QUALITY MANAGEMENT COMMITTEE
BOARD OF GOVERNORS
Wednesday, September 28, 1994
Board Room
9:30 A.M.

AGENDA

| I. | Approval of the June 22, 1994 Minutes | Approval | 22 |
| II. | Medical Staff-Hospital Council Report: | | |
| | - Credentials Committee Recommendations | Endorsement/Consent | 25 |
| | - Marvin Goldberg, M.D. | | |
| III. | Quarterly Safety Report | Information | 30 |
| | - Robert Nygren | | |
| IV. | Infection Control Report | Information | |
| | - Frank Rhame, M.D. | | |
| | - Vancomycin Resistant Enterococcus | | |
| | - Water Damage and Aspergillus | | |
| | - Occupational Exposure to TB | | |
| V. | Other Business | | |
| VI. | Adjournment | | |
THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

BOARD OF GOVERNORS

QUALITY MANAGEMENT COMMITTEE

SEPTEMBER 22, 1993
### AGENDA

| I. | Approval of the July 28, 1993 Minutes | Approval | 1 |
| II. | JCAHO Update | Information |  |  
|   | -Jean Harris, M.D. |  |  |
| III. | Clinical Chiefs Evaluation | Endorsement/Consent | 4 |
|   | -Robert Maxwell, M.D. |  |  |
| IV. | Medical Staff-Hospital Council Report: | 8 |
|   | - Credentials Committee Recommendations | Endorsement/Consent |  |
|   | - Robert Maxwell, M.D. |  |  |
| V. | Quality Management Steering Committee Report | Endorsement/Consent | 12 |
|   | - Jean Harris, M.D. |  |  |
| VI. | Infection Control Committee Report | Endorsement/Consent | 45 |
|   | - Jean Harris, M.D. |  |  |
| VII. | Other Business |  |  |
| VIII. | Adjournment |  |  |
Call to Order

Mr. Hanser called the meeting to order at 10:10 a.m.

Approval of the June 23, 1993 Minutes

The Committee recommended approval and forwarded the minutes of the June 23, 1993 meeting as submitted.

JCAHO Update

Dr. Harris presented a JCAHO preparation status report. The JCAHO survey is tentatively scheduled for November 2 - 5, 1993. Dr. Harris noted that work continues on previous JCAHO recommendations. The JCAHO Survey Preparation Team is primarily focusing on staff competency assessment, organization-wide education, and improved reporting to the Board.

The Committee will receive regular reports regarding the progress of JCAHO survey preparations.
Medical Staff-Hospital Council Report

Dr. Maxwell presented Credentials Committee recommendations addressing reappointment of Medical and Dental staff in Unit I for the years 1993 - 1995 deferred from the last meeting. The report included recommendations related to reappointment, reappointment/reinstatement, provisional status appointment, addition or deletion of clinical privileges, changes in staff category, resignations, and individuals who have completed their provisional status and are eligible for regular appointments. Also included were appointments to the psychology staff with requests for clinical privileges. The credentialing process was reviewed and clarified for Committee members by Dr. Maxwell, Dr. Harris, and Keith Dunder.

The Committee recommended approval and forwarded the Credentials Committee recommendations.

Appointment of Medical Staff-Hospital Council Committee Chair

Dr. Maxwell presented the Medical Staff-Hospital Council recommendation that Robert Wilson, M.D., Chair the Cardiovascular Services Advisory Committee. Dr. Maxwell described the role of this Advisory Committee and noted Dr. Wilson, a Cardiologist, is well qualified to lead this Committee.

The Committee recommended approval and forwarded the proposed Medical Staff-Hospital Council Committee Chair appointment.

Annual Review of Home Health Care Services

Ms. Wells and Ms. Dorsey presented the annual review of Home Health Care Services. This hospital-based department was initiated in 1989 and serves primarily UMHC discharges and UMHC clinic referrals within a 30 mile radius. The types of activities provided were reviewed, and the role of the Public Health Nurse was described. Committee discussion included review of a policy for accepting referrals from non-UMHC providers, and interest in marketing this service to patients and all providers.

Ms. Wells noted an error in the cover memo submitted with the report: 1992-93 should be replaced with 1993-94.

The Committee recommended approval and forwarded the annual review with the noted correction.

Service Committee Progress Report

Dr. Harris reported the Service Committee has referred physician-related service recommendations to the University of Minnesota Clinical Associates (UMCA) Professional Services Committee. It was noted the Professional Services Committee will exert substantial influence through the Executive Committee and directors of UMCA.

The Quality Management Committee will continue to receive progress reports related to Service Improvement initiatives.
CQI Education

Dr. Harris introduced Ms. Diane Jacobsen who has recently joined Quality Support Services as the Quality Improvement Manager and point person for organization-wide CQI development. Ms. Jacobsen presented a CQI education proposal for the Board of Governors retreat in September. The Committee recommended the education be significant and relevant, and acknowledge previous Board member knowledge and experience. Areas of particular interest include how CQI relates to State ISN initiatives and the CQI philosophy of the organization. The Committee recommended a CQI resolution be drafted for Board approval.

Ms. Huntington presented a CQI education proposal targeted at team leaders and facilitators. Six to eight teams would be formed to address selected UMHC CQI projects. A consultant would provide training, consultation, and support to the teams through three site visits over a three month period. The goals of this proposal were reviewed and potential projects discussed.

Patient Satisfaction Data

Ms. Green, Director, Patient Relations, presented the Patient Satisfaction survey results for April through June of 1993. Ms. Green reviewed the survey process and provided examples of survey responses for Committee review. She noted the survey focuses on service improvement priorities identified by the Service Task Force. Improvements identified through the April-June data include an increase in the proportion of patients reporting the care and service they received was very good or excellent, and an increase in patients reporting they were very satisfied their physicians were skilled and knowledgeable.

The Committee requested followup reports at three month intervals.

Adjournment

There being no further business, the meeting was adjourned at 11:45 a.m.

Respectfully submitted,

Sally Huntington
Director, Quality support Services
TO: Members, Quality Management Committee

FROM: Greg Hart
      General Director

Robert Maxwell, M.D.
Chief of Staff

Roby Thompson, M.D.
Chair, Clinical Chiefs

Shelley N. Chou, M.D.
Interim Dean, Medical School

DATE: September 16, 1993

RE: Chief of Clinical Service Reappointments and Appointments

We are writing to recommend the reappointment and appointment of Chiefs of Clinical Services.

As you know, at the May meeting of the Board of Governors criteria for evaluation of clinical chiefs were approved. A copy of those criteria is attached. At the June meeting of the Board of Governors the appointments of all current clinical chiefs were extended until the September Board meeting. In June the Board also adopted a resolution directing the Chief of Staff, the General Director, the Dean, and the Chairperson of the Clinical Chiefs to apply the criteria and to make recommendations to the Quality Management Committee. The recommendations that follow are a result of application of the criteria as directed by the Board of Governors.

The following clinical chiefs have served in that capacity for the past year, are due for reappointment, and are recommended for reappointment:

George Adams, M.D. Otolaryngology
Edward Ciriacy, M.D. Family Practice
Thomas Ferris, M.D. Medicine
Leo Fucht, M.D. Laboratory, Medicine & Pathology
Roberto Heros, M.D. Neurosurgery
Seymour Levitt, M.D. Therapeutic Radiology
Peter Lynch, M.D. Dermatology
Alfred Michael, M.D. Pediatrics
Richard Palahniuk, M.D. Anesthesia
The following individuals are recommended as new appointments as clinical chiefs. Curriculum Vitae are attached:

Edward Humphrey, M.D. Surgery

Dr. Humphrey has recently completed his responsibilities and obligations as Chief of Surgery at the VA Medical Center and is now able to assume the responsibilities as Clinical Chief at UMHC, in addition to his ongoing duties as Interim Head of the Department of Surgery in the Medical School.

Jay Krachmer, M.D. Ophthalmology

Dr. Krachmer assumed responsibility as Head of the Department of Ophthalmology in July, 1992.

James Mitchell, M.D. Psychiatry

Dr. Mitchell is recommended to serve as Clinical Chief of Psychiatry, given that Dr. Paula Clayton is on sabbatical at the National Institute of Mental Health until mid-1994.

Pratap Reddy, M.D. Urology

Dr. Reddy is recommended to serve as Clinical Chief, given the recent departure of Dr. Elwin Fraley. It should be noted that Dr. Reddy is not serving as Interim Head of the Department of Urology; Dr. Robert Heros is serving in that capacity.

The following individual is serving in his initial three year term as Chief of Clinical Service, thus reappointment is not required this year.

Dennis Dykstra, M.D. Physical Medicine and Rehabilitation

We will be happy to answer any questions you may have at the September 22nd meeting of the Quality Management Committee.
CRITERIA FOR CLINICAL CHIEFS EVALUATION

1. Each Clinical Chief shall be responsible for and shall demonstrate commitment to the fulfillment of the mission of UMHC, and the implementation of the strategic plan of UMHC within his or her clinical department.

2. Each Clinical Chief shall be accountable for all professional, clinical, and related administrative activities within his or her service, and shall be responsible in all respects for the implementation of actions and policies set by the Board, the Council of Chiefs of Clinical Services, and the Medical Staff Hospital Council, and for the performance of all functions of Clinical Chiefs as set forth in the UMHC Medical Staff Bylaws.

3. Each Clinical Chief shall participate in appropriate administrative and committee processes in order to carry out the objectives of UMHC and the medical staff.

4. Each Clinical Chief shall be responsible for the active and successful interaction and liaison between the clinical service, UMHC, UMCA and the Medical School.

5. Each Clinical Chief shall conduct him or herself in such a fashion as to promote the positive public image of UMHC, and the clinical service, and shall maintain him or herself in good public and professional standings in all respects.

6. Each Clinical Chief shall be responsible for maintaining a sound administrative clinical organization within his or her service, for promoting the quality of service and the morale of the members of the clinical service, and for demonstrated leadership of the clinical faculty.

7. Each Clinical Chief shall be responsible for the continuous monitoring and improvement of the quality of service within the clinical service.
8. Each Clinical Chief shall be responsible for compliance with applicable standards, rules, regulations, and protocols relating to research or other regulated activity conducted within the clinical service at UMHC, including but not limited to those promulgated by JCAH, FDA, NIH, and the IRB (Human Subjects Committee).

9. Each Clinical Chief shall be responsible for compliance with practice guidelines established for his or her clinical service.

10. Each Clinical Chief shall be responsible for the compliance of all members of the clinical service in regard to the standards set forth in this policy.
TO: Quality Management Committee
FROM: Robert E. Maxwell, 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 endorsed the attached Credentials Committee Report and Recommendations on September 14.

I am forwarding these recommendations to you for your review and consideration. Following your consideration of these recommendations, we ask that you forward them to the Board of Governors for approval.

Thank you.

REM/cf
Attachment
September 13, 1993

TO: Medical Staff-Hospital Council

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

SUBJECT: Credentials Committee Report and Recommendations

The Application for Reappraisal and Reappointment to the Medical Staff of the following member of the medical staff is in progress. The Credentials Committee hereby recommends reappointment and privileges be extended for 90 days pending clarification of application.

Department of Hospital Dentistry
Mohamed El Deeb

Category
Attending Staff
August 20, 1993

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 recommends 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 Hospital Dentistry**
  - Allen M. Lepinski
    - Category: Clinical Staff

- **Department of Medicine**
  - Jordon M. Dunitz
  - Category: Attending Staff
  - David W. Faling
  - Category: Attending Staff-ER
  - Brendan M. McGuire
  - Category: Attending Staff-ER

- **Department of Obstetrics and Gynecology**
  - Peter R. Johnson
  - Category: Attending Staff

- **Department of Pediatrics**
  - David N. Cornfield
  - Category: Attending Staff
  - Vicki M. Oster
  - Category: Attending Staff
  - Kevin J. Sheridan
  - Category: Attending Staff
  - Judith L. Zier
  - Category: Attending Staff

- **Department of Radiology**
  - Lillian U. Palmon
  - Category: Attending Staff
  - Steven E. Stawson
  - Category: Attending Staff
  - Emily H. Wang
  - Category: Attending Staff

- **Department of Therapeutic Radiology**
  - Kwan H. Cho
  - Category: Attending Staff
The following medical staff have submitted applications and supporting documentation requesting addition of clinical privileges. The Committee has reviewed and considered their requests and hereby recommends approval.

**Department of Medicine**

**George C. Haidet**  
Attending Staff  
Add: Cardiology: thoracentesis-aspiration only  

**Jane A. Little**  
Attending Staff  
Add: General Internal Medicine: anoscopy; Oncology: hormone response testing, incision and drainage of abscess, skin biopsy  

The following medical staff have submitted new clinical privileges forms with no changes. The Committee has reviewed and considered their requests and hereby recommends approval.

**Philip C. Halverson**  
Clinical Staff  
new clinical privilege form-no changes  

**David J. Ridley**  
Clinical Staff  
new clinical privilege form-no changes  

**John A. Wangsness**  
Clinical Staff  
new clinical privilege form-no changes  

The Credentials Committee has considered and hereby recommends the reinstatement/reappraisal and reappointment of the following physician in Unit I for 1993 - 1995.

**Department of Neurology**

**Frank J. Ritter**  
Attending Staff  

The following medical staff have submitted applications and supporting documentation requesting change in staff category. The Committee has reviewed and considered their requests and hereby recommends approval.

**Department of Hospital Dentistry**  
**Present Category**  
**Requested Category**  

**Rick L. Diehl**  
Attending Staff  
Clinical Staff  

**Department of Neurology**

**Frank J. Ritter**  
Attending Staff  
Clinical Staff  

**Department of Obstetrics and Gynecology**

**Jacques P. Stassart**  
Attending Staff  
Clinical Staff  

**Department of Pediatrics**

**Julie M. Hauer**  
Attending Staff  
Clinical Staff
The following medical staff 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.

<table>
<thead>
<tr>
<th>Department of Orthopaedic Surgery</th>
<th>Category</th>
<th>Date Eligible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jeffrey B. Husband</td>
<td>Clinical Staff</td>
<td>June 16, 1993</td>
</tr>
<tr>
<td>Scott A. McPherson</td>
<td>Clinical Staff</td>
<td>June 16, 1993</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Department of Orthopedics</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Garry M. Banks</td>
<td>Attending Staff</td>
</tr>
<tr>
<td>Mark B. Dekutoski</td>
<td>Attending Staff</td>
</tr>
<tr>
<td>Alfred E. Geissele</td>
<td>Attending Staff</td>
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<table>
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<tr>
<th>Department of Radiology</th>
<th>Category</th>
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<tbody>
<tr>
<td>Joel M. Berman</td>
<td>Attending Staff</td>
</tr>
<tr>
<td>Thomas R. Beidle</td>
<td>Attending Staff</td>
</tr>
<tr>
<td>Thomas J. Maginot</td>
<td>Attending Staff</td>
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<tr>
<td>Scott A. Wegryn</td>
<td>Attending Staff</td>
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HB/cf
September 8, 1993

TO: Medical Staff-Hospital Council

FROM: Jean Harris, M.D.
Chair, Quality Management Steering Committee

SUBJECT: Quality Management Steering Committee Report

The Quality Management Steering Committee reviewed and endorsed the attached Quarterly Safety Officer Report on August 24, 1993. The Committee also reviewed and endorsed four organization-wide program plans:

**Quality Management Plan** - Significantly revised to address the recommendations of the Quality Assurance Steering Committee Task Force endorsed by the Medical Staff-Hospital Council in 1992.

**Risk Management Plan** - A new document describing UMHC's Risk Management System. It has been reviewed and endorsed by all departments which have a role in Risk Management.

**Utilization Review Plan** - Minor revisions to the plan previously approved by the Council. Revisions include a commitment to strengthened support for the Utilization Review Program by Quality Management Steering Committee Subcommittees.

**Safety Management Program** - A new document which has been in the development and revision process since March of 1992. It received final revision and approval by the Safety Committee this summer.

I am forwarding these materials to you for your review and approval at the September 14 Council meeting.

Thank you.
INTRODUCTION
The mission of the University of Minnesota Hospital and Clinic (UMHC) is to provide high quality patient services, diverse educational programs, and an environment supportive of research. Strategic priorities include a commitment to excellence in clinical outcomes, consumer service, and cost-effectiveness. To fulfill its mission and accomplish its strategic objectives UMHC has developed a system-wide management approach designed to assess and continuously improve the value of its products and services.

PHILOSOPHY
UMHC's Quality Management Program is based on leadership commitment to both the philosophy of continuous improvement and the importance and accountability of each individual. The program strives to build upon the improvements which result from clinical research and traditional quality assurance by promoting system-wide evaluations of patient care and organizational functions. It is founded on the following:

- We are committed to providing highest quality care
- We are committed to consistently exceeding patients and families expectations
- We are committed to exceeding internal and external customers expectations
- The greatest opportunity for improvement occurs through collaborative efforts of healthcare professionals.

PURPOSE
The purpose of the Quality Management Program is to promote the mission and strategic goals of UMHC by providing an integrated system-wide quality and utilization management program. This program focuses on systematically evaluating and continuously improving key clinical, support, managerial and governance systems and processes.

OBJECTIVES
A. Integration of the Quality Management Program into the ongoing operations of the medical center.

B. Monitoring and evaluation of the quality and appropriateness of patient care and performance of healthcare providers.

C. Interdisciplinary assessment and improvement in the effectiveness and efficiency of systems and processes.

D. Education opportunities which facilitate and promote continuous improvement and maintain excellence.

E. Coordination and communication among hospital departments, clinical services, committees, and the governing body.
F. Optimal compliance with accreditation standards and governmental regulations.

G. Provision of an environment conducive to the identification and dissemination of new knowledge related to improvements in patient care.

AUTHORITY
The overall responsibility and authority for quality management lies with the Hospital Board of Governors which delegates responsibility and appropriate authority to the organized medical staff and to the Hospital and Clinic's management. The medical staff, through the Medical Staff-Hospital Council, in turn, delegates responsibility and appropriate authority to the committees and task forces of the medical staff. Likewise, Hospital and Clinic management delegates to the management committees and individual departments.

ORGANIZATION
The quality management program structure diagram is presented in Attachment I. Each committee referenced in this Plan is numbered on the structure diagram. Committees already noted include the Hospital Board (1), the Medical Staff-Hospital Council (3), Medical Staff-Hospital Council Committees (4), and the management committees (6).

Quality Management Steering Committee (5)
The Quality Management Steering Committee establishes program direction and priorities, assures integration and coordination of all aspects of the Quality Management Program, and provides the resources necessary to sustain effectiveness. This Committee consists of the General Director; the Senior Associate Directors/Directors of Finance, Medical Affairs, and Nursing; a minimum of three Clinical Chiefs including the Chair of the Council of Clinical Chiefs and the Chief of Staff; and others as appropriate. The Committee meets quarterly or as often as is necessary to accomplish its duties.

The duties of this Committee are to:

(a) Oversee the quality management activities of the organization's clinical, support, management and governance functions.

(b) Evaluate all quality management activities within the hospital and clinic at least annually.

(c) Recommend organizational changes in UMHC's quality management systems.

The Committee maintains a permanent record of its findings, proceedings, and actions, and provides reports to the Medical Staff-Hospital Council and the Board of Governors.

Patient/Systems Quality Management Subcommittee (8)
The Quality Management Steering Committee has appointed this Subcommittee to implement and evaluate the Quality Management Programs which relate to patient care and patient care systems. The Committee is chaired by the Senior Associate Director/Director of Medical Affairs. Membership represents major clinical and support services throughout the institution.

The duties of this Committee are to:

(a) Implement ongoing assessment and improvement activities of patient care and patient care systems in hospital and clinic departments, medical services, and interdisciplinary teams.
(b) Identify, prioritize, and oversee the assignment and progress of specially assigned quality improvement project teams.

(c) Serve as a problem-solving and decision-making resource for issues which cannot be resolved at a lower committee/team level.

(d) Oversee the quality management activities of Medical Staff-Hospital Council and UMHC Management Committees, particularly those related to surgical case review, drug usage evaluation, the Pharmacy and Therapeutics function, medical record review, blood usage review, utilization review, and infection control.

(e) Oversee and coordinate patient-related Risk Management.

This Committee shall meet at least quarterly, shall maintain a permanent record of its proceedings and actions, and shall report to the Quality Management Steering Committee, the Medical Staff-Hospital Council, and the Board of Governors.

Quality Environment and Safety Subcommittee (7)
The Quality Environment and Safety Committee has responsibility for direction of all safety activities for UMHC in accordance with the governing board's objectives, the standards of JCAHO, the Life Safety Code (NFPA 101), Minnesota OSHA, the Minnesota State Fire Marshal, Minneapolis Fire Department, and University of Minnesota Environmental Health and Safety. Committee membership shall include at least one member of the Medical Staff and four representatives of hospital management.

This Committee shall manage a comprehensive safety management program designed to provide a physical environment free of hazards, and to manage staff activities to reduce the risk of human injury.

(a) Development of written policy and procedure designed to enhance safety within the hospital and clinic to the maximum extent possible.

(b) Management of an ongoing process to collect and evaluate information about hazards and safety practices used to identify issues for resolution.

