UNIVERSITY OF MINNESOTA
TWIN CITIES

The University of Minnesota Hospital and Clinic
Harvard Street at East River Road
Minneapolis, Minnesota 55455

January 7, 1988

TO: Joint Conference Committee Members

Phyllis Ellis	James Moller, M.D.
Robert Dickler	Michael Popkin, M.D.
Patricia Ferrieri, M.D.	Bruce Work, M.D.

FROM: George Heenan, Chair

The January meeting of the Joint Conference Committee will be held on:

Wednesday, January 13, 1987
4:30 P.M.
The Board Room, University Hospital

The agenda and background materials for the meeting are enclosed. Dinner will be served at the conclusion of the business meeting. I will look forward to seeing you on Wednesday.

cc: Jan Halverson
Greg Hart
Nancy Janda
Geoff Kaufmann
Frank Rhame, M.D.
Barbara Tebbitt
Ted Yank

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JOINT CONFERENCE COMMITTEE

BOARD OF GOVERNORS

Wednesday, January 13, 1988
4:30 P.M.
The Board Room, University Hospital

AGENDA

I.	Approval of the Minutes	Approval
II.	Medical Staff-Hospital Council Report - James Moller, M.D.	
	• Credentials Committee Report	Endorsement
III.	AIDS Update - Frank Rhame, M.D.	Information
IV.	Clinical Chiefs Report -Bruce Work, M.D.	Information
V.	Other Business	
IV.	Adjournment	

MINUTES
Joint Conference Committee
Board of Governors
November 11, 1987

ATTENDANCE:

Present:
Robert Dickler
Phyllis Ellis
Patricia Ferrieri, M.D.
Donald Gilmore
George Heenan
James Moller, M.D.
Bruce Work, M.D.

Absent:
Michael Popkin, M.D.

Staff:
Jan Halverson
Greg Hart
Nancy Janda
Barbara Tebbitt
Ted Yank

Guest:
Jan Brockway
Adella DeLappe, M.D.
Donald Hansen

I. JCAH UPDATE

As Dr. Moller was involved with the JCAH survey, the meeting began with an introduction of the Committee to Mr. Donald Hansen, the administrative surveyor from the Joint Commission for Accreditation of Healthcare Organizations.

Mr. Hansen described his role in the survey process and briefly outlined the other surveyor's roles. Discussion ensued regarding the Joint Commission's position relative to Board involvement with Quality Assurance. Mr. Hansen stated that there should be some evidence in board minutes that indicated active board involvement, but noted that JCAHO understands the position of university hospitals where board meetings are open to the public.

Mr. Hansen noted that current focus of JCAHO on Quality Assurance is varifying that a process is in place at institutions. As of January 1, 1988 it will be necessary for institutions to demonstrate the efficacy of their program.

Mr. Hansen also disclosed that the future direction of the JCAHO in quality assurance will be the development and implementation of outcome monitoring. He admitted that this is very difficult, but assured the committee that expert teams are working on the problem. Their goal is to have a system in place by 1990.

II. MEETING TIME

Mr. George Heenan solicited committee members opinions of the appropriateness of the time allocated for the monthly meeting and questioned whether or not it was necessary to have a meal served. Discussion ensued and it was concluded that members should block out 4:30 – 6:30 P.M. on the second Wednesday of each month for meeting days and make an effort to notify Nancy Janda if they would be having dinner.

III. MORE JCAH

Dr. Moller returned with Dr. Adella DeLappe, the Joint Commission physician surveyor. Dr. DeLappe was introduced and made a brief presentation that echoed many of the themes that Mr. Hansen had already discussed.

IV. APPROVAL OF THE MINUTES

The minutes of the October 14, 1987 meeting were approved as submitted.

V. MEDICAL STAFF–HOSPITAL COUNCIL REPORT

Dr. James Moller discussed the use of lasers at UMHC and the conclusions of a group that studied their use. These four recommendations were the result of that study:

- There should be a "Laser Safety Officer"
- There should be an advisory committee to the Credentialling Committee that certifies competence with laser procedures
- Residents should not use lasers without supervision from staff physicians
- Some type of on-going committee should be established to investigate and assess new technologies.

VI. PEDIATRIC CARDIOLOGY MULTICENTER QUALITY ASSURANCE PROJECT

Dr. Moller described to the committee a multicenter quality assurance program that monitors 22 separate pediatric procedures at 18 sites

throughout the country. Data is gathered from each site and the data base amassed now holds over 11,000 cases. From this data base hospitals are able to compare their case-mix adjusted mortality rates against a broad based average. Centers that deviate too far from expected mortality then are able to examine their program and learn from other more successful programs.

Discussion ensued concerning the costs and ability to generalize this model to other specialties.

VII. **ADJOURNMENT**

There being no further business, the meeting was adjourned at 7:00 P.M.

Respectfully submitted,

Ted Yank/kff

Ted Yank
Administrative Fellow

TY/kff

UNIVERSITY OF MINNESOTA
TWIN CITIES

The University of Minnesota Hospital and Clinic
Harvard Street at East River Road
Minneapolis, Minnesota 55455

January 8, 1988

TO: Members of the Joint Conference Committee

FROM: Nancy Janda

REGARDING: AIDS Update

On Wednesday, January 13, 1988 Dr. Frank Rhame, Assistant Professor, Department of Medicine, Infectious Diseases Section, will be discussing several issues related to acquired immunodeficiency syndrome (AIDS). He intends to review the national epidemiological profile of the disease, our experience with AIDS at UMHC and to discuss some of the unique policy considerations associated with the care of this patient population.

The attached Universal Blood and Body Substance Technique policy outlines the approach that we havve taken to minimize transmission of the human immunodeficiency virus (HIV) that causes AIDS at our hospital. In sum, it requires staff to manage all patients and patient specimens as if they are hazardous.

We will look forward to discussing these important issues with you on Wednesday. See you then.

NCJ/kff

Attachment

POLICY: NEW

SUBJECT: **UNIVERSAL BLOOD AND BODY SUBSTANCE TECHNIQUE**

SOURCE: Hospital Infection Control Committee

POLICY

All patients and patient specimens are potentially infectious and will be cared for/handled using Universal Blood and Body Substance Technique.

PROCEDURE

1. **Description of Universal Blood and Body Substance Technique.** When contact with blood or body substance (e.g., body fluid, excretions, secretions, sputum, any drainage, or non-intact skin) from any patient is anticipated healthcare workers should routinely use barrier precautions to prevent exposure of their own skin and mucous membranes.

   Gloves should be worn for touching blood and body fluids, mucous membranes, or non-intact skin of all patients, for handling items or surfaces soiled with blood or body fluids, and for performing venipuncture and other vascular access procedures. Gloves when worn should be changed (not washed) between each patient. Hands should be washed immediately after gloves are removed.

Universal Blood and Body
Substance Technique

Gowns, laboratory coats or aprons should be worn during procedures that are likely to generate splashes of blood or other body fluids or any time uniforms or clothing are likely to be soiled. A moisture resistant gown should be chosen for procedures likely to produce blood or body fluid enough to soak through ordinary fabric.

Masks and protective eyewear or face shields should be worn during procedures that are likely to splatter or spray droplets of blood or other body fluids to prevent exposure of mucous membranes of the mouth, nose, and eyes. Eyeglasses will suffice for most situations but goggles, safety glasses with side protection may be needed depending on the procedure and the direction of the anticipated splash.

Hands and other skin surfaces should be washed immediately and thoroughly if there has been unanticipated contact with blood or other body substances.

All healthcare workers should take precautions to prevent injuries caused by needles, scalpels, and other sharp instruments or devices during procedures; when cleaning used instruments; during disposal of needles; and when handling sharp instruments after procedures. To prevent needlestick injuries, needles

should not be recapped, purposely bent or broken by hand, removed from disposable syringes, or otherwise manipulated by hand. After they are used, disposable syringes and needles, scalpel blades, and other sharp items should be placed in puncture-resistant containers for disposal; the puncture-resistant containers should be located as close as practical to the use area (in patient rooms when patient safety is not compromised). Large-bore reusable needles should be placed in a puncture-resistant container for transport to the reprocessing area.

To minimize the need for emergency mouth-to-mouth resuscitation a safety ventilation device (mouthpiece, resuscitation bag) should be ordered by the physician and placed at the bedside of infectious patients who are not on "DNR" status (~~physician assessment and doctor's order required~~; see Policy #16.4, Resuscitation of the Hospitalized Patient). ~~and~~ Devices will also be available in areas where cardio-respiratory arrests frequently occur.

2. **Department responsibilities.** Individual departments are responsible for determination of risk associated with work procedures, application of Universal Blood and Body Substance Technique to these procedures and monitoring of employee compliance.

3. **Exposures.** All actual and potential unprotected exposures shall be reported to Employee Health Service/Emergency Department (see Policy 33.18, Needlestick or other Signigicant Exposure to Blood and Body Fluids). Exposures include parenteral (e.g., needlestick, or cut) or mucous membrane (e.g., splash to the eye or mouth) exposure to blood or other body fluids or cutaneous exposure involving large amounts of blood or prolonged contact with blood -- especially when the exposed skin is chapped, abraded, or afflicted with dermatitis.

Office of the Chief of Staff

UNIVERSITY OF MINNESOTA
TWIN CITIES

The University of Minnesota Hospital and Clinic
Box 707
Harvard Street at East River Road
Minneapolis, Minnesota 55455
(612) 626-1945

January 4, 1988

TO: Joint Conference Committee

FROM: James H. Moller, M.D., Chief of Staff
Chairman, Medical Staff-Hospital Council

SUBJECT: Credentials Committee/Medical Staff-Hospital Council
Report and Recommendations

The Medical Staff-Hospital Council will act on the attached Credentials Committee Report and Recommendations on January 12, a day prior to the next Joint Conference Committee meeting.

I am forwarding these recommendations to you for your review and consideration on January 13, 1988. I will report the outcome of the Council's action at that time. Following your consideration of these recommendations, we ask that you forward them to the Board of Governors for approval on January 27, 1988.

Thank you.

JHM/cf
Attachment

UNIVERSITY OF MINNESOTA
TWIN CITIES

The University of Minnesota Hospital and Clinic
Harvard Street at East River Road
Minneapolis, Minnesota 55455

January 4, 1988

TO: Medical Staff-Hospital Council

FROM: Henry Buchwald, M.D.
Chairman, Credentials Committee

SUBJECT: Credentials Committee Report and Recommendations

The Credentials Committee after examining all pertinent information provided to them concerning the professional competence and other necessary qualifications, hereby recommend the approval of provisional status and clinical privileges to the following applicants to the Medical Staff of The University of Minnesota Hospital and Clinic.

Anesthesiology	Category
John M. Jackson	Attending Staff
Robert L. Gauthier	Attending Staff
Dermatology	
Richard S. Kalish	Attending Staff
Family Practice and Community Health	
Stephen L. Hanson	Clinical Staff
William E. Jacott	Attending Staff
Maurice L. Lindblom	Attending Staff
Laboratory Medicine and Pathology	
Thomas W. Amsden	Clinical Staff
James M. Greenberg	Attending Staff - Joint Appointment Pediatrics
Medicine	
Jeanne E. Gose	Clinical Staff
David D. Laxson	Attending Staff
Richard J. Sveum	Clinical Staff
John C. Winkelmann	Attending Staff
Stevan D. Zimmer	Attending Staff
John P. Jones	Attending Staff - ER
Steven D. Pletcher	Attending Staff - ER

Provisional status and clinical privileges continued:

Neurology	Category
Michele E. Metrick	Clinical Staff
Pediatrics	
Clifford E. Kashtan	Attending Staff
Peter S. Hesslein	Attending Staff
Ophthalmology	
John D. Brown	Clinical Staff
Psychiatry	
Daniel R. Hanson	Attending Staff
Radiology	
Flavio Castaneda-Mendoza	Attending Staff
David R. Eckmann	Attending Staff
David H. Epstein	Attending Staff
Robert A. Halvorsen	Attending Staff
Steven D. Johnson	Attending Staff
Glenn P. Moradian	Attending Staff
Paul R. Rosel	Attending Staff
Bertrand W. Schlam	Attending Staff
Surgery	
Jerome H. Abrams	Attending Staff
Jolene M. Kriett	Attending Staff
Westley D. Wong	Clinical Staff

The following physicians are completing their provisional status and are eligible for regular appointments as members of the Medical Staff of The University of Minnesota Hospital and Clinic. The Committee has reviewed recommendations concerning their appointment and hereby recommends approval.

Urology	Category	Date Eligible
George A. Haikel	Clinical Staff	March 24, 1987
Harold J. Hoppmann	Clinical Staff	March 24, 1987
Keith W. Kaye	Clinical Staff	March 24, 1987

The Committee recommends acceptance of the resignations of Medical Staff appointments from the following physicians.

Medicine	Category
Frank Linn	Attending Staff
Stephen D. Phinney	Attending Staff
Lewis Steinberg	Attending Staff
Surgery	
Richard L. Simmons	Attending Staff

The following Specified Professional Personnel (Psychology) has applied for appointment to the psychology staff and has requested clinical privileges. The Committee hereby recommends approval of this applicant and her request for privileges.

Family Practice and Community Health	
Kathy J. Harowski	Attending Staff

The Committee recommends acceptance of the resignation from the Specified Professional Personnel (Psychology) Staff from the following psychologist.

Physical Medicine and Rehabilitation	Category
Nancy Crewe, Ph.D.	Attending Staff

HB/cf

UNIVERSITY OF MINNESOTA
TWIN CITIES

The University of Minnesota Hospital and Clinic
Harvard Street at East River Road
Minneapolis, Minnesota 55455

February 4, 1988

TO: Joint Conference Committee Members

Sally Booth
Robert Dickler
Phyllis Ellis
Patricia Ferrieri, M.D.
James Moller, M.D.
Michael Popkin, M.D.
Bruce Work, M.D.

FROM: George Heenan, Committee Chair

The February meeting of the Joint Conference Committee will be held on:

Wednesday, February 10, 1988
4:30 P.M.
The Board Room, University Hospital

The agenda and background materials for the meeting are enclosed. Dinner will be served at the conclusion of the business meeting. I will look forward to seeing you on Wednesday.

cc: Paul Abramowitz
Jan Halverson
Greg Hart
Nancy Janda
Geoff Kaufmann
Barbara Tebbitt
Ted Yank

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JOINT CONFERENCE COMMITTEE

BOARD OF GOVERNORS

Wednesday, February 10, 1988
4:30 P.M.
The Board Room, University Hospital

AGENDA

I.	Approval of January 13, 1988 Minutes	Approval
II.	Medical Staff-Hospital Council Report - James Moller, M.D.	
	• Credentials Committee Report	Endorsement
III.	Clinical Pharmacy Relationships - Paul Abramowitz	Information
IV.	Clinical Chiefs Report - Bruce Work, M.D.	Information
V.	Other Business	
VI.	Adjournment	

MINUTES
Joint Conference Committee
Board of Governors
January 13, 1987

ATTENDANCE: Present: Robert Dickler
Phyllis Ellis
Patricia Ferrieri, M.D.
George Heenan
James Moller, M.D.
Mike Popkin, M.D.
Bruce Work, M.D.

Absent:

Staff: Jan Halverson
Greg Hart
Nancy Janda
Barbara Tebbitt
Ted Yank

Guest: Frank Rhame, M.D.

I. Approval of Minutes

The minutes of the November 11, 1987 meeting were approved as submitted.

II. Medical Staff Hospital Council Report

Dr. James Moller submitted the recommendations of the Credentialing Committee. Some discussion ensued about the training of some individual physicians. All questions being satisfactarily answered, Dr. Moller entertained a motion to approve the recommendations, the motion was seconded and approved unanimously be the committee.

III. AIDs Update

Dr. Frank Rhame presented to the committee a general information update on the state of clinical and research programs here at the University and around the country. Dr. Rhame described the clinical and research programs of the Hospital's AIDs Treatment and Evaluation Unit (ATEU).

He noted that the number of inpatients has remained flat at about three patients per day over the past year. The volume of outpatient visits has gone up dramatically, primarily due to the use of AZT and prophylactic pentamamine inhalation protocols. He noted that our ATEU has the 9th largest enrollment of any such

clinic in the country, but has the largest number of asymptomatic patients on protocols. He noted that when treating asymptomatic AIDs patients, the hospital must take particular care to preserve patient confidentiality.

Discussion ensued concerning the hospital's obligations and the challenges it faces with the AIDs epidemic. It was agreed that the ethical and clinical problems are staggering and that the Universal Blood and Body Fluid Policy that is being adopted by the hospital is an aggressive and appropriate response to the challenge.

Chairman Heenan asked Dr. Rhame to address the full board at a future date and asked Nancy Janda to make arrangements for the presentation. The Committee thanked Dr. Rhame for his presentation.

IV. **Clinical Chiefs Report**

Dr. Bruce Work noted that there have been constant discussion over the past several weeks concerning the issues of:

1. Malpractice Insurance

2. Resident Medical Fellow Stipends

3. Planning for an OB unit

4. Advertising and Public Relations Efforts

Bob Dickler also mentioned that the clinical chiefs have been examining the issues of the rights and privileges of house staff, and the implications of the AAMC guidelines set forth on resident hours.

V. **Adjournment**

There being no further business, Chairman Heenan adjourned the meeting at 6:20 PM.

Respectfully Submitted

Ted Yank

Ted Yank
Administrative Fellow

Office of the Chief of Staff

UNIVERSITY OF MINNESOTA
TWIN CITIES

The University of Minnesota Hospital and Clinic
Box 707
Harvard Street at East River Road
Minneapolis, Minnesota 55455
(612) 626-1945

February 2, 1988

TO: Joint Conference Committee

FROM: James H. Moller, M.D., Chief of Staff
Chairman, Medical Staff-Hospital Council

SUBJECT: Credentials Committee/Medical Staff-Hospital Council
Report and Recommendations

The Medical Staff-Hospital Council will act on the attached Credentials Committee Report and Recommendations on February 9, a day prior to the next Joint Conference Committee meeting.

I am forwarding these recommendations to you for your review and consideration on February 10. I will report the outcome of the Council's action at that time. Following your consideration of these recommendations, we ask that you forward them to the Board of Governors for approval on February 24, 1988

Thank you.

JHM/cf
Attachment

UNIVERSITY OF MINNESOTA
TWIN CITIES

The University of Minnesota Hospital and Clinic
Harvard Street at East River Road
Minneapolis, Minnesota 55455

February 2, 1988

TO: Medical Staff-Hospital Council

FROM: Henry Buchwald, M.D.
Chairman, Credentials Committee

SUBJECT: Credentials Committee Report and Recommendations

The Credentials Committee after examining all pertinent information provided to them concerning the professional competence and other necessary qualifications, hereby recommend the approval of provisional status and clinical privileges to the following applicants to the Medical Staff of The University of Minnesota Hospital and Clinic.

Department of Medicine	Category
David Guidot	Attending-ER
Connie Standiford	Attending-ER

Department of Radiology	Category
Becky L. Murray	Attending

Department of Urology	
Jerome S. Mayersak	Clinical

The following physicians have submitted applications and supporting documentation requesting addition and/or deletion of clinical privileges. The Committee has reviewed and considered their requests and hereby recommend approval.

Department of Neurology	Category
Ilo Leppik	Attending

Clinical Privileges:
Add: Spinal Tap, Electroencephalography with pharmacologic agents, electroencephalography for evoked potentials, electroencephalography for special leads
Delete: Pneumonencephalography, myelography, cerebral angiography, brachial angiography

Addition and/or deletion of clinical privileges continued:

Department of Obstetrics and Gynecology	Category	Clinical Privileges
George E. Tagatz	Attending	Add: CO_2 Laser-Laparotomy and Laparoscopy YAG/KTP Laser-Endometrial Ablation
Department of Pediatrics		
Mark E. Nesbit	Attending	Add: Bone Marrow Harvest
Department of Surgery		
John G. Shearen	Clinical	Add: CO_2 and Nd:YAG Lasers-Endoscopic laser surgery

The following physicians are completing their provisional status and are eligible for regular appointments as members of the Medical Staff of The University of Minnesota Hospital and Clinic. The Committee has reviewed recommendations concerning their appointment and hereby recommend approval.

Hospital Dentistry	Category	Date Eligible
Judith L. Marshall	Clinical	December 24, 1987
Department of Family Pracitce and Community Health		
Joseph M. Keenan	Attending	December 24, 1987
Department of Radiology		
Bennett A. Alford	Attending	December 24, 1987
Kenneth P. Korte	Clinical	December 24, 1987

The Committee recommends acceptance of the resignations of Medical Staff appointments from the following physicians.

Department of Anesthesiology	Category
Ellen L. Finch	Attending
Department of Ophthalmology	
Thomas Lindquist	Attending
Department of Surgery	
Nancy L. Ascher	Attending
W. Steves Ring	Attending
Department of Urology	
Dexter L. Jeffords	Clinical

HB/cf

UNIVERSITY OF MINNESOTA
TWIN CITIES

The University of Minnesota Hospital and Clinic
Harvard Street at East River Road
Minneapolis, Minnesota 55455

March 3, 1988

TO: Joint Conference Committee Members

Sally Booth
Robert Dickler
Phyllis Ellis
Patricia Ferrieri, M.D.
James Moller, M.D.
Michael Popkin, M.D.
Bruce Work, M.D.

