OPTN/UNOS Minority Affairs Committee
Summary

Action Items for Board Consideration

- None

Other Significant Items

- The Committee continues its review of computer modeling simulations used for development of the new kidney allocation system. (Item 2, Page 2)

- The Committee continues its development of the survey instrument and research design to be used in the Board approved Survey on Public Comment Opinion and Outreach. (Item 3, Page 4)

- The Committee continues its review of data on access to kidney transplantation. (Item 4, Page 5)

- The Committee continues its review of data on access to liver transplantation. (Item 5, Page 5)

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

Richmond, VA
June 27, 2007

Carlton J. Young, MD, Chairman
Pang-Yen Fan, MD, Vice-Chairman

The following report contains the OPTN/UNOS Minority Affairs Committee discussions and recommendations on matters considered during its February 23, 2007, and April 20, 2007, meetings.

1. Progress Toward HHS Donor-Related Program Goals. During the February and April meetings, Wida Cherikh, Ph.D, presented updates on the OPTN's progress on meeting the HHS Program Goals.

   In February, Dr. Cherikh reported that the number of deceased donor transplants were projected to meet the program goals for 2006. The goals to increase the number of deceased donors were also expected to be met for 2006. However, the goals to increase the number of donation after cardiac death (DCD) donors and increase the number of organs transplanted per DCD and deceased donors were not projected to meet the program goals for 2006. The Committee discussed analyzing the data to determine if there have been measurable improvements to the donation rates of key ethnic subgroups resulting from the efforts of the collaborative. Dr. Cherikh informed the Committee that she would provide the requested analysis at the next Committee meeting.

   In April, Dr. Cherikh provided the Committee with updated program goal data, including new information on donor-related program goals by ethnicity since implementation of the Collaborative **(Exhibit A).** From 2004-2006, the donation rate for African Americans increased by 25% compared to an increase of less than 10% for Whites. The number of DCD organs donated was less compared to deceased donors with a sharp increase in Whites and Hispanics between 2004-2005. Dr. Cherikh reported that the number of organs transplanted per DCD donors for all ethnic groups are reported to be below the goals. However, the total number of organs transplanted per DCD donor by African Americans increased from 1.6% in 2005 to 2.3% in 2006. There was an increase in the number of deceased donor organs transplanted in Whites, Blacks and Hispanics. Also, conversion rates for deceased donors under 70 by region are reported to be almost 75% for some regions based on information submitted by hospitals.

   Members noted that the updated data shows the donation growth rate in African Americans is approximately 2.5 times that of Whites. This indicates that African Americans are now donating at a rate above their representation in the population. Unfortunately the donation rate is still not high enough to accommodate the large number of candidates waiting. A member of the Committee suggested that the data be shown in such a way to allow for comparison across regions. It was also suggested that the DCD potential within a region be examined so that regions could assess how they are performing against the national average.

2. Update on Kidney Allocation Policy Development. In February, Alan Leichtman, MD, reported to the Committee about the public forum hosted by the Kidney Transplantation Committee in Dallas, Texas. During this forum, the proposed elements of a new national kidney allocation system were presented for public input. Dr. Leichtman explained that one of the metrics under consideration (previously called Quality of Life Adjusted, Estimated Net Lifetime Survival Benefit or QENLSB) had been renamed to more accurately reflect what it is intended to measure. The term is now Life Years from Transplant or LYFT. LYFT is the estimated difference in candidate survival with a transplant minus their estimated survival with a transplant.

   In February and April, Dr. Leichtman provided the Committee with the results from the Kidney-Pancreas Simulated Allocation Model (KPSAM). The function of KPSAM is to compare alternative allocation rules to predict the consequences of proposed policy changes before they are implemented.

Three subtypes of simulation models make up the KPSAM: a model of the current rules, a model of the simulated rules incorporating LYFT, and a model of the simulated rules showing priority using other allocation considerations. The Committee reviewed results from KPSAM which demonstrated the impact of using LYFT in the kidney allocation system and its effect on minority candidates **(Exhibit B).**

KPSAM tested a system based on LYFT with the following modifiers:

- Elimination of the existing payback system
- Elimination of 0 HLA MM sharing and absolute priority for non-sensitized candidates
- Nationalization of the blood type A_2 to B and A_2B to B system
- Elimination of local allocation boundaries (i.e., national allocation of standard criteria donor (SCD) kidneys to adults.)
-

The simulations showed that Standard Criteria Donor (SCD) kidney allocation incorporating LYFT would:

- Have little effect on the racial and blood type distribution of recipients;
- Shift kidney transplants towards non-diabetics and lower PRA candidates;
- Reduce (with elimination of zero HLA MM sharing and priority) the number of zero HLA MM kidney transplants;
- Increase the percentage of higher LYFT recipients;
- Shift kidney transplants towards younger recipients;
- Increase the number of years of life that can be achieved each year with the current donor pool by more than 10,000 life years;
- Wider geographic sharing would increase life years gained from transplantation.

