codes used in the previous analysis to ICD-10 codes to obtain the total number of liver waiting list registrants and waiting list and post transplant deaths in 2004, separating patients with acute and chronic liver disease. The analysis included counts of new and prevalent waiting list candidates and transplants and repeated earlier data for comparison purposes. The relative liver waitlisting rate was calculated overall and for age group, sex, ethnicity, and geographic region subgroup for 1999, 2001 and 2004.

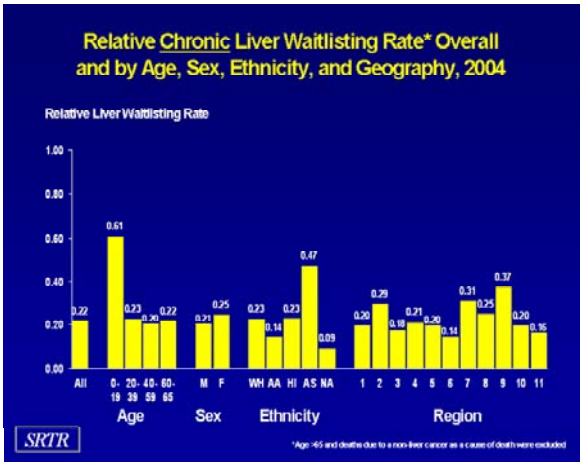
The data show that in 2004, the overall relative liver waitlisting rate for acute liver failure was 0.10. Similarly, the relative waitlisting rate for all chronic liver failure was 0.22. All subgroup analyses showed that younger patients had higher rates than older patients and females had higher rates than males. There was also large variation by race/ethnicity and region. Analyses of data in prior years (1999 and 2001) showed similar results.

The Committee discussed the results shown in the analysis. Dr. Randall noted that Hepatitis C (HepC) was shown with the highest listed acute liver failure rate. HepC is not usually an acute etiology for liver disease. It was also noted that the magnitude of difference between the waitlisted 0-19 population was almost 4-8 times that of older adults. In addition there was also a significant gender difference with females showing a three-fold greater access to the waiting list as compared to males (see Figures 3 and 4). The SRTR acknowledged that HepC in clinical experience and in the literature results in almost no deaths. The results shown could be due to the way that death certificates are coded, resulting in under reporting of deaths for patients with liver disease. The case mix could include patient deaths related to chronic HepC but from other causes, patients who actually died because of chronic HCC, or a combination of both situations. Within the analysis, there is the possibility of some differences between sub groups, or geographic regions due the way in which the death certificates are completed, which could have a substantial effect on the estimates of the access rates.

Committee members discussed the access problem for minority candidates on the liver waiting list shown in the data. A member commented that the combined data presentations show higher MELD/PELD scores for minorities at waitlisting and a lower overall waitlisting rate for minorities. Further, the results show a fairly consistent waitlisting rate for all groups, except a significant reduction is shown for the African American group. He remarked that the data demonstrated an unsettling consistency as the analysis has currently been performed three times with the same result.



(Figure 3)



(Figure 4)

A prior analysis conducted by the SRTR on minority access to transplantation showed an unexplained 17% difference in transplant rates for African American candidates, as compared to all other minority candidates, after all adjustments. The member suggested that the Committee evaluate why this is occurring through an initiative to study patients with liver disease.

The member suggested the need for an action item to try to tease out the problem. It was noted that there is a gap in literature with regard to how well the community is doing with referrals for liver transplantation. Members inquired whether or not there was a way for the committee to review data on time to waitlisting for liver candidates as there is with dialysis patients. It was responded that all centers should be able to track the referrals coming into the transplant center; though some of the potential referrals may be missed. It was suggested that the Committee develop a survey similar to the kidney referral survey to analyze the number of people actually referred, as this information should be collected by each center. The objective would be to determine if Centers are screening patients and then turning them down, or if patients are not being referred at all.

The Committee agreed by consensus to develop an online survey for Liver Referrals similar to the Kidney Referral Survey that would be useful to explore barriers to liver referral for different ethnic groups. The group determined that it should use the kidney referral questionnaire as a model. The Committee agreed to select a few of its members and staff to modify the questionnaire so that it can be used for this purpose.