FROM: George Heenan, Committee Chair

The March meeting of the Joint Conference Committee will be held on:

Wednesday, March 9, 1988
4:30 P.M.
The Board Room, University Hospital

The agenda and background materials for the meeting are enclosed. Dinner will be served at the conclusion of the business meeting. Please let Kay Fuecker (626-6222) know if you are unable to stay for dinner. I will look forward to seeing you on Wednesday.

cc: Jan Halverson
Greg Hart
Nancy Janda
Geoff Kaufmann
Barbara Tebbitt
Ted Yank

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JOINT CONFERENCE COMMITTEE

BOARD OF GOVERNORS

Wednesday, March 9, 1988
4:30 P.M.
The Board Room, University Hospital

AGENDA

I.	Approval of February 10, 1988 Minutes	Approval
II.	Medical Staff-Hospital Council Report - James Moller, M.D.	
	• Medical Staff Bylaws Changes	Endorsement
III.	Malpractice Insurance Update - Jan Halverson	Information
IV.	End Stage Renal Disease Policies - Barbara Tebbitt	Endorsement
V.	Clinical Chiefs Report - Bruce Work, M.D.	Information
VI.	Other Business	
VII.	Adjournment	

MINUTES
Joint Conference Committee
Board of Governors
February 10, 1988

CALL TO ORDER:

In the absence of Chairman Heenan, Phyllis Ellis called the February 10, 1988 meeting of the Joint Conference Committee to order at 4:38 p.m. in Room 8-106 in the University Hospital.

Attendance:

Present:	Sally Booth Phyllis Ellis James Moller, M.D. Michael Popkin, M.D. Bruce Work, M.D.
Absent:	Robert Dickler Patricia Ferrieri, M.D. George Heenan
Staff:	Jan Halverson Greg Hart Nancy Janda Barbara Tebbitt Ted Yank
Guest:	Paul Abramowitz

APPROVAL OF MINUTES:

The minutes of the January 13, 1988 meeting were approved as submitted.

CLINICAL CHIEFS REPORT:

Dr. Bruce Work reported that at the January 19th meeting of the Clinical Chiefs the group discussed the Medical School's objective relative to student and resident education. At the 26th meeting the adoption of Universal Blood and Body Fluid precautions by the Hospital was discussed along with the changing requirements of residency contracts. He noted that the contractual language is moving towards more objective performance requirements and that these requirements have been put forward by both JCAH and LCGME. The group also discussed the state of negotiations with Health East in relation to perienatal, obstetrical and neonatal care and the Hospital financial report. Dr. Work noted that the session on February 9th was an executive session.

MEDICAL STAFF HOSPITAL COUNCIL REPORT:

Dr. James Moller submitted the recommendations of the Credentialing Committee. Dr. Moller noted the resignation of Drs. Nancy Ascher and W. Steves Ring, two main figures in UMHC's transplant program.

Discussion ensued and with all questions being satisfactorily answered, the Chair entertained a motion to approve the recommendations. The motion was seconded and approved unanimously by the Committee.

CLINICAL PHARMACY RELATIONSHIPS:

Paul Abramowitz, Director of the Pharmacy at UMHC, delivered a presentation that reviewed changes in the practice of pharmacy over the past 20 years, the practice of pharmacy in the hospital today and a view of how it will be practiced in the future. He noted that the major movement in the profession had been away from the distribution and chemistry of pharmeceuticals, towards more of an involvment in pharmacology and pharmacokenetics.

Mr. Abramowitz described the drug distribution system at UMHC as centralized with several satellites in specific areas of the hospital. He also described the role of the decentralized pharmacists who act as drug information source and have responsibility for the review of all drug orders for areas that generally include about three nursing units. In addition to the decentralized pharmacists, there are clinical specialists in the BMT, ICUs, NICU and transplant areas who have detailed knowledge of the pharmeceuticals that are used in those area and participate in the planning of drug therapies for patients.

He predicted that in the future pharmacists will become even more clinically oriented. More liberal use of pharmacy technicians and automated drug dispensing systems will allow pharmacist to concentrate on clinical work. Beyond this he noted that the nature of drugs and delivery systems are changing rapidly, including transdermal delivery of drugs, implantable devices, timed release oral drugs, and drugs tailored to individual patient's through applications of monoclonal antibody technology.

JAN HALVERSON – STATE BOARD OF MEDICAL EXAMINER'S CONTROVERSY:

Mr. Halverson, Hospital Attorney, wanted to appraise the Committee of a controversy that was developing around the State Board of Medical Examiners. The controversy revolves around the ascendancy of statutory obligation to report physician misconduct vs the obligation for confidentiality in peer review.

This becomes particularly crucial in relationship to hospital quality assurance practices including departmental and committee procedure review. If the information obtained through these sources becomes public, then few physicians would be willing to participate in any part of the process.

Mr. Halverson stated that he will update the Committee as the issue develops over the course of the legislative session.

ADJOURNMENT:

There being no further business, the meeting was adjourned at 6:00 P.M.

Respectfully Submitted

Ted Yank

Theodore J. Yank

UNIVERSITY OF MINNESOTA
TWIN CITIES

Office of the Chief of Staff

The University of Minnesota Hospital and Clinic
Box 707
Harvard Street at East River Road
Minneapolis, Minnesota 55455
(612) 626-1945

February 17, 1988

TO: Members of the Joint Conference Committee

FROM: James H. Moller, M.D.
Chief of Staff

SUBJECT: Proposed Revisions to the Rules and Regulations of the Medical and Dental Staff

Enclosed are proposed revisions to the Rules and Regulations of the Medical and Dental Staff forwarded to you for your review and recommendation. The revisions have been endorsed by the Medical Staff-Hospital Council and the Council of Chiefs of Clinical Services.

The following is an explanation of the revisions:

Section I. Staff Membership., D. Malpractice Insurance Requirements

Relates to the appearance of deductibles in insurance certificates for physician members associated with two large non-University group practices, three UMHC clinical services associate groups, and one individual policy of a full-time member of the Medical Staff

Section V. Conduct of patient Care., E. Medical Record Requirements

Revisions are proposed to make the Rules and Regulations consistent with revisions made to medical record policies approved by the Medical Staff-Hospital Council October 13, 1987. Most of the language is taken directly from the JCAH Standards.

JHM/cf

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

RULES AND REGULATIONS OF THE MEDICAL AND DENTAL STAFF

PROPOSED AMENDMENTS:

Section I. Staff Membership.

D. Malpractice Insurance Requirement.

1. General. In order for any physician or dentist to be qualified for membership on the Medical Staff or to exercise any particular clinical privileges, or for reappointment to the Medical Staff, the physician or dentist shall submit evidence that he or she is covered by a policy of liability insurance covering the legal defense of, and the possible liability for, cases of professional liability (malpractice) relative to the person's staff category. It shall be the duty of the physician or dentist to maintain the required coverage at all times during his or her membership on the Medical Staff, to provide the Hospital with current evidence of coverage at any time a policy is renewed or changed. If action is anticipated to change the limits of malpractice liability insurance coverage, or termination of coverage for any reason, immediate written notice must be submitted to the Medical Staff Office.

Reasonable deductibles shall be allowed by the Board of Governors at levels consistent with the community standards. Each situation will be evaluated on a case-by-case basis by the Chief of Staff and exceptional requests shall be brought to the attention of the Board of Governors.

E. Medical Record Completion Requirements

1. (No change)

2. Data Base/History and Physical

a. A history and physical report must be provided for each admission. It is the responsibility of the attending physician to see that the report is recorded in the record within 24 hours after admission. A complete history and physical shall include a patient profile, chief complaint, present illness, past history, family history, review of systems, physical examination, mental status, known laboratory results, and provisional diagnosis(es) and/or impressions.

b., c., d. (No change)

3. Progress Notes

a. Pertinent progress notes shall be recorded at the time of observation and be sufficient to permit continuity of care and transferability. Progress notes shall be written at least

daily on critically ill patients and those where there is difficulty in diagnosis or management of the clinical problem. Attending staff physicians shall countersign or write progress notes at least every three days and as often as is necessary to substantiate their active participation in and supervision of the patient's care.

4., 5. (No change)

6. Diagnostic Summary Sheet. A Diagnostic Summary Sheet must be completed prior to or at the time the discharge order is written. The Diagnostic Summary Sheet shall contain the principal diagnosis, additional diagnoses and/or complications, operations and/or procedures; names of the responsible attending physician, ~~Medical Fellow of Medical Fellow Specialist,~~ resident physican, and all consultants; the discharge service; admission and discharge dates; and discharge disposition. Abbreviations are not to be used on the Diagnostic Summary Sheet.

7. (No change)

8. Operative Reports

a. Operative reports shall include the preoperative diagnosis and a detailed account of the findings at surgery as well as the details of the surgical technique, the specimens removed, the postoperative diagnosis, and the name of the primary surgeon and any assistants.

b. A dictated operative report shall be required for all procedures performed in the Main Operating Rooms, Ambulatory Surgery, Cystoscopy Suite, the Heart Catheterizations Laboratories, or the Obstetrics Unit, except for normal deliveries and fiberoptic bronchoscopies, regardless of the type of anesthesia or whether performed on inpatients or outpatients. Fiberoptic bronchoscopies will be reported using the procedure report from which will be accepted as a substitute for a dictated operating report.

c. (No change)

9. Discharge Summary

a. Discharge summaries shall include the principal diagnosis and all other diagnoses, and complications, the reason for hospitalization, all significant findings, procedures

performed and treatment rendered, condition of the patient on discharge, and any specific instructions given to the patient and/or family including those relating to physical activity, medication, diet and follow-up care.

b. ~~a.~~ A discharge summary ~~should~~ shall be dictated within 24 hours of discharge.

c. ~~b.~~ A discharge summary shall be completed and signed within 21 calendar days of discharge. ~~unless a physician has been granted a permanent exception by the Utilization Medical Records Committee.~~

10. (No change)

11. (No change)

12., 13. (No change)

1mo-1

UNIVERSITY OF MINNESOTA
TWIN CITIES

The University of Minnesota Hospital and Clinic
Harvard Street at East River Road
Minneapolis, Minnesota 55455

TO: Members of Joint Conference Committee

FROM: Barbara Volk Tebbitt

DATE: February 29, 1988

RE: New and Revised Policies for Kidney Dialysis Unit (KDU)

Attached are the updated organizational structures and new and revised policies for KDU and corresponding justification.

Philosophy, Responsibilities and Objectives-Dialysis Unit II.2

The previous philosophy statement and a narrative description of resources and systems were combined and revised.

Consultation Process III.2

Policy title change was made to clarify purpose of policy. The consultation role was expanded to include physician, medical service and areas of responsibility.

Medical Records III.5

Policy was completely revised to comply with End Stage Renal Disease (ESRD) standards and specify accountability for confidential maintenance of patient medical records.

Patient Rights and Responsibilities III.7

Policy was expanded to include the patient and primary nurse accountability in information sharing, regarding patient rights and responsibilities.

Patient Team Rounds and Care Conferences - Adult Area III.12

This is a new policy developed in response to End Stage Renal Disease standards which formalizes the responsibility of professional communication regarding patient care.

TO: Members of Joint Conference Committee

RE: New and revised policies for Kidney Dialysis Unit 1986 - 1987 (continued)

Kidney Dialysis: Medical Advisory Committee III.13

This is a new policy developed to assure accountability of professionals to comply with Joint Commission of Accreditation Hospital Organization (JCAHO) standards for medical integration into unit activities.

Patient Selection Criteria III.14

Previously patient selection criteria were superficially contained within another Kidney Dialysis Policy. Joint Commission of Accreditation Hospital Organization (JCAHO) standards are explicit in the need to address specifics in regard to patient selection. This policy now brings The University of Minnesota Hospital and Clinic (UMHC) into compliance with this JCAHO standard.

Termination of Treatment III.15

This is a new policy specifically to address the termination of treatment and complies with the Joint Commission of Accreditation Hospital Organization (JCAHO) standards.

Charting by Kidney Dialysis Technicians IV.13

Change reflects the writing of a Data, Assessment and Plan (DAP) note by the technicians versus the Subjective, Objective, Assessment, Plan (SOAP) note to comply with changes in the nursing documentation system.

On Call Guidelines IV.15

Change indicates increase in time allowed for the on call staff to arrive at the hospital from 20 to 40 minutes which is considered a more realistic time frame and moves the on call pay from restricted to at home ($3.55 to $1.75).

Pregnant Personnel IV.20

Policy changes deleted requirements for employee health counseling, M.D. written permission, and signage of informed consent in order to conform with current hospital infection control policies.

TO: Members of Joint Conference Committee

RE: New and revised policies for Kidney Dialysi Unit
1986 - 1987 (continued)

Preparation and Connection of Equipment for Continuous Arterio-Venus Hemofiltration (CAVH) IV.24

This is a new policy/procedure developed to provide guidelines to establish clear lines of authority and accountability in preparing and connecting equipment for CAVH.

Chief Executive Officer Responsibilities V.2

Format changes were made and lines of accountability were clarified in response to revised ESRD standards.

Guidelines for Use of Universal Blood And Body Substance Technique for The Kidney Dialysis Unit VI.1

This is a new policy/procedure developed to provide guidelines for use of universal blood and body substance technique in the Kidney Dialysis Unit. These guidelines reflect the Center for Disease Control (CDC) recommendations for infection control.

Electrical Safety IX.3

Policy deleted the statement indicating where hospital policies/procedures for prevention of electrical hazards are stored. Policies concerning electrical safety are located in the Hospital Policy and Procedure Book.

Board of Governors

The University of Minnesota Hospital and Clinic

End-Stage Renal Disease Program

Policy Statement for

The Renal Transplant Center and Dialysis Unit

The services of the Renal Transplant Center and the Dialysis Units are organized and operated as components of the Hospital and Clinic. Bylaws of this Board of Governors and those of the Medical and Dental Staff plus University Policies and Procedures and those of the Hospital and Clinic apply. Patient Care Services are supportive of our Mission and Goals which include service to the state, region and nation, consistent with support for academic objectives of education and research.

The policies and procedures specific to the operation of these services have been recommended by the Medical Directors. The Joint Conference Committee has recommended their approval and they are hereby approved by the Board of Governors. The Medical Staff is directed to review these policies each year. Any recommended changes must be approved by this Board.

The Chart of Organization specific to the Renal Transplant Service and Dialysis Units is attached. The General Director/Chief Executive Officer is responsible for management of these services. Medical direction is established and organized according to the Medical and Dental Staff Bylaws.

Approved:_____

Chairman, Board of Governors

Date:_____

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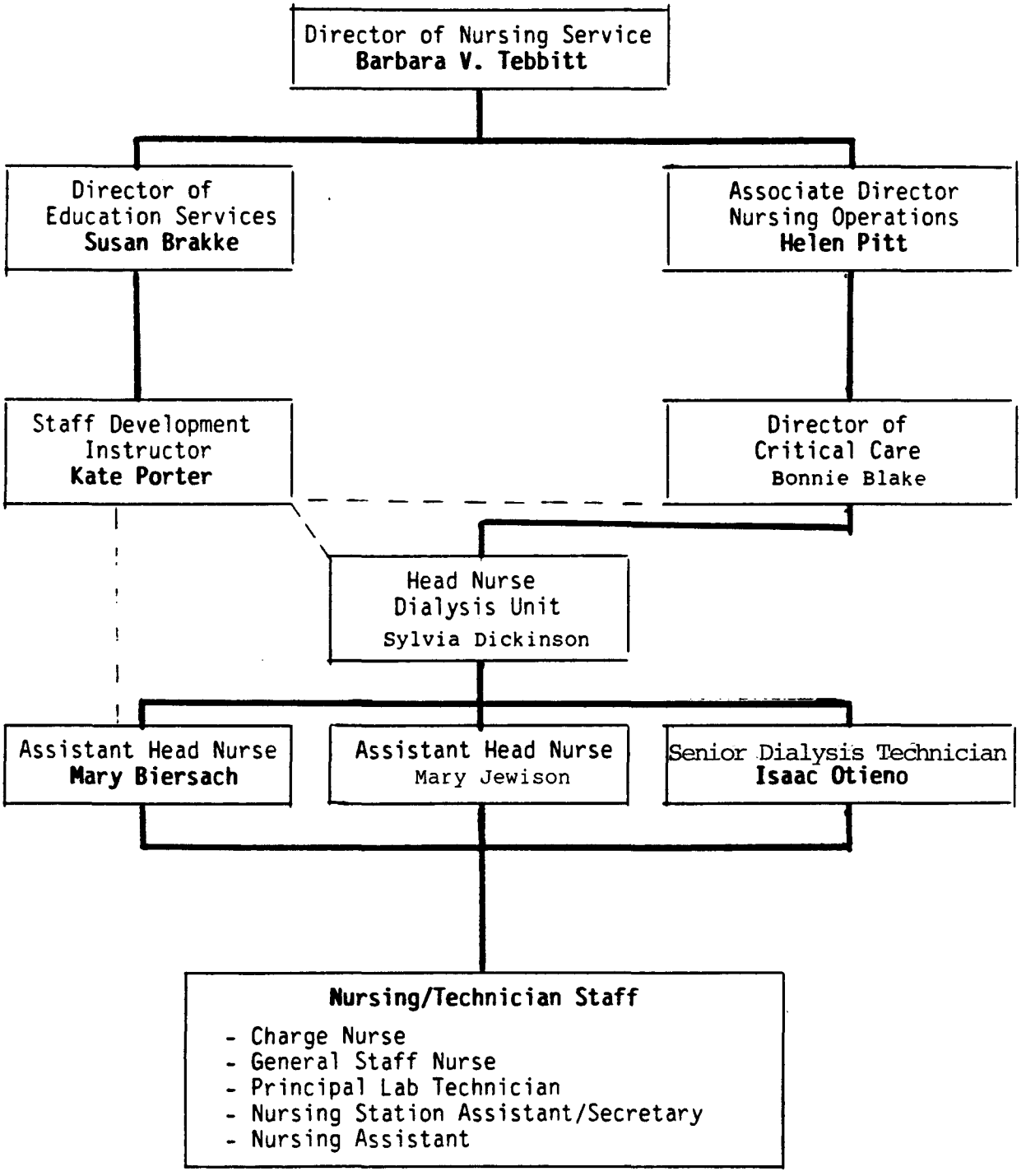
University of Minnesota Hospital and Clinic

NURSING SERVICE

ORGANIZATIONAL STRUCTURE
for the
DIALYSIS UNIT



LEGEND:

_____ indicates direct responsibility and authority

- - - -indicates consultation, education, reference/resource-sharing, etc.

Revised 1/88

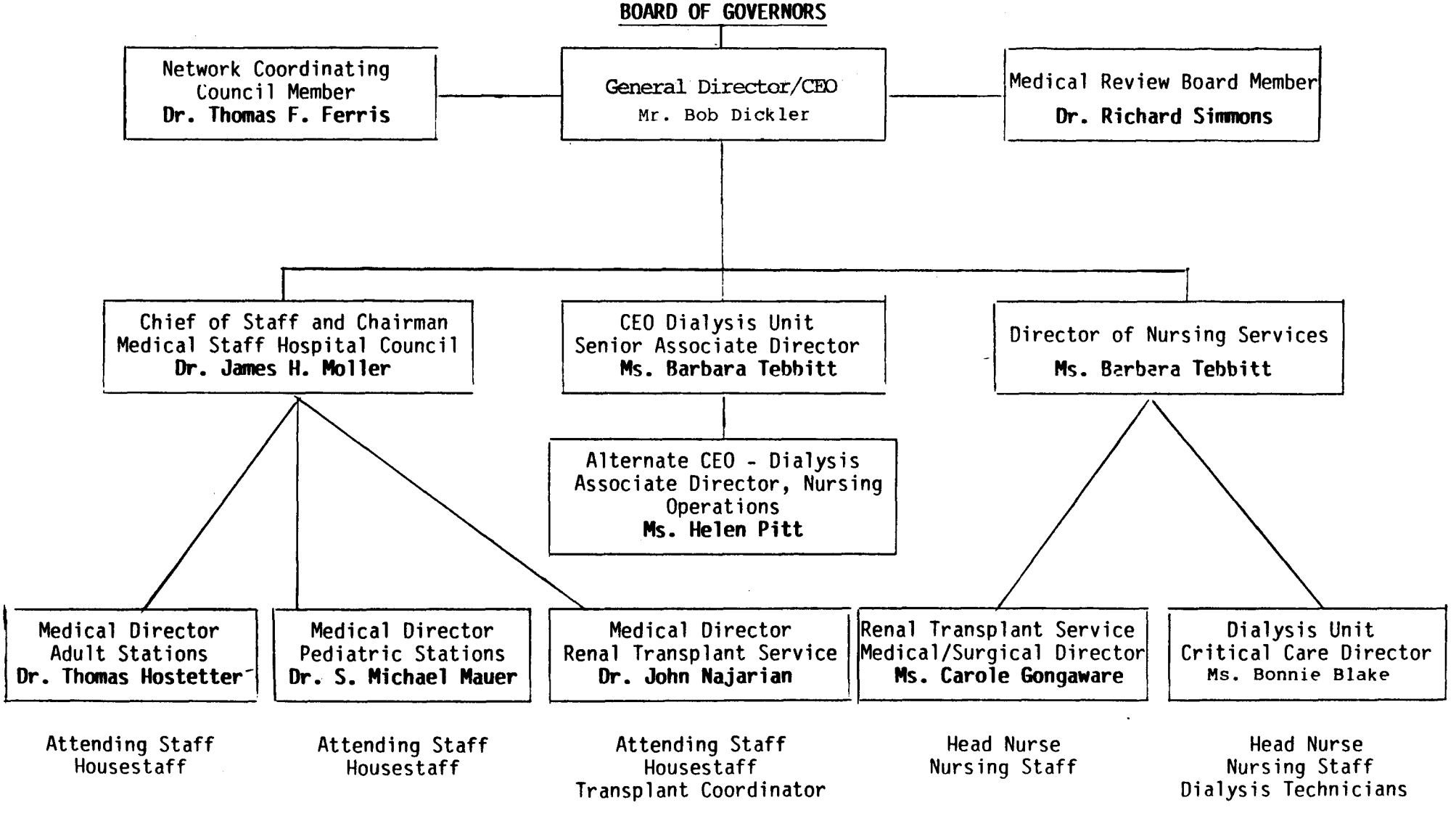
Revised 1/88

University of Minnesota Hospital and Clinic

Chart of Organization

End-Stage Renal Disease Program

Renal Transplant Service and Dialysis Unit



POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

SECTION:	Goals and Objectives Page 1 of 7
VOL.:	POLICY NUMBER: 11.2
EFFECTIVE:	6/83
REVISION:	6/83, 1/86, 12/87
REVIEWED:	1/84, 1/85, 1/86, 12/87

SUBJECT: **PHILOSOPHY, RESPONSIBILITIES AND OBJECTIVES - DIALYSIS UNIT**

SOURCE: Medical Directors

PHILOSOPHY AND RESPONSIBILITIES

In order to reduce fear and anxiety and promote self-care and patient input, the patient will be provided:

1. An environment that provides physiological safety and psychological support.
2. Skilled assessment and monitoring of his/her symptoms and need with corresponding adjustment in care.
3. Care that provides ongoing, individual adjustment in his/her care plan.
4. Ongoing dialogue regarding his/her condition, progress, plan of care, individual needs, and long term program.
5. Personnel that are trained to be proficient in hemodialysis, critical care nursing, pediatric dialysis, and peritoneal dialysis.

