NEWEST FIRST

Jodell Hill: Thank you for this necessary discussion. This will help me better present the possibilities and help us make a better decision.

Jane Tansiongco: Great presentation Dr. Kahn. If our clinicians decide that their critically-ill patient is a candidate for glucose meter using venous or arterial samples only, is that acceptable?

Peggy Mann: You bet.

Stephen Kahn: Thanks, Peggy and to all of you for your comments and questions. It's great to have colleagues who are in the 'hot water' together.

Stephen Kahn: Replying to Kim's comment, the impact on more line draws on patient care and our CLABSI rates is paramount in all of our priorities. There's no easy solution.

Peggy Mann: We all can appreciate 'good timing'! We all suffer enough from 'bad timing', don't we! Thank you so much for taking the time to explain so effectively this subject, Dr. Kahn.

susan salerno: Appropriate education sorely needed for nursing through nursing conferences and journals. Continue to get major push back as changes affect nursing staffing and workflow.

Stephen Kahn: There's no doubt that was part of it. But that decision by our parent system also came within weeks of the March '15 CMS second letter. That made our long term plans pretty clear. As my talk covered, we just had to do a lot of work in meeting and communicating with key stakeholders to keep everyone in the loop.

Kimberly Skala: I can see that it might help with a subset of patients but with central line infection rates being scrutinized this may not be a robust solution. No lack of stress and challenges in hospitals for sure!

Peggy Mann: Favorably because you needed to review/renew a glucose meter contract?

Stephen Kahn: I should add that the timing of a lot of issues fell somewhat favorably for us although we've all had a lot of stress and challenges over all the issues.

Stephen Kahn: Yes, when we were in the time after the first CMS directive and before the March 15 follow-up from CMS, we discussed blood gas analyzer and other moderately complex options for some of our ICU's.

Peggy Mann: Thanks Mary

Mary Snyder: All RN's can perform capillary testing except on the critically ill patients. It then becomes the BSRN's that meet the 24 Science Credits required.

Peggy Mann: Dr. Kahn, has your POC team set up any type of 'monitoring fingersticks' as Lou Ann was asking about?

Kimberly Skala: Dr. Kahn-wonderful presentation with practical advice. Have you discussed the use of blood gas analyzers for glucose testing at all?

Peggy Mann: Mary, do you mean RNs with bachelors?

Lori Williams: Lou Ann, FS monitoring has been tough, left to the unit managers. I do not have any good data for compliance.

Danyel Tacker: Yeah, our group quickly had to suppress location-specific classification because patients may be in the ICU but stable and relatively close to discharge. There were some salient discussions about status by physiology rather than geography.

Mary Snyder: Our hospital had the Nursing Administration and Critical Care provider chose to limit the use of meters to RN's and define the criteria.

Lou Ann Wyer: I have to jump off as your moderator. Feel free to continue to chat with Dr Kahn.

Stephen Kahn: Again, I can only paraphrase the laws, but it doesn't define critically ill. It says patients needing critical care are usually, but not always, in ICU's. We all know that as well. So confining this to ICU patients only wouldn't work for us. That is why we

Nicolle Ellious: We simply use the intended use, limitations of the meter criteria, and interferences as the definition of critically ill. These patients should have a lab draw for appropriate glucose.

Shana Nowelani Gaug: Aloha Dr. Kahn, what is the definition the state of Illinois came with?

Stephen Kahn: We have the same challenges to some extent. But we've really worked hard to keep meeting with different stakeholders. In just the past month, we had consensus on a proposed set of clinical criteria from our ICU medical directors, IP glycemic mgt team and others on what issues will mitigate use of capillary fingerstick specimens with our next meter going live in June.

Lou Ann Wyer: Lori--do you monitor for compliance on fingerstick usage?

Susan O'Mara: We use defined limitations by the manufacturer.

Lori Williams: Based on nursing definition of their most critical patients, we defined critically ill as those patients in ICU requiring a 1 to 1 nursing ratio. We also intensified finger stick education on when not to use a finger for glucose.

Peggy Mann: Dr. Kahn: in all your years of Clin Lab Directing, is the 'glucose meter controversy' one that caused the most consternation to 'deal with' in terms of med staff at your institution? If not, what in the world was? (!)

Marissa Chupp: We are struggling with how the staff performing POC glucose will determine if the patient is a candidate for a finger stick. We have RN's and CNA's performing tests.

Lou Ann Wyer: Please note that CLSI POCT 17 is a free download.

Danyel Tacker: We even had nursing, critical care representation, ED, and other representatives at multiple meetings. Once we made the importance of this topic clear, the team worked for months, hit the wall, and we've been "hovering" ever since. We had a TJC inspection for POCT last fall and got a "bye" but again...not satisfying/reassuring.

Andrea King: We had physician participation in defining but still have resistance with complying.

Lou Ann Wyer: Dr. Kahn- do you hear the same challenges as noted by Danyel and Connie? How do we handle those situations and get to some consensus to move ahead?

Stephen Kahn: Besides CLSI's POCT 06 and the white paper, POCT 17-ED1, there are a few other related CLSI documents. But these two have been most helpful to our group.

Danyel Tacker: Yes, one definition to rule them all seemed to be our sticking point as well.

Stephen Kahn: POCT 06 has a wealth of information on different sample types on glucose measurements,

Lou Ann Wyer: With the concern of whether whole blood glucose can be measured as “plasma-equivalent glucose,” do you know of other references or resources on specimen types besides the paper by Dr. Lyon that you discussed?

Connie Cable: we have tried coming up with a definition but are unable to get the physicians and medical directors to agree. Cardiologists want certain criteria, Internal med. wants a little different.

Danyel Tacker: Yes, we reached out to the CMO and some other high-ranking physicians, but on the floors the proposal was shot down. So the lab said, "OK, well...we warned you, and the print has been in the SOP and training materials all along." But that's not very satisfying.

Stephen Kahn: Hi Lou Ann

Lou Ann Wyer: thanks for a great presentation, Dr. Kahn! We have some good questions already.

Peggy Mann: Dr. Tacker, did you have participation with MDs when you needed it for a task force or whoever you convened med staff?

Danyel Tacker: We proposed the definition relying on hemodynamic criteria, as Dr. Kahn showed...but it was rejected by the council. How do you convince physicians that this could be a really sticky situation without "getting hit" first?...

Lou Ann Wyer: Maybe we can start with a question for everyone here in the chat room with us today? Tell us "How is your facility handling the issue of blood glucose meter testing in a “critically ill” patient population?"

Lou Ann Wyer: Thank you for making your way to the Networking Lounge for our Q&A. I will be moderating this session with you and with Dr. Stephen Kahn. I suspect that many of you are looking for ways to address your near-patient blood glucose meter services. We will start shortly.