says males, check no, and females, and I don't understand the reason. The "no" doesn't fit with the question.

If I were reading this, and it was in capital letters, where it said female donors or male donors, it would be clear to me that is not for me to answer if it said female donors, but then when I read on, it says, "Males, check no," it just doesn't make sense.

DR. FRIDEY: This falls into the category of the quality assurance questions or tools, if you will, that we wanted to embed into the questionnaire. Now, granted, it is not perfect, it doesn't make exactly perfect sense to tell males to say check no to a question that applies to females, we recognize that, but we have those little parenthetical phrases in there as one means of trying to determine whether or not the donor really is paying attention and is following instructions.

So, while I understand your concern, when we had that concern also with that, what overrode that was the fact that we felt we needed to have something in there to make sure that the donors were paying attention when they were going through the questionnaire, and following directions.

It is also part of the auditing function, as well, when blood centers review the questionnaires afterwards, and that part of the questionnaire was also evaluated in the NCHS cognitive evaluations, and did not seem to pose a significant problem.

DR. HOLLINGER: The other question has to do under the section says, "Have you ever." I know you used this once before when you have added the word "even once." I felt that at least in 36, even though you say, "Have you ever," to me it would be better if that sentence said, "Have you ever used needles even once to take drugs, steroids, or anything."

It is one of those added words there that I think is important for people who take injection drugs, it just doesn't seem to come across often even once--that if they had just done it once, you know, it is okay. So, oh, yeah, I only did it once. That is often the answers I get back, and I would like to see at least that be put in there somewhere on that question or at least considered.

DR. NELSON: Do people share needles when they use steroids?

DR. ALLEN: High school students certainly

can, and I assume college.

DR. FRIDEY: The reason we took "even once" out of that, and several other questions, is that the focus groups that were conducted or in the focus groups, the participants indicated that this was really redundant and unnecessary.

If we put it into one question, like we did put it back into Question--for males who have had sex with other males, we have it in there--it's Question No. 34. It was in a number of other questions, and looking at all the questions that had that in there, the input from the focus groups was this really did add some excessive verbiage, and we felt that the question in itself was clear enough that it justified removing the "even once."

DR. NELSON: I am not sure I agree. I think I agree with Blaine because when we find donors who test positive for hepatitis C, they have injected drugs maybe once or a few times, often years ago, and they have a chronic infection, and this question, they would not answer it the way it is, and I am not sure your focus group has specific expertise to tease out this question. I think Blaine probably agrees.

DR. HOLLINGER: I agree. This a very

important question, the needle question, as well as the other question that you had where you put it in, and maybe even once. I mean those are important questions. At least I would like that to be considered as a possibility--

DR. FRIDEY: And it will be.

DR. HOLLINGER: --for other comments, and see what you think about that.

DR. FRIDEY: Okay. It will be.

DR. HOLLINGER: The other thing is the issue about have you had hepatitis, and you have probably resolved this, but at one point we took it out. I think we said if you had hepatitis before the age of 11, that that wouldn't be considered as an exclusion, but then I noticed that that is not in here about have you had hepatitis after the age of 11. Did you feel that that created more of a problem than not?

DR. FRIDEY: It is essentially we are using it as a capture question. If they say yes, I have had it, then, we would ask how old were you when you had it, and we will try to determine if they had it before the age of 11. If they say yes, then, obviously, they can go on to donate; if they say I have had it after 11, then, they cannot

donate. So that information will be captured in a follow-up format.

DR. HOLLINGER: The final question--I am sure this may be a problem in the blood bank--about had any problems with your heart or lungs. The lungs, I guess could be a real problem. It sounds like a lot of people with asthma and other things, and I take it that is not an exclusion for anybody there, but that seems like that creates a real problem on the question about lungs.

DR. FRIDEY: We talked about actually including specific pulmonary conditions on that, such as asthma, but felt that we ran the risk of donors focusing on that to the exclusion of other conditions that they may have.

So, this was one question that was extensively discussed by the Task Force and in the cognitive evaluations where we felt we should ask a very broad question.

DR. HOLLINGER: What was the question there, Joy, that was because of tuberculosis before, or what was the real reason that question has been asked?

DR. FRIDEY: It was in the CFR, acute pulmonary disease, and that originated in the CFR

many, many years ago when TB was a concern.