The Committee was informed that future runs will test the consequences of allocation incorporating time on dialysis, candidate level of Panel Reactive Antibody (PRA), medical urgency, quotas, removal of HLA A and B from the LYFT calculation, and discounting of future life-years.

The Committee expressed concern that minority candidates do not receive much LYFT in the simulation models which would indicate that they would not experience increased transplants under the system. When LYFT was first developed, the Committee assumed that the system would shift more kidneys toward minority candidates. Although African Americans enter the waitlist at a younger age (a positive factor in the LYFT calculation), they also tend to be diabetic (a negative factor in the LYFT calculation). With LYFT SCD kidney allocation to diabetics under the age of 50 decreases from 7%-3% for all organs, with allocation to diabetics over age 50 decreasing from 18% to 4%. Members noted that removing 0 ABDR sharing would potentially increase access for minorities, but could also increase the number of less well-matched transplants, possibly at the expense of graft and patient survival. Additionally, PRA distribution of SCD kidney recipients changes when LYFT is used. This could decrease access for high PRA patients, many of whom are minority candidates.

The Committee also discussed how other allocation priorities being proposed within LYFT may not improve the level of access to transplantation enough to compensate for past inequities. For example, the impact of geography seems to negatively affect allocation to minority candidates. Despite adding the A_2/A_2B variance and time on dialysis into the new system, the data shows only a small increase in transplantation to minority candidates. This may be because African-Americans are not uniformly distributed throughout the country and therefore do not receive uniform benefit from the A_2/A_2B system.

Geography may also dilute the impact of time on dialysis. The data indicated that allocation to African Americans only increased from 3.3 to 3.7 when incorporating time on dialysis, even including waiting times over 7 years. If all geographical boundaries were removed and zero mismatched sharing and paybacks were eliminated, the percentage of kidneys allocated to African Americans still only

increased from 32.7 percent to 33.3 percent. Although none of the additions to the model resulted in very large improvements, it was suggested they could make a big difference in cities like Philadelphia, New York, and Chicago, where there are large populations of African-Americans listed with long waiting times. The Committee ultimately determined that the proposed kidney allocation model incorporating LYFT, is not sufficient to address the Minority Affairs Committee's goals to improve access to renal transplantation.

The Committee discussed other methods to increase access. As part of the policy development checklist, both the OPTN and the SRTR are required to model alternative proposals to allow the community to choose from among different options. At the next Kidney Committee meeting in May, the SRTR will present results from additional simulations. These simulations include the Donor Profile Index (DPI), which is a method of assigning a score to each donor based on certain characteristics. Kidneys from donors with high DPI scores would be allocated primarily by candidate LYFT and kidneys from donors with low DPI would be allocated primarily by waiting time. Kidneys from donors with mid-range DPI would be allocated using a combination of LYFT and waiting time. It was suggested that another possible strategy to counteract the impact of geography on minority transplantation could be to require minimum high and low LYFT scores for transplant, similar to minimum MELD criteria. For example, in order for someone to be transplanted in New York City, they would need very high LYFT scores. The Committee also discussed institution of a national list. The Committee expressed interest in seeing some of these suggestions modeled in the near future.

The Committee determined that it would request that KPSAM model various scenarios from which the Committee could choose. These requests will be coordinated through the Kidney Committee to avoid duplication and ensure that both Committees are reviewing the same information. The SRTR will present the analyses provided to the Kidney Committee at the next MAC meeting with the data outputs presented by ethnicity. The Committee also discussed the need for more active dialogue with the Kidney Committee regarding the kidney allocation policy development process. The Committee agreed to draft a memo with its principles and goals for the new kidney allocation system outlined. The document would then become the baseline reference for the Committee's work moving forward.