Survey on Referral to Liver Transplantation

A subgroup of the Committee met on August 2, 2009 to suggest modifications to the Kidney Referral Survey to make it applicable to liver transplantation. The group determined that the questionnaire should be directed to the medical and surgical directors of the transplant centers to ensure the questionnaire reached its intended targets. However, because many of the liver patients are referred from either a hepatologist or a gastroenterologist, it was determined that a two tier approach would be appropriate to get an accurate representation of how referrals are tracked through the evaluation process. The initial online survey questionnaire would be distributed to the transplant centers, and then another more specific questionnaire would be distributed which would target hepatologists and gastroenterologists though the use of the newsletters and websites from the professional organizations and other relevant communication vehicles.

UNOS staff would make the suggested modifications to the survey instrument and then circulate a draft questionnaire to the subgroup. Following this review, the survey will be sent to the full

committee via e-mail prior to distribution. The group hoped to be able to distribute the survey before the November meeting so that preliminary results can be presented.

9. Living Donation Issues

Prior Living Kidney Donors who Subsequently Developed End Stage Renal Failure
The Committee has been examining data that pertain to safety of living donation, particularly with respect to individuals who donated their organ and ended up on the waiting list due to end stage organ failure. The Committee has been interested in determining if the rate of being placed on the waiting list within 5-6 years is higher for previous living kidney donors who are Black as compared to non-Black. Data were previously viewed showing that the rate of being on the waiting list was substantially higher for Black donors than White donors.

At the November 21, 2008 meeting the Committee was presented with information showing that the median age at donation and age at start of dialysis was younger for Black than White donors and the number of years from donation to dialysis was similar between Black and White donors. The Committee was interested in learning if the rate at which these African American donors are experiencing renal failure is what would be expected given their specific diagnoses.

During the March meeting, the Committee reviewed the tabulation of the diagnoses that were reported in the CMS Medical Evidence (Form 2728) database **(Exhibit G).** The data showed that:

- Overall, there seemed to be more prior living donors reported with hypertension diagnosis at the time of dialysis, whereas diabetes was the most common diagnosis for overall waitlisted patients.
- Hypertension seemed to be a more common diagnosis for Black prior living donors who were subsequently placed on dialysis, or among Black waitlisted patients.

The Committee determined that until additional donors are added to the dataset the analysis is considered to be completed for now. The focus at this time should be to get the literature out into the public domain as the information may have some bearing on living donation efforts in the future.

In July, for the benefit of the new members, Dr. Cherikh provided a verbal summary of the work of the Committee in attempting to determine the long term risks to minority kidney donors. The Committee was informed that the data were presented at several national meetings, including ATC most recently. Dr. Cherikh reported that she is currently preparing the data for manuscript submission along with Drs. Fan, Young, and Randall.

10. Access to Heart Transplantation

Waiting List Mortality Rates for Pediatric Candidates by Ethnicity
The Committee became aware of a paper presented at a national conference showing that minority pediatric heart candidates had a higher likelihood of dying on the waiting list. The Minority Affairs and Thoracic Organ Transplantation Committees were contacted to provide comment on the study. The Thoracic Committee ultimately responded to the queries. The Committee was advised that the cohort used for the analysis was prior to the revised heart allocation system implemented on July 12, 2006. Outcomes following the implementation of the revised heart allocation system have been examined by status and era; however, there has not been a comparison of outcomes by candidate ethnicity. The Committee became interested in examining the issue to ensure that there were not any unintended consequences of the policy change.

During the March meeting, the Committee was provided with waiting list mortality rates and probability of waiting list outcomes for pediatric candidates since the policy change, stratified by candidate ethnicity **(Exhibit H).** Dr. Wida Cherikh presented the information to the Committee.

The data showed the following:

- There appeared to be no significant differences in death rates per 100 patient-years at risk for any of the ethnicity groups compared to White candidates, within medical urgency status or across all statuses in the post-policy era.
- In the pre-policy era there were no differences within medical urgency statuses.
- There appeared to be a slightly higher death rate pre-policy in the Blacks and Hispanics compared to Whites when all statuses were combined.
- Since there were no differences within status, this may have partially been a reflection of differences in distribution of medical urgency across the ethnicity groupings.
- There did not appear to be any significant differences in the probability of removal for death or too sick; the probability of removal for transplant; or the probability of removal for other reasons within 182 days of listing between the ethnicity groups pre- or post-policy.
- The same trend holds whether examining rates over all statuses or when stratified by initial medical urgency status.

