



# In a Different Vein

A NEWSLETTER OF THE  
**MICHIGAN  
ASSOCIATION  
OF  
BLOOD BANKS**

Vol. XVIII, No. 2  
Spring, 2001

## President's Message

by Sharon Cisco, MT(ASCP)SBB

### SPRING BRINGS A MESSAGE OF HOPE

The longer days, the warm sun and the tips of green buds peeking through the ground are the heralds of a new season and with that we can put the cold winter behind us. Just as the winter was colder this year than normal, the MABB had a rough start. It seems the post office lost many of our renewal notices and we began to think that our membership was failing. After checking with several loyal members who had not renewed, it was realized that there was a problem. Another renewal notice has been sent out and we now have 191 current members, which means that there are still 112 members from 2000 that have not responded. Many thanks to everyone for renewing your support of the MABB. If you are one of those who has not yet renewed, please do so soon. Your support is very much needed to continue the level of activities MABB provides. If you are in need of a membership application, please contact Janet Silvestri in the Administrative Office (810) 573-2500 or email: janet@hfcc.net.

Also we have received dues from **Gambro BCT** and **Pall Medical** as Corporate members. Thank you to these companies for believing in the mission of MABB enough to lend your support. Gambro BCT and Pall Medical will be exhibiting at the MABB Annual Meeting September 12-13, 2001. Two other organizations that have already registered to exhibit are **Helmer Labs** and **Jewett, Inc./MSA Marketing**.

Several new members have joined and it is my pleasure to welcome them to the MABB. Hello and welcome to:

**M. Elizabeth Atkins, MD ~**

Michigan Community Blood Centers

**Marianne Bondalapati, MT(ASCP) ~**

St. Mary Mercy Hospital

**Melissa McEwan Kristofice, MT(ASCP) ~**

Providence Hospital

**Mary Lynn Lower, MT(ASCP) ~**

Michigan Community Blood Centers

**Mary Ann Max, MT(ASCP) ~**

Henry Ford Health Systems

**Arleen L. Papazian, MT(ASCP) ~**

CCH Lab

**Darlene Shier, MT(ASCP) ~**

Citation Lab/Providence Hospital  
(former member rejoining in 2001)



*Melissa Kristofice and Darlene Shire ~  
Welcome to the MABB!*

Do take full advantage of the many educational and networking opportunities your MABB provides. I look forward to greeting you in person at some of our events.

Our Membership Database has been updated so that we can better track our membership information. This includes a field for "year joined" so that we are aware when former members rejoin and who our long-standing members are. We have been very pleased each year to see 8 -10 former members rejoin. That reemphasizes the fact that our members derive many benefits from being affiliated with the MABB.

On February 21<sup>st</sup> we had the first Board Meeting of the new year (see Minutes on page 9). The entire Board was in attendance, and many exciting and innovative plans were discussed. The

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**MICHIGAN ASSOCIATION  
OF BLOOD BANKS**

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*In a Different Vein* is a quarterly publication of the Michigan Association of Blood Banks.

Please feel free to submit any articles, announcements, advertisements, or case studies to *In a Different Vein*. Items of a personal note regarding colleagues are also welcome.

**Send articles to editors:**

**Mary DePouw**

Crittenton Hospital Blood Bank  
1101 W. University Drive • Rochester, MI 48307  
(248) 652-5275

-or-

**Ann Steiner**

Ortho-Clinical Diagnostics  
1 (800) 322-6374 Ext. 4103

**2000 - 2001 MABB OFFICERS**

**PRESIDENT**

Sharon Cisco, MT(ASCP)SBB

**PRESIDENT-ELECT**

Linda Cardine, MT(ASCP)SBB

**PAST PRESIDENT**

Sharron Zimmerman, MT(ASCP)SBB

**SECRETARY/TREASURER**

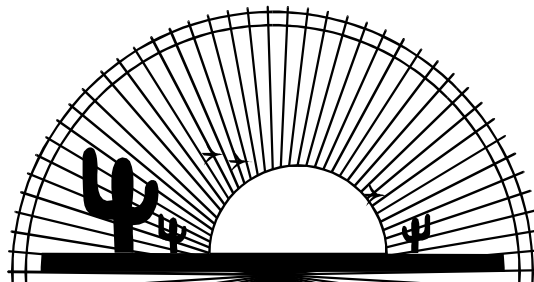
A. Bradley Eisenbrey, MD, PhD

**SECRETARY/TREASURER-ELECT**

Patricia Fedoronko, MT(ASCP)SBB

**MEMBERS-AT-LARGE**

MaryJo Drew, MD, MHSA  
Peggy Stoe, MT(ASCP)SBB, CQA, ASQ  
Michelle Tuson, BS, MT(ASCP)SBB  
Margaret Wilde, MT(ASCP)SBB