(c) New employee orientation to the safety program and continuing safety education and training.

(d) Management of hazardous materials and wastes.

(e) Maintaining an emergency preparedness program designed to manage the consequences of natural disasters and other emergencies.

(f) Maintaining the life safety program designed to protect patients, visitors, staff, and property from fire and smoke.

(g) Maintaining the equipment management program designed to assess and control the clinical and physical risks of fixed and portable equipment used for diagnosis, treatment, monitoring, and care of patients and of other fixed and portable electrically powered equipment.
(h) Maintaining the utilities management program designed to assure the operational reliability, assess special risks, and respond to failures of utility systems that support the patient care environment.

(i) Oversee and coordinate visitor and staff-related Risk Management.

This Committee shall meet at least bi-monthly, shall maintain a permanent record of its proceedings and actions and shall make reports to the Quality Management Steering Committee, the Medical Staff-Hospital Council, and the Board of Governors.

Committees of the Medical Staff (4)
Each of the following committees of the Medical Staff-Hospital Council is involved in quality management activities. In addition to routine activities, if an area of concern or an opportunity for improvement falls within the scope of one of these committees, the committee is responsible for initiating an appropriate assessment and improvement process. The Committees are:

- Biomedical Ethics Committee
- Cardio-Respiratory Advisory Committee
- Cardiovascular Services Advisory Committee
- Credentials Committee
- Emergency Department Committee
- Infection Control Committee
- Intensive/Special Care Unit Advisory Committee
- Medical Record and Patient Care Information Committee
- Operating Room Committee
- Outpatient Committee
- Pharmacy and Therapeutics Committee
- Product Evaluation and Standardization Committee
- Tissue and Procedure Review Committee
- Transfusion Therapeutics Committee

UMHC Management Committees (6)
Each of the Hospital and Clinic's management committees is involved in quality management activities. In addition to routine activities, if an area of concern or an opportunity for improvement falls within the scope of one of these committees, the committee is responsible for initiating an appropriate assessment and improvement process. The Committees are:

- Budget Committee
- Cost Reduction Implementation Work Group
- External Strategies Committee
- Human Resources Committee
- Information Systems Management Committee
- Service Improvement Committee
- Space/Remodeling Equipment Committee

UMHC Departments, Medical Services, Interdisciplinary Programs (9)
Hospital and Clinic departments, medical services, and interdisciplinary programs are responsible for effective participation in quality management activities. Each department or interdisciplinary program will have a quality management plan and will follow the established quality improvement process. As the hospital-wide quality management program matures all departments will move towards collaborative quality improvement activities.
Minimum quality management program components include:

1. Consideration of the full range of care/service in the identification and prioritization of important aspects of care/service and the development of indicators.

2. Consideration of the JCAHO quality indicators where applicable.

3. Implementation of the established quality improvement process including a needs assessment to identify target areas, the regular collection and analysis of data, the development of actions where appropriate, evaluation of effectiveness, and communication.

4. Analysis of problems or issues identified through hospital-wide monitoring systems such as surgical case review, drug usage review, the Pharmacy and Therapeutics function, medical record review, blood usage review, utilization review, and infection control.

5. Documentation and reporting to the Quality Management Steering Committee.

**Special Task Forces and Improvement Teams**

While opportunities for improvement may be identified and communicated through many formal and informal mechanisms, a formal communication and prioritization mechanism has been established through the Quality Management Steering Committee and its Subcommittees.

When an area of concern is identified and selected as a priority, the Quality Management Steering Committee and/or its Subcommittees assign responsibility for assessment and appropriate action according to the following guidelines:

- If the target area falls clearly within the scope of one of the standing committees of the medical center, the chair of the committee will be responsible for assigning individuals to investigate and address the concern.

- If the target area does not fall within the scope of one of the standing committees but is related to one UMHC department or medical service, the department head will be responsible for assessment, resolution, and followup activities.

- If the target area does not fall into the scope of a standing committee and relates to more than one department; the Chair of the Quality Management Steering Committee, usually through the Chairs of one of the two Subcommittees, will be responsible for assigning appropriate individuals to investigate and address the concern.

In all cases the designated chair or department head will be responsible for following the established UMHC quality improvement process.
The Quality Support Services Department

Quality Support Services is a consultative and support resource to UMHC's quality management program. The primary responsibilities of the department are to:

- provide leadership and monitor progress relative to established program objectives, recommending modification as necessary
- serve as a central quality management information resource
- provide quality management program staff support.

While each department/program is responsible for its own quality management activities, Quality Support Services' staff may be consulted to facilitate program development; assist with prioritization and study design; support data collection, compilation and display; facilitate the development and implementation of improvements; and promote integration, communication, and coordination to minimize duplication of activities.

APPROACH

UMHC has modified and endorsed a quality improvement process initially described by Ronald Butterfield in "A Quality Strategy for Service Organizations". This process provides a systematic and consistent approach to quality assurance and quality improvement initiatives across the institution.

The established process is identified in bold print below. Activities which will be implemented as appropriate within each step of the process are also described.

Needs assessment to identify target areas:
- assign responsibility
- define the scope of care, important aspects of care, and/or the situation to be evaluated
- identify potential causes, generate an hypothesis
- design a study, develop indicators, develop a data collection strategy establish benchmarks, thresholds, or improvement targets

Data collection and analysis:
- determine if further evaluation is needed
- draw conclusions
- verify root causes

Taking action:
- implement process change
- may occasionally be a decision not to intervene

Evaluating the effectiveness of the actions:
- confirm improvement
- plan to maintain the gain

Communication:
- document and communicate conclusions and actions to relevant leadership; those involved in appointment process if appropriate; and any relevant department, program, committee, or individual.
CONFIDENTIALITY
All data and information acquired and prepared for the Quality Management Program is strictly confidential and is not considered discoverable or admissible 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 Quality Management.

No person shall disclose to any individual, organization or association any Quality Management 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. Information, documents, or records otherwise available from original sources do not become confidential merely because they were utilized in connection with a Quality Management activity. (See Policy 15.16 in the Hospital Policy and Procedure Manual: Confidentiality Policy for Quality Management Information).

ANNUAL EVALUATION
The Quality Management Program shall be evaluated at least annually to assure it meets the quality management needs of the Medical Center. As often as this ongoing evaluation process indicates, the organizational plan shall be reviewed and revised, if necessary, by the Quality Management Steering Committee with input and assistance from across the institution. The Medical Staff-Hospital Council, UMHC management, and the Governing Board, shall approve revisions.

APPROVED BY:

__________________________________________________________
Chief of Staff and Chair, Medical Staff-Hospital Council

__________________________________________________________
General Director

__________________________________________________________
Chair, Board of Governors

Revised: June 15, 1993
QUALITY MANAGEMENT STRUCTURE

Note: Communication occurs across all components of this structure.

BOARD OF GOVERNORS

QUALITY MANAGEMENT COMMITTEE

MEDICAL STAFF - HOSPITAL COUNCIL

GENERAL DIRECTOR

MANAGEMENT CABINET

OTHER COMMITTEES OF THE MS-HC

QUALITY MANAGEMENT STEERING COMMITTEE

SERVICE IMPROVEMENT COMMITTEE

EXTERNAL STRATEGIES COMMITTEE

HUMAN RESOURCES COMMITTEE

BUDGET COMMITTEE

QUALITY ENVIRONMENT & SAFETY COMMITTEE

PATIENT SYSTEMS QUALITY MANAGEMENT COMMITTEE

COST REDUCTION IMPLEMENTATION WORK GROUP

SPACE/REMODELING EQUIPMENT COMMITTEE

INFORMATION SYSTEMS MANAGEMENT COMMITTEE

HOSPITAL DEPARTMENTS, MEDICAL SERVICES, AD HOC QI TEAMS, ICU COMMITTEES, WORK GROUPS, CLINICAL PROGRAMS, TASK FORCES, ETC.
INTRODUCTION

The mission of the University of Minnesota Hospital and Clinic (UMHC) is to provide high quality patient services, diverse educational programs, and an environment supportive of research. Strategic priorities include a commitment to excellence in clinical outcomes, consumer service, and cost-effectiveness. To fulfill its mission and strategic objectives UMHC has developed a system-wide management approach designed to assess and continuously improve the value of its products and services. The Risk Management Program applies the principles of continuous quality improvement and is integrated into the organization-wide quality management program.

PURPOSE

The Risk Management Program promotes the mission and strategic objectives of the University of Minnesota Hospital and Clinic by developing strategies to identify, evaluate, and reduce the risk and liability that may result from injury to patients, visitors, and staff. The Program continually strives to proactively identify and eliminate factors which may place individuals at risk.

AUTHORITY

Overall responsibility for quality management lies with the Hospital Board of Governors. The Board delegates responsibility and authority for the risk management program to the General Director who, in turn, relies on Hospital Legal Counsel, the Director of Medical Affairs, and Director of Support Services. Patient Relations, Human Resources, the Safety Officer, Protection Services, Maintenance and Operations, Biomedical Engineering, and Quality Support Services provide coordination and staff support.
COMPONENTS

The key components of the Risk Management Program are risk identification, risk analysis, and risk treatment and prevention.

Risk Identification

Concurrent - UMHC has established mechanisms for identifying unusual incidents, unexpected patient outcomes, patient complaints, concerns expressed by staff, and any event which may result in a claim.

Key mechanisms include:
- the Patient Complaint System managed by Patient Relations
- direct staff referrals to Patient Relations, Legal Counsel, and the Safety Officer
- the Incident Reporting System coordinated by Quality Support Services
- surveillance by and referrals to Protection Services, Maintenance and Operations, and Biomedical Engineers
- Infection Control surveillance
- referrals from outside agencies such as the Peer Review Organization, the State Health Department, and the Medical Examiner
- requests for release of medical records which suggest potential legal issues
- referrals or requests from Hospital Committees

Preventative - UMHC reviews new technology and services for potential risk management implications. Key reviews are conducted by Hospital Departments such as Biomedical Engineering; and Committees of the Medical Staff-Hospital Council such as the Pharmacy and Therapeutics Committee, Value Analysis Committee, and Transfusion Therapeutics Committee. Prevention programs, including education, training, inspection and maintenance, and policy development, are initiated by the reviewing body to minimize injuries to patients, visitors, and staff.

Risk Analysis

Single events - When a serious quality issue and/or potentially compensable event is identified, the event is communicated to Hospital Legal Counsel who immediately initiates an investigation to determine potential liability and necessary preventive action. Participants in this investigation include a designated representative of Legal Counsel and appropriate Medical Department and UMHC leadership.

When significant interdepartmental or administrative issues are identified, the Patient Incident Review Committee may be convened to review issues and make recommendations.
Aggregate data - Risk exposures of all severity levels are summarized and reviewed by appropriate medical staff and hospital management committees. Examples include:

<table>
<thead>
<tr>
<th>Committee/Committee</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Environment and Safety Committee</td>
<td>Worker’s Compensation summaries</td>
</tr>
<tr>
<td></td>
<td>Staff and visitor incidents</td>
</tr>
<tr>
<td></td>
<td>Patient incidents with environmental and safety implications</td>
</tr>
<tr>
<td>Patient/Systems Committee</td>
<td>Patient Incidents</td>
</tr>
<tr>
<td>Departmental QI Committees</td>
<td>Incident report and patient complaint trends related to the department</td>
</tr>
<tr>
<td>Pharmacy and Therapeutics Committee</td>
<td>Medication-related incident reports</td>
</tr>
<tr>
<td>Operating Room Committee</td>
<td>Operating Room incident report trends</td>
</tr>
<tr>
<td>Transfusion Therapeutics Committee</td>
<td>Incidents related to blood products</td>
</tr>
<tr>
<td>Credentials Committee</td>
<td>Medical liability claims experience</td>
</tr>
<tr>
<td>Tissue and Procedure Review Committee</td>
<td>Invasive procedures</td>
</tr>
<tr>
<td>Child Abuse &amp; Neglect and Vulnerable Adult Committees</td>
<td>Analysis of all cases reported</td>
</tr>
</tbody>
</table>

Risk Treatment and Prevention

The loss reduction aspects of the risk management program include effective management and minimization of claims when injury occurs by means of straightforward communication and negotiation. This includes, as appropriate, communicating with the patient/family, interfacing with medical departments and UMHC staff, establishing a claim file, negotiating claim adjustments and settlements, and reporting actual and potential claims to the insurance company. Hospital Legal Counsel delegates portions of this responsibility as appropriate, usually to the Director of Patient Relations.

The loss prevention components of the risk management program implement prevention programs to minimize injury to patients, visitors, and staff. The risk identification and analysis groups noted above are responsible for implementing and evaluating loss prevention interventions based on the conclusions of data review. These interventions include education of Hospital staff and physicians in methods of liability control.
To further prevent loss, the Quality Management Steering Committee systematically identifies general areas of potential risk in the clinical aspects of patient care and safety. General areas of potential risk are identified based on information which suggests actual or potential causes of injury including national and state trends as well as UMHC experience. In each high priority area criteria are identified, data is collected and evaluated, actions are taken if necessary, and followup evaluation is performed.

FLOW OF INFORMATION

The Risk Management Program includes operational linkages across departments and committees to ensure the confidential flow of information as well as effective communication and coordination. These linkages include but are not limited to:

- information obtained through the risk management process which identifies clinical concerns or potential to improve patient care is communicated to Quality Support Services;
- information obtained through the risk management process which has credentialling implications is referred to the Medical Staff Office;
- information which identifies security issues is communicated to Protection Services;
- information which identifies environment and safety problems is communicated to the Safety Officer;
- information which has implications for other specific departments and/or patient care units is communicated to the appropriate area.

The Quality Management Steering Committee, Medical Staff-Hospital Council, and Board of Governors receive risk management reports semiannually. These reports reflect the status of current litigation; the frequency, severity, and causes of adverse occurrences; actions taken; and evaluation of educational and preventative efforts.

ANNUAL EVALUATION

The Quality Management Steering Committee evaluates the effectiveness of the Risk Management Program at least annually to assure it meets the needs of the organization. The Medical Staff-Hospital Council, UMHC Management Cabinet, and the Governing Board reviews and approves recommended revisions.
<table>
<thead>
<tr>
<th>Priority Area/Rationale</th>
<th>Indicators/Criteria (abbreviated)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesia</td>
<td>Intraoperative arrest PACU respiratory depression PACU respiratory instability 24 hour post-op complications</td>
</tr>
<tr>
<td>- high volume</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular Thoracic</td>
<td>Return to OR for bleeding</td>
</tr>
<tr>
<td>Surgery</td>
<td></td>
</tr>
<tr>
<td>- high risk</td>
<td></td>
</tr>
<tr>
<td>Emergency Department</td>
<td>Dead on arrival or within 48 hours Admission within 24 hours of ED visit Seen in ED and transferred to another facility</td>
</tr>
<tr>
<td>- high risk</td>
<td></td>
</tr>
<tr>
<td>ICUs</td>
<td>Compliance with the No CPR Policy</td>
</tr>
<tr>
<td>- sentinel event</td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Medication errors Adverse drug effects leading to morbidity/mortality</td>
</tr>
<tr>
<td>- high volume</td>
<td></td>
</tr>
<tr>
<td>- high risk</td>
<td></td>
</tr>
<tr>
<td>Blood Products</td>
<td>Adverse reactions</td>
</tr>
<tr>
<td>- high risk</td>
<td></td>
</tr>
<tr>
<td>Psychiatry</td>
<td>Seclusion and restraint</td>
</tr>
<tr>
<td>- high risk</td>
<td></td>
</tr>
</tbody>
</table>
UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
UTILIZATION REVIEW PLAN

I. Introduction:
Utilization Review (UR) activities are part of the Quality Management Program's system-wide management approach designed to assess and continuously improve the value of its products and services. The UR program works to assure that health care resources are used appropriately and efficiently in the delivery of patient care. The scope of utilization review has expanded to include additional levels of service and a more thorough examination of medical and psychiatric practices for all types of admissions, including those covered by Medicare, Medicaid, Blue Cross and Blue Shield, health maintenance organizations and private review agencies.

II. Purpose:
The purpose of the Utilization Review Program is to enhance the quality and appropriateness of patient care through systematic monitoring and evaluation activities which support the continuous improvement of identified problems in overutilization, underutilization, and inefficient application of resources.

III. Authority:
A. The Quality Management Steering Committee establishes program direction and priorities, assures integration and coordination of all aspects of the Quality Management Program, and provides the resources necessary to sustain effectiveness. The committee members consist of the General Director, the Senior Associate Directors/ Directors of Finance, Medical Affairs, Nursing and a minimum of three Clinical Chiefs including the Chair of the Council of Clinical Chiefs and the Chief of Staff. This committee has appointed the Patient/Systems Quality Management Subcommittee to implement and evaluate the Quality Management Programs which relate to patient care and patient care systems.

B. The Patient/Systems Quality Management Committee (P/S QMC) is chaired by the Senior Associate Director/ Director of Medical Affairs. Membership represents major clinical and support services throughout the institution. The utilization review responsibilities of the P/S QMC Committee include identification and resolution of issues related to over and under utilization of resources. To identify utilization problems and to monitor the hospital's utilization of resources, the Committee or its representative examines the findings of related activities, including PRO generated hospital profiles, study results and third party utilization reports. Where potential concerns are identified closer professional assessment is initiated using comprehensive objective criteria and standards which are approved by the Quality Management Steering Committee or other committees of the medical staff as appropriate.

C. Quality Support Services is responsible for the management of the Utilization Review Program, submits issues to the Patient Systems Quality Management Committee for review and recommendation and reports administratively to the Director of Medical Affairs. Utilization Review Specialists (URS) are the primary facilitators of the Utilization Review Plan and are all licensed nurses in the State of Minnesota.
IV. Functions:
The functions of the Utilization Review Program are as follows:

A. Direct the activities of Utilization Review Specialists, who are responsible for conducting utilization review activities.

B. Chart review of selected patients to evaluate the appropriate utilization of resources while the patient is hospitalized, at the time of discharge or after discharge, by comparing the condition of the patient against the UR Program's criteria. (See Appendix A)

C. Identification of patterns of hospital resource overutilization, underutilization and the quality and appropriateness of patient care and report these patterns to the appropriate hospital departments, clinical services and committees for evaluation and recommendations.

D. Initiate the discussion of disposition planning with the responsible physician and department staff.

E. Coordinate and monitor compliance of review activities with external agencies and maintain utilization review records.

F. Coordinate and communicate utilization review information with regards to federal and state agencies, third party payers, HMO's, private review agencies and Utilization Review Program criteria to hospital departments and clinical services.

G. Facilitate annual evaluation of the Utilization Review Program Plan by the Patient/Systems Quality Management Committee.

V. Confidentiality:
All data and information acquired and prepared for the Utilization Review Program's activities is strictly confidential. The data will be used, disseminated or published only to the extent required to effectively carry out activities associated with the Utilization Review Program and will only be disclosed to authorized individuals.

VI. Conflict of Interest:
No member of the Patient/Systems Quality Management Committee may participate in the review of any case in which (s)he has had significant professional involvement.

VII. Utilization Review Process:
Review and evaluation activities are conducted using a variety of methods and data sources. These methods and data sources provide the Hospital with various types of information essential to appropriate and effective evaluation of utilization patterns and practices. The methods of review include preadmission, concurrent and retrospective analysis of patient information to expose and address utilization related
problems with practitioners, diagnoses, medical necessity of admissions, continued stays, use of resources and supportive services. Reviews are also conducted at the request of third party payers.

A. Preadmission Review
Elective admissions are screened by a URS at least 3 days prior to admission for medical necessity of admission, severity of illness and required intensity care. This review includes the following:

1. Evaluation of the appropriateness of the admission.
2. Evaluation to determine if procedures can be done prior to admission to reduce the hospital length of stay.

If significant issues are identified which cannot be resolved by the UR Program the issue is documented and summarized for review by the Patient/Systems Quality Management Committee.

B. Admission Review
Unscheduled admissions are reviewed by a URS within one working day of the admit date, to determine the medical necessity of the admission using the same criteria as "Preadmission Review". If the criteria are met the admission is approved and further reviews are scheduled according to the concurrent review process.

C. Concurrent Review
Concurrent Review is performed at appropriate points during the inpatient stay, depending on the previous determination of the appropriate level and intensity of care and approved length of stay. The process begins on admission or whenever it is deemed necessary or appropriate. It is conducted in the following manner:

1. A URS from Quality Support Services screens the documentation in the medical record against the Criteria for Inpatient Care (Appendix A) to determine if the admission or continued stay is medically necessary.

2. If the case meets the criteria or is otherwise considered appropriate, the URS will approve the admission or continued stay and schedule the next review date based upon the documentation on the patient's condition.

3. If the case does not meet the criteria or is otherwise considered inappropriate, a peer physician reviewer may be asked to review the case, as appropriate.

4. If the peer physician reviewer does not consider the admission or continued stay to be appropriate, the peer review physician or the URS will contact the attending physician for additional input. Any additional information will be considered and reevaluated for medical necessity and current LOS.

5. If the attending physician agrees with the URS's or physician reviewer's proposed denial, the treatment plan changes accordingly.