OBJECTIVES

1. The hemodialysis areas will provide procedures and policies that maintain safe and effective standards for patient care and operation of the Unit including:
   - A. Written Dialysis Orders
   - B. Standing Orders
   - C. Dialysis Procedures
   - D. Written Patient Orientation Program
   - E. Discharge and Interfacility Transfer Protocols
   - F. General Policies

kd1231877nm

APPROVED:	DATE:
TITLE: Medical Director Medical Director CEO	01/01/88

2. Provide emergency equipment such as:
   A. Arrest Cart
   B. Tracheal and NG Suction
   C. Oxygen and accessory respiratory therapy equipment
   D. Tracheostomy Tray
   E. Defibrillator
   F. EKG Monitoring
3. Provide continuous infection control and monitoring including:
   A. Cleaning procedures and assignments
   B. Isolation procedures
   C. Sterile technique
   D. Hepatitis procedures
   E. Serum Hepatitis surveillance of patients and personnel
4. Provide safe maintenance and repair of equipment including:
   A. Procedures
   B. Assignments
   C. Maintenance schedule and program
   D. Periodic safety evaluations on all electronic patient care equipment
5. Provide continuous monitoring, assessment and treatment of the patient.
   A. Orientation Program for Personnel and Patients
   B. Dialysis Record
   C. Progress Notes
   D. Graphs and "Flow Sheets"
   E. Primary Nursing Care Plan
   F. Cumulative Records
   G. Categorization of each dialysis acuity level

6. Provide evaluation of continuity and quality of dialysis treatment.
   - A. Cumulative Records
   - B. Graphs
   - C. Dialysis Records
   - D. Categorization Records
   - E. Bedside assessment
   - F. Nursing Care Plans
   - G. Primary Nursing Care Audits
   - H. Patient Care Conferences
   - I. Long Term Program

7. Provide staff training and development.
   - A. Orientation program - (Central Orientation and Dialysis Orientation)
   - B. Clinical application
   - C. Assignments
   - D. Individual conferences with personnel
   - E. In-service classes
   - F. Hospital-wide courses
   - G. Personnel evaluations

8. Define roles of patient care personnel.
   - A. Unit Medical Directors
   - B. Renal Fellows
   - C. Job descriptions of Head Nurse, Assistant Head Nurse, Inservice Nurse, Senior Dialysis Technician, Principal Lab Technician, General Staff Nurse, Secretary, Nursing Assistant

9. Provide trained personnel for hemodialysis.
   - A. On-call system (Physician, Nurse and Technician)
   - B. Nursing/technician Hours scheduled four weeks in advance.

10. Promote staff participation.
    A. Open communication to critique the approach to care or organization of the areas in a constructive and organized manner.
    B. Regular meetings with the Medical Directors or their delegates
    C. Staff meetings at least six times per year
    D. Patient Care Conferences
    E. Staff Development Conferences

FACILITY AND STAFF RESOURCES

The Dialysis Areas at the University of Minnesota Hospital and Clinic are comprised of 4,000 square feet in Mayo Hospital and 1,171 square feet in the Main Hospital. The two areas combined have fourteen operating stations that are certified for chronic hemodialysis. Capabilities for acute hemodialysis elsewhere in the hospital exist with mobile hemodialysis units and peritoneal dialysis.

The patient care staff consists of a Head Nurse, one Chief Technician, two Assistant Head Nurses (one with an adult focus and one with a pediatric focus), registered nurses, technicians, nursing assistants, a nursing station secretary and a secretary.

The physician staff consists of Board Certified or Board Eligible Nephrologists who rotate to the Dialysis Areas approximately every two months. They are assisted by Medical Fellows who are Board Certified or Board Eligible in Internal Medicine or Pediatrics. Additionally, residents and medical students may be involved in the training and care of renal patients.

An on-call schedule is maintained with fellows on first call and staff members on second call. Both first and second on-call physicians can be reached either through the paging or by long range beeper system. Beeper numbers are kept at the Hospital Information Desk. One nurse and one technician are also on-call for treatment when the Dialysis Areas are closed.

All chronic dialysis patients are evaluated every dialysis by nurses and physicians, and weekly by the transplant service. The areas operate very closely with local dialysis facilities, and transfer and receive patients to and from dialysis units in all fifty states and throughout the world.

PATIENT INFORMATION

Before being accepted on dialysis, patients are informed about the procedure by nurses, social workers and/or physicians. During these discussions, patients are made aware of the relative merits of hemodialysis, CAPD and/or renal transplantation. Patients receive information about the dialysis procedure by nurses and technicians while the procedure is bieng performed and are given educational material to read. All patients who are not expected to regain renal function are worked-up and evaluated by the Transplant Team.

PRIORITY AND DIALYSIS

Under some circumstances, there may be more patients needing dialysis than the facility is able to accommodate. On these occasions, the Medical Director reviews all patients who need dialysis to determine the options available. Some patients may be able to undergo two rather than three dialysis per week or may be able to tolerate having their dialysis treatments shortened. When making such a decision, special attention will be paid to the potential consequences of decreasing dialysis time with regard to the patient's urea, potassium, creatinine and fluid status.

CARE EVALUATION SYSTEMS

Care is evaluated by the health care team in the following ways:

1. The patients are evaluated at each treatment by the nurses and technicians before and during the entire dialysis procedure. Their observations are charted and any changes are reflected in the Care Plan.

2. Staff physicians and fellows make daily rounds on the patients and review any chemistry studies.

3. At discharge, each patient's record is reviewed by the Medical Director for appropriateness of care and outcome.

ORIENTATION AND CONTINUING EDUCATION

New personnel (nurses and technicians) are oriented by designated registered nurses and technicians who have been trained and are proficient in the appropriate procedures. They prograss in a logical fashion from the dialysis of chronic dialysis patients to the dialysis of the extremely difficult acute newborn. The fellows and staff are oriented by the Medical Director or his substitutes.

Continuing education for nurses and technicians is arranged by the Staff Development Instructor and the Assistant Head Nurse. Inservice education is provided within the Units at least six times per year. Physician continued education is done through weekly conferences, journal clubs, lectures, and meetings where specialists from outside are invited to lecture.

SELECTION OF TREATMENT/MONITORING/VASCULAR ACCESS

On a short term basis, the most suitable treatment is decided by the Medical Director or his associates. The actual performance of these procedures is done following the Standing Orders available in the Dialysis Areas.

During Dialysis, all patients are closely monitored by nurses and technicians and daily rounds are performed by the dialysis physician or fellow covering dialysis. This is documented on the dialysis record.

Vascular access procedures are done under the supervision of a Board Certified surgeon. Except for the placement of temporary access, there are no vascular access operations done in the Dialysis Areas except on an emergency basis.

PLAN OF CARE

The care of patients with end-stage renal disease is a complicated matter involving all members of the health care team. All these members are skilled in obtaining and evaluating different forms of information. In order to facilitate the sharing of this expertise in planning care for a patient, all members of the health care team including: medical nephrologists, staff physicians, residents and fellows who are caring for dialysis patients, primary dialysis nurse, transplant surgeons, dieticians, social workers and the patient, are requested to participate in planned patient care conferences. The purpose of care conferences is to allow the widest dissemination and input of current information and changes in each of the patient's status. During these meetings, the patient's care plan is formed and/or updated and the long term care plan is from time to time updated and signed by the various members of the health care team.

END-STAGE RENAL DISEASE PROGRAM

MEDICAL SPECIALTIES AND SERVICES

Cardiology
Endocrinology
Hematology
Infectious Disease
Neurology
Orthopedics
Pathology
Pediatrics
Psychiatry
Urology
Vascular Surgery
Dietary
Inhalation Therapy
Inhospital Patient Care
Rehabilitation
Social Services
Angiography
EM and Immunomicroscopy
Urine Glucose
Urine Microscopic
CSF-Smear and Cultuer
CSF-Glucose
CSF-Protein

CSF-Cell Count
Prothrombin Time
CBC
Platelet Count
ABO Blood Grouping
ABO Blood Grouping, Rh typing, cross-matching
Blood Glucose (serum, plasma)
BUN
Creatinine
Serum Calcium
Serum Potassium
Serum Phosphorus
SGOT
LDH
Blood pH
Blood Gases
Fungal Smear and Culture
TB Smear and Culture
Cross-matching of recipient serum and donor lymphocytes
Phenotyping donor and recipients
Screening of recipient serum for preformed antibodies

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UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

POLICY AND PROCEDURES MANUAL

SECTION	General Policies
VOL.	POLICY NUMBER III.2
EFFECTIVE	3/79
REVISION	6/83, 1/86, 12/87
REVIEWED	1/84, 1/85, 1/86, 12/87

SUBJECT

CONSULTATION PROCESS

ACUTE DIALYSIS - ADULT & PEDIATRIC

SOURCE

Dialysis Leadership Team

POLICY

Attending, Fellow and Pediatric Nephrologist consultation is provided for all patients requiring dialysis for acute renal failure in both adult and pediatric patients.

PROCEDURE

Responsible Individual	Action
Green Medicine Consultation Attending and Fellow or Pediatric Nephrologist	1. Evaluate patient. 2. Determine the need for acute hemodialysis. 3. Confer with the appropriate dialysis area physician. 4. Write appropriate orders. 5. Contact the Charge Nurse during regular hours or call the on-call nurse during on-call hours. 6. Are available for questions and problem solving.

kd1231874nm

APPROVED	DATE
T Hatt S M Mauer Barbara Turbett	01/01/88
TITLE: Medical Director Medical Director CEO	

POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

SECTION:	Page 1 of 2
VOL.:	POLICY NUMBER: III.5
EFFECTIVE:	1/79
REVISION:	6/83, 1/86, 9/87, 1/88
REVIEWED:	1/84, 1/85, 1/86, 1/87, 1/88

SUBJECT: **MEDICAL RECORDS**

SOURCE: Dialysis Leadership Team

POLICY

The facility will maintain in a central location the complete medical record on all dialysis patients. The medical record will be readily available, and systematically organized to facilitate the compilation and retrieval of information. The facility will provide safeguards to protect the patient's medical record against loss, destruction, or unauthorized use. (See Hospital Policies #14.2 and #14.4.) With proper authorization, interchange of medical and other information necessary or useful in the care and treatment of patients will be provided.

PROCEDURE

Responsible Individual	Action
Medical Record Supervisor	1. Ensures that medical records are retained for a period of time that complies with state statutes.
	2. Provides for adequate facilities, equipment, and space for efficient processing of medical records.
Senior Dialysis Secretary	1. Ensures that current medical records and those of discharged patients are completed promptly.
	2. Centralizes all clinical information pertaining to the patient and includes it in the patient's medical record.
	3. Transfers the patient's medical record to the central medical records department in the facility.

kd0105881nm

APPROVED:	P. Hatt	S.M. Maier	Barbara Van Tuinen	DATE: 01/01/88
TITLE:	Medical Director	Medical Director	CEO	

Responsible Individual	Action
Renal Fellow, Attending Physician	1. Document accurately in patient's medical record sufficient information to identify patient clearly, justify the diagnosis and treatment. 2. Document the results of treatment accurately.
Station Secretary, Nursing Staff	1. Ensure the following items are included in each outpatient medical record: a). face sheet b). physician's orders c). progress notes d). flow sheets e). all diagnostic results f). initial dialysis order form g). problem list h). kidney dialysis data base i). entry form j). nursing care plan k). long term program l). consultation reports m). correspondence n). discharge summaries o). care conference record p). parenteral fluid sheet 2. Provide new blank forms for each chart as needed.

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POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

SECTION:	Page 1 of 1
VOL.:	POLICY NUMBER: III.7
EFFECTIVE:	1/79
REVISION:	6/83, 1/86, 4/87, 12/87
REVIEWED:	1/84, 1/85, 1/86, 1/87, 4/87, 12/87

SUBJECT: PATIENT RIGHTS AND RESPONSIBILITIES

SOURCE: Dialysis Leadership Team

POLICY

It is the policy of the University of Minnesota Hospital and Clinic to promote the interest and well-being of patients receiving care at the University Hospital. It is also our policy that these rights shall be respected and that no patient may be required to waive his or her rights as a condition of admission to the University of Minnesota Hospital Dialysis Unit.

PROCEDURE

Responsible Individual	Action
Primary Nurse	1. Gives the University of Minnesota Hospital and Clinic Patient Rights and Responsibilities Booklet to each patient or their guardian.
	2. Reads Rights and Responsibilities to patient if patient is visually impaired, or provides translator if language barrier exists.
	3. Answers questions patients and family may have regarding Rights and Responsibilities.
Patient (guardian, if patient unable)	1. Signs his or her name on Dialysis Patient Data Base, indicating that he or she has received and understands the Rights and Responsibilities information.

kd1231876nm

APPROVED:	DATE:
TITLE: Medical Director Medical Director CEO	01/01/88

POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

SECTION:	Page 1 of 3
VOL.: III	POLICY NUMBER: 12
EFFECTIVE:	4/6/87
REVISION:	12/87
REVIEWED:	12/87

SUBJECT: PATIENT TEAM ROUNDS AND CARE CONFERENCES - ADULT AREA

SOURCE: Medical Director

POLICY

I. Purpose

Multidisciplinary Patient Team Rounds are held to provide patient care review and patient care conferences are monthly.

II. Participants

The following team members participate: Renal Fellow, Dialysis Attending R.N., dietician, social worker, Head Nurse, Assistant Head Nurse, Primary Staff Nurses, and the appropriate patient and/or his/her guardian or family. Additional informational resources are included as necessary (representatives from nursing homes, rehabilitation therapy, consult services, etc.).

III. Frequency

The care plans and lab work of all acute hemodialysis patients* and non-stable, chronic hemodialysis patients** will be reviewed at each meeting. Patients and/or families are welcome to participate in that portion of the review that is related to them.

Stable, chronic hemodialysis patients*** will have their care plans and Long Term Program reviewed in detail every six months during Patient Team Rounds. Patients and/or their families are invited to attend the care conference. If the patient is unable to attend, his/her Primary Nurse will share the outcome of the review process.

* Acute hemodialysis patients - patients in whom renal failure is expected to resolve: e.g., post-transplant patients with acute tubular necrosis, post trauma patients, drug overdose patients, ICU patients with any form of acute renal failure, etc.

kd1229874nm

APPROVED:			DATE:
TITLE:	Medical Director	Medical Director CEO	01/01/88

** Non-stable, chronic hemodialysis patients - patients who require chronic hemodialysis but have complications that require very close follow-up: e.g., first 2-3 weeks after initiating hemodialysis, hospitalized for longer than 48 hours, major surgery, frequent chest pain and/or severe hypotensive episodes during dialysis, etc.

*** Stable, chronic hemodialysis patients - patients who, as outpatients, require very little to moderate follow-up of their disease and its complications: e.g., more than 3 weeks after the initiation of dialysis, stable weight gains, no chest pain during or off dialysis, etc.

PROCEDURE

IV. Schedule

Patient Team Rounds and Care Conferences will be held on alternating Tuesdays of each month.

Responsible Individual	Action
Assistant Head Nurse - Adult Area	1. Informs the Head Nurse in advance of a patient's need for a care conference.
	2. Follows up on the completion of the care plan review event.
Head Nurse	1. Prepares the agenda for each Tuesday meeting, citing the patients requiring review in each category.
	2. Forwards a copy to the patient team and to the Primary Nurse(s) whose patient(s) require(s) total care plan review.
	3. Assures that a Nurse is in attendance for Patient Team Rounds.
	4. Maintains documentation of meeting content for two years.

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Responsible Individual	Action
Primary Nurse	1. Informs the patient and/or family of the date and time of his/her care plan review. 2. Extends an invitation for them to attend. 3. Has the patient/family member complete the End Stage Renal Disease (ESRD) Patient Care Plan Review Document. 4. Represents the patient if he and/or his family are not able to attend and informs those people of the outcome of the care plan review. 5. Leads the care conference for his/her primary patient.
Patient/Family Member	1. Completes and signs the End Stage Renal Disease (ESRD) Patient/Family Member Care Plan Review Document.
Renal Fellow	1. Presents current information. 2. Assists in patient care problem solving.
All Team Members	1. Completes and signs the End Stage Renal Disease (ESRD) Patient Care Plan Review Document.

kd1229874nm bp

POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

SECTION:	General Policies Page 1 of 1
VOL.:	POLICY NUMBER: III.13
EFFECTIVE:	11/87
REVISION:	
REVIEWED:	

SUBJECT:
KIDNEY DIALYSIS
MEDICAL ADVISORY COMMITTEE

SOURCE: Kidney Dialysis Medical Advisory Committee

POLICY

The Kidney Dialysis Medical Advisory committee is a multidisciplinary committee organized to guide the activities of the Renal Dialysis Unit (Adult and Pediatric areas). Informational resources from other disciplines will be invited to the committee as appropriate.

PROCEDURE

Responsible Individual	Action
Advisory Committee	1. Is accountable for developing renal dialysis program objectives, related policy/procedures, reviewing Quality Assurance activities, and problem solving.
	2. Meets bi-monthly or at least quarterly.
Medical Director or Designee	1. Chairs the committee.
	2. Is accountable for policy approval.
Kidney Dialysis Unit Head Nurse, Chief Technician, Assistant Head Nurses, and Director of Critical Care	1. Participate on the committee.
	2. Rotate documentation of minutes.
Head Nurse and Director of Critical Care	1. Maintain and review quality assurance activities.
	2. Submit changes annually to the University of Minnesota Hospital and Clinic, Board of Governors, for approval.

kd1229873nm

APPROVED: [signatures]	DATE: 01/01/88
TITLE: Medical Director Medical Director CEO	

POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

SECTION: General Policies	
VOL.:	POLICY NUMBER: III.14
EFFECTIVE: 11/87	
REVISION:	
REVIEWED:	

SUBJECT:
PATIENT SELECTION CRITERIA

SOURCE: Dialysis Leadership Team, Critical Care Director, and Medical Directors

POLICY

CHRONIC DIALYSIS

Both stable and non-stable patients are considered for chronic dialysis when chronic renal failure can no longer be managed by more conservative measures. There is no specific disease or disease process that would automatically exclude a patient from receiving chronic dialysis. The interdisciplinary team (social worker, dietician, dialysis nurse, medical nephrologist, staff physicians, residents, and fellows) works with each individual patient and family to assess their rehabilitative, social, economic, psychological, and emotional factors concerned with adjusting to a dialysis regimen. The team considers these factors in the selection of treatment modalities. Patient selection for chronic dialysis is based on the patient's desire for treatment and approval of the medical nephrologists.

ACUTE DIALYSIS

Patients are considered for acute dialysis when they demonstrate acute renal failure that is not responsive to other treatment modalities. The option of dialysis is discussed and explained to the patient and/or family. Dialysis is begun only after informed approval. The patient's need for dialysis treatments will be evaluated daily. A patient judged by the nephrologist to be physically unable to tolerate the treatment will not receive dialysis. Improved or stabilized acute renal failure may result in terminating treatment. If the acute renal failure becomes chronic, the interdisciplinary team will follow the selection criteria for chronic renal failure.

kd1229871nm

APPROVED:			DATE:
TITLE: Medical Director	Medical Director	CEO	01/01/88

POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

SECTION:	General Policies
VOL.:	POLICY NUMBER: 111.15
EFFECTIVE:	12/87
REVISION:	-
REVIEWED:	

SUBJECT: TERMINATION OF TREATMENT

SOURCE: Dialysis Leadership Team, Critical Care Director and Medical Directors

POLICY

When circumstances arise which raise the issue of termination of treatment (e.g., advanced malignancy or dementia), interdisciplinary team conferences are held followed by discussions with the patient or family, as appropriate. No patient's treatment is terminated unless the patient or competent and responsible family members are in total agreement. In addition, Hospital Policy 4.7 will be utilized.

kd1229872nm

APPROVED:	DATE:
TITLE: Medical Director Medical Director CEO	01/01/88

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

POLICY AND PROCEDURES MANUAL

SECTION	
Page 1 of 1	
VOL.	POLICY NUMBER IV.13
EFFECTIVE 9/76	
REVISION 6/83, 1/85, 1/86, 6/87, 12/87	
REVIEWED 1/84, 1/85, 1/86, 1/87	

SUBJECT

CHARTING BY KIDNEY DIALYSIS TECHNICIANS

SOURCE

Dialysis Leadership Team

POLICY

Kidney Dialysis Technicians will chart all pertinent data that they have collected on patients to whom they are assigned each shift. They will follow the charting policies using the Problem Oriented Medical Records (POMR) system after orientation to data collection and the policies. A Data Assessment Plan (DAP) note will be written on each patient pre-dialysis, describing the patient's condition and plan of care for the dialysis treatment. The charge nurse will read and review the DAP note, and sign his/her name to indicate awareness of the technician's charting.