*Spring Workshop 2001*

*Blazing a New Frontier*

*Blood Banking for the 21<sup>st</sup> Century*

**Thursday • May 10, 2001  
Immunoematology Seminar**

**Friday • May 11, 2001  
Wet Workshop**

Michigan State University  
Kedzie Hall  
East Lansing, Michigan

***Late registrations will be accepted  
until Tuesday, May 8<sup>th</sup>  
only by phone***

For information contact:  
Janet Silvestri  
MABB Administrative Office  
(810) 573-2500

## President's Message

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newest item was the decision to enter the MABB as a candidate for the AABB's Organizational Award. The MABB has a long rich history of supporting the Blood Banking field by presenting educational programs and providing the fabric for professional consulting in the state of Michigan. Certainly the MABB may boast of the many outstanding members over the years that have given so much to the development of modern Blood Banking and Transfusion Medicine. It would be an honor for them and all MABB members past and present if the American Association of Blood Banks were to recognize our organization through this award. **Dr. Rob Davenport**, MABB past president, took on the task of preparing the entry. It was an honor to be nominated. Thank you, Rob.

Also our Secretary/Treasurer, **Dr. Brad Eisenbrey**, has announced that he will step down from his position at the end of this year's term since he recently received a promotion in the Michigan Air National Guard to Colonel. Brad's official title is: A. Bradley Eisenbrey, Col(s), MC SFS, Commander, 127th Medical Squadron, MI ANG(ACC). The ACC stands for Air Combat Command. The other acronyms are: MC - Medical Corps (physician) and SFS - Senior Flight Surgeon. The (s) after Col stands for select, which simply means that Brad has not yet received Federal Recognition, which he expects in November or December. It is a very long process. Congratulations Brad on your new responsibilities and thank you for the **many** years you have served on the MABB Board. The Nominations Committee and the Board have unanimously selected **Pat Fedoronko** as the Secretary/Treasurer-Elect. Pat has graciously accepted and will be working with Brad this year to prepare for assuming the position next January. Thank you, Pat, for your commitment.

The Membership Committee, under the guidance of **Jan Keersmaekers**, has been busy working on ways to interest the technologist of today in our organization. They have designed a brochure, appropriately titled "Invest Yourself," which plays on the importance of investing in your future. Thank you to **Tony Armor** and **Melissa Kristofice** for their role in developing this important public relations tool.

**Dr. Mary Jo Drew** and her committee have been very busy also working on the many educational events scheduled for this year. Congratulations on their first very successful project, a RAP Session held on

February 15<sup>th</sup>. This session was on a very timely topic, Biological Product Deviation Reporting. Thank you to **Colleen Olsen** and **Jan Keersmaekers** for successfully chairing the event, and to **Suzanne Butch** and **Jan Hamilton** as the guest speakers of the evening. Not only was the information valuable, but everyone enjoyed the delicious meal in the company of their fellow Blood Bankers.

On May 10<sup>th</sup> and 11<sup>th</sup>, the Spring Workshop ~ "Blazing a New Frontier - Blood Banking in the 21<sup>st</sup> Century" will be presented at Michigan State University. The co-chairs ~ **Deb Bose, Michelle Horan Bensette, and Kathryn Watkins**, have done an excellent job in organizing this difficult event. There are many seminars presented through our organization and others BUT a seminar **and** a wet workshop are a rare offering indeed. This is the only wet workshop scheduled yearly by the MABB, and one of the few throughout the country. The best way to learn is "Hands-on" and this workshop gives techs the opportunity to do just that.