6. If the attending physician does not agree with the peer physician or URS reviewer's proposed denial the case will be referred to Jean Harris, M.D., Sr. Associate Director, Director of Medical Affairs.
D. Denial Process
The denial process is carried out when the admission or continued stay does not meet criteria for inpatient care. An impending denial is communicated in person or telephonically to the treatment team which consists of the charge nurse of the patient care unit, the attending physician, social worker and URS. A follow up letter regarding the denial is sent to the attending physician, URS and the patient.

E. Reconsideration Process
Any party (physician, patient or URS) who receives a determination that care proposed or being provided is not medically necessary may appeal this determination. The appeal is accomplished by submitting additional medical information to a Utilization Review Specialist who facilitates the physician reviewer's reevaluation of the clinical information against the inpatient criteria. The additional information may be submitted by telephone or in writing. The patient and physician will be notified of the results of the reconsideration.

F. Discharge Planning
Discharge planning is the process of evaluating the post-hospitalization health care needs of the patient early in the patient's stay and assisting the patient and family in meeting those needs. The goal of discharge planning is to eliminate unnecessary and costly delays and appropriately discharge patients. A discharge plan for each patient is developed by the interdisciplinary health care team and is implemented as soon as an acute level of care is no longer required. The URS reviews the patient discharge plan to ensure that a timely discharge or transfer is planned and carried out.

VIII. External Agencies
The Utilization Review Program operates under the requirements of federal and state law and according to guidelines established by JCAHO. The Utilization Review staff serve as a liaison between the hospital and several agencies on utilization review issues.

A. Medicare: The hospital is subject to review by the Minnesota PRO, The Foundation for Health Care Evaluation. Formal review notifications are issued to patients in accordance with federal law.

B. Medicaid: The Utilization Review Program satisfies the requirements of the Medicaid program administered through the State of Minnesota and subject to review by Blue Cross and Blue Shield of Minnesota.

C. Blue Cross and Other Third Party Payers: The Utilization Review Program will comply with requirements for review, including criteria and data collection through special 'memorandums of understanding' signed with the hospital.

D. HMO/PPO: The hospital may enter into contracts with various HMOs and PPOs. The program will comply with utilization review requirements specified in each HMO and PPO contract.

E. Private Review Agencies: The hospital may choose to participate in utilization review programs established by health care coalitions or private review agencies. Participation will be on a delegated basis. Each program will be
described in a 'memorandum of understanding' which will be reviewed and approved by the Hospital Director or other hospital staff appointed by the Director to review contracts.

APPROVED BY:

Chief of Staff and Chair, Medical Staff Hospital Council  (date)

General Director  (date)

Chair, Board of Governors  (date)

Revised June 21, 1993
August 2, 1993

TO: Quality Management Steering Committee
    Administration, Department Heads

FROM: Robert Nygren, Safety Officer

    Quality Environment and Safety Committee

Safety Management

- The committee has prepared a questionnaire to be used as a monitor of effectiveness of
  basic safety education and practice. (See attached). Committee members will begin
  surveying staff in random departments using statistical process control to determine
  where to focus education efforts.
- OSHA UPDATE—see attached report
- The Safety Committee is now called the Quality Environment and Safety Committee, and is
  a subcommittee of the Quality Management Steering Committee. A new Safety
  Management Program has been endorsed by the group and is attached for your review
  and approval.
- Disaster committee policy and procedures have been reviewed and revised. A small
  group met to update the External Disaster Plan, which will be distributed later this
  summer.

(SECURITY REPORT WILL BE INCLUDED NEXT QUARTER)

Life Safety Management

- The fire committee conducted fire drills and follow up as required. There were 48 fire
  alarms during the quarter, a significant decrease.
- Corridor clutter is being surveyed on a monthly basis, and a letter is being developed to
  send out to problem areas asking for cluttered areas to be cleared and cleaned.

Equipment Management

- The Equipment Management Committee met on June 3. The new equipment list was
  reviewed, and changes were made to update policy #34.1 to include the Safe Medical
  Device Act procedure. Other business was routine with no issues to take to the Safety
  Committee or Administration.

Utilities Management

- The following groups have met and submitted summaries of meetings to the Safety
  committee which are available upon request: Ventilation, Electrical, Transport,
  Chillers and Pumps, Clinical Piping, Preventive Maintenance, Records and Autocad, and
  Hardware. No issues for the Committee or Administration to address this quarter.
The Hospital Safety Committee has determined that all UMHC employees should know the answers to the questions below. These questions about Hospital Safety are very general in nature. More department-specific knowledge may be expected of employees in addition to this. These questions will be asked of random UMHC employees by department heads and/or members of the Safety Committee on a quarterly basis. The committee will use this tool to monitor the effectiveness of the overall Safety training effort. Questions marked with an "*" should be asked of staff in patient care areas only.

SAFETY MANAGEMENT

S1. How would you go about reporting an unsafe condition you noticed on the job?  
   Notify supervisor, complete an incident report

S2. What would you do if you were injured on the job?  
   Notify supervisor, report to Employee Health Service (or the ER after hours); complete incident report

S3. When, by whom, and how often have you been oriented to hazards specific to your work area (MERTKA), and to the location of Materials Safety Data Sheets?  
   Initially upon employment or assignment change, annually thereafter, by supervisor

LIFE SAFETY MANAGEMENT

L1. What should you do when you hear the announcement "Green Grass" over the public address system?  
   Close doors and windows, stop traffic, wait for further instructions

L2. If you discover a fire, how should you report it?  
   By activating the nearest alarm pull station and dialing 1-2-3 from a safe phone

EQUIPMENT MANAGEMENT

E1. *When did you receive orientation on the patient care equipment you operate?  
   Before I started operating it, and annually thereafter

E2. Who would you call if you have a problem operating equipment or if the equipment malfunctions?  
   Supervisor; Biomedical Engineering; appropriate maintenance personnel; contracted repair

UTILITIES MANAGEMENT

U1. *If working in a patient care area, when would you close medical gas (oxygen) emergency shut-off valves?  
   I would not close them. Never.

U2. Who would you call with questions about the medical gas system?  
   Cardio-respiratory services

U3. Which electrical outlets in your area operate under emergency power?  
   This differs by building—either says "emergency" on the outlet, or glows, or has red sticker

U4. How does a power outage affect elevator service in your area?  
   A few minutes after emergency generators start, one elevator in each bank (of Unit J) or one elevator in the building will resume operating.
# Summary of Recent OSHA Activity

<table>
<thead>
<tr>
<th>Date</th>
<th>Area</th>
<th>Complaint</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>7-13-93</td>
<td>Ther. Rad.</td>
<td>Air quality--lead, cadmium, MERTKA, etc.</td>
<td>further invest. pending</td>
</tr>
<tr>
<td>7-8-93</td>
<td>Pt. Acctg.</td>
<td>air quality--CO, CO2, etc.</td>
<td>unfounded, dismissed</td>
</tr>
<tr>
<td>5-10-93</td>
<td>PACU</td>
<td>Employee mixes O-Syl, no eyewash available.</td>
<td>Under investigation</td>
</tr>
<tr>
<td>4-27-93</td>
<td>OR CSP</td>
<td>Needles and sharps left on case carts. Employee at risk of cuts and punctures due to carelessness of OR staff. Employee was punctured in the past.</td>
<td>Closed, recommended redo training manual and post warning signs. No citation. (7-26-93)</td>
</tr>
<tr>
<td>4-27-93</td>
<td>M&amp;O</td>
<td>Eyewash station difficult to access in battery room on third floor unit J.</td>
<td>Under investigation</td>
</tr>
<tr>
<td>4-27-93</td>
<td>M&amp;O</td>
<td>Citation and notice of violation from 2-11-93 not posted as required. (Faceshields in Eto tank rm.)</td>
<td>fine of $2100 paid 7-12-93</td>
</tr>
<tr>
<td>4-27-93</td>
<td>M&amp;O</td>
<td>Liquid dripped from pipe above ceiling onto employee sitting in break room below. (M&amp;O break room). Employee developed rash on shoulder.</td>
<td>Under investigation</td>
</tr>
<tr>
<td>4-15-93</td>
<td>Child-Family Life</td>
<td>Room C239 Mayo is littered with dead insects, paint chips from walls and ceiling, ceiling tiles are falling.</td>
<td>Abated 4-27-93. No penalty.</td>
</tr>
<tr>
<td>2-11-93</td>
<td>M&amp;O</td>
<td>Face shield not provided in Eto tank changing room.</td>
<td>In contestation. $803.00 fine pending.</td>
</tr>
<tr>
<td>2-11-93</td>
<td>UMHC</td>
<td>No written AWAIR program.</td>
<td>Abated 2-19-93. No penalty, no further action.</td>
</tr>
<tr>
<td>2-1-93</td>
<td>ES</td>
<td>Asbestos-containing debris in room C185 Mayo.</td>
<td>Inspection and analysis showed no asbestos. No further action.</td>
</tr>
<tr>
<td>10-8-92</td>
<td>M&amp;O</td>
<td>Training not specific to hazards found in the workplace.</td>
<td>In contestation. $548.00 fine pend.</td>
</tr>
</tbody>
</table>
UMHC

Safety Management Program
I. OVERVIEW OF SAFETY MANAGEMENT PROGRAM

A. The Board of Governors for University Hospital and Clinic, assumes the responsibility for requiring and supporting a comprehensive Safety Management Program.

B. The Administration is delegated the authority and accountability for the delivery and evaluation of Safety Management review functions and activities, and shall be responsible for Quality Environment and Safety Committee membership appointments.

C. The Administration shall require all hospital departments/services to participate in the Safety Management Program and will appoint a Safety Officer to serve as a focal point for facility-wide and departmental safety management activities.

D. The Chairperson of the Quality Environment and Safety Committee (or designee) shall report quarterly to the Board of Governors (through the Quality Management Steering Committee), CEO and the Departments on the activities of the Committee and present for consideration a summary of key incidents, trends, identified problems and subsequent actions.

E. The Quality Environment and Safety Committee shall oversee and evaluate the comprehensive Safety Management Program designed to provide a physical environment free of hazards and to manage staff activities to reduce the risk of injury. The Safety Management Program shall operate in accordance with the Governing Board’s objectives, and shall assure compliance with the PTSM standards of the JCAHO and all applicable regulatory and accrediting agencies.

F. Whenever a situation exists that poses an immediate threat to life or health, or a threat of damage to equipment or buildings, the Quality Environment and Safety Committee Chairperson or the Safety Director has the authority to intervene as necessary in order to mitigate that threat.

G. Emergency response will typically consist of three phases described below.

immediate: person discovers problem, follows procedures, reports to supervisor and/or dials 1-2-3.

prompt: management of incident by supervisor, nursing supervisor or administrator; investigate cause, begin response, estimate time to rectify situation.

continuing: management of continuing response and recovery by Administration, Safety Officer, and management of area(s) affected by the emergency.

For further detail, please consult the Emergency Preparedness Manual.
II. ORGANIZATION--Quality Environment and Safety Committee (QESC)

A. The Quality Environment and Safety Committee shall consist of representatives from the following departments, with others serving as appropriate:

- Safety Officer
- Quality Support Services
- Employee Health
- Human Resources
- Laboratories
- Operating Room
- Infection Control
- Engineering
- Administration
- Nursing
- Emergency Department
- Anesthesiology

B. The duties of the Quality Environment and Safety Committee are as follows:

1. Development of written policy and procedure designed to enhance safety within the hospital and clinic to the maximum extent possible.
2. Oversight of the ongoing process to collect and evaluate information about hazards and safety practices used to identify issues for resolution.
3. New employee education to the safety program and continuing safety education and training.
4. Oversight and evaluation of hazardous materials and wastes handling.
5. Maintaining an emergency preparedness program designed to manage the consequences of natural and man-made disasters and other emergencies.
6. Maintaining the life safety program designed to protect patients, visitors, staff, and property from fire and smoke.
7. Maintaining the equipment management program designed to assess and control the clinical and physical risks of fixed and portable equipment used for diagnosis, treatment, monitoring, and care of patients and of other fixed and portable electrically powered equipment.
8. Maintaining the utilities management program designed to assure the operational reliability, assess special risks, and respond to failures of utility systems that support the patient care environment.

The Quality Environment and Safety Committee shall meet at least bi-monthly.

C. Each committee member shall serve on or chair one or more sub-committees responsible for development, implementation, and monitoring of policy, procedure, and practice specific to the Safety Management Program; for information collection and evaluation; and for making regular reports and recommendations to the Quality Environment and Safety Committee. The sub-committees shall be organized as follows:

**Employee Safety and Health Sub-Committee**

Responsible for:
- reviewing, monitoring, and evaluating employee injuries and exposures.
- the AWAIR program.
- the Right to Know program.
- reviewing, monitoring, evaluating and reducing workers' compensation experience.
- monitoring and evaluating OSHA compliance
- ergonomic policy
- ADA safety issues
- visitor injuries
Membership: Employee Health  Environmental Health and Safety
     Human Resources  Safety Officer
     Infection Control  Rehabilitation Therapies
     Quality Support Services

Meeting Frequency: bi-weekly, with report to the QESC at each meeting.

**Emergency Management Sub-Committee**

Responsible for:
- development, testing, and evaluating internal and external disaster protocols.
- coordination with University, Hennepin County, State of Mn., FEMA, and the National Disaster Medical System.
- assisting with development/maintenance/review of departmental emergency plans.
- developing and maintaining a directory of resources available in emergency situations.
- review and evaluate security trends.
- semi-annual hazard surveillance.
- life safety program
- review of hazardous waste program

Membership: Safety Officer+
     Administration*
     Security+
     Engineering+
     Laboratories+
     Environmental Health and Safety+
     Social Work*
     Pharmacy*
     U of M Emergency Management*

Meeting Frequency: + core group, meets monthly, focus on Life Safety
     * expanded group, meets quarterly

Reports quarterly to the QESC.

**Equipment Management Sub-Committee**

Responsible for:
- product recalls and alerts.
- equipment inventory.
- evaluation of user errors for education needs or equipment action.
- Safe Medical Device Act monitoring and compliance.

Membership: Director of Engineering  Materials Management
     Safety Officer  Operating Room
     Biomedical Engineering  Cardio-pulmonary services
     Central Sterile Supply  Accounting

Meeting Frequency: Semi-annually, reports semi-annually to the QESC.
Utilities Management Sub-Committee

Responsible for:

- evaluating utilities problems and failures for proper action.
- scheduling and coordinating tests of back-up utilities systems.
- contingency planning for utilities outages.
- orientation, education, and documentation of same for individuals who use or maintain utility systems.
- maintaining current set of documents showing distribution of each utility system, including controls for complete or partial shutdown.

Membership: Principal Engineer
Divided by systems, with a group for each system
Each group consists of management, engineering, and mechanics

Meeting Frequency: Semi-annually, reports semi-annually to the QESC.

Policy Review and Quality Safety Education Sub-Committee

Responsible for:

- annual review of hospital-wide safety policies.
- review of departmental safety policies every three years.
- developing and monitoring new employee safety orientation.
- monitoring and coordinating education needs of the other safety sub-committees.
- development and implementation of new educational programs mandated by regulatory and accrediting agencies.
- assisting hospital departments with departmental safety training resources.

Membership:* Nursing Education (Chair)
Human Resources Staff Development
Safety Officer

*others to be added as necessary based on need at the time.

Meeting Frequency: Quarterly, with quarterly reports to the QESC.

D. All proceedings, conclusions, recommendations, actions taken, and results of actions taken in any facet of the Safety Management Program, including infection control and quality support services shall be documented and reported to the Quality Environment and Safety Committee.

III. DEPARTMENTAL RESPONSIBILITIES

A. Hospital Administration, through the Quality Environment and Safety Committee, shall require the development of departmental safety programs, and the reviewing and monitoring of safety activities within individual departments. Departmental management is required to comply with the following activities:
1. Initial safety orientation and training for new employees.
2. Required annual updates and refresher training for all staff.
   a. MERTKA
   b. AWAIR program
   c. Life Safety program
   d. Bloodborne Pathogens (if occupationally exposed)
   e. Operation of patient care equipment
   f. Emergency procedures
3. Semi-annual hazard surveillance within the department, using the attached form “Hazard Surveillance”, with copies submitted to the Safety Director.
4. Completion of the attached “Safety Monitoring and Evaluation” report quarterly, with copies submitted to the Safety Officer.

B. Department Directors shall make all staff aware of the incident reporting system and assure that all unusual incidents involving safety hazards, injuries, hazardous materials and defective products/equipment are documented on the incident report form and managed per UMHC policy.

C. Department Directors shall ensure the use of the “First Report of Injury” form to document and investigate all employee injuries, and that the form is forwarded promptly as directed.

D. Department Directors shall maintain any written department-specific safety programs, policies, and procedures necessary. These shall be reviewed tri-annually, with updates submitted to the Policy Review and Quality Safety Education Subcommittee.

IV. HOSPITAL SAFETY OFFICER RESPONSIBILITIES

The CEO or designee shall designate a Hospital Safety Officer qualified by experience and/or education, who shall be charged with the responsibility for the comprehensive Safety Management Program. Specific duties shall include but are not limited to the following:

A. Serve as the organization’s coordinating center of safety related information.
   1. Manage the information collection and evaluation system of the safety program.
      a. Receive, review, make recommendations on, and monitor hospital incident reports related to safety, hazard surveillance reports, Safety Management Monitoring and Evaluation Reports, Bloodborne Pathogen compliance monitoring reports, Employee Injury/Exposure Reports, and Quality Environment and Safety sub-committees’ minutes.
   B. Ensure organizational compliance with regulatory and accrediting agencies regarding safety issues.
   C. Assist departments with development, implementation, and monitoring of departmental safety programs.
   D. Assist departments with safety training needs.
E. Serve as the liaison with local emergency managers, OSHA, and other safety related regulators.

F. Report quarterly to the Board of Governors on the activities of the Safety Management program, presenting summaries of key incidents, trends, identified problems and subsequent actions, and the results of those actions.

G. Keep abreast of and inform Quality Environment and Safety Committee and others as appropriate regarding new or updated regulations, laws, standards, industry trends, practices, etc.

ATTACHMENTS

Hazard Surveillance Report Form
Safety Management Monitoring and Evaluation Form
Training Documentation Form
Hazard Surveillance Report

UMHC

### SAFETY MANAGEMENT

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the area clean?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the area pest-free?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safe storage of hazardous materials?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; Is there proper labelling of same?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there 18&quot; clearance between top of storage and sprinkler heads?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are employees properly using personal protective equipment (ppe's)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; Are they appropriately located?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are staff in the area familiar with...</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; MERTKA?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; Bloodborne Pathogens Standard?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; Personal Injury Procedures?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>comments</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### LIFE SAFETY AND EMERGENCY MANAGEMENT

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are staff familiar with...</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; green grass procedures?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; exit routes?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; extinguisher locations/usage?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; Mr. Blue/Adult Team?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; their role in Orange Alert?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; how to contact security?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; severe weather procedure?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are exit signs lighted?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; exit routes unobstructed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are fire alarm pull stations and fire extinguishers unobstructed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are MSDS's accessible to staff if hazardous substances are used?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In areas where required, are eye-wash stations and deluge showers unobstructed and in working order?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are any items stored in corridors?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>comments</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### EQUIPMENT MANAGEMENT

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have staff been trained in equipment operation initially and annually?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do employees know how to get help with operational problems?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; with equipment malfunctions?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is dept. equipment part of a regular preventive maintenance program?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If electrical equipment requires extension cords, are they provided by maintenance and operations?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there a current equip. inventory?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>comments</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### UTILITIES MANAGEMENT

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are staff aware of location of emergency power outlets?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are staff familiar with when to close medical gas zone valves? (never)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; where to call with questions or concerns about medical gases?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there a plan, and are staff aware, for failure of telephone system?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are staff aware of what to do in case of a steam failure?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are there any problems with utilities that need to be reported to M&amp;O?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>comments</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please sign below and send copy to Robert Nygren, Safety Director, Box 1000.

Surveyor: ____________________________  Dept. head signature: ____________________________

Page 1
DOCUMENTATION OF TRAINING
FOR INDIVIDUAL EMPLOYEES

This form is to be completed for each new employee or each existing employee assigned to a new work area, job classification, or task.

Training Topic

Name of trainer (title, department)

Materials used (describe, and attach copies of handouts)

Employee Name SS# 

Date of hire or date of new assignment requiring training

I hereby certify that I have received training by the trainer, in the topic, using materials as described above. I understand the training, and that I have the right to ask safety-related questions at any time without fear of reprisal.

