

OPTN/UNOS POLICY OVERSIGHT COMMITTEE SUMMARY

I. Action Items for Board Consideration:

- The Board is asked to approve a resolution requesting that the HHS Secretary's Advisory Committee on Transplantation (ACOT) review: (1) the current HHS Program Goals for the OPTN for organs transplanted per donor, (2) the data used to establish these goals, and (3) how these goals might be impacted by the standards set by CMS. (Item 1, page 3)

II. Other Significant Items:

- The Committee supports the Histocompatibility Committee's request for incorporating CPRA into the existing Tennessee State alternative system for kidneys. (Item 2A, page 5)
- The Committee does not support the Organ Availability Committee's proposed modifications to OPTN/UNOS Policy 3.5.9 (Minimum Information/Tissue for Kidney Offer). (Item 2B, page 6)
- The Committee supports the Operations Committee's proposed modifications to OPTN/UNOS Policy 4.0 (Acquired Immune Deficiency Syndrome (AIDS), Human Pituitary Derived Growth (HPDGH), and Reporting of Potential Recipient Diseases or Medical Conditions, including Malignancies, of Donor Origin), as modified. (Item 2C, page 7)
- The Committee does not support the Operations Committee's proposed modifications to OPTN/UNOS Policy 7.4 (Submission of Organ-Specific Transplant Recipient Follow-up Forms) and asks that the Operations Committee provide further details about and evidence for the proposal. (Item 2D, page 8)
- The Committee does not support the Living Donor Committee's proposed Guidelines for the Medical Evaluation of Living Kidney Donors and Guidelines for the Consent of Living Donors. (Item 2E, page 9).
- The Committee reviewed an inventory of SRTR studies related to geographic differences in access to transplantation. (Item 3, page 9)
- The Committee will recommend to the Liver and Intestinal Organ Transplantation and Pediatric Committees that Policy 3, Appendix B (Indications for Liver Transplantation in Children) should be deleted (Item 4, page 11).

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**REPORT OF THE
POLICY OVERSIGHT COMMITTEE TO THE
BOARD OF DIRECTORS
Los Angeles, CA
September 17-18, 2007
Janis M. Orlowski, M.D., Chair**

Framework for Committee Discussions

At the start of the July 24, 2007, meeting, Janis M. Orlowski, M.D., Committee Chair, reviewed the charge to the Policy Oversight Committee (POC) and the proposed 2007-2008 Annual Goals for the POC (**Exhibit A**).

1. Program Goal Progress: Current Results. Erick Edwards, Ph.D., reviewed progress towards the following HHS Donor-related Program Goals for the OPTN for 2006:

1. Increase number of deceased donor transplants;
2. Increase number of non-Donation after Cardiac Death (DCD) donors;
3. Increase number of DCD donors;
4. Increase organs transplanted per donor (OTPD) – non-DCD; and
5. Increase organs transplanted per donor (OTPD) – DCD.

These data were displayed graphically, with results by donor service area (DSA) (**Exhibit B**). After reviewing the data, Committee members expressed the following concerns about the Program Goals:

- Some goals may be in opposition. For example, increasing the number of donors through use of expanded criteria donors (ECDs) or DCDs generally leads to fewer organs transplanted per donor.
- The Collaborative model has been as successful in increasing yield (OTPD) as it has in increasing conversion rates and the number of donors.
- While the Collaborative is encouraging centers to be more aggressive in the use of DCD/ECD organs, CMS is seeking better results from transplant programs, which could lead to decreased use of ECDs.
- Additionally, the CMS “intent to procure ruling¹” may provide a disincentive to increasing the number of organ transplants. A Committee member hypothesized that if “costs were off the table,” the number of OTPD would increase significantly. This could be a demonstration project conducted by an DSA or several DSAs.
- There are financial implications of taking ECD/DCDs, e.g. an increasing patient length of stay post-transplant.

Committee members asked whether there is a mechanism for the goals to be revised based on scientific analysis of recent data. Christopher McLaughlin, Chief, Operations and Analysis Branch, Division of Transplantation/HRSA, noted that HRSA does not have the ability to modify the goals, but an analysis of the goals would be helpful when the opportunity for a change arises. When asked whether the original goals were data-driven, one Committee member noted that the goals for OTPD were based on analyses of the highest-performing DSAs, although it was likely calculated using standard criteria donors (SCDs); changes in the donor population may have shifted the potential. One

¹ “Cost associated with a particular organ must be allocated to that organ’s cost center if the OPO intended to procure it for transplant (regardless of whether that organ was ever actually procured).” Ruling No.: CMS-1543-R Date: December 21, 2006

suggested approach was to relay the concerns about the goals to the HHS Secretary's Advisory Committee on Organ Transplantation (ACOT), as HHS oversees both CMS and HRSA.