The Committee briefly discussed the analysis. It was suggested that the cohorts selected for the study were probably used to provide a large enough sample for analysis; however, because previous policies were in place at that time, different results were shown. It was remarked that it appeared as if the issue was already beginning to correct itself with implementation of the new policies.

Access to the Heart Waitlist

At the July 2004 meeting, the Committee reviewed an analysis the SRTR had prepared for the ACOT meeting in September 2003, regarding access to the heart waitlist among all patients with heart diseases. Since there is no national registry of patients with heart failure as with the dialysis population, the waitlist rate was estimated by examining the population that died of causes related to heart failure, using national mortality data from the National Center for Health Statistics (NCHS) for deaths in 1998 of heart disease.

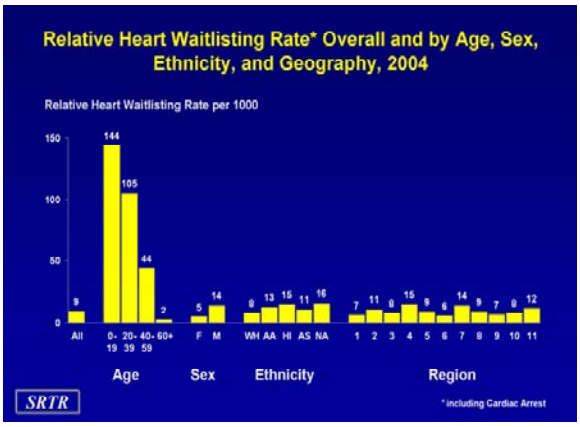
During the March meeting, the Committee reviewed an update to the heart analysis using 2004 national mortality data from the National Center for Health Statistics (NCHS) and SRTR data **(Exhibit I)**. Valarie Ashby, SRTR presented the information to the Committee. The analysis mapped the ICD-9 codes used in the former analysis to current ICD-10 codes, along with several additional diagnostic codes supplied by the Committee, to obtain a total count of heart waitlist registrants and waitlist and post transplant deaths. The Relative Heart Waitlisting Rate (RHWR) was calculated overall and for age group, sex, ethnicity, and geographic region subgroups with and without cardiac arrest as cause of death (see Figures 1 and 2 below) due to the ubiquitous and non-specific usage of that diagnosis in most death certificates.

It was noted that there could be differences between subgroups that are not shown in the analysis due to the way in which death certificates are completed. This could have a substantial effect on estimates of the access rates. Also, all calculations were based on the assumption that the number of new cases and transplant rate would remain constant over time. In general, the data show that younger patients had a higher waitlisting rate than older patients. This is because the denominator includes patients over age 60 which consists of almost 90% of the dataset. The other age groups are

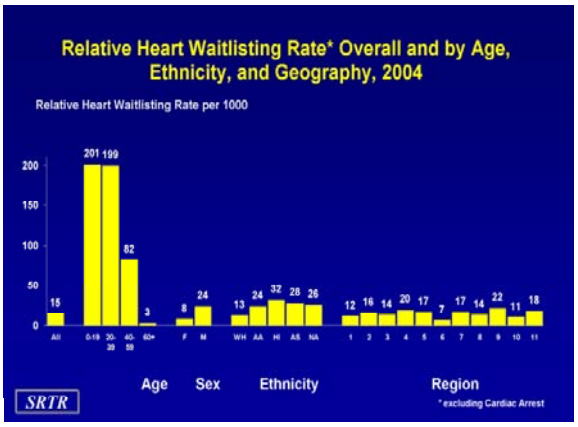
shown with much smaller numbers and so the true impact of the rate may be magnified. For this reason, the analysis attempted to highlight the differences that exist by subgroup.

