safety, admittedly a very difficult thing to do because of the low incidence of any infectious disease related negative outcomes now in the recipient population, so studies are very difficult to conduct.

With that, I will turn the session over to our informational speakers, and thank you very much.

DR. NELSON: The first speaker will be Dr. Joy Fridey from the AABB, but first Dr. Smallwood has an announcement.

DR. SMALLWOOD: Excuse me. Before our speakers come, in order to preclude any appearance of conflict of interest, I just need to announce that Dr. Joy Fridey is an employee of the Blood Bank of San Bernadino, California, and that Dr. Sharon Orton is an employee of American Red Cross. Thank you.

DR. FRIDEY: Thank you very much. Thank you, Mr. Chairman and BPAC committee members, and all of you who have stayed here and are going to spend the rest of the evening with us. Today we're going to debate what the meaning of "is" is. Actually, we'll avoid that discussion.

Just briefly, I'm going to cover the

current state of affairs with regard to the donor questionnaire, our change plan, the specific proposed changes, and where we are right now. This is very important because what I'm going to present to you tonight and discuss with you basically are very provisional changes.

The final proposal that will go to the FDA will not only include a questionnaire that has been reworded, some questions presumably will have been eliminated, there will be revised educational materials that the donors will be required to read, there will be a user's pamphlet and other written materials. So what you're seeing tonight really will only be one part of the overall package, so context is very important.

Okay, just to give you a very brief historical overview in one slide, the first blood donor record was recommended by the AABB, the American Association of Blood Banks, in 1953. There were 21 medical and infectious disease questions that were asked, and as you can appreciate, over the years more and more items were asked of the donor. This does not include demographic information. This just is information about medical, travel, and infectious disease

risks, and now we are asking donors for somewhere in the vicinity of about 72 specific items.

I'll call your attention to this pink line, which shows you the number of questions, numbered questions, that are actually on the questionnaire, and I'll explain what this is all about in a second. So while the number of items has been increasing, the number of numbered questions has stayed the same, and we'll talk about that in a second.

Well, right now there are 24 questions that address one item. There are 14 questions that are compound questions, and there are 8 questions that have multiple informational items requested of the donors. This is the reason why the number of numbered questions has not increased over time. It's because we have been adding compound or developing compound and multi-item questions to accommodate the increased number of things about which we have to ask donors.

Twenty of the items come from the AABB, 50 from the FDA. These items are basically not up for discussion about elimination, and so we have focused on the AABB items with an eye towards maintaining safety.

Well, this is a wish list that has come from the FDA constituents about the donor history questionnaire, and this is for those of you who may not be familiar with all the issues. First of all, a shorter questionnaire for all donors. Don't know if we're going to get there, but we're hoping that simplification will make it a little more palatable. An abbreviated questionnaire for repeat donors. We have donors that are coming in sometimes twice a month if they are plateletpheresis donors. If they're plasmapheresis donors, going to a commercial endeavor, they may be coming in eight times a month.

Questions that are easier to understand, less intrusive. We don't know that we'll get there, eliminate some of these questions, but certainly easier to understand. Less repetition. By this I mean that after the donors have written, have responded in writing to the questions, the HIV risk questions have to then be asked orally by the staff, the screening staff.

We're hoping, folks are hoping that we can get to a self-administered questionnaire where the oral portion can be eliminated, and what we have also wanted or desired over the years is that the

questions could actually be validated by the proposing agency, and don't know if we'll quite get there in the future. The task force will be trying to address at least parts of this issue.

Just to tell you where we are, in '92 the American Association of Blood Banks, in cooperation with the Blood Centers of California, put together the first uniform donor history card, which was submitted to the FDA for review and approval. In the next six years, a number of different items were added, and this is why we started having all these multiple item and compound questions.

In 1998, the questions were reorganized because things were starting to get a little chaotic, but by the end of '99 people, organizations were asking the FDA for approval of abbreviated versions for repeat donors, and there were enough of these coming in and there were enough problems with the questionnaire, its complexity, its length, and concerns that it might be driving donors away, that the FDA came to the AABB and asked that a multi-agency task force be put together to address some of the problems.

And these are the members or the organizations that are represented: The American

Association of Blood Banks; ABRA, American Blood Resources Association, which is the plasma group; the Red Cross; America's Blood Centers; CDC; the National Center for Health Statistics, which is a part of CDC and will be very key in carrying out some of the comprehension studies that we need; the DOD; the FDA, of course. We have an ethicist; this gentleman is the public member on the AABB Standards Committee. We have a statistician, and two research survey design specialists. We felt that this was very important in order to be able to give credibility to the kinds of changes that we're proposing in the questions.

Now, when the FDA approached the AABB, the following parameters were indicated. First of all, in terms of research, the FDA expressed expectation that perhaps this would be based on focus groups, pilot studies, and existing data, but at that time indicated that major research initiatives of the REDS study dimension were not expected. No research funds were offered, and the proposal is due in 2001. So these are kind of the parameters within which we are working to achieve our goals.

Then in October of 2000 there was a workshop co-hosted by the AABB and the FDA to

discuss the streamlining of the blood donor questionnaire, and there were many recurring themes: the discussion for safety versus availability; the need for an abbreviated version for repeat donors; the need for emphasis on donor education; simplified wording of the questionnaire; and, obviously, realistic validation approaches. And there was some discussion about computer-assisted interviewing. I'm not going to say a whole lot about that tonight, except the task force will be making some kind of recommendation about that in our final proposal.

Our plan overall is to first of all evaluate the questions, reword, combine, separate, when possible eliminate. And then, for those questions that will undergo revision and will be retained, there will be tests for comprehension. We actually are in the middle of this process right now. Then the questionnaire will be reformatted, both the full-length questionnaire for first time or infrequent donors, and then the abbreviated version for repeat donors will be developed.

Okay, so this is where we are right now for this part. We are not here yet to the formatting, and then we'll be assessing these new

formats. Concurrent with this, we are developing revised donor educational materials. We've taken materials submitted by blood centers around the country, and these will be harmonized, and then we'll also be working on a user's brochure to accompany the new card when it is finally approved.

I'm not going to go through all of these, but suffice it to say that we kicked off our charge, we kicked off in June a year ago, just a little over a year ago. We've been doing it in as low budget a way as possible, mostly conference call, e-mail and so forth. We've had a few face-to-face meetings, and there have been some kind of peripheral activities we've been involved in, but the most important activity to date has been to develop simplified questions and look at the AABB-required or recommended questions to see if it would be possible to eliminate some items.

So what do we hope to achieve by simplifying things? Dr. Williams has already alluded to some of these anticipated benefits. First of all, better donor comprehension of the questions. If the donors understand the questions better, hopefully the information that we're getting from them will be more accurate and more

relevant. We're hoping that, as a result of this, that there will be improved safety of those units that are collected, although this will be somewhat difficult to quantify for reasons that Dr. Williams stated. We're hoping that there will be fewer errors made on the part of the staff, and thus fewer discarded units.

Our approach to simplifying is--and this is very important--when we got down to the nitty-gritty of deciding how we would simplify these questions, we took this approach: What is the target information of the question? What is it we're really trying to get at? What's the key issue, the core issue?

What is the simplest way that a question can be stated? Forget the fancy words. Can we just put this into plain English that someone of a 7th or 8th grade level would understand.

We took our cues from the FDA Error and Accident Reports and an AABB survey that went out in the fall, to identify problematic questions. We used published and project-specific focus group information, and Dr. Orton will be covering this information in a few minutes.

And we called on the judgment and the

experience of the task force members. These are seasoned blood bankers and people who have been involved in donor issues for a long time. And we relied very heavily on the experience and the input of the health survey design experts.

So, our approach to simplifying in terms of the practicalities is that we broke the task force up into subcommittees, and they took every single one of the questions on the card and developed alternative wording; or if the wording we felt was simple and great, we retained it. For each of these subcommittees there was a survey design specialist that participated in those conference calls.

Then the entire task force reviewed these proposals and made additional revisions, and then Sharon Orton of Holland Laboratories had conducted focus groups on those revisions.