Robert Wolfe, Ph.D., Deputy Project Director for the SRTR, stated that it would be useful to develop statistics about DSA performance that account for donor characteristics. This would allow for a calculation of an observed vs. expected number of OTPD, for example. Jeff Orlowski, Vice-Chair of the OPO Committee, noted that the OPO Committee is planning to request an analysis to determine which characteristics of donors are predictive of high yield (OTPD). The number of OTPD has been flat or declining despite considerable efforts, and the community needs to understand why in order to address this. It will be important to understand why some DSAs have higher utilization rates than others, and how these data can be used to set realistic goals. One member noted that DSAs with high OTPD tend to have large pancreas and lung programs, and that these organs are harder to place at distant centers.

The Committee asked that the SRTR determine metrics that could be used to measure high, average and low-performing DSAs, and define characteristics of donors, patients, DSAs, and transplant centers that are predictive of success. In addition, the Committee submits the following resolution for consideration by the Board of Directors:

**** RESOLVED, that the OPTN requests that the HHS Secretary's Advisory Committee on Transplantation (ACOT) review: (1) the current HHS Program Goals for the OPTN for organs transplanted per donor, (2) the data used to establish these goals, and (3) how these goals might be impacted by the standards set by CMS.**

Committee Vote: 14-0-0

2. Review of Proposed Policies. The Committee reviewed six proposals during its July 24, 2007, meeting. Four proposals had been circulated for public comment in May 2007 and two in June 2007. These proposals are summarized in **Table 1** and are described in items A-E, below.

Policy Evaluation Scorecard

The Committee reviewed the proposed scorecard (**Exhibit C**), which will be used as a tool for reviewing new proposals. The scorecard will provide consistent ranking of policies across meetings and reviewers. The scorecard categories include:

1. Positive impact on the OPTN Program Goals and Strategic Plan;
2. Positive impact on a high proportion of candidates and/or recipients (to include Improvement in Patient Safety);
3. OPTN/SRTR contractor cost/risk Factor;
4. Member cost;
5. Cost Reduction/Efficiency Gain to OPTN (Members or Staff);
6. Policy Easy to Understand/Accessible; and
7. Serves a special or disenfranchised group.

All seven categories will be ranked using the same score (0 to 5), where 0 equals low/costly and 5 equals high/efficient. The first two items would receive a weight of 3 while the rest would receive a weight of 1. The intent is to balance the ranking based on the most important categories versus other factors that are important but do not carry the same weight as the program goals and impact on patients. The reviewers of those proposals that the Committee supports will use the scorecard to evaluate those proposals.

Table 1. Summary of Proposals Reviewed by the Policy Oversight Committee, July 24, 2007

	Proposal* *Modification to existing policies unless otherwise stated	Sponsoring Committee	POC Comments
A	Request for Incorporating CPRA into an Existing Alternative System for Kidneys	Histocompatibility	Supports. POC asks that participants provide criteria for defining unacceptable antigens.
B	Proposed Modifications to OPTN/UNOS Policy 3.5.9 (Minimum Information/Tissue for Kidney Offer)	Organ Availability	Does not support.
C	Proposed Modifications to OPTN/UNOS Policy 4.0 (Acquired Immune Deficiency Syndrome (AIDS), Human Pituitary Derived Growth (HPDGH), and Reporting of Potential Recipient Diseases or Medical Conditions, including Malignancies, of Donor Origin)	Operations	Supports, with minor clarifications.
D	Proposed Modifications to OPTN/UNOS Policy 7.4 (Submission of Organ-Specific Transplant Recipient Follow-up Forms)	Operations	Does not support at this time. The Operations Committee is asked to demonstrate: 1. The mechanism by which the data will get to the recipient transplant centers; 2. Whether or not there is science to support the belief that organs from the same donor are likely to cause death or organ failure in other recipients; and 3. Some estimate of compliance rate for the current reporting period of within 2 weeks.
E	Guidelines for the Medical Evaluation of Living Kidney Donors and Guidelines for the Consent of Living Donors	Living Donor	Does not support.