DR. HOLLINGER: So, if you took that out, one could ask the question of have you had TB, or if you don't ask that, is there any other lung condition that creates a problem, then, in terms of blood donation either for the safety of the donor or--

DR. FRIDEY: There are a number, but in infectious conditions, such as pneumonia, for example, or a cold, we feel that we capture that by three questions. We ask donors if they are feeling healthy and well today. We ask if they are on an antibiotic or if they are taking any other medication for an infection. So, that is how we try to get at that.

DR. HOLLINGER: I guess the final question that I have, you took the question out about intranasal cocaine?

DR. FRIDEY: That was never an FDA required question. There was an article published after the original one that raised concerns that essentially refuted the concept that that was an independent risk factor for HCV infection.

DR. HOLLINGER: But you ask you about kissing and saliva for hepatitis B. On the one

hand, I mean the CDC and others talk about, well, you don't have to worry about that kind of casual contact being transmissible, and I agree with that in there, and I can agree with the saliva since most of the studies in chimps, at least that they did with chimps, one study in which they took 18 chimps, 13 of them were given it orally. None of them came down--this was an infectious saliva--none of them came down with hepatitis B. Five of them that were given it parenterally all came down with hepatitis B, and that has sort of been--

DR. SIMON: I think they are looking for A there, for acute A, is that what you were looking for primarily on that question?

DR. NELSON: Even with A, and they don't mention stool, have you changed a diaper or have you, you know, whatever.

DR. SIMON: That's the critique that Judy was talking about.

DR. FRIDEY: If I could just make a comment about that, in our subsequent discussions with the FDA about that, the FDA explicitly stated their concern, which was that we did not ask about specific risk factors for hepatitis A.

Now, intuitively, perhaps that is

something that we should do, but this would basically represent a policy change, and it was the Task Force's position, in fact, they are charged from the AABB Board that we basically should not be tackling policy issues, and we felt that the questionnaire perhaps was not the most appropriate vehicle for introducing a policy change.

So, what we did do was ask the FDA if they are concerned specifically about hepatitis A, that should be the usual channels for communicating that and getting public comment, and so forth, should be followed rather than implementing a policy by way of the questionnaire.

DR. NELSON: Was the FDA concerned about the transmission of hepatitis A by saliva, or B?

DR. FRIDEY: No, that was the fecal/oral comment. Hepatitis B was the concern that we were trying to address by having the saliva question.

DR. NELSON: It was B.

DR. SIMON: But there was, Joy, a classic old question about close contact with hepatitis.

DR. FRIDEY: Right, and the concern has been for hepatitis B and C, so that is why we broke that question out to ask if they had kissed someone or come in contact with someone who had Hepatitis

B.

DR. HOLLINGER: Who has hepatitis, I think is the word in here. I guess if I were looking at that, I would consider the risk factors for intranasal cocaine use far exceeds that of the kissing on there, which is a question you have.

DR. FRIDEY: That was a hep-B concern. That was trying to capture hep-B.

DR. HOLLINGER: Those are the major concerns that I have.

DR. STUVER: Joy, I just wanted to follow up on Blaine's comment about the gender-specific questions, because I guess I have doubts as to their quality control value. Is there data that they do provide a quality control?

DR. FRIDEY: To the extent that they were evaluated by the participants in the cognitive interviews, there is information about that. The people who were involved in those interviews understood the purpose of the questions there.

No, there is not. Do we have data to demonstrate there won't be changes in sensitivity or specificity or predictive value, if we implement this version, no, that would require a large, long, expensive study, but given the tools that were

available for assessing donor attentiveness, this was one. Again, this was done with the input and at the suggestion of our survey design specialists.

So, we had to rely on that.

MS. KESSLER: I just want to mention, in addition, that one of the reasons why that was put there, probably of equal weight, was that after a donor has donated one or two times, somebody is auditing that form, and you can't really leave an empty spot.

Usually, there is a pattern of answers that you expect to see, and if you see a blank, then, you are putting it in some clerk's hand or some nurse's hand, or somebody's hand, who is doing a million of these, to look at the question, see whether it was a male or a female, and so we wanted to be able to make the process run smoothly, be able to be consistent with the later audit, which is not part of the donor history discussion between the health historian and the donor, but for the later audit not to be compromised.