PROCEDURE

Responsible Individual	Action
Dialysis Technician	1. Collects data on assigned patients.
	2. Writes Data Assessment Plan (DAP) note pre-dialysis, describing patient's condition, complaints, and plan of care for the dialysis treatment.
Charge Nurse	1. Reads and reviews charting completed by Dialysis Technician.
	2. Signs name to Data Assessment Plan (DAP) note.

APPROVED	DATE
TITLE Medical Director Medical Director CEO	01/01/88

POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

SECTION:	Personnel Policies Page 1 of 3
VOL.:	POLICY NUMBER: IV.15
EFFECTIVE:	6/83
REVISION:	1/84, 8/84, 1/86, 1/87, 12/87
REVIEWED:	1/84, 1/85, 1/86, 1/87, 12/87

SUBJECT: **ON-CALL GUIDELINES**

SOURCE: Dialysis Leadership Team

POLICY

New employees are assimilated into the Call Schedule 4 to 6 months after completing Dialysis Orientation. From time-to-time, this may vary depending on the new employee's background and experience in this Dialysis Unit.

Weekday Call starts at 12 Midnight Sunday and lasts until 7:30 a.m. Monday morning. From Monday - Friday, call begins at 11:30 p.m. and ends at 7:30 a.m. the following morning. Call starting at 11:30 p.m. Friday ends at 9:00 a.m. Saturday morning, resumes at 5:30 p.m. Saturday and ends at 12 Midnight Sunday.

On-call pay is $1.75 per hour. Call pay must be taken as pay rather than time back. When on-call staff are called in, the hours worked begin from the time they are called in and continue until they leave the hospital. When personnel are called in and dialysis is cancelled, staff should claim three hours on their paycards. If staff are called in, hours worked may be claimed as paid hours or time back.

Dialysis personnel are to be called in only by Dialysis Physicians. When on-call staff are contacted by others, such as a unit secretary or another physician, staff should feel comfortable in instructing that individual to contact the Dialysis Physician on call. The Dialysis Physician will then contact the on-call staff.

Staff should not hesitate to discuss the need for emergency dialysis with the Dialysis Physician. On-call personnel should be called only for emergency situations or when the dialysis schedule runs past the usual hours of Unit operation. On-call staff (nurse and technician) will not work more than 16 consecutive hours.

Pregnant staff members are deleted from the Call rotation because of the possibility of being called in to dialyze patients with contagious infections.

kd1231879nm

APPROVED:	DATE:
TITLE: Medical Director Medical Director CEO	01/01/88

PROCEDURE

Responsible Individual	Action
Nurse and Technician On-Call	1. Carries a long range beeper when away from home.
	2. Reports to the Unit within 40 minutes when called in.
Nurse On-Call	1. Picks up the Unit and narcotic keys in the Resource Office on arrival.
	2. Locks the Unit and returns the Unit and narcotic keys to the Resource Office when leaving.
	3. Pages the Resource Nurse at the front desk of the Hospital if the Resource Office is locked.
	4. Requests help from the patient's Unit and/or the Resource Nurse if the patient's acuity is such that assistance is needed. One-to-one patients require that the Unit nurse provide care during dialysis.
	5. Contacts the Resource Nurse if:
	a. Staff anticipate exceeding 16 consecutive hours of work.
	b. The number of patients to be dialyzed exceeds:
	1). One acute patient 2). One pediatric patient 3). Three stable chronic patients

kd1231879nm

Responsible Individual	Action
The Resource Nurse	1. Contacts other dialysis staff to come in to assist. 2. Contacts the Head Nurse and then each Assistant Head Nurse if the Head Nurse is not available.
Dialysis Physician On-Call	1. Contacts both the nurse and technician on-call if emergency dialysis is needed. 2. Sets priorities when more than one patient requires emergency dialysis.

kd1231879nm

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

POLICY AND PROCEDURES MANUAL

SECTION	Page 1 of 1
VOL.	POLICY NUMBER IV.20
SUBJECT: PREGNANT PERSONNEL	EFFECTIVE: 3/79
	REVISION: 6/83, 11/85, 9/87, 12/87
SOURCE: Dialysis Leadership Team	REVIEWED: 1/84, 1/85, 1/86, 1/87 12/87

POLICY

The pregnant staff member will be given the option of transferring out of the Renal Unit. The pregnant nurse or technician will be removed from the on-call rotation.

PROCEDURE

Responsible Individual	Action
Nurse or Technician	1. Notifies the Head Nurse of her pregnancy as soon as it is known.
	2. Seeks information regarding the possible dangers of Cytomegalovirus and Hepatitis B to the fetus and to the mother.

kd1231872nm

APPROVED	DATE: 01/01/88
TITLE: Medical Director Medical Director CEO	

POLICY AND PROCEDURES MANUAL

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

SECTION:	Personnel Policies
VOL.:	POLICY NUMBER: IV.24
EFFECTIVE:	9/9/87
REVISION:	12/24/87
REVIEWED:	12/87

SUBJECT: PREPARATION AND CONNECTION OF EQUIPMENT FOR CONTINUOUS ARTERIO-VENOUS HEMOFILTRATION (CAVH)

SOURCE: Dialysis Leadership Team

POLICY

When CAVH is required for patient care, a dialysis technician will prepare the required equipment and a dialysis technician or a dialysis nurse will complete the patient-blood pathway connection. All preparation and connection will be under the orders of an adult or pediatric nephrologist or renal fellow.

PROCEDURE - Pediatrics

Responsible Individual	Action
Pediatric Nephrologist or Pediatric Renal Fellow	1. Contacts the Charge Nurse in the pediatric dialysis area during regular working hours and requests a CAVH set-up; writes orders in the CAVH Record and Progress Note.
	2. Contacts the technician on call and requests a CAVH set-up and connection during on-call hours; writes orders on the CAVH Record and Progress Note.
	3. Remains with the technician and Pediatric ICU Nurse during the patient-blood pathway connection.
Charge Nurse - Dialysis (if during regular working hours)	1. Designates a technician to prepare and connect the CAVH set-up.
	2. Transcribes the doctor's orders.

kd1230871nm

APPROVED:			DATE:
TITLE:	Medical Director	Medical Director CEO	01/01/88

Responsible Individual	Action
Charge Nurse - Peds ICU (if during Dialysis Unit on-call hours)	1. Transcribes the doctor's orders. 2. Reviews orders with the Dialysis Technician.
Dialysis Technician	1. Sets up and prepares the necessary equipment for CAVH. 2. Completes the middle section of the CAVH Record noting pre-treatment vital signs, lab results and all other information. 3. Makes any notes or comments in that section of the CAVH Record regarding special set-up, access problems, etc. 4. Completes the patient-blood pathway connection with the Pediatric Nephrologist present and with the assistance of the Pediatric ICU Nurse. 5. Notes the time the connection was complete. 6. Signs his/her name at the bottom of the CAVH Record.
The Individual Who Terminates the CAVH Treatment (technician or nurse or physician)	1. Notes the time the procedure was completed. 2. Signs his/her name at the bottom of the CAVH Record. 3. Notes the post-treatment vital signs and any other relevant lab work in the middle section of the CAVH Record.

kd1230871nm

PROCEDURE - Adult

Responsible Individual	Action
Renal Fellow or Dialysis Nephrologist	1. Contacts the charge nurse in the adult dialysis area during regular working hours and requests a CAVH set-up; writes orders on the CAVH Record and Progress Note.
	2. Contacts the nurse and the technician on-call and requests a CAVH set-up during on-call hours; writes the orders on the CAVH Record and Progress Note.
	3. Remains available to the nurse on-call during the patient-blood pathway connection.
Charge Nurse - Dialysis (if during regular working hours)	1. Designates a technician to prepare the CAVH set-up.
	2. Transcribes the doctor's orders.
	3. Designates an R.N. to complete the CAVH patient-blood pathway connection.
Technician	1. Sets up and prepares the necessary equipment for CAVH.
	2. Accompanies nurse to the bedside.
Staff Nurse	1. Transcribes the doctor's orders, if on-call.
	2. Completes the middle section of the CAVH Record noting pre-treatment vital signs, lab results and all other information.

kd1230871nm

Responsible Individual	Action
Staff Nurse (continued)	3. Makes any notes or comments in that section of the CAVH Record regarding special set-up, access problems, etc. 4. Completes the patient-blood pathway connection. 5. Notes the time the connection was complete. 6. Signs his/her name at the bottom of the CAVH Record.
The Individual Who Terminates the CAVH Treatment (technicians, dialysis nurse, Adult ICU nurse)	1. Notes the time the procedure was completed. 2. Signs his/her name at the bottom of the CAVH Record. 3. Notes the post-treatment vital signs and any other relevant lab work in the middle section of the CAVH Record.

kd1230871nm

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

POLICY AND PROCEDURES MANUAL

SECTION	
Page 1 of 2	
VOL. V	POLICY NUMBER 2
EFFECTIVE 1/85	
REVISION 8/86, 9/87	
REVIEWED 1/85, 1/86, 1/87	

SUBJECT

CHIEF EXECUTIVE OFFICER RESPONSIBILITIES

SOURCE

KDU Management/Leadership

POLICY

The Chief Executive Officer is responsible for overall administrative direction for the Renal Transplantation Center and is aware of communication regarding policies, rules, and regulations.

PROCEDURE

Responsible Individual	Action
Chief Executive Officer for End Stage Renal Disease (ESRD)	1. Implements the policies of the facility and coordinates the provision of services in accordance with delegations by the Board of Governors.
	2. Organizes and coordinates the administrative functions of the facility, redelegating duties as authorized, and establishes formal means of accountability.
	3. Assures administrative accountability for the competent financial management of the center.
	4. Assures staff orientation/education complies with all policies, rules and regulations, and applicable Federal, State and Local laws and regulations.

kd1231878nm

APPROVED	DATE
TITLE Medical Director Medical Director CEO	01/01/88

Responsible Individual	Action
Chief Executive Officer for ESRD (continued)	5. Submits such records and reports as may be required by the Medical Review Board for the ESRD program and other agencies including the Secretary of Health and Human Services.
	6. Participates in developing and implementing contract agreements into which the Hospital may enter subject to the approval of the University and Board of Governors as required.
Associate Director of Nursing Operations	1. Assumes responsibilities for Chief Executive Officer duties in his/her absence.

kd1231878nm

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

POLICY AND PROCEDURES MANUAL

SECTION	Page 1 of 4
VOL.	POLICY NUMBER VI .1
EFFECTIVE	
REVISION	
REVIEWED	

SUBJECT: GENERAL GUIDELINES FOR UNIVERSAL BLOOD AND BODY SUBSTANCE TECHNIQUE FOR THE KIDNEY DIALYSIS UNIT

SOURCE:

POLICY

In the dialysis population there exists the continual risk of exposure, contamination, cross contamination and infection of many different infectious agents. Standardization of practice in such a divergent, potentially infectious population is seen as the best approach to ensure that adequate infection control practices are used on all dialysis patients. All patients and patient specimens will be considered potentially infectious and will be cared for/handled using Universal Blood and Body Substance Technique. (See Hospital Policy 33.21)

PROCEDURE

Responsible Individual	Action
All Kidney Dialysis Personnel and Medical Staff	1. Wear gloves for: a) Touching blood and body fluids, mucous membranes or non-intact skin; b) Handling items or surfaces soiled with blood or body fluids; c) Initiation and termination of dialysis; d) All access procedures; e) Blood-drawing; f) IV medication administration via bloodlines; g) Initiation or termination of a blood transfusion;

APPROVED	DATE
TITLE: Medical Director; Medical Director; CEO	02/11/88

SECTION	
Page 2 of 4	
VOL.	POLICY NUMBER
	VI .1
SUBJECT General Guidelines for Universal Blood and Body Substance Technique for The Kidney Dialysis Unit	

PROCEDURE (continued)

Responsible Individual	Action
All Kidney Dialysis Personnel and Medical Staff (continued)	h) Clean-up; i) Any emergency where leakage of blood is possible. 2. Change gloves (not washed or re-used) after each patient contact. 3. Perform handwashing/skin cleansing: a) Immediately after gloves are removed; b) After contamination with blood or body fluids; c) Upon entering and leaving the unit; d) Before and after attending to personal hygiene. 4. Wear a moisture resistant gown during all procedures that are likely to generate blood or other body fluids enough to soak through an ordinary fabric gown, such as: a) Initiation and termination of dialysis; b) All access procedures; c) During tearing-down of dialysis. 5. Remove gown when: a) It is soiled; b) Leaving patient care area.

PROCEDURE (continued)

Responsible Individual	Action
All Kidney Dialysis Personnel and Medical Staff (continued)	6. Wear masks and protective eyewear when involved in a procedure that is likely to generate droplets of blood or other body fluids such as: a) Initiation and termination of dialysis; b) All access procedure; c) Tearing-down of dialysis machines.
	7. Dispose of sharps appropriately (see page 2 of Hospital Policy 33.32).
Respiratory Therapist, Kidney Dialysis Head Nurse, Assistant Head Nurses and Charge Nurses	1. Ensure that ventilation devices (mouthpiece, resuscitation bag) are available for emergencies.
	2. Replace used ventilation devices with new ones, when contaminated.
Nursing Assistant	1. Ensures that each patient cubicle contains a puncture resistant container for all sharps.
	2. Changes .5% bleach solution, used for mopping, every morning, and after each blood spill.
Kidney Dialysis Nurses and Technicians	1. Remove visible blood from machines with .5% bleach solution.
	2. Clean entire surface of machine with .5% bleach solution.
	3. Discard bloodlines and dialyzer into the bio-hazardous waste container.

PROCEDURE (continued)

Responsible Individual	Action
Kidney Dialysis Nurses and Technicians (continued)	4. Clean dialysate pathway with .5% bleach and heat cycle, if blood leak has occurred during run.
	5. Put all machines through heat sterilization, daily.
All Kidney Dialysis Personnel	1. Document all actual and potential unprotected exposures.
	2. Report all exposures immediately to Employee Health Service/Emergency Department. (see Hospital Policy 33.18).

UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

POLICY AND PROCEDURES MANUAL

SECTION	IX. Miscellaneous
VOL.	POLICY NUMBER IX.3
SUBJECT	ELECTRICAL SAFETY
EFFECTIVE	3/79
REVISION	6/83, 1/87, 12/87
SOURCE	Dialysis Head Nurse
REVIEWED	1/84, 1/85, 1/86, 1/87 12/87

POLICY

The Dialysis Unit has an equipotential ground system. The Biomedical Engineer includes electrical safety checking within the routine preventive maintenance of equipment (Policy VIII.4).

PROCEDURE

Responsible Individual	Action
Biomedical Engineering	1. Performs electrical safety checks on dialysis related equipment: a. Dialysis delivery systems are checked every month. b. Defibrillator output and EKG operations checked every three months. 2. Places a sticker on the tested equipment indicating the date checked. 3. Records results of checks and keeps the records in the Biomedical Engineering Department.

kd1231871nm

APPROVED	DATE
TITLE Medical Director Medical Director CEO	01/01/88

handout for at March Court Conference

The acceptance by the claimant of any such settlement shall be final and conclusive on the claimant and shall constitute a complete release of any claim against the state and against the employee of the state whose act or omission gave rise to the claim, by reason of the same subject matter.

Subd. 3. No settlement made under the provisions of this section shall be valid unless it is supported by a claim in writing, and is approved in writing by the attorney general as to its form and legality. The claim shall be in such form as the attorney general may prescribe.

Subd. 4. [Repealed, 1978 c 793 s 98]

Subd. 5. Nothing in this section is to be construed as to deny a claimant who is not paid pursuant to the provisions hereof from bringing an action at law in the courts of this state.

Subd. 6. The head of each department or agency, or a designee, acting on behalf of the state, may enter into structured settlements, through the negotiation, creation, and utilization of annuities or similar financial plans for claimants, to resolve claims arising from the alleged negligence of the state, its agencies, or employees. The requirements set forth in sections 16.07, 16.08, and 16.098 shall not apply to the state's selection of and contracts with structured settlement consultants or purveyors of structured settlement plans.

History: *1971 c 962 s 13; 1973 c 123 art 5 s 7; 1973 c 349 s 2; 1974 c 557 s 8-10; 1975 c 271 s 6; 1975 c 321 s 2; 1976 c 331 s 30-32; 1978 c 669 s 1; 1983 c 193 s 1; 1983 c 258 s 9; 1983 c 301 s 58; 1984 c 619 s 10; 1985 c 166 s 1; 1Sp1985 c 13 s 374; 1986 c 444*

3.735 [Repealed, 1976 c 331 s 42]

3.736 TORT CLAIMS.

Subdivision 1. **General rule.** The state will pay compensation for injury to or loss of property or personal injury or death caused by an act or omission of any employee of the state while acting within the scope of office or employment or peace officer who is not acting on behalf of a private employer and who is acting in good faith pursuant to section 629.40, subdivision 4, under circumstances where the state, if a private person, would be liable to the claimant, whether arising out of a governmental or proprietary function. Nothing in this section waives the defense of judicial or legislative immunity except to the extent provided in subdivision 8.

Subd. 2. **Procedure.** Claims of various kinds shall be considered and paid only in accordance with the statutory procedures provided. Where there is no other applicable statute, a claim shall be brought pursuant to this section as a civil action in the courts of the state.

Subd. 3. **Exclusions.** Without intent to preclude the courts from finding additional cases where the state and its employees should not, in equity and good conscience, pay compensation for personal injuries or property losses, the legislature declares that the state and its employees are not liable for the following losses:

(a) Any loss caused by an act or omission of a state employee exercising due care in the execution of a valid or invalid statute or rule;

(b) Any loss caused by the performance or failure to perform a discretionary duty, whether or not the discretion is abused;

(c) Any loss in connection with the assessment and collection of taxes;

(d) Any loss caused by snow or ice conditions on any highway or public sidewalk that does not abut a publicly-owned building or a publicly-owned parking lot, except when the condition is affirmatively caused by the negligent acts of a state employee;

(e) Any loss caused by wild animals in their natural state;

(f) Any loss other than injury to or loss of property or personal injury or death;

(g) Any loss caused by the condition of unimproved real property owned by the

state, which means land that the state has not improved, and appurtenances, fixtures and attachments to land that the state has neither affixed nor improved;

(h) Any loss incurred by a user within the boundaries of the outdoor recreation system and arising from the construction, operation, or maintenance of the system, as defined in section 86A.04, or from the clearing of land, removal of refuse, and creation of trails or paths without artificial surfaces, or from the construction, operation, or maintenance of a water access site created by the iron range resources and rehabilitation board, except that the state is liable for conduct that would entitle a trespasser to damages against a private person;

(i) Any loss of benefits or compensation due under a program of public assistance or public welfare, except where state compensation for loss is expressly required by federal law in order for the state to receive federal grants-in-aid;

(j) Any loss based on the failure of any person to meet the standards needed for a license, permit, or other authorization issued by the state or its agents;

(k) Any loss based on the usual care and treatment, or lack of care and treatment, of any person at a state hospital or state corrections facility where reasonable use of available appropriations has been made to provide care;

(l) Any loss, damage, or destruction of property of a patient or inmate of a state institution;

(m) Any loss for which recovery is prohibited by section 169.121, subdivision 9.

The state will not pay punitive damages.

Subd. 4. **Limits.** The total liability of the state and its employees acting within the scope of their employment on any tort claim shall not exceed:

(a) $200,000 when the claim is one for death by wrongful act or omission and $200,000 to any claimant in any other case.

(b) $600,000 for any number of claims arising out of a single occurrence. If the amount awarded to or settled upon multiple claimants exceeds $600,000, any party may apply to any district court to apportion to each claimant a proper share of the $600,000. The share apportioned each claimant shall be in the proportion that the ratio of the award or settlement bears to the aggregate awards and settlements for all claims arising out of the occurrence.

The limitation imposed by this subdivision on individual claimants includes damages claimed for loss of services or loss of support arising out of the same tort.

Subd. 4a. **Securities claims limits.** The total liability of the state and its employees acting within the scope of their employment on any claim of whatever matter arising from the issuance and sale of securities by the state shall not exceed:

(a) $100,000 to any one person or

(b) $500,000 to all claimants in respect of the securities of the same series.

The foregoing limitations in clauses (a) and (b) shall not affect the obligation of the issuing state entity to pay the indebtedness under the securities in accordance with their terms and from the sources pledged to their payment.

