

Interim Report of the
OPTN/UNOS Policy Oversight Committee Meeting

July 15, 2008

Chicago, IL

1. Committee Orientations. The Committee received several orientations during the July 2008 meeting:

- Orientation to OPTN Committees and the POC;
- An introduction to the OPTN and UNOS, and the OPTN Regulatory Framework;
- OPTN/UNOS Policy Development Framework and Process: Strengthening Evidence-Based Health Policy Capabilities to Improve Transplantation;
- Policy Implementation Technology Considerations;
- Progress Toward Reaching the HHS Donor-Related Program Goals; and
- An Introduction to the SRTR.

Committee members asked how the Program Goals were developed, and whether there is a process for input. Christopher McLaughlin, Chief of the Operations and Analysis Branch for the Division of Transplantation OPTN, agreed to provide a description of how the goals are developed at the next committee meeting.

2. Annual Goals. Edward Garrity, M.D., Committee Chair, reviewed the Committee Goals for 2008-2009, which have been aligned with the OPTN's Long-range Strategic Goals and Priorities. The goals for the Committee are as follows:

- Review policies related to donor organ supply and make recommendations for needed policy development by other OPTN Committees (Relevant Goal: Maximum Capacity).
- Address geographic variation in organ supply and transplantation that may be influenced by organ allocation policy (Relevant Goals: Maximum Capacity, Equitable Access).
- Review policies related to living donation/paired kidney donation and make recommendations for needed policy development by other OPTN Committees (Relevant Goals: Maximum Capacity, Patient Safety).

3. Proposed New Policy Review Process. Dr. Garrity reviewed the Committee's charge with regard to policy review, which is to review existing and proposed policies to determine:

- If the OPTN policy goals are objective and measurable;
- That the goals further the mission, strategic plan and long term goals of the OPTN and HHS Organ Transplantation performance goals; and
- That the goals are scientifically based.

The Committee reviews policies that are either in circulation for public comment or in development. A revised scorecard was proposed to facilitate the review, which integrates the OPTN's Strategic Goals with the POC's policy review charge. Policies would receive a score ranging from -3 to +3 for each category listed (with 0 indicating no impact), and a total score will be tabulated. The scorecard can be modified as the Committee deems appropriate. Mr. McLaughlin asked that the scorecard categories be supplemented with more specific details to enable the reviewers to assign a more meaningful score.

There were several new Committee members in attendance at the July 2008 meeting who were not familiar with the review process. Therefore, the entire Committee reviewed the proposals currently out for public comment during the meeting. Members will be asked to score the proposals after the meeting and report back in September. In future review cycles, two reviewers will be assigned to each proposal: a primary reviewer that is not a member of the sponsoring committee, and a secondary reviewer that may or may not be on the sponsoring committee.

4. Review of Proposals Circulated for Public Comment, June 2008. The Committee reviewed five proposals that had been circulated for public comment, and provided initial feedback.
 - A. Proposal to add the factor "change in bilirubin" to the lung allocation score (LAS). Mark Barr, M.D., Vice-chair of the Thoracic Organ Transplantation Committee, described this proposal for the Committee. The LAS is used to prioritize candidates who are 12 years of age or older on the lung transplant waiting list. The implementation of the LAS three years ago was a dramatic change from the former allocation method, which used time on the waiting list independent of disease process or severity. The LAS is based on medical urgency and transplant benefit. The Thoracic Committee has been monitoring the impact of the LAS on the four diagnostic groups (Groups A, B, C, and D) as outlined in the lung allocation policy. While the death rate in the overall population has declined since the implementation of the LAS, the death rate for candidates in diagnosis Group B (primarily candidates with pulmonary hypertension) appears to have increased slightly.

Several analyses revealed an association between high bilirubin levels and waitlist mortality. This association was statistically significant only for candidates in diagnosis Group B. Further analyses showed that an increase in a lung transplant candidate's bilirubin level that is 50% or higher than the value at listing, observed in a 6 month period, increases the candidate's waitlist mortality. This proposal would add the change in bilirubin to the lung allocation score (LAS), with the intent to reduce deaths on the waiting list for candidates in diagnosis Group B. The current and change in bilirubin were not significant predictors of post-transplant mortality. The presentation outlined the statistical evidence used to support the proposal, as well as supporting literature and clinical observations. The proposal will require additional data to be collected on the lung waiting list, and programming changes to UNetSM.