So, that was part of it, and it was also being able to perhaps capture somebody who was not paying attention.

DR. STUVER: So, that wouldn't happen

right away, that they would look through it and then they would see that they have a blank, and if they have a blank, then, are all the questions administered orally with the assumption that the person hasn't paid attention? I guess I am just not clear about the quality control aspect of it.

I mean is it just for later use? Do you see my point?

MS. KESSLER: The committee didn't make any recommendation of whether or not the whole questionnaire would be re-administered. That was left to local decision of what their quality control SOPs were in the blood centers where they implement it, but there is separately from the donor historian reading over the answers and making sure everything is cool and the donor should proceed to donation, there is an audit function, which is just kind of a clerical audit, making sure that everything was filled out properly, that this person really is eligible to donate, and the product should be used.

DR. NELSON: One other option would be instead of a "No," to have a Not Applicable answer to those two questions.

DR. HOLLINGER: I think actually, if it

were left blank, to me, if it were left blank, and it was a male, they left the female one blank, that would be a better audit than if they had a no. That would show that at least, if that is the one that they had, and a female, if they left that blank when the question is for the male donors, that would to me be a much stronger audit than if you put a no in there.

DR. FRIDEY: I really appreciate the comments and the concern and that everyone who is involved in this process is asking these kinds of questions. The reason we had two survey design experts on the task force, so that they would lend their expertise, and their input was that this was the best way to try to assess donor attentiveness.

As our resident experts/consultants, we felt that it was appropriate to follow their advice is really what it comes down to.

DR. LEW: I guess what I am kind of hearing, though, maybe it is because it's on my mind, is this whole idea of getting some validation. I think, in general, we have all said, in general, this type of question is a good thing, they have tried to do their best in validating it, but we all know with focus groups, they have lot a

lot of political campaigns with the wrong focus group, and we are a different focus group, and we are coming up with different ideas.

I think before it actually goes out, it need to have some sort of validation with the population you are after, and particularly the target populations, because I can see just with this question, you may not capture necessarily who is not paying attention, you are just capturing people who misunderstand that question.

DR. FRIDEY: The cognitive evaluations were not focus groups. They were a much different and scientifically very well accepted approach to evaluating this information.

Now, in the real world--

DR. LEW: But that is still the population that you gave it to, and it is a limited number of people who--

DR. FRIDEY: One of the slides that I showed when I was talking about the Task Force and its resources had, as a last bullet item, in gold letters, the comment that there was not funding available aside from that provided by the NHLBI. That was an $80,000 interagency funds transfer agreement. There was no other money made

available.

We would have loved to have had much more money to evaluate a larger group and a broader spectrum. The reality was the FDA, other governmental agencies, other entities were not able to provide funding, so basically, we did the best with what we had, and, yes, as Dr. Beatty said, it would have been important and useful to try to capture some of the other groups, and from the comments that Judy Ciaraldi made, but we were very limited in terms of what we could do, so we made the best use of the funds that were available.

DR. LEW: And I appreciate that, and I think you all did a fabulous job, many of you unpaid for all the work that you all did, but it seems to me that such an important questionnaire, you know, maybe someone needs to cough up the money to do the appropriate validation.

DR. FRIDEY: The validation was the cognitive interviews. That was the validation. We were looking for comprehension, we were looking for usability. That was the validation.

DR. CHAMBERLAND: Judy, can you maybe amplify a little bit more, or Sherri, a little bit more when you use the term "validate the

questionnaire," what you are thinking of? What would, in your mind, constitute a more adequate or comprehensive validation?

DR. LEW: Maybe that's not the right word.

DR. CHAMBERLAND: I don't know if Paul Beatty or anybody else wants to make any comments about this.

DR. LEW: It has been mentioned by several people it would be good to have people who actually are going to be the donors, but not just in general the donors, take this questionnaire and see how they feel about it, and if it really helps for them.

But also, in a sense, because you are trying to capture those people who have these risk factors, to me, those are a critical group, to read the questionnaire, and that, in their best ability to answer it, and that you know that they are understanding the questions, and whether they honestly or not, but at least they are given the opportunity and urge to.

When I looked at the different focus groups that actually--there were four, I think, different focus groups, and one of them was elicited from a group of people who went to church,

and then they mentioned some were just others, and I asked myself, well, are these representative of people who actually go to donate at the blood bank.