These highlights show the following:

- In 2004, the overall relative heart failure wait listing ratio was about 0.015 (excluding cardiac causes).
- All analyses showed that younger patients had higher ratios (0.105 under age 60) than older patients (0.003 over age 60).
- These analyses also suggest a two-fold or greater difference among regions.
- Ratios by gender and ethnicity are very different for all patients but similar for those under age 60.
- Analyses of data in prior years (1999 and 2001) showed similar results generally, with the notable difference of a large reduction in deaths for age 0-19 in 2004 versus 1999 and 2001.



(Figure 1)



(Figure 2)

The Committee briefly discussed the results. A member of the Committee noted that the data seem to show that the heart transplant access rate of African Americans over 60 is twice as high as for those under 60. He inquired whether the data suggested that older African Americans are being waitlisted more often than younger Caucasians. It was responded that the true findings may be difficult to interpret because the population of younger heart candidates is so small. The member also inquired whether the data analyzed regional variation in access, as the analysis showed that some differences between regions that were quite large. The SRTR responded that the data were not adjusted for regional variation although this is something that can be incorporated into the analysis in the future. A member remarked that examining other organs will be very important in coming years. It was suggested that the Committee continue to refine the data in subsequent analyses in an attempt to improve the results.

For the next meeting, the Committee requested to review an updated analysis regarding access to the liver waitlist among all patients with liver failure for (a) acute and (b) chronic liver failure including more recent data.

11. <u>Review of CPRA vs. PRA</u>

Calculated PRA (CPRA) is a measure of candidate's sensitization level that is based on unacceptable HLA antigens listed for candidates. The goal of CPRA is to provide a more accurate and consistent measure of patient sensitization, and to improve the efficiency of organ allocation by reducing the

number of predictably positive crossmatches. Because CPRA is obtained by determining the actual frequency of potential deceased donors who have one of more unacceptable antigens for a given transplant candidate, CPRA may benefit ethnic minority candidates who are sensitized to HLA antigens that are relatively common in the deceased donor population.

Phase I of the calculated PRA (CPRA) policy was implemented on 12/5/07 requiring centers to enter at least one unacceptable antigen in order for their highly sensitized patients (PRA ≥80%) to receive the additional 4 points to receive deceased donor kidney transplant. The Committee has been reviewing the results of on-going Histocompatibility Committee analysis to monitor the policy by comparing CPRA and PRA by the old method and been presented with histocompatibility results by ethnicity **(Exhibit J).** During the March meeting, Dr. Cherikh presented an updated analysis to the Committee.

The data show that:

- 34% of the active registrations had CPRA values present, as compared to 27% of the inactive registrations.
- Black registrations were more likely to have CPRA present than all other ethnic groups, whether active or inactive.
- Concordance between Match PRA and CPRA seemed to increase as Match PRA values increased.
- Concordance rates seemed comparable for both White and Black registrations across all Match PRA groups.
- Across all ethnic groups, the median CPRA seemed to be higher than the median Match PRA for registrations with Match PRA of 0-20 and 21-79.
- Across all ethnic groups, the median CPRA seemed comparable with the median Match PRA for registrations with Match PRA of 80+.

It was noted that the data did not appear to show major ethnic differences or patterns. One Committee member restated a concern voiced previously that CPRA may needlessly prevent people who are not actually sensitized against a particular antigen from being transplanted. He restated a belief that antigen specificity should be used to determine the specific alleles that the patient is sensitized against. The determination of unacceptable antigens is an area that the Committee intends to closely examine.

The Committee requested to continue to be updated on CPRA analysis by candidate ethnicity.

12. Discussion of Public Comment Items Distributed on February 6, 2009

The Committee briefly discussed the eight policy proposals being distributed for public comment.

1. Proposed listing requirements for simultaneous liver-kidney transplant candidates (Policy proposed: 3.5.10 - Simultaneous Liver-Kidney Transplantation) (Kidney Transplantation Committee and Liver and Intestinal Organ Transplantation Committee)

   The Committee determined that the proposal establishes safeguards for people who experience renal failure after a liver transplant. Though the proposal will not address the imbalance in access to transplantation that currently exists with the minority population; it was noted that any proposal that would enhance the supply of organs to the ESRD population could ultimately provide greater opportunities for transplantation for minority candidates.

The Committee declined a formal vote noting that there did not appear to be an overt minority impact with regard to the proposal.