So what we are essentially doing is that we're using less complicated phraseology. We've broken up many of the compound questions. I will talk about what we plan to do with medications. On health conditions, we want to focus on those that we think are the most germane for donor safety, eliminate some non-FDA questions, and hopefully--

and we will make this recommendation--move to a self-administered questionnaire.

Now, again, before I launch into this section, I just would like to remind the attendees and the participants here that these questions are being presented without the other supporting documents, so please keep that in mind, and I thank you in advance for your kind attention and indulgence. I know the day is late, time is short, and I appreciate the attention that you will give to this.

Okay. There are a number of questions about specific medical conditions, kind of mixing apples and oranges. What the committee felt was important is to try to lump things together in more logical categories. I'm not going to read all these because you can do this.

But we felt that the key health conditions are listed here: cancer, heart, lung disease, bleeding conditions or blood problems. Now, if a specific medical director feels that there are other questions that should be asked, for instance, if there should be a specific question about autoimmune disease, the medical director would have the option to have their own--to add questions or

have a separate list of items about which they would like donors to be asked.

Hepatitis, right now we're asking a lot of questions, kind of dancing around trying to find out if the person has ever had hepatitis. And rather than take this more kind of symptomatic approach, which can obviously yield a lot of false positives, why not just say, ask the donor, "Have you ever had hepatitis?"

Now, question number 10 on the AABB uniform donor history questionnaire--and I just want to point out, when I'm listing these questions by number, this is how they appear on the AABB uniform donor history questionnaire, which is listed on the AABB web site. If you're not a member, you won't be able to access it just now, but you can contact me, you can contact Kay Gregory or any of the other folks from the AABB.

Right now, question number 10 lists a number of individual medications, and every time a new medication has to be added, blood centers do go back, have to reprint their cards, add the new question. This does add some operational difficulties. And so what we're proposing is that we ask the donors if they're taking any medications

on the medication list, and then they will be given a list that lists the medications and the deferral periods, and I would like to show you how this would look.

Very simple, bulleted items. We say please do not donate if you have taken any of these medications, medicines, in the past month, and then we list them; then in the past three years, and there's one for that, that falls into that category; or ever, and this would be Tegison, this would be growth hormone from human cadaveric pituitary glands, or insulin from cows. So they would be given this card, they would look at it, read through it, say yes or no, and then move on.

Okay, let's get into the issue of travel. Basically, what happened with this question, this is the United Kingdom travel, variant CJD deferral question, was put together jointly by the FDA and the AABB, the original question. Based on focus group information predominantly, we revised this question to read as follows: "Between 1980 through 1996, did you spend time in the U.K. that adds up to six months or more?" Okay, just trying to make it simpler for the donor.

Question No. 15, again about CJD. Rather

than having cadaveric derived pituitary gland on the card, it will actually be listed on the medication list separately. And what we are proposing is that rather than ask Question number C as it's written, a very long, a very complex question, really what we want to know about is if the donor or their family has been diagnosed with CJD, and so that's what we are proposing be asked.

This is just to address the fact that there are more ways in which patients can be subjected to foreign tissues or allergenic tissues, if you will. It could be blood, it could be a transplant, it could be a graft, and while we don't particularly like the fact that we have made three questions from one, it addresses the fact that there are more complex procedures, surgical procedures, taking place that do use human tissue.

Okay, the money to sex questions. We were able to, and we felt fairly effectively, to reduce this from three to two questions. And what we did, basically, was to take Questions 21 and 22B, and these are in pink, and reword them in the following manner. So we felt we were able to address both types of risks in one question, and then we just reworded Question 22A to read as you see it listed

below.

Here's another travel question. Again, the African travel questions were put together jointly by the FDA and the AABB a few years ago, and we really--you know, I guess we all thought that we had the best way to say it. And based on focus group information and discussions that the task force had, we felt that some changes were indicated.

So rather than give them this big, long song and dance from part A, we felt that we should simply ask a capture question: "Have you ever been in Africa?" If the donor says yes, you say, "When was it," and then "Have you lived in, traveled to, or were born in Africa?" If they say no, you move on. And the other revisions that we're proposing, again, were based on focus group information.

Okay, so those are just examples. It's not a comprehensive list. The committee does have the other proposed revisions that we've developed, and you've been given those, those materials, to review. But let's talk now about some of the specific questions that we think should be eliminated.

Again, I emphasize that none of these

questions are required or recommended by the FDA. They fall into three categories: They are either not in AABB's Standards or FDA documents. They are in AABB's Standards, but again there is no FDA requirement or regulation. Or the FDA has promulgated a regulation or a recommendation, and the AABB has responded to that by developing a question.

So let's start with Category 1, and again, I won't go through all of these, but just to give you a flavor. We currently ask donors if for any reason they've been deferred or refused as a blood donor. We are picking up a lot of very non-specific information. If you've ever donated blood, you know what this is like.

"Yes, I've been deferred." "Well, what have you been deferred for?" I'll talk personally about myself. "Well, I took Motrin because I had some cramps," or "Three years ago I was in a malarial area when I was vacationing." And every time I donate, I have to go through this.

And we felt that, based on the non-specificity and information, that this was the one question that really seemed to bother donors. We suggested that it be removed.

"Are you giving blood because you want to be tested for HIV or the AIDS virus?" Again, not an AABB requirement or an FDA requirement or recommendation. Now, intuitively or on the surface you'd say, "Gee, this is really a good question to ask people," but almost 50 percent of U.S. blood donors already are not being asked this question.

There are some other data showing that the number of donors that answer in the affirmative is very small, .01 to .03 percent, and we know from the REDS survey data that--donors who answered a questionnaire after donation--that somewhere in the vicinity of 3 percent of donors said that somewhere along the line in their donation career, that they had donated in order to undergo an HIV test. And this is information that was given after the donation, in response to a questionnaire. So we know that people aren't responding honestly, many people are not responding honestly to this question already.

Information about test-seeking is already posted at blood centers, it's already included in donor education materials of most blood centers, and our goal is to reinforce this in the revised educational materials.

I'm not going to spend a lot of time on this, except to say that the AABB Standards Committee put this in a few years ago. There were some concerns about the preparation of the vaccination, the shots, that possibly it could be infectious material. While not trying to Monday-morning quarterback, probably we should have gone to the experts on that. When this task force went to the experts, the response that came back is pretty much, "Why are you asking this question? There's not an indication for asking this kind of information."

This is an old issue, but because the FDA has to give the final okay, we are including it. The AABB board requested a few years ago that we ask donors about the use of intranasal cocaine because it was a potential risk, possibly a risk for HCV infection. That was based on one CDC study. But then the REDS study did some additional research and showed that intranasal cocaine use was not an independent risk factor for HCV infection, so the AABB has already decided to eliminate it from the 20th edition of Standards, which is the current edition, and that will continue for the next edition as well.

Well, this one is a fairly complicated one. I just would ask the committee to review our rationale for striking this question. Suffice it to say, it's fairly nonspecific, and we are already testing donors for syphilis and we feel that, based on the rationale that is listed in your handouts, that that would explain why we feel it should go.

Okay, another question that we have asked donors for years, "Have you ever donated or attempted to donate using a different name, or another name, here or anywhere else?" The reality is that the AABB put this question in in response to a CFR statement that a record should be available so that you could basically defer unsuitable donors and not collect their products or not allow their products to be issued for transfusion.

What this is really referring to, is having and maintaining a deferral database, so the task force is asking how this question really addresses that requirement, and we really feel that the ability to link or access donor records is a local issue. It depends on the computer technology and donor identification systems of a specific

center.

Okay, and I think this probably will be the last example that I give you: "Have you read and understood all the donor information presented to you, and have all your questions been answered?" Now, this was a question that the AABB put in in response to an April '92 FDA memorandum saying that information should be written in language that assures the donor should understand.

Well, the purpose of the task force is to assure, as much as is possible, that we are complying with this memo, that the questions are written in language that the donors can understand. But this question, if this question really were following the spirit and the letter of this particular memo, it would read: "Has this been written in a language that you understand?" And so we feel that it's not really clear how this current question addresses this particular FDA requirement.