A. Request for Incorporating Calculated PRA (CPRA) into an Existing Alternative System for Kidneys. Committee members Janis Orlowski, M.D., and James Wynn, M.D., reviewed this proposal from the Histocompatibility Committee. The transplant centers and OPOs in Tennessee have asked to incorporate the CPRA into their existing alternative allocation system for kidneys, which assigns 2 points for candidates with a PRA of 40-79%. This was approved by the

Histocompatibility and Kidney Committees. Supporting data and a study plan were included in the proposal.

Dr. Wynn stated that moderately sensitized patients suffer in terms of access to transplants and was supportive of this proposal, which is a continuation of their current alternative system. The alternative system seems to be working in that a higher proportion of moderately sensitized patients are transplanted as compared to national numbers. Dr. Orlowski asked whether additional metrics should be added to evaluate waiting time as compared to those with low or no sensitization and to compare life year benefits. However, the size of the sample may not be sufficient for such analyses.

Policy 3.5.11.3 (Sensitized Wait List Candidates - Calculated PRA (CPRA)) states that “Each transplant center may define the criteria for unacceptable antigens that are considered as contraindications for transplantation.” Committee members asked what criteria that the Tennessee centers and laboratories will use to define unacceptable antigens for their candidates. This may be helpful information for the community in more fully understanding the CPRA. While national information would be more useful, getting this information from Tennessee can be seen as a starting point.

The Committee agreed that this proposal was appropriate for the Board to consider. The Committee asks that the participating laboratories provide the criteria that they will use to determine unacceptable antigens for their candidates.

By a vote of 14 in favor, 0 opposed, and 0 abstentions, the Committee supports the Histocompatibility Committee’s request for incorporating CPRA into the existing Tennessee State alternative system for kidneys.

- B. Proposed Modifications to OPTN/UNOS Policy 3.5.9 (Minimum Information/Tissue for Kidney Offer). James Wynn, M.D. and Jeffrey Orlowski reviewed this proposal from the Organ Availability Committee (OAC). The proposal encourages renal machine perfusion for all ECD kidneys, and also for SCD and DCD donor kidneys at the request of the accepting transplant surgeon or physician. The goal of the proposal is to decrease discard rates, reduce the rate of delayed graft function (DGF), and decrease transplant-related financial costs caused by delayed graft function. The OAC proposes to evaluate the following at 18 months post-implementation: (1) the number of machine-perfused kidneys (2) the number of machine-perfused kidneys transplanted (3) the rate of DGF for kidneys transplanted and (4) the number of discarded kidneys. Mr. Orlowski noted that there is no measurement of the transplant cost component included in the proposal. The reviewers felt that the proposal was clearly worded, and, if successful, would meet the performance measures from the OPTN Final Rule and the Program Goals.

Retrospective analyses were performed by the SRTR to determine the impact of machine perfusion on kidney DGF, discard rates, etc. Mr. Orlowski noted that there have been some concerns that the data have potential for selection bias, and that the ultimate data needed to support a policy recommendation should be a prospective, randomized trial. Dr. Wynn agreed that selection bias presents a challenge. Both reviewers supported this recommendation to expand renal perfusion. Mr. Orlowski suggested that the data analyzed at 18-months should include only perfused donors from whom at least one kidney was transplanted, rather than all kidneys that were perfused (i.e., remove donors from utilization/discard calculations where neither organ was used as this is one significant area where the reliability of data comes into

question). He also suggested that kidney utilization rates be evaluated rather than discard rates, and that a randomized, prospective trial should be encouraged.

Robert Merion, M.D., Clinical Transplant Director for the SRTR, expressed concerns that approving this proposal will imply that there are data that support it. Perfusion of ECD kidneys appears to be related to a decreased rate of DGF; however, without a prospective clinical trial, the SRTR cannot establish anything other than practice patterns, which may be driving most of the results. The SRTR cannot support the contention that perfusion reduces discard rates for kidneys. There is also a concern that this proposal could lead to expectations about cost savings, and there are no data on costs.

David Hull, M.D., acting Chair of the OAC, stated that there is one prospective trial in Europe that includes 300 kidneys. However, enrollment for the study just closed and it will take some time to analyze outcome data for this. He also cited studies that showed increased utilization of ECD kidneys and decreased DGF when kidneys are machine-perfused. His OPO demonstrated a financial advantage to machine perfusion associated with a decrease in the discard rate. Mr. Orlowski cited an abstract presented at AOPO that examined the impact of perfused kidneys on utilization and cost per kidney. The first year showed an increase in costs per kidney, but in the second year there was a lower cost per kidney than before perfusion and higher utilization rate. However, this abstract cited the experience of one DSA only.