The **47<sup>th</sup> Annual Meeting**, chaired by **Linda Cardine**, will be held at the Doubletree Hotel this year on **September 12<sup>th</sup> and 13<sup>th</sup>**. Although it is a new meeting place, the area will be familiar, since it is right across the street from where the meeting was held last year. The Doubletree is in Romulus, very close to the airport and I-94 expressway. Since it has become increasingly difficult for members to have time away from the lab, it has been decided to reduce the number of days that the meeting will be held from three to two, Wednesday and Thursday. There will not be an entire day dedicated to management topics as in the past. Pertinent management topics have been planned throughout the year by differing venues such as the RAP Session. Technical topics will remain the major focus of our meeting. So please put the dates on your calendar. Also if you have not started planning your poster presentation for the annual meeting, please start thinking about it now.

Thank you to **Michelle Tuson** for being our representative at the recent OABB meeting in Ohio. Michele extended our hand of friendship and sharing to our neighboring organization. Now that we have begun that relationship, hopefully we will continue to strengthen it through resource sharing.

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## President's Message

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Also, a big THANK YOU goes out to the 2001 Spring Workshop Committee, who have worked tirelessly to make this year's Spring Workshop a success:

### *Co-Chairpersons*

**Deb Bose, MS, MT(ASCP)SBB**  
**Michelle Horan Bensette, MT(ASCP)**  
**Kathryn Watkins, MT(ASCP)**

### *Committee*

**Vija Miske MT(ASCP)**  
**Glenda Barager, MT(ASCP)**  
**Christi Brooks, MT(ASCP)**  
**Debbie Dondzila, MT(ASCP)**

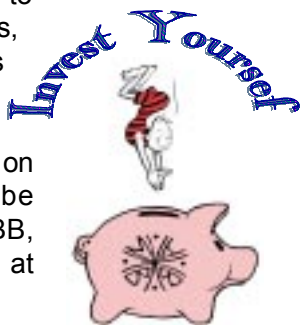
We will have a complete report and photos from the Spring Workshop in the next issue of "In a Different Vein."

Space does not allow me to recognize all the volunteers on our many other committees that are keeping this organization alive and vigorous, but on behalf of the members you serve, I thank you for being involved and "investing yourself" in MABB.

## Membership Update

*by Jan Keersmaekers, MT(ASCP)SBB*

The MABB Membership Committee is diligently working on a plan to recruit new members to the association. Earlier this year we developed a new Membership/Renewal brochure, which was sent to current and past members, and will be available at MABB events. Several past members have rejoined the association this year, and we have welcomed seven new members since January. There are still many members from last year that have not sent in their renewal for 2001. If you have not sent in your membership dues yet, please do so as soon as possible. By renewing your MABB membership, you can continue to receive mailings regarding events, as well as the newsletter, "In A Different Vein." Members also receive reduced rates for attendance at MABB seminars and workshops. Through membership in MABB, you can have the opportunity to share knowledge, gain insights, and have fun with individuals working in all aspects of blood banking. If you would like membership brochures to pass on to co-workers who may be interested in joining the MABB, please contact Janet Silvestri at (810) 573-2500.



## EDUCATION COMMITTEE UPDATE

*by MaryJo Drew, MD*

The MABB Education Committee has had a busy year thus far coordinating educational events for the membership. An evening RAP session on FDA Biological Product Deviation reporting, held on February 15, 2001 at Pasquale's restaurant in Royal Oak, was a great success. Thirty-five attendees heard thought-provoking presentations by **Suzanne Butch** and **Jan Hamilton** on implementation of this new requirement in registered establishments and transfusion services. Attendees were unanimous in praising the timeliness of this session, as well as the practical content presented. Of course, the hearty Italian meal was also enjoyed by all!

The SBB review session, scheduled for April 6 & 7, 2001, at St. Joseph Mercy Hospital in Ann Arbor, was cancelled due to the small number of registrants. The committee would appreciate input on whether this conference is a useful offering, as registration and attendance have been lower the last few sessions. Please contact Dr. Drew at 313-916-1573 or [mdrew1@hfhs.org](mailto:mdrew1@hfhs.org) with your comments.

The committee is planning several events for the fall meeting, including an evening RAP session, the proposed topic of which is "Staffing in the New Millennium — How to Recruit, Retrain & Revitalize Employees." In addition, the call for posters continues. We need to make the fall meeting a place to present new ideas and innovations in transfusion, apheresis, management, quality assurance, and other topics. If you are interested in submitting a poster, please contact Dr. Drew with your topic — she'll be happy to guide you through the submission process, which will be painless!

