

**OPTN/UNOS Minority Affairs Committee**  
**Report to the Board of Directors**  
**June 25-26, 2012**  
**Richmond, VA**

**Summary**

**I. Action Items for Board Consideration**

- None

**II. Other Significant Items**

- The Board is updated on committee progress toward developing its Educational Guidelines for *Patient Referral to Kidney Transplantation* (Item 1, Page 3)
- The Board is asked to grant approval for committee review of data in support of a potential committee project *Development of a Survey on Referral to Heart Transplantation* (Item 3, Page 7)
- The Board is asked to grant approval for committee review of data in support of a potential educational initiative, *Study of Best Practices in Minority Donor Conversions* (Item 3, Page 7)
- The Board is updated on continued committee review of *CPRA Data by Ethnicity* (Item 4, Page 10)

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

This report includes items addressed by the Minority Affairs Committee (MAC) during its meetings held on November 29, 2011 and March 13, 2012, and subcommittee conference calls.

1. Educational Guidelines on Appropriate Patient Referral to Kidney Transplantation

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

Overall, the guidelines:

- Emphasize the benefits of transplantation vs. dialysis
- Define a “medically appropriate” transplant candidate
- Establish the optimal timeframe for patient referral
- Provide facts to refute myths about transplant
- Present common barriers to transplant

During its meeting on November 29, 2011, the committee was updated on a subcommittee conference call on September 16, 2011, to review the most recent draft of the guidelines document. Subcommittee members were assigned specific sections of the document to review, revise or expand. Each subcommittee member was also asked to provide 1-2 questions to contribute to the Frequently Asked Questions (FAQ) section. The committee was also provided with a report on the changes to the document with a revised timeline. The draft is planned for full committee review in mid-December with plan to finalize the document in early January. The expanded subcommittee meeting with other OPTN Committees and professional associations will be scheduled to occur soon thereafter. During discussion, members commented positively on the progress of the document with a concern expressed that the document contained a significant amount of detail on post-referral processes. It was suggested that the document may be deviating from its primary focus on referral and some details may be more appropriate for inclusion in a similar referral guidelines document targeted to patients.

During its meeting on March 13, 2012, the committee reviewed the completed draft document. Silas P. Norman, MD, Chairman of the committee, provided an introduction and explanation of the goals and intent of each section of the document and what is intended to be communicated. The committee

was informed that the revised draft document was approved by the subcommittee during its meeting in February. Following very minor comment and discussion, the document was approved by the full committee for review by an expanded subcommittee group. After a rewrite of one section of the document, the committee plans to invite volunteers from other OPTN committees, including the Kidney, Patient Affairs, Living Donor and Transplant Administrators Committees, as well as professional transplant partners (National Kidney Foundation (NKF), American Society for Transplantation (AST), American Society of Transplant Surgeons (ASTS), Kidney Disease Outcomes Quality Initiative (KDOQI), Association for Multicultural Affairs in Transplantation (AMAT), and the Society of Transplant Social Workers (STSW), etc.) to review the document.

2. Disparities in Provision of Transplant Information Affect Access to Kidney Transplantation: Manuscript Presentation by Dorry Segev, MD

During its March 2012 meeting, the committee was provided with a presentation by Dorry Segev, MD et.al, *Disparities in Provision of Transplant Information Affect Access to Kidney Transplantation*. (AJT October 2011, Kucirka et. al) (**Exhibit A**). The Centers for Medicare and Medicaid Services (CMS) requires providers to complete the CMS Medical Evidence Form 2728 within 45 days of initiating dialysis treatment. CMS also requires providers to note on the form whether they informed patients about transplantation, and if not, to select a reason. The study attempted to describe national transplant education practices and analyze associations between practices and access to transplantation.

The study compared three years of United States Renal Disease System (USRDS) data (2005-2007). The reference category used was “informed.” Unassessed patients were matched to informed patients upon completion of Form 2728 and adjusted for initial time spent on dialysis. The data were stratified by age, cause of renal failure, diabetes, insurance type, prior nephrologist care, needs assistance with daily living, chronic obstructive pulmonary disease, cerebrovascular disease, congestive heart failure, atherosclerotic heart disease, peripheral vascular disease, and malignant neoplasm/cancer. Patients who were alcohol dependent, drug dependent or institutionalized for any reason were excluded.

The data show that 70% of providers informed patients about their transplant options. Of these, 14% subsequently achieved access to transplant as evidenced by gaining access to the waiting list or receiving a transplant. Of the 30% of patients who were not informed about transplant options (as of filing of Form 2728), only 3% achieved access to transplantation. For the patients who were uninformed of kidney transplant options at the time of Form 2728 filing, the most common reason reported was that the patient was not assessed at time of filing. Patients currently under the care of a nephrologist and with private insurance versus public insurance were also less likely to be uninformed or assessed as unfit for transplant. For-profit dialysis centers were more reluctant to note patients as medically and psychologically unfit, and were much more likely to not inform patients because they had not assessed them at the time of Form 2728 filing. More women were likely to be assessed as non-suitable due to age. African Americans were more likely to be noted as psychologically unfit, but interestingly, were not any more likely to be uninformed because they were unassessed. Obese patients were more likely to be unassessed.

In addition:

- Patients who were uninformed about their transplant options (within the 45 day requirement) were half as likely as informed patients to achieve transplantation (as measured by either access to the waiting list or via living donation.)
- For profit dialysis centers were associated with a 20% lower rate of access to transplantation than non-profit dialysis centers.
- African Americans have slightly lower access to transplantation but much lower access to living donation.

0.47 (0.45-0.49)	0.49 (0.47-0.51)	0.35 (0.31-0.41)
0.66 (0.65-0.66)	0.69 (0.68-0.69)	0.56 (0.54-0.57)
0.87 (0.85-0.89)	0.87 (0.85-0.89)	0.84 (0.79-0.90)
0.76 (0.74-0.78)	0.86 (0.84-0.88)	0.36 (0.33-0.40)
Reference	Reference	Reference
0.75 (0.70-0.81)	0.74 (0.69-0.80)	0.77 (0.64-0.93)
0.71 (0.69-0.74)	0.78 (0.74-0.80)	0.54 (0.48-0.59)
1.73 (1.68-1.77)	1.72 (1.67-1.77)	1.73 (1.61-1.87)
Reference	Reference	Reference
1.67 (1.62-1.72)	1.60 (1.55-1.66)	2.07 (1.89-2.27)
0.85 (0.82-0.89)	0.90 (0.86-0.93)	0.61 (0.54-0.69)
0.75 (0.71-0.79)	0.79 (0.75-0.84)	0.54 (0.46-0.64)
0.80 (0.78-0.82)	0.82 (0.79-0.84)	0.72 (0.68-0.78)
1.05 (1.04-1.06)	1.08 (1.06-1.09)	0.94 (0.91-0.97)