Again, they only had a limited amount of money and I understand that, a limited amount of time, but I still have that concern that if this major questionnaire that is going to go out to all these people, and we are going to say this is the best, shouldn't we put a little more effort into it.

DR. NELSON: I think a group that could be surveyed, and that is what essentially Dr. Williams is doing today, is people who have had a lot of experience dealing with blood donors, and particularly blood donors who later are found to have risk factors that weren't captured in a questionnaire, and that is why I think the issue of adding the "even once" to the drug use or steroid injection is maybe redundant, and maybe the focus groups didn't like it, but I think it is important.

DR. CHAMBERLAND: Paul, I know you are at the mike, and I guess one other thing I would ask you is, I don't know, this questionnaire may be the most frequently administered questionnaire in America when you consider it, and I was just

wondering if it would help if you could tell us, for example, what kind of pre-administration evaluation is done for a questionnaire that goes to, not certainly the same size, but a very large population.

I am thinking perhaps of the census, although I don't think CDC would be involved in the census.

DR. NELSON: IRS forms.

DR. CHAMBERLAND: But I am thinking of the Health Interview Surveys, and things like that. Would that be helpful if you can tell us--because I think you said in your comments that usually cognitive interview, cognitive testing really does usually involve a small number of interviewees, and it's complementary to focus groups.

I mean there is no one way to do it and make sure you have got it right.

DR. BEATTY: It is different than focus groups in a lot of ways. Focus groups really do put the person that you are talking to in the role of the expert. You are asking them to evaluate something without actually using it the way that a user actually does.

As for the kind of larger issue of whether

this is a validation or not and whether it is typical of what is done in other surveys, it is not a true validation and we know that, and we are pretty upfront about what it is and what it isn't.

It is probably the best that can reasonably be done given the resources that are available a lot of the time. Certainly, studies like the HIS, the Health Interview Survey, are put through multiple types of quality control.

Cognitive interviewing, I think, is probably the best of those layers in terms of figuring out which specific wordings are working and what exactly are the problems, not just what the problems are, but how you can identify what it is about the question that is creating them in the first place.

Generally, it is true that a lot of those questions are not tested as thoroughly as these were. This was a pretty thorough type of evaluation. We don't usually put questionnaires through as much intense scrutiny as this one was through, and then it also--it wasn't just us, I mean we brought recommendations back to the Task Force and discussed them at great length.

I also don't want to create any appearance

of inconsistency among ourselves and the Task Force, but I will just kind of touch on one thing briefly about the males and females Check No box. That wasn't what we actually tested. The version you can see in the questionnaire itself says--it had something slightly different like "males, check here," or something like that. It is actually in the materials that we had.

The recommendation that that could be used as a quality control, we did say that, but it didn't come up exactly as a part of the cognitive testing, because you really can't say whether something worked or not if you didn't actually ask it that way.

We were just thinking that it didn't make sense really the way that it was in there, and what could we do differently. That seemed like one alternative that might have some quality control aspects. I think we have to be a little more agnostic as to whether we think that is really a great way to do it.

I certainly didn't strongly advocate that as a great way to insert some quality control measures. It might work, might not. We didn't really look at it, and there might be better ways

to ask it.

The one comment about whether it would be better to have a box that said, "Males, please check here," is a better way of paying attention. That might very well be. We really didn't spend enough time to tell for sure.

DR. DiMICHELE: Actually, I could ask you, Dr. Beatty, or just certainly I just bring it up to everyone for historical perspective, you know, we do have a tool that has been out there. It is being used over and over again.

DR. BEATTY: No, we don't. We have lots of different tools.

DR. DiMICHELE: Well, in any case, you have lots of different tools, okay, that are out there, but it sounds like you are still going to have lots of different tools because this one isn't going to be mandated either.

But the thing is it seems like it has been working pretty well? Not well, terribly. I guess my point is, is that--anyway, maybe there is no points--but I guess what I am trying to say is that this tool is undergoing more validation than the previous basic tool that everyone has adapted and used, and if it's working reasonably well, what

might end up having to happen is that you might end up having to go with your best, and put it out in the field, and then figure out how you can validate it, because it may not really be validatable until you kind of get it out in the field and really use it and see if it's turning up some very glaring omissions, et cetera.