The third thing is that most of the question content is already in the blood donor questionnaire consents, and we have obtained these questionnaires from many of the blood centers around the country, and most centers already have this information embedded in that. And what we

would ask is that blood centers include this kind of information in the consent section of the questionnaire.

So where we are right now is that we are waiting for funding, for the NCHS to take the comprehension assessment up to the next level, using one-on-one cognitive interviews which are very sophisticated, very intense. It's a very sophisticated, intense tool for assessing donor comprehension, ability to recall certain kinds of information, and also response bias.

And, as I mentioned, we don't have any funding allocated for this, and we--NCHS is--we are trying to work through an intergovernmental approach for obtaining funding to do this. And we've already submitted our preliminary proposal, and we will be waiting for your feedback.

So we are hoping that you will--we are looking forward to receiving the feedback that the committee will provide, performing interviews, refining wording based on any of the above observations. Then reformat the questionnaire, develop an abbreviated questionnaire for repeat donors, revise the educational materials, try to harmonize them, develop a user's brochure, and then

submit, hopefully by the end of this year, a final proposal to the FDA.

So, just to close, this effort is a very special effort because the FDA has requested that the constituents come together and work on it. The FDA has become an integral and engaged contributor to the effort. There has been a groundswell of support for this effort, from the blood banking community, from donors. And, finally, this approach, which embraces validation as a key element, really is essentially the first of its kind for developing donor screening materials. And with that, I'll close and yield to the chairman.

DR. NELSON: Thank you. Are there questions? Yes, Toby?

DR. SIMON: Since close to half of the donations in this country are for source plasma, I think it's probably fairly simple. On the main one you can just asterisk certain questions that aren't asked of source plasma donors, and I don't know if there are any that would be added. I assume you're paying some attention to that through you ABRA liaison?

DR. FRIDEY: Right. Yes, we are.

DR. SIMON: Are you also looking at two

different abbreviated questionnaires, one for blood donors and one for plasma donors, or--

DR. FRIDEY: Well, I think that it will be very important for the representatives from ABRA to give us feedback to that effect.

DR. SIMON: And I take it that it's not within this committee's purview to look at policy issues, for example, on the hepatitis thing where the BPAC has given--

DR. FRIDEY: Right.

DR. SIMON: So you're taking current policy and then working--

DR. FRIDEY: Right. It's the MSM, malaria, syphilis testing, all the policy issues. While we weigh, may weigh in on them and say something in our final proposal, we are not going to basically deal with policy issues.

DR. NELSON: On the repeat donor question, I mean, we have some cohort studies, like of drug users and gay men and stuff, and we have a baseline questionnaire when the person is enrolled, and then on follow-up we ask, "Since the last time you were here" or "In the last six months" have you, etcetera. Is that what you're planning to do?

DR. FRIDEY: Right.

DR. NELSON: Or you're going to, you know, so you'll change the "paid for sex," if the person donated two months ago, you'll say in the last two months; is that right?

DR. FRIDEY: That's the general idea. First we have to define what constitutes a repeat donor, and then there are a number of different approaches we can take, but that's the general idea. Those things that could have changed since they last donated are the ones that will be addressed.

DR. NELSON: Right, and so you wouldn't have to ask again, the U.K. between 1980 and 1996, because if they once denied it, theoretically it couldn't have happened in the interim.

DR. FRIDEY: Right. Yes.

DR. NELSON: Okay. Yes?

DR. MITCHELL: You talked about perhaps going to a written questionnaire instead of doing any oral, and I was wondering, it seems to me with literacy and other people that you might just offer them the option of saying, you know, "Would you like me to go over this form with you, or do you want to handle it?" Have you talked about those kinds of issues?

DR. FRIDEY: That's something that we will address, because there are also issues about people who are, for instance, visually impaired, may not be able to read the questionnaire. This kind of thing would apply for them.

DR. NELSON: Yes. We have used not computer-assisted but ACASI, audio-computer assisted. In other words, the question appears on the screen and the person can answer it, but it's--also a voice reads the question and tells the person, you know, what to answer. And if there's, you know, an inconsistent answer downstream in the questionnaire, that's recorded and it's clarified, so that those work reasonably well. But it's expensive to develop that, but you can also deal with language issues that way. It can be in Spanish or Chinese or whatever.

DR. FRIDEY: Yes, I think that donor screening really has to move towards computer-assisted. I mean, the pen-and-paper approach, given the technology, technological potential, you know, it's kind of not in the dark ages but hopefully we'll move toward that rapidly, within the next couple of years.

DR. NELSON: Okay. Yes?

DR. STUVER: So you decided to drop the intranasal cocaine use question?

DR. FRIDEY: Right.

DR. STUVER: Then what was the rationale to keep the tattooing and ear and skin piercing question?

DR. FRIDEY: Because there are still fairly good data out there that both of those activities are risk factors for infectious diseases. The key with the intranasal cocaine is that it is not an independent risk factor for HCV; that there oftentimes was an associated history of IV drug use.

DR. STUVER: And not with the--these would be considered independent risk factors?

DR. FRIDEY: Right.

DR. NELSON: In certain populations, I would say skin piercing is becoming more common, I hope not in the BPAC membership but in some populations, like kids that I happen to know. It's becoming more fashionable.

DR. HOLLINGER: A couple of questions. First of all, do you think that somewhere you will probably go more towards the video type of things for questionnaires and so on, like computerization

and so on? You mentioned that, but I wonder--

DR. FRIDEY: Right. There are already systems that are in use. One is operating under an IND at several blood centers, and then there's another system that is already being implemented by at least one center in the country, and I have to admit we're also looking at that system as well.

And these are--either consist of use of a laptop which has the questions, which are either--they are asked both orally and written format. That's great for people who are hearing-impaired or visually impaired. You have both media. Or something that uses a hand-held device, a Palm Pilot, for example, to answer questions.

And the idea with that is that it needs to be interfaced with your computer, your system database, so that the answers are already recorded. It's set up in such a way that the donor can't go on and answer the next question if the donor has failed to respond to a previous one, so there are a lot of problems that will be solved by going in that direction.

The task force basically will take a look a some of those and make--and put together, I think, a "wish list" of what we would like to see

with the computer-assisted self interviewing. But those programs are, while not video, they use a computer screen or personalized digital system where they can actually read the questions.

DR. HOLLINGER: For the record, I do have a couple of questions I want to ask. I know Alan doesn't want to maybe get into some of these, but there are some questions I'd like to bring up anyway about the questionnaires and so on. They are sort of specific.

But you mentioned about simplifying it, but I noticed in Question 2 you ask something about, "Have you given double red cells," and I wasn't even sure what that, initially, what it meant.

DR. FRIDEY: Okay.

DR. HOLLINGER: I know what you mean now, but that was a question that I was a little confused over, just being asked a question like that, and that was just one.

The other is about jaundice, and I like your attempt to change that to just hepatitis. But I'll tell you, and maybe Ray could comment on this after I finish, but often patients don't equate jaundice with hepatitis. The others are sort of

superfluous. Often when they say hepatitis, they don't equate alcoholic liver disease and things like this, but that's not an issue in terms of transmission and so on.

But jaundice is an issue, and so I think it's something one might want to think about, leaving either that terminology or something else in, along with hepatitis. I think most of them understand hepatitis, and they do, they mostly feel this is talking about viral hepatitis in general. But jaundice they sometimes don't equate with hepatitis. That's one other difference.

The question about medications, I presume they'll be thinking of things like Plavix and stuff like this which essentially binds the platelet receptors, and essentially for at least the life of the platelets while they're in the body. That's one that is used not infrequently, and certainly could lead to bleeding, along with any ensades. But I noticed that those may not be included in the medications.

DR. FRIDEY: Aspirin is, by the way. I ran through that, yes.

DR. HOLLINGER: The other has to do about the rabies shots, and I know that's probably a

question that shouldn't be in there, but you know some of the rabies vaccines contain--and I don't think this is an issue, but I'll just throw it out--contain processed bovine gelatin. I don't know if that's an issue anymore in this country, and I don't know whether gelatin is an issue, either, but--

DR. FRIDEY: Gummi bears are.