Figure 1

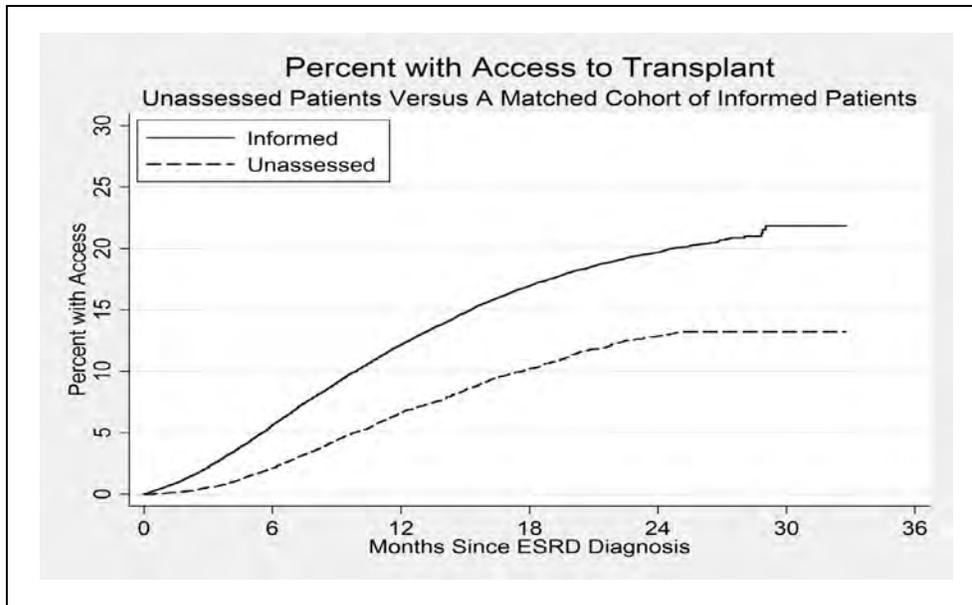


Figure 2

- Dr. Segev also provided the committee with a summary of a soon-to-be published manuscript, *Transplant Education at For-Profit Dialysis Centers* by Kamna Balhara, Lauren Kucirka, Bernard Jaar, Dorry Segev (AJT in revision) based on an electronic survey distributed to 6,000 for-profit dialysis centers across the United States. The results of the survey suggest that providers at for-profit centers are more likely to state that <20 minutes is an ideal amount of time for counseling a patient on transplantation, and are much less likely to spend >20 minutes counseling patients.

The committee believes that the results of both papers are relevant and support the current work and ongoing projects of the committee and expressed interest in being updated on the status of the soon-to-be published manuscript and similar works.

### 3. Discussion/Update on MAC Project Review Process

During its March 2012 meeting, the committee was updated with regard to the proposed MAC Projects for 2012-2013. The projects submitted for consideration include the following:

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

The committee discussed the limitations with regard to the two new projects requested by the committee; the launching of an online survey to assess barriers to heart transplantation similar to the kidney and liver referral surveys and a study of minority donor conversion rates.

#### *Survey on Referral to Heart Transplantation*

The committee recently revisited concerns expressed previously about possible delays in minority access to heart transplantation. Members noted that a survey of transplant centers seemed to be the logical next step for the committee in its work attempting to identify and address overall barriers to referral. As a result, it was suggested that the committee undertake this survey as a new committee project. However, previous data reviewed by the committee several years ago did not provide strong enough evidence to document minority delays in referral to heart transplantation. Therefore, the first step of the committee in undertaking a new project would be a review of the evidence to support its hypothesis. However, due to the difficulty in capturing the population of patients that experience heart failure to estimate the percentage of patients not referred, the proposed review of evidence would forge the committee into an entirely new area of focus, which could potentially be time consuming. The committee discussed potential analyses that could be conducted to obtain the evidence. The first determination that needed to be made was to learn if minorities are being treated for heart failure appropriately in order to determine if they are being referred at the same rate as other heart patient populations.

The following data questions were posed for discussion/answer:

- The total number of programs treating patients with heart failure
- Whether these programs are certified heart transplant centers
- How many minorities have access to an appropriate heart failure clinic?
- Is there a discrepancy in availability/access to these centers for patients?
- If there is a geographic discrepancy, and if so, does it correlate to a lack of access of minorities to those centers? (i.e. is the facility not located on bus line? etc.)

The committee also suggested review of data that could be attached to methodologies used to collect information on patients with kidney disease, as the number one cause of heart failure in African Americans is hypertension, which also leads to kidney disease. Following discussion, it was determined that if the project is approved by the Executive Committee, the committee will discuss the options proposed for review of evidence and act upon the option which would generate the most relevant information.

#### *Eligible Donor Conversion Rates by Region and Ethnicity: Study of Best Practices in Minority Donor Conversions*

During its July 12, 2011 meeting, the committee was presented with a UNOS Research Department orientation that included descriptions of various data collection tools, one of which was the Donor Notification Registration (DNR). Since February 2008, a DNR is required on all imminent neurological and eligible deaths in the OPO's DSA. Previously, the OPOs were only required to provide monthly totals by donor hospital. The more detailed information is critical for analyzing donor conversion practices. The committee has been historically interested in donor conversion rates for different donor ethnic groups and requested the data for different donor ethnic groups, stratified by region. Since this information is now readily available and has been presented at other

meetings and to other committees, the committee requested to view the updated data at the November meeting to be presented at the face to face meeting on March 13, 2012.

In March 2012, the committee reviewed data on eligible donor conversion rates by region and ethnicity, presented by Wida Cherikh, PhD, of the UNOS Research Department (**Exhibit B**).

For reporting purposes to the OPTN, an eligible death is defined as:

- 0-70 Years of Age
- Legally Declared Brain Dead
- Exhibits no active bacterial or viral infections, malignancies or diagnoses or active fungal, parasitic, viral, or bacterial meningitis or encephalitis as named in the eligible death definitions.

The analysis included eligible death data as reported on the Death Notification Registration (DNR) records and eligible deceased donors who donated during 2/1/08-11/30/11. For the purpose of the study, an eligible donor was defined as an actual donor who meets the eligible death criteria. The conversion rate was defined as the percentage of eligible deaths that were converted to actual donors and was calculated by dividing the number of eligible donors by the number of eligible deaths and multiplying by 100. The conversion rate was calculated by the OPO region and donor ethnicity. Information provided was based on OPTN data as of February 3, 2012.

