

**Interim Report of the Minority Affairs Committee Meeting
March 13, 2012
Chicago O’Hare Hilton 10-4 EST**

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

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

The Minority Affairs Committee was updated on the development of a new proposed kidney allocation system (KAS) by Ciara Samana, MS, Liaison to the Kidney Committee. 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 A₂ and A₂B kidneys into B candidate’s allocation protocol.

Since the government has determined that age may only be used in an allocation formula if it is intended as a surrogate for a patient’s medical condition (not prioritized using age as the sole factor), the working model of the KAS system proposed by the Kidney Committee awards the top 20% KDPI kidneys to the top 20 of kidneys allocated to patients with the highest estimated post transplant survival (EPTS). There is also 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 these kidneys.

For these patients, allocation is proposed to be based upon waiting time using broader (regional) sharing for the most highly sensitized candidates. For OPO’s 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 to help reduce waiting time discrepancies due to geography.

The limitations of the current system as compared to the proposed KAS allocation concepts were outlined for the committee:

Stated Limitation of the Current System	Applicable Concepts
Mismatch between potential survival of the kidney and the recipient	Longevity matching
Variability in access to transplantation by blood group and geographic location	A ₂ /A ₂ B, 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 also presented with the highlights of 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 proposal to date. Currently, the Kidney 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.

Ms. Samana also updated the committee on the status of the variance review process being conducted 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 A₂/A₂B 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.

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

April 6, 2012	Policy Oversight Committee Review of 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

2. Kidney Paired Donation Pilot Program (KPDPP)

The committee was provided with an update on the background and current status of the Kidney Paired Donation Pilot Program (KPDPP). 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 persons they initially hoped would receive their kidney. The OPTN and UNOS implemented the OPTN KPDPP, which ran its first match in October 2010 and has continued to conduct successful matches under the pilot program to date. It is estimated that if all US transplant centers fully participate in one national KPD program, it could result in an additional 3000 transplants per year.

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 is termed a bridge donor and re-enters the KPD program following a match run to extend the chain. The number of possible transplants that could 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 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 ≥ 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)

3. Discussion/ Update on Committee Project Review Process

The committee was updated with regard to the proposed MAC Committee Projects for 2012-2013. The MAC 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 Thoracic Transplantation*

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

Survey on Referral to Thoracic 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. However, previous data reviewed did not provide strong enough evidence to document minority delays in referral to Thoracic transplantation. Therefore, the first step of the committee would be a review of the evidence to support its hypothesis. The committee discussed potential analyses that could be conducted to obtain the information. 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. If the project is approved by the Executive Committee, the committee will discuss the options proposed for review of evidence.

Eligible Donor Conversion Rates by Region and Ethnicity Eligible Donor Conversion Rates by Region and Ethnicity/Minority Donor Conversion Education Project

At 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.

During its meeting on March 13th, the committee reviewed available data on minority conversion rates presented by Wida Cherikh, PhD, OPTN Research Liaison to the committee

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 data and methodology used in the analysis included eligible death data as reported on the Death Notification Registration (DNR) records. Eligible deceased donors who donated during 2/1/08-11/30/11 were included in the current analysis. An eligible donor is defined as an actual donor that meets the eligible death criteria. The conversion rate is defined as the percentage of eligible deaths that became 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 in 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 committee has submitted a request to continue to review data to develop an educational initiative to provide information on minority donor conversion rates to OPO's. A possible goal of the initiative would be to discern minority donor potential in a given area to gauge progress with conversions and help donation education professions improve rates of donation in minority communities. It was mentioned during the discussion that the lower donor conversion rate among Blacks may have been contributed to their declining health. For the next committee 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 such as information that may have been produced by the Regional Collaborative, the Center for Transplant Excellence, and other related works.

If the project is approved by the Executive Committee, the committee will continue its review of the data to explore options for an educational initiative.

4. Educational Guidelines on Appropriate Patient Referral to Kidney Transplantation

Data reviewed by the committee since its existence has 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 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 debunk myths about transplant
- Present common barriers to transplant

The revised draft document was approved by the subcommittee during its meeting in February and was approved by the full committee at the March meeting. Following the rewriting of one section of the document, the committee will convene expanded subcommittee to include review by Kidney, Patient Affairs, Living Donor and Transplant Administrators Committee as well as professional transplant partners (NKF, AST, ASTS, KDOQUI, AMAT, NSTSW, etc.)

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

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.

6. Review and Discussion of Public Comment Proposals for Distribution March 16, 2012

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.

Current policy does not clearly state whether prior living organ donors should get priority with each and every kidney registration or just one registration. Data reviewed by the Kidney committee show that 280 prior living donors were listed for a kidney transplant since 1996 and 33 prior living donors have been listed for more than one kidney transplant. The policy proposal now clearly states that the local priority and 4 points for prior living donors applies with each and every kidney registration.

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 RuthAnn Hanto, KPD Program Manager.

This proposal converts the existing OPTN Kidney Paired Donation (KPD) Pilot Program rules, housed in the OPTN KPD Pilot Program Operational Guidelines, into OPTN policy. The full range of adverse actions will be available to the MPSC for violations of KPD policy, up to and including designation of member not in good standing. The policy also includes additional elements of potential donor informed consent that are specific to KPD and requirements for how the OPTN contractor will conduct matching in the OPTN KPD Program. The proposed changes would consolidate all rules for the OPTN KPD Program into a single location and allow the MPSC to follow its standard processes for potential violations of KPD policy.

The committee was provided with an overview of the OPTN KPD proposal including 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.

Following brief discussion, 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 RuthAnn Hanto, KPD Program Manager.