Subd. 5. **Notice required.** Except as provided in subdivision 6, every person, whether plaintiff, defendant or third party plaintiff or defendant, who claims compensation from the state or a state employee acting within the scope of employment for or on account of any loss or injury shall present to the attorney general of the state or, in the case of a claim against the university of Minnesota, to the person designated by the regents of the university as the university attorney, and any state employee from whom the claimant will seek compensation, within 180 days after the alleged loss or injury is discovered, a notice stating the time, place and circumstances thereof, the names of any state employees known to be involved, and the amount of compensation or other relief demanded. Actual notice of sufficient facts to reasonably put the state or its insurer on notice of a possible claim complies with the notice requirements of this section. Failure to state the amount of compensation or other relief demanded does not invalidate the notice, but the claimant shall furnish full information available

regarding the nature and extent of the injuries and damages within 15 days after demand by the state. The time for giving the notice does not include the time during which the person injured is incapacitated by the injury from giving the notice.

Subd. 6. **Claims for wrongful death; notice.** When the claim is one for death by wrongful act or omission, the notice may be presented by the personal representative, surviving spouse, or next of kin, or the consular officer of the foreign country of which the deceased was a citizen, within one year after the alleged injury or loss resulting in the death. If the person for whose death the claim is made has presented a notice that would have been sufficient had the person lived, an action for wrongful death may be brought without any additional notice.

Subd. 7. **Payment.** A state agency, including any entity defined as part of the state in section 3.732, subdivision 1, clause (1), incurring a tort claim judgment or settlement obligation or whose employees acting within the scope of their employment incur the obligation shall seek approval to make payment by submitting a written request to the commissioner of finance. The request shall contain a description of the tort claim precipitating the request, specify the amount of the obligation and be accompanied by copies of judgments, settlement agreements or other documentation relevant to the obligation for which the agency is seeking payment. Upon receipt of the request and review of the claim, the commissioner of finance shall determine the proper appropriation from which to make payment. If there is sufficient money in an appropriation or combination of appropriations to the agency for its general operations and management to allow the claim to be paid from that source without unduly hindering the operation of the agency, the commissioner shall direct that payment be made from that source. Claims relating to activities paid for by appropriations of dedicated receipts shall be paid from those appropriations if practicable. On determining that an agency has sufficient money in these appropriations to pay only part of a claim, the commissioner shall pay the remainder of the claim from the money appropriated to the commissioner for this purpose. On determining that the agency does not have sufficient money to pay any part of the claim, the commissioner shall pay all of the claim from money appropriated to the commissioner for this purpose. On January 1 and July 1 of each year, the commissioner of finance shall transmit to the legislature and to the chair of the house appropriations and senate finance committees copies of all requests in the preceding six months together with a report on the payments made with respect to each request. Payment shall be made only upon receipt of a written release by the claimant in a form approved by the attorney general, or the person designated as the university attorney, as the case may be.

No attachment or execution shall issue against the state.

Subd. 8. **Liability insurance.** A state agency, including any entity defined as a part of the state in section 3.732, subdivision 1, clause (1), may procure insurance against liability of the agency and its employees for damages resulting from the torts of the agency and its employees. The procurement of this insurance constitutes a waiver of the defense of governmental immunity to the extent of the liability stated in the policy but has no effect on the liability of the agency and its employees beyond the coverage so provided.

Subd. 9. **Indemnification.** The state of Minnesota shall defend, save harmless, and indemnify any employee of the state against expenses, attorneys' fees, judgments, fines, and amounts paid in settlement actually and reasonably incurred by the employee of the state in connection with any tort, civil, or equitable claim or demand, or expenses, attorneys' fees, judgments, fines, and amounts paid in settlement actually and reasonably incurred by the employee of the state in connection with any claim or demand arising from the issuance and sale of any securities by the state, whether groundless or otherwise, arising out of an alleged act or omission occurring heretofore or hereafter during the period of employment if the employee provides complete disclosure and cooperation in the defense of the claim or demand and if the employee was acting within the scope of employment. Except for elected employees, an employee of the state shall be conclusively presumed to have been acting within the scope of

employment if the employee's appointing authority issues a certificate to that effect. This determination may be overruled by the attorney general. The determination of whether an employee of the state was acting within the scope of employment shall be a question of fact to be determined by the trier of fact based upon the circumstances of each case (i) in the absence of a certification, (ii) if a certification is overruled by the attorney general, (iii) if an unfavorable certification is made, or (iv) with respect to an elected official. The absence of the certification or an unfavorable certification shall not be evidence relevant to such a determination. It is the express intent of this provision to defend, save harmless, and indemnify any employee of the state against the full amount of any final judgment rendered by a court of competent jurisdiction arising from a claim or demand described herein, regardless of whether the limitations on liability specified in subdivision 4 or 4a hereof are, for any reason, found to be inapplicable. This subdivision does not apply in case of malfeasance in office or willful or wanton actions or neglect of duty, nor does it apply to expenses, attorneys' fees, judgments, fines, and amounts paid in settlement of claims for proceedings brought by or before responsibility or ethics boards or committees.

Subd. 9a. **Peace officer indemnification.** The state of Minnesota shall defend, save harmless, and indemnify a peace officer who is not acting on behalf of a private employer and who is acting in good faith pursuant to section 629.40, subdivision 4, the same as if the officer were an employee of the state.

Subd. 10. **Judgment as bar.** The judgment in an action under this section is a complete bar to any action by the claimant, by reason of the same subject matter, against the state employee whose act or omission gave rise to the claim.

Subd. 11. **Statute of limitation.** The statute of limitations for all tort claims brought against the state shall be as set forth in chapter 541 and other applicable laws.

History: *1976 c 331 s 33; 1978 c 669 s 2,3; 1978 c 793 s 32; 1982 c 423 s 1; 1983 c 331 s 1; 1985 c 84 s 1,2; 1985 c 166 s 2,3; 1985 c 248 s 70; 1Sp1985 c 13 s 64; 1Sp1985 c 16 art 1 s 1; 1986 c 444; 1986 c 455 s 1,2*

3.737 LIVESTOCK OWNERS; COMPENSATION FOR DESTROYED OR CRIPPLED ANIMALS.

Subdivision 1. Notwithstanding section 3.736, subdivision 3, paragraph (e) or any other law to the contrary, a livestock owner shall be compensated by the commissioner of agriculture for livestock that is destroyed or is crippled so that it must be destroyed after July 1, 1977 by an animal classified as endangered under the federal endangered species act of 1973. The owner shall be entitled to the fair market value of the destroyed livestock, not to exceed $400 per animal destroyed, as determined by the commissioner of agriculture, upon recommendation of the county extension agent for the owner's county and a conservation officer. The commissioner, upon recommendation of the agent and conservation officer, shall determine whether the livestock was destroyed by an animal described in this subdivision. The owner shall file a claim on forms provided by the commissioner of agriculture and available at the county extension agent's office.

Subd. 2. Any payments made pursuant to this section shall be reduced by amounts received by the owner as proceeds from any insurance policy covering livestock losses, or from any other source for the same purpose including, but not limited to, a federal program.

Subd. 3. The commissioner of agriculture shall adopt and may amend rules to carry out the provisions of this section which shall include: (a) methods of valuation of livestock destroyed; (b) criteria for determination of the cause for livestock loss; (c) notice requirements by the owner of destroyed livestock; and (d) any other matters determined necessary by the commissioner to carry out the provisions of this section.

Subd. 4. **Commissioner's determination; appeals.** If the commissioner finds that the livestock owner has shown that the loss of the livestock was caused more probably than not by an animal classified as an endangered species, the commissioner shall pay compensation as provided in this section and in the rules of the department.

RUMINCO LTD.
c/o Alxander Insurance Managers Ltd.
Dorchester House, P.O. Box HM2020
Hamilton 5, Bermuda

POLICY NUMBER CG-3041

DECLARATIONS -- COMPREHENSIVE GENERAL LIABILITY AND PROFESSIONAL LIABILITY

ITEM NO. 1: INSURED'S NAME and ADDRESS

Regents of the University of Minnesota

and any other corporation, commission, foundation, board of directors or governing organization, sponsored, directed by or authorized by the Regents of the University of Minnesota as now or hereinbefore or hereinafter constituted, and which is to include the Named Insured's interest in any partnership or joint venture, and the Minnesota Supercomputer Center, Inc.

231 Administrative Services Center
1919 University Avenue
St. Paul, Minnesota 55104

ITEM NO. 2: PERIOD

From the 30th day of December, 1986 to the 31st day of December, 1989, at 12:01 A.M., Standard Time. Both days at the address of the Insured.

ITEM NO. 3: LIMITS OF LIABILITY

Coverages A, B & C	$1,000,000 Each Claim
	$3,000,000 Each Occurrence
	$5,000,000 Annual Aggregate

ITEM NO. 4: RETROACTIVE DATE December 30, 1986

ITEM NO. 5: PREMIUM FOR POLICY PERIOD

First Year	$857,813
Second & Third Years	To Be determined

ITEM NO. 6: PREMIUM FOR OPTIONAL EXTENSION PERIOD:

The premium for the Optional Extension Period, General Conditions, Paragraph F., is 100% of the full annual premium hereunder.

ITEM NO. 7: ENDORSEMENTS

Retrospective Premium Endorsement

MINNESOTA CHAMBER OF COMMERCE & INDUSTRY

MMA
MINNESOTA MEDICAL ASSOCIATION
612/378-1875

minnesota hospital association

Dear Medical and Business Leaders:

February 29, 1988

We have a serious problem.

The Minnesota Trial Lawyers Association (MTLA) is pushing hard to repeal a law that was passed in 1986. The law has helped to add consistency and fairness to our civil justice system. Plaintiff attorneys dislike the **"future damage discount formula"** because it has added predictability to a system which is partially based on an attorney's court room skills. They have waged an emotional battle which has caused misinformation and misunderstanding on the part of the public and legislators.

What does this mean to you? Remember the crisis of 1985 when many of your associates were struggling to find and/or afford liability insurance? While many types of liability rates are still too high, in Minnesota there has been a stabilization of rates due, in part, to the tort reforms passed in 1986.

While our organizations' legislative agendas call for further tort reform, the MTLA wants to void the progress we've already made.

In each community throughout Minnesota, business owners must band together with physicians and clinic and hospital administrators. Together, we must fight to hold on to what the Minnesota Legislature passed in 1986 and to fight for further progress.

We would like each of you to take the unprecedented step of contacting your legislator together with representatives of your medical and business community. We must alert legislators to the fact that this is a small business issue and this is a health care issue.

We must keep the reforms we already gained to protect against a tailspin for both the business and medical industries. Enclosed is a fact sheet on the issue. Please feel free to call either of our organizations for more information. **However, you must act quickly to convey to your legislators that the business and medical representatives of your area are opposed to going backwards on tort reform and strongly support further reforms.**

Thank you for your assistance on an issue of vital importance to each of you and to the goals of our organizations.

Sincerely,

Winston W. Borden
President,
MN Chamber of Commerce
and Industry

Steven D. Carter
Chief Executive Officer,
MN Medical Association

Stephen Rogness
President,
MN Hospital Assn

CC: Minnesota Legislators

February, 1988

Facts about the Future Damages Discount Formula (fair judgement bill)

1. What is the Discount Formula?

When a jury has found in favor of the plaintiff in a personal injury or malpractice suit, it decides on the amount of the award. The judge then uses the formula to calculate what the "present value" of the award is. This means, the award is discounted to reflect what the plaintiff will receive from investing some of the award. In the much publicized Baby Ashton case, the award that was discounted could still net Baby Ashton $22 million if conservatively invested.

2. Why discount the decision of the jury?

Discounting to present value has always been done. The change in the law requires that the judge do it with a fair formula rather than the jury doing it behind closed doors after long hours of economic testimony. Before the 1986 reforms, the jury announced only the discounted award and did not have to defend how the discounting was done.

Now the discounting is done in a more predictable and consistent manner and in full view of the public. This has caused some emotional stances by some people who do not understand -- or do not wish others to understand -- that discounting has always been a part of the judicial system.

3. Are we saving money with the formula?

The law has been in effect for such a short time, this is a difficult question to thoroughly answer. However, based on comparisons of the few awards where the formula has been applied and similar awards under the old system, it appears there has been a slight increase in awards.

However, the formula adds consistency to the award amounts so that an insurance carrier does not go into a tailspin because of one huge award. It basically helps to steady a very uneven industry.

4. Is the formula unfair to some plaintiffs?

While some tinkering may need to be done with the components of the formula, there seems to be no basis in fact for the arguments for repeal. The arguments being used by the opposition do not ring true with economic facts and forecasts.

5. What about the insurance companies?

The insurance industry is very heavily regulated by the government. It must meet standards in both reserves and consumer pricing. The MTLA has used misleading numbers in its crusade, taking one figure out of one year and not adding in projected cases which have already been filed. While the numbers game can be complex but easy to manipulate, we believe the system is in much better balance than it was three years ago. However, improvements should continue to be made.

6. Besides retaining the formula, aren't more reforms needed?

You bet. The Minnesota Chamber, the Minnesota Medical Association and the Minnesota Hospital Association all support changes in the joint and several liability statute and other civil justice initiatives. Certainly we are committed to assuring that people who are injured because of someone else's negligence are adequately compensated. However, we also want to protect against creating new victims of the system or destroying the delicate balance between victims and those who must pay the premiums to see that plaintiffs are compensated.

In order to protect and improve our system, the Minnesota Legislature must understand that <u>this is an issue of vital importance to main street business and vital community health care facilities.</u>

For more information, please contact:

Jack Murphy at MCCI, 612/292-4650
Gary Goetzke at MMA, 612/378-1875 or
John Kingrey at MHA, 612/331-5571

UNIVERSITY OF MINNESOTA
TWIN CITIES

The University of Minnesota Hospital and Clinic
Harvard Street at East River Road
Minneapolis, Minnesota 55455

April 7, 1988

TO: Joint Conference Committee Members

Sally Booth
Robert Dickler
Phyllis Ellis
Patricia Ferrieri, M.D.
James Moller, M.D.
Michael Popkin, M.D.
Bruce Work, M.D.

FROM: George Heenan, Committee Chair

The April meeting of the Joint Conference Committee will be held on:

Wednesday, April 13, 1988
4:30 P.M.
The Board Room, University Hospital

The agenda and background materials for the meeting are enclosed. Dinner will be served at the conclusion of the business meeting. Please let Kay Fuecker (626-6222) know if you are unable to stay for dinner. I will look forward to seeing you on Wednesday.

cc: Jan Brockway
Jan Halverson
Greg Hart
Nancy Janda
Geoff Kaufmann
Mark Koenig
Michael Steffes, M.D.
Barbara Tebbitt
Ted Yank

TABLE OF CONTENTS

JOINT CONFERENCE COMMITTEE

BOARD OF GOVERNORS

Wednesday, April 13, 1988
4:30 P.M.
The Board Room, University Hospital

AGENDA

I.	Approval of March 9, 1988 Minutes	Approval
II.	Medical Staff-Hospital Council Report - James Moller, M.D.	
III.	Cost Evaluation Committee Report - Michael Steffes, M.D.	Information
IV.	Joint Commission Follow-Up - Nancy Janda	Information
V.	Future Committee Work Plan - George Heenan	Discussion
VI.	Clinical Chiefs Report - Bruce Work, M.D.	Information
VII.	Adjournment	

MINUTES
Joint Conference Committee
Board of Governors
March 9, 1988

CALL TO ORDER:

Chairman Heenan being delayed, Phyllis Ellis called the March 9, 1988 meeting of the Joint Conference Committee to order at 4:38 p.m. in Room 8-106 in the University Hospital.

Attendance:

Present:
Sally Booth
Robert Dickler
Phyllis Ellis
George Heenan
James Moller, M.D.
Michael Popkin, M.D.
Bruce Work, M.D.

Absent:
Patricia Ferrieri, M.D.

Staff:
Jan Halverson
Greg Hart
Nancy Janda
Barbara Tebbitt
Ted Yank

Guest:
Sylvia Dickinson, R.N.

APPROVAL OF MINUTES:

The minutes of the January 10, 1988 meeting were approved as submitted.

CLINICAL CHIEFS REPORT:

Dr. Bruce Work reported that at the February 16 meeting the group discussed the topic of house officers hours. He noted that this is not only a concern at UMHC, but is a national issue. At the meeting on the 23rd the topics of discussion included promotion and tenure of faculty as well as the implimentation of a uniform resident contract across the different medical departments. Dr. Work noted that LCGME is recommending this contracting strategy. Robert Dickler presented a discussion of current facility master planning at this meeting. On the 30th there was a discussion of the implications for UMHC of a new chief of surgery at Hennepin County Medical Center (HCMC). The group also noted that a new chief of medicine would soon be recruited there and that this recruitment may have some equally important

implications for UMHC. A the March 8th meeting the council discussed the committment to focus plan, revisions to the medical staff bylaws, malpractice insurance and documentation of progress notes. At that meeting Robert Dickler informed the group of the State sales tax issue, facility recemmendation developed by the Strategic Plannin Coordinating Committee and results of the Joint Commission, Medicare Validation and PPS review site surveys. Cliff Fearing also discussed future capital planning and expenditures with the group.

End Stage Renal Desease (ESRD) Policies

Barbara Tebbitt provided a brief overview of the proposed ESRD policies and then introduced Sylvia Dickenson, Head Nurse of the Kidney Dialysis Unit. Ms Dickenson provided more information about the policies and aswered questions concerning the impact of Universal Blood and Body Fluid Precautions (UBBFP) on the renal dialysis units. She noted that most patients are very pleased that the staff is taking the extra precautions and that there are few complaints. Discussion also ensued concerning the relative merits of hemo and peritoneal dialysis and the procedures in place for dealing with patients who would like to discontinue dialysis.

It was noted that on page 16 of the proposal the ESRD organizational chart should be ammended to include Dr. David Dunn as the Medical Review Board Member instead of Dr. Richard Simmons.

A motion to endorse the ammended policies was heard, seconded and passed unanimously by the committee.

Medical Staff - Hospital Council Report

Dr. James Moller described two revisions to the Rules and Regulations of the Medical and Dental Staff. He noted that both of the revisions had been endorsed by the Medical Staff-Hospital Council and the Chiefs of the Clinical Services. The first revision in Section I relates to the appearance of deductibles in insurance cetificates for Medical staff. The revision allows for reasonable deductibles to be included in insurance, but mandates a case-by-case evaluation of the coverage before the physician or dentist receives clinical priveledges. The Second revisions, from Section V, were proposed to make the Rules and Regualtion consistent with revisions made to medical record policies approved by the Medical Staff-Hospital Council on October 13, 1987. Most of the language was taken directly from the JCAHO Standards.

Discussion ensued concerning the rationale for a three day time period for Attending Staff to countersign progress notes to substantiate their active participation in patient care. Dr. Moller noted that this was the time specified in the Federal Regulations.

Dr. Moller noted that compliance with the current rules and regulation varied widely from department to department and physician to physician. He indicated that compliance to the new standard by the Medical Staff would be more closely monitored. Dr. Moller stressed that the Chairman of the Medical Records Committe, Dr. Marvin Goldberg, is the person that is responsible for medical record compliance and noted that he has done an outstanding job.

It was suggested that Dr. Goldberg be invited to a Committee meeting to discuss problems with medical record compliance.

Malpractice Insurance Update

Jan Halverson, Hospital Attorney, described the history and present status of of malpractice Insurance at the UMHC. Mr. Halverson noted that until 1976 the Hospital was protected by the legal doctrine of Sovereign Immunity, which exempted public agencies from malpractice actions. As that legal doctrine eroded, the University developed its own captive insurance company, RUMINCO, to cover University Wide liability claims. However, there is currently a statutory limit to remidies against a public institution without liability coverage of $200,000 per individual claim or $600,000 total per incident. Though the University has a statutory limit to claims against it, it believes that the liability coverage is prudent.

Mr. Halverson wanted the Board to be aware that the maximum coverage for any claim has decreased from $100 million in 1983-84, to $5 million in 1986-87. This decrease has been instituted because the cost of liability coverage has increased dramatically and that in the University's experience there have been few sucessful cases that exceeded the statutory limits. Therefore, more trust has been put in the statutory limitations.

In fiscal 87, UMHC payed $634,000 of the $857,000 that the University paid to RUMINCO for liability coverage and that in fiscal 88 UMHC will be paying $1,004,000 of a total $1,500,000. It is difficult to determine the precise cause of the increase, but in general the number of cases is down, but the remedies for those cases are up. It was noted that though this is a large sum of money, it is very reasonable compared to similar coverage that UMHC could obtain on the market.

Mr. Halverson noted that Bob Dickler, as General Director of the Hospital, has been granted the authority to decide which Hospital liability cases should be settled and the size of those remedies. Mr. Dickler also noted that the RUMINCO policy covers the Board of Governors and beyond that the members are covered by the full faith and credit of the University.

Other Business

Robert Dickler appraised the Committee of a possible threat to the Hospital's sales tax exemption at the legislature and asked that members contact any legislators that they know as well as their own Representative and Senator.

Greg Hart provided a brief summary of the findings from the November 1987 JCAHO site survey. It was noted that the Hospital recieved the maximum three year accreditation status and 21 contingencies. He explained that this was more of a reflection in changes in the survey processwith the Joint Commission than a statement about the Hospital's operation. Additionally there is some doubt that the Ambulatory Care section of the findings are those from UMHC.

Chairman Heenan suggested that the Committee should advise the board as to the status of the findings and will bring a complete report to the board when all questions have been answered.

Chairman Heenan and Phyllis Ellis shared with the Committtee that they had attended a CHC sponsored discussion of quality assurance in health care organizations that featured Don Wegmiller. He noted that Mr. Wegmiller's thoughts parallel our own thinking. He requested that a copy of our quality assurance plan be forwarded to Mr. Wegmiller.