Committee members noted that the proposal does describe the complexities about the data that have been discussed at the meeting. Members felt that the data are still being generated and that these issues are still being debated within the scientific community. Further, there was strong sentiment that OPTN policies should contain rules rather than suggestions or encouragement.

A motion to support this proposal was defeated by a vote of 2 in favor, 11 opposed, and 0 abstentions.

- C. Proposed Modifications to OPTN/UNOS Policy 4.0 (Acquired Immune Deficiency Syndrome (AIDS), Human Pituitary Derived Growth (HPDGH), and Reporting of Potential Recipient Diseases or Medical Conditions, including Malignancies, of Donor Origin). Maryl Johnson, M.D., and Judy Tisdale, Ph.D., reviewed this proposal from the Operations Committee. The goal of the proposal is to clarify OPO and transplant center requirements for screening, communicating, and reporting all potential or confirmed donor-related disease and malignancy transmission events. UNOS staff will monitor reporting of potential and confirmed donor related disease transmission events. This information will be provided to the Disease Transmission Advisory Group at the time of report submission and to the Operations Committee bi-annually through center and patient blinded reports. With respect to the performance measures in the Final Rule and the Program and Strategic Plan Goals, the proposal should help to avoid futile transplants, improve compliance with policies to protect patient safety and preserve public trust, and improve the OPTN data system.

Dr. Johnson asked whether the third line in section 4.6.2.3 (Intra-Cranial Hemorrhage) is correct or whether this actually should be “Non-traumatic intra-cranial hemorrhage in non-hypertensive donors may be due to intra-cranial malignant metastases, which have been observed in some malignancies” (rather than infections). This appears to be a typographical error in the proposal. There were also two items previously listed under “Malignancy Histories” that were stricken: Kaposi’s and Merkel cell. The UNOS liaison to the Operations Committee agreed to investigate these omissions. The proposal was not specific in terms of when a recipient of a donor identified

as having a potential disease will be notified, and the Committee asked that this be made clear. Both reviewers recommended that the proposal be supported, as modified.

By a vote of 12 in favor, 0 opposed, and 0 abstentions, the Committee supports the Operations Committee's proposed modifications OPTN/UNOS Policy 4.0 (Acquired Immune Deficiency Syndrome (AIDS), Human Pituitary Derived Growth (HPDGH), and Reporting of Potential Recipient Diseases or Medical Conditions, including Malignancies, of Donor Origin), as modified.

- D. Proposed Modifications to OPTN/UNOS Policy 7.4 Submission of Organ-Specific Transplant Recipient Follow-up Forms. Ray Gabel and Felicia LeClere, Ph.D., reviewed this proposal from the Operations Committee. The premise of the proposal is that timely reporting of recipient death will help the other recipients of organs from the same donor. The proposed modification would require that deaths within the first year must be reported within two working days of notification. Currently, Transplant Recipient Follow-up forms must be submitted to the OPTN within 14 days of notification of the recipient's death or graft failure.

Dr. LeClere noted that the policy was clearly written, however, no data are associated with the proposal. Questions to be answered include: (1) is there strong evidence that organs from the same donor are likely to cause death or organ failure in other recipients? (2) is there evidence that timely reporting of data will get to the physician treating recipients of the organ from the same donor? (3) how timely is the current reporting of the data? and (4) what are the consequences/costs for the reporting unit to speed up this process? A Committee member asked whether the statement "The OPTN has observed deaths of recipients who received organs from the same donor but were transplanted at different centers" is based in fact or is anecdotal. There is also no explanation of what the OPTN's response will be when notified of a recipient death and how the recipient centers will be contacted.