The goal of this proposal is to increase matching opportunities in the OPTN KPD Program by allowing bridge donors (a donor who does not have a match identified during the same match run

as his paired candidate) in the OPTN KPD Program. Currently, the OPTN KPD Pilot Program requires that donor chains end with a donation to a candidate on the deceased donor waiting list. As a result, donor chains could end when there may be the potential to extend the chain and transplant more candidates. Additionally, many transplant hospitals have expressed a desire for the OPTN KPD Program to include bridge donors. A secondary goal of this proposal is to increase participation in the OPTN KPD Program by providing more options for participating transplant hospitals. The proposed changes would allow potential donors who are not matched in the same match run as their paired candidates to enter a later match run to find a KPD match rather than donating to the deceased donor waiting list.

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.

This proposal would allow transplant programs to voluntarily place well-compensated candidates with stable or well-treated HCC in inactive status ("HCC Hold", where no livers will be offered) without losing accumulated exception points. These candidates may then be reactivated at the discretion of the transplant center if the tumor shows growth or other concerning features. Candidates listed with an HCC exception continue to receive additional points every three months regardless of whether the HCC tumors have changed in size or have responded to ablative therapy. In some cases, a transplant center may wish to put a candidate with an HCC exception 'on hold' (in inactive status) at a particular MELD score until the tumor(s) show growth or change if the tumor is stable or if there has been a successful response to therapy. Currently, the UNetSM application does not allow this without loss of exception points. If an exception expires while a candidate is inactive,

the application must be resubmitted as an initial application with loss of accumulated points, or the case must go to the Regional Review Board (RRB) for prospective review.

The proposed change would facilitate more appropriate timing of liver transplantation for candidates with HCC based on the size and number of their tumors, as well as encourage alternative therapies for HCC besides transplantation.

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.

The proposed revisions to the LAS system include modifications to the covariates in the waiting list and post-transplant survival models, coefficients of the covariates, and baseline waiting list and post-transplant survival rates used in the LAS calculation. The Thoracic Organ Transplantation Committee intended for the LAS system to be dynamic so that it addresses disease severity and post-transplant survival for a given current candidate population. Except for the addition of partial pressure of carbon dioxide (PCO₂) as a covariate to the LAS system's waiting list model, a thorough revision of the LAS system has not occurred since its implementation in 2005.

The LAS system prioritizes candidates who are at least 12 years of age for allocation of deceased donor lung offers. The revisions to the LAS system will enable prioritization of candidates using data derived from a candidate population transplanted due to their LASs, instead of their waiting time.

Following a question from a member, the committee briefly discussed potential disadvantages to patients under the new LAS system. 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 differences 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)*

Current OPTN/UNOS policy requires specific infectious disease testing for all deceased organ donors. It also requires that any unexpected potential or proven disease transmission, including infections and malignancies, discovered after donation be reported to the OPTN Contractor. The types of events reported to date include small renal cell carcinomas (RCC) found in the living donor during recovery and malignancies and viral infections identified in the recipient or the donor after donation. This policy change is being proposed to help improve the reporting of disease transmissions involving living donors.

The committee declined a formal vote on the proposal.

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.

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

The committee was provided with a presentation by Dorry Segev, MD on the article by L. M. Kucirka, et.al, *Disparities in Provision of Transplant Information Affect Access to Kidney Transplantation*. The committee viewed a presentation (in AJT October 2011, Kucirka et. al) by Dorry Segev, MD showing disparities in provision of transplant information. The data show that many patients uninformed of kidney transplant options at the time of 2728 filing. The most common reason reported was patient not assessed at time of filing. Patients are less likely to be informed and assessed for transplant if they are at a “for profit” dialysis center, if they are older age and female, have African American ethnicity, are obese and have public insurance. Patients currently under the care of a nephrologist and with private insurance are more likely to be informed and assessed for transplant.

The committee was also provided 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).

The study suggests that:

- Many disparities exist in providing information about transplantation to patients on dialysis (insurance, but – interestingly – not race)
- At for-profit centers, patients are more likely to be uninformed early about transplantation because their provider reports that they were not yet assessed
- 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

8. Evaluation of Calculated PRA (CPRA) Policy for Allocation of Deceased Donor Kidneys: Transplant Rates by Ethnicity and Sensitization Level Of adult kidney registrations as of 2/10/2012:

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 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 MAC 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. During the March 13th meeting, the committee was provided with updated waiting list numbers and transplant rates by candidate ethnicity and sensitization level by Wida Cherikh, Ph.D.

The committee was provided with brief background regarding the use of CPRA as compared to PRA as well as datasets and methodologies used to conduct the analysis. 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 presentation was followed by committee discussion. A member of the committee inquired about the use of desensitization protocols in the analysis. Though this data is not captured in the analysis, the results presented probably would not change the results due to the small numbers of patients involved. The committee also discussed the tendency of African Americans to be sensitized more often as a group and potential causes to address the issue as a possible committee project. The committee has not attempted to address this issue as a group in the past, though specific reasons for minority sensitization have been discussed. Another member of the committee inquired about viewing the data by gender to show if women are more sensitized due to pregnancies, etc. and whether or not the CPRA policy would impact access for these patients. The committee also discussed viewing CPRA information for heart transplant candidates as many heart patients become sensitized following the implant of a VAD. It was also noted that the Thoracic Committee at one time considered the addition of CPRA for addition to the heart waiting list. The committee was reminded that any foray into development of new initiatives would need to be submitted as a new project. 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.

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

Committee Members	Position	In Attendance
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
UNOS Staff		
Deanna L. Parker, MPA	Committee Liaison/Policy Analyst	Yes
Wida Cherikh, PhD	Sr. Research Biostatistician	Yes
Guests/Visitors		
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)
MMRF Staff		
Tabitha Leighton	SRTR	(Phone)