Employee signature Date

Keep this form in the employee’s departmental file. Thank you for your commitment to promoting employee health and safety at University of Minnesota Hospital and Clinic.
### Employee Safety

<table>
<thead>
<tr>
<th>Employee Safety</th>
<th>Required Frequency</th>
<th>Action Taken (Describe)</th>
<th>Monitoring (Describe)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ES1 Air Training</td>
<td>I/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ES2 MERTKA Training</td>
<td>I/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ES3 BBP Training</td>
<td>I/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ES4 Incident Review</td>
<td>M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ES5 Accident Trends</td>
<td>M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ES6 Ergonomic Review</td>
<td>Q</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ES7 Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Emergency Management

<table>
<thead>
<tr>
<th>Emergency Management</th>
<th>Required Frequency</th>
<th>Action Taken (Describe)</th>
<th>Monitoring (Describe)</th>
</tr>
</thead>
<tbody>
<tr>
<td>EM1 Procedure Review</td>
<td>I/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EM2 Hazard Survey</td>
<td>6MO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EM3 Fire Drills</td>
<td>M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EM4 Disaster Drills</td>
<td>6MO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EM5 Fire Training</td>
<td>I/A</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Environmental Safety

<table>
<thead>
<tr>
<th>Environmental Safety</th>
<th>Required Frequency</th>
<th>Action Taken (Describe)</th>
<th>Monitoring (Describe)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NS1 WASTE MGMT</td>
<td>Q</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NS2 HAZARD. MATER.</td>
<td>Q</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NS3 LABELING</td>
<td>Q</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NS4 PPE USAGE**</td>
<td>Q</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NS5 SPILL REVIEW</td>
<td>I/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NS6 OTHER</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* BLOODBORNE PATHOGEN TRAINING
** PERSONAL PROTECTIVE EQUIPMENT

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Page 1
Revision of Policy 33.10

Subject: Sterilization or Disinfection of Items that Contact Patients

Source: Hospital Infection Control Committee

POLICY

Items that contact patients in the course of patient care or research will be cleaned and disinfected or sterilized on the basis of the intended use. Acceptable techniques will be specified by the Hospital Infection Control Committee. Disposable items will not be reused or resterilized. Exceptions to this policy, for specific items, may be made by the Hospital Infection Control Committee.

PROCEDURE

I. Definitions.

A. Sterilization. The complete elimination or destruction of all forms of microbial life.

B. Disinfection. A process of cleaning and use of germicidal agents that eliminates many or all pathogenic microorganisms on inanimate objects.

1. High level disinfection kills destroys all vegetative microorganisms and viruses but not necessarily all bacterial or fungal spores.

2. Intermediate level disinfection kills all vegetative microorganisms, including Mycobacterium tuberculosis, but not necessarily all viruses or fungi.

3. Low level disinfection kills most pathogenic bacteria, viruses and fungi but not necessarily Mycobacterium tuberculosis.
C. Cleaning. A process that removes all visible foreign material (e.g., soil, organic material) from objects. It is normally accomplished with water, mechanical action and detergents. Cleaning must precede disinfection and sterilization procedures.

II. Required level of disinfection/sterilization (see Table 1). Users may choose any of the techniques listed in the required or higher level.

A. Sterilization. Items through which blood flows or items which enter tissue, the vascular system, or the biliary tract; items which enter the vagina of a woman in labor or after rupture of membranes; items which can be kept sterile to the point of contact with normally sterile mucous membranes (e.g., bladder); blood-contacting surfaces of blood recirculating machines.

B. High level disinfection. Items which contact normally sterile mucous membranes but cannot be kept sterile to the point of membrane contact (e.g., bronchi); items which contact mucous membranes with minimal flora (e.g., conjunctiva); dialysis machine surfaces in contact with dialysate.

C. Intermediate level disinfection. Items which contact normally non-sterile mucous membranes (except the vagina after rupture of membranes); items which contact non intact skin.

D. Low level disinfection. Items which normally require only cleaning but which may be mouthed by infants; items which are used repeatedly in the mouth of a single patient, hydro therapy tanks and infant bath tubs.

E. Cleaning. Non-invasive items which contact patient's intact skin or are unlikely to be a source of cross transmission.
III. Techniques for disinfection/sterilization (see Table 2).

A. Germicide selection criteria.

1. **Sodium hypochlorite, alcohol.**

Any brand of sodium hypochlorite, ethyl alcohol and isopropyl alcohol, at the concentration indicated in Table 2, may be selected to produce the indicated level of disinfection. These germicides should be freshly dispensed at least daily. Other liquid germicides must meet the following criteria.

2. **Other germicides.**

   a. **Sterilization.** The selected product must have a label claim as sterilant. It must be used as the label directs to produce sterilization.

   b. **High level disinfectant.** The selected product must have a label claim as sterilant and tuberculocidal. It must be used as the label directs to produce tuberculocidal activity.

   c. **Intermediate level disinfectant.** The selected product must have a label claim as hospital disinfectant and tuberculocidal. It must be used for at least 10 minutes.

   d. **Low level disinfectant.** The selected product must have a label claim as hospital disinfectant. The use duration is not specified.

B. General comments.

1. **Manufacturer's recommendations.** Users should be aware of the item manufacturer's recommendations regarding
reprocessing the item and the implications of the selected technique on maintenance of warranty and on liability for product failure.

2. **Cleaning.** All items must be completely cleaned before any further disinfection/sterilization process.

3. **Contact.** The disinfection/sterilization modality must be in contact with all surfaces for the full specified contact time.

4. **Safety standards.** There are OSHA standards specifying personnel exposure limits for several germicides, including glutaraldehyde, phenol, and ethylene oxide. Material safety data information is available from the University of Minnesota Department of Environmental Health and Safety for all germicides.

5. **Equipment maintenance.** A preventive maintenance program, including performance verification records must exist for all processing equipment.

6. **Performance monitoring.** Performance monitoring and documentation is the responsibility of the department performing the sterilization.

   a. **Spore strips.** Each sterilizer must be monitored at least weekly with a commercial preparation of spores; or with each load if sterilization activities are performed less frequently.
b. **Chemical indicators.** Chemical indicators are used as appropriate with individual items.

c. **Implantables.** When implantable or intravascular material is sterilized, live spore tests must be used with each load and the result of the spore tests recorded.

7. **Flash sterilization.** Use of flash sterilization (unwrapped, 132°C, 4 min.) should be limited to urgent situations in which patient care requirements preclude use of other sterilization methods.

8. **Rinsing and packaging.**

a. **Items distributed as sterile.** Whenever possible, items distributed as sterile should be sterilized in a package which will maintain sterility. Flash autoclaved items in an operating room may be sterilized unwrapped. Items sterilized using liquid germicides should be rinsed in sterile water, completely dried and packaged, all using sterile technique.

b. **Package integrity and sterility statement.** All sterilized items will have a label applied which states, "Sterile unless opened or damaged." It is the users' responsibility to confirm the package integrity.

c. **Shelf life.** Packaged, sterilized items have an indefinite expiration. Expiration is event- rather than time-related. All items sterilized at UMHC will be labeled such that the day and year the item was
sterilized, the sterilizer that was used and the load that contained the item can be determined. A rotation system will ensure use of oldest supplies first.

d. Items disinfected between patient uses. Since disinfection of these items is partially intended to eliminate pathogen transfer from patient to patient, sterile technique and packaging are not required. Tap water may be used for rinsing liquid germicides. After rinsing the item must be completely dried. Disinfected surfaces must be protected from human pathogens and wet environmental contact. Surfaces requiring high level disinfection should not be touched.

9. **Recall.** Recall of UMHC processed items is initiated and directed by processing departments. If a recall involves items which may have placed patients at risk, the processing department will notify Infection Control and, with Infection Control consultation, notify the attending physicians of the patients who may have been placed at risk.

C. **Creutzfeldt-Jakob Agent.** Items which have been in contact with brain tissue from a patient with known or suspect Creutzfeldt-Jakob disease should be discarded or treated with one of the following methods.

1. Steam autoclave at 132° C for one hour.
2. Soak in 1 N sodium hydroxide for one hour.
3. Soak in undiluted bleach for two hours.
IV. Items labeled as disposable or single use.

A. Items will be considered disposable if the package label indicates "disposable", "for single use"; or wordings of similar meaning.

B. Request for re-use of "single use" or disposable items should be made in writing to the Infection Control Department and Biomedical Engineering. Such requests will be considered first by the Subcommittee on Technical Review and Materials Handling and then by the Infection Control Committee. The request should include a proposed reprocessing procedure as outlined in (3) IV.C.1 and a cost analysis. The cost analysis should include the price of the item and the cost of the entire reprocessing procedure, including testing. The disinfection and sterilization procedure should be consistent with Sections I, II, III of this policy.

C. Exceptions permitting reuse of disposable items are acceptable for specific items if criteria 1., 2., and 3. below are met.

1. There is a written procedure for the reprocessing of the item. This procedure will include (1) a description of the cleaning and sterilization or disinfection process, (2) a plan for maintenance of records of reprocessing and testing, (3) an upper limit on the total number of reuses, and (4) a procedure for testing the item to be sure that the integrity of the item is preserved.

2. The Infection Control Committee determines that the proposed procedure describes a method which adequately cleans and disinfects or sterilizes the item.

3. Biomedical Engineering determines that the physical
characteristics or quality of the device will not be adversely affected and the device will remain safe and effective for the specified number of uses.

D. Alteration in the reprocessing process or testing procedure must be approved by the same process outlined in paragraph C.

E. Exceptions permitting resterilization of unused disposable items after the initial issue from Central Sterile Processing are acceptable for specific items if the individual or department responsible for the device seeks written instruction from the manufacturer of the device which includes information about the type of sterilization processes which are allowable, the number of times items can be resterilized and applicable data. Such instructions shall be made available to the department responsible for the sterilization process.
Table 1. Minimum sterilization/disinfection level requirements for various items.

<table>
<thead>
<tr>
<th>Sterilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthroscope</td>
</tr>
<tr>
<td>Cardiac catheter</td>
</tr>
<tr>
<td>Culdoscope</td>
</tr>
<tr>
<td>Cystoscope</td>
</tr>
<tr>
<td>Dermabrasion wheel</td>
</tr>
<tr>
<td>Endoscopic biopsy forceps, cannulas, papillotomes, guidewires</td>
</tr>
<tr>
<td>Endoscope, rigid</td>
</tr>
<tr>
<td>Implantable device</td>
</tr>
<tr>
<td>Intravascular device</td>
</tr>
<tr>
<td>Needle</td>
</tr>
<tr>
<td>Peritoneoscope</td>
</tr>
<tr>
<td>Surgical and dental instruments</td>
</tr>
<tr>
<td>Transducer head</td>
</tr>
<tr>
<td>Ureteroscope</td>
</tr>
<tr>
<td>Urinary catheter</td>
</tr>
<tr>
<td>Urological laser</td>
</tr>
<tr>
<td>Vaginal speculum (for use after rupture of membranes)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>High level disinfection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronchoscope</td>
</tr>
<tr>
<td>Cryoprobe</td>
</tr>
<tr>
<td>Burr, dental</td>
</tr>
<tr>
<td>Dialysis machine surfaces in contact with dialysate</td>
</tr>
<tr>
<td>Endoscope, flexible fiberoptic or video</td>
</tr>
<tr>
<td>Endotracheal tube</td>
</tr>
<tr>
<td>Laryngeal blades</td>
</tr>
<tr>
<td>Maschiladscope</td>
</tr>
<tr>
<td>Prostate ultrasound probe</td>
</tr>
<tr>
<td>Sinuscope</td>
</tr>
<tr>
<td>Tonometer tip</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intermediate level disinfection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anoscope</td>
</tr>
<tr>
<td>Bite blocks (between patients)</td>
</tr>
<tr>
<td>Breast pump surfaces in contact with milk</td>
</tr>
<tr>
<td>Breathing circuit</td>
</tr>
<tr>
<td>Dental hand piece, including air/water syringe tip</td>
</tr>
<tr>
<td>Ear speculum and ear examining instruments</td>
</tr>
<tr>
<td>EEG/EKG electrode</td>
</tr>
<tr>
<td>Electric razor head</td>
</tr>
<tr>
<td>Laryngeal mirror</td>
</tr>
<tr>
<td>Mouthpiece, anesthesia or pulmonary function</td>
</tr>
<tr>
<td>Nasal speculum</td>
</tr>
<tr>
<td>Saliva ejector, dental</td>
</tr>
<tr>
<td>Thermometer (between patients)</td>
</tr>
<tr>
<td>Transesophageal electrode</td>
</tr>
<tr>
<td>Vaginal speculum (except during labor or after rupture of membranes)</td>
</tr>
<tr>
<td>Vaginal ultrasound probe</td>
</tr>
</tbody>
</table>
Ventilation bag connector

LOW LEVEL DISINFECTION
Bath tub, infant
Bite blocks, radiation therapy (between uses by a single patient)
Hydrotherapy tanks
Infant furniture and toys
Thermometers (between uses by a single patient)

CLEANING
Bath tubs, ceramic
Bed pan
Bed rails
Blood pressure cuff
Dental impressions (before personnel handling)
Earphones
Electric razor body
Examination table
Food utensil
Nasal gas administration hood, dental
Shampoo tray
Sliding board
Suction canister, outer surfaces
Ventilation bag
### Table 2: Minimum techniques to produce the indicated levels of disinfection/sterilization.

<table>
<thead>
<tr>
<th>Expected Result</th>
<th>Method/Chemical</th>
<th>Concentration/Time</th>
<th>Minimum Exposure Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sterilization</td>
<td>Steam</td>
<td>121°C (250°F, 15 lb/sq in)</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Solid objects</td>
<td>gravity¹ or vacuum, 30 min.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>lumenless with lumen</td>
<td>vacuum only, 30 min.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Liquids ≤1000 ml</td>
<td>- gravity only, 30 min.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&gt;1000 and ≤2000 ml</td>
<td>gravity only, 45 min.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>132°C (270°F, 30 lb/sq in)</td>
<td>- gravity only, 45 min.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Solid objects</td>
<td>- gravity only, 45 min.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>wrapped</td>
<td>- gravity only, 45 min.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>unwrapped</td>
<td>- gravity only, 45 min.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>lumenless and non-implantable and non-porous</td>
<td>- gravity only, 45 min.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Label conc/Temp to produce sterilization</td>
<td>- gravity only, 45 min.</td>
</tr>
<tr>
<td></td>
<td>Dry heat</td>
<td>160°C (320°F)</td>
<td>- gravity only, 45 min.</td>
</tr>
<tr>
<td></td>
<td>Ethylene oxide ETO⁶</td>
<td>12X, 66°C (140°F), 30-35% R.H.</td>
<td>- gravity only, 45 min.</td>
</tr>
<tr>
<td></td>
<td>Glutaraldehyde⁴,⁶</td>
<td>Label conc/Temp to produce sterilization</td>
<td>- gravity only, 45 min.</td>
</tr>
<tr>
<td></td>
<td>Glutaraldehyde/phenole/phenol⁴,⁶</td>
<td>Label conc/Temp to produce sterilization</td>
<td>- gravity only, 45 min.</td>
</tr>
<tr>
<td></td>
<td>Stabilized hydrogen peroxide⁶</td>
<td>Label conc/Temp to produce sterilization</td>
<td>- gravity only, 45 min.</td>
</tr>
<tr>
<td></td>
<td>Peracetic acid⁶</td>
<td>Label conc/Temp to produce sterilization</td>
<td>- gravity only, 45 min.</td>
</tr>
<tr>
<td></td>
<td>Pasteurization</td>
<td>140°C (285°F)</td>
<td>- gravity only, 45 min.</td>
</tr>
<tr>
<td></td>
<td>Steam decontamination (washer sterilizer)</td>
<td>Label conc/Temp to produce tuberculocidal activity</td>
<td>- gravity only, 45 min.</td>
</tr>
<tr>
<td>High level disinfection</td>
<td>Glutaraldehyde⁴,⁶,⁸</td>
<td>Label conc/Temp to produce tuberculocidal activity</td>
<td>- gravity only, 45 min.</td>
</tr>
<tr>
<td></td>
<td>Glutaraldehyde/phenole/phenol⁴,⁶,⁸</td>
<td>Label conc/Temp to produce tuberculocidal activity</td>
<td>- gravity only, 45 min.</td>
</tr>
<tr>
<td></td>
<td>Peracetic acid⁶</td>
<td>Label conc/Temp to produce tuberculocidal activity</td>
<td>- gravity only, 45 min.</td>
</tr>
<tr>
<td></td>
<td>Sodium hypochlorite</td>
<td>Label conc/Temp to produce tuberculocidal activity</td>
<td>- gravity only, 45 min.</td>
</tr>
<tr>
<td></td>
<td>Phenolic⁸,⁰</td>
<td>Label conc/Temp to produce sterilization</td>
<td>- gravity only, 45 min.</td>
</tr>
<tr>
<td>Intermediate level disinfection</td>
<td>Iodophor⁸,¹⁰</td>
<td>Label conc/Temp to produce sterilization</td>
<td>- gravity only, 45 min.</td>
</tr>
<tr>
<td></td>
<td>Sodium hypochlorite</td>
<td>70-90%</td>
<td>- gravity only, 45 min.</td>
</tr>
<tr>
<td></td>
<td>Ethanol</td>
<td>70-90%</td>
<td>- gravity only, 45 min.</td>
</tr>
<tr>
<td></td>
<td>Isopropyl alcohol</td>
<td>70-90%</td>
<td>- gravity only, 45 min.</td>
</tr>
<tr>
<td>Low level disinfection</td>
<td>Phenolic¹⁰</td>
<td>Label conc/Temp to produce hospital disinfection</td>
<td>- gravity only, 45 min.</td>
</tr>
<tr>
<td></td>
<td>Iodophor¹⁰</td>
<td>Label conc/Temp to produce hospital disinfection</td>
<td>- gravity only, 45 min.</td>
</tr>
<tr>
<td></td>
<td>Quaternary ammonium compounds¹⁰</td>
<td>Label conc/Temp to produce hospital disinfection</td>
<td>- gravity only, 45 min.</td>
</tr>
<tr>
<td></td>
<td>Sodium hypochlorite</td>
<td>100 ppm (1:50 bleach)</td>
<td>- gravity only, 45 min.</td>
</tr>
<tr>
<td></td>
<td>Ethanol</td>
<td>70-90%</td>
<td>- gravity only, 45 min.</td>
</tr>
<tr>
<td></td>
<td>Isopropyl alcohol</td>
<td>70-90%</td>
<td>- gravity only, 45 min.</td>
</tr>
</tbody>
</table>

1. In gravity displacement autoclaves, objects with cavities or depressions should be oriented so that all air can drain downwards as steam is introduced.
2. To be used only in OR, Ambulatory Surgery, or Cystoscopy.
3. Lumen should be moist prior to autoclaving.
4. There are OSHA standards limiting personnel exposure.
5. Aeration chamber 12 hrs.
6. Must be a product with a label claim to be a sterilant.
7. Sterile water rinse, thorough drying, and sterile packaging.
8. Must be a product with a label claim to be a tuberculocidal.
9. (1) Sterile water rinse and sterile packaging or (2) water rinse, thorough drying and clean handling.
10. Must be a product with a label claim to be a hospital disinfectant.
sterile³
EDWARD W. HUMPHREY, M.D.

Curriculum Vitae

HOME ADDRESS: 9734 Russell Circle
               Minneapolis, Minnesota 55431

OFFICE ADDRESS: Veterans Administration Medical Center
                Department of Surgery (112)
                One Veterans Drive
                Minneapolis, Minnesota 55417

BIRTHDATE: December 6, 1926
BIRTHPLACE: Fargo, North Dakota

CITIZENSHIP: U.S.A.