The results show that:

- Across all regions and donor ethnicities, the donor conversion rate was 70.1% which ranged from 67% in 2008 to 73% in 2011.
- Overall, the conversion rate was the highest among donors of multiracial ethnicity (85%), followed by White donors (78%), Hispanics (67%), Blacks (55%), Asians (48%), Native Hawaiians/other Pacific Islanders (46%), and American Indians/Alaska Natives (40%).
- Within each region, eligible donor conversion rates varied among donor ethnic groups.
- Regions 4 and 6 seemed to have increasing conversion rates across different donor ethnic groups during 2008-2011.

The presentation was followed by lengthy discussion. The largest increase shown in minority donor conversions across the board was in the multi-racial category. It was explained that the multi-racial category shown in the analysis reflects pre-selected ethnic categories available on the form. If more than one ethnic category was selected (with the exception of Hispanic and White that would be classified as Hispanic), the individual would be categorized as multi-racial. However, this does not necessarily explain the increase observed in the data. The committee further discussed trends that seem to be observed in some regions. For example, in Regions 3 and 6, Hispanic rates are rising. In Regions 3, 4 and 6 there is an increasing trend for the Asian population. In Region 6 there is also an increase in Native Hawaiian and all ethnic groups. In Region 5 there is an increasing trend among Native Americans; however, the rate is still very low as compared to other ethnic groups.

The data also show differences in conversion rates by geographic region and ethnicity, particularly in the Southern states. From an anecdotal perspective, the differences may be due to a lack of access to health care overall which contributes to the disproportionate burden of ESRD disease in minority communities and may also affect the suitability of minority donor organs. It was also suggested that provider behavior may also be contributing to the problem. In some areas providers are unwilling to

declare brain death until they have determined that the family is able to come to the acceptance of their loved one's death. However, if the determination of brain death is prolonged for an extended period of time (3-5 days or more) the result is a less than optimal donor.

The committee discussed efforts geared toward improving consent rates and translating consent into an actual donation. A member reported that his OPO in Hawaii is now consistently able to achieve a 95% - 98% conversion rate among registered donors. The OPO has been working with local hospitals to ensure that they all have a brain death policy and that the policy is being exercised. In Hawaii, in concert with the Association of Multicultural Affairs in Transplantation (AMAT), there has been a concentrated effort in the last four years to encourage people to sign the donor registration card through the Department of Motor Vehicles (DMV). This program has been very successful in increasing donation rates because the registration allows the donation decision of the actual deceased donor to be honored without having to obtain consent from the family. The committee also discussed partnerships with the Minority Organ and Tissue Transplantation Education Project (MOTTEP) in Hawaii and in Michigan, which seek to encourage donation from an educational standpoint.

The committee also discussed the CMS OPO conditions for coverage which include outcome measures regarding donation rates of eligible donors as a percentage of eligible deaths. Under the requirements, an OPO may not fall below 1.5 standard deviations from the national standard in donor conversion rates (85%). If an OPO falls below this number it is at risk of losing its certification. It was also noted that CMS does not adjust the rate for donor (demographic) characteristics. For example, in Hawaii a state with a very diverse ethnic makeup, culture, and belief system, the OPO must meet a standard that is based upon Caucasian donors. CMS has not previously taken action on OPO's that did not meet this condition; however, OPO's have been informed that action will be taken on the outcomes conditions in the next CMS survey cycle. OPO's approaching recertification must meet the standards by 2014.

Finally, the committee discussed the potential for a defined committee project in this area. It was suggested that the committee survey OPO's to determine if the differences observed by geographic area are the result of a specific effort or intervention, and if there is anything known to have occurred to either improve or worsen donor conversion rates. This information could then be used to determine if there are practices or procedures that can be replicated nationally as a standard or as best practice. To support the idea of a national survey, one possible goal of the initiative would be to discern minority donor potential in a given geographic area to gauge progress with conversions. The data could also help OPO's and donation education professions improve rates of donation in minority communities and better meet CMS outcomes measures for donor conversions.

For the next meeting, the committee requested to review donor conversion rates for different donor ethnic groups, stratified by age, gender, and cause of death. The committee also discussed obtaining access to information already available in the public domain, including information that may have been produced by the SRTR from the OPO Specific Reports, the Regional Collaborative, the Center for Transplant System Excellence, and related works by other groups. The committee was informed that the new project request submitted for Executive Committee review seeks approval for review of additional data to gather enough evidence to support a possible educational initiative on minority donor conversion rates targeted to OPO's. If the project is approved by the Executive Committee, the committee will continue its review of the data to explore options in this area.

4. Evaluation of Modification to OPTN Policy on Using Calculated PRA (CPRA) for Allocation of Deceased Donor Kidneys: Transplant Rates by Ethnicity and Sensitization Level

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

In July 2011, the committee reviewed updated data showing CPRA results over a 12 month period. The data showed that:

- There was an increase in the reporting of unacceptable antigens on the waiting list and a substantial decrease in the number of kidney refusals due to positive crossmatch.
- The percentage of low sensitized registrations (1-20% PRA/ CPRA) decreased; while the percentage of non-sensitized (0/Not reported PRA/CPRA) and very broadly sensitized (PRA/CPRA > 95%) registrations went up.
- Transplant rates for broadly sensitized candidates significantly increased.

During its March 2012 meeting, the committee was provided with updated waiting list numbers and transplant rates by candidate ethnicity and sensitization level by Wida Cherikh, Ph.D. UNOS Research Department staff liaison to the committee (**Exhibit C**).

The committee was provided with brief background regarding the use of CPRA as compared to PRA. Prior to October 1, 2009, allocation was based on the allocation PRA, defined as the current PRA if the waiting list record indicated that the current PRA be used, or peak PRA if peak was indicated. As of October 1, 2009, centers are required to enter at least one unacceptable antigen in order for their highly sensitized patients (PRA  $\geq$ 80%, now CPRA  $\geq$ 80%) to get the additional 4 points to receive a deceased donor kidney transplant. CPRA defaults to zero if no unacceptable antigens are entered, and CW antigens are excluded from CPRA calculations. Some unacceptable antigens are rare and lead to a CPRA value being rounded to zero.

Adult, kidney alone registrations added to the waiting list during the 26 months post-CPRA (10/1/09-11/30/11) policy implementation were analyzed. Adult registrations waiting on the kidney alone waiting list as of February 10, 2012 were summarized. Adult, kidney alone registrations that were ever on the waiting list during 26 months pre- (8/1/07-9/30/09) and 26 months post-CPRA (10/1/09-11/30/11) policy implementation were analyzed.