Dr. Barr felt that this change will not adversely affect other diagnostic groups and may better predict the risk for patients that have been disadvantaged. The policy change would likely have a neutral effect on many of the scorecard categories.

The Committee discussed how this will be communicated to the public and potentially affected parties. Members of the Pulmonary Hypertension Association (PHA) (who would be affected by this change), made a presentation to the Thoracic Committee during the development of the proposal. UNOS staff will communicate with the PHA when the policy is approved. There is

already a brochure that describes the LAS, which professionals distribute to their patients. This brochure will be updated with the change to the LAS if the policy is approved.

- B. Proposal to verify that foreign agencies importing organs to the United States, or receiving organs exported from the United States, are legitimate and test organs for transplant safety. The Ad Hoc International Relations Committee (AHIRC) is proposing this change to policies 6.4.2 (Developmental Protocols in Organ Exchange) and 6.4.3 (Ad Hoc Organ Exchange). Vipra Ghimire, policy analyst for the AHIRC, reviewed the proposal for the Committee.

One of the annual goals for the AHIRC was to clarify policy language related to organ exchanges. The proposed modifications are intended to clarify and strengthen the existing policy language for importing and exporting deceased donor organs to and from the United States. Policy 6.4 (Exportation and Importation of Organs – Developmental Status) allows OPTN members to develop formal or ad hoc organ exchange agreements with foreign organizations. However, some of these foreign organizations may not have the same laws or organ procurement standards as the US. The AHIRC believes that it is necessary to verify the legitimacy of foreign organizations, as there are no organizations that credential organ procurement and transplantation organizations at an international level. In summary, the proposed changes address the following:

- Clinical (laboratory) safety of imported organs;
- Application of ethical practices in recovering deceased donor organs imported for transplant;
- Application of ethical practices in distributing organs exported from the US; and,
- Legitimacy of the foreign organization engaged in importing an organ to an OPTN member or receiving an organ exported from an OPTN member.

The proposal would require that members who enter into formal exchange agreements with a foreign transplant center or OPO must develop protocols to address laboratory testing and safety of organs, legitimacy of the foreign participants, and ethical procurement and transplantation practices of the foreign participants. Ms. Ghimire noted that the AHIRC has already reviewed protocols between the Miami OPO and the Bahamas and between the New England Organ Bank and Bermuda. Committee members asked if the Miami OPO and the New England Organ Bank are the only OPOs that are impacted by this policy, and whether the OPOs in Canada or Mexico are handled differently from the Bahamas and Bermuda.

The policy stipulates that if a center participates in fewer than 6 exchanges with a foreign entity per year, these are considered “ad hoc organ exchanges” and do not require formal agreements. Above this number of exchanges, the center must have a formal protocol. Committee members asked whether this means 6 times in total or 6 times per foreign entity. For example, if an OPO in the U.S. sends two organs to Canada, two to the Bahamas, and three to Bermuda, would a protocol be required for all of these entities, or just one? The Committee asked that the AHIRC clarify this policy. Committee members made several other comments:

- While the member is asked to obtain documentation, there is no requirement that the documentation be verified.
- Standards held by organizations in other countries may not be as stringent as those in the U.S., so that being recognized by their own government may not be an assurance of safety.

- The AHIRC should consider including isolated pancreatic islets shipped overseas to recipients and other cellular transplants in the policy.

As part of its evidence review, the AHIRC reviewed media reports about transplant tourism, as well as reports from the World Health Organization, and held a discussion with an expert on global transplant tourism. Most of these reports involve living donation. The AHIRC did not find much evidence available on which to base the policy changes.

Because so many questions were raised during the review, the Committee did not feel that this proposal is ready for Board submission at this time, but will consider the public comments and feedback from the AHIRC prior to making a recommendation.