MARITAL STATUS: Married

CHILDREN: Two

ELEMENTARY EDUCATION

Grammar School, Moorhead, Minnesota

HIGH SCHOOL ATTENDED AND DATE OF GRADUATION

Moorhead High School 1944

MILITARY SERVICE

A.U.S. June 1945 through November 1946

COLLEGES AND UNIVERSITY ATTENDED WITH DATES AND DEGREES

University of Minnesota  B.A. 1948  B.S. 1949  B.M. 1951
University of Minnesota Medical School  M.D. 1952
University of Minnesota Graduate School  PhD Major - Physiology
                                           Minor - Biochemistry  1959

Title of Thesis: Potassium Flux in the Isolated Perfused Rabbit Heart

INTERNERSHIP

Minneapolis General Hospital, Minneapolis, Minnesota 1951 - 1952

RESIDENCIES

University of Minnesota and Veterans Administration Medical Center, Minneapolis, Minnesota 1954 - 1958 General Surgery
Chief Resident, University of Minnesota Hospitals 1958 General Surgery
Veterans Administration Medical Center, Minneapolis, Minnesota 1958 - 1960 Thoracic Surgery

MEDICAL LICENSURE: Minnesota 1952
FIELD OF MAJOR INTEREST AS UNDERGRADUATE
Medicine

FIELD OF MAJOR INTEREST AS GRADUATE STUDENT
Physiology

HONORS WON AS UNDERGRADUATE
Alpha Omega Alpha
Sigma Xi
Andrews Prize 1951

HONORARY FRATERNITIES
Sigma Xi 1951
Alpha Omega Alpha 1951

SPECIAL CERTIFICATION
American Board of Surgery September 1959
American Board of Thoracic Surgery November 1960

MEMBERSHIP IN SOCIETIES
American Surgical Association
American College of Surgeons
Society of University Surgeons
American Association for Thoracic Surgery
Societe Internationale de Chirurgie
Central Surgical Association
Minneapolis Surgical Society (President 1973-74)
Minnesota Surgical Society
Minnesota Chapter, American College of Surgeons
American Medical Association
American Physiological Society
International Association for the Study of Lung Cancer
Society for Experimental Biology & Medicine
American Association for Advancement of Science
Society for History of Medicine
American Thoracic Society
Society for Surgery of the Alimentary Tract
STAFF POSITIONS

Interim Chairman
Department of Surgery
University of Minnesota
Minneapolis, Minnesota
February 1993 - Present

Professor of Surgery
University of Minnesota
Minneapolis, Minnesota
1965 - Present

Associate Professor
Department of Surgery
University of Minnesota
Minneapolis, Minnesota
October 1961 - 1965

Chief, Surgical Service
Veterans Administration Medical Center
Minneapolis, Minnesota
September 1962 - October 1993

Director, Experimental Surgery Laboratory
Veterans Administration Medical Center
Minneapolis, Minnesota
October 1960 - September 1962

Staff Surgeon
Veterans Administration Medical Center
Minneapolis, Minnesota
1958 - October 1960

Assistant Professor
Department of Surgery
University of Minnesota
Minneapolis, Minnesota
July 1960 - September 1961

Instructor, Department of Surgery
University of Minnesota
Minneapolis, Minnesota
1958 - July 1960

MEMBERSHIP ON NATIONAL CONSULTANT COMMITTEES

Clinical Trials Task Force - N.I.H.
Solid Tumor Task Force - N.I.H.
Pharmacology Subcommittee of the Acute Leukemia Task Force - N.I.H.
VA Cancer of the Lung Study Group Executive Committee
Surgical Records Committee, VA Central Office
VA Surgical Research Evaluation Committee, Central Office
Chemotherapy Subcommittee of the National Large Bowel Cancer Project
VA Participant Chiefs of Surgery, VA Central Office
American College of Surgery Commission on Cancer, Chairman Cancer of the Lung Study
Specialist Site Visitor, Residency Review Committee for Surgery
Committee on Graduate Medical Education
Examination Consultant to The American Board of Surgery

AWARDS

Owen Wangensteen Award for Academic Excellence in Teaching 1982
BIBLIOGRAPHY

BOOKS AND MONOGRAPHS


JOURNAL ARTICLES AND BOOK CHAPTERS


34. Mizuno, NS and Humphrey, EW: Combination therapy of sarcoma 180 and L1210 with 1-8-D-Arabinofuranosylcytosine and 1,3-Bis (2-Chloroethyl) - 1 - Nitrosourea. Cancer Chemotherapy Reports.53:215-221, 1969.


41. Humphrey, EW: Preoperative evaluation of patients with cancer of the lung. Tape for Northlands Regional Medical Program.

42. Lindsay, W and Humphrey, EW: Considerations in pulmonary fluid space measurements. Amer. College of Chest Physicians, Chicago, October, 1969.


73. Humphrey, EW: Carcinoma of the lung. Medical Student Syllabus on Respiratory Disease, University of Minnesota, 1975.


ABSTRACTS
(Partial List)


VISITING PROFESSORSHIPS AND INVITED LECTURES

Invited Lecturer, Little Rock Surgical Association
Little Rock, Arkansas, 1972.

Visiting Professor, VA Medical Center
Dayton, Ohio, 3/5 and 3/6/74.

Visiting Professor, Hurley Medical Center
Flint, Michigan, 10/29 and 10/30/75.

Invited Lecturer, Little Rock Surgical Association
Little Rock, Arkansas, 3/24/76.

Invited Lecturer, Little Rock Academy of Surgery
Little Rock, Arkansas, 10/26/77.

Invited Lecturer, University of Michigan
Continuation Course in Surgery
Ann Arbor, Michigan, 3/16 and 3/17/78

Invited Lecturer, VA Medical Center
Hines, Illinois, 12/12/78.

Invited Lecturer, St. Paul Surgical Society
St. Paul, Minnesota


Visiting Professor, Good Samaritan Hospital
Phoenix, Arizona, 2/5 to 2/7/79.

Five invited lecturers at Mediclinics
Ft. Lauderdale, Florida, 2/28 to 3/7/81.

Visiting Professor at Veterans General Hospital and Tri-Service General Hospital
Taipei, Taiwan ROC, 3/20 to 3/25/81.

Invited Lecturer, Surgical Association of the Republic of China
Taipei, Taiwan ROC, 3/27/81.

Invited Lecturer, Queen Mary Hospital
Hong Kong, 3/81.

Invited Lecturer, Southern Thoracic Surgical Association
Hilton Head, South Carolina, 11/4/82.

Five invited lectures at Mediclinics
Ft. Lauderdale, Florida, 3/83.

Invited Lecturer, Spring Meeting, American College of Surgeons

Invited Lecturer, University of Indiana Continuation Course in Surgery
Indianapolis, Indiana, August 5-6, 1983.
Invited Lecturer at Mediclinics
Ft. Lauderdale, Florida, March 4-8, 1985.

Invited Lecturer at Long Island College Hospital, Brooklyn, New York
October 24, 1985.

Invited Lecturer, Henry Hoffert Memorial Lecture, Methodist Hospital Foundation
Minneapolis, Minnesota, September 18, 1985.

Invited Lecturer, International Symposium on Stapling in Surgery
University of Pittsburgh, April, 1986.

Invited Lecturer, Pulmonary Conference, "Survival Rates in Visceral Tumors", Mayo Clinic

Anniversary Lecturer, St. Paul Surgical Society, "Patterns of Care for Carcinoma of the Lung"

Sixth Annual Wangensteen-Eietl Lecturer, Minneapolis Surgical Society
"Adenocarcinoma of the Esophagus"
Minneapolis, Minnesota, February 1, 1990.

Invited Lecturer, University of Arkansas, VA Medical Center
"Patterns of Care for Carcinoma of the Lung"
Little Rock, Arkansas, April 18, 1990.

Invited Lecturer, Lenox Hill Hospital
"The Present Patterns of Care for Carcinoma of the Lung in the United States"

Invited Lecturer, New York Press Corp., "Current Status of Cancer of the Lung"

Invited Lecturer, Medical Update 1991

Invited Lecturer, Medical Update 1992

Invited Lecturer, Medical Update 1993
Fort Lauderdale, Florida, March 8-12, 1993.
CURRICULUM VITAE

Jay Harold Krachmer, M.D.

Date of Birth: September 25, 1941
Birth Place: Cedar Rapids, Iowa
Citizenship Status: U.S.A.
U.S. Social Security No.
Marital Status: Married
Number of Children: Three

Education:
1962 - College: Tulane University, New Orleans, Louisiana
1966 - M.D. Tulane Medical School, New Orleans, Louisiana

Post-Graduate Education:
1966-67 Internship, University of Iowa, Iowa City, Iowa
1967-70 Residency, University of Iowa, Iowa City, Iowa
June 1965-Aug. 1965 Fellow, University of Miami (neuro-ophthalmology) with J. Lawton Smith, M.D.
Aug. 1967-Dec. 1967 Fellow, Baylor Medical School, Houston, Texas (corneal and scleral contact lenses with Louis J. Girard, M.D.)
Jan. 1973-74 Fellow, Wills Eye Hospital, Philadelphia, Pennsylvania (Cornea and external disease with Peter R. Laibson, M.D.) Heed Foundation Fellow

Academic Appointments:
July-Dec. 1970 Instructor, Department of Ophthalmology, University of Iowa, Iowa City, Iowa
Jan.-July 1971 Deputy Chief of Ophthalmology, Gallup Indian Medical Center, Gallup, New Mexico
February 1974 Assistant Professor, Department of Ophthalmology University of Iowa, Iowa City, Iowa
July 1978 Associate Professor, Department of Ophthalmology University of Iowa, Iowa City, Iowa
July 1981 Professor, Department of Ophthalmology University of Iowa, Iowa City, Iowa
Curriculum Vitae
JH Krachmer, M.D.

July 1992

Professor and Chairman, Department of Ophthalmology University of Minnesota, Minneapolis, Minnesota

Certification and Licensure:

American Board of Ophthalmology - May 21, 1972
Iowa Medical License to Practice Medicine and Surgery; No. 18248, Renewal Date 09/01/93
Minnesota Medical License to Practice Medicine and Surgery; No. 4585

Professional Affiliations:

American Medical Association
Iowa Medical Society
Johnson County Medical Society
Contact Lens Association of Ophthalmologists (Board, 1983-85)
Association for Research in Vision and Ophthalmology
American Academy of Ophthalmology (Chairman, Eye Bank Committee - present)
Iowa Academy of Ophthalmology
Eye Bank Association of America (Chairman of Board, 1986-88; R. Townley Paton Award, 1991)
American Board of Ophthalmology
Castroviejo Society (Program Chairman, 1985-87)
Iowa Lions Eye Bank (Medical Director, 1974 to June, 1992)

Honorary Societies:

Omicron Delta Kappa
Kappa Delta Phi
Society of Heed Fellows (1982 Award recipient)
American Ophthalmological Society

Areas of Research Interest:

Corneal and external diseases of the eye including clinical and laboratory study of corneal dystrophies and other corneal disorders.

Papers Published or In Press


Books and Chapters Published or In Press


Short Publications and Non-referred Publications: Letters to the Editor, Editorials, Published Discussions of Papers, Book Reviews


Papers Delivered At Meetings:


Curriculum Vitae

James E. Mitchell, M.D.

Professor
Director, Division of Adult Psychiatry
Department of Psychiatry
University of Minnesota Medical School
Box 393 Mayo, University Hospital
420 Delaware Street SE
Minneapolis, MN 55455

Date of Birth: 6/19/47
Place of Birth: Chicago, Illinois

EDUCATION:

Undergraduate: B.A. Zoology
Indiana University, 1965-1968
Honoraries - Phi Eta Sigma, Alpha Epsilon Delta,
Phi Beta Kappa

Graduate: Northwestern University Medical School, 1968-1972

Internship: Internal Medicine, Indiana University Hospitals,
Indianapolis, Indiana, 1972-1973

Residency Training: Psychiatry, University of Minnesota, Minneapolis
Minnesota, 1973-1976

Fellowship: Consultation-Liaison Psychiatry, University of
Minnesota, Minneapolis, Minnesota, July 1976-July 1977

Board Certification: American Board of Psychiatry and Neurology, June 1979

ACADEMIC APPOINTMENTS:

Clinical Instructor - Department of Psychiatry, University of Minnesota, 1976-1977

Clinical Assistant Professor - Department of Psychiatry, University of Minnesota, 1977-1979

Assistant Professor - Department of Psychiatry, University of Minnesota, 1979-1984

Associate Professor - Department of Psychiatry, University of Minnesota, 1984-1990

Professor - Department of Psychiatry, University of Minnesota, 1990-Present

EMPLOYMENT:

1976-1979: Private Practice - Psychiatry, Minneapolis
1979-Present: University of Minnesota, Department of Psychiatry
GRANT SUPPORT:

Treatment of Bulimia with Amitriptyline - R03 MH 35068; N.I.M.H. 7/1/81-6/30/82. Principal Investigator. $13,379.


Neuroendocrine and Neuropharmacological Investigations into Appetite Control Mechanisms in Patients with the Bulimia Syndrome. Protocol using General Clinical Research Center - Grant RR400, 1982-1985. Principal Investigator. Approx. $18,000.

Randomized, Double-blind, Placebo Controlled Study of Naltrexone in Obese Patients - NAL6-OSX-177A; Dupont Pharmaceuticals, 8/1/83-8/1/84. Principal Investigator. $55,000 (direct costs). Investigator initiated protocol.

Multicenter Evaluation of Nicorette as an Aid to Smoking Cessation; Merrell Dow, 5/1/85-11/1/85. Investigator. $22,343 (direct costs).

Bulimia Treatment: Group Therapy Versus Antidepressants - R01 MH 40377; N.I.M.H. 9/1/85-9/1/89. Principal Investigator. $592,288 (direct costs).

Treatment of Bulimia with Naltrexone; Minnesota Medical Foundation, 6/1/86-6/1/87. Principal Investigator. $3,000.

Fluoxetine vs. Placebo: Fixed Dose in Smoking Withdrawal; Lilly Research Laboratories, 10/1/86-4/1/88. Investigator. $89,762 (direct costs).


Narcotic Antagonists and Feeding in the Prader-Willi Syndrome. Joseph P. Kennedy Foundation Research Scientist Award. 4/1/88-4/1/89. Principal Investigator. $10,000


Training Program for Physicians in Nutrition Research, NIDVK Nutritional RFA89-DK-06, 4/1/90-3/31/95. Core Faculty. $1,197,718.
Biobehavioral Training in Neurodevelopmental Disabilities Grant. NICHD, 7/1/90 - 6/30/95 Core Faculty. $942,662.


Imipramine in the Treatment of School Refusal- R01 MH NIMH, 4/1/92 - 4/1/95 Investigator $911,580 (direct costs)

Multicenter Study of Fluvoxamine Treatment of Binge-Eating Disorder. Upjohn Pharmaceuticals, 2/1/93-2/1/94, Principal Investigator, $120,000 (direct costs).

Multicenter Study of Relapse Prevention in Anorexia Nervosa. McKnight Foundation, 7/1/93 - 7/1/98. Principal Investigator at University of Minnesota. $450,000 (direct costs)

Multicenter Study of The Treatment of CBT Non-Responders with Bulimia Nervosa. McKnight Foundation, 7/1/93-7/1/98. Principal Investigator at University of Minnesota. $350,000 (direct costs)

Nociception in Bulimia Nervosa - R01 MH 49385; NIH. 8/1/93 - 7/31/95. Principal Investigator. $353,476 (direct costs).

PROFESSIONAL ORGANIZATIONS:

- American Association for Social Psychiatry (Fellow)
- American Psychiatric Association (Fellow)
- American Psychopathological Association (Fellow)
- Hennepin County Medical Society
- International Society of Psychoneuroendocrinology
- Minnesota State Medical Association
- Minnesota Psychiatric Association
- North American Association for the Study of Obesity
- Sigma Xi
- Society for Psychotherapy Research
- Society for the Study of Ingestive Behavior

PROFESSIONAL HONORS:

Minnesota Psychiatric Residents Association Awards:

1978-1979 Teacher of the Year
1980-1981 Teacher of the Year
1982-1983 Teacher of the Year
1983-1984 Seminar Teacher of the Year
1984-1985 Seminar Teacher of the Year
1985-1986 Award for Excellence in Teaching
Curriculum Vitae
James E. Mitchell, M.D.

Distinguished Professor Award - Annual Symposium on Psychiatric Medicine, Orlando, Florida - 3/91

Annual Clinical Scholar Award - University Hospital and University of Minnesota Medical School - 5/92


DEPARTMENTAL ACTIVITIES:

1979 - Present  Residency Committee-Department of Psychiatry
1985 - Present  Resident Progress Committee-Department of Psychiatry,
1989 - Present  Director, Division of Adult Psychiatry
1990 - Present  Research Committee

UNIVERSITY ACTIVITIES:

1979 - 1982  Training Committee - Program in Health Care Psychology, University of Minnesota, Department of Public Health
1986 - 1990  University of Minnesota Medical School-Faculty Advisor Confidential Peer Assistance Program
1989 - 1992  University Hospital Quality Assurance Steering Committee
1989 - 1993  Executive Committee, Institute for Disability Studies
1989 - 1993  Scientific Advisory Committee, Institute for Disability Studies
1984 - Present  University of Minnesota Hospitals Pharmacy and Therapeutics Committee
1992 - Present  Medical School Promotions and Tenure Committee (alternate)

STATE OF MINNESOTA ACTIVITIES:

1975 - 1977  Consultant - Hastings State Hospital, Hastings, Minnesota
1978 - 1981  Advisory Board - Faribault State Hospital, Faribault, Minnesota
1981 - 1989  Consultant - Anoka Metro-Regional Treatment Center, Anoka, Minnesota
1986 - Present  Minnesota Department of Human Services Institutional Review Board (Chairman 1986-Present)
Curriculum Vitae
James E. Mitchell, M.D.

GRANT REVIEW ACTIVITIES:

Federal


NIH General Clinical Research Center - Ad hoc reviewer and site visitor - 1987, 1988

NIMH Small Grants Committee - Ad hoc reviewer - 1989, 1990

Maternal and Child Health Research Program - Ad hoc reviewer, 1989

NIMH Physician Scientist Award Committee - Ad hoc reviewer - 1990

NIMH Health Behavior and Prevention Review Committee - Ad hoc reviewer - 1992

NIMH Behavioral Medicine Study Section - Ad hoc reviewer - 1992

NIMH Treatment Assessment Review Committee - Ad hoc reviewer - 1992

NIAAA Clinical and Treatment Center Grant committee - Ad hoc reviewer, site visitor - 1992

NIH Treatment Assessment Review IRG - member 1993 - present

Local

Minnesota Medical Foundation Grant Review Committee, 1987 - present

University of Minnesota General Clinical Research Center Advisory Committee, 1986 - present

AMERICAN PSYCHIATRIC ASSOCIATION ACTIVITIES:

1987 - 1989 American Psychiatric Association Task Force on Psychiatric Therapies


1988 - 1993 American Psychiatric Association Task Force on DSM-IV Eating Disorders Committee

1986 - 1989 Minnesota Psychiatric Society Clinical Standards Committee

1991 - Present Executive Council, Minnesota State Psychiatric Society

1992 - Present Research Committee, Minnesota State Psychiatric Society

OTHER PROFESSIONAL ACTIVITIES:


Curriculum Vitae
James E. Mitchell, M.D.

1979 - 1984  Guest Lecturer - St. Olaf School of Nursing, Minneapolis, Minnesota
1981 - 1989  Advisory Board - Behavioral Achievement Center, Minneapolis, Minnesota
1985-Present  International Advisory Committee-Anorectic Aid Society
1986-1993  Psychopharmacology Consultant - V.A. Medical Center, Minneapolis, MN

JOURNAL ACTIVITIES:

Ad hoc reviewer:  Addictive Behaviors
               American Journal of Clinical Nutrition
               American Journal of Psychiatry
               Archives of General Psychiatry
               Biological Psychiatry
               Brain Research Bulletin
               Contemporary Psychology
               Hospital and Community Psychiatry
               Human Sexuality
               International Journal of Psychiatry in Medicine
               Journal of Abnormal Psychology
               Journal of Affective Disorders
               Journal of Clinical Psychiatry
               Journal of Clinical Psychopharmacology
               Journal of Consulting and Clinical Psychology
               Journal of Nervous and Mental Disease
               Journal of the American Dietetic Association
               Journal of the American Geriatric Society
               Journal of the American Medical Association
               Life Sciences
               Mayo Clinic Proceedings
               Neuroscience and Biobehavioral Review
               New England Journal of Medicine
               Physiology and Behavior
               Psychiatry
               Psychiatry Research
               Psychological Bulletin
               Psychosomatics
               Psychosomatic Medicine

Editorial Boards:  International Journal of Eating Disorders  1982 - present
                  Eating Disorders Newsletter  1990 - present
TEACHING ACTIVITIES:

Clinical Teaching Assignments

1. Supervision of students, residents and fellows in Consultation - Liaison Psychiatry (1976-1978, 1993-present)

2. Supervision of residents and students in outpatient psychiatry including psychotherapy and medication clinics (1978-1983)


4. Rural Physicians Associate Program - (Lecturer, 1975-1985)

5. Supervision of residents and students in combined inpatient/outpatient psychiatry rotation (1983-present)

6. Group Leader-Second year medical student psychiatry course (1985-present)

Courses and Seminars

1. Medical School
   Psychiatry Course (INMD 5-212) - (Lecturer, 1976-present)

2. Dental School
   Neuroanatomy Course (ANAT 5110/PHSK 5100)- (Lecturer, 1982-present)

3. Law School
   Biomedical Ethics (Lecturer, 1987-1988)

4. School of Pharmacy
   Psychiatric Therapies (Lecturer, 1986-present)

5. Graduate School
   Psychophysiology (AdPy 8226) - (1982-1985) (Coordinator with V. Ramani, M.D. Lecturer)
   Neuropharmacology (Neur 8220) - (Lecturer, 1982-1985)
   Psychobiology of Addictive Behavior (Psy 5609) - (1981-1985) (Lecturer)
   Psychopharmacology Seminar (AdPy 5602) - (1975-1987)
   (Coordinator with F. Abuzzahab, M.D., Ph.D.)
   Psychiatry Research Seminar (AdPy 5062) - (1987-1989) (Coordinator, Lecturer)
   Administrative Psychiatry (AdPy 8228) - (1987-1988) (Lecturer)

   Topics in Behavioral Neurology and Psychophysiology (AdPy 8226) - (1985-1989) (Coordinator, Lecturer)

   Advanced Psychopathology (AdPy 8226) - (1981-Present)
   (Coordinator and Lecturer 1981-1991, Lecturer 1991-present)
Curriculum Vitae
James E. Mitchell, M.D.

Biological Psychiatry - Basic Concepts (AdPy 8226) - (1981-Present)
(Coordinator and Lecturer 1981-1991, Lecturer 1991-present)

Physiological Treatments in Psychiatry (AdPy 8208) - (Lecturer, 1976-present)

Clinical Psychopathology - (AdPy 8209) (Lecturer, 1979-present)

Research Methodology and Design (AdPy 8226) - (Coordinator and Lecturer 1986-present)

Behavioral Neuroscience (Neurosci 5660) - (Lecturer 1987-present)

Introduction to Psychotherapy (AdPy 8226) - (1991-present) (Coordinator with W. Meller, M.D., 1991-present, Lecturer, 1991-present)

JOURNAL ARTICLES:


Curriculum Vitae
James E. Mitchell, M.D.