For calculating transplant rates per active years, adult, kidney alone registrations ever on the waiting list during 26 months pre- (8/1/07-9/30/09) and 26 months post-CPRA (10/1/09-11/30/11) implementation were included. Transplant rates in different sensitization level categories were calculated by dividing the number of transplants that occurred during a policy period by the total number of active years candidates spent on the waiting list stratified by ethnicity. Due to the small number of transplants in some of the groups, a few additional or less transplants could dramatically

change the rates, and therefore transplant rates in these groups should be interpreted with caution. Although some candidates may have waiting time contributed to both periods, a transplant was only attributed to the period in which it occurred.

Registrations waiting prior to October 1, 2009 were analyzed based on allocation PRA, while registrations waiting after October 1, 2009 were analyzed based on CPRA.

The following sensitization categories were used:

- Non-sensitized: PRA/CPRA value of 0% or not reported (NR)
- Low sensitized: PRA/CPRA value of 1-20%
- Moderately sensitized: PRA/CPRA value of 21-79%
- Highly sensitized: PRA/CPRA value of 80-100%

To further examine the highly sensitized group, the 80-100% category was also analyzed as two PRA/CPRA categories: 80-97% and 98-100% (very broadly sensitized). Results are based on OPTN data as of February 10, 2012.

The data show that:

- Of the adult kidney alone registrations waiting as of February 10, 2012, 38% were White, 34% Black, 18% Hispanic, 7% Asian and 2% were of other ethnicities.
- 16% of adult kidney alone registrations waiting as of February 10, 2012 had a CPRA value of 80-100%.
- 9.8% of adult kidney alone registrations on the waiting list as of February 10, 2012 were waiting with a current CPRA  $\geq$  98%, and of these, 43% were Black, 35% White, 14% Hispanic, 6% Asian, and 2% were of other ethnicities.
- For non-sensitized and low sensitized White, Black, and Hispanic candidates, transplant rates significantly decreased post-policy.
- Transplant rates for White, Black, and Asian moderately sensitized candidates significantly increased following policy implementation.
- There was no significant change in transplant rates among American Indian/Alaska Native, Native Hawaiian/Other Pacific Islander, or Multiracial candidates, regardless of sensitization level.
- For highly sensitized (CPRA 80-100%) White, Black, and Hispanic candidates, transplant rates significantly increased post-policy implementation.

In summary, there was a significant increase in transplant rates among White, Black, and Hispanic candidates with a CPRA of 80-97%, but a decrease (although not significant) in transplant rates for those with CPRA of 98-100%. This was also true for Asian candidates, although the decrease in transplant rate for those candidates with CPRA  $\geq$  98% was significant.

The committee followed the presentation with brief discussion. The committee discussed the exclusion of patients enrolled in desensitization protocols in the analysis. It was noted that African Americans have higher rates of sensitization. Sensitized patients have higher rates of rejection and are more likely to need a second transplant, further disadvantaging their status. Potential causes of minority sensitization were also discussed, particularly decreased access to healthcare which increases the likelihood for patients to experience health related events requiring a transfusion. Women are also often sensitized as a result of multiple pregnancies. It was further commented that

the increased use of ventricular assist devices (VAD) may also result in sensitization as these patients often require transfusions. Though patients using desensitization protocols were not included in the analysis and have not been studied systematically by the committee, this information can be captured. The committee discussed potential ways to improve access to minority transplantation using desensitization protocols; however, it was cautioned that any approach developed would need to address how to preserve the priority status of these patients.

The committee also expressed interest in reviewing data on sensitization protocols for heart transplantation and rates of access to heart transplantation by gender. A member inquired whether or not CPRA is factored into heart allocation. Though this is not currently built into the heart allocation system, it is being considered for addition to policy by the Thoracic Organ Transplantation Committee. It was also commented that sensitization is also an issue with regard to the allocation of combined organs. For the next meeting, the committee requested to continue to be updated with the on-going evaluation of the CPRA policy and how it is being incorporated in the new kidney allocation concepts.

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

The committee continues to receive periodic updates on progress toward development of a new proposed kidney allocation system (KAS). During its meeting on November 29, 2012, the committee was informed that the system to allocate kidneys using an age matching formula (allocation to candidates + or – 15 years) was construed as age discrimination by the federal government. It was determined that age may be used in an allocation formula as long as it is intended as a surrogate for a patient's medical condition and does not award priority on the basis of age alone. Subsequently, the Kidney Committee is reviewing modeling of concepts with the top 20% of kidneys allocated to patients with the highest estimated post transplant survival (EPTS) with the other proposed elements remaining in the formula (rank ordering for waiting /ESRD dialysis time, HLA DR matching, sliding score for panel reactive antibody (PRA) patients, the national variance transplanting A<sub>2</sub> and A<sub>2</sub>B kidneys into B candidates) and the addition of regional sharing.

The new formula also proposes an opt-in system for the highest 15% KDPI kidneys where the patients at the lower end of the EPTS score would be eligible to receive expedited placement for high KDPI kidneys (an improved expanded criteria donor (ECD) kidney) and would have to consent in advance to receive the kidneys. For these patients, allocation would be based upon waiting time using broader (regional) sharing for the most highly sensitized candidates. For OPOs in a region with shorter waiting times, kidneys procured within the DSA would not stay within the region but would first be offered out to patients in regions with longer waiting times. This is proposed to help reduce waiting time discrepancies due to geography.

The committee reviewed simulation modeling results for the most recent run (Run 37) showing the number of transplants by age, ethnicity, ABO, diagnosis and PRA. Run 37 demonstrates the following results as compared to the current kidney allocation rules (shown in Run 36) and those proposed in the previous KAS concept document. Pang-Yen Fan, MD, a member of the Kidney Committee and a crossover member on the Minority Affairs Committee, presented the information to the committee. The data shows that:

- Transplants to older recipients (aged 50-65+) decrease compared to the current rules but increase slightly as compared to the concept document.

- Transplants by ethnicity decrease slightly as compared to the current rules and the concept document.
- Transplants by ABO blood group are unchanged from both the current rules and the concept document.
- Transplants to diabetics decrease as compared to the current rules, but increase as compared to the concepts outlined in the Kidney concept document.
- Transplants to highly sensitized patients decrease compared to the current rules but represent an increase compared to the concept document.

The Kidney Transplantation Committee continues to discuss how to best accommodate very highly sensitized patients (98 %+ ) in the kidney allocation algorithm to improve the likelihood that high panel PRA patients receive an opportunity for an organ offer.