2. Proposal to create regional distribution of livers for Status 1 liver candidates (Policy affected: 3.6 - Allocation of Livers) (Liver and Intestinal Organ Transplantation Committee)

   The Committee determined that the proposal should improve broader sharing to sicker patients and reduce deaths on the waiting list. It was also noted that public comment sentiment seemed to debate the relative benefit of shipping organs versus using them locally for comparable patients.

   The Committee declined a formal vote noting that there did not appear to be an overt minority impact with regard to the proposal.

3. Proposal to create regional distribution of livers for MELD/PELD candidates (Policy affected 3.6 - Allocation of Livers) (Liver and Intestinal Organ Transplantation Committee)

   As with the previous proposal, the Committee noted the benefit of the proposal from an allocation perspective. However, an additional negative impact would be that insurance companies would now select the institutions where they would direct their patients for transplantation, possibly forcing some smaller volume centers to close. It was also remarked that travel could be an issue for minority candidates. If the proposal is approved, this is an area the Liver Committee should closely examine.

   The Committee declined a formal vote noting that there did not appear to be an overt minority impact with regard to the proposal.

4. Proposal to standardize MELD/PELD exception criteria and scores (Policy affected: 3.6.4.5 - Liver Candidates with Exceptional Cases) (Liver and Intestinal Organ Transplantation Committee)

   The Committee declined a formal vote noting that there did not appear to be an overt minority impact with regard to the proposal.

5. Proposal to add the factors “current bilirubin” and “change in bilirubin” to the lung allocation score (LAS) (Policy affected: 3.7.6.1 – Candidates Age 12 and Older) (Thoracic Organ Transplantation Committee)

   The Committee declined a formal vote noting that there did not appear to be an overt minority impact with regard to the proposal.

6. Proposal to modify the high risk donor policy to protect the confidential health information of potential living donors (Policy affected: 4.1.1 - Communication of Donor History) (Living Donor Committee)

   The Committee declined a formal vote noting that there did not appear to be an overt minority impact with regard to the proposal.

7. Proposal to change the OPTN/UNOS Bylaws, to clarify the process for reporting changes in key personnel (Bylaw affected: Appendix B, Section II,E (Key Personnel); Appendix B, Attachment 1, Section III (Changes in Key Personnel) (Membership and Professional Standards Committee)

The Committee discussed the proposal from a transplant center perspective. Because UNOS does not allow more than one person to be certified as a primary surgeon at one time, smaller centers could be forced to deactivate their program temporarily if the primary surgeon was going to be absent for more than two weeks. It was commented that UNOS should relax the qualifications in this regard. A Committee member remarked that this could be a minority issue depending on the specific patient demographics at the center.

The Committee declined a formal vote noting that there did not appear to be an overt minority impact with regard to the proposal.

8. Proposal to clarify, reorganize and update OPTN policies on OPO and transplant center packaging, labeling and shipping practices (Policy affected: 5.0 – Standardized Packaging, Labeling and Transporting of Organs, Vessels and Tissue Typing Materials) (Organ Procurement Organization (OPO) Committee)

   The Committee declined a formal vote noting that there did not appear to be an overt minority impact with regard to the proposal.

13. Discussion of Public Comment Items Distributed on July 10, 2009

The Committee briefly discussed the eight policy proposals being distributed for public comment.

1. Proposal to Include Non-Directed Living Donors and Donor Chains in the Kidney Paired Donation Pilot Program (Affected Program: Kidney Paired Donation Pilot Program) (Kidney Transplantation Committee)

   The Committee declined a formal vote on the donor chains proposal, noting that there did not appear to be an overt minority impact.

   The Committee; however, restated concerns previously voiced regarding monitoring the data from the pilot program to determine accessibility to the KPD system.

2. Proposal to Improve the ABO Verification Process for Living Donors (Affected Policy: ABO Identification (Policy 12.3.1); Reporting Requirements (12.8.1.1 and 12.8.1.2) (Living Donor Committee)

   The Committee declined a formal vote noting that there did not appear to be an overt minority impact with regard to the proposal.

3. Proposed Guidance for the Medical Evaluation of Living Liver Donors (Living Donor Committee)

   The Committee declined a formal vote noting that there did not appear to be an overt minority impact with regard to the proposal.