Curriculum Vitae
James E. Mitchell, M.D.


120. Halmi K, Mitchell JE, Rigotti N: Anorexia and bulimia: You can help. Patient Care, in press

BOOKS
1. Mitchell JE (editor): Anorexia Nervosa and Bulimia: Diagnosis and Treatment, University of Minnesota Press, Minneapolis, 1985

BOOK CHAPTERS


BOOK REVIEWS, MONOGRAPHS, PUBLISHED LETTERS, PUBLISHED MANUALS, AND OTHER PUBLICATIONS


PAPERS AND INVITED PRESENTATIONS AT SCIENTIFIC MEETINGS


CURRICULUM VITAE

PRATAP KONUDULLA REDDY, M.D.

Business Address:

University of Minnesota
Department of Urologic Surgery
Box 394, Mayo Memorial Building
420 Delaware Street S.E.
Minneapolis, MN 55455

Home Address:

5610 Hyland Greens Drive
Bloomington, MN 55437

Business Telephone:

(612) 725-2000, x3460 (VA)
(612) 625-9933 (University)

Home Telephone:

(612) 835-6922

Personal Data:

Citizenship: U.S.A.
Date of Birth: July 17, 1950
Place of Birth: Nellore, India
Marital Status: Married, Sarita Talei Reddy, M.D.
2 children

Present Position:

Professor
Department of Urologic Surgery
University of Minnesota Medical School
Minneapolis, Minnesota

Chief
Urology Section
VA Medical Center
Minneapolis, Minnesota

Education:

1967, Matriculation (with honors)
Don Bosco High School
University of Madras
Madras, India
1961 - 1967
1968, PUC
Pre-University Course
Loyola College
University of Madras
Madras, India
1967 - 1968

1969, PPC
Pre Professional Course
(with honors)
Loyola College
University of Madras
Madras, India
1968 - 1969

1975, MBBS
Madras Medical College
University of Madras
Madras, India
1968 - 1975

Post Doctoral Training:

1974 - 1975
1/74 - 1/75 Flexible Internship
Government General Hospital
University of Madras
Madras, India

1975
2/75 - 4/75 Senior Resident
Department of Urologic Surgery
Government General Hospital
University of Madras
Madras, India

1975 - 1977
5/75 - 1/77 Resident
Department of General Surgery
Government General Hospital
Madras, India

1977 - 1979
7/77 - 6/79 Resident
Department of General Surgery
Bronx Lebanon Hospital Center
Albert Einstein College of Medicine
New York, New York

1979 - 1981
7/79 - 9/81 Resident
Department of Urologic Surgery
University of Minnesota Medical School
Minneapolis, Minnesota
1981 - 1982 10/81 - 9/82 Chief Resident
Department of Urologic Surgery
University of Minnesota Medical School
Minneapolis, Minnesota

Academic Appointments:

1982 - 1984 Instructor
Department of Urologic Surgery
University of Minnesota Medical School

1984 - 1987 Assistant Professor
Department of Urologic Surgery
University of Minnesota Medical School
Minneapolis, Minnesota

1988 - 1991 Associate Professor
Department of Urologic Surgery
University of Minnesota Medical School
Minneapolis, Minnesota

1991 - Present Professor
Department of Urologic Surgery
University of Minnesota Medical School
Minneapolis, Minnesota

1982 - 1988 Assistant Chief
Urology Section
VA Medical Center
Minneapolis, Minnesota

1985 - 1987 Acting Chief
Urology Section
VA Medical Center
Minneapolis, Minnesota

1988 - Present Chief
Urology Section
VA Medical Center
Minneapolis, Minnesota
Licensure and Certification:

1986  
1978  
1976  
1979  
1980  
1980  
1982  
1986 - American Board of Urology, Inc.
F.L.E.X.
E.C.F.M.G.
State of Maryland - License #D23314
Issued - July 1979
State of New York - License #140856
Issued - January 4, 1980
State of Minnesota - License #0252340
Issued - May 27, 1980
State of Iowa - License #23316
Issued - October 20, 1982

Teaching Responsibilities:

1982 - Present  
1982 - Present  
1983 - Present  
1984 - Present  
1986 - Present  
Urology Residency Training
Medical Students
Endourology Fellow
Surgical Interns Rotating in Urology
Family Practice Residents

Professional & Society Memberships:

1982 - 1987  
1982 - 1987  
1982 - 1988  
1985 - 1988  
Tissue and Procedure Committee,
VAMC, Minneapolis, MN
Infection Control Committee, VAMC,
Minneapolis, MN
Pharmacy and Therapeutics Committee,
VAMC, Minneapolis, MN
Laser Committee, VAMC, Mpls., MN
1985 - Present
Endourology Society

1985 - Present
Minnesota Urologic Society

1985 - Present
American Association of Indian Urologists

1986 - Present
Urologic Society of India

1987 - Present
North Central Section of American Urological Association

1987 - Present
American Medical Association

1987 - Present
Society of University Urologists

1987 - Present
National Association of VA Physicians

1987 - Present
Hennepin County Medical Association

1988 - Present
American Urological Association

1988 - Present
Urologic Society of India

1988 - Present
Eastern Cooperative Oncology Group (ECOG)

Major Clinical Interests:
Oncology
Reconstructive Surgery
Endourology

Editorial Service:
Journal of Urology
Journal of Endourology
Urology
Awards:

1985  Second Prize  
"Pearls From My Practice" competition  
80th Annual American Urological Association Meeting

1988  Certificate of Merit  
Scientific Exhibit  
Annual Meeting of the Radiological Society of North America

1988  First Prize  
"Pearls From My Practice" competition  
83rd Annual American Urological Association Meeting

1989  Certificate of Merit  
Scientific Exhibit  
American Roentgen Ray Society Meeting

1989  Superior Performance Award  
VA Medical Center
Basic Research and Grants:


CLINICAL RESEARCH

Investigational:


### Corporate Grants/Support:

<table>
<thead>
<tr>
<th>COMPANY</th>
<th>AMOUNTS</th>
<th>Project Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roussel - UCLAF (1987 - Present)</td>
<td>$50,000</td>
<td>Comparison of Anandron and Leuprolide and Placebo in Treatment of Prostate Cancer Co-investigator: P.K. Reddy</td>
</tr>
<tr>
<td>American Medical Systems (1987)</td>
<td>10,000</td>
<td>A Study of the Urinary Continence Device in Male Incontinence Co-investigator: P.K. Reddy</td>
</tr>
<tr>
<td>American Medical Systems (1987 - Present)</td>
<td>40,000</td>
<td>Balloon Dilation of Prostate in Treatment of Human BPH P.I.: P.K. Reddy</td>
</tr>
<tr>
<td>Roche Pharmaceuticals (1989 - Present)</td>
<td>16,000</td>
<td>Comparison of Fleroxacin vs. Ceftazidime in Complicated Urinary Tract Infections Co-investigator: P.K. Reddy</td>
</tr>
<tr>
<td>Pfizer Pharmaceuticals (1990)</td>
<td>12,000</td>
<td>Study of Doxazosin Efficacy in Patients with Benign Prostatic Hyperplasia Hypertension P.I.: P.K. Reddy</td>
</tr>
</tbody>
</table>
Visiting Professorships & Invited Lectures:

November 1982  
Spermatic vein embolization: Techniques and results.  
Endourology Seminar, University of Minnesota  
Minneapolis, Minnesota

December 1982  
Rigid endoscopy and power lithotripsy.  
Endourology Seminar, University of Minnesota  
Minneapolis, Minnesota

December 1982  
Spermatic vein embolization: Techniques and results.  
Endourology Seminar, University of Minnesota  
Minneapolis, Minnesota

January 1983  
Percutaneous nephrolithotomy.  
Mercy Hospital, Des Moines, Iowa

February 1983  
Rigid endoscopy and power lithotripsy.  
Endourology Seminar, University of Minnesota  
Minneapolis, Minnesota

February 1983  
Nephrostolithotomy, electrohydraulic lithotripsy, rigid endoscopy.  
Endourology Seminar, University of Minnesota  
Minneapolis, Minnesota

March 1983  
Rigid endoscopy and power lithotripsy.  
Endourology Seminar, University of Minnesota  
Minneapolis, Minnesota

April 1983  
Endourology: Percutaneous Techniques.  
American Urological Association Post Graduate Course  
Las Vegas, Nevada

May 1983  
Rigid endoscopy and power lithotripsy.  
Endourology Seminar, University of Minnesota  
Minneapolis, Minnesota

June 1983  
Rigid endoscopy and power lithotripsy.  
Endourology Seminar, University of Minnesota  
Minneapolis, Minnesota
August 1983  Nephrostolithotomy instrumentation and techniques.
The 4th Biennial Leadbetter Symposium, University of Minnesota
Minneapolis, Minnesota

September 1983  Rigid endoscopy and power lithotripsy.
Endourology Seminar, University of Minnesota
Minneapolis, Minnesota

November 1983  Rigid endoscopy and power lithotripsy.
Endourology Seminar, University of Minnesota
Minneapolis, Minnesota

December 1983  Phadke Memorial Lecture: Renal calculus surgery - past, present, and future. All India Surgical Society Meeting Madras, India

March 1984  Results of nephrolithotomy.
Advanced Endourology Course, University of Minnesota
Minneapolis, Minnesota

March 1984  Live case demonstration of nephrolithotomy via video transmission.
Advanced Endourology Course, University of Minnesota
Minneapolis, Minnesota

May 1984  Endourology: Percutaneous techniques.
American Urological Association Post Graduate Course
New Orleans, LA

June 1984  Live case demonstration of nephrolithotomy via video transmission.
Advanced Endourology Course, University of Minnesota
Minneapolis, Minnesota

September 1984  Live case demonstration of nephrolithotomy via video transmission.
Advanced Endourology Course, University of Minnesota
Minneapolis, Minnesota
August 1985  
Impotence: Pathogenesis and treatment  
Postgraduate Course, University of Madras, Madras, India

August 1985  
Newer techniques of percutaneous nephrolithotomy.  
Tokyo Medical College, Tokyo, Japan

August 1985  
Intracavernous vasoactive drugs in the management of erectile dysfunction.  
Tokyo University, Tokyo, Japan

November 1985  
Results of percutaneous nephrolithotomy at the University of Minnesota  
Advanced Endourology: Changing Options in the Management of Urinary Calculi. University of Minnesota, Minneapolis, Minnesota

November 1985  
Flexible cystourethroscopy and retrograde catheterization.  
Advanced Endourology: Changing Options in the Management of Urinary Calculi. University of Minnesota, Minneapolis, Minnesota

November 1985  
Clinical applications of CO2 and YAG laser in urology.  
Laser Surgery Seminar, University of Minnesota Minneapolis, Minnesota

July 1986  
Endourology Seminar: Percutaneous nephrolithotomy  
Valencia General Hospital, Valencia, Venezuela

July 1986  
Live case demonstration of percutaneous techniques.  
Valencia General Hospital, Valencia, Venezuela

October 1986  
Percutaneous management of calyceal diverticula.  
Argentina Urologic Congress, Mendoza, Argentina

October 1986  
Recent trends in management of staghorn calculi.  
Argentina Urologic Congress, Mendoza, Argentina

October 1986  
Management of Pediatric calculus disease.  
Argentina Urologic Congress, Mendoza, Argentina

October 1986  
Advances in urinary diversion.  
Argentina Urologic Congress, Mendoza, Argentina
October 1987  Alternatives to cutaneous urinary diversion.  
Continuous Medical Education, American Urological Association  
Atlanta, Georgia

May 1988  Continent urinary reservoirs.  
Long Island Jewish Medical Center, New York, New York

November 1988  Transurethral dilation of prostate: Techniques and results.  
Transrectal ultrasound of prostate and seminal vesicle course,  
University of Minnesota, Minneapolis, Minnesota

November 1988  Workshop on transurethral balloon dilation of prostate.  
Transrectal ultrasound of prostate and seminal vesicle course,  
University of Minnesota, Minneapolis, Minnesota

December 1988  Urinary reconstruction following cystoprostatectomy.  
Association of Surgeons of India Annual Meeting,  
New Delhi, India

March 1989  Role of balloon dilation of prostate in treatment of BPH.  
Annual meeting of the Cooperative Study Group on Randomized Study of Prostatic Surgery for Moderately Symptomatic BPH  
Chicago, IL

April 1989  Detubularized Sigmoid Neobladder Experience.  
Minnesota Urologic Society, Inc. Spring Seminar  
Minneapolis, Minnesota

April 1989  A comparative analysis of continent stomal reservoirs and neobladders to standard ileal conduit.  
Minnesota Urologic Society, Inc. Spring Seminar  
Minneapolis, Minnesota

May 1989  New Approaches in the Treatment of Benign Prostatic Hyperplasia -- The role of balloon dilation.  
Symposium held at 84th Annual American Urologic Association, Dallas, TX
June 1989  Incision and non-incisional alternatives in the treatment of BPH. Frontiers in Endosurgery, Washington University St. Louis, MO

June 1989  Ureteral dilation techniques. Frontiers in Endosurgery. Washington University, St. Louis, MO


November 1989  Role of Balloon Dilation of Prostate in the Management of BPH. Greater Miami Urological Society, Miami, FL

December 1989  Sigmoidocystoplasty: Update in Urological Surgery NYU Medical Center, New York, New York

December 1989  Non-surgical management of BPH: Update in Urological Surgery NYU Medical Center, New York, New York


April 1990  Televised surgical demonstration: Prostate balloon dilation and prostate block. The Center for Urologic Treatment and Research Nashville, Tennessee

April 1990  Prostate balloon dilation: Long-term experience and guidelines for treatment selection. The Center for Urologic Treatment and Research Nashville, Tennessee
<table>
<thead>
<tr>
<th>Date</th>
<th>Event and Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 1990</td>
<td>The role of symptom scoring in benign prostatic hyperplasia. The Center for Urologic Treatment and Research Nashville, Tennessee</td>
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<tr>
<td>June 1990</td>
<td>Transurethral dilation of prostate: A new option for treatment of BPH. The Cook County Graduate School of Medicine, Chicago, IL</td>
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<tr>
<td>June 1990</td>
<td>Microwave, balloon dilation, and TUIP: Alternatives to TURP Frontiers in Endosurgery, Washington University School of Medicine St. Louis, Missouri</td>
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<tr>
<td>June 1990</td>
<td>Current status of non-surgical therapy for BPH. Family Medicine Review. University of Tennessee, Chattanooga, TN</td>
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<td>June 1990</td>
<td>Use of intestine in the urinary tract. Family Medicine Review University of Tennessee, Chattanooga, TN</td>
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<tr>
<td>September 1990</td>
<td>Difficult percutaneous nephrolithotomies. 24th Annual Meeting of the Urologic Society of India Kerala, India</td>
</tr>
<tr>
<td>Date</td>
<td>Event Description and Location</td>
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<tr>
<td>September 1990</td>
<td>Urinary reconstruction following radical cystectomy. 24th Annual Meeting of the Urologic Society of India Kerala, India</td>
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<tr>
<td>September 1990</td>
<td>Management of Incontinence. 24th Annual Meeting of the Urologic Society of India Kerala, India</td>
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<tr>
<td>October 1990</td>
<td>Balloon dilation of prostate. Gunderson Medical Foundation LaCrosse, WI</td>
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<tr>
<td>May 1990</td>
<td>Can urodynamics select the best therapy for BPH? Biomedical Engineering Forum, AUA, New Orleans, LA</td>
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<tr>
<td>May 1990</td>
<td>New and alternative forms of urinary diversion. Post graduate course, AUA, New Orleans, LA</td>
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<tr>
<td>April 1991</td>
<td>Alternatives in the Management of Benign Prostatic Hyperplasia. Specialty Review in Urology. The Cook County Medical School Chicago, IL</td>
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<tr>
<td>May 1992</td>
<td>Laparoscopic Urologic Surgery Department of Urologic Surgery, U of M Selection of Patients for Laparoscopic Lymphadenectomy Minneapolis, Minnesota</td>
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<tr>
<td>Date</td>
<td>Event</td>
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<tr>
<td>June 12, 1992</td>
<td>Alternative Therapies for BPH</td>
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<tr>
<td></td>
<td>Visiting Professor</td>
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<td></td>
<td>Roger Williams Medical Center</td>
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<td></td>
<td>Brown University</td>
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<td>Rhode Island</td>
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<td>September 10, 1992</td>
<td>Bladder Reconstruction Following Radical Cystoprostatectomy</td>
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<td>Visiting Professor</td>
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<td></td>
<td>Marmara University</td>
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<td>Istanbul, Turkey</td>
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<tr>
<td>September 11, 1992</td>
<td>Radical Retropubic Prostatectomy: Techniques and Results</td>
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<td></td>
<td>Symposium on Prostate Cancer</td>
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<td>Third Marmara Medical Days</td>
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<td>Marmara University</td>
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<td>Istanbul, Turkey</td>
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<td>September 11, 1992</td>
<td>Management of Stage A1 Prostate Cancer</td>
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<tr>
<td></td>
<td>Symposium on Prostate Cancer</td>
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<td>Marmara University</td>
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<td>Istanbul, Turkey</td>
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<tr>
<td>September 11, 1992</td>
<td>Role of Laparoscopic Pelvic Lymphadenectomy in the Treatment of Prostate Cancer</td>
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<td>Third Marmara Medical Days</td>
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<td>Marmara University</td>
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<td></td>
<td>Istanbul, Turkey</td>
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<td>October 23, 1992</td>
<td>Prosthetic Urologic Devices</td>
</tr>
<tr>
<td></td>
<td>Fall 1992 Medical Education Update</td>
</tr>
<tr>
<td></td>
<td>The University of Minnesota Hospital &amp; Clinic</td>
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<td></td>
<td>St. Luke's Midland Regional Medical Center</td>
</tr>
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<td></td>
<td>Aberdeen, South Dakota</td>
</tr>
</tbody>
</table>
Course Director (CME and Instructional Seminars):

December 1983 1st Endourology Workshop: Lectures and Live Case Demonstration.
University of Madras, India

March 1984 Endourology Course: Percutaneous Access to the Urinary Tract.
University of Minnesota, Minneapolis, MN

June 1984 Endourology Course: Percutaneous Access to the Urinary Tract.
University of Minnesota, Minneapolis, MN

September 1984 Endourology Course: Percutaneous Access to the Urinary Tract.
University of Minnesota, Minneapolis, MN

University of Minnesota, Minneapolis, MN

July 1990 Balloon Dilation of Prostate. Chicago, IL

August 1990 Balloon Dilation of Prostate. San Francisco, CA

September 1990 Balloon Dilation of Prostate. Boston, MA

November 1990 Balloon Dilation of Prostate. Orlando, FL
PUBLICATIONS


* REFEREED ARTICLES*


PUBLICATIONS
SUBMITTED


* REFEREED ARTICLES
MEDICAL MOVIES AND TAPES


PUBLICATIONS IN PREPARATION


PUBLISHED ABSTRACTS


Papers Presented at Scientific and Professional Meetings:


PSA response to radiation therapy (RT) after radical prostatectomy (RP): Correlation with biopsy (bx) and rectal exam. Lightner, D.J., Reddy, P.K., Lange, P.H. Presented at the Annual Meeting of the American Urological Association, Dallas, TX, May 1989.


QUALITY MANAGEMENT COMMITTEE
BOARD OF GOVERNORS
Wednesday, October 26, 1994
Board Room
9:30 A.M.

AGENDA

| I. | Approval of the September 28, 1994 Minutes | Approval | 22 |
| II. | Medical Staff-Hospital Council Report: | | |
| o | Credentials Committee Recommendations | Endorsement/Consent | |
| | -Marvin Goldberg, M.D. | | |
| (under separate cover) | | | |
| III. | Proposed Bylaws Changes | Information | |
| | -Keith Dunder | | |
| IV. | Patient Satisfaction Survey Results | Information | |
| | -Jean Harris, M.D. | | |
| V. | Referring Physician Satisfaction Survey Results | Information | |
| | -Ted Thompson, M.D. | | |
| VI. | Other Business | | |
| VII. | Adjournment | | |
THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

BOARD OF GOVERNORS

QUALITY MANAGEMENT COMMITTEE

OCTOBER 27, 1993
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<thead>
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<th>Agenda Item</th>
<th>Description</th>
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</tr>
</thead>
<tbody>
<tr>
<td>I.</td>
<td>Approval of the September 22, 1993 Minutes</td>
<td>Approval</td>
</tr>
<tr>
<td>II.</td>
<td>JCAHO Update</td>
<td>Information</td>
</tr>
<tr>
<td></td>
<td>-Jean Harris, M.D.</td>
<td></td>
</tr>
<tr>
<td>III.</td>
<td>Medical Staff-Hospital Council Report:</td>
<td>Endorsement/Consent</td>
</tr>
<tr>
<td></td>
<td>- Credentials Committee Recommendations</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>-Robert Maxwell, M.D.</td>
<td></td>
</tr>
<tr>
<td>IV.</td>
<td>Medical Staff Bylaws Revisions</td>
<td>Endorsement/Consent</td>
</tr>
<tr>
<td></td>
<td>-Robert Maxwell, M.D.</td>
<td>8</td>
</tr>
<tr>
<td>V.</td>
<td>Other Business</td>
<td></td>
</tr>
<tr>
<td>VI.</td>
<td>Adjournment</td>
<td></td>
</tr>
</tbody>
</table>
THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC
BOARD OF GOVERNORS
QUALITY MANAGEMENT COMMITTEE

SEPTEMBER 22, 1993
MINUTES

Attendance

Present: Michael Fay
S. Albert Hanser (Chair)
Greg Hart
Charles Jones

Absent: Kathleen Annette
Frank Cerra, M.D.
Roberto Heros, M.D.
Robert Maxwell, M.D.
Donald Sudor

Staff: Keith Dunder
Jean Harris, M.D.
Sally Huntington

Guests: Roby Thompson, M.D.