DR. HOLLINGER: What?

DR. FRIDEY: Gummi bears are.

DR. HOLLINGER: So it probably has nothing to do with it but, I mean, that was only one thing. You'll just have to answer that, because I don't know.

Yes, about the questions about the name change and so on, is that a problem for people who are newly married and change their name, or people who get divorced and change their names back, is that a problem for the blood banks? I know you said it's a local issue, but is it a problem in not asking the question, then?

DR. FRIDEY: First of all, they would, a center would have the option to retain that if they did not have an identification system that could link the names. For instance, if a center uses the

Social Security number as the identification number, or if the donor has a specific donor number that has been assigned, then those two things could be linked. If a center is not setup to do that or they don't feel comfortable, they would certainly have the option to retain that question.

DR. HOLLINGER: And then the final thing is the question about intranasal cocaine use. Many of us believe that this is--and if you just talk to people who use cocaine, and the fact that cocaine causes vascularization of the nasal passages, they're sticking a tube in their nose, either a dollar bill or a tube of any sort, snorting cocaine, passing it down to the next person. I don't see how anybody can look at that and think that that's much different than doing injection drugs or any other type of body piercing.

And whether there's a study that suggests that there is not--there's a lot of compound variables. You're right, a lot of them are injection drug users, but some are not, and there are other studies which have suggested that there is a relationship with transmission. I think unless the NIH has withdrawn their thoughts about intranasal cocaine, that's a good study. And so

the fact you have one that said maybe there wasn't any association, there's another that you have, and I think one has to really think very carefully about the use of intranasal cocaine. I mean, I certainly feel it's got a very strong possibility of transmission of bloodborne pathogens.

DR. NELSON: Yes?

DR. KOERPER: Blaine, I appreciate you, as the non-hematologist, bringing up the issue of the Plavix and the ensades, because I was going to bring that up, also. You know, Motrin, for instance, will also interfere with, and ibuprofin in all of its names, will interfere with platelet function.

I'm curious why you only said aspirin in the last 36 hours. Aspirin interferes with platelet function irreversibly for the life of the platelets, which is 10 days, plus it may also interfere with the platelets that are being formed in the bone marrow, and so we say 14 days. You can have an aspirin effect for up to 14 days, prolonging the bleeding time and causing bleeding. So I'm curious why you limited it to 36 hours.

DR. FRIDEY: We actually didn't. That has been an AABB standard that now has been in place

for a couple of years, and that has been--

DR. KOERPER: Well, I'm suggesting that the AABB, whoever wrote that standard, needs to reevaluate it.

DR. SIMON: That's based on a study which showed that if you use pheresis donors who had aspirin in I think the last 12 hours, that they would be ineffective in correcting the bleeding time, but if you use platelets from donors who had aspirin 36 hours ago, they would be effective. And while they still have aspirin related platelets circulating, they have newer platelets that are not. So it's based on empirical data that was published some time ago. I think the FDA actually put it in their guidance, and that's where it comes from.

DR. NELSON: Alan, do you want to talk about--

DR. WILLIAMS: Yes, if I could just comment briefly about the intranasal cocaine studies.

Yes, the NIH study was a very good study, and there's no need to retract the study at all. The major difference is, that particular study did not include sexual contact with an IV drug user as

one of the variables, and the REDS study that was a case-controlled study, did. And when that variable was included, intranasal cocaine use disappeared as a predictive variable.

DR. HOLLINGER: If you believe that sexual contact with hepatitis C is a real problem, then I would say you really ought to examine that a little bit closer, because we don't think it's a very big problem.

DR. WILLIAMS: That's not the issue. It's not specifically sexual contact with an IV drug user. It's probably a surrogate for some other aspect of that lifestyle that has placed that person at increased risk. Those are the data.

DR. HOLLINGER: Why do you think it would be a surrogate, Alan, when you can just perceive of sticking tubes into somebody's nose where there's blood, getting blood on a tube, and you stick it in somebody else's nose and they have blood, too? I mean, I don't see how that can be looked at as a surrogate.

DR. WILLIAMS: That's a theoretically possible way that it can be transmitted. However, the data don't support it at this point.

DR. KOFF: Some data support it, and some

don't, and it's biologically plausible, so I think Blaine's question is appropriate. It may be a little bit premature to remove it.

With regard to Blaine's other comments about the yellow jaundice, liver disease, viral hepatitis, yellow jaundice is the best kind of jaundice. Blue jaundice, brown jaundice--

[Laughter.]

The question was funny from the beginning, when it was first put in, and I guess leaving it generically as hepatitis may miss a few, but most of those would have been so many years ago, most of them would have been in kids. I think it's probably not--I think this will stand up reasonably well.

DR. NELSON: I don't know. A population that I used to deal with in my internship and residency at Cook County Hospital in Chicago didn't know what hepatitis was. They knew what yellow jaundice was.

DR. STUVER: Can I just make another comment on the question on intranasal cocaine use? I mean, just because it's an independent risk factor in that one data set, or it was an independent risk factor, doesn't mean that it

should be just considered to be eliminated, because it may be that some person who would answer no on the IV drug use question, might answer yes here. And I think you'd have to test it to see whether it picked up someone who, for whatever reason, said no on that question but said yes and then turned out to have a positive donation.

DR. ORTON: I'm Sharyn Orton from the Red Cross. I have a little bit of information that has to do with the HCV NAT study, interview study, that we're doing right now. And we're looking at risk factors, and as it turns out, we do ask a lot about intranasal cocaine use, and in that particular population where we're looking at fairly recent exposure, everybody who admits to intranasal cocaine use has admitted to IV drug use as a risk factor, too. We have no one who is independently intranasal cocaine use.

DR. HOLLINGER: Well, I will say we do have several patients who have had just intranasal cocaine use and not injection drug use.

DR. NELSON: Okay. Thanks.

DR. FRIDEY: Thank you very much.

DR. NELSON: Dr. Sharon Orton from the Red Cross will--

DR. ORTON: I'd like to thank the committee for letting me speak today and share this information I have on focus groups, and I'd also like to thank the task force for asking me to participate.

The focus groups I've done, I work with a woman by the name of Victoria Virvos. She is a behavioral scientist and has her own business out of Richmond, Virginia.

I want to explain very briefly to the committee, you have three pages of questions, I believe, and I want to make it very clear that the one page, we address seven questions in a paper that you also have a copy of. The methodology of how we actually do these focus groups was published in November 2000 in "Transfusion."

Seven of the questions that we looked at, like I said, are listed, both-- the Red Cross question was the question that was actually done in the focus groups. It was part of a study I was doing. I have also listed for you the AABB questions, so that you can see how similar they were. Those AABB questions were not the ones that the task force has already looked at and done some work to. They were the older version of the

question. I just wanted to make that clear.

Also, in 1999 when the U.K. travel question was coming out, we did focus groups on that question and the bovine insulin, and then more recently for the task force we looked at 13 additional questions that had not been covered, and all of that information was summarized and sent to the task force.

For the individuals in the audience, the few who are here, the task force has--I mean, the committee does have the questions. The 1999 focus groups covered hepatitis history or test and hepatitis contact, the parenteral question of tattoo, piercing, acupuncture, other blood exposure, etcetera. It addressed the question on Chagas and babesiosis, cancer, the CJD/dura mater questions, the U.K. travel, and bovine insulin.

The basic comments made by the focus group participants were that the compound questions were too long. If they were read aloud and the person was just listening, they were most definitely too long. They recommended splitting up all of them.

A history of hepatitis before the age of 11 they felt was too hard to remember. The use of the terms "liver disease" or "yellow jaundice" were

vague and unnecessary. Our participants, the demographics are listed in the papers, and whether they were high school students or people who were in their '60s and '70s, if you wanted to know about hepatitis, they all knew what hepatitis was, and didn't feel that these terms were necessary at all.

Many of the questions, any questions that had to do with sex, the risk behaviors associated with the term "sex" they felt should be clarified.