The Cyberconference, to be held on October 23, 2001, at several sites statewide, is also in the planning stages. Topics under discussion for the event include: FDA Biological Product Deviation reporting, universal leukoreduction, ABO compatibility & platelet transfusion, variant CJD and transfusion, APC reimbursement for transfusion services, and a serologic topic to be announced. Stay tuned for a final topic and site listing in the MABB event calendar.

# MABB RAP Session:

## What do CBER, BPDR, CFR, CGMP, RAP, and MABB have in common?

by Mary DePouw, MT(ASCP)SBB

The MABB sponsored a Rap session on Biological Product Deviation Reporting (BPDR) on Feb 15, 2001 to identify the role of the transfusion service in the FDA Final Rule on error and Accident Reporting. Since the FDA is responsible for ensuring the safety of our nation's blood supply, the Center for Biologics Evaluation and Research (CBER) develops and enforces quality standards by monitoring reports of errors, accidents and adverse clinical events.

The current regulation referred to as Biological Product Deviation Reporting (BPDR) becomes mandatory on May 7, 2001 and affects all of us in the blood manufacturing and transfusing community. Current Regulation - 21CFR 600.14 – Reporting of Errors and Accidents, specifically states that CBER shall be notified promptly of errors or accidents in the manufacture of products that may affect the safety, purity, or potency of any product.

**Colleen Olsen** and **Jan Keersmaekers** coordinated a Rap Session on Feb 15, which was very well attended. **Suzanne Butch** from the University of Michigan Blood Bank and **Jan Hamilton** from the American Red Cross delivered lively and comprehensive presentations for transfusion service responsibilities in error and accident reporting to the FDA.

The purpose of reporting is to identify deviations from proper procedure, which may affect the safety, efficacy or purity of the product. To be reportable under BPDR guidelines it must meet the following criteria:

1. The product has left the transfusion service. The question to ask: "Has the product gone out your door out of your immediate control?"
2. The product was under your control at one time?. You did have responsibility for the product's safety, purity and potency.
3. There was an error or deviation from the procedure for Good Manufacturing Practice.

The BPDR final rule focuses on deviations involving only *distributed products because such deviations may involve products administered to patients presenting the greatest risk to public health.*

In contrast, any incident resulting in transfusion related death must be reported under entirely different guidelines. See 21CFR 606.170.

To report a BPDR it is not necessary to include any confidential information such as the donor, patient or employee personal identification.

Suzanne Butch presented several examples of incidents to help identify those which are reportable.

**Note: In each example assume that the component has been released from the transfusion service. These examples are not meant to be all inclusive and may change with updated requirements:**

- ✓ A defective unit is issued (i.e. broken bag of plasma leaks in transport to nursing)
- ✓ Incorrect infectious disease testing.
- ✓ Unit mislabeled with a longer outdate.
- ✓ Improper storage of components in the blood bank
- ✓ Wrong patient sample used for compatibility testing
- ✓ Outdated reagents used for testing
- ✓ SOP for collection not followed
- ✓ Product contaminated
- ✓ Additional information- name, SSN on autologous unit missing or incorrect
- ✓ Incorrect addition of reagents
- ✓ Incorrect ABO, Rh, antigen or antibody or unit number
- ✓ Incorrect product issued
- ✓ Clotted unit
- ✓ Special order ( IRR, CMV, LR) not provided
- ✓ Improper ABO/Rh selected for patient
- ✓ Irradiation not performed correctly

### Non-reportable incidents are:

- ✓ Unit mislabeled with a shortened outdate
- ✓ Improper storage of components on patient care units
- ✓ Nurse transfused wrong patient
- ✓ A filter issued with a product is not used
- ✓ Problem corrected before distribution
- ✓ Autologous donor came down with a cold
- ✓ Donor record not reviewed prior to distribution
- ✓ Phlebotomist's signature missing
- ✓ Donor reaction
- ✓ Directed unit, suitable for allogeneic use labeled with incorrect name, SSN or date of birth
- ✓ Disposition unknown
- ✓ Incorrect weight, facility identification
- ✓ Unit shipped to incorrect facility
- ✓ Product breaks during thawing
- ✓ Unit returned to blood bank determined to be unsuitable and is discarded
- ✓ Discrepancy between shipping form and shipment

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In A Different Vein*



# MABB RAP Session:

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Suzanne presented a to do list for implementing this regulation.