4. OPTN Notification Requirements for OPOs, Transplant Hospitals, and Histocompatibility Labs When Faced With an Adverse Action Taken By Other Regulatory Agencies. (Affected Bylaws: Appendix B (Sections I, II, III): Criteria for OPO, Transplant Hospital, and Histocompatibility Laboratory Membership) (Membership and Professional Standards Committee)

The Committee declined a formal vote noting that there did not appear to be an overt minority impact with regard to the proposal.

5. Proposal to Change the UNOS Bylaws to Reconcile Discrepancies in Patient Volume Requirements for Full and Conditional Program Approval When Qualifying Kidney, Liver and Pancreas Primary Transplant Physicians (Affected Bylaw: Appendix B, Attachment I) (Membership and Professional Standards Committee)

   The Committee declined a formal vote noting that there did not appear to be an overt minority impact with regard to the proposal.

6. Proposal to Add Language to the OPTN/UNOS Bylaws Requiring Transplant Center and OPO Members to Follow State Law Regarding Anatomical Gifts. (Affected Bylaws/Policy: Article I, Sec 1.10, Appendix B, Section I and II, and Policy 3.4: Organ Procurement, Distribution and Alternative Systems for Organ Distribution or Allocation)(Membership and Professional Standards Committee)

   The Committee declined a formal vote noting that there did not appear to be an overt minority impact with regard to the proposal.

7. Proposal to transfer responsibilities of labeling and packaging to the transplant center when they recover their own organs (Policy Affected: 5.0 – Standardized Packaging, Labeling and Transporting of Organs, Vessels and Tissue Typing Materials (Organ Procurement Organization) (OPO) Committee)

   The Committee declined a formal vote noting that there did not appear to be an overt minority impact with regard to the proposal.

14. Discussion of Public Comment Item Distributed on August 17, 2009

The Committee reviewed the proposal from the Ad Hoc Disease Transmission Advisory Committee (DTAC) recommending that retrospective HTLV-1/2 screening tests be required for all deceased donors, and that all screen positive tests be followed with confirmatory testing to differentiate between HTLV-1 and HTLV-2. Because the proposal was released after the Committee met in July, the review was conducted via e-mail.

Overall, the Committee did not identify any minority specific issues relevant to the proposal as retrospective testing would not result in any change in therapy. However, sentiment was expressed by several on the Committee that based on the extremely low incidence (0.035-0.046% of blood donors) of HTLV-1/2 confirmed in donors, and the fact that there are no reported cases in the U.S. of transplant recipients infected with HTLV-1 that actually develop the disease, the OPTN should not proceed with a requirement for retrospective donor testing. Concern was expressed with regard to the resources that would be expended for a relatively low projected yield and the possibility that retrospective testing would lead to more refusals and kidney discards. Members commented that the testing would not serve the recipients and would only add costs to the donor workup. Further, any benefit derived from such testing that was not academic, was unclear. One member commented that testing would be only useful if a medication regimen were to be given shortly after transmission, and with the retrospective testing proposed, the administration of an antiviral would not be timely.

15. New Member Orientation

During the July meeting, the Committee was provided with an overview of the Minority Affairs Committee, to include an orientation from the committee liaison, the OPTN Research Department, and the SRTR contractor, for the benefit of both new and existing members. The Committee was also informed about an upcoming mandatory comprehensive committee orientation that will be conducted via Live Meeting and scheduled within the next month.

16. Future MAC Issues

During the July meeting, the Dr. Randall requested feedback on additional issues that the Committee might consider addressing during the year. A member commented on a paper presented at ISHLT in Paris showing differences in outcomes between males and females by ethnicity in heart transplantation. He noted that the issue seemed to be an appropriate area for the Committee to study further. It was suggested that the member obtain contact information for the speaker so the Committee could view study results for a possible future data presentation.