- C. Proposal to improve the safety of living donation by restricting the acceptance and transplant of living donor organs to OPTN member institutions. Lee Bolton, liaison to the Living Donor Committee, reviewed a proposal that would require that living donor organs must be recovered only from OPTN member institutions. He summarized the June 16, 2006, notice in the Federal Register, which emphasized that living donor guidelines and policies developed by the OPTN should “promote the safety and efficacy of living donor transplantation for the donor and recipient.” Non-OPTN/UNOS facilities are not subject to the membership criteria required of OPTN member transplant programs that perform living donor transplants. Therefore, living donors recovered at non-OPTN members facilities may not be guaranteed the same protections provided at OPTN member institutions. The intent of the proposal is to offer the best possible protection to living donors. If a living donor experienced complications or died after donating their organ at a non-OPTN member institution, UNOS would not be able to investigate the circumstances contributing to this adverse donor outcome.

A review of OPTN Living Donor Registration (LDR) forms revealed that 22 living donors donated their organ at a non-OPTN member hospital during the preceding five years. The Living Donor Committee discussed the possibility that donors may want to donate at a non-OPTN member hospital, but ultimately decided that the proposed requirement was necessary to offer the best possible protection to living donors.

Policy Oversight Committee members inquired whether UNOS had explored the reasons why the donors were procured at non-OPTN institutions in these 22 cases. It was reported that only 3 or 4 centers that performed the majority of these cases. However, during their discussions, the Living Donor Committee members expressed the opinion that this practice should not occur, regardless of the reason. One member asked for the percentage of these cases that involve donation to a pediatric recipient, theorizing that this could be a result of pediatric centers that are unable to recover adult donors.

Committee members discussed the possibility of a new membership category for institutions wanting only to perform living donor organ recoveries, as proposed by the Living Donor Committee in the public comment proposal. This would also enable the OPTN to modify its policies to require that the recovery center must be responsible for the donor follow-up. Members asked whether a parallel activity is planned with the Membership and Professional Standards Committee (MPSC), in order to facilitate this aspect of the proposal. The Living Donor Committee plans to review the public comment to determine if there is support for a new membership category prior to taking further steps. While several members felt that such a process must not pose an undue burden on centers, noting that a streamlined application

process would be helpful, other members expressed concerns about making this process too easy for any hospital to become a donor center without some oversight.

In general, Committee members felt that UNOS should have oversight over the living donation process so that any adverse outcomes can be investigated thoroughly. The small numbers of centers receiving organs from non-OPTN members suggest that any unintended consequences of the proposed requirement (e.g., disadvantages to recipients, adverse impact on donation) should also be small. The Committee accepted the proposal in principle, and a final recommendation will be made in September.

- D. Proposal to modify the bylaws pertaining to conditional approval status for liver transplant programs that perform living donor transplants. Sally Aungier, liaison to the MPSC, provided an overview of this proposal. She explained that the bylaws currently include the option of conditional approval for programs that do not have a second living donor liver surgeon who fully meets the criteria as specified in the Bylaws. However, the bylaws do not clearly delineate the path forward for programs that reach the end of the two-year conditional approval period and still do not meet the requirements for full approval. The proposed language will provide clear direction by stating the options available to a program when it reaches the end of its conditional approval term. Under the proposed change to the bylaw, the transplant center must inactivate or stop performing living donor liver transplants when transplant program personnel do not fully satisfy the criteria for full program approval by the end of the conditional approval period. This change was approved by the Board in June 2008, concurrent with public comment. This preliminary approval allowed the OPTN to give more specific direction to 5 programs that fell into this category. The Committee had no comments about this proposal.
- E. Proposal to change the OPTN/UNOS Bylaws to better define functional inactivity, voluntary inactive membership transplant program status, relinquishment of designated transplant program status, and termination of designated transplant program status. Jacqueline O’Keefe, liaison to the MPSC, summarized this proposal, which clarifies the definition of “functional inactivity” to include waiting list inactivation in UNetSM. The proposed language also defines short and long-term voluntary inactivation and specifies responsibilities for Member institutions that choose to inactivate a transplant program, including patient notification requirements.

Currently, the bylaws define functional inactivity based on a lack of transplant activity, but do not specifically address waiting list inactivation. The MPSC reviewed data for several programs with inactive wait lists for greater than 14 days, with some inactive for more than 100 days. The MPSC was concerned that candidates were not notified of periods greater than 14 days during which the waiting list was set to “inactive” and therefore no organ offers would be made on their behalf. Under this proposal, candidates must be notified of these periods of wait list inactivation. The proposal also clarifies responsibilities for transplant programs that voluntarily inactivate and removes duplicative language from Attachment I of Appendix B. If the proposal is adopted, the MPSC will include waiting list inactivation as part of its functional inactivity review process. Programs that inactivate a wait list for greater than 14 consecutive days or 28 cumulative days in a year will be identified for MPSC Data Subcommittee review.