The committee discussed the simulation results. Run 37 shows no change by ethnicity as compared to the current rules. However, there is a slight decrease in access to transplants as compared to the rules proposed in the concept document. Members commented on the loss of the small increase in transplants to minority candidates demonstrated in previous versions of the kidney allocation models. Though the increase shown in previous modeling results was not large (3-5%), in the new proposed system there is no demonstrable improvement in access for minority candidates as compared to the current kidney allocation rules. Further, transplantation by ABO blood group is unchanged with a decrease in transplants to patients with diabetes. Minorities are disproportionately represented in both the ABO blood group B and diabetic populations and subsequently are disadvantaged in the model because the overall life span of these patients is shorter. Members also commented on the fact that more benefit was not shown for minorities with the inclusion of dialysis time and the variance transplanting A2/A2B kidneys into B candidates in the model. It was suggested that the model may be reflecting the type of patients who are actually being placed on the waiting list, as the simulations are limited to demonstration of results using current behavior patterns. If provider behavior changes under a new kidney allocation system and patients with longer waiting times gain access to the waiting list, then the numbers may show improvement.

A member of the committee inquired whether there was any discussion of age banding within the high PRA group. It was reported that this has not been discussed by the Kidney Transplantation Committee but may have been addressed within the CPRA discussion. Another member inquired whether or not ECD kidneys are proposed to be taken out of the UNOS metrics for evaluation of transplant center performance as their use affects transplant center outcomes. This is unknown at this time.

During its March 13 meeting, the committee received further KAS updates from Ciara Samana, MS, liaison to the Kidney Transplantation Committee (**Exhibit D**). The committee was informed that the current working model for the new system is the same as reported in the last update provided to the committee in November. Patients are rank ordered by waiting /ESRD time, HLA DR matching and a sliding scale calculated panel reactive antibody (CPRA) score and the national variance transplanting A<sub>2</sub> and A<sub>2</sub>B kidneys into B candidate's allocation protocol.

As a reminder, Ms. Samana highlighted the limitations of the current system as compared to the proposed KAS allocation concepts for the committee:

<b>Stated Limitation of the Current System</b>	<b>Applicable Concepts</b>
Mismatch between potential survival of the kidney and the recipient	Longevity matching
Variability in access to transplantation by blood group and geographic location	A2/A2B, broader sharing
High discard rates of kidneys that could benefit candidates on the waiting list	KDPI, expedited placement,
Reduce differences in transplant access for populations described in NOTA (e.g., candidates from racial/ethnic minority groups, pediatric candidates, and sensitized candidates).	ESRD time, broader sharing, CPRA sliding scale, maintain peds priority

The committee was provided with a summary of the rationale for the proposed system:

- Allocation based on longevity matching is accepted and sustains legal scrutiny
- The majority of kidneys are still allocated very similarly to current rules
- Waiting time remains the primary determinant of kidney allocation with a more inclusive definition
- Improved “ECD” system addresses concerns of older recipients with the following considerations:
  - “Opt in” preserves choice
  - Allows trade off of a kidney with more longevity for more rapid transplantation
  - Regional allocation might improve recovery and placement
  - Allocation on time alone makes it predictable and allows list management.

The committee was updated on the status of the KAS proposal to date. Currently, the Kidney Transplantation Committee is awaiting final simulation modeling of sharing for candidates with CPRA  $\geq 98\%$  as well as regional sharing of ECD kidneys. It is estimated that the earliest projected release of a KAS proposal would be in the Fall of 2012 with the earliest date for Board consideration in June of 2013. The Kidney Transplantation Committee continues to debate the appropriate number of points to award to patients who may only receive one organ offer a decade to allow them to qualify for that organ, as compared to other candidates who may have other opportunities for offers.

Ms. Samana also updated the committee on the status of the variance review process being undertaken by the Kidney Committee in concert with development of the KAS. As a result of its review, the Kidney Committee has decided to recommend discontinuation of all variances except for the Dialysis Waiting Time Study and the National A<sub>2</sub>/A<sub>2</sub>B Variance. The Kidney Committee will recommend that these changes take place at the time a new system is implemented. The Kidney Committee has received letters from several OPOs who wish to keep their existing variances in the new allocation system. OPOs that currently have a variance not recommended for inclusion in the new system may either apply for a 1-step transition or apply for a new variance. Details for each option were sent to the OPOs which submitted appeals. It was proposed that there will be no changes

in the system for approximately 18 months to two years and so the OPTN is not accepting any new applications for variances that would require programming.

The committee was provided with a timeline for completion of the variance review:

April 6, 2012	Policy Oversight Committee review of the committee's recommendations
May 15, 2012	Transition plan applications due
June 25, 2012	OPTN/UNOS Board of Directors reviews recommendations for discontinuation (no action at this time)
Fall 2012	Public comment for new national kidney allocation system and transition plans approved by the committee
June 2013	Board of Directors considers proposal and transition plans
Fall 2013	Approved transition plans implemented
TBD (likely 2014)	New kidney allocation system implemented and transition plans ended

The committee requests to continue to be updated on the development of the system.

6. Kidney Paired Donation Pilot Program (KPDPP)

During its March 2012 meeting, the committee was also provided with an update on the background and current status of the Kidney Paired Donation Pilot Program (KPDPP) by Ruthanne Hanto, KPD Program Manager (**Exhibit E**). KPD matches living donors and their intended candidates with other living donor/intended candidate pairs when it is determined that the living donors cannot donate to the person they initially hoped would receive their kidney. The OPTN and UNOS implemented the OPTN KPDPP, which conducted its first match in October 2010 and has continued to conduct successful matches under the pilot program to date. It is estimated that an additional 3000 transplants could be achieved annually if all US transplant centers fully participated in one national KPD program.

For illustration purposes, the committee was provided with several examples of incompatible exchanges. In a two way exchange, Donor A would donate to Candidate B and Donor B would donate to Candidate A. In a three-way exchange, Donor A would donate to Candidate B, Donor B would donate to Candidate C and then Donor C would donate to Candidate A. In the examples provided to the committee, all transplants would occur simultaneously but could take place at different transplant centers.

The committee was also provided with an explanation of closed and open donor chains. A closed donor chain begins with a non-directed donor who donates to a first paired candidate, whose donor donates to another paired candidate. The last donor in line donates to someone on the waiting list of the transplant center who entered the non-directed donor. All transplant procedures do not need to be performed on the same day but the candidate must receive a transplant prior to their donor donating

and each donor must donate within 3 weeks of their recipient receiving a transplant. In an open chain, the donor at the end of the chain becomes a “bridge” donor and re-enters the KPD program following a match run to extend the chain. It was noted that the number of possible transplants that can be achieved using open donor chains is unlimited; therefore the use of bridge donors is essential in maximizing the number of KPD transplants. Currently the OPTN KPD program does not utilize bridge donors. For the current March 13, 2012 public comment cycle, the KPDPP system is being proposed for adoption into national kidney allocation policy. The use of bridge donors in the KPD system is also being proposed for inclusion in KPD policy but is being proposed separately as the proposal has the potential to generate more controversy.