ADJOURNMENT:

There being no further business, the meeting was adjourned at 6:10 P.M.

Respectfully Submitted

Theodore J. Yank

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Board of Governors
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ADJOURNMENT:

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Respectfully Submitted

Ted Yank

Theodore J. Yank

UNIVERSITY OF MINNESOTA
TWIN CITIES

The University of Minnesota Hospital and Clinic
Harvard Street at East River Road
Minneapolis, Minnesota 55455

MEMORANDUM

DATE: April 6, 1988

TO: Joint Conference Committee

FROM: Michael Steffes, M.D., Chairman, Cost Evaluation Committee

RE: Cost Evaluation Committee Findings and Recommendations

The Cost Evaluation Committee was appointed by James H. Moller, M.D., and C. Edward Schwartz in January 1987. The Committee was appointed in response to increasing constraints on reimbursement, substantial increases in ancillary utilization per admission, evidence that our charges per admission had grown farther away from the community norm, and a belief that our patient acuity or severity level was increasing. During the year, the committee and three work groups reviewed actual performance and methods required to improve our ability to monitor and evaluate ancillary utilization, productivity, and severity.

An executive summary of the findings and recommendations is enclosed for your review. The findings and recommendations reflect and impact on activities of Medical Staff - Hospital Council committees as well as hospital and clinical departments. Thus, I look forward to discussing them with you at your next meeting and welcome your comments, reactions, and suggestions.

MS/JRB/vrn

MEMBERSHIP

COST EVALUATION COMMITTEE:

Michael Steffes, M.D., Chairman
Jan Brockway
George Adams, M.D.
Shelley Chou, M.D.
Al Dees
Cliff Fearing
Thomas Ferris, M.D.
Greg Hart
Alfred Michael, M.D.
James H. Moller, M.D.
Randall Moore, M.D.
John Najarian, M.D.
Barbara Tebbit, RN
William Thompson, M.D.
Vic Vikmanis

ANCILLARY INTENSITY WORK GROUP:

William Thompson, M.D., Chairman
Jan Brockway
Nancy Ascher, M.D.
Patricia Ferrieri, M.D.
Ian Gilmour, M.D.
Thomas Green, M.D.
Russell Lucas, M.D.
Carter McComb
Bruce Peterson, M.D.
Bruce Wilson, M.D.

PRODUCTIVITY WORK GROUP:

Helen Pitt, RN, Chairperson
Jan Brockway
Al Dees
Marvin Goldberg, M.D.
Nancy Janda
Mark Koenig
Nels Larson
Carter McComb
Jeffrey McCullough, M.D.
Mary Ellen Wells
Donna Wieb

SEVERITY MEASUREMENT WORK GROUP:

Al Dees, Chairman
Jan Brockway
Frank Cerra, M.D.
Ruth Krueger, RN
Peter Lynch, M.D.
Robert Maxwell, M.D.
Chris Peterson
Leo Twiggs, M.D.

STAFF SUPPORT:

Jan Brockway
Vincent R. Netz

COST EVALUATION COMMITTEE
EXECUTIVE SUMMARY OF FINDINGS AND RECOMMENDATIONS

BACKGROUND

The University of Minnesota Hospital and Clinic has undergone significant growth and change in recent years, most notably since early 1986. During this time a number of factors suggested a need to evaluate ancillary utilization, productivity and patient severity. Among the factors were:

- Substantial increases in ancillary utilization per admission since early 1986 which have led to increased personnel requirements in ancillary departments.

- Continuing pressures from third party payors to reduce costs, most notable was the Blue Cross AWARE contract which threatened to reduce reimbursement by over $1 million per year.

- Increasing evidence that UMHC's casemix adjusted charges per admission had grown further away from the community norm, substantiated by the November, 1986, Council of Community Hospitals price comparison report.

- A growing belief that UMHC's patient acuity level has been increasing, coupled with growing community and payor interest in severity measurement systems, potentially to be used as quality assessment and reimbursement tools.

At the same time the hospital and medical staffs addressed the need to improve our interaction with patients, their friends and families and referring physicians. Several successful programs and the new hospital enlarged our image as a purveyor of excellent and highly specialized medical care in a warm and supportive environment. This report covers the years in which this transaction took place.

At the time of the formation of the Cost Evaluation Committee, the Hospital was concerned about the rise in the number of full-time equivalents per admission, particularly since the beginning of 1986. The rationale behind the staffing increases related to increased use of ancillary services, driven by an increasingly

more severely ill patient population. Given the competitive environment and increasing constraints on reimbursement, it has become important for the Hospital to constructively challenge this rationale and to develop improved systems to monitor and evaluate changes in severity levels, ancillary utilization and productivity among other factors contributing to health care costs.

CHARGE OF THE COMMITTEE

The Cost Evaluation Committee was charged with the responsibility to review the University of Minnesota Hospital and Clinic's performance from a productivity, ancillary utilization, and patient severity perspective. In addition, the Committee was asked to identify system needs required to monitor and modulate change on an ongoing basis.

METHODS AND LIMITATIONS:

The Cost Evaluation Committee's evaluation follows that of the previous Cost Containment Committee, chaired by John Najarian, MD, whose analysis spanned five years ending in fiscal year 1982-83. For this reason and because fiscal year 1984-85 marked the beginning of the Medicare prospective payment system at UMHC, we chose fiscal year 1983-84 as the baseline period to consider trends in the utilization of resources at UMHC.

The Cost Evaluation Committee's methods were shaped by several limitations and assumptions. First, while some efforts of the committee and its work groups addressed outpatient as well as inpatient activities, others were limited to inpatient activity only. Specifically, the analysis of ancillary utilization did not include outpatient utilization because of data and system limitations. However, the staffing analysis did factor in outpatient activity by using the Financial Accounting Department's formula to index its additive impact on hospital-wide staffing. Further, the recommendations of the Productivity Work Group are intended to address outpatient as well as inpatient activity.

Second, while quality of care and quality of services were recognized by the Committee as critical variables related to both productivity and ancillary utilization, the Committee did not attempt to evaluate quality. However, the Productivity Work Group concluded that methodologies and procedures aimed at improv-

ing quality will actually increase productivity and thereby reduce costs. Thus, a major recommendation of theis Work Group is for an across-the-hospital effort to monitor and evaluate quality of services.

Third, the Committee did not attempt to evaluate programs or ancillary services from a profitability standpoint. Questions of program subsidy or profitability were deemed to be more appropriately reviewed in other forums. While resource utilization is one factor that goes into a profitability analysis, other factors such as pricing, reimbursement, volume, indirect costs, and allocation methodologies are variables outside of the charge to the Committee.

Fourth, the evaluation was organized by ancillary categories rather than by clinical departments because organization of data by clinical departments results in low numbers of patients in many DRGs. This would compromise the statistical validity of the casemix analysis and adjustments required for overall trending. Further, review by ancillary category, with subsets of data by DRG and Major Diagnostic Category, provided the Ancillary Work Group and the ancillary departments with a methodology that allowed them to identify the success of previous and existing utilization monitoring efforts, both hospital-wide and by major clinical groups.

Fifth, the Committee used charges for services and procedures utilized rather than costs since there is no uniform procedure that allows for identification of costs by DRG. Since charges for each ancillary category increased in a well-documented manner for the years covered in this report (1983-84 to 1986-87), charges specific to each DRG for each fiscal year were adjusted using the annual price increases for each ancillary category. These individual adjustments, therefore allowed for all charges to be expressed in fiscal year 1986-87 dollars. The price increases for each ancillary category and for total hospital charges can be found in the Appendices of this report. (See Charges Summarized for Each Category section.)

METHODS USED TO ADJUST FOR CHANGES IN CASEMIX

In order to evaluate staffing and ancillary utilization changes since the 1983 Cost Containment Committee's report, this Committee used an analysis which depends heavily upon two techniques that adjust for changes in "casemix." The techniques

were based on Diagnostic Related Groups (DRGs). Although the Committee hoped that other weighting factors would be available (see Severity Measurement Work Group section), the DRG system was the only available option to measure long-term changes in patient mix and severity. Below is a general description of what casemix is and the two methods used to adjust for changes in it:

It is generally understood that utilization (i.e., number of laboratory tests, respiratory therapy procedures, etc.) per admission will vary with the nature of cases being treated. Changes in the nature of cases being treated are referred to as changes in "casemix." For example, a hospital whose casemix consists of normal deliveries and uncomplicated pneumonia cases will use fewer resources than a hospital whose casemix consists of transplantation and open-heart cases. Likewise, a given hospital can monitor changes in its own casemix over time, in a manner which may reflect the need for greater or lesser resource utilization per admission. In order to make utilization comparisons over different time periods, changes in casemix need to be taken into account; in other words, "casemix adjustment" calculations are applied.

In this report, one method for casemix adjustment uses what are referred to as "DRG relative weights." These are numbers, or weights, assigned to each diagnostic group. DRGs which consume more resources are assigned higher weights than those consuming lesser resources. The relative weights of each DRG are multiplied by the percent of discharges in the DRG and the products are summed to arrive at a "casemix index," a single number which can be thought of as representing all the relative weights. Thus, when a category under study, such as total hospital charges, is multiplied by casemix index, increases or decreases in resource consumption due to changes in casemix are factored in. The DRG relative weights used are the same as those used in the Medicare DRG reimbursement system.

The second method uses what are referred to as "weighted averages." The distribution of cases (i.e. casemix) for one of the Fiscal Years (FY 85-86) is selected as representative of all years. This distribution then becomes the baseline used to neutralize changes in casemix from year to year. With this method, the number of cases in each DRG is divided by the total number of cases for the "baseline year" to arrive at a ratio or "weight." These ratios are then applied to the average charges for each of the fiscal years to arrive at a "weighted average" charge per

discharge, effectively eliminating variations in the distribution of cases from year to year. Thus, changes in the average charges will reflect changes in utilization instead of casemix.

Throughout this report, then, an attempt is made to accommodate changes in the mix of cases seen over time by using either the DRG relative weights or weighted average calculations. While those calculations are complex, the concept is relatively simple. This concept is also very important, as it can have a major effect on the conclusions which are drawn about changes in the hospital's utilization levels and resource consumption.

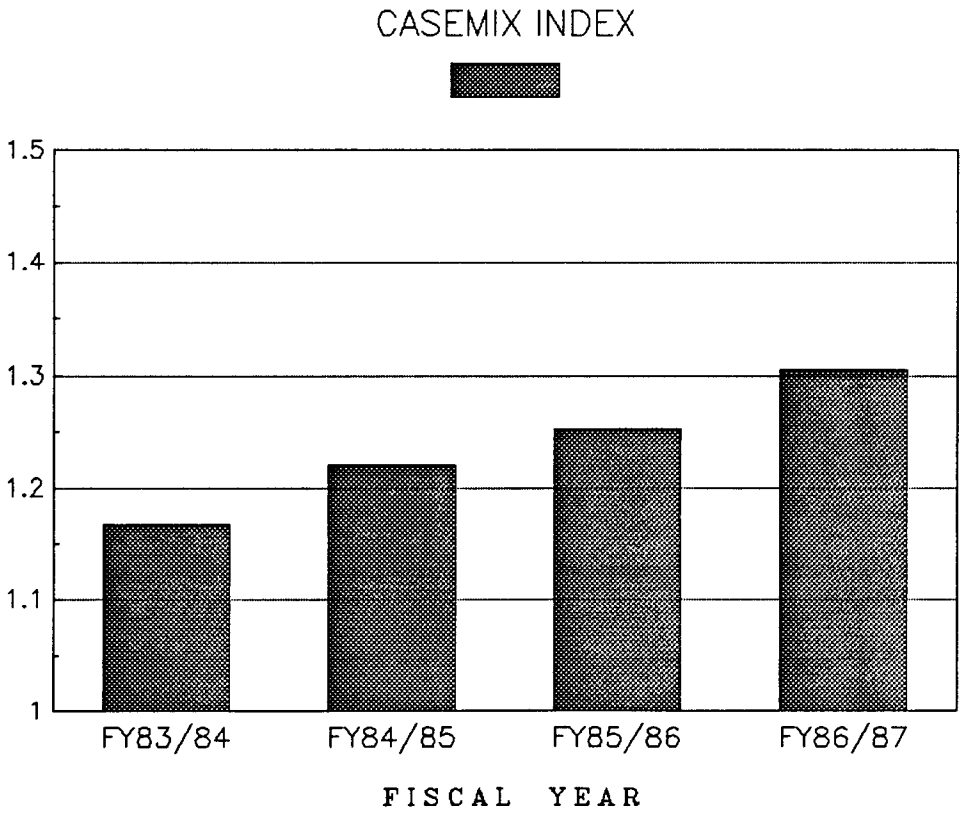
REVIEW OF CASEMIX, UTILIZATION, AND STAFFING SINCE FISCAL YEAR 1983-84

Casemix Index

As indicated above, the casemix index is calculated by multiplying the relative value or weight of each DRG times the percent of discharges in that DRG and summing the products over all DRGs. Thus the casemix index represents the estimated average relative historical cost of the cases in the hospital. A hospital with a casemix index of 1.100 on Year 2 would have patients who, on average, should require 10% more resources than the average patient during Year 1 with a casemix index of 1.000.

As is shown on Figure 1, UMHC's casemix index has increased each year. Overall, it has increased by more than 10% since FY 1983-84.

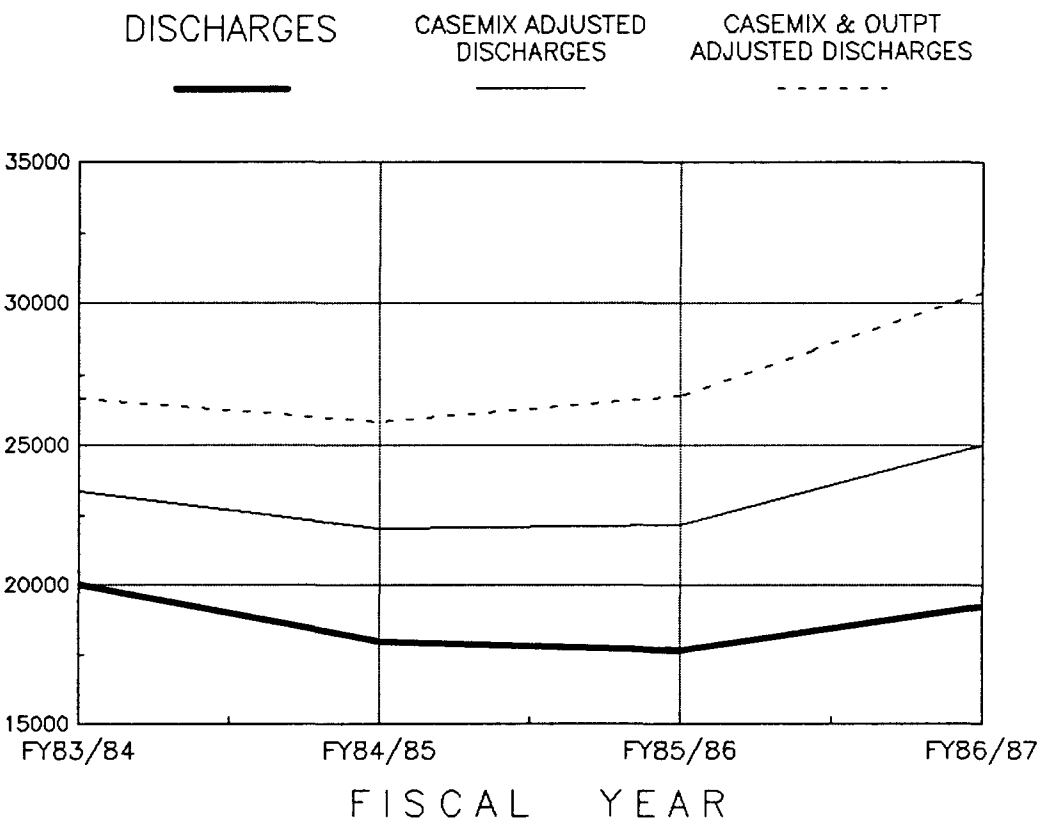
FIGURE 1



Casemix and Outpatient Adjusted Discharges

In order to determine the impact of the increasing casemix index, we multiplied the number of discharges times the casemix index for each year to arrive at casemix adjusted discharges. As is shown on Figure 2, although the number of discharges decreased slightly (4.1%) between FY 1983-84 and July-December, 1986, there was an increase (7.1%) in the number of casemix adjusted discharges. Further, the steady increase in outpatient activity was factored in by using the Financial Accounting Department's formula to index its additive impact on hospital-wide staffing. With this calculation, there was a sharper increase (nearly 12%) in the number of casemix-and-outpatient adjusted discharges. This adjustment for outpatient-related activities was applied only in Figures 2 and 3 and Tables 2, 4, and 5 of the Appendices.

FIGURE 2



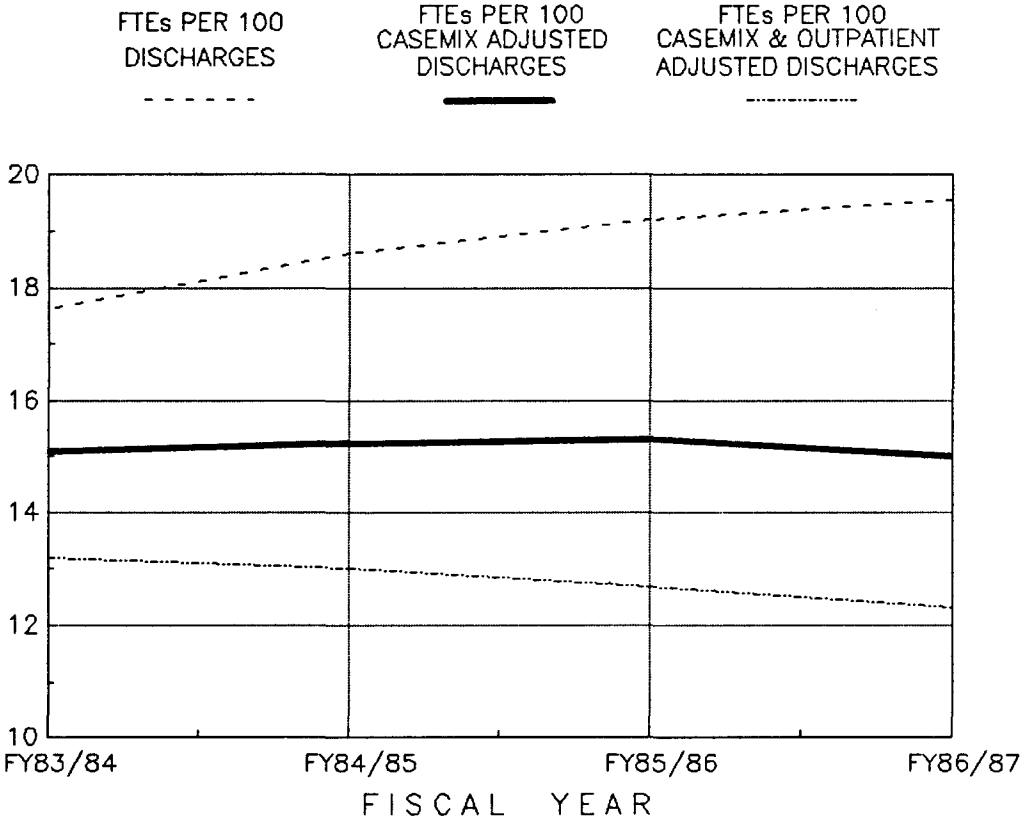
Staffing

Hospital-wide staffing changes were reviewed (Figure 3 and Table 2 of Appendices). Excluding the Community University Health Care Center (CUHCC), the number of full-time equivalents increased by 6.4% between FY 1983-84 and FY 1986-87. However, when the number of full-time equivalents (FTEs) is reviewed in relationship to casemix-and-outpatient adjusted discharges, staffing has actually decreased by more than 6%.

FIGURE 3

The University of Minnesota Hospital and Clinic

HOSPITAL–WIDE STAFFING TRENDS



Staffing by Departmental Groupings:

Staffing was grouped into three broad categories for review: Inpatient Nursing, *Other Patient Related Services, and All Other Services. Inpatient Nursing Staffing per 100 discharges increased by 12.8% but when the casemix adjustment was made there was essentially no increase in Nursing staffing (less than one percent). Likewise, for the Other Patient Related Services category, staffing per 100 discharges increased by 11.6% but when the casemix adjustment was made there was no increase. Further, when the adjustment for increased outpatient activity was made, the staffing for the Other Patient Related Services category actually decreased by 6.1%. The third category, All Other Staffing, which is less directly effected by casemix changes, showed an increase of 7% with no adjustments; a 4.2% decrease with the casemix adjustment; and a 9.9% decrease with the casemix and outpatient adjustment (Tables 3, 4, and 5 of Appendices). Thus, based on the casemix adjustment, staffing either remained the same or decreased for each of the three categories.

* Other Patient Related Services = Laboratories, Blood Bank, Diagnostic Radiology, Patient Monitoring, Respiratory Therapy, Pharmacy, Admissions, Medical Records, Radiation Therapy, Outpatient/Emergency Room, Operating Rooms, Rehabilitation, and Social Work (Inpatient and Outpatient).