3. Update on MAC Subcommittee on Public Education and Public Outreach Initiatives. At the February meeting, Dr. Young updated the Committee on the status of the Board Approved Minority Affairs Committee public comment survey project. The Board of Directors charged the Committee to develop a working plan for the project, including a plan to spend the earmarked funds. A subgroup of the Committee, comprised of Dr. Carlton Young, Dr. Pang-Yen Fan, Deanna Parker, Wida Cherikh, Ph.D, and Dielita McKnight, worked with Cleve Corlett, Ph.D, to develop a research design for the survey project.

   Some challenges encountered in developing the research design included limitations regarding patient privacy with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as well as institutional review board (IRB) requirements for the organizations and dialysis centers included in the study. The study sample would include two sets of patients. The first set would consist of patients in the dialysis center receiving treatment. The second set would consist of transplant candidates and recipients returning to their centers for evaluation or follow-up. Geographic areas studied include the Birmingham, Alabama Center (UAB) and four centers in the Boston, Massachusetts area, where Dr. Young and Dr. Fan practice, respectively.

   The subcommittee met by conference call on March 23rd to review the draft survey. Following the call, feedback from several members of the Committee and UNOS staff was incorporated into the survey. During its meeting on April 20, the full Committee reviewed the draft survey with Dr. Corlett. Following this review, additional changes were made to the questionnaire to improve its clarity and allow the results to be more easily quantified. During discussion, the length of the survey was noted as a concern; however, members remarked that the pilot test should identify any problems in this area. The Committee was also urged to think about the purpose of the survey and how the information will be used as it moves forward in its planning. Following the meeting, the survey will be finalized before submission to the dialysis centers for IRB approval in the two regions.

4. Access to Kidney Transplantation In February, Valarie Ashby, MS, provided the Committee with a time dependent Cox analysis examining deceased donor transplantation rates among kidney transplant registrants with various adjustments from 1996-2004, accounting for the change in the kidney allocation system to eliminate HLA B matching points (**Exhibit C**). The Committee has reviewed data in this area for the past year in an attempt to explain a 15% unexplained lower transplant rate as compared with Whites. The analysis sampled 123,812 kidney waitlist patients entering the waitlist for the first time between 2000-2005 with follow-up until 7/31/06.

   Prior analyses have shown that African Americans, Hispanics, Asian American, and Native American candidates have had unadjusted deceased donor kidney transplantation rates that were lower than Whites. Among new patients to the kidney transplant waitlist from 2000-2005, African Americans, Asian Americans, and Native Americans also had higher deceased donor transplantation rates after the policy change on May 7, 2003 than before the policy change. The Committee discussed the possibility that a higher proportion of African Americans may be listed at donor service areas (DSA's) with long waiting times. It was suggested that the vast majority of minorities are located in 10-15 major metropolitan areas and that this geography factor may be affecting the distribution rate. It was further suggested that these patients may be located in OPOs that are not performing well and are disadvantaged as a result.

   In April, Ms. Ashby provided the Committee with updated data on transplant rates for different ethnic groups for DSA's with short, medium and long waiting times, accounting for the policy change. The same data source and study population was used in the analysis. Previously reviewed data has shown that before and after the policy change transplants increased among non-Whites. The updated data shows that among new patients added to the kidney transplant waitlist from 2000-2005, African Americans experienced adjusted deceased donor transplant rates that are lower than those of other ethnicities (20-24%). This deficit is most pronounced in OPOs that have long waiting times (>1350 days). However, the change in BDR policy resulted in higher deceased donor transplantation rates for non-Whites, especially Asians, than before the policy change. Among OPOs that have short waiting times (<700 days) African Americans and Native Americans have lower adjusted deceased donor transplant rates when compared to Whites, Hispanics and Asians. In OPOs that have medium waiting times (700-1350 days) Native Americans, Asians, African Americans, and Hispanics have lower adjusted deceased donor transplant rates when compared to Whites. In the short waiting time OPO, Native Americans had lower adjusted deceased donor transplant rates after the policy change (35%) than before to the change.

   The Committee discussed the results. It was suggested that the study may still be showing the tail end of a bolus effect. The updated analysis did not include currently listed patients to adjust for the bolus effect and give a more realistic view of the effect of the policy change. However, members noted that transplant rates continue to lag across the board in short, medium and long waiting time OPOs. The Committee expressed interest in seeing more description of the study cohort to help them understand the results better. The Committee requested to see the following information for the pre and post policy implementation periods for the next meeting:

   - Percent of additions by DSA and ethnic group;
   - Number and percent of candidates by ethnicity and waiting times (using more granularity in waiting time categories);
   - Distribution of length of dialysis by ethnicity; and
   - Percent or distribution with inactive times by age and ethnicity.