- ✓ Read FDA materials: 21 CFR Parts 600 and 606
  - ✓ Reporting of Biological Product Deviations in Manufacturing.
- ✓ Write an SOP
- ✓ Include FDA forms: FDA form 3486 (7 pages)
- ✓ Design an internal report form
- ✓ Train staff
- ✓ Keep a log of reports
- ✓ Edit what is on the report
- ✓ Report within the time frame –45 days
- ✓ Filling out the form:
  - ✓ Describe the incident
  - ✓ Give it a category
  - ✓ Send it in
- ✓ If in doubt-report it

Mail report to:

Director, Office of Compliance and Biologics Quality (HFM-600)  
Center for Biologics Evaluation and Research  
Food and Drug Administration  
1401 Rockville Pike, Suite 200N  
Rockville MD 20852-1448

## For forms and information:

<http://www.fda.gov/cber/biodev/bpdrinstr.htm>

<http://www.fda.gov/opacom/morechoices/fdaforms/fdaforms.html>

Contact CBER at (301) 827-6220

email: [bp\\_deviations@cber.fda.gov](mailto:bp_deviations@cber.fda.gov)

A sample of the report form is on [page 5](#) and can be ordered from CBER.

Test your skill in evaluating reportable incidents by taking the attached Biological Product Deviation Competency Assessment, which Suzanne generously shared from University of Michigan Health System.

by Mary DePouw



*Jan Hamilton and Suzanne Butch were the featured speakers at the MABB RAP Session*



*Dr. Tim Mervak, Judy Easter, Pam Mayer, Margaret Wilde and Suzan Bowers*



*Marilyn Bean (left) and Weihang Zhang (far right) enjoy the discussion, while Secretary/Treasurer-Elect Pat Fedoronko and MABB President-Elect Linda Cardine review the Biological Product Deviation Report forms*

# Biological Product Deviation Reports Competency Assessment

Name: \_\_\_\_\_ Date: \_\_\_\_\_

By circling "N" for Not reportable, "R" for Reportable or "I" for more information needed, indicate if the event is reportable to the FDA under 21CFR 606.171.

- N R I 1. In an audit of record completeness, a unit of Autologous blood did not have the predonation hematocrit recorded. The unit has not been issued.
- N R I 2. The hospital staff transfused the wrong unit to the patient. The unit was ABO compatible.
- N R I 3. The wrong patient sample was used for compatibility testing and the unit was issued.
- N R I 4. The wash solution used to prepare a Washed Red Blood Cell was outdated.
- N R I 5. The NTL notifies us that the testing was not done correctly on an Autologous unit and the unit has been transfused.
- N R I 6. There are three donor history questions that are not completed on a donor history form for an Autologous donation. The unit has been transfused.
- N R I 7. A unit of platelets was placed in the irradiator without a Rad-Sure label and the unit was issued.
- N R I 8. The person who irradiated the unit did not initial the irradiation log.
- N R I 9. Screen Cell II was used in both tubes to perform an antibody screen on a patient. The crossmatch was OK. The unit was issued.
- N R I 10. A patient required leuko-reduced components but we issued RCAS units.
- N R I 11. Six units of blood were emergency released to a patient.
- N R I 12. The blood bank staff issued a unit for Sam Spade and the nursing unit wanted a unit for Joe Bloe.
- N R I 13. A unit that expired on 12/31/00 was issued with a label with the outdate 1/1/01.
- N R I 14. Unit labeled with incorrect antigen typing information.
- N R I 15. Incorrect Social Security Number on unit or tie tag.

## Key

The quiz questions were based on a specific set of standard operating procedures. Depending on the policies and procedures used in a facility, the answers may vary.