Committee members asked why the threshold of 14 days was selected, and were informed that this time period is already used by the bylaws. The Committee had no further comments.

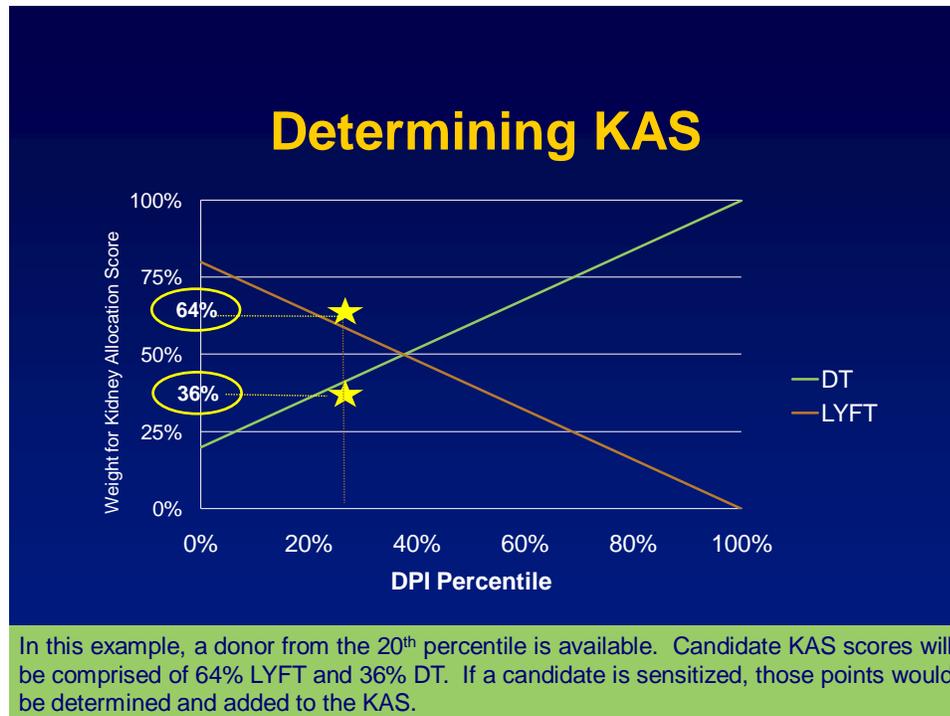
4. Update on Revisions to the Kidney Allocation System. Kenneth Andreoni, Vice-chair of the Kidney Transplantation Committee, provided an update on the status of the proposal. The OPTN is awaiting a final decision by Office of Civil Rights on the use of age in the Life Years Following Transplant (LYFT) score calculation. Dr. Andreoni outlined the major components of the proposal, which include:

- Ranking candidates based upon objective medical criteria (LYFT);
- Replacing standard- and extended criteria donor designations with donor profile index (DPI);
- Changing from time since listing to time on dialysis (DT); and
- These 3 components are combined into a Kidney Allocation Score (KAS).

Other items under consideration include: maintaining priority for pediatric candidates and prior living donors; including a sliding scale priority for sensitized candidates; eliminating absolute priority for O-ABDR mismatch to unsensitized candidates' eliminating the kidney payback system; changes to simultaneous kidney-pancreas allocation; and incorporation of the A₂/A₂B system into the national system. Dr Andreoni described several limitations to the current system and the objectives of the proposed system.

The KAS is based on LYFT, DT, DPI, and candidate sensitization level, and is calculated for each candidate when a donor becomes available. The factors included in each calculation were described for the Committee. The interactions between LYFT, DPI, and DT in determining the KAS are depicted in Figure 1.

Figure 1



Dr. Andreoni also presented the impacts of the KAS on patients by race, blood type, diagnosis, sensitization level, and age, as modeled using LSAM. He also presented a spreadsheet created by

the SRTR that will allow individuals to calculate the LYFT, DPI and KAS based upon various patient and donor characteristics. The spreadsheet will also provide an estimate of how long a patient might wait in a given OPO for organs of varying quality. A Committee member noted that patients might also want to know how long they might expect to live post-transplant for a given DPI.