Just to that point, I just wanted to say that the question then if we are going to do that, or we are going to do that in the blood banking industry, how much of a routine SOP should we be mandating, because otherwise you main not be able to validate it out in the field, because I think that is what is going to end up being most important anyway, and eventually, you have just got to take it and run with it, I guess. That is all I was going to say.

DR. SIMON: I will follow up on that point. There is an old quote that the best is the enemy of the good, and I think that for those of us who have been in the field, I think we recognize what you have just said, these many different instruments do, in fact, work in terms of donor safety, but there are all the other problems that have been brought up about turning donors off, and

that sort of thing.

When you look at what this committee has done and put together, it is so far superior to what we have that I would hate to see anything prevented from going forward. I think putting in our best comments and suggestions and recommendations is appropriate, but I would just like to put in a plug for the process and for the movement.

The one thing I would differ, I think from what Dr. Williams said, my interpretation is when FDA goes out with a guidance with this, any center that chooses to use a different one, would have to prove that theirs has more validation.

So, my belief is that this would be, in fact, out there as the single prevalent blood screening device, and I think it would be a great improvement over the status quo.

DR. STUVER: I would agree with what Toby said. I mean certainly what has gone on to develop this questionnaire, the process is excellent and much better than anything that has happened before.

I think as far as like doing validation studies, I mean I don't really see how you could do a formal kind of validation because there is not

really a gold standard that you could say, well, this is the truth, and does the questionnaire capture the truth.

I don't really see how you could do that unless you had medical record data or some other source that had the truth in it. But I think there are things that you could to get a better sense, like you were saying, of how it is going to actually work in the place in which it would be used.

I mean you could do some kind of pilot testing of the instrument in a blood donation facility and see how people answer it. If they are male, do they leave that female question blank? Then, you would know right off, well, okay, everybody is going to leave it blank or a large portion are going to leave it blank, maybe we should redo something like that.

I think another thing that could be done potentially would be to do repeat questioning with it, so you give it some blood donors and then when they come back a month or several months later, give it to them again and see if they answer in the same way, barring whatever time changes, actual real changes have happened.

So, little things like that, it is not validation per se, but I think it would give you a sense, a more true field sense of how it is going to work.

DR. KLEINMAN: I think people are getting hung up on the term "validation." I think Paul has made that point, and I just want to make it again, might be better off if we talked about evaluations of the questionnaire because I think that is what was done.

I think the intent of the evaluations, the panel should understand the intent of the evaluations, and they were really at not whether this questionnaire gets to the truth, because obviously, for low risk behaviors that happen 1 in 1,000 times, you cannot evaluate that in 35 responses or four focus groups of five people each.

So, the sense of the evaluation was can we get wordings of questions that people appear to understand better than the current wordings that we are using, can we present it in a way, so can we evaluate comprehension, not can we evaluate the accuracy of response.

I appreciate that it would be nice to be able to evaluate the accuracy of response, and I

think in the cognitive studies, there was some, you know, create a scenario and see if you can do that, but it was really more towards comprehension.

The second point I wanted to make was that you can't really pilot this in a blood donor setting because the screening process is part of an FDA license, and so you can't just say I am going to change my process for a month and put in this new questionnaire.

I mean you can't give it in addition to the questionnaire that you use, it wouldn't make sense, and you can't substitute it because you would have to change all your SOPs and get FDA approval that you could use this new thing.

So, you can't really, unless somebody can come up with a creative mechanism, sort of pilot this out for a month and say, gee, I want to make these changes. So, you are really, I think, left with postimplementation evaluations. You put the best thing you can out there and then I think it would be important as this would be used within a month, in a million people, if you had the right network, quickly try to tabulate some information and get some feedback, and do another iteration of this relatively quickly.

So, I think that may have to be the approach.

DR. BIANCO: I don't want to prolong this, but a true evaluation, the objective of a medical history is to prevent collection of blood from people that should not be donating. We ask the questions, we ask "even once," but we find people with hepatitis C. The "even once" didn't help. Finally, we got a group of people that worked day and night, and they found a way to ask better questions.

There are many ways by which we will evaluate the true impact of that, but we are improving comprehension, we are improving the process, and it is the first time in history, and we have been using medical history for over 60 years, that we are being able to do something that is more rational that what is currently done. What is currently done is not good.