After discussion, the Committee approved the following:

Motion: The Proposed Modifications to OPTN/UNOS Policy 7.4 (Submission of Organ-Specific Transplant Recipient Follow-up Forms) should be sent back to the Operations Committee for further refinement. The Operations Committee is asked to demonstrate:

- 1. The mechanism by which the data will get to the recipient transplant centers;*
- 2. Whether or not there is science to support the belief that organs from the same donor are likely to cause death or organ failure in other recipients; and*
- 3. An estimate of the compliance rate for the current reporting period of within 2 weeks.*

Committee Vote: 13-0-0

Proposed Revisions to Policy 7.13

In June 2006, the Board approved the Committee's recommendation to modify Policy 7.1.3. The intent was to discontinue follow-up after graft failure for kidney or kidney-pancreas recipients. However, the proposal as worded would require that all patients must now be followed until death. The SRTR was asked to define a time frame for follow-up post-graft failure for kidney, pancreas, kidney-pancreas, and perhaps intestine recipients. During the May 2007 meeting, Robert Merion, M.D., Clinical Transplant Director of the SRTR, reported that there are very few deaths after graft failure that are only known through OPTN data (i.e., cannot be found from another source).

During the July 2007 meeting, Ann Harper, Committee Policy Analyst, explained that the policy language that had been drafted to address this issue is inconsistent with the Operations Committee's proposed revisions to Policy 7. UNOS staff policy analysts will develop language to address both the POC's and the Operations Committee's concerns. All the revisions to Policy 7 will be sent to the Board in February 2008 as part of the Operations Committee's final proposal.

E. Guidelines for the Medical Evaluation of Living Kidney Donors and Guidelines for the Consent of Living Donors. Committee members expressed the following concerns about the Guidelines for the Medical Evaluation of Living Kidney Donors and Guidelines for the Consent of Living Donors, which were proposed by the Living Donor Committee:

- Members felt that the guidelines were too granular and overly prescriptive. For example, specific tests may become obsolete, or the acceptable ranges/values for tests could change over time. Further, there was some concern that insurance companies or other organizations may decide to make these guidelines "mandatory" in terms of reimbursement or ability to select donors that might be appropriate but fall outside the guidelines.
- Members were unclear about the role of the OPTN to develop such guidelines, as opposed to organizations such as AST/ASTS, which may be the more appropriate bodies. Cooperation with such groups is important as well. OPTN Committees may need direction from the Board regarding the OPTN's role in living donation. Other Committee members felt that the OPTN has an important role in living donation and donor safety.
- A list of guiding principles might be more appropriate. Acceptable protocols could be cited as examples but not included in the guidelines. More details could be added later if necessary.
- The guidelines should include general principles applicable to all living donors, but should be expanded to include principles specific to each organ group (liver, kidney, and lung) as appropriate.
- There may be other methods that would meet the goal of protecting and educating living donors, such as brochures or other educational materials that would describe the options available to potential donors and outline what issues should be discussed with their physician.

No vote was taken on this proposal. However, the consensus of the Committee was that these guidelines are not ready for Board consideration in their current form.

Living Donor Data Task Force

In June 2007, the Board approved the Committee's resolution that "a joint OPTN Committee be established to evaluate the use of living donor data." This Task Force will also be asked to develop strategies for data specific to each organ. This may include investigating novel ways of collecting the data. Dr. LeClere noted that the Mayo Clinic has a survey center that utilizes a good model for patient follow-up. More information will be provided to the Committee as it is available.

3. Working Group to Study Geographic Variations in Organ Allocation. In June 2007, the Board approved the Committee's resolution that "the OPTN undertake a study to address geographic disparities in organ allocation." The Committee will spearhead the effort and provide goals and a path forward to the Executive Committee in September 2007.

Alan Leichtman, M.D., Transplant Co-Investigator for the SRTR, presented an inventory of SRTR studies related to geographic differences in access to transplantation (**Exhibit D**). Metrics useful for

describing access to transplantation include waiting time and transplant rates, organ and offer acceptance rates, and conversion and discard rates. Access can be defined as access to the waitlist or access to transplant after waitlisting. Metrics related to allocation systems include the Model for End Stage Liver Disease (MELD), the Lung Allocation Score (LAS), Life Years from Transplant (LYFT), Donor Risk Index (DRI) for liver, and the Donor Profile Index (DPI) for kidney. Potential units of geography to be studied include:

- Region / OPTN or CMS;
- DSA / OPO;
- State / County / Zip Code;
- Transplant Program or Center;
- Donor Hospital;
- Distance / Travel Time;
- Per population (total or those with disease); and
- Organ failure treatment provider (dialysis units, physicians, etc.).