Overall Hospital Charges:

The Committee reviewed total hospital charges, average hospital charge per discharge, and *weighted average hospital charge per discharge. All charges were adjusted to Fiscal Year 1986/87 dollars so that the charges could be used as a proxy measure of overall utilization. Total charges and, therefore, overall utilization increased by 3.6% between FY 1983-84 and July-December, 1986. The average charge per discharge and therefore utilization per discharge increased by 13.4%. However, when changes in casemix are taken into account by comparing the weighted average hospital charge per discharge, there was essentially no change in the weighted average charge (less than one percent). Thus, overall utilization, whether appropriate or inappropriate, had not changed from 1983-84 to July-December, 1986 (Table 1).

Charges by Charge Category:

As shown on Table 1, the weighted average charges for room and board and the ICU surcharge decreased by 10% and 12% respectively between 1983-84 and July-December, 1986. In contrast, with the exception of blood product administration, the weighted average charges of the ancillary categories increased. Thus, the Committee endorsed further review of the six ancillary categories accounting for the greatest proportion of the average hospital charge per discharge: laboratory, blood product administration, pharmacy, diagnostic radiology and nuclear medicine, respiratory therapy, and patient monitoring (Figure 4).

* The average charges per discharge were weighted to the Fiscal Year 1985-86 casemix. That is, the weighted average charge for each year was computed by multiplying the average charge of each DRG for that year by the proportion of discharges in the DRG in FY 1985-86 and then summing the products. This process was used to adjust for differences in the distribution of DRGs from year to year to allow for comparison of charges and therefore utilization over time.

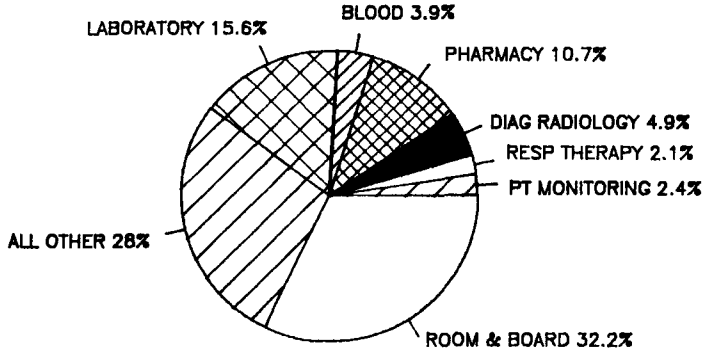
TABLE 1

ALL DIAGNOSTIC CATEGORIES

CHARGE CATEGORY	TOTAL CHARGES (expressed in millions and in FY 86/87 dollars)							WEIGHTED AVERAGE CHARGE PER DISCHARGE (weighted to FY 85/86 case mix)						
	FY83/84	FY84/85	FY85/86	FY86/87 (est)	% Chg. 83/4-85/6	% Chg. 85/6-86/7	% Chg. 83/4-86/7	FY83/84	FY84/85	FY85/86	FY86/87 (est)	% Chg. 83/4-85/6	% Chg. 85/6-86/7	% Chg. 83/4-86/7
# of Disch.	19,926	17,871	17,229	18,200	-13.5%	5.6%	-8.7%							
Room and Board	58.637	50.376	47.391	52.784	-19.2%	11.4%	-10.0%	3,144	2,894	2,749	2,842	-12.6%	3.4%	-9.6%
ICU Ancillaries	13.250	13.499	13.051	12.946	-1.5%	-0.8%	-2.3%	698	745	756	614	8.3%	-18.7%	-12.0%
Operating Room/ Anes/PAR/Del	15.411	14.061	14.539	17.342	-5.7%	19.3%	12.5%	NA	NA	NA	NA	—	—	—
Laboratory	28.448	26.309	27.468	30.654	-3.4%	11.6%	7.8%	1,518	1,500	1,596	1,572	5.1%	-1.5%	3.6%
Blood Administration and Blood Take Home	6.407	6.077	5.750	6.489	-10.3%	12.8%	1.3%	347	341	335	309	-3.4%	-7.7%	-11.0
Pharmacy & Pharmacy Take Home	21.405	23.090	23.170	26.049	8.2%	12.4%	21.7%	1,157	1,306	1,347	1,308	16.4%	-2.9%	13.1%
Diagnostic Radiology & Nuc. Medicine	8.981	8.454	8.804	9.190	-2.0%	4.4%	2.3%	486	492	511	497	5.1%	-2.8%	2.3%
Therapeutic Radiology	0.706	0.630	0.689	0.847	-2.4%	22.9%	20.0%	39	33	40	36	1.8%	-9.3%	-7.7%
Respiratory Therapy	3.867	NA	3.934	4.866	1.7%	23.7%	25.8%	202	NA	228	250	12.5%	10.0%	23.8%
Patient Monitoring	4.346	NA	5.651	6.507	30.0%	15.1%	49.7%	243	NA	327	313	34.6%	-4.3%	28.8%
Other	21.662	NA	18.253	20.820	-15.7%	14.1%	-3.9%	NA	NA	NA	NA	—	—	—
TOTAL HOSPITAL	181.944	170.459	168.572	188.494	-7.3%	11.8%	3.6%	9,770	9,709	9,791	9,719	0.2%	-0.7%	-0.5%

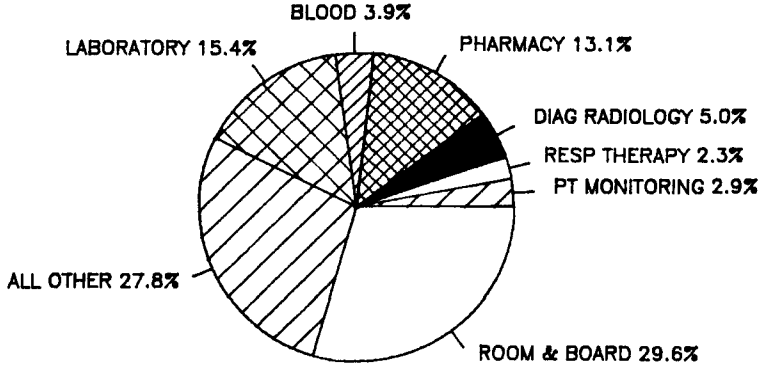
va10-6M373

FIGURE 4
AVERAGE HOSPITAL CHARGE PER DISCHARGE



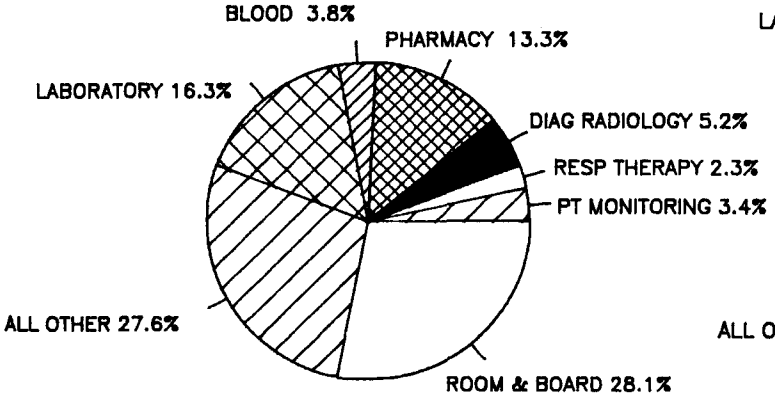
AVG CHARGE = $9,131

FY 83/84



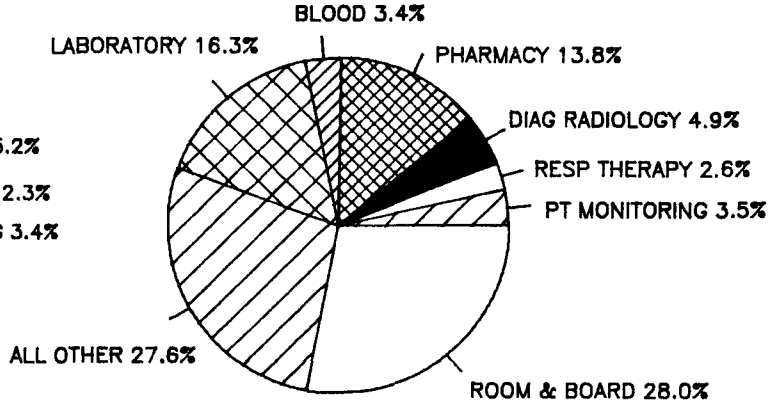
AVG CHARGE = $9,538

FY 84/85



AVG CHARGE = $9,784

FY 85/86



AVG CHARGE = $10,357

FY 86/87

(BASED ON 6 MONTHS: JUL–DEC, 1986)

PREPARED BY V. NETZ, QUALITY ASSURANCE SERVICES, 12/4/87

THE WORK GROUPS

To address the manner in which the medical staff and hospital departments could improve their evaluation of costs factors (i.e. severity, productivity, and utilization), the Committee formed three work groups: Productivity Work Group, Severity Measurement Work Group, and Ancillary Intensity Work Group.

The Ancillary Work Group

The group addressing the utilization of ancillary services looked at several ancillary areas within the hospital and identified three in which the utilization has risen in a greater than average manner: respiratory therapy, patient monitoring, and pharmacy. In addition, the work group identified one area where a significant decrease in utilization relative to the patient population was achieved: use of blood products. The work group decided that the success or problems of these areas fundamentally relate to the application of educational efforts and monitoring systems to control the ordering or provision of services by the physicians. Thus, they felt that physician education and/or careful monitoring of ordering practices would be most effective in controlling the utilization of these different services. The marked reduction in the use of blood products followed a careful implementation and monitoring of blood products (especially platelet utilization) using a desk-top computer-based system in the Blood Bank. This system was put in place with the active involvement of the faculty on the oncology and hematology services and the medical staff in the Blood Bank.

The Productivity Work Group

The Productivity Work Group concluded that methodologies and procedures aimed at improving patient care services will actually increase productivity of the staff and reduce costs. Specifically, they identified the need for an across-the-hospital effort to monitor and evaluate accuracy and timeliness in the delivery of health care. Resultant changes would improve productivity by eliminating ineffectual activities and duplicate efforts among personnel. Since productivity, as expressed in FTEs per casemix-and-outpatient adjusted discharges, appears to have improved (Figure 4) over the period covered by this report, the new hospital and programs aimed at improving our interaction with patients, their families and friends, and the referring physicians were made possible without a discernable negative impact on hospital-wide productivity.

The Severity Measurement Work Group

The Severity Measurement Work Group fundamentally felt there are no systems to measure changes in intensity or severity across our patient population other than the DRG-based relative weights and DRG-based casemix analysis that were used for the Cost Evaluation Committee and Ancillary Work Group. They did identify several systems that are applicable to the intensive care units and have been used, to some extent, by these units to measure severity of their populations. It is possible that these systems could be employed in a limited manner within our intensive care areas to maximize delivery of care and monitor costs within that setting.

RECOMMENDATIONS

1. Emphasis on physician education is imperative to maintain or improve the control of utilization and, thereby, costs in our Hospital. Newly enlisted house staff and house staff rotating back to the University of Minnesota Hospital and Clinic should, with the existing house staff, receive careful instruction regarding the use of services within the institution. While the attending staff has assumed responsibility to educate resident physicians in the utilization of services and resources, an additional step to increase the effectiveness would involve a greater interaction among physicians from all departments. Specifically, specialists in individual areas (respiratory therapy, laboratory, radiology, and pharmacy) should provide more information to the physicians ordering these services. This effort can be facilitated through existing committees such as the Pharmacy and Therapeutics Committee and Cardio-Respiratory Advisory Committee and improved review of laboratory and radiology services.

2. As a corollary to the need to maintain a strong educational program at all levels in the hospital, we should continue to implement systems that monitor ordering practices by the clinical services. The success of the effort to reduce platelet utilization directly resulted from a conjoined effort by Oncology, Hematology, and the Blood Bank to monitor ordering patterns for

platelets and other blood products. Although there were some difficulties to overcome in implementing this process, the success of this effort in the reality of an increasingly difficult-to-manage patient population underlines the importance of creating such tools.

3. The Cost Evaluation Committee's efforts to review utilization has produced a potential methodology (i.e., casemix adjustment) to improve our ability to monitor and manage costs associated with utilization. Several ancillary departments that have attempted to control utilization have not had the tools to monitor the success of their efforts using a casemix adjusted methodology. Specifically, the recent success on the part of the new leadership in Pharmacy and the Pharmacy and Therapeutics Committee to optimize drug utilization was not revealed until the analysis that was performed for the Cost Evaluation Committee. Thus, the Committee strongly recommends that tools to facilitate casemix adjustment and analysis be fashioned to permit all hospital and medical services to monitor the success of newly implemented decisions and strategies. These tools should be available, not only to administration and such oversight committees as the Cost Evaluation Committee, but also to those providing the service and needing feedback as to the success of their strategies to control utilization and costs. The Cost Evaluation Committee strongly believes that the provision of tools to allow for casemix adjustments and analyses will be well worth the small added cost.

4. As an adjunct to the provision of tools to facilitate casemix adjustments and analyses, efforts to improve the usefulness of the DRG system, at least internally, are needed. Specifically, we need to develop the capability to remove outliers and special groups of patients with complex underlying diseases (e.g., cancer, AIDS, status post organ transplants). The impact of these factors should be evaluated and documented periodically until the Health Care Financing Administration's (HCFA) efforts to refine the DRGs results in a system that adequately reflects our patient population or until there is an acceptable severity measurement system. This effort should be facilitated through improved data management. Further, the results of this effort should be well integrated into the hospital information system reporting capabilities.

5. From the above discussions there is obviously a clear need for better data management tools at all levels for those who must manage resources and provide patient care within this institution. The Cost Evaluation Committee's need for information was addressed through active and involved procurement of data fashioned only in response to the needs of the Committee. As stated above and as is evidenced in the reports of the Ancillary and Productivity Work Groups, managers and physicians within the hospital require more comprehensive, readily available data to make decisions and to evaluate the efficacy in implementing those decisions. This is the major recommendation of the Committee, and one which may be implemented through reorientation of our current data management services.

6. While the provision of data recommended above will help in monitoring and implementing decisions concerning patient care, there needs to be hospital-wide encouragement of innovative programs to improve the utilization of resources in providing patient care. These programs can be hospital-wide, or in many instances can target specific areas within the hospital. The smaller, demonstration programs may be especially important in pointing the way towards policies or tools that may be brought to bear upon our total patient population. The desk-top computer-implemented service of the Blood Bank, Pharmacy's program to address ordering of drugs, and Respiratory Therapy's new concurrent monitoring system are three examples of such pilot programs which should be endorsed and supported. Additionally at this time, the success of the Intensive Care Units (ICUs) in monitoring their costs and optimizing patient care can specifically be addressed by increasing support for a computer service to monitor provision of therapy, to optimally display data on each patient and to induce significant savings by closely monitoring utilization of ICU services.

7. Similar to the efforts aimed at improving the medical staff's utilization of services, all hospital departments should develop methodologies to monitor and evaluate accuracy and timeliness of the delivery of services. This effort should be facilitated through improved data management aimed at more timely and efficient availability of information.

SUMMARY OF RECOMMENDATIONS:

In summary, all recommendations made by the Committee devolve upon the need to provide readily useable information to those who make decisions. Computer system costs have decreased; connectability through networks has increased. Therefore services to support the gathering of data can be implemented much more efficiently than in the past. Optimally, individual computer systems provided to separate units within the Hospital (e.g., Radiology, Pharmacy, Intensive Care Units, and the Clinical Laboratories) may be interconnected through networks including the hospital information system, to provide the important monitoring and service-utilization data recommended by this Committee.

UNIVERSITY OF MINNESOTA
TWIN CITIES

The University of Minnesota Hospital and Clinic
Harvard Street at East River Road
Minneapolis, Minnesota 55455

May 5, 1988

TO: Joint Conference Committee Members

Sally Booth
Robert Dickler
Phyllis Ellis
Patricia Ferrieri, M.D.
James Moller, M.D.
Michael Popkin, M.D.
Bruce Work, M.D.

FROM: George Heenan, Committee Chair

The May meeting of the Joint Conference Committee will be held on:

Wednesday, May 11, 1988
4:30 P.M.
The Board Room, University Hospital

The agenda and background materials for the meeting are enclosed. Dinner will be served at the conclusion of the business meeting. Please let Kay Fuecker (626-6222) know if you are unable to stay for dinner. I will look forward to seeing you on Wednesday.

cc: Jan Brockway
Jan Halverson
Greg Hart
Nancy Janda
Geoff Kaufmann
Barbara Tebbitt
Ted Yank

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JOINT CONFERENCE COMMITTEE

BOARD OF GOVERNORS

Wednesday, May 11, 1988
4:30 P.M.
The Board Room, University Hospital

AGENDA

I.	Approval of April 13, 1988 Minutes	Approval
II.	Medical Staff-Hospital Council Report - James Moller, M.D.	
	• Credentials Committee Report	Endorsement
III.	Quality Assurance Report - Jan Brockway - James Moller, M.D.	Information
IV.	Clinical Chiefs Report - Bruce Work, M.D.	Information
V.	Other Business	
VI.	Adjournment	

MINUTES
Joint Conference Committee
Board of Governors
April 13, 1988

CALL TO ORDER:

Chairman Heenan called the April 13, 1988 meeting of the Joint Conference Committee to order at 4:37 p.m. in Room 8-106 in the University Hospital.

Attendance:

Present:
Robert Dickler
Patricia Ferrieri, M.D.
George Heenan
James Moller, M.D.

Absent:
Sally Booth
Phyllis Ellis
Michael Popkin, M.D.
Bruce Work, M.D.

Staff:
Jan Halverson
Greg Hart
Nancy Janda
Barbara Tebbitt
Ted Yank

Guest:
Michael Steffes, M.D.
Jan Brockway

APPROVAL OF MINUTES:

The minutes of the March 9, 1988 meeting were approved with some minor wording amendments.

CLINICAL CHIEFS REPORT:

Robert Dickler, Hospital Director, noted that in the most recent Chiefs' meetings capital planning has been the primary topic of discussion.

Medical Staff - Hospital Council Report

Dr. James Moller indicated that there was no report for this meeting, beyond the cost evaluation report presented by Dr. Steffes.

Cost Evaluation Committee Report

Dr. Michael Steffes, Chairman of the Cost Evaluation Committee, supported by Jan Brockway, Director of Quality Assurance, described the findings and recommendations of the Committee's final report. He noted that one of the greatest difficulties in the study had been the adequacy of casemixe and severity measures. The measure used in the report is based on the DRG casemix index which is widely accepted as one of the most reliable measures. In general he noted that the casemix index has increased and UMHC's use of FTE's per casemix adjusted and outpatient adjusted discharges, has declined slightly over the four year (FY's 83-86) analysis period. He also noted that UMHC's weighted average charge per discharge has remained relatively constant over the period, though some areas such as Respiratory Care and Pharmacy demonstrated marked increases.

The Committee made seven recommendations which essentially centered either on education of both physicians and staff of the Hospital to improve the control of utilization and, thereby, decrease UMHC's costs or a Hospital-wide effort to enhance the quality and accessibility of utilization information based on casemix adjusted analysis of improved patient and cost data.

Discussion ensued concerning the course of action that should be pursued relative to the recommendations. Chairman Heenan suggested that we focus on a number of limited areas such as Respiratory Therapy or Pharmacy initially, but also noted that some of the recommendations call for long-term institutional value changes that must be developed over time.

Joint Commission Follow-Up

Nancy Janda, Associate Director, distributed a document that briefly summarized the 75 findings from UMHC's November JCAHO site visit and the responses that are now being implemented to address those findings. Ms. Janda elaborated on a number of specific examples. The Committee focused on the recommendations concerning Hospital oversight of quality assurance activities. Chairman Heenan questioned if it would be appropriate for the Committee to review quarterly summaries of Departmental QA reports and minutes. There was also concern expressed that there was not an adequate mechanism in place to assure that Clinical Chiefs take responsibility for this function. It was suggested that a clearer job description should be developed for the clinical chief role, and that Chiefs should be held more strictly accountable for the job requirements by the Board of Governors.

Future Work Plan

Chairman Heenan presented a Joint Conference Committee - Preliminary Work Plan for 1988. The list included three types of work: "Routine" Items, Issue Development and Monitoring, and a Major Focus Area - Quality Assurance. Mr Heenan asked for feed back and additions to the list. It was suggested that "other items as needed" be included on the list as well as Don Wegmiller's litany on QA for discussion at one of the meetings. The Chairman asked that any other items that members thought appropriate be communicated to him.

Other Business

No other business was conducted.

ADJOURNMENT:

There being no further business, the meeting was adjourned at 6:20 P.M.

Respectfully Submitted:

Ted Yank

Theodore J. Yank

Office of the Chief of Staff

UNIVERSITY OF MINNESOTA
TWIN CITIES

The University of Minnesota Hospital and Clinic
Box 707
Harvard Street at East River Road
Minneapolis, Minnesota 55455
(612) 626-1945

May 4, 1988

TO: Joint Conference Committee

FROM: James H. Moller, M.D., Chief of Staff
Chairman, Medical Staff-Hospital Council

SUBJECT: Credentials Committee/Medical Staff-Hospital Council
Report and Recommendations

The Medical Staff-Hospital Council will act on the attached Credentials Committee Report and Recommendations on May 10, a day prior to the next Joint Conference Committee meeting.

I am forwarding these recommendations to you for your review and consideration on May 11. I will report the outcome of the Council's action at that time. Following your consideration of these recommendations, we ask that you forward them to the Board of Governors for approval on May 25.

Thank you.

JHM/cf
Attachment

UNIVERSITY OF MINNESOTA
TWIN CITIES

The University of Minnesota Hospital and Clinic
Harvard Street at East River Road
Minneapolis, Minnesota 55455

May 4, 1988

TO: Medical Staff-Hospital Council

FROM: Henry Buchwald, M.D.
Chairman, Credentials Committee

SUBJECT: Credentials Committee Report and Recommendations

The Credentials Committee after examining all pertinent information provided to them concerning the professional competence and other necessary qualifications, hereby recommend the approval of provisional status and clinical privileges to the following applicants to the Medical Staff of The University of Minnesota Hospital and Clinic.