DR. HOLLINGER: I appreciate that, but also you don't know how many you picked up because you asked the question "even once." It is true that you might have even missed some when you asked "even once," but you really don't know how many you picked up because you asked "even once."

DR. NELSON: You don't know how many you are going to drop by dropping the "even once."

DR. BIANCO: I understand your point, Ken, but I think that this is a rational way. The medical history is the first step, is the first layer of selection. We know that our prevalence is several fold lower than the prevalence of the general population for any of those infectious disease's marker.

So, we have to say that there are several processes - donor education, the populations that are recruited to donate blood, they are susceptible to recruitment to donate blood, and the medical history made that reduction, and I hope that improving the process will make it even better. We can measure prevalence, and we can measure surveys, as Alan proposed a few minutes ago, so help us.

DR. LEW: Just one last comment because I want to go on the record that I would agree that it sounds like this particular revision is so much better than what we have now, and I agree with that and I would rather have good than best if that is all we can have.

On the other hand, I just feel we have an opportunity now to do some additional looking at

it, that may not be tremendously expensive, just to see if the people can use it who are really going to be the ones will be answering these questions out in the field.

I feel sad that it sounds like we won't be able to do that unless we go with what one of the speakers suggested, just go ahead and just mass use it, and then within a few months, try to gather some data and make some corrections. It seems such a shame to have to do that if you could do a pilot first.

I think the validation work should be left out, because that was the question, but rather than evaluation.

DR. NELSON: I think it could be evaluated after it was implemented, very soon there afterwards and see what happened without a pilot, if you will.

DR. HAMILTON: I would like to point out that there is a lot of informal evaluation of this questionnaire that took place over the two years that it was being developed. People who are on that committee took that questionnaire back to various centers and said please administer this questionnaire to donors and see how it works.

While we didn't administer to 10,000 people, we didn't make this questionnaire in a vacuum. We did take it back. Every iteration went back to the centers informally to centers that we worked with directly, and "What do you think about this, can you give us feedback, is this making sense to people," so it didn't rely just on the cognitive interviews. There was a lot of informal testing going on, so it hasn't taken place outside the context of a blood or a plasma collection facility.

DR. NELSON: Thank you.

DR. ALLEN: I think these are very important comments that have been made. This has been looked at far more carefully than any other donor screening in the past.

I have been a blood donor for 37 years in a variety of settings. This is so much better than anything that has ever been administered to me before. It is much clearer, it is much more precise, it gets the information out in a variety of ways. It is not going to be implemented in a single way in blood centers across the United States.

We do need to have follow-up evaluation

and comparison to see how, you know, what ways seem to work better. It does need to be refined.

I think what concerns me the most is that given all the concern about blood safety over the last 15, 20 years, that there is no budget for this, and I would hope that this committee tomorrow morning would consider a question or a motion to urge the FDA and the CDC and the NIH to really put in a budget item for evaluation monies for this sort of thing, because I think we are going to make a huge step forward, it needs to be implemented rapidly, and then we need to refine it and follow up in the future.

DR. HOLLINGER: I think this is tomorrow morning, isn't it, Jim?

DR. NELSON: Dr. Williams, I hope the detailed discussion of the committee will answer the final question.

DR. WILLIAMS: I think we have the information we need, and I thank you all for your insightful comments. Certainly, if there is funding available, the studies can become more elegant and the process can become further refined.

DR. NELSON: See you tomorrow morning at 8 o'clock.

DR. SMALLWOOD: I just have to make a statement for the record on the question that the committee voted on. There was a unanimous yes vote, but I have to indicate that there were 11 individuals that participated in that voting, and there was a written and signed note from Dr. Harvath that she would have voted yes, which I did not count, but I read it I want it to be known into the record.

Thank you.

[Whereupon, at 7:00 p.m., the proceedings were recessed, to be resumed on June 14, 2002, at 8:00 a.m.]

- - -

CERTIFICATE

I, **ALICE TOIGO,** the Official Court Reporter for Miller Reporting Company, Inc., hereby certify that I recorded the foregoing proceedings; that the proceedings have been reduced to typewriting by me, or under my direction and that the foregoing transcript is a correct and accurate record of the proceedings to the best of my knowledge, ability and belief.

Alice Toigo

ALICE TOIGO