Dr. Leichtman reviewed an analysis of access to the waiting list (for kidney) or to transplant (for kidney, liver, heart) by insurance, race, and geography. Geography had a much stronger effect than race or insurance for transplant once a patient is on the list. The presentation included an analysis of the MELD/PELD “Share 15” policy, under which livers are offered locally and regionally to candidates with MELD/PELD score of 15 or higher before offering them to local patients with lower MELD/PELD scores. While this policy reduced geographic differences in transplantation for patients with higher MELD/PELD scores, it did not lead to redistribution from local to regional as some expected. Other analyses presented include:

- Simulation of Wider Sharing of Hearts;
- Wait-Listing Rate among ESRD Patients versus deceased donor transplantation rate among waiting list patients, by state;
- Measures of Donation for the U.S. and 58 DSAs and various DSA characteristics;
- Distribution of LYFT by DSA;
- Distribution of Kidney Wait Time (25th Percentile) by DSA;
- Percent Living Kidney Donors by Transplant Center;
- Unrelated Living Donors (as % of all Living Donors), by Transplant Center;
- Distribution of DPI by DSA;
- Adjusted Odds Ratio of Discard for ECD/non-ECD Kidneys by DSA;
- Percent of Candidates on ECD List as of 10/31/2003 by DSA; and
- Deceased Donor Transplantation Rates Among Kidney Transplant Registrants With Various Adjustments, 2000-2005.

The details of the studies are included in **Exhibit D**. The presentation was summarized as follows:

- Differences exist in access to waitlisting and to transplantation.
- Many –but not all- of these differences can be measured and characterized with existing SRTR metrics.
- Some differences will be highly dependent on existing geographic boundaries and others on practice patterns.

Dr. Leichtman presented an additional slide listing geographic issues in allocation (**Exhibit E**), which included:

- Procurement rates and practices;
- Listing rates and practices;
- Waitlist issues and management; and
- Allocation and acceptance.

Committee members asked whether the Committee's role would be to understand, address, or "fix" the problems. Some members felt that the Committee's role is to study the issue and to direct specific questions/issues to the appropriate committees. Dr. Orłowski and Committee staff will create a statement outlining proposed goals and methods.

4. Review of Policy 3, Appendix B (Indications for Liver Transplantation in Children). Simon Horslen, M.D., reviewed this policy as part of the existing policy review process. This appendix was originally intended to outline the minimum listing criteria for a pediatric patient to be listed as a Status 3. The language in Policy 3.6 (Allocation of Livers) referencing the appendix was removed when MELD/PELD was implemented in 2002. Dr. Horslen felt that Appendix 3B is inaccurate and obsolete. By unanimous vote, the Committee recommended to delete the appendix. This recommendation will be sent to the Liver and Intestinal Organ and Pediatric Transplantation Committees.

Policy Oversight Committee		Meeting Date: 7/24/2007
NAME	POSITION	
Janis Orłowski, M.D.	Chair	X
Ray Gabel	At Large	X
Simon Horslen, M.D.	At Large	X
Maryl Johnson, M.D.	At Large	X
Dixon Kaufman, M.D., Ph.D.	At Large	X
Mary Kelleher, B.S., M.S.	At Large	X
Felicia LeClere, Ph.D.	At Large	X
Jeffrey Orłowski, M.S., C.P.T.C.	At Large	X
Richard Pierson, III, M.D.	At Large	X
Henry Randall, M.D.	At Large	
Cedric Sheffield, M.D.	At Large	X
Judy Jones Tisdale, Ph.D.	At Large	X
W. Kenneth Washburn, M.D.	At Large	X
James Wynn, M.D.	At Large	X
Monica Lin, Ph.D.	Ex Officio, non Voting	By telephone
Christopher McLaughlin	Ex Officio, non Voting	X
Friedrich Port, M.D.	Ex Officio, non Voting	
Robert Wolfe, Ph.D.	Ex Officio, non Voting	X
Robert Merion, M.D.	SRTR Liaison	X
Guests		
David Hull, M.D.	Acting Chair, Organ Availability Committee	By telephone
UNOS Staff		
Ann Harper	Policy Analyst/Committee Liaison	X
Erick Edwards Ph.D.	Assistant Director, Research	X
Mary D. Ellison, Ph.D., M.S.H.A	Assistant Executive Director, Federal Affairs	X
Karl J. McCleary, Ph.D., MPH	Director, Policy, Membership, and Regional Administration, Committee Liaison	X
Lori Gore	Liaison, Histocompatibility Committee	By telephone
Kim Johnson, MS	Liaison, Organ Availability Committee	By telephone
Joyce Hagar, MPH	Liaison, Operations Committee	By Telephone