Call to Order

Mr. Hanser called the meeting to order at 10:12 a.m.

Approval of the July 28, 1993 Minutes

The Committee recommended approval and forwarded the July 28, 1993 minutes as submitted.

JCAHO Update

Dr. Harris presented a JCAHO status report. The survey dates have been changed to November 5, 8, 9 and 10. Dr. Harris summarized the work which remains to be completed and reported that a second mock survey has been scheduled.

Clinical Chiefs Evaluation

Dr. Roby Thompson and Greg Hart presented the recommendations for reappointment and appointment of Chiefs of Clinical Services. The Committee was reminded that in June 1993 the Board adopted a resolution directing the Chief of Staff, the General Director, the Dean, and the Chairperson of the Clinical Chiefs to apply the criteria for evaluation of Clinical Chiefs and make recommendations. The Committee reviewed the criteria and the recommendations, and requested clarification of the reappointment and appointment process.
Following discussion the Committee recommended approval and forwarded the proposed Clinical Chief reappointments and appointments. Dr. Harris communicated a proxy vote for Dr. Cerra.

Medical Staff-Hospital Council Report

Dr. Harris and Keith Dunder presented the Credentials Committee report and recommendations. Recommendations for provisional status and clinical privileges, additions to existing clinical privileges, new clinical privileges, reappointment, change in staff category, extension of privileges, and resignations were reviewed. Questions and discussion related to clarification of the meaning of some of the categories, and the significance of changes.

The Committee endorsed approval and forwarded the Credentials Committee recommendations.

Quality Management Steering Committee Report

Dr. Harris reviewed the Quarterly Safety Report, the Quality Management Plan, the Risk Management Plan, the Utilization Review Plan and the Safety Management Program. She noted each of the plans has received extensive review and approval by the appropriate UMHC bodies and requested a recommendation for approval from the Quality Management Committee. Dr. Harris noted the purpose of strengthened support for the Utilization Review Program is to promote UMHC's responsiveness to the competitive environment.

The Committee recommended approval and forwarded the Safety Report, the Quality Management Plan, the Risk Management Plan, the Utilization Review Plan and the Safety Management Program.

Infection Control Committee Report

Dr. Harris reviewed the Hospital Infection Control Committee Policy related to sterilization or disinfection of items that contact patients. Included in the policy are minimum sterilization/disinfection requirements for various instruments and recommended sterilization/disinfection techniques.

Adjournment

There being no further business, the meeting was adjourned at 11:20 a.m.

Respectfully submitted,

Sally Huntington
Director, Quality Support Services
October 14, 1993

TO: Quality Management Committee

FROM: Robert E. Maxwell, 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 endorsed the attached Credentials Committee Report and Recommendations on October 12.

I am forwarding these recommendations to you for your review and consideration. Following your consideration of these recommendations, we ask that you forward them to the Board of Governors for approval.

Thank you.

REM/cf
Attachment
September 27, 1993

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 recommends 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
Richard H. Cochrane
Category: Attending Staff

Department of Medicine
Edward W. Greeno
Category: Attending Staff

Department of Neurosurgery
Paul J. Camarata
Category: Attending Staff

Department of Orthopedics
Douglas F. Geiger
John M. Olsewski
Category: Attending Staff

Department of Pediatrics
Sixto F. Guiang
Category: Attending Staff

Department of Physical Medicine and Rehabilitation
Marshall H. Taniguchi
Category: Attending Staff

Department of Radiology
James R. Andersen
Haraldur Bjarnason
Geoffrey R. Bodeau
Wolodymyr I. Bula
Eric D. Lindgren
Category: Attending Staff
The following medical staff have submitted applications and supporting documentation requesting addition and/or deletion of clinical privileges. The Committee has reviewed and considered their requests and hereby recommends approval.

### Department of Medicine

#### Category

<table>
<thead>
<tr>
<th>Name</th>
<th>Category</th>
<th>Requests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Robert J. Bache</td>
<td>Attending Staff</td>
<td>Add: Cardiology: cardiopulmonary stress testing with interpretation; echocardiographic interpretation; exercise stress testing; holter monitor interpretation; swan ganz catheterization</td>
</tr>
<tr>
<td>David C. Homans</td>
<td>Attending Staff</td>
<td>Add: Cardiology: exercise stress testing; holter monitor interpretation; swan ganz catheterization</td>
</tr>
<tr>
<td>Thomas H. Hostetter</td>
<td>Attending Staff</td>
<td>Add: General Internal Medicine: central line placement; joint aspiration and injection excluding the hip joint; I.V. sedation for procedures; simple abscess incision and drainage; nasogastric intubation and lavage; treatment of drug overdose</td>
</tr>
<tr>
<td>M. Colin Jordan</td>
<td>Attending Staff</td>
<td>Add: General Internal Medicine: I.V. sedation for procedures; simple abscess incision and drainage; nasogastric intubation and lavage. Infectious Diseases: biopsy ulcerated tumors; bone marrow aspiration; CNS chemotherapy; small intestine intubation</td>
</tr>
<tr>
<td>Spencer H. Kubo</td>
<td>Attending Staff</td>
<td>Add: Cardiology: swan ganz catheterization; thoracentesis-aspiration only</td>
</tr>
<tr>
<td>Naip Tuna</td>
<td>Attending Staff</td>
<td>Add: General Internal Medicine: joint aspiration and injection excluding the hip joint; anoscopy; simple abscess incision and drainage. Cardiology: swan ganz catheterization</td>
</tr>
<tr>
<td>Yang Wang</td>
<td>Attending Staff</td>
<td>Add: Cardiology: holter monitor interpretation; myocardial biopsy (percutaneous)</td>
</tr>
<tr>
<td>Robert F. Wilson</td>
<td>Attending Staff</td>
<td>Add: Cardiology: cardiopulmonary stress testing with interpretation; echocardiographic interpretation; electrophysiologic testing (invasive); holter monitor interpretation; myocardial biopsy (percutaneous)</td>
</tr>
<tr>
<td>Paul N. Yakshe</td>
<td>Attending Staff</td>
<td>Add: General Internal Medicine: central line placement; arterial puncture; thoracentesis (aspiration only); abdominal paracentesis; managing patient in intensive care unit; lumbar puncture; manage blood transfusions; I.V. sedation for procedures; anoscopy; simple abscess incision and drainage; nasogastric intubation and lavage; foley catheterization of the bladder. Gastroenterology; esophageal motility and esophageal pH monitoring</td>
</tr>
</tbody>
</table>
Addition and/or deletion of clinical privileges continued:

Carl W. White  
Attending Staff  
Add: Cardiology: holter monitor interpretation; myocardial biopsy (percutaneous); swan ganz catheterization; pericardiocentesis; intraaortic balloon pump insertion

Department of Neurology

Frank J. Ritter  
Clinical Staff  
Delete: arterial puncture; electroencephalographic monitoring during carotid compression; electromyography; nerve conduction time testing; injection therapy of nerves, muscles, and joints; visual field perimetry; electroretinography

Department of Therapeutic Radiology

Kwan H. Cho  
Attending Staff  
Add: stereotactic radiosurgery

The following medical staff member has submitted an application and supporting documentation requesting the addition of clinical privileges and a joint appointment. The Committee has reviewed and considered this request and hereby recommends approval.

Department of Pediatrics  
Category

Gregory A. Plotnikoff  
Attending Staff  
Add: General Internal Medicine; arterial puncture; thoracentesis (aspiration only); abdominal pracentesis; managing patients in intensive care unit; lumbar puncture; manage blood transfusions; I.V. sedation for procedures; anoscopy; simple abscess incision and drainage; nasogastric intubation and lavage; foley catheterization of the bladder; treatment of drug overdose; anterior nasal pack for hemorrhage  
Add: Joint appointment in the Department of Medicine

The following medical staff have submitted new Department of Medicine clinical privileges forms with no changes in clinical privileges from those previously approved. The Committee has reviewed and considered their requests and hereby recommends acceptance of the new forms.

Department of Medicine  
Category

Scott F. Davies  
Clinical Staff

Catherine Verfaillie  
Attending Staff
The following medical staff have submitted applications and supporting documentation requesting change in staff category. The Committee has reviewed and considered their requests and hereby recommends approval.

<table>
<thead>
<tr>
<th>Department</th>
<th>Present Category</th>
<th>Requested Category</th>
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<tbody>
<tr>
<td>Department of Medicine</td>
<td></td>
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<tr>
<td>Yang Wang</td>
<td>Attending Staff</td>
<td>Emeritus Staff</td>
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<tr>
<td>Department of Pediatrics</td>
<td></td>
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<tr>
<td>Bruce Bostrom</td>
<td>Attending Staff</td>
<td>Clinical Staff</td>
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</table>

The following medical staff member has applied for a leave of absence from the medical staff for the period September 7, 1993 through September 7, 1994. The Committee hereby recommends approval.

<table>
<thead>
<tr>
<th>Department</th>
<th>Category</th>
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<tbody>
<tr>
<td>Department of Psychiatry</td>
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<tr>
<td>Paula J. Clayton</td>
<td>Attending Staff</td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Department</th>
<th>Category</th>
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<tbody>
<tr>
<td>Department of Family Practice</td>
<td></td>
</tr>
<tr>
<td>and Community Health</td>
<td>Attending Staff</td>
</tr>
<tr>
<td>Earl Peterson</td>
<td></td>
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<tr>
<td>Department of Laboratory Medicine</td>
<td></td>
</tr>
<tr>
<td>and Pathology</td>
<td>Attending Staff</td>
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<tr>
<td>Anthony Kileen</td>
<td></td>
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<tr>
<td>Department of Surgery</td>
<td></td>
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<tr>
<td>Edgar Pineda</td>
<td>Attending Staff</td>
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<tr>
<td>Department of Urology</td>
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<tr>
<td>Richard Evans</td>
<td>Clinical Staff</td>
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</tbody>
</table>

The Committee recommends acceptance of the resignation of the following Specified Professional Personnel-Psychology Staff member.

<table>
<thead>
<tr>
<th>Department</th>
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<tbody>
<tr>
<td>Department of Neurosurgery</td>
<td></td>
</tr>
<tr>
<td>Manfred J. Meier</td>
<td>Attending staff</td>
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<tr>
<td>HB/cf</td>
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</table>
October 15, 1993

TO: Members of the Quality Management Committee

FROM: Robert Maxwell, M.D.
Chief of Staff

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

The Bylaws Committee has reviewed the Bylaws, Rules and Regulations of the Medical and Dental Staff in their entirety.

Enclosed are amendments to these documents for your consideration. Underlining indicates additions to existing language. Strike-outs indicate deletions from existing language.

These amendments were endorsed by the Medical Staff-Hospital Council and the Council of Chiefs of Clinical Services on October 12 and are being forwarded to you for your review and approval.

Thank you.

RM/cf
Enclosures
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Part A: Qualifications for Appointment
- Qualifications particularized.

Part C: Application for Initial Appointment and Clinical Privileges
- Application to Medical Staff Office, then to clinical chief.

Section 5. Submission of Application
- Application to Medical Staff Office, then to clinical chief.

Part D: Procedure for Initial Appointment
- Recommendations from clinical chief go to Medical Staff Office through chief of staff.

**ARTICLE III: POLICIES RELATING TO CLINICAL PRACTICE**

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</table>

Part A: Clinical Services
- Particularization of functions per JCAHO standards.

Section 5. Function of Clinical Chiefs
- Particularization of functions per JCAHO standards.

Part C: Procedure for Initial Clinical Privileges
- Application to chief of staff, transmitted to clinical chief for recommendation, and finally to Credentials Committee through Medical Staff Office.

Section 1. Application for Clinical Privileges
- Application to chief of staff, transmitted to clinical chief for recommendation, and finally to Credentials Committee through Medical Staff Office.

**ARTICLE IV: ACTIONS CONCERNING MEDICAL STAFF MEMBERS**

<table>
<thead>
<tr>
<th>18</th>
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<td>18</td>
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</table>

Part A: Procedure for Reappraisal and Reappointment
- Application to chief of staff.

Section 1. Schedule for Reappraisal and Reappointment
- Application to chief of staff.

Section 3. Clinical Service Procedure
- Clinical chief recommendations to chief of staff, then to Credentials Committee.

Section 4. Credentials Committee Procedure
- Clinical chief recommendations to chief of staff, then to Credentials Committee.

**ARTICLE VI: COMMITTEES OF THE MEDICAL STAFF**

<table>
<thead>
<tr>
<th>32</th>
<th>11</th>
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<tr>
<td>33</td>
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<tr>
<td>34</td>
<td>11</td>
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</tbody>
</table>

Part B: Medical Staff-Hospital Council
- Duties particularized per JCAHO standards.

Section 4. Duties
- Duties particularized per JCAHO standards.

Part E: Bylaws Committee
Section 1. Composition

- Committee to consist of five staff members and general director.

Part G: Cardiovascular Services Advisory Committee

- Requirement that Clinical Laboratories director must serve as chair omitted.

Part P: Pharmacy and Therapeutics Committee

- Additional duty of identification and review of untoward drug reactions.

Part Q: Product Evaluation and Standardization Committee

- Committee omitted.

Part R: Quality Management Steering Committee

- Becomes "Part Q."

Section 1. Composition

- Director of Ambulatory Care omitted.

Section 2. Purposes

- Section omitted.

Section 2. Duties

- Becomes "Section 2"; Duties particularized.

Section 4. Meetings

- Becomes "Section 3."

Part S: Safety Committee

- Committee Omitted.

Part T: Tissue and Procedure Committee

- Becomes "Part R."

Part U: Transfusion Therapeutics Committee

- Becomes "Part S."

RULES AND REGULATIONS OF THE MEDICAL AND DENTAL STAFF

Section I. STAFF MEMBERSHIP

E. Resignation

- Requirements for reinstatement after resignation.

F. Failure to Reapply for Reappointment

- New provision; Requirements for reinstatement after failure to reapply for reappointment.

F. Amendments

- Becomes "G."

G. Cardiopulmonary Resuscitation

- Becomes "H."

A: 9/13/93

- 2 -
BYLAWS OF THE MEDICAL AND DENTAL STAFF

THE UNIVERSITY OF MINNESOTA HOSPITAL AND CLINIC

Originally adopted May 21, 1975
Last Amended January 27, 1993
ARTICLE II

APPOINTMENT TO THE MEDICAL STAFF

PART A: QUALIFICATIONS FOR APPOINTMENT

1. Membership on the medical staff of University Hospital is a privilege which shall be extended only to professionally competent physicians and dentists who continuously meet the qualifications, standards and requirements set forth in these bylaws.

2. Only physicians and dentists who have been appointed to faculty rank in the University of Minnesota, with documented experience, training, and demonstrated competence in the specialty in which the applicant seeks clinical privileges, shall be qualified for membership on the medical staff. Applicants must be licensed in the State of Minnesota.

Only physicians and dentists who satisfy the following conditions shall be qualified for appointment to the medical staff:

(a) are currently licensed to practice in the state of Minnesota;

(b) possess current, valid professional liability insurance coverage in such form and in amounts satisfactory to the hospital;

(c) have successfully completed a residency program approved by the Accreditation Council for Graduate Medical Education ("ACGME") or its equivalent in the specialty in which the applicant seeks clinical privileges;

(d) are certified by the appropriate specialty board in the area in which the applicant seeks clinical privileges or are admissible for examination or certification by the American Board of Medical Specialties and thereafter certified within seven years of initial staff appointment, unless such requirement is waived by the Board of Governors after considering the specific competence, training, and experience of the individual in question; and
(e) can document their background, experience, training, and demonstrated competence, their adherence to the ethics of their profession and their good reputation with sufficient adequacy to assure the medical staff and the Board that any patient treated by them in the hospital will receive a high quality of medical care.

3. No physician or dentist shall be entitled to membership on the medical staff or to the exercise of particular clinical privileges in the hospital merely by virtue of the fact that the applicant is duly licensed to practice medicine or dentistry in Minnesota or any other state, or that the applicant is a member of any professional organization, or that the applicant had in the past, or currently has, medical staff membership or privileges in another hospital.

4. No physician or dentist shall be denied membership on the basis of sex, race, creed, color or national origin.

***

PART C: APPLICATION FOR INITIAL APPOINTMENT AND CLINICAL PRIVILEGES

***

Section 5. Submission of Application:

The completed application for medical staff appointment shall be submitted by the applicant through the chief of service Medical Staff Office to the chief of staff. After collecting references and other materials deemed pertinent, the chief of staff shall transmit the application and all supporting materials to the chief of service for recommendation. The chief of service will return the application with recommendation and all supporting materials to the chief of staff, who will then forward the application and all supporting materials to the Credentials Committee for evaluation.

***

PART D: PROCEDURE FOR INITIAL APPOINTMENT

Section 1. Credentials Committee Procedure:

(a) Within 75 days after receipt of the completed application for membership from the chief of staff, the Credentials Committee shall make a written report and recommendation on the applicant through the Medical Staff-Hospital Council to the Board. The Board shall consider the recommendation at its next regular meeting after receipt of recommendations from the Joint Conference Committee of the Board.
(b) Prior to making this report, the Credentials Committee shall examine the evidence of the character, professional competence, qualifications and ethical standing of the applicant and shall determine, through information contained in references given by the applicant and from other sources available to the committee, including an appraisal from the clinical department in which privileges are sought, whether the applicant has established and meets all of the necessary qualifications for the category of staff membership and clinical privileges requested. The chief of each clinical service in which the applicant seeks clinical privileges shall provide the Credentials Committee, through the chief of staff, with specific written recommendations for approving or disapproving the application and for delineating the applicant’s clinical privileges, and these recommendations shall be made a part of the report.

* * *
ARTICLE III
POLICIES RELATING TO CLINICAL PRACTICE

PART A: CLINICAL SERVICES

* * *

Section 5. Function of Clinical Chiefs:

Each chief shall:

(a) be accountable for all professional, clinical and administratively-related activities within his or her service;

(b) be a member of the Council of Chiefs of Clinical Services, giving guidance with regard to and assuring implementation of the overall medical policies and procedures of the hospital and making specific recommendations and suggestions regarding his or her own service in order to assure a high quality of patient care;

(c) maintain continuing review of the professional performance of all individuals with clinical privileges in his or her service and report thereon to the Credentials Committee chief of staff as necessary;

(d) be responsible for enforcement within his or her service of the hospital bylaws, policies and directives and of these medical staff bylaws, rules and regulations;

(e) be responsible for implementation within his or her service of actions taken and policies set by the Board, the Council of Chiefs of Clinical Services and the Medical Staff-Hospital Council;

(f) transmit to the Credentials Committee, through the chief of staff, his or her recommendations concerning the appointment, reappointment, and delineation of clinical privileges for all individuals in and applicants to his or her service;

(g) participate in every phase of administration of his or her service, including: with-the-hospital-management-in-matters affecting patient care, including personnel, supplies, special regulations, standing orders and techniques; qualifications and competence of service personnel who are not licensed independent practitioners and who provide patient care services; recommendations for a sufficient number of qualified and competent persons to provide services; and recommendations for space and other resources needed by the service;
(h) assist in the preparation of such annual reports, including budgetary planning, pertaining to his or her service as may be required by the chief of staff or the Board;

(i) recommend to the medical staff in the department clinical service the criteria for clinical privileges;

(j) assure continual monitoring and evaluation including review of quality assessment and improvement activities for patient services surgical-and-ether-invasive-procedures within his or her clinical service, for example, by maintenance of quality control programs, as appropriate, and

(k) be responsible for the orientation and continuing education of all persons in the clinical service.

The clinical chief of a service may establish sections within the service, appoint annually directors thereof, and assign them such duties as he or she deems necessary.

* * *

PART C: PROCEDURE FOR INITIAL CLINICAL PRIVILEGES

Section 1. Application for Clinical Privileges:

(a) Each physician or dentist practicing in this hospital by virtue of medical staff membership or otherwise, shall, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted to him or her by the Board, except as provided under Part E of Article II relating to temporary privileges.