   The Committee also requested to see adjusted waiting list rates for different states, overall and by ethnicity, before and after the elimination of points for HLA B matching in kidney allocation.

5. Access to Liver Transplantation. In February, Sangeetha Mahadevan provided the Committee with an updated analysis addressing access to a deceased donor liver transplant by region and ethnicity and likelihood to multiple list for a deceased donor liver transplant region by ethnicity, accounting for

MELD/PELD scores for allocation and exception cases (**Exhibit D**). The Committee began reviewing data in this area in an attempt to determine the reason for lower deceased donor liver transplantation rates in Hispanics. The purpose of the analysis was to examine differences in rates of deceased donor liver transplants by ethnicity and medical urgency (MELD/PELD scores). A previous analysis examined MELD/PELD score by geography. The sample included 36,170 registrants entering the liver waiting list between 2/27/2002 and 12/31/2005 with follow-up until 4/30/2006.

The data showed that:

- Hispanic candidates have a 5% lower deceased donor liver transplantation rate than Whites.
- Asians and Native Americans have 9% and 24% higher deceased donor liver transplantation rates than Whites, respectively.
- African Americans have deceased donor liver transplantation rates similar to whites.
- Deceased donor liver transplantation rates varied widely across patients in the different MELD categories. As expected, patients in higher MELD categories had higher transplant rates.
- Patients who were "inactive" had 44% lower deceased donor transplantation liver rates compared to the MELD 11-20 category.
- Hispanics had significantly lower deceased donor liver transplantation rates in the MELD 11-20 category.

The presentation was followed by brief discussion. A member observed that there did not seem to be much difference in transplant rates with MELD scores over 20. Committee members also inquired generally whether the MELD range was too broad. After additional brief discussion, the Committee requested an updated analysis using the following MELD categories: <15; 15-29; and 30+.

In April, Dr. Leichtman provided the Committee with the updated analysis. The same data source and study cohort were used. The data show that access to orthotropic liver transplantation varies among ethnicities. Hispanic candidates have a 6% lower deceased donor liver transplantation rates than Whites. Asians and Native Americans have 8% and 23% higher deceased donor liver transplantation rates than Whites, respectively. African Americans have deceased donor liver transplantation rates similar to that of Whites. As expected, patients in higher MELD categories had higher deceased donor liver transplantation rates. Patients in the MELD 1-5 category had a 61% lower deceased donor liver transplantation rates compared to the MELD 15-30 category. Patients who were inactive had a 64% lower deceased donor transplantation liver rates compared to the MELD 15-30 category. Within MELD categories, Hispanics had 8% and 7% significantly lower deceased donor liver transplantation rates than Whites in the MELD 1-15 and MELD 15-30 categories, respectively. Blacks and Asians had 9% significantly higher deceased donor liver transplantation rates respectively than Whites in the MELD 15-30 category.

The Committee discussed whether or not minorities were being listed with higher MELD scores. It was suggested that if the analysis is used as a surrogate for access then the results are not good. The results could indicate that minorities are getting transplanted more only because they are sicker. It was noted that the patient mortality risk is lower if a patient enters the waiting list with a lower MELD and is followed through the course of their disease progression. It was also noted that once waitlisted, access to transplantation seems to be the same.

6. Evaluation of Kidney Allocation After the Elimination of HLA B Matching Points The Committee has been monitoring the effects of the changes to the kidney allocation policy that eliminated priority points for HLA-B matching. The purpose of the review is to determine if the policy has increased kidney transplantation rates for minority candidates. In February, Dr. Cherikh provided the Committee with updated data on the number of transplants by ethnicity, HLA, DR mismatch (MM) level, PRA level, and months on the waiting list; and post transplant outcomes (i.e., acute rejection and survival) before and after implementation of the policy **(Exhibit E).** The data reviewed continue to indicate that, despite an increasing number of DR mismatched transplants, in general the acute rejection rate and 6 months and one year were lower after the policy change.

To assess the effects of the new HLA point system, the number of adult non-zero HLA mismatched transplants was divided into 7 time periods. The pre-policy period included the first full six months prior to the implementation of the policy (11/7/02-5/6/03), the post-policy periods consisted of the sequential 6-month periods after the policy was implemented.