Department of Anesthesiology	Category
Mark T. Sontag	Attending
Department of Hospital Dentistry	
Darla J. Roelofs	Clinical
Charles R. Wilkinson	Clinical
Department of Family Practice and Community Health	
Christopher L. Krogh	Attending
Department of Laboratory Medicine and Pathology	
John G. Strickler	Attending
David F. Stroncek	Attending
Department of Medicine	
Alvin C. Holm	Attending-ER & Internal Medicine
John T. Strony	Attending
Lyle J. Swenson	Clinical
Department of Ophthalmology	
Marian R. Rubenfeld	Clinical

Approval of provisional status and clinical privileges continued:

Department of Pediatrics	Category
Carolyn J. McKay	Clinical
Department of Physical Medicine and Rehabilitation	
LeAnn M. Snow	Attending
Department of Radiology	
Benjamin C.P. Lee	Attending
Department of Urology	
Robert D. Fisher	Clinical

The following physician submitted an application and supporting documentation requesting additional clinical privileges. The Committee has reviewed and considered the request and hereby recommend approval.

Department of Neurosurgery	
Erich Wisiol	Clinical

Privileges: Add-CNS laser for Neurosurgical cases, CO_2

The following physicians are completing their provisional status and are eligible for regular appointments as members of the Medical Staff of The University of Minnesota Hospital and Clinic. The Committee has reviewed recommendations concerning their appointment and hereby recommend approval.

Department of Pediatrics	Category	Date Eligible
Ann C. Dunnigan	Attending	December 24, 1988
Ralph S. Shapiro	Attending	December 24, 1988
Department of Urology		
Neil A. Stein	Clinical	December 24, 1988

The Committee recommends acceptance of the resignations of Medical Staff appointments from the following physicians.

Department of Pediatrics	Category
Richard P. Nelson	Clinical
Karen N. Olness	Clinical

Department of Orthopedics	
John E. Lonstein	Attending
Robert Winter	Attending

Resignation of Faculty Appointment/Loss of Medical Staff Appointment

Department of Obstetrics and Gynecology	
Donald Pavelka	Attending

HB/cf

UNIVERSITY OF MINNESOTA
TWIN CITIES

The University of Minnesota Hospital and Clinic
Harvard Street at East River Road
Minneapolis, Minnesota 55455

May 5, 1988

TO: Members, Joint Conference Committee

FROM: Greg Hart
Senior Associate Director

SUBJECT: Quality Assurance Report

As was discussed at the Joint Conference Committee's April meeting, Quality Assurance will be a major focus for the Committee's work for the rest of this year.

We thought it would be beneficial to the Committee to begin this effort with a broad overview of the elements of the Quality Assurance function within the Hospital. Dr. Moller and Jan Brockway will lead this presentation, reviewing various QA activities and the QA plan which the Board approved earlier. In addition, we will go into one example in some depth. Through the example, we hope to give the Committee a more tangible perception of the nature of the QA activities which are going on throughout the organization.

We are planning additional follow-up presentations for future Committee meetings. As you review this information and listen to the presentation, we would ask that you consider what approaches would be most useful to the Committee in the future, in terms of the role that you would wish to see the Committee play in Quality Assurance.

We will also be discussing data confidentiality considerations as it relates to review of quality assurance information in a public setting. This will need to influence the approach which we take in future Joint Conference Committee and Board of Governors discussions of Quality Assurance.

We look forward to our meeting on May 11.

GH/kj

QUALITY ASSURANCE ACTIVITIES

EXTERNAL REVIEW

- PRO
- Third Party Payors
- Third Party Review Agencies
- Medical Examiner
- Joint Commission

HOSPITAL-WIDE REVIEW

- Infection Control
- Surgical Case Review
- Drug Usage Review
- Blood Usage Review
- Medical Record Review
- Respiratory Therapy Usage Review
- Utilization Review
- Complaint Followup
- Malpractice Claims
- Credentials Review

DEPARTMENTAL REVIEW

- Studies
- Clinical Research
- Protocols Requiring Long-Term Followup
- Grand Rounds
- Mortality and Morbidity Conferences
- Registries
- Monitors of Quality and Appropriateness of Care

QUALITY ASSURANCE PROGRAM

ORGANIZATIONAL PLAN

The University of Minnesota Hospital and Clinic

QUALITY ASSURANCE PROGRAM
ORGANIZATIONAL PLAN
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QUALITY ASSURANCE PROGRAM

ORGANIZATIONAL PLAN

INTRODUCTION:

As reflected in The University of Minnesota Hospital and Clinic's Statement of Mission and Goals, the Hospital and Clinic has many different responsibilities and goals requiring that its mission be uniquely broad. In pursuit of patient care, education, and research goals, the Hospital and Clinic strives to provide leadership through the development of model programs.

As a teaching hospital of national stature, the Hospital and Clinic has many activities that are intended to assure high quality patient care at the lowest possible costs. Participation of students, residents, and staff physicians in rounds and clinical conferences, particularly death and complications conferences, provides a protocol for constant evaluation of clinical judgement. Multidisciplinary committees of the organized medical staff also serve important quality assurance functions. All Hospital and Clinic's clinical services and hospital clinical support departments have ongoing quality and appropriateness of care monitoring and evaluation activities. The Hospital and Clinic's Quality Assurance Program is designed to enhance patient care and assure appropriate allocation of health care resources through ongoing objective assessment of important aspects of patient care and the correction of identified problems.

PURPOSE OF THE HOSPITAL AND CLINIC'S QUALITY ASSURANCE PROGRAM:

The purpose of the Hospital and Clinic's Quality Assurance Program is to provide for coordination and to enhance, where necessary, the many quality and appropriateness of care monitoring and evaluation activities. Along with this coordination, the intent of the Quality Assurance Program is to improve the process of focusing these quality and appropriateness of care monitoring and evaluation activities on the most important aspects of patient care and to aid in the correction of identified problems. The Hospital and Clinic believes best results will be achieved by sharing information and integrating studies where a synergistic outcome can be predicted.

AUTHORITY:

The overall responsibility and authority for quality assurance lies with the Governing Board which delegates authority to the organized medical staff and to Hospital and Clinic's management. The organized medical staff, through the Medical Staff-Hospital Council, in turn, delegates authority to committees or task forces of the medical staff. Likewise, Hospital and Clinic's management delegates authority to individual departments. The Quality Assurance Steering Committee, an advisory committee to the Medical Staff-Hospital Council and Hospital and Clinic's management, is charged with the responsibility for coordinating all quality assurance activities and providing program direction.

COORDINATION;

Quality Assurance Steering Committee:

The Quality Assurance Steering Committee facilitates coordination of these committee and department activities and provides program direction. This Committee, chaired by the Chief of Staff, is composed of the chairmen of the Credentials Committee, the Outpatient Committee, and the Tissue and Procedure Review Committee; Two clinical chiefs, one of whom shall be the chairman of the Council of Chiefs of Clinical Services; Three other representatives of the Medical Staff; Director of Nursing, or designee, General Director, or designee; Director of Medical Staff Services; Director of Quality Assurance Services; and Director of Patient Relations.

The Committee meets as often as is necessary to advise the Medical Staff-Hospital Council as to directions that should be taken to improve the hospital and clinic's quality assurance and utilization review systems. The advice will be based on the committee's evaluation of patient care concerns and of the effectiveness of the continuous monitoring and other quality assurance and utilization review activities carried out by hospital departments, clinical departments, and medical staff committees.

(a) Evaluate the continuous monitoring systems and other quality assurance and utilization review activities of each department and of Medical Staff-Hospital Council committees at least annually.

(b) Identify problems with the quality of patient care and utilization of services, and recommend assignment of assessment, resolution, and follow-up activities for these problems.

(c) Develop an annual work plan for the quality assurance and utilization review activities. The work plan will be submitted for approval to the Medical Staff-Hospital Council, and the Board of Governors.

(d) Serve as an advisory group to Quality Assurance Services.

(e) Coordinate and monitor compliance with JCAH, PRO, and other external quality assurance and utilization review requirements.

(f) Recommend organizational changes in the hospital and clinic's quality assurance and utilization review systems, as needed.

Quality Assurance Services:

The Quality Assurance Services department of evaluation specialists will facilitate the Quality Assurance Program process by providing quality assurance staff support throughout. The responsibilities of the department are to:

1. provide quality assurance activity staff support to the Board of Governors, the Medical Staff-Hospital Council, the Quality Assurance Steering Committee, the standing committees of the Medical Staff-Hospital Council, and hospital and clinical departments as determined by the Quality Assurance Steering Committee
2. serve as a central quality assurance information monitoring resource
3. provide a central resource for following up on actions recommended through the quality assurance system
4. coordinate and monitor compliance with JCAH, PRO, and other external quality assurance and utilization review requirements, recommending modification or improved coordination as necessary
5. document Hospital and Clinic's program activity and actions taken

QUALITY ASSURANCE PROGRAM COMPONENTS:

Committees of the Medical Staff

Each of the following committees of the Medical Staff-Hospital Council is involved in ongoing monitoring and evaluation activities. In addition to these routine activities, if an area of concern or problem falls within the scope of one of the committees, the committee will be responsible for the assessment, resolution, and follow-up activities. (See Section A of Appendix A, Guidelines for Determining Assignment of Approved Quality Assurance Program Activities.)

Each of the committees reports and makes recommendations to the Medical Staff-Hospital Council. The Committees are:

Biomedical Ethics Committee
Cardio-Respiratory Advisory Committee
Credentials Committee
Emergency Room Committee
Hospital Infection Committee
Medical Record and Patient Care Information Committee
Operating Room Committee
Outpatient Committee
Pharmacy & Therapeutics Committee
Product Evaluation and Standardization
Tissue and Procedure Review Committee
Transfusion Therapeutics Committee

Clinical Departments:

Individual clinical departments are routinely involved in quality and appropriateness of care monitoring and evaluation activities. Each clinical service will have a defined quality assurance process. The clinical service will submit a copy of the process to the Quality Assurance Steering Committee for approval. Each Clinical Service will incorporate the following, at minimum, into its quality assurance review process:

1. Monthly meetings at which clinical performance and patient care are discussed with the staff of the service. During the course of a year the minutes of these meetings should include evidence of consideration of the following:
   - o comprehensive mortality and morbidity review which should be conducted at least once a month
   - o data from the Clinical Service Quality Assurance Monitoring System
   - o problems or issues identified through hospital-wide monitoring systems such as tissue and procedure review, drug usage review, medical record review, blood usage review, utilization review, infection control, patient monitoring usage review, and respiratory therapy usage review

- o occasional instructive case reports or presentations of a topic relevant to patient care

2. A written response to the Clinical Service Quality Assurance Monitoring System data at least once a quarter. The response will include conclusions and recommendations or actions taken as a result of reviewing the monitoring data and any additional data judged by the clinical service to appropriately monitor quality and appropriateness of patient care. The response will be forwarded to Quality Assurance Services for review and for consideration by the Quality Assurance Steering Committee, as appropriate.

   In lieu of a separate written response to the Quality Assurance Monitoring data a clinical service can choose to forward copies of its minutes provided the minutes include conclusions and recommendations or actions taken as a result of reviewing the data.

In addition to these routine activities, if an area of concern or problem does not fall within the scope of one of the committees of the Medical Staff-Hospital Council but relates to one department, responsibility for the assessment, resolution, and follow-up activities may be assigned to the department chairperson. (See Section B of Appendix A, Guidelines for Determining Assignment of Approved Quality Assurance Program Activities.)

Hospital Clinical Support Departments:

Hospital clinical support departments are routinely carrying out quality and appropriateness of care monitoring and evaluation activities. Each hospital clinical support department will have in writing a defined quality assurance process. The department will submit a copy of this document to the Quality Assurance Steering Committee for approval.

Each hospital clinical support department will incorporate the following, at minimum, into their quality assurance review process:

1. A systematic process for monitoring and evaluating the quality (e.g., outcomes, timeliness, effectiveness) and appropriateness of the care or services provided by the department. Such monitoring and evaluation will be accomplished through the following:

   - o Identification of critical indicators reflecting important aspects of care or services provided by the department.

   - o Routine collection of data related to the critical indicators.

   - o Periodic assessment of the collected information in order to identify important problems and opportunities to improve care. Criteria will be used, as needed, in the evaluation process.

2. A written response to the monitoring system data at least once a quarter. The response will include conclusions and recommendations or actions taken as a result of reviewing the data and any additional data judged by the department to appropriately monitor quality and appropriateness of the care and services prepared by the department. The response will be forwarded to Quality Assurance Services for review and for consideration by the Quality Assurance Steering Committee, as appropriate.

The Quality Assurance Program Review and Evaluation Reporting Form, minutes of staff meetings, or other formats can be used for this response provided they include conclusions and recommendations or actions taken as a result of reviewing the data.

In addition, if an area of concern or problem does not fall within the scope of one of the committees of the Medical Staff-Hospital Council but relates to one department, responsibility for the assessment, resolution, and follow-up activities may be assigned to the department head. (See Section B of Appendix A, Guidelines for Determining Assignment of Approved Quality Assurance Program Activities.)

DATA SOURCES:

The Quality Assurance Program will use a variety of data sources to identify potential areas for review, evaluation, and resolution and to properly monitor the quality and appropriateness of patient care provided at The University of Minnesota Hospital and Clinic. These may include but are not limited to:

1. Committee findings
2. Hospital and Clinic's department findings
3. Clinical service findings
4. Medical staff concerns
5. Hospital and Clinic's staff concerns
6. Profiles (external and internal)
7. Studies
8. Incident reports
9. Patient surveys
10. Complaints and compliments
11. Financial reports
12. Outside agency reports
13. Claims data
14. Malpractice claims data
15. Medical examiner cases

CONFIDENTIALITY:

All data and information acquired and prepared for Quality Assurance Program or Credentialing activities are strictly confidential and are not considered discoverable or admissable in a court of law (protected under Minnesota State Statute 145.64). These data will be used, disseminated or published only to the extent required to effectively perform activities associated with the carry out Quality Assurance or Credentialing activities.

No person shall disclose to any individual, organization, or association, any Quality Assurance or Credentialing Information that was discussed at any meeting or other review proceeding, except to the extent required to effectively perform those evaluation activities as set forth in Minnesota State Statute 145.61, Subdivision 5. Obviously, information, documents, or records otherwise available from original sources do not become confidential merely because they were utiliz-

ed in connection with a Quality Assurance or Credentialing activity (See Appendix D, Confidentiality Policy for Quality Assurance/Credentialing Information).

EVALUATION OF THE QUALITY ASSURANCE PROGRAM:

The quality assurance process of each hospital and clinical department and Medical Staff-Hospital Council committee shall be evaluated at least annually to assure that they meet the quality assurance needs of the Hospital and Clinic. As often as this ongoing evaluation process indicates, the organizational plan shall be reviewed and revised, if necessary, by the Quality Assurance Steering Committee with input and assistance from other committees, clinical departments, Hospital and Clinic's departments, and the Director of Quality Assurance Services. The Medical Staff-Hospital Council, hospital management, and the Governing Board, through the Joint Conference Committee, shall approve revisions and changes.

APPENDIX A

GUIDELINES FOR DETERMINING

RESPONSIBILITY FOR MONITORING OR EVALUATION AND RESOLUTION OF ISSUES OR CONCERNS

SUMMARY:

When an area of concern is identified, responsibility for assessment and resolution will be assigned to a department, committee, task force, or individual according to the guidelines outlined below. In summary,

- If an area of concern falls clearly within the scope of one of the standing committees of the Medical Staff-Hospital Council, the chairman of the committee will be responsible for assigning appropropriate individuals to assess the concern and to develop recommendations for resolution and followup.

- If an area of concern does not fall within the scope of one of the committees of the Medical Staff-Hospital Council but relates to one department (clinical service or hospital department), the department head will be responsible for the assessment, resolution, and followup activities.

- If an area of concern does not fall within the scope of one of the committees of the Medical Staff-Hospital Council and is a concern relating to more than one department, the chairman of the Medical Staff-Hospital Council will be responsible for assigning appropriate individuals to assess the concern and to develop recommendations for resolution and followup.

In each case, the above chairman or department head will be responsible for the reporting of findings and recommended or actual resolutions to the Board through the Medical Staff-Hospital Council and the Joint Conference Committee.

The Quality Assurance Services department will facilitate coordination of these activities by providing staff support, as appropriate, on an approved basis.

The University of Minn[illegible]a Hospital and Clinic

NEONATAL INTENSIVE CARE UNIT

July 1986 - December 1987

INDICATORS	Jul-Sep '86		Oct-Dec '86		Jan-Mar '87		Apr-Jun '87		Jul-Sep '87		Oct-Dec '87	
	#	%	#	%	#	%	#	%	#	%	#	%
VOLUME INDICATORS												
Patients Admitted or Transferred to NICU*												
Direct Disch to Another Hospital												
Direct Disch to Other Facilities												
Direct Disch to Home												
NICU Patient Days												
Average Length of Stay												
NUMIS class (% of pts) - 3C Only												
1												
5												
6												
7												
8												
9												
10												
UTILIZATION INDICATORS												
DRG 386 (Extreme Immaturity, Neonate) Average LOS												
DRG 386 (Extreme Immaturity, Neonate) Avg Charges												
QUALITY INDICATORS												
DEATHS (% of Pts on NICU)												
Autopsy (% of Deaths)												
COMPLICATIONS												
Cardiac/Respiratory Arrest												
Adverse Drug Reactions/Toxicity												
Transfusion Reaction												

INDICATORS	Jul-Sep '86		Oct-Dec '86		Jan-Mar '87		Apr-Jun '87		Jul-Sep '87		Oct-Dec '87	
	#	%	#	%	#	%	#	%	#	%	#	%
COMPLICATIONS, continued												
Cicatrical Retinopathy of Prematurity												
Necrotizing Enterocolitis												
Non-Elective Reintubation (% of Vent Pts)												
Subglottic Stenosis (% of Vent Pts)												
VENTILATOR PATIENTS												
Complications Associated with Ventilators												
Airleak Syndrome (overall) (% of Vent Pts)												
Pneumothorax (% of Vent Pts)												
Pneumopericardium (% of Vent Pts)												
PIE (severe) (% of Vent Pts)												
BPD (% of Vent Pts)												
Other (% of Vent Pts)												
LINES PLACED												
UAC												
UVC												
Jugular												
Long Silastic Catheter												
Femoral												
Radial Arterial												
Other Arterial												
Complications Associated with Line Placement												
Thrombosis (% of Lines Placed)												
Infection (% of Lines Placed)												
Major Blood Loss (% of Lines Placed)												
Skin Damage (% of Lines Placed)												
Accidental Removal (% of Lines Placed)												
Pericardial Tamponade (% of Lines Placed)												

INDICATORS	Jul-Sep '86		Oct-Dec '86		Jan-Mar '87		Apr-Jun '87		Jul-Sep '87		Oct-Dec '87	
	#	%	#	%	#	%	#	%	#	%	#	%
OUTLIERS												
PATIENT RELATED INCIDENT REPORTS												
Falls/Injuries (# per 100 Pt Days)												
IV/Medications (# per 100 Pt Days)												
All Others (# per 100 Pt Days)												
Total Incidents (# per 100 Pt Days)												
PT CARE CONCERNS SUBMITTED TO PT RELATIONS												
DEVELOPMENTAL ASSESSMENT AT ON YEAR BASED ON BAYLEY'S SCORE:												
Mental Developmental Index (MDI):												
Within 2 std deviations												
Below 2 std deviations												
Psychomotor Developmental Index (PDI):												
Within 2 std deviations												
Below 2 std deviations												

NOTES: All Percentages listed are based on the total number of patients on the NICU, unless otherwise specified.
N/A = Data for this indicator not available.
\- = Data item not applicable.

*Admissions of patients during the quarter who were on the NICU at some time during their stay.

Source: Corporate Reports IR990, Admissions Census Reports, ALEXIS Incident Report Analyses,
and Data Collected by the NICU Nursing Staff.
Prepared by Quality Assurance Services, V. Netz, 2/5/88.
File: {QUAS}[Sys]<VINCEMP>MON.NICU

The University of Minnesota Hospital and Clinic
DEPARTMENT OF NURSING SERVICES QUALITY ASSURANCE PROGRAM
MEDICATION AND I.V. RELATED INCIDENTS: Fiscal Year 1987/88 (July 1987 - June 1988)

PATIENT CARE UNIT

INDICATOR	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Medication Incidents												
Wrong Medication Administered												
Wrong Dose Administered												
Med Administered to Wrong Patient												
Med Administered at Wrong Time												
Med Administered by Wrong Route												
Medication Omitted												
Other												
I.V. Incidents												
Too Fast												
Too Slow												
Wrong Solution												
Wrong Additive												
Wrong Administration Apparatus												
I.V. Infiltrated												
Other												
Total Number of Incidents												
Patients Treated												
Incidents per 100 Patients Treated												
Controlled Substance Audit												
Quantity Missing: Doses												
cc's												
Quantity Extra: Doses												
cc's												
Different Medication Arrived on Unit												

Source: Information compiled by Nursing Services using Department of Pharmacy Services incident summaries and stored on the Quality Assurance Services Database. V. Netz 4/1/88
File: {QUAS}[Win]<NURSING>MEDIRSmodel.mp