The committee was also provided with a brief summary of the characteristics of candidates entered in the most recent KPDPP match run as outlined below.

Table 1 Candidate Characteristics Candidates entered in January 2012 Match Run

Characteristics	Candidates
Total	104
Blood Type O	65.4% (68)
CPRA $\geq$ 80%	60.6% (63)
Ethnicity- Black	14.4% (15)
Ethnicity- Hispanic	5.8% (6)
Age over 50	38.7% (43)
DD Waiting Time > 1 year	74.0% (77)
Previous Kidney Transplant	58.4% (87)
Willing to accept a shipped kidney from any center	93.3% (97)

7. Review and Discussion of Public Comment Proposals Distributed September 16, 2011

The following proposals were discussed during the November 29, 2012 full committee conference call:

1. *Proposal to Clarify Requirements for Waiting Time Modification Requests (Kidney Transplantation Committee)*

The committee did not identify an inherent minority impact resulting from the proposal.

2. *Proposal to Extend the “Share 15” Regional Distribution Policy to “Share 15 National” (Liver and Intestinal Organ Transplantation Committee)*

The committee discussed the two liver proposals as a unit. The committee did not identify any obvious minority impact as a result of the proposals and supported the concept of regional sharing in general as long as the concepts presented are executed as outlined in the proposal. The

committee noted that the proposals were reasonable and represented the small incremental changes needed to improve geographic disparities in liver transplantation. The committee expressed general concern with regard to broader sharing of livers and stressed the importance of the OPO metrics being used in conjunction with broader sharing to try to mitigate the “center effect” and in particular, the “OPO effect.” The committee also suggested that the Liver and Intestinal Organ Transplantation Committee undertake a recurring analysis to determine if there are any unintended consequences as a result of the proposals (to include negative consequences for minority patients and controlling for the OPO effect).

3. *Proposal for Regional Distribution of Livers for Critically Ill Candidates (Liver and Intestinal Organ Transplantation Committee)*

The committee discussed the two liver proposals as a unit. The committee did not identify any obvious minority impact as a result of the proposals and supported the concept of regional sharing in general as long as the concepts presented are executed as outlined in the proposal. The committee noted that the proposals were reasonable and represented the small incremental changes needed to improve geographic disparities in liver transplantation. The committee expressed general concern with regard to broader sharing of livers and stressed the importance of the OPO metrics being used in conjunction with broader sharing to try to mitigate the “center effect” and in particular, the “OPO effect.” The committee also suggested that the Liver and Intestinal Organ Transplantation Committee undertake a recurring analysis to determine if there are any unintended consequences as a result of the proposals (to include negative consequences for minority patients and controlling for the OPO effect).

4. *Plain Language Modifications to the Adult and Pediatric Heart Allocation Policies, Including the Requirement of Transplant Programs to Report in UNet<sup>SM</sup> a Change in Criterion or Status within Twenty-Four Hours of that Change (Thoracic Organ Transplantation Committee)*

The committee did not identify an inherent minority impact resulting from the proposal.

5. *Proposed Revisions to and Reorganization of Policy 6.0 (Transplantation of Non-Resident Aliens), Which Include Changes to the Non-Resident Alien Transplant Audit Trigger Policy and Related Definitions (Ad Hoc International Relations and Ethics Committees)*

The committee discussed the proposal at length and expressed primary concern with both the audit and reporting language as written in the policy. The committee was concerned that the proposal did not define:

- (1) The actions that would trigger an audit (1<sup>st</sup> non-resident alien transplant or the 100<sup>th</sup>?)
- (2) What the Ad Hoc International Relations Committee (AHIRC) might be looking for in an audit
- (3) The details describing what actions might lead to punitive action

The committee expressed concern that the lack of detail in the policy would leave transplant centers vulnerable and ill-prepared to comply with the policy. The committee also expressed concern about the AHIRC independently and at its own discretion, auditing programs. Such a review could be arbitrary, based on the changing composition of committee membership. The committee also expressed concern about self-reported immigration status. The committee is in favor of the data collection requirement approved by the Board; however, it recommends that data first be collected, reviewed and analyzed before any discussion of a review or audit takes place. This would allow determination of the scope of the problem (who is being transplanted

and under what circumstances) and the threshold under which a review or audit might be undertaken. The committee cautioned against public reporting of data results without first reviewing and understanding the information and the resulting implications. Information presented incorrectly, could be exploited and used for political opportunism under the current political environment. It was further suggested that the determination of an appropriate review of transplant centers might be completed as part of a separate policy development effort.

Finally, the committee discussed the potential minority impact resulting from the proposal. A member noted that in Texas this proposal would greatly impact minority patients because it is not wealthy individuals from the Middle East who are seeking transplants, but individuals who have crossed the Mexican border into the US. These patients have access to immunosuppression and future medication and so they are transplantable. However, transplanting these patients would raise many flags for centers in Texas.

6. *Proposed Update to the Calculated PRA (CPRA) (Histocompatibility Committee)*

The committee reviewed the proposal but did not offer specific comment.

7. *Revision of the UNOS Bylaws, the OPTN Bylaws and the OPTN Policies that Govern HLA Laboratories (Histocompatibility Committee)*

The committee reviewed the proposal but did not offer specific comment.

8. *Proposal to Establish Requirements for the Informed Consent of Living Kidney Donors (Living Donor Committee)*

The committee reviewed the proposal but had limited time in which to offer comment. General feedback was offered regarding the need to tie living donor follow up to reimbursement in order for it to be meaningful and for all transplant centers to become compliant.

9. *Proposal to Establish Minimum Requirements for Living Kidney Donor Follow-Up (Living Donor Committee)*

The committee reviewed the proposal but had limited time in which to offer comment. General feedback was offered regarding the need to tie living donor follow up to reimbursement in order for it to be meaningful and for all transplant centers to become compliant.

10. *Proposal to Establish Requirements for the Medical Evaluation of Living Kidney Donors (Living Donor Committee)*

The committee reviewed the proposal but had limited time in which to offer comment. General feedback was offered regarding the need to tie living donor follow up to reimbursement in order for it to be meaningful and for all transplant centers to become compliant.