If a diagnosis of CJD is associated with dementia, they wanted to know why you were asking a donor if they had CJD. They thought they would probably be too sick to be donating, and recommended you remove that. And I had to tell them that scientists wrote the question.

Regarding the bovine insulin, we did have a diabetic who happened to be participating in the focus group, and she said that unless she had received it within the last few months, she would never remember whether she had ever had bovine insulin.

This is just to show you the more recent groups that we've done. We had a variety. The demographics are pretty thorough.

Because we did 13 questions, we broke them

up into two groups. The first set of questions had to do with cancer, heart or lung disease, bleeding disorders or disease, leukemia, transplants or grafts, the use of needles for drugs or steroids, sex with an IDU, travel to Africa and then receiving blood transfusion or other treatment with blood products, and the question about jail or prison.

The second set of questions were primarily related to "sex with," and they included sex with prostitute, money, drugs or other payment; sex for money, drugs or other payment; MSM; females having sex with an MSM; sex with someone with a bleeding problem or hemophilia; and then sex with someone born or who had lived in Africa.

In general, the comments were, for the particular questions, that if they were oral only, some of them are probably too long, but if they could just read them, they probably weren't too bad as far as length went. However, regardless of the length, the compound questions could be made more clear by splitting them up.

They went very, very carefully through the questions and removed one or two words as unnecessary, like "ever" or "even once", removed

the "even once."

They felt that cancer should be separate from other nonmalignant diseases like lung and heart disease.

This was a very interesting one. The word "disorder" had a negative connotation, and people recommended that it be changed to "condition" which was used in other questions. And this happened to come up in our predominantly black group, where they talked about blood "disorder" and they wanted to know, you know, whether sickle cell disease is considered a disorder, and that sounded very, very negative to them, and they wanted to know why "condition" was used for everything else and why "disorder" was used for this particular question. So we recommended that they just use "condition" all the time when they were talking about blood.

They felt you should separate "transplant" from "graft" and include bone marrow as a transplant.

For IDU, their concern was if you were looking at needle use, by just specifying drugs or steroids you were going to miss other injections like vitamins and supplements, particularly supplements in the health industry where people

might be using steroids and other supplements.

Regarding travel to Africa, "other medical treatment with a product made from blood" was not clear, and at the time I couldn't tell them what we were even talking about.

They recommended including juvenile hall and lockup with jail or prison. Juvenile hall is actually what came out of our high school group, and when we talked about exposure to individuals, they said certainly juvie hall, you're going to have exposure to individuals just as much as at jail or prison.

They thought the use of "prostitute" with "payment for sex" was unnecessarily redundant. None of them had any doubt in their mind what "payment for sex" meant.

Criteria for "lived in Africa" they felt should be specified, and they did have a question whether extended travel to Africa for long periods of time was considered a risk. I couldn't really answer that, and therefore didn't.

Again, risk behaviors associated with the term "sex" should be clarified.

That's it.

DR. NELSON: Okay.

DR. ORTON: Any questions?

DR. NELSON: Questions? What were the composition of the focus groups? You mentioned that there were both whites and blacks and--

DR. ORTON: Yes. The 1999 group--

DR. NELSON: To what extent would they be applicable to blood donor population, you know, throughout the country or locally or--

DR. ORTON: The 1999 focus group participants, the demographics are in the paper. We had a group from business. We had two groups that were kind of general. They were some from business, some from church, and high school.

The 2001, I did show the slide. Again, multiple ages. When we recruited these people, they all had to be eligible to be blood donors, so we specified that up front. And like I said, the ages went from high school up to the sixties, a variety of educational levels. We did not, in all of our focus groups, have anyone who was Hispanic, but we did--

DR. NELSON: And you didn't include people who had been blood donors, or--

DR. ORTON: In the first set of focus groups we were specifically looking for individuals

who had never donated before, so the 1999 questions were by individuals who had never donated before. For the task force questions, the one done in the year 2000, we actually did have individuals who were blood donors, as well, so we had a mixed group.

DR. HOLLINGER: Dr. Orton, does it depend on where questions come in a questionnaire? I guess I'm saying, should there be a prioritization of questions, or the most important questions or what you think might be the most important questions, if they come earlier, does it make a difference? And if they come 23, 25, 27, what kind of--

DR. ORTON: We did not look at, we didn't look at that at all. The only time, the only thing that I can say, there were two questions that we gave the way they're listed on the questionnaire, and one asked about bleeding disorder including leukemia, and the next question was cancer. And so they said, well, isn't leukemia--first they said, "Isn't leukemia a cancer?" Well, that's the next question. So I would say, yes, that's probably true, but we did not look at the order at all.

DR. FITZPATRICK: On the bovine insulin,

did you poll more than the one diabetic in the group?

DR. ORTON: No. It turns out when those questions came out, we were finishing up some of the other focus groups, and so we were asked to kind of throw those questions in quickly. And we just happened, the group we were doing just happened to have someone who was diabetic. We didn't do it any more extensively than that.

DR. FITZPATRICK: Do you believe changing the question based on that one answer is warranted, then?

DR. ORTON: Well, I don't think we changed the question. The question was, "Have you ever had bovine insulin?" And the person said, "I wouldn't remember." And I don't think that we changed it to any specific time period. I don't know.

DR. FITZPATRICK: Because the issue came about because there's a very specific process for an insulin-dependent diabetic who wanted to stay on bovine insulin, to import it from the U.K. So if they had been on it, they would remember.

DR. ORTON: I'm just telling you what they told me.

DR. FITZPATRICK: Well, that just worries

me a little bit, that you would advocate doing away with the question based on--

DR. ORTON: No, they aren't doing away with it. The question is still on the questionnaire.

DR. FRIDEY: It will appear on the medication list.

DR. FITZPATRICK: Okay. I misunderstood. I'm sorry.

DR. NELSON: And I like the one about how, "I'm getting so old and forgetful, I think I may have what's-its-name disease." That's great.

Yes, John?

DR. BOYLE: Actually, this is more in the way of a comment, because I had the opportunity to sit in on all too many of these conversations.

When you are working on a questionnaire, developing a questionnaire, there's usually three phases. The first phase is an expert phase, and that's what we have been doing for the last six or nine months, and I would like to take the opportunity as one of several members of this committee to say I had the opportunity to observe a broad group of experts who were trying to find consensus around these issues, in hewing to the

requirements for what's necessary yet at the same time trying to make things as efficient as possible.

Having done that, you just got the best sense of that group of people, which may or may not turn out to be, you know, perfectly right. So the next phase is what Sharon is talking about here, is qualitative research with a bigger group of people who are not experts, to see whether or not you can learn anything more, particularly in areas of comprehension.

One of the things that's really sought after, should funding ever be available, would be to go to in-depth where you can truly test order effects and other things in terms of comprehension. We know some general things. For instance, we know if you jerk your questions around all over the place, people lose the flow and they make mistakes. So if you can group them and flow them in sort of a temporal, you get better results.

In terms of a self-administered form, whether it appears at the first or the last probably doesn't make as much difference as how long the question is. Because if it's a long question and includes a number, a series of things,

some people read those as "ands" rather than "ors", and there's a whole series of other things. But the qualitative phase is underway to identify some of that.

What is lacking from the project at this point in time, due to lack of funding, is the ability to go out and find out, in a large scale survey, and it doesn't have to be on the basis of a REDS type of thing, but doe these risk factors coexist, and will a person who says this not say that, and do people understand. You know, in a large population, how many people would say "no" to hepatitis and "yes" to yellow jaundice? Don't know.

A large-scale survey could demonstrate that, but according to the parameters of the study, both time and resources but more resources, you know, that is not currently in the cards, and I for one wish it was. But anyway, I'd like to congratulate all the people, many of whom are here, many of whom are not here, who gave so much of their time on this project, because I thought it was really good work.

DR. NELSON: Alan?

DR. WILLIAMS: Okay, we are cognizant of

the hour just as much as you are. If you could bring up slide 12, as promised, we will just ask for key comments, reaction to the question components that will be placed in front of you. While that's coming, two points of clarification that I think may not have come out.