The updated analysis indicated that during the post policy periods:

- White patients received fewer deceased donor kidney transplants while minority patients and those with longer wait times had greater access to deceased donor kidneys,
- Higher DR mismatch level has not resulted in higher acute rejection rates or accelerated graft loss, and;
- Patient and graft survival within 30 months of transplant for different ethnicities have not been adversely affected by the policy change.

When the Committee discussed the results, members remarked that the rate for increased volumes of transplants seems to have slowed, though many hoped that rates would continue to increase. A member of the Committee inquired as to how poorer matching led to greater access. Dr. Leichtman remarked that that the study did not occur in a controlled environment and that there were many other things occurring in the system at the same time. It was noted that as longer term follow-up data become available, post-transplant outcomes need to be re-examined.

At the next meeting the Committee will review adjusted rates of waiting lists for different states, overall and by ethnicity, before and after the elimination of points for HLA B matching in kidney allocation.

7. Legislative Update: Paired Kidney Donation. During its February meeting, Bill Lawrence, Esq., UNOS Director of Patient Affairs, provided the Committee with an update on the Living Kidney Organ Donation Clarification Act. This legislation would clarify that federal regulations intended to prohibit the sale of organs do not inadvertently prohibit the practice of paired kidney donation. The Committee was informed that the legislation had passed in the U.S. House of Representatives and was expected to pass in the Senate. In April, the Committee was informed that different versions of the legislation were passed by both the U.S. House of Representatives and the Senate and that the differences must be reconciled before passage of a final bill.

8. Update on Consensus Conference. During the February and April meetings, Dr. Young updated the Committee on the status of the Consensus Conference to improve the amount and quality of input into OPTN matters, sponsored by the UNOS Communications Department. The conference will be held on May 22, 2007, in Chicago with participation from over 20 invited constituent groups. Participants have been separated into four distinct work groups that will serve as the basis for the break out groups at the conference. The Committee was informed that group leaders and volunteers have been selected for each group with conference calls being held to facilitate the meetings planning and discussion.

   The four work groups will address the following topics:

   - Closing the Gaps
   - Education and Outreach
   - Public Comment
   - Communication

9. Minority Issues for Future Discussion. During the last several meetings, Dr. Young has urged the Committee to consider additional issues that should be studied by the MAC. In February, Dr. Cherikh presented the Committee with basic descriptive information on combined kidney-liver transplants performed in the US between 1988 and 2006, stratified by transplant year, recipient ethnicity, and age group (**Exhibit F**).

   The data show the following:

   - Steady increase in the number of transplants;
   - Sharp increase observed for white recipients;
   - Minorities were more clustered together;
   - Asians were more clustered toward the bottom;
   - Majority of transplants occurred in patients aged 35-54;
   - Second largest number of transplants occurred in patients aged 55 +; and
   - The pediatric "Other" category represented the largest ethnic group.

   The Committee expressed an interest in exploring the data further to see whether a significant number of these kidneys were shifted away from candidates waiting for kidney alone transplants. After brief discussion, the Committee requested additional descriptive information on the distribution of transplants by region or DSA, diagnosis category, MELD/PELD score and how many were repeat transplants (either received a previous primary liver or combined kidney-liver.)

   Due to time considerations, review of the data was deferred to the July 2007 meeting.

10. Update on Issues presented to the Board of Directors, December 13, 2007. In February, Deanna Parker updated the Committee on issues of particular interest to the Committee that were considered by the Board of Directors at its meeting on December 13-14, 2006.

    - The Board approved best practice guidelines for Histocompatibility testing practices. The Histocompatibility Committee believes that implementation of the guidelines is vital to ensure expedient placement of donor organs and to minimize organ wastage. It was also noted that the guidelines are meant as recommendations only and are not intended to be requirements at this time.

    - The Board also approved modifications to Policy 3.5.11.3 (Panel Reactive Antibody), which will replace PRA with a calculated PRA (CPRA). CPRA is defined as the percentage of incompatible donors for a particular candidate (i.e., donors expected to have one or more of the unacceptable antigens indicated on the Waiting List for the candidate). The policy would change the way sensitized kidney, pancreas, and kidney-pancreas candidates are identified and would more efficiently pair sensitized candidates with donors likely to be HLA compatible by requiring centers to specify a set of unacceptable antigens for each candidate. Under this policy, a PRA would be calculated (CPRA) for each candidate by comparing the unacceptable antigens provided by the center with the HLA antigen/allele group and haplotype frequencies found in the donor pool.