11. *Proposal to Eliminate the Use of an “Alternate” Label when Transporting Organs on Mechanical Preservation Machines and to Require the OPTN Distributed Standardized Label (Organ Procurement Organization (OPO) Committee)*

The committee did not discuss the proposal.

12. *Proposal to Change the Term “Consent” to “Authorization” Throughout Policy When Used in Reference to Organ Donation (Organ Procurement Organization (OPO) Committee)*

The committee did not discuss the proposal.

13. *Proposal to Modify the Imminent and Eligible (I & E) Neurological Death Data Reporting Definitions (Organ Procurement Organization (OPO) Committee)*

The committee did not discuss the proposal.

14. *Proposal to Clarify and Improve Variance Policies (Policy Oversight Committee (POC))*

The committee did not discuss the proposal.

8. Review and Discussion of Public Comment Proposal Distributed February 3, 2012:

The following proposal was discussed during the March 13, 2012 full committee meeting:

1. *OPTN Bylaws Substantive Rewrite of Appendix A: Application and Hearing Procedures for Members and Designated Transplant Programs*

The committee was provided with a brief update on the proposed OPTN Bylaws Substantive Rewrite of Appendix A: Application and Hearing Procedures for Members and Designated Transplant Programs.

Following the update, the committee determined that there was no inherent minority impact resulting from the proposal and declined a formal vote.

9. Review and Discussion of Public Comment Proposals for Distribution March 13, 2012

The following proposals were discussed during the March 13, 2012 full committee meeting:

1. *Proposal to Clarify Priority Status for Prior Living Organ Donors who Later Require a Kidney Transplant (Kidney Transplantation Committee)*

The committee was provided with a brief summary of the proposal by Ciara Samana, MS, Liaison to the Kidney Committee.

Following very brief discussion, the committee voted by consensus to approve the proposal.

2. *Proposal to Establish Kidney Paired Donation (KPD) Policy (Kidney Transplantation Committee)*

The committee was presented with an overview of the proposal by Ruthanne Hanto, KPD Program Manager. The overview included the rules applying to OPTN KPD enrollment, program specific content, data requirements, choosing matches, additional consent requirements, policies for living donors, and requirements for OPTN contractor operation of the program.

The committee voted by consensus to approve the proposal.

3. *Proposal to Include Bridge Donors in the OPTN Kidney Paired Donation (KPD Program) (Kidney Transplantation Committee)*

The committee was presented with an overview of the proposal by Ruthanne Hanto, KPD Program Manager. The committee was provided with an overview of the proposal including the rules for ending a chain with a bridge donor, consent of the potential donor to be a bridge donor, informed consent rules for the potential donor's transplant hospital regarding continuation as

bridge donor, donating to the waiting list, declining a donation, potential for multiple medical evaluations, etc.

Following the presentation, the committee discussed the question posed for comment regarding whether there should be a limit on how long a bridge donor should be allowed to wait in the OPTN KPD Program after his candidate receives a transplant. It is standard practice in many transplant centers to require a one year window of time in which a candidate would have to complete their medical evaluation prior to the donation. Committee members expressed some concern with the possibility that bridge donors would have to repeat parts or all of their medical evaluations depending on the time frame in which they would need to wait to be able to donate to a compatible recipient in the KPD program. It was recommended that there be a clear end point to the time that donors should have to wait in the program in order to limit costs and avoid long waiting times. It was noted that though donors are asked every three months or so if they wish to continue to wait to donate to the KPD program or donate to the list, it was acknowledged that the potential for a donor to possibly have to repeat a medical evaluation is a valid concern and has been a topic of continued discussion by the KPD Work Group. This can pose an issue even for non-bridge donors depending on the time frame from their medical evaluation to the surgery and should be disclosed upon consent to participate in the program.

The committee reiterated its concerns that repeated testing may create additional barriers to participation in the KPD program and should be avoided with a reasonable cut-off time period for consideration for donation. Following the discussion, the committee voted by consensus to support the proposal with the recommendation for a one year time limit for bridge donors.

4. *Proposal to Allow Transplant Centers to Place Liver Candidates with HCC Exceptions on 'HCC Hold' Without Loss of Accumulated MELD Exception Score (Liver and Intestinal Transplantation Committee)*

The committee was provided with a brief summary of the proposal by a member of the committee. Following brief discussion, the committee determined that there was no inherent minority impact resulting from the proposal and declined a formal vote.

5. *Proposal to Revise the Lung Allocation Score System (Thoracic Organ Transplantation Committee)*

The committee was provided with a brief summary of the proposal by Vipra Ghimire, liaison to the Thoracic Committee.

Following a question from a member, the committee briefly discussed potential disadvantages to patients under the new proposed LAS system. It was reported that although there are no disadvantages expected to affect minority patients in particular, for about 5% of patients the difference between the new LAS and the old LAS will be about 5 points. However, for about 15% of patients there may be a significant difference in scores and ranking, particularly for patients with pulmonary hypertension. This would possibly be improved with the addition of bilirubin as a factor in the LAS system. This proposed addition has been approved by the Board but has not yet been implemented.

Following brief discussion, the committee determined that there was no inherent minority impact resulting from the proposal and declined a formal vote.

6. *Proposal to Require Reporting of Unexpected Potential or Proven Disease Transmission Involving Living Organ Donors (Living Donor Committee)*

The committee discussed the proposal but declined a formal vote.

7. *Proposal to Require Extra Vessel(s) Disposition to be Reported to the OPTN within Five Days of Transplant or Disposal (Operations and Safety Committee (OSC))*

The committee did not discuss the proposal.

8. *Proposal to Require Documentation of Second Unique Identifier (OPO Committee)*

The committee did not discuss the proposal.

9. *Proposed Changes to the Donation after Cardiac Death (DCD) Model Elements (OPO Committee)*

The committee did not discuss the proposal.

10. *Proposal to Update Data Release Policies (Policy Oversight Committee)*

The committee reviewed the proposed revisions to the OPTN Data Release Policies will combine Policy 9 and Policy 10 into a single policy (Policy 9 – Release of Data). The proposed changes will:

- Allow the OPTN to release more data than is currently released
- Provide an appeals process if the OPTN denies a data request
- Set requirements for the release of confidential information
- Allow the OPTN to release non-confidential data by institution to *any* requester
- Eliminate the list of data elements that can be released in special circumstances out of policy to allow for greater flexibility in data release.
- The process for release of person-identified data will not change.

During the evaluation of the policies as part of the Plain Language Rewrite Project, it was noted that the data release policies contained outdated elements that required substantive changes. The proposed revisions align these policies with current practice and present the information in a simpler format.

A member of the committee commented on concerns expressed during the POC meeting that the policy was now too broad. The committee determined that there was no inherent minority impact and declined a formal vote on the proposal.