The NCHS was mentioned. That's the National Center for Health Statistics. It's a component of the Centers for Disease Control. They run a cognitive research lab which does this type of study on a full-time basis, so they are the professionals in the business.

Second thing is, the validation comprehension studies that we're doing, this is a first for this donor questionnaire. This questionnaire is used at least 12 to 13 million times each year for the past X number of years, and yet these studies have never been done, so just to create that awareness, as well. Now, as we move into the future, there may be other studies that will collect similar information, but this information is new.

So, looking at Question 1, "Is the task force using the best overall approach in revising the donor screening instrument with respect to (a)

donor comprehension studies"--would you like to take them as a group or separate them?

DR. NELSON: As a group.

DR. WILLIAMS: "(b) identification of questions proposed for elimination; and (c) transfer some question content to the written donor information materials?"

I think also it wasn't specifically made clear, we are not looking for a vote on these questions. We are really just looking for key comments to help guide the task force activities.

DR. NELSON: Comments on this one?

DR. MITCHELL: I vote yes.

[Laughter.]

No, on the first question, I think that the approach for the donor comprehension, I think that that's the right approach, but I'm afraid that there are a lot of regionalisms that are going to need to be taken into account, and I agree that that type of study really does need to be funded in order to look at it, such as the issues on juvie hall. I mean, you know, you say juvenile facility in other places.

Anyway, so you know, I like the idea of the focus groups to get more information. I think

more of that needs to be done, probably even before doing the large-scale questionnaire. Thank you.

DR. STRONCEK: Will there be any efforts to have these written in different languages when they're done?

DR. WILLIAMS: To the extent that this emerges as a standardized questionnaire instrument, certainly I think for areas of the country where Spanish is a major language, that it would be appropriate to have the appropriate regional translations into Spanish. I think, as Joy alluded to, once you get a computer-interactive questionnaire, this can be done much more effectively, and hopefully down the line those systems will become available. But, yes, different languages would be appropriate. I'm not sure the task force has agreed to undertake this as part of the current work scope, but yes, it's appropriate.

DR. NELSON: Well, as somebody who has got research studies going in Thailand and China and the Republic of Georgia in Russia, to get IRB clearance you've got to get consent forms in all of these languages, and back translations and upside down translations and all kinds of things to get through the IRB. So this isn't as daunting a

procedure, I think, as you--now, to test whether it means the same thing to the people that speak that language or are from that country is a different issue, but getting it translated into Spanish is not a big deal, I wouldn't think.

MS. KNOWLES: Although you have to be very careful, because some people who are very--they can speak very high Castilian, and there are other people that won't understand that at all.

DR. NELSON: Yes. Yes, that's true.

MS. KNOWLES: So I think you have to watch that to some degree.

DR. NELSON: But it's not as big a deal as you're
--I mean, it can be done. And certainly if it's just Spanish, that wouldn't cost much.

DR. WILLIAMS: Okay, next question, please.

So, looking at some of the elements of the redesign, are the following elements of the redesigned questionnaire instrument-appropriate? First, use of capture questions to identify individuals who are candidates for more in-depth questions regarding travel and similar clusters of questions like that? It's intrinsically appealing.

We have had difficulty locating data that say it's a better way to do it, but like intranasal cocaine, it has an intrinsic appeal to it.

Any comments on that one?

DR. NELSON: I think that for travel, I mean, you wouldn't list all of the 169 countries in the world in one question, but I think you have to use this approach for some questions where you're worried about malaria or other kinds of exposures, I would think. Yes?

DR. McCURDY: I think the concept is a good one, but it has occurred to me from a certain amount of experience and side information I've picked up, that one needs to exercise some quality control in the questionnaire process itself. I have the impression that in many instances a lot of the questions are asked in rather perfunctory fashion, and although it's desirable and appropriate to pick up body language in the responses, it's done so quickly that you're unlikely to do that.

And some of the amount of time that I have heard listed that's devoted to the questionnaire is amazingly short, and couldn't conceivably really ask all the questions in a fashion that's

particularly meaningful rather than perfunctory. In that situation, a computer-assisted approach would be very useful. But in any event, I think it would be advisable to try and build in a certain amount of quality assurance in the questionnaire process.

DR. MACIK: I think the use of capture questions is very good, and I think it would also shorten because, you know, we kind of gear this to different populations, but there's a large number of blood donors who have never been outside of the U.S. And you can just say, "Have you ever been outside of the U.S.A.?" and skip over everything else, and then if necessary expand to, oh, you have? Have you been to this country, this country? Malaria, etcetera. And so I think that simplifies matters, also, for those who have not been outside of the States. It keeps them from getting bored with the questions.

DR. MITCHELL: Yes, I also think it's a very good approach. However, I think that you need to sort of caution against something that looks discriminatory. Like you say, you know, "Have you ever been to Africa?" I think when I talk to people about that sort of question, they say,

"Well, you know, if there's a reason for that, then it's fine." And so maybe something that says, you know, that there are certain risk factors in some countries that aren't in the U.S., have you ever--you know. So that's what I would--

DR. NELSON: Yes?

DR. STRONCEK: Hopefully you can get this set up with the computers soon, because one of the big issues with travel is, as we have talked about here before, is which areas are at risk for malaria and which aren't, and it's a very fine line between parts of--some cities in some countries are, and other places aren't. So if that can be made uniform for all centers, and updated from time to time, and the same information be available, it would be a help, too.

DR. NELSON: Mike?

DR. FITZPATRICK: Alan, I'm not qualified to say whether it's appropriate or not on either 1 or 2, because I leave that up to the health survey people. What I would like to have seen would have been, one, the process as to how we go through the validation, because I think that's more the concerns that have been raised in the past by the committee, is that there be a firmly established

process for doing this. And I applaud the efforts that are being made, because the AABB and the task force are going far beyond anything that has ever been done before.

But what we lack is an establishment of a process, and the funding piece is deplorable. I mean, this is something that has been an issue for many years, has been addressed as a problem for many years, and the fact that FDA or NIH or somebody can't come up with the money to put together a process on, as you say, 12 million questionnaires that have been used yearly, over and over and over, is deplorable. Something needs to be done to establish the process so this just isn't a one-time thing, or as long as the AABB puts together the task force at the behest of the FDA, it gets done.

And to get all these volunteers to devote all their time and effort to it, is not a reliable process for the establishment of something so important as far as donor questionnaires. I think that that establishment of process is what the Blood Action Committee and the plan, was of the most concern of the group that developed that.

DR. NELSON: Yes, John?

understanding them?

DR. WILLIAMS: Okay. Second components, there is a recommendation currently to ensure understanding of the questionnaire by the donors, and this is handled in different ways by different blood centers. Are there comments on the need to do this or the process by which this is best accomplished?

DR. MITCHELL: Yes. Again, I commented previously that I thought that asking people if they want to go over it, but I think that eventually we probably should try to not only get to a computer but actually do get a video type of a thing, where you can have a touch screen and sort of--you have a lot of different options, you know, where you have a person talking, maybe even--anyway, visuals as well as the writing across the bottom, and it can be in different languages and so on, like that, and it can go at different people's paces. But we are becoming such a visual society, I think that it would be helpful to do that.

DR. NELSON: Go ahead.

DR. KOERPER: I think there is still a place for somebody who can read the questions, because some people don't have computers, you know,

older people who didn't grow up with computers in school or at their job, who may need some help; visually impaired people we've already spoken about; and I think there are some people who frankly don't know how to read, and yet they might be perfectly suitable as blood donors.

So I do think, while for those people who are comfortable with the computer setting, it could go quite quickly for them and not tie up a lot of interviewers, it still--I would vote that there still be some people who could sort of up front assess whether the person is more comfortable with a computer or with a face-to-face interview.

DR. CHAMBERLAND: As a member of the task force, I guess I wanted to be sure I understood the question to be, in that it could mean different things. I mean, it could refer to the effort that's currently underway, that hopefully NCHS will do, to do this overall validation. Or it actually could refer to individual validity checks, if you will, at the time each donor comes up to complete a questionnaire or work through a computer process. It's the latter that you're referring to?