- |    |   |     |   |     |   |
|----|---|-----|---|-----|---|
| 1. | N | 6.  | R | 11. | N |
| 2. | N | 7.  | R | 12. | R |
| 3. | R | 8.  | N | 13. | R |
| 4. | I | 9.  | R | 14. | I |
| 5. | R | 10. | R | 15. | I |

## ABO ERRORS. HOW CAN WE PREVENT THEM?

### QUESTION:

Recently, a patient at our hospital received an ABO-incompatible red cell transfusion because of a blood administration error. The two nurses administering the blood did not match the unit or the requisition against the patient's hospital bracelet. This is required by hospital policy. How can we prevent or minimize this type of error?

### ANSWER:

While minimizing the risk in the hospital blood bank is critical, 56-79% of the errors occur outside of the hospital blood bank. Reducing these errors requires a multi-team effort within a hospital. One reported study suggested that most of the blood administration errors were failures to follow hospital policies as opposed to inadequate policies.(1) The study found that auditing the nursing staff quickly improved compliance with all critical steps in the procedure from 50% to close to 100%. The study also emphasized a strong up-front educational effort for the nursing and anesthesiology staff. It is critical that nurses who infrequently transfuse blood do so step-by-step with the procedure in-hand.

A second report involving 712 hospitals evaluated pretransfusion sample collection.(2) The key issues are initial patient identification, maintaining the patient's identification throughout the hospital admission, correct identification of the patient just prior to collection of the pretransfusion sample, and labeling of the tubes and requisition at the bedside and not anywhere else. The report emphasized the best policies associated with the lowest misidentification rates.(2)

Although ABO errors are unusual, they are still a significant problem today. The best data on the ABO error rate comes from the New York State Department of Public Health. They require hospital blood banks (transfusion services) to report all errors, accidents, and incidents. In New York State, one in every 33,000 red cell units transfused was ABO-incompatible.(3) The number of red cell units transfused to the wrong patient was surmised to be one in every 12,000 because 64% of randomly transfused red cells are

statistically ABO-compatible.(3) The ABO-related death rate was one in 600,000. This is consistent with several major studies of ABO-incompatible red cell transfusions that showed an overall death rate of 6% (7/118).

New York State and FDA data suggest that 46-57% of the ABO errors were blood administration errors, 10-22% were pretransfusion sample collection errors, and 33% were hospital blood bank errors. Half of the hospital blood bank errors also involved a second blood administration error.

While technological advances may be helpful in the future, low-tech solutions are available today to minimize the risk of having an ABO-incompatible transfusion. A multi-team effort is required. Implementation activities include staff education, compliance audits relative to blood administration, and implementation of best policies and procedures for collection of pretransfusion samples. Hospitals can take actions to further minimize their risk for an ABO-incompatible transfusion reaction. Currently, three to four times more people die from ABO errors than from transfusion-related AIDS.

### References:

1. Shulman IA, Lohr K, Derdarian AK, Picukaric JM. Monitoring transfusionist practices: a strategy for improving transfusion safety. *Transfusion* 1994; 34:11-15.
2. Renner SW, Howanitz PJ, Bachner P. Wristband identification error reporting in 712 hospitals: A CAP's Q-probes study of quality issues in transfusion practice. *Arch Path Lab Med* 1993; 117:573-577.
3. Linden JV, Paul B, Dressler KP. A report of 104 transfusion errors in New York State. *Transfusion* 1992; 32:601-606.

THIS IS A SLIGHTLY  
MODIFIED REPRINT  
FROM THE MARCH 1998  
ISSUE OF AABB NEWS.



# MABB Executive Committee Meeting

21 February 2001, ARC NTL, Detroit

The President, Sharon Cisco, called the meeting to order at 1515. In attendance were Linda Cardine, Michelle Tuson, Mary Jo Drew, Peggy Stoe, Margaret Wilde and Brad Eisenbrey. Sharron Zimmerman joined by telephone.

**Minutes (action item):** Minutes from the previous meeting (6 December 2000) were distributed. Minutes were approved.

**Financial Report:** Dr. Eisenbrey is preparing the Federal Tax filing, which is due 15 May 2001.

Recommendations for Secretary/Treasurer were solicited. Pat Fedoronko has been recommended. She reports that she is interested and has experience as a treasurer for a non-profit organization. The nomination will be submitted to the Nominating Committee for recommendations for action.