    - The Board approved a revised statement of purpose for the Minority Affairs Committee. A Board member added language to the statement to address the study of issues related to minority living donors. The new statement is as follows:

      "The Committee seeks to develop policies that will directly address challenges faced by minorities in need of transplantation, candidates, recipients, and donors in the United States, as well as living donor issues pertaining to minorities. Through periodic review of data including rates of referral for transplant evaluation, listing and transplantation, waiting list morbidity and mortality, graft and patient survival, and indicators of morbidity and quality of life for different ethnic groups, the Minority Affairs Committee will assess the impact of policies on minority transplant candidates and recipients."

11. Update on Issues presented to the Board of Directors, March 23, 2007. In April, Deanna Parker updated the Committee on items approved at the March 2007 meeting of the Board of Directors which impact the HHS program goals and OPTN strategic plan. The Committee was informed about the following actions:

    - The Board approved a limited set of data elements for the transplant recipient form (TRF) for five years post transplant.

    - The Board approved modifications to the OPTN/UNOS Bylaws regarding the development of protocols to facilitate the recovery of organs from DCD donors.

    - The Board approved reallocation of organs according to the progression of brain death. In its approval, the Board made the determination that this reallocation is not a violation of OPTN policy. The language is temporary until the Board meets again in June to reconsider the issue.

    - The Board passed a resolution to change its meeting cycle. Currently, the Board meets four times per year. Under the new cycle, the Board will meet three times per year. The new Board cycle will begin in January of 2008.

12. Minority Affairs Committee Sponsored Alternative System to Transplant A_2/A_2B Kidneys into B Candidates. During its February meeting Dr. Cherikh presented the Committee with updated data on the number of A_2/A_2B to B transplants, ethnic distribution of the A_2/A_2B to B transplant recipients, and post-transplant outcomes (delayed graft function, serum creatinine, acute rejection, graft and patient survival), including the two DSA's **(Exhibit G)**. Since implementation of the variance, the Committee has been monitoring the data quarterly to determine if the variance is increasing the number of transplants to B candidates without negatively impacting overall graft survival rates, thus increasing access of blood group B minority patients to transplantation.

    The OPTN database was queried to determine the number of A_2/A_2B donors and the number of B recipients of the A_2/A_2B kidneys at the participating DSAs. The following observations were noted:

    - Results continue to demonstrate that these transplants are clinically successful.
    - Since majority of the recipients were non-Whites, this allocation algorithm may provide another mechanism to increase access of blood group B minority candidates to kidney transplant.
    - The current A_2/A_2B system is being considered for the national system by the Kidney Allocation Review Subcommittee (KARS).

    A member of the Committee commented that the information showing the percentage of minority recipients experiencing benefit from the variance did not differ greatly from the KARS simulations including the variance presented by the SRTR. The Committee will continue to review the data quarterly.

13. Public Comment Document Distributed November 20, 2006

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

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

    - Proposed Modifications to OPTN/UNOS Policy 5.0 (Standardized Packaging and Transporting of Organs and Tissue Typing Materials) (Operations Committee)

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

- Proposed Modifications to OPTN/UNOS Policy 3.1 (Organ Distribution: Definitions) (Operations Committee)

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

- Proposed Modifications to Data Elements on UNet^{SM} Transplant Recipient Follow-up (TRF) Form (Policy Oversight Committee)

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

14. Public Comment Document Distributed March 2, 2007

- Proposed Modifications to Data Elements for Pediatric Candidates and Recipients on UNet^{SM} Transplant Candidate Registration (TCR), Transplant Recipient Registration (TRR) and Transplant Recipient Follow-up (TRF) Forms (Pediatric Transplantation Committee)

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

- Proposed Modifications to OPTN/UNOS Policy 7.1.5 "Reporting Definitions" and OPTN/UNOS Policy 7.3.2 "Submission of Organ Specific Transplant Recipient Registration Forms and Submission of Living Donor Registration Forms."

  A brief summary of all three living donor proposals was presented for discussion. The Committee emphasized that the proposals were a necessary first step in UNOS assuming responsibility for the establishment of living donor policies. The Committee expressed support for the proposals, noting the importance of collecting better data elements on all living donors to gain knowledge about the safety of the practice. They Committee also acknowledged the need to assign responsibility for costs associated with follow up care through a living donor registry.