DR. WILLIAMS: Yes, it's more specific. It's the latter. It should--the interviewer, by

whatever process the donor answered the question, should there be some means to determine whether or not the donor understood that questionnaire process, whether it's a single question at the end, "Did you understand? Do you have any questions?" or it's a test question earlier to ensure that they--the individual can read and can read the English language, some way of in fact providing some degree of validation that they did understand the set of questions.

DR. CHAMBERLAND: Now, hopefully I'm right on this, but currently the questionnaire asks a question that's sort of a wrap-up question, "Are you sure you understood everything? Do you have any questions?" etcetera, which the task force has proposed be eliminated as a question because the--

DR. FRIDEY: Right, but that's already in the consents somewhere.

DR. CHAMBERLAND: Yes, exactly where I was going, because it is included in other materials that the donor has to read, and in this case of the consent form, sign. But currently we don't do anything other than that in terms of an individual validity check, such as asking the same question different ways or these other approaches or

techniques that can be embedded in a questionnaire to try and get a handle on individual validity.

DR. NELSON: What did the REDS study find when it looked at donors who in fact had markers? I mean, you found that many of them had admitted to risk behaviors, but was that because they didn't understand the question or was it for other reasons, those who in fact had risk behaviors that should have excluded them?

DR. WILLIAMS: There are a number of studies that address that, from interview studies of HIV seropositive donors to the survey research of the accepted blood donors, and basically the rationale is all over the board. There are those who indicate that they did not comprehend the question. I would say in most instances this is not the major component. In some cases it's just a denial thing, "I didn't think they meant me," but there are a wide range of responses. I wouldn't say comprehension is an overwhelming reason. It is not. That was my impression. But then again, people who are answering surveys would have to be able to read the survey to determine whether or not, answer whether or not they could read the original questionnaire.

DR. MACIK: I guess one thing I don't have a sense for, since I'm not a blood banker, how many people actually get deferred because of the questionnaire? Say you're having a blood drive, and they come in--

DR. NELSON: Oh, a lot.

DR. FRIDEY: Quite a lot.

DR. MACIK: So how much effort is put in before the church comes in for the big blood drive, of putting out pamphlets that say, "If you've taken aspirin yesterday, you're done this, you've done that, don't come"? I mean--

DR. NELSON: It's the opposite. "Please come, and we'll find out if you are"--

DR. MACIK: It is, but I mean--

DR. NELSON: The reason I say, I'm not a blood banker either, but my wife for the last couple of years has been in charge of recruiting donors every two months for this, and you know, sometimes 40 donors come and 28 are acceptable after--you know, some of them because of low hemoglobin but a lot of them because of various donor exclusions.

DR. SIMON: There's tremendous variation, and with that many blood centers do try to get some

information, but generally most keep it very limited because they don't want the donor interpreting themselves out of the donor pool before they get there.

DR. MACIK: But some things are pretty simple.

DR. SIMON: Yes, they usually say if you've ever had AIDS, hepatitis, or risk factors--

DR. MACIK: If you've traveled outside the--you know.

DR. SIMON: That gets very detailed, if you've traveled--

DR. MACIK: Well, but I mean there are some simple questions, like some of the medication lists or something that could be, you know, shown ahead of time to keep people from going through the wasted effort of showing up and being turned away.

DR. NELSON: Yes?

DR. FRIDEY: I think there is a great deal of variability. Speaking for our own blood bank, and we're fairly small, we collect about 100,000 units a year, we do work with the donor chairpeople at the organizations where we do the drives, and do give them some basic information. Although, like Dr. Simon said, we don't give them basically a

whole list of everything that would constitute reason for a deferral, because we want to reserve the judgment, once the donor is there, to make a decision about whether or not they really and truly are eligible to donate. Major things like history of HIV, hepatitis, those are things we include, age parameters, and other things. But we do give them some information in advance.

DR. HOLLINGER: What percentage usually, say, are lost with the donor questionnaire, either from repeat donors or from new donors?

DR. FRIDEY: Well, at our blood center it runs around 15 percent, but I would say 3 to 4 percent of those deferrals at the time of screening are for low hemoglobin levels, but we do have somewhere in the range of 8 to 10 percent who are deferred on the basis of the questions that we ask.

DR. NELSON: You collect them at your blood center, or are these volunteer donors in the community? Because I think that number is higher than--

DR. FRIDEY: Well, yes. It depends. But speaking for the Red Cross, because we have a loose affiliation with them, it is somewhere between 12 to 15 percent overall at the time of screening,

including low hematocrits. Yes, but we do that at our centers and at mobiles.

DR. FITZPATRICK: Ours, DOD runs about 15 percent for medical history.

DR. NELSON: Yes. Well--

MR. GILCHER: Ron Gilcher, Oklahoma. I was just presenting this data last week at an NIH symposium, and at our blood center in the calendar year 2000 it was 13.6 percent of our donors were deferred. Of that, approximately one-half are for elevated blood pressure or hemoglobin, which is the majority. So your question of how many are deferred by the questions themselves on the donor registration form, it's about half of the deferrals that occur from the questions themselves on the deferrals, whereas the other half occur from what we detect from the vital signs or a determination of the hemoglobin level.

DR. HOLLINGER: Ron, do these patients, just for my own information, do these donors usually come--are they really lost most of the time, or will they come back again a second time or a third time because of these, either because of the vital signs being abnormal or because of the question?

MR. GILCHER: Well, that was one of the very important questions that was actually asked last week at the symposium, and we're lucky if we can get back one-third of those donors. Once we defer them, there is a feeling of rejection, self-rejection, by that donor, and we'll lose about two-thirds of them.

DR. WILLIAMS: Okay. Let's cover (b) and (c) together. The proposal was made that the actual medications be split out of individual questions and included in a medication list, which would be eligible for expansion at local option if desired, and then--

DR. HOLLINGER: Al, will this include both generic as well as common names in the medication list?

DR. WILLIAMS: Yes. And then cover at the same time an issue that didn't get a lot of attention, that is, provision of a user manual for the donor screening process. There might still be some questions about that, but we'd be happy to hear any comments about these two issues.

MS. KNOWLES: I think that's a good idea.

DR. WILLIAMS: Okay. We're almost home, and the last question I think we'll take as a

package. The concept here is, once the task force product emerges, and hopefully we'll find the funding and get the higher level of comprehension studies conducted--and FDA is going to be charged with looking at this very detailed revised questionnaire and deciding, you know, what further studies need to be done, how to evaluate it, and ultimately whether it should be approved--can you make any suggestions as to how this review process should be conducted in terms of the contents of the questionnaire, the format, and you might want to consider the secondary structure, the attention/comprehension studies that have been conducted, and the validation in terms of blood safety? Can you think of anything that we ought to do to assess these changes in terms of safety of the blood supply or safety to the donor, recognizing that this is a difficult task?

DR. HOLLINGER: No, but I think it would be useful to have a common ground that all of the blood organizations would accept, including the FDA. I mean, you know, when you see all of these things there, and the FDA recommends this, and the AABB recommends this, maybe the American Red Cross recommends this, this is one of the times I think

where it would be nice if there could be an agreement with all these competing organizations to have a solid questionnaire that everyone would agree on as much as possible. I think that would be useful.

DR. NELSON: I guess the way it works now is, the FDA mandates some questions and people can add to it, and I suspect that probably may continue, if one blood collection organization wants to add something that there isn't general agreement on.

DR. SIMON: Well, I think--I mean, I guess what Alan is looking at, particularly in number (d), I mean, I think that you obviously make sure the content reflects all of the guidance and policy issues that have been established and are still in place, the format that is at least something people will pick up on and can follow, and I would allow multiple formats as long as they conform and the people can comprehend it.

I think estimating impact on donor and/or blood safety is going to very, very difficult. Any way you can get such data, I think using tests now because the numbers are so low is going to be very difficult, but I would say that yourself and the

others who have been involved in the REDS study probably have the greatest insight of anyone into how one might get some tidbits of data on this or some element of data to submit, either by surveying people who have gone through the questionnaire after the fact or something like that, pretty much--I mean, I think you all set the standard for how one can do that.