10. Update on November 14-15 Board of Directors Meeting

During its subcommittee teleconference call on November 29, 2012, committee members were provided with a brief summary of relevant actions from the November 14-15, 2011 Board of Directors meeting in Atlanta, GA of interest to the committee.

The committee was updated on the following:

- Board approval of modifications to multiple Policies and Bylaws requiring OPOs to perform a second ABO sub-typing test when a donor is identified as non-A<sub>1</sub> or non-A<sub>1</sub>B.
- Board approval of modifications to Policy 3.7.12.3 (Essential Information for Lung Offers) and 3.7.12.4 (Desirable Information for Lung Offers) for currency and readability, and adding non-contrast computed tomography (CT) scan of the chest to Policy 3.7.12.4.
- Board approval of modifications to Policy 3.7.6.3 (Candidate Variables in UNet<sup>SM</sup>) requiring transplant programs to update in no more than 14 days, any observed changes in certain clinical values most important to determining a candidate's Lung Allocation Score for high-LAS candidates.
- One year extension of the interim approval of modifications to Policy 3.7.3 (Adult Candidate Status), approved in November 2010 to December 1, 2012, permitting listings at Status 1A or 1B for outpatient adult candidates implanted with total artificial hearts.
- Board approval of modifications to Policy 3.6.4.4 (Liver Transplant Candidates with Hepatocellular Carcinoma (HCC) more clearly defining the imaging characteristics of HCC.
- Board approval of modifications to Policy 3.6 (Adult Donor Liver Allocation Algorithm) providing broader access to deceased donor organs for candidates awaiting a combined liver-intestine transplant.
- Board approval of a committee-sponsored alternative allocation system for split liver allocation allowing a transplant center that accepts a right lobe for transplantation into a candidate on its list to transplant the left lobe/left-lateral segment into any other medically suitable patient listed at that institution or an affiliated pediatric institution.
- Board approval of modifications to Policies 5.10.1 (Vessel Recovery and Transplant) and 5.10.2 (Vessel Storage) restricting storage of Hepatitis C antibody positive and Hepatitis B surface antigen positive extra vessels when they are not transplanted during the original transplant procedure.

**ATTENDANCE FOR THE NOVEMBER 29, 2011  
OPTN/UNOS MINORITY AFFAIRS COMMITTEE MEETING**

<b>Committee Members</b>	<b>Position</b>	<b>In Attendance</b>
Silas P. Norman, MD	Chair	Yes
Meelie A. Debroy, MD	Vice-Chair	Yes
Isabel Zacharias, MD	Region 1 Representative	(Phone)
Stacey H. Brann, MD	Region 2 Representative	Yes
Yma Waugh, MBA	Region 3 Representative	Yes
Sherilyn 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
Antonio Sanchez, MD	Region 8 Representative	Yes
Lani V. Jones, PhD, MSW	Region 9 Representative	(Phone)
Asif A. Sharfuddin, MD	Region 10 Representative	Yes
Kelly C. McCants, MD	Region 11 Representative	Yes
Remonia A. Chapman, MD	At-Large	(Phone)
Pang-Yen Fan, MD	At-Large	Yes
Mohamed A. Hassan, MD	At-Large	Yes
Eddie Island, MD	At-Large	Yes
Maria R. Lepe, MD	At-Large	No
Rosaline Rhoden, MPH	At-Large	Yes
M. Christina Smith, MD	At Large	No

Karen A. Sullivan, Ph.D	At-Large	(Phone)
Henry B. Randall, MD	At-Large	Yes
Mesmin Germain, MBA, MPH	Ex-Officio, HRSA	(Phone)
Chinyere Amafulé	Ex-Officio, HRSA	No
<b>UNOS Staff</b>		
Deanna L. Parker, MPA	Committee Liaison/Policy Analyst	Yes
Wida Cherikh, PhD	Sr. Research Biostatistician	Yes
<b>MMRF Staff</b>		
Monica M. Colvin Adams, MD	SRTR	Yes
W. Ray Kim, MD	SRTR	No
<b>Guests</b>		
None		

**ATTENDANCE FOR THE MARCH 13, 2012  
OPTN/UNOS MINORITY AFFAIRS COMMITTEE MEETING**

<b>Committee Members</b>	<b>Position</b>	<b>In Attendance</b>
Silas P. Norman, MD	Chair	Yes
Meelie A. Debroy, MD	Vice-Chair	Yes
Isabel Zacharias, MD	Region 1 Representative	Yes
Stacey H. Brann, MD	Region 2 Representative	Yes
Yma Waugh, MBA	Region 3 Representative	Yes
Sherilyn A. Gordon Burroughs, MD	Region 4 Representative	No
Ricardo Elizondo, RN, CPTC	Region 5 Representative	No
Stephen A. Kula, Ph.D, NHA	Region 6 Representative	Yes
Bruce A. King, MSW	Region 7 Representative	No
Antonio Sanchez, MD	Region 8 Representative	No
Lani V. Jones, Ph.D, MSW	Region 9 Representative	Yes
Asif A. Sharfuddin, MD	Region 10 Representative	Yes
Kelly C. McCants, MD	Region 11 Representative	Yes
Remonia A. Chapman, MD	At-Large	No
Pang-Yen Fan, MD	At-Large	No
Mohamed A. Hassan, MD	At-Large	(Phone)
Eddie Island, MD	At-Large	Yes
Maria R. Lepe, MD	At-Large	No
Rosaline Rhoden, MPH	At-Large	Yes
M. Christina Smith, MD	At Large	(Phone)

Karen A. Sullivan, Ph.D	At-Large	No
Henry B. Randall, MD	At-Large	No
Mesmin Germain, MBA, MPH	Ex-Officio, HRSA	Yes
Chinyere Amafulé	Ex-Officio, HRSA	Yes
<b>UNOS Staff</b>		
Deanna L. Parker, MPA	Committee Liaison/Policy Analyst	Yes
Wida Cherikh, PhD	Sr. Research Biostatistician	Yes
<b>Guests/Visitors</b>		
Dorry Segev, MD	John Hopkins University	(Phone)
Ruthann Hanto, MS	UNOS	(Phone)
Ciara Samana, MS	UNOS	(Phone)
Jim Bowman, MD	HRSA	(Phone)
Marissa Clark, MS	UNOS	(Phone)
Elizabeth Miller	UNOS	(Phone)
Cliff McClenney, MA	UNOS	(Phone)
Manny Carwile	UNOS	Yes
Laura Sigmon	UNOS	(Phone)
<b>MMRF Staff</b>		
Tabitha Leighton	SRTR	(Phone)