  The Committee voted unanimously to approve the proposal.

- Proposed Modification to OPTN/UNOS Policy 7.3.3 "Submission of Living Donor Death and Organ Failure Data" (Living Donor Committee)

  A brief summary of all three living donor proposals was presented for discussion. The Committee emphasized that the proposals were a necessary first step in UNOS assuming responsibility for the establishment of living donor policies. The Committee expressed support for the proposals, noting the importance of collecting better data elements on all living donors to gain knowledge about the safety of the practice. They committee also acknowledged the need to assign responsibility for costs associated with follow up care through a living donor registry.

  The Committee voted unanimously to approve the proposal.

- Proposed Modifications to the UNet^{SM} Living Donor Registration (LDR) and Living Donor Follow-up (LDF) Forms (Living Donor Committee)

  A brief summary of all three living donor proposals was presented for discussion. The Committee emphasized that the proposals were a necessary first step in UNOS assuming responsibility for the establishment of living donor policies. The Committee expressed support for the proposals, noting

the importance of collecting better data elements on all living donors to gain knowledge about the safety of the practice. They Committee also acknowledged the need to assign responsibility for costs associated with follow up care through a living donor registry.

The Committee voted unanimously to approve the proposal.

- Proposed Modifications to Data Elements on UNet^{SM} Deceased Donor Registration (DDR) Form. (Organ Availability Committee)

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

- Proposed Imminent Neurological and Eligible Death Definition Data Elements (OPO Committee)

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

- Proposed Modifications to OPTN and UNOS Bylaws, Appendix A2-1, Section 2.06A, (b), (3) "Probation," (4) "Member Not in Good Standing," (5) "Suspension of Member Privileges," (6) "Termination of Membership or Designated Transplant Program Status," (7) "Action Specified in OPTN Final Rule." (Patient Affairs Committee)

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

- Role and Authority of the OPTN

  The Committee briefly discussed a communication from UNOS seeking to clarify the legal authority and role of the OPTN within the transplant community.

Attendance at Minority Affairs Committee Meetings
February 23 and April 20, 2007

		JANUARY 1, 2007 - JUNE 30, 2007			
	MONTH	JANUARY	FEBRUARY	MARCH	APRIL
	DAY				
	FORMAT (select)				
NAME	POSITION				
Carlton Young MD	Chair		X		X
Pang-Yen Fan MD	Vice Chair		X		X
Pang-Yen Fan MD	Regional Rep.				
Meelie DebRoy M.D.	Regional Rep.		X		X
Maggie Valdes RN, BSN, CPTC	Regional Rep.				X
Alejandro Mejia MD	Regional Rep.		X		
Okechukwu Ojogho MD	Regional Rep.				X
Ali Olyaei PharmD	Regional Rep.				
Maurice Goodwin ORT/NREMT	Regional Rep.		X		
Lisa Atkins	Regional Rep.				X
Moro Salifu MD	Regional Rep.		X		
Silas Norman MD	Regional Rep.		X		X
Debra Winston BS	Regional Rep.				X
Bradley Collins MD	At Large		X		X
Lee Downing	At Large				
Steven Geier PhD, ABHI Diplomat	At Large		X		X
Judith Joseph RN, BSN, CCTC	At Large				X
Henry Randall MD	At Large		X		X
Cedric Sheffield MD	At Large				
Helen Spicer RN	At Large		X		X
H. Gareth Tobler MD	At Large				X
Winfred Williams MD	At Large		X		X
Jerry Butler	BOD - Liaison				X
Renee Dupee Esq.	Ex Officio		X		
Gregory Fant Ph.D.	Ex Officio				X
Valerie Ashby	SRTR Liaison		X		X
Alan Leichtman MD	SRTR Liaison		X		X
Sangeetha Mahadevan	SRTR Liaison		X		
Katherine Pearson	SRTR Liaison				
Randall Sung MD	SRTR Liaison				

Deanna Parker	Committee Liaison		X		X
Wida Cherikh Ph.D	Support Staff		X		X
Dielita McKnight	Support Staff		X		X
Sam Perry	Support Staff				

Number of Committee Members Attending	**19**	**22**
Total Number of Committee Members	**34**	**34**
Percentage of Committee Attending	**56%**	**65%**
Meeting Format	0	0