DR. WILLIAMS: Two comments in terms of the way the agency looks at the process. The first thing is, for centers that would want to institute a question that is more precautionary and more conservative, generally there is not a basis for saying that can't be done, as long as the standards described by the agency are adhered to.

And then another concept, some of the questions either arose from AABB standards or other sources and are not recommended or required by FDA. FDA has remained silent on those questions, but I think reserves the right to comment and review whether or not their elimination is appropriate in context of the fact that they have become an industry standard.

DR. NELSON: Mike?

DR. FITZPATRICK: I think you've got the

recommendation from the health survey people on what you need for the end points, but you need the funding to get there. And if you don't get there, you won't know the answers to (a), (b) and (c), if you don't get that funding.

As far as (d), if you get the funding and do the validation, you're now establishing a baseline, so I don't know that you can estimate any impacts of what you're currently doing. But then when we add a question or change a question in the future, you may be able to assess that because you'll have a baseline to work from.

DR. NELSON: Marion?

DR. KOERPER: Well, in a sense you know what the frequency now is of HIV-positive donations or HCV-positive donations, for instance. And so once this is implemented, one could look to see if there was a change in the rate of people who donated and subsequently had positive tests. It won't help the FDA to approve it and put it into use, but I think that checking that kind of data once it goes into effect would be helpful to validate whether the rewriting of the questions was--

DR. WILLIAMS: That's a good observation.

The difficulty is, the prevalence and certainly the incidence is quite low. There's quite a bit of variance in it, month-to-month, quarter-to-quarter, seasonality and changes with demographics. To try to get enough power to evaluate the impact of a question change, again, is very difficult.

DR. NELSON: Jay, did you have a comment? Or are you just standing?

DR. EPSTEIN: No, I just wanted to encourage committee members to submit further comments in writing to the agency in the next couple of weeks, because we recognize that you didn't have the opportunity to really dive into the details. There was a desire to do so. We certainly would like that feedback, recognizing that this is a work in progress.

What we were hoping to do in today's session was to, you know, get the global picture on process, and I think we're having that discussion, but I just wanted to be sure you understand that we're also interested in particular comments, that you may want to think about some of the details. You've gotten a lot of material in the mail. We solicit your comments.

DR. NELSON: One issue that NIDA, NIMH,

etcetera, have looked at when they're trying to assess what a behavioral intervention is, when they don't have enough power to--you know, when let's say the HIV incidence isn't high enough without a huge study, is they use a behavioral surrogate, what people report about condom use, or an STD surrogate, and it's not exactly the end point, but maybe some of that same--in other words, you could re-interview enough donors to see, you know, what the questionnaire might do to those who were excluded and those who weren't, based on a new questionnaire.

DR. MITCHELL: Yes, but I think that in order to do that, you're going to have to look at--see, what can happen is that once it's introduced, also the number of people self-deferring can either go up or go down, and you don't know why unless you've looked at the people beforehand who have self-deferred and sort of asked them why they've self-deferred, and have looked at the people afterwards, after the new instrument goes into effect, and asked the people again why they self-deferred, because it might be good that the number of people who self-defer goes up. I mean, that might be a good thing.

DR. SIMON: I just thought this was a comment I've been reluctant to make, but since Dr. Fitzpatrick has several times brought up the funding issue, we have Dr. McCurdy here as our link to NIH, and at least from what I read back home, there's no agency being so blessed by the budget people these days as NIH is, and I would think the--

DR. NELSON: Certainly not the FDA.

DR. SIMON: Yes, I know. Certainly we might ask that we get due consideration for a little bit of money for Dr. Fridey and her corps of people to do these studies.

DR. MITCHELL: Do we vote on that?

[Laughter.]

DR. McCURDY: Actually I'd appreciate being educated a little bit more about what the funding issues are. It's my understanding from the discussion today that the NCHS has a section that does the type of interviewing on a fairly broad scale to do this. They have a budget, and I'm sure that they could use a little bit more, like everybody else does. But before one makes an attempt to sell this at the upper echelons of NHLBI and NIH, one needs to know a bit more about what

the issues are, what might be currently available, what supplements are necessary, what the priorities are, and so forth.

DR. FRIDEY: There actually has been a proposal, I think, which was put together by NCHS with a request for an interagency funds transfer agreement, and that went to the higher-ups, if you will, several months ago, back in March. I think it was wise that this discussion take place today because obviously any governmental agency that's going to be funding something wants to know that it has a reasonable chance to get off the ground and fly.

And while certainly we need to go back and make some adjustments based on the comments from today and the comments we'll be receiving, it would appear that, at least conceptually and from a policy perspective, that this committee seems to be weighing in on a positive side for the process that's taking place. But the budget, basically we're asking for somewhat under $100,000 in order to be able to carry out the one-on-one cognitive interviews. So that is where things stand in terms of attempting to get funding.

DR. McCURDY: I'm sure that NCHS has both

a budget and its own priorities, and I guess the question that I'm likely to be asked--and my relationship with NHLBI is getting more tenuous by the hour--but in order to make a pitch, one needs to know about other priorities, and this committee obviously and the blood banking community thinks this is an extremely high priority item.

The NHLBI has, I think, offers probably, at least from past experience, offers to spend twice their budget on the part of the community outside, so they need to assign priorities also and see how much self-help there might be around. Is there room for sharing the expenses, matched dollars, or a whole raft of different questions along that line.

DR. CHAMBERLAND: Maybe I'll just make a brief comment, which is, NCHS has already been actively engaged in the process in terms of providing a representative who has been very helpful to the group. NCHS has also indicated that they have a very keen interest in the project. They really view this as something that would have wide-ranging implications for a very large population. Today the questionnaire is used, you know, 12, 13 million times a year in whole blood

and an equal number in plasma donations.

NCHS has evaluated, just to speak to it very generally, since I don't work at NCHS, they have evaluated the resources on hand, and would be unable to do the work without additional supplementation to their budget. Or to do it in a way, I think, that would provide the data that I think people we have generally heard here would want to see, the level of detail and thoroughness.

DR. NELSON: Ray?

DR. KOFF: Are the current questionnaires used outside of the United States and Canada? Are they used by the European Commission countries? Would there be interest on the part of--the term "global" was used a few moments ago.

DR. SIMON: Well, they have their own. I think the experience of the plasma industry is, it tends to still be different in Europe to some extent, but they do look to FDA for some guidance as to what they put in. I think harmonization has been slower in coming than most of us would like.

DR. STRONCEK: I have a real concern that you could get buy-in from all the blood collection organizations in this country, and I think this is going to be one of the problems with getting the

Federal Government to fund this. You've had a situation where there has been a number of public committees deciding on policy decisions around CJD, and one of the largest blood collection organizations I guess is deciding to decide something different. And if they're going to behave in that manner, and down the line not be cooperative and decide that they don't want to participate in such a standardized questionnaire, then there's going to be problems and nobody is going to want to fund it.

DR. FRIDEY: Well, we have made it very clear through the representatives to the committee that buy-in from the organizations that sit on the committee is absolutely critical to this effort, and while I can't stand here and guarantee that everybody will adopt the proposal once it's approved by the FDA, I do believe that there will be an effort on the majority of the blood organizations in this country to go with this questionnaire.

DR. WILLIAMS: And I guess I might add, if they don't go with a questionnaire that has been subjected to a validation process, then I think they would be expected to submit data that's

comparable in submitting a separate questionnaire.

DR. NELSON: Well, I know what the term is for a meal that occurs between breakfast and lunch. It's called brunch. I don't know what the word is for one that occurs between dinner and breakfast, but I guess that's what we're going to have right now. So thank you very much.

DR. WILLIAMS: Thank you all for sticking with us on this. We really appreciate the comments that you have made.

[Whereupon, at 8:25 p.m., the committee adjourned, to reconvene at 8:30 a.m. on Friday, June 15, 2001, the following day.]

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CERTIFICATE

I, **ELIZABETH L. WASSERMAN,** 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.

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