One potential consequence of providing this information is that it may make “DSA-shopping” easier for candidates looking to shorten their waiting times. However, patients can list at multiple centers now, using existing data on USTransplant.org for guidance about waiting times and survival. A member asked about transition plans for currently waiting patients. Dr. Andreoni noted that, upon implementation, waiting time will continue to dominate LYFT scores in many DSAs because of the weight given to time on dialysis in the KAS.

5. Update on the Kidney Paired Donation (KPD) Proposal. Dr. Andreoni provided an update on the status of the KPD proposal. He noted that during the March 12, 2008 meeting, the Kidney Committee voted to send the proposal that had been circulated for public comment in 2006 to the Board, with the following revisions:
 - Include three-way matching as well as two-way matching; and
 - Allow donor and candidate preferences (travel, age, etc) to go into effect at the beginning of the program.

The proposal was approved by the Board in June 2008. It will be conducted as a pilot program and the Kidney Committee will evaluate the program every 6 months for the first three years of the pilot program and recommend appropriate adjustments to the system.

Dr. Andreoni explained that the Kidney Committee has agreed to take a two-tiered approach to HLA. First, centers will be asked to list all unacceptable antigens for each candidate, even those with low levels of antibody. If the donor has none of the candidate’s unacceptable antigens, then there is a high likelihood that there will be a negative crossmatch. The center can also list those antigens that have some level of antibody, but that the center feels that they are not truly unacceptable antigens as “undesirable.” The candidate could receive offers for donors with these antigens, knowing that there may be a higher chance of a positive crossmatch. Dr. Andreoni reviewed the point assignments that will be used for HLA match level, prior living donor status, sensitization, age, waiting time, and geographic proximity. Both donors and recipients will be able to specify their choices with regard distance traveled, and recipients will be able to choose the nephrectomy type and donor characteristics. Additional elements (e.g., closed and open altruistic donor chains) will be circulated for public comment separately. The Financial and Education Subcommittees will continue to study the costs and develop educational materials. The Kidney Committee will also assess the need for central oversight of the process after the match results are sent to transplant centers.

6. Proposed changes to Policy 3.2.4 (Match System Access), Policy 3.1 – (Definitions), and Policy 3.9.3 (Organ Allocation to Multiple Organ Transplant Candidates). Betsy Coleburn and Catherine Monstello, liaisons to the MPSC, described this proposal for the Committee. Policy 3.2.4 requires recipients of deceased donor organs to appear on a match run. However, other policies (e.g. 3.5.2) prevent members from complying with this requirement in some allocation scenarios, such as directed donations, compatible transplants intended to prevent organ wastage, and multiple organ allocation to a single recipient. In its review of potential policy violations, the MPSC has identified

the need to provide instruction to members about what to do when a candidate does not appear on the match run. The MPSC intends to do this by modifying three policies as follows:

- Including a definition of directed organ donations in policy (Policy 3.1);
- Creating new requirements for allocating organs to candidates who do not appear on the match run (Policy 3.2.4); and
- Clarifying which match runs a multi-organ candidate must appear on (Policy 3.9.3).

The intent is to extend the same safety screening performed by the match run to candidates who cannot appear on the match run. The MPSC also hopes to promote a consistent understanding of (1) directed organ donations and (2) what “on a match run” means for a recipient of multiple organs from the same donor. This will improve the MPSC’s ability to assess potential policy violations by providing clear instruction to members in the form of policy language.

The MPSC directed staff to draft language to address problem in November 2007. In February 2008, the MPSC reviewed the draft policy language, and asked that the proposed language should:

- Not undermine or create conflict with existing policies;
- Not empower a transplant center to transplant candidates who do not appear on the match run; and
- Include the legitimate reasons a transplant center may transplant a candidate who does not appear on the match run.

In April 2008 the Operations Committee reviewed proposed policy language and suggested that the policy should define the time point when a transplant center must provide written justification to OPTN. The Operations Committee also asked that the definition of directed donation be reworded so that it is stated in positive rather than a negative manner. The Operations Committee further asked that the MPSC explore potential conflicts between State UAGA laws and the Final Rule, and consider what documentation an OPO is expected to maintain in a directed donation situation and to communicate that expectation to the OPOs.