## Committee Reports —

**Education Committee:** Mary Jo Drew presented the Education Committee activity report. The Rap Session, held at Pasquale's Restaurant, Royal Oak, was extremely successful. There were 32 attendees and feedback was excellent. Mary Jo gave credit to the whole committee for their efforts with special recognition to Colleen Olsen. Peggy Stoe presented the Spring Workshop update. The meeting will be two days at Michigan State University. The committee is working diligently to reduce budgeted expenses by about \$1000. The faculty dinner will be dropped. It is also planned to reduce the program to one day in 2002. Dr. Drew also presented the SBB review program, 6-7 April, St Joseph Mercy Hospital, Ann Arbor. There is a problem with one speaker which was discussed in order to find a replacement. Mary Jo and Sharron Zimmerman presented the Cyberconference information. The program will be broadcast through the REMEC system again, hosting through University of Michigan and Grand Rapids. The conference is scheduled for 23 October. Topics are transfusing platelets across ABO, BPDR, universal LR and a serology topic to be determined. There was additional discussion about outstate staffing for problems.

**Annual Meeting:** Annual Meeting 2001 plans were discussed by Linda Cardine. The meeting dates are 12 and 13 September 2001 (Wednesday and Thursday).

The meeting will be held at the Doubletree Hotel across the street from the 2000 site. Linda presented the Meeting and Rap Session agendas. There was extended discussion about providing halfday options for attendance and different fees for partial day attendance. The Board agreed to consider halfday options for the first day of the meeting. The Course Description and Objectives, required for accreditation and to get a speaker from the FDA, were discussed and modified. Sponsored speakers: Marilyn Moulds (Kay Beattie, MCBC), Dr. Klein (ARC), Dr. Petrides (ARC), FDA. Michelle Tuson presented the contract. Rooms are \$129 per night. We will provide the audiovisual equipment. The hotel will provide gift baskets, gratis, to out-of-state speakers.

**Budget:** The final budget for 2001 was presented by Sharon Cisco. Dues for individual members have been raised to \$30. Physician dues have been increased to \$60. Corporate membership has been increased to \$450. Expenses have been adjusted based on postal rate increases and increased costs due to inflation. The proposed budget is attached.

**Membership Committee:** Linda Cardine presented the membership brochures which are to be distributed person-to-person and as a mailer to members who have not renewed. The design was selected to appeal to younger technologists. Motion to spend \$175 for two-color printing was accepted.

**Newsletter Committee:** Margaret Wilde was appointed to contact the Newsletter Committee.

**Bylaws, Archiving and Nomination Committees:** No reports.

**Old Business:** None.

**New Business:** Peggy Stoe brought up problems with the website for discussion. After discussion, Peggy was tasked with facilitating upgrading the website.

Sharon Cisco presented the AABB request for Outstanding Achievement nominees. The Board decided to nominate the MABB for an Organizational Achievement Award.

**Adjournment:** The meeting was adjourned at 1705 by Sharon Cisco. The next meeting will be 13 June 2001 at the ARC NTL.

Respectfully submitted,  
A. Bradley Eisenbrey, MD, PhD

**MICHIGAN ASSOCIATION OF BLOOD BANKS**  
P.O. Box 3605 • Center Line, MI 48015-0605



## Calendar of Events

**May 9, 2001** **AABB Audioconference "AABB Assessment Series: Quality Systems Essentials-Equipment and Supplier Issues, Facilities and Safety".** Contact AABB Education Department, (301)215-6482; email [education@aabb.org](mailto:education@aabb.org).

**May 23, 2001** **AABB Audioconference "Problem Solving in the Blood Bank (It is not Anti-K)."** Contact AABB Education Department, (301) 215-6482; email [education@aabb.org](mailto:education@aabb.org)

**May 10-11, 2001** **Spring Workshop 2001**  
"Blazing a New Frontier ~  
Blood Banking in the 21st Century"  
Michigan State University

**Sept 12-13, 2001** **MABB Forty-Seventh Annual Meeting**  
Doubletree Hotel • Romulus, MI

**ASCP Teleconference calendar: For registration information, go to: [www.ascp.org/programs/teleconferences](http://www.ascp.org/programs/teleconferences)**

**May 24, 2001** **Ask the Experts in Blood Banking and Transfusion Medicine**

**June 6, 2001** **Blood Component Therapy- Practical Issues**