(b) Every initial application for staff appointment must contain, as a part thereof, a request for the specific clinical privileges desired by the applicant. The clinical privileges requested should be only those necessary to fulfill the applicants responsibilities at The University of Minnesota Hospital and Clinic. The evaluation of such requests shall be based upon the applicant’s education, training, experience, demonstrated competence and judgment, references and other relevant information, including an appraisal by the chief of the clinical service in which such privileges are sought. The applicant shall have the burden of establishing his or her qualifications for and competence to exercise the clinical privileges he or she requests. Recommendations of the chief of the clinical service in which clinical privileges are sought shall be forwarded to the Credentials Committee through the chief of staff and thereafter processed as part of the initial application for staff membership.
PART D: PROCEDURE FOR INCREASE IN CLINICAL PRIVILEGES

Section 1. Application for Increased Clinical Privileges:

Whenever during the term of appointment to the medical staff a physician or dentist desires to have an increase in clinical privileges considered, he or she shall apply in writing to the Chief-of-Service chief of staff on an application for change in clinical privileges or staff category form as prescribed by the Board. The application shall state in detail the specific additional clinical privileges desired and the applicant's relevant recent training and experience which justify increased privileges. This application will be transmitted by the chief of service for recommendation and then to the Credentials Committee through the Chief-of-Staff Medical Staff Office. Thereafter it will be processed in the same manner as an application for initial clinical privileges if the request is made during the term of appointment, or as a part of the reappraisal and reappointment application if the request is made at that time.

* * *
ARTICLE IV
ACTIONS CONCERNING MEDICAL STAFF MEMBERS

PART A: PROCEDURE FOR REAPPRAISAL AND REAPPOINTMENT

Section 1. Schedule for Reappraisal and Reappointment:

Members of the medical staff shall be reappraised and considered for reappointment to the medical staff biennially unless the staff member is on leave of absence. If a member of the Medical Staff is on an approved leave of absence at the time that members of his or her department are considered for reappointment, his or her application shall not be acted upon until the term of the leave of absence has expired. At the expiration of the leave of absence, the application for reappointment shall be submitted at that time through his or her chief of service to the chief of staff in accordance with the usual process for reappointment. The reappraisal and reappointment of medical staff shall be conducted on a rotation basis of the medical staff in a clinical service department of one of two designated units. The units of clinical services and the schedule for processing are as follows:

Unit I: (Odd-numbered years):
- Anesthesiology
- Dentistry
- Dermatology
- Family Practice & Community Health Medicine
- Neurology
- Neurosurgery
- Obstetrics & Gynecology
- Ophthalmology
- Urology

* * *

Unit II: (Even-numbered years):
- Orthopedic Surgery
- Otolaryngology
- Pediatrics
- Physical Medicine & Rehabilitation
- Psychiatry
- Laboratory Medicine & Pathology
- Therapeutic Radiology
- Diagnostic Radiology
- Surgery

Section 3. Clinical Service Procedure:

(a) By March 15 the chief of staff shall transmit to the clinical chief of each service within the appropriate clinical services unit a current list of all members of that service, together with the following documents which the chief of service shall forward to the listed staff members.

1. An application for reappraisal and reappointment;

2. A copy of the currently approved clinical privileges of each staff member;
3. any other supporting documentation requested which will require completion and submission by a staff member being considered for reappraisal and reappointment.

(b) The chief of service shall then submit to the Credentials Committee a letter which will include the names of members of his or her service recommended for reappointment in the same medical staff category with the same clinical privileges they then hold. In addition, the chief of service shall submit to the chief of staff individual recommendations, and the reasons therefore, for any changes recommended in staff category, in clinical privileges, or for non-reappointment both for those who applied for changes and those who did not. Each chief of service shall then submit said letter and such recommendations along with the completed applications for reappraisal and reappointment, applications for change in clinical privileges or staff category, and any other requested documentation to support each individual application for reappraisal and reappointment to the Credentials Committee by April 20.

(c) Recommendations for increase or decrease of clinical privileges or for non-reappointment shall be based upon relevant recent training and upon the direct observation of patient care provided, review of records of patients treated in this or other hospitals and review of all other records of the medical staff which evaluate the members participation in the delivery of medical care. In the case of a decrease in privileges or non-reappointment, a written description of these considerations or copies of documents that describe the matters considered shall be included with the chief’s recommendation.

Section 4. Credentials Committee Procedure:

(a) The Credentials Committee after receiving recommendations from the chief of service through the chief of staff, shall review all pertinent information available for the purpose of determining its recommendations for staff reappointment, for change in staff category, and for the granting of clinical privileges for the ensuing two years.

(b) The Credentials Committee will transmit its report in the form of a list of medical staff members recommended for reappointment without change in the staff category and clinical privileges then held, as well as recommendations for non-reappointment and for all changes in category or privileges and the reasons therefore in all cases where application for change has been made.

(c) The Credentials Committee shall transmit its report and recommendations to the Medical Staff-Hospital Council. The Medical
Staff-Hospital Council shall transmit its report and recommendations to the Board of Governors in time for the Board to consider this report at its regularly scheduled June meeting. Where non-reappointment, change in staff status, or change in clinical privileges is recommended, the reason for such recommendation shall be stated and documented.

(d) Reappointments shall be for a period of not more than two medical staff years.

***
ARTICLE VI
COMMITTEES OF THE MEDICAL STAFF

* * *

PART B: MEDICAL STAFF-HOSPITAL COUNCIL
* * *

Section 4. Duties:

The duties of the Medical Staff-Hospital Council shall be:

(a) to represent and to act on behalf of the medical staff, subject to such limitations as may be imposed by these bylaws;

(b) to receive and act upon committee reports, and to make recommendations concerning them to the general director and Board;

(c) to establish and implement policies of the medical staff which are not the responsibility of the individual services or the Council of Chiefs of Clinical Services;

(d) to recommend action to the general director on matters of a medical-administrative and hospital management nature;

(e) to discharge the medical staff’s accountability to the Board for the medical care rendered to patients in the hospital;

(f) to ensure that the medical staff is kept abreast of the accreditation program and informed of the accreditation status of the hospital;

(g) to take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all members of the medical staff including recommendations from the Credentials Committee on actions described in Article IV and to make recommendations regarding the mechanism by which membership on the medical staff may be terminated and the mechanisms for fair hearing procedures.

(h) to make a written report to the Board on each applicant for medical staff membership or clinical privileges after reviewing the report of the Credentials Committee.

(i) to make recommendations to the Board pertaining to the organization of the quality assessment and improvement activities of the medical staff, as well as the mechanism used to conduct, evaluate, and revise such activities.
PART E: BYLAWS COMMITTEE

Section 1. Composition:

The Bylaws Committee shall be composed of at least five representatives of the medical staff at large and the general director, or his or her designee.

PART G: CARDIOVASCULAR SERVICES ADVISORY COMMITTEE

Section 1. Composition:

The Cardiovascular Services Advisory Committee shall consist of at least nine representatives of the medical staff; which shall include representatives of Cardiovascular Surgery, Pediatric Cardiology, Internal Medicine Cardiology, Laboratory Medicine and Pathology, Diagnostic Radiology, Nuclear Medicine, and Hospital Administration as well as the Medical Director of the Heart Catheterization Laboratory and the director(s) of the Cardiopulmonary Laboratory. The director of the Clinical Laboratories and the chair of the committee shall be designated as the chair of the committee.

PART P: PHARMACY AND THERAPEUTICS COMMITTEE

Section 1. Composition:

The Pharmacy and Therapeutics Committee shall consist of at least six representatives of the medical staff, one from the nursing service and one from the hospital management. A hospital pharmacist shall be a member of and act as secretary for the committee.

Section 2. Duties:

The duties of the committee shall be to examine and survey all drug utilization policies and practices within the hospital in order to assure optimum clinical results and a minimum potential for hazard. The committee shall assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures and all other matters relating to drugs in the hospital. It shall also perform the following specific functions:

(a) Serve as an advisory group to the hospital medical staff and the pharmacist on matters pertaining to the choice of available drugs.
(b) make recommendations concerning drugs to be stocked on the nursing unit floors and by others services;

(c) make recommendations in relationship to the quality and costs of drug therapy and associated practice within the hospital;

(d) develop and review periodically a formulary or drug list for use in the hospital;

(e) prevent unnecessary duplication in stocking drugs and drugs in combination having identical amounts of the same therapeutic ingredients;

(f) evaluate clinical data concerning new drugs or preparations requested for use in the hospital;

(g) establish standards concerning the clinical use and control of investigational drugs and of research in the use of recognized drugs.

(h) the definition and review of all untoward drug reactions.

Section 3. Meetings:

The Pharmacy and Therapeutics Committee shall meet at least quarterly, shall maintain a permanent record of its findings, proceedings and actions, and shall make a report thereof to the Medical Staff-Hospital Council and the general director.

PART-Q: PRODUCT-EVALUATION-AND-STANDARDIZATION-COMMITTEE

Section 1. Composition

-----The Product Evaluation and Standardization Committee shall be composed of at least three representatives of the medical staff as well as representatives as designated by the general director from hospital management.

Section 2. Duties

-----The Committee shall have the responsibility for evaluating existing products presently in use in the hospital and evaluating the utility of new products that are requested for use in the hospital.

Section 3. Meetings

-----The Product Evaluation and Standardization Committee shall meet as often as necessary to accomplish its function, shall maintain a permanent record of its proceedings and actions, and shall make reports and recommendations as appropriate to the Medical Staff-Hospital Council and the general director.
PART RQ: QUALITY MANAGEMENT STEERING COMMITTEE

Section 1. Composition:

The Quality Management Steering Committee shall consist of the general director; the senior associate directors, director of finance, director of medical affairs, and director of nursing; the director of Ambulatory Care, a minimum of three clinical chiefs including the chairman of the Council of Chiefs of Clinical Services, director of nursing, chief of staff, and others as appropriate.

Section 2. Purposes:

The committee shall define the mission, set the direction, develop policies, and provide the resources necessary to develop and sustain a quality management program unique to UMHC.

Section 3. Duties:

The committee shall advise the Medical Staff-Hospital Council as to directions that should be taken to improve UMHC's quality of care, operations, and utilization of resources. The Quality Management Steering Committee shall establish a program of direction and priorities, assure integration and coordination of all aspects of the Quality Control Management Program, and the resources necessary to maintain its effectiveness. Specifically, the committee shall:

(a) To coordinate the implementation of quality management activities of the organization's governance, management, clinical and support systems, oversee the quality management activities of the organization's clinical, support, management, and governance functions;

(b) To evaluate all the quality improvement activities within the hospital and clinic at least annually.

(c) To recommend organizational changes in UMHC's quality management review systems.

(d) To serve as an advisory group to Quality Support Services.

(e) To recommend organizational changes in the hospital and clinical quality assurance and utilization review systems, as needed.

Section 4. Meetings:

The Quality Management Steering Committee shall meet quarterly or as often as is necessary to accomplish its duties, shall maintain a permanent record of its findings, proceedings, and actions, and shall
provide reports to the Medical Staff-Hospital Council and the Board of Governors.

**PART 5 -- SAFETY COMMITTEE**

Section 1 -- Composition

--- The Safety Committee shall consist of at least three members of the medical staff and four representatives of hospital management.

Section 2 -- Duties

--- The Safety Committee has responsibility for direction of all safety activities for UMHG in accordance with the governing board's objectives, the standards of the JCAHO, the Life Safety Code (NFPA-101), Minnesota OSHA, the Minnesota State Fire Marshall, Minneapolis Fire Department and University of Minnesota Environmental Health and Safety.

--- The Safety Committee shall manage a comprehensive safety management program designed to provide a physical environment free of hazards and to manage staff activities to reduce the risk of human injury. The safety program includes:

----- (a) development of written policy and procedure designed to enhance safety within the hospital and clinic to the maximum extent possible;

----- (b) management of an ongoing process to collect and evaluate information about hazards and safety practices used to identify issues for resolution;

----- (c) new employee orientation to the safety program and continuing safety education and training;

----- (d) management of hazardous materials and wastes;

----- (e) maintaining an emergency preparedness program designed to manage the consequences of natural disasters and other emergencies;

----- (f) maintaining the life safety program designed to protect patients, visitors, staff, and property from fire and smoke;

----- (g) maintaining the equipment management program designed to assess and control the clinical and physical risks of fixed and portable equipment used for diagnosis, treatment, monitoring, and care of patients and of other fixed and portable electrically-powered equipment;

----- (h) maintaining the utilities management program designed to assure the operational reliability, assess special risks, and respond...
PART I: TISSUE AND PROCEDURE REVIEW COMMITTEE

Section 1. Composition:

The Tissue and Procedure Review Committee shall consist of at least ten representatives of the medical staff, which shall include each of the surgical services and a representative from the Department of Laboratory Medicine and Pathology, and the general director or his or her designee.

Section 2. Duties:

The duties of the Tissue and Procedure Review Committee shall be:

(a) to oversee and review, as appropriate, cases referred by members of the medical staff and cases identified through the ongoing screening process of all cases in which a specimen (tissue or non-tissue) is removed. The scope of review may encompass indications, appropriateness, and extent of operative and other procedures; procedures in which there is a marked disparity between the preoperative diagnosis and the pathologic findings; and cases which raise issues of a policy nature;

(b) to monitor the non-tissue procedure review activities carried out by each clinical department and other committees and recommend changes in the review activities, as needed.

Section 3. Meetings:

The Tissue and Procedure Review Committee shall meet at least quarterly, shall maintain a permanent record of its findings, and shall make reports to the Medical Staff-Hospital Council and the general director.

PART II: TRANSFUSION THERAPEUTICS COMMITTEE

Section 1. Composition:

The Transfusion Therapeutics Committee shall consist of at least eight members of the medical staff and representatives of hospital management and nursing services.
Section 2. Duties:

The duties of the Transfusion Therapeutics Committee shall be:

(a) to serve as an advisory group to the medical staff, nursing staff, and the Blood Bank on matters pertaining to transfusion therapy;

(b) to analyze pertinent clinical data concerning use of blood products, to evaluate the quality of health care and review and recommend policies for blood product use so as to improve the quality of care rendered in the institution;

(c) to review and recommend policies for handling and infusing blood products and regarding therapeutic procedures involving blood resources;

(d) to initiate and support educational efforts related to transfusion therapy.

Section 3. Meetings:

The Transfusion Therapeutics Committee shall meet at least quarterly, shall maintain a permanent record of its findings, and shall make reports to the Medical Staff-Hospital Council and the general director.

PART V: SPECIAL COMMITTEES

In addition, special committees shall be appointed by the chief of staff as they are required. Such committees shall confine their activities to the purpose for which they were appointed, and shall report to the Medical Staff-Hospital Council.
THE UNIVERSITY OF MINNESOTA HOSPITAL & CLINIC

RULES AND REGULATIONS OF THE MEDICAL
AND DENTAL STAFF

Adopted by The University of Minnesota
Hospital and Clinic Board of Governors
October 24, 1984

Last Amended January 27, 1993
RULES AND REGULATIONS

SECTION I. STAFF MEMBERSHIP

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E. Resignation.

1) All members leaving the Medical Staff shall notify the chief of staff in writing of their intention to relinquish their Medical Staff appointment and clinical privileges.

2) If a staff member has submitted a resignation from the medical staff, and if the Board has not taken final action with respect to that resignation, the staff member may be reinstated without submission of a new Application for Appointment to the Medical and Dental Staff provided that:

(a) the request is made within three months of the resignation;

(b) the applicant for reinstatement submits a letter to the Medical and Dental Staff requesting reinstatement;

(c) the chief of service of the applicant for reinstatement submits a letter to the Medical and Dental Staff supporting the request for reinstatement; and

(d) all qualifications for continued appointment to the medical staff are being met, including the submission of a current Application for Reappraisal and Reappointment, if appropriate, as discussed at Paragraph 3, below.

3) If a staff member has submitted a resignation from the medical staff, and if the Board has taken final action with respect to that resignation, and if the applicant for reinstatement follows the aforementioned procedures, the Board may reconsider its action and reinstate the applicant for reinstatement.

4) If the applicant for reinstatement applies for reinstatement within thirty days of submitting his or her resignation, and if, in the time between resignation and reinstatement the applicant would not have been up for reappraisal and reappointment had the applicant not resigned, the applicant is not required to submit an Application for Reappraisal and Reappointment with his or her application for reinstatement. If, however, the applicant for reinstatement applies for reinstatement more than thirty days after his or her resignation, or if, in the time between resignation and reinstatement the applicant would have been up for reappraisal and reappointment had the applicant not resigned, the applicant must submit an Application for Reappraisal and Reappointment with his or her application for reinstatement.
5) If the applicant for reinstatement requests any changes in privileges or a change in staff category, the applicant must, in addition to the procedures set forth above, submit to the Medical and Dental Staff an Application for Change in Clinical Privileges or Medical Staff Category, as appropriate.

F. Failure to Apply for Reappointment.

If a staff member has neglected to apply for reappointment to the medical staff, and if the Board has not taken final action with respect to the staff member's failure to apply for reappointment, the staff member may be reinstated without submission of a new Application for Appointment to the Medical and Dental Staff provided that:

(a) the request for reinstatement is made within three months of the date the staff member was to apply for reappointment;

(b) the applicant for reinstatement submits an Application for Reappraisal and Reappointment to the Medical and Dental Staff;

(c) the applicant for reinstatement submits a letter to the Medical and Dental Staff requesting reinstatement;

(d) the chief of service of the applicant for reinstatement submits a letter to the Medical and Dental Staff supporting the request for reinstatement; and

(e) all qualifications for continued appointment to the medical staff are being met.

If a staff member has neglected to apply for reappointment to the medical staff, and if the Board has taken final action with respect to the staff member's failure to apply for reappointment, and if the applicant for reinstatement follows the aforementioned procedures, the Board may reconsider its action and reinstate the applicant.

If the applicant for reinstatement requests any changes in privileges or a change in staff category, the applicant must, in addition to the procedures set forth above, submit to the Medical and Dental Staff an Application for Change in Clinical Privileges or Medical Staff Category, as appropriate.

FG. Amendments. The approved application forms may be amended from time to time in the same manner as other amendments to these Rules and Regulations.

GH. Cardiopulmonary Resuscitation. Persons who apply for Medical Staff membership whose primary function will be in the Emergency Department shall provide evidence of proficiency in ACLS (Advanced Cardiac Life Support) within the first quarter of their provisional appointments.
QUALITY MANAGEMENT COMMITTEE
BOARD OF GOVERNORS
Wednesday, November 17, 1993
Bridges Conference Room
11:00 A.M.

AGENDA

I. Approval of the October 27, 1993 Minutes

II. JCAHO Update
   -Jean Harris, M.D.

III. Medical Staff-Hospital Council Report:
   o Credentials Committee Recommendations
     -Robert Maxwell, M.D.

IV. Other Business

V. Adjournment
November 16, 1993

Dear Quality Management Committee Members:

Qualified new applicants to the Medical Staff receive temporary privileges when they first come to The University of Minnesota Hospital and Clinic (UMHC), pending the grant of regular privileges when their application is fully processed. As you may know, last year, upon the recommendation of the Credentials Committee the time during which one could hold temporary privileges was shortened to 120 days, with an extension of no more than 30 days granted at the discretion of the Chief of Staff, where the applicant had been unable after reasonable effort to obtain necessary documentation or the like.

The Medical Staff Office presently has applications for regular privileges pending for the following physicians who have temporary privileges:

Markus Gapany
Setti Rengachary
Vibhu Kshettry

Because the Director of the Medical Staff Office was recently forced to go on an unexpected medical leave of absence, and because of difficulties in obtaining documentation in these files, it is apparent that the applications will not be fully processed by the Credentials Committee and the Medical Staff Hospital Council before the time limit of their temporary privileges expires. It is further apparent that the 30 day extension period administered by the Chief of Staff is not really a useful tool because at the time that the request for extension is generally made, 30 days is not a sufficient period of time to complete the necessary cycle of committee meetings, through the Credentials Committee, the Medical Staff Hospital Council, and the Quality Management Committee, for timely presentation to the Board.
Accordingly, we are requesting a special dispensation from the Board to extend the privileges for the above physicians for an additional 30 days beyond the normal limit of temporary privileges, in order that the applications can be properly processed. In addition, we will be reconsidering the time limits imposed on temporary privileges, and the Credentials Committee may return to the Board with a proposal to further modify the temporary privileges time limits.

Thank you for your consideration.

Very truly yours,

Robert E. Maxwell, M.D.
Chief of Staff
University of Minnesota
Hospital and Clinic

Henry Buchwald, M.D.
Professor of Surgery
Chair, Credentials Committee
University of Minnesota
Hospital and Clinic
QUALITY MANAGEMENT COMMITTEE
BOARD OF GOVERNORS
Wednesday, December 15, 1993
Bridges Conference Room
11:00 A.M.

AGENDA

I. Approval of the November 17, 1993 Minutes

II. JCAHO Update
   -Jean Harris, M.D.

III. Medical Staff-Hospital Council Report:
   o Credentials Committee Recommendations
     -Robert Maxwell, M.D.

IV. Clinical Chief Appointment
    -Robert Maxwell, M.D.

V. Other Business

VI. Adjournment
The Application for Reappraisal and Reappointment to the Medical Staff of the following member of the medical staff is in progress. The Credentials Committee hereby recommends reappointment and privileges be extended for 30 days pending further information.

Department of Hospital Dentistry
Mohamed El Deeb
Category
Attending Staff