The proposed policy language includes a provision that, “if the transplant center deems it necessary to transplant a candidate who does not appear on a match run for the donor, such as in the event of a directed organ donation or to prevent organ wastage, the transplant center must maintain all related documentation and provide written justification to the OPTN upon request.” The proposal includes a list of items that must be included in the written justification. New proposed Policy 3.1.13 provides a definition of directed donation. Finally, proposed language for Policy 3.9.3 (Organ Allocation to Multiple Organ Transplant Candidates) provides clarity for listing these candidates appropriately.

Committee members discussed the proposed policy modifications, and provided the following comments as feedback:

- Please specify if there is additional documentation other than the routine documentation that the OPO must maintain for a directed donation; and

- Please make it clear, either through policy language or the Evaluation Plan document, how members are expected to submit documentation to the OPTN.

Dixon Kaufman, M.D., Vice-chair of the Pancreas Transplantation Committee noted that the Pancreas Committee is developing a policy that would require centers that reallocate pancreas islets to send documentation directly to the Pancreas Committee. UNOS staff members were asked to ensure that these policies (once developed) are not in conflict with the proposed policy, so that transplant centers know where to send documentation if they reallocate islets.

7. Allocation of Organs from Altruistic Donors. Mr. Bolton explained that this proposal arose from an Annual Goal set for the Living Donor Committee for 2007-2008, which asked the Committee to consider if components of the Ethics Committee white paper on altruistic living donation should become policy. That white paper proposed that *“non-directed organs from living donors be allocated according to the existing algorithm governing the allocation of cadaveric organs within the appropriate sharing unit.”* The Living Donor Committee is recommending that centers complete a “test match run” of their waitlist candidates, and that the organ would be allocated according to that test match run. This would enable UNOS to verify that the organ was allocated to most appropriate waitlist candidate. The Committee provided early feedback in January 2008, with several comments related to the potential impact on live donor exchange chains.

The Living Donor Committee noted that there are no data to support a requirement that the recovery center should also place the altruistic donor organ, and was unsure what the Policy Oversight Committee would recommend in such a situation. The Living Donor Committee was also seeking comment on whether these organs should be offered to the best candidate at the local, regional or national level. The Living Donor Committee noted that studies on the effects of cold ischemia time on kidneys do not support limiting allocation to the recovery center, but that there is a small risk of damage or loss of the organ if transported.

Committee members asked if donors usually prefer to donate to a specific hospital or to the general transplant pool. Individuals at the center paying for the donor work-up may feel that the center should be able to place the organ. Lori Brigham, MBA, Vice-chair of the OPO Committee, explained that among the transplant programs in the Washington, DC area there is an agreement that the organ is a community resource. The donor chooses the recovery center, but the organ is allocated among the transplant centers in that area. Some Committee members asked why the local area was selected, versus regional or national allocation. These donors could also be used to start a chain within a wider area, thereby resulting in multiple transplants and making the most of the donation. The Committee asked that the Living Donor Committee provide the number of altruistic living donors that have donated each year, so that they might better understand the potential impact of this policy. The Committee will provide final comments when it meets in September 2008.

8. Annual Data Review. As part of the data reduction project conducted in 2006, the Board asked that the Committee conduct an annual data review to (1) assess the impact of the reduction in data elements, and (2) to review requests for new data elements. As the data reduction project was not fully implemented until March 2008, the Committee did not conduct an annual review in 2007. Additionally, the Board approved the following resolution in June 2006: “The POC proposes to collect malignancy data for another 2 years, until the SRTR analyses of linkage to other sources have been completed, at which point the issue will be revisited by the POC and Board.”

Ann Harper, Policy Analyst, provided a list of potential new data elements that committees either have requested or may be considering requesting. Additional items may be identified during the organ-specific committees' review of the SRTR center-specific report methodology. Four of the items identified may require modifications to the UNetSM forms, which cannot be modified until the forms are resubmitted to the Office of Management and Budget (OMB) for approval in 2010. Six items would involve changes to the waiting list, which was not part of the original Data Reduction project. Finally, the Pancreas Transplantation Committee may request forms for pancreas islet recipients, as there are no forms for these transplants. Mr. McLaughlin agreed to find out whether new forms could be requested prior to the 2010 OMB cycle. As all of these requests are formalized, the Ad Hoc Data Management Working Group will review the requests and report back to the Committee.