ATTENDANCE FOR THE March 27, 2009

OPTN/UNOS MINORITY AFFAIRS COMMITTEE MEETING

Committee Members	Position	In Attendance
Pang-Yen Fan, MD	Chair	Yes
Henry B. Randall, MD	Vice-Chair	Yes
Diego G. Martinez	Region 1 Representative	Yes
Kenny Boyd, EMT-P, CPTC	Region 2 Representative	Yes
Gaetano Ciancio, MD, FACS	Region 3 Representative	No
Ronald H. Kerman, Ph.D	Region 4 Representative	Yes
R. Kelvin Satcher, MBA, CPTC	Region 5 Representative	Yes
AJ Johnson	Region 6 Representative	Yes
Beth Plahn, RN, BA, MHA	Region 7 Representative	Yes
Andrew C. Kao, MD	Region 8 Representative	No
Joselito Nuqui	Region 9 Representative	Yes
Silas P. Norman, MD	Region 10 Representative	Yes
Gloria T. Hairston, BS	Region 11 Representative	Yes
Bonita Balkcom Guilford	At-Large	Yes
L. Ebony Boulware, MD	At-Large	Yes
Meelie A. DebRoy, MD	At-Large	Yes
Eddie Island, MD	At-Large	No
Charles S. Modlin Jr., MD	At-Large	Yes
Terri Rihner, MSW, LCSW	At-Large	Yes
Rachel C. Thomas, MBA, BSN, RN, CNN	At-Large	No
Roberta L. Wager, RN	At-Large	Yes

Carlton J. Young, MD	At-Large	No
Mesmin Germain, MBA, MPH	Ex-Officio, HRSA	Yes
Richard Laeng, MPH	Ex-Officio, HRSA	Yes
Jerry Butler, MBA	Visiting Board Member	No
UNOS Staff		
Deanna L. Parker, MPA	Committee Liaison/Policy Analyst	Yes
Charlotte Carroll, MS	Research Biostatistician	Yes (Phone)
Wida Cherikh, PhD	Sr. Research Biostatistician	Yes
Stacy J. Burson, MS	Business Analyst	Yes(Phone)
Arbor Research Staff		
Valarie Ashby, MS	SRTR Analytic Staff	Yes
Alan B. Leichtman, MD	SRTR Principal Biostatistician	Yes
Guests		
Nadine Rozier-Lawrence	Compliance Auditor	Yes

ATTENDANCE FOR THE July 14, 2009

OPTN/UNOS MINORITY AFFAIRS COMMITTEE MEETING

Committee Members	Position	In Attendance
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	Yes
Rosaline Rhoden, MPH	Region 3 Representative	Yes
Ronald H. Kerman, PhD	Region 4 Representative	Yes
R. Kelvin Satcher, MBA, CPTC	Region 5 Representative	No
AJ Johnson	Region 6 Representative	Yes
Beth Plahn, RN, BA, MHA	Region 7 Representative	Yes
Ioana Dumitru, MD	Region 8 Representative	Yes
Joselito Nuqui	Region 9 Representative	No
Remonia A. Chapman	Region 10 Representative	Yes
David G. Jacobs, MD	Region 11 Representative	Yes
L. Ebony Boulware, MD	At-Large	No
Oscar H. Grandas, MD	At-Large	Yes
Camille Hill –Blue, PA-C	At-Large	Yes
Eddie Island, MD	At-Large	Yes (Phone)
Terri Rihner, MSW, LCSW	At-Large	Yes
M. Christina Smith, MD	At-Large	Yes
Rachel C. Thomas, MBA, BSN, RN, CNN	At Large	Yes

Roberta Wager, RN	At-Large	No
Carlton J. Young, MD	At-Large	No
Bobby A. Howard	Visiting Board Member	Yes
Pang-Yen Fan, MD	Ex-Officio	Yes
Mesmin Germain, MBA, MPH	Ex-Officio, HRSA	Yes
Richard Laeng, MPH	Ex-Officio, HRSA	Yes
UNOS Staff		
Deanna L. Parker, MPA	Committee Liaison/Policy Analyst	Yes
Charlotte Carroll, MS	Research Biostatistician	Yes
Wida Cherikh, PhD	Sr. Research Biostatistician	Yes
Stacy J. Burson, MS	Business Analyst	Yes(Phone)
Arbor Research Staff		
Valarie Ashby, MS	SRTR Analytic Staff	Yes
Amit K. Mathur, MD, MS	SRTR Principal Biostatistician	Yes
Alan B. Leichtman, MD	SRTR Principal Biostatistician	Yes
Guests		
Manny Carwile	UNOS IT Department	Yes