Robert Merion, M.D., presented slides from the Transplant Cancer Match Study, which is a collaborative effort between the Division of Cancer Epidemiology and Genetics within the National Cancer Institute (NCI) and the SRTR, under contract to HRSA. The project links OPTN transplant registry data with multiple cancer registries in order to systematically identify cancers in transplant recipients, candidates and donors.

Dr. Merion explained that there is under-ascertainment of cancers due to reliance on OPTN data, as recipients are most closely followed in first years after transplant but may be less so in later years, when the risk of cancer increases. Further, the cancers are often treated at non-OPTN institutions and the data are not reported back to the OPTN. In order to obtain more complete information, the SRTR has been trying to link OPTN data with data from individual Surveillance Epidemiology and End Results (SEER) sites. Within the SEER coverage areas, there is a high ascertainment of cancer.

An initial study included data from four SEER sites (CA, DE, IA, SE Michigan) covering 40,423 recipients. The SRTR identified 1,296 cancers from the OPTN data, and the SEER data identified an additional 776 cancers. The Transplant Cancer match study will expand this endeavor to all 18 SEERs. The objectives of the study are to quantify cancer risk in transplant recipients and transmission of cancer from donors. The cohort will include transplant recipients between 1987 and 2005 and donors from 1990-2005. The 18 registries represent just under 50% of these recipients. Although the NCI approved the project in June 2006, issues related to protocol review, confidentiality and data security, and lack of a centralized process have slowed the project down.

Dr. Merion noted that the Transplant Cancer Match Study will miss some outcomes due to incomplete reporting to cancer registries, in particular early-stage post-transplant lymphoproliferative disorder and squamous cell skin cancer. Thus, the Transplant Cancer Match Study is not a substitute for continuing OPTN data collection on malignant outcomes. The SRTR would recommend that the OPTN continue to collect malignancy data.

9. Geography Study. In 2007, the Committee recommended to the Board that the OPTN conduct a study of geography. The Board approved this recommendation and assigned it to the Committee. The Committee reviewed an inventory of all the projects that the Liver Committee is undertaking related to geography. The Committee received a similar list of projects that the Thoracic Committee has worked on related to geography. The Committee will review these projects and assess whether there are other projects that the Thoracic Committee should undertake.

**Attendance at the July 15, 2008 meeting of the
OPTN/UNOS Policy Oversight Committee
Chicago, IL**

Member	Position	Attended
Edward Garrity Jr., M.D., M.B.A.	Chair	X
Kenneth Andreoni M.D.	At-Large	By Telephone
Mark Barr M.D.	At-large	X
Lori Brigham M.B.A.	At-large	X
David Campbell M.D.	At-large	X
Laura Ellsworth	At-large	
Dixon Kaufman M.D., Ph.D.	At-large	X
Mary Kelleher M.S., C.I.P.	At-large	X
Henry Randall M.D.	At-large	X
W. Kenneth Washburn M.D.	At-large	X
Monica Lin Ph.D.	Ex-Officio	By Telephone
Christopher McLaughlin	Ex-Officio	By Telephone
UNOS Staff in Attendance		
		X
Erick Edwards, Ph.D.	Assistant Director, Research	X
Mary D. Ellison, Ph.D., M.S.H.A.	Assistant Executive Director, Federal Affairs	X
Ann Harper	Policy Analyst/Liaison	X
Karl J. McCleary, Ph.D., M.P.H.	Director, Policy, membership, and Regional Administration	X
Sally Aungier	Liaison, MPSC	By Telephone
Lee Bolton	Liaison, Living Donor Committee	By Telephone
Betsy Coleburn	Liaison, MPSC	By Telephone
Alex Garza	Liaison, MPSC	By Telephone
Vipra Ghimire	Liaison, Thoracic Committee	By Telephone
Catherine Monstello	Liaison, MPSC	By Telephone
Elizabeth Sleeman	Liaison, Pancreas Committee	By Telephone
SRTR Staff in Attendance		
Robert Merion, M.D.	SRTR Representative	X