

Laboratory Regulations Update

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Objectives

- Describe the use of glucose meters in critically ill patients
- Identify changes to CLIA Interpretive Guidelines for Individualized Quality Control Plans (IQCP)
- Review the top AACC government affairs committee priorities for Capitol Hill Visits this year

POCT Glucose

A glucose test is not necessarily a
glucose test

This fact has been known
for many years

Glucose Testing Methods

- Core Laboratory – glucose hexokinase
- POCT – glucose oxidase, glucose dehydrogenase
- Critical Care – glucose oxidase

- Method differences
- Calibration differences
- Whole blood to plasma considerations

Blood Glucose Meter Precision

- 95% of results fall within $\pm 2SD$
- Core Lab
 - 93.7 \pm 0.9 mg/dL (1.0% CV)
 - 282.7 \pm 1.9 mg/dL (0.7% CV)
- POCT
 - 49.0 \pm 9.2 mg/dL (18.6% CV)
 - 283.0 \pm 15.0 mg/dL (5.3% CV)
- Clinically the ADA has recommended glucose meters to have CV's of <5% at all levels and accuracy to within 5% of a lab result. (1987)

Blood Glucose Meter

- 95% of results within $\pm 20\%$ if >100 mg/dL
- 95% of results within ± 20 mg/dL if <100 mg/dL
- Most recent evaluation by FDA on patient samples:

	<100 mg/dL		>100 mg/dL	
	<20 mg/dL	>20 mg/dL	$<20\%$	$>20\%$
Meter A	0%	22%	0%	24%
Meter B	0%	14%	0%	0%
Meter C	2%	6%	0%	0%
Meter D	4%	10%	4%	0%

- Currently marketed glucose meters fail to meet consensus criteria in the hypoglycemic range.

Chen ET, Nichols JH, Duh SH, Hortin G. Performance evaluation of blood glucose monitoring devices. *Diabetes Technol Ther* 2003;5:749-68.

Glucose Meter Potential Interferences

- Environmental
 - Air, exposure of strips
 - Altitude
 - Humidity
 - Temperature
- Operational
 - Hemolysis
 - Anticoagulants
 - Generic test strips
 - Amniotic fluid/Animal
 - Arterial and catheter
 - Volume of sample
 - Reuse of strips
- Physiologic
 - Hematocrit (neonates)
 - Prandial state
 - Hyperlipidemia
 - Oxygenation
 - pH
- Drugs
 - Maltose
 - Acetaminophen
 - Ascorbate
 - Mannitol
 - Dopamine

Table 1—Confounding variables in glucose measurement

Variable	Methodology affected*	
	GO	GD
Hematocrit		
Anemia	↑	↑
Polycythemia	↓	↓
Oxygen concentration		
Hypoxia	↑	—
Oxygen therapy	↓	—
pH (6.8–7.55)	—	—
Low pH	—/↓	—
High pH	—/↑	—
Hypothermia	↑	↓/↑
Hypotension	↑	↑/↓
Drugs		
Ascorbic acid	↓	↑/—
Acetaminophen	↓	↑
Dopamine	—	↓
Icodextrin	—	↑
Mannitol	↑	—

*Change relative to venous plasma measured at central laboratory. GO, glucose oxidase.

Glucose Measurement: Confounding Issues in Setting Targets for Inpatient Management

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source of the sample, and specimen matrix (i.e., plasma versus whole blood). This article will review assay principles

DIABETES CARE, VOLUME 30, NUMBER 2, FEBRUARY 2007

The Hospital Issue

- The critical nature of hospitalized patients presents extreme conditions to bedside glucose meters in terms of PO2 and hematocrit, and increasing the potential for interferences from drugs and hospital therapies like intralipid nutrition. Because of these circumstances, the same meters utilized for home self-testing do not always perform well when applied to hospitalized patients.

Table 1. COMPARISON OF HOME AND HOSPITAL POINT-OF-CARE GLUCOSE TESTING

Home POCT Glucose	Hospital POCT Glucose
Single operator	Multiple operators
Single meter	Multiple meters
Serial monitoring on one meter	Single samples on multiple meters
Ambulant patient	Bedridden patient
Relatively healthy patient	Acute and chronic illnesses
Capillary samples only	Noncapillary samples possible

Clarke W, Nichols JH. Bedside Glucose Testing : Applications in the Home and Hospital. *Clinics in Laboratory Medicine: Point-of-Care Testing*. Lewandrowski K editor. June 2001.

Glucose Meters

- FDA clears glucose meters for the following intended uses:
 - For quantitative measurement of glucose in whole blood (e.g., capillary, venous, arterial)
 - For use by healthcare professionals or lay users
 - A few are cleared for use on neonates

For the following indications:

- As aid in monitoring the effectiveness of diabetes control program
- Not intended for the diagnosis of or screening for diabetes

Other ways they are also used (off-label):

- Glycemic control protocols in hospitals (diabetics and non-diabetics)
- Critically ill patients
- Anything they are needed for in the hospital



Glucose Meters

- Manufacturers submit the meters to FDA with home use claims even when they intend to sell them as hospital use meters
- They submit validation data suitable for home use capillary self testing, and minimal validation in arterial and venous blood (if claimed)
- This submission strategy allows the hospital meters to be waived (due to OTC status) without the need for CLIA waiver studies



Glucose Meters

- In recent years concerns have been raised citing the inability of currently cleared glucose meters, if not adequately validated and controlled by the hospital, to perform effectively in critical care settings, given that these devices were not originally designed or evaluated for this type of use.
- Patients in critical care settings can be more acutely ill and medically fragile, and are more likely to present physiological, pathological and pre-analytical factors that could interfere with glucose measurements as compared to other types of users.
- For critically ill patients who by their very nature tend to be more seriously ill, any inaccuracies in the meters could further increase the risk to these patients.

Glucose Meters

- For many years, FDA has requested that all labeling for glucose meters include a statement in their device labeling indicating that the system is not intended to be used in the critically ill patient population.
- FDA requested this statement because the device has not been designed for use in, or studied in this population.
- By including the statement in the Limitation section, FDA hoped to clarify that use in the critically ill population is an off label use and hospitals need to validate that use and place appropriate controls to assure the accurate and appropriate use of the device.

Off Label Use

- Hospitals are recently becoming more aware of these limitation statements
- FDA has been receiving more questions about these limitations, including whether use of meters in the ICU would be off label use
- Because off-label use would void the waived status, facilities would technically need CLIA high complexity certification to use these meters:
 - In critically ill patients
 - In people without diabetes
 - Health fairs and screening the general public for diabetes
- **Challenge** – abrupt disruption of glucose meter use in hospital settings may adversely affect patient safety

Blood Glucose Monitoring Test Systems for Prescription Point-of- Care Use

Draft Guidance for Industry and Food and Drug Administration Staff

DRAFT GUIDANCE

**This guidance document is being distributed for comment purposes only.
Document issued on: January 7, 2014**

You should submit comments and suggestions regarding this draft document within 90 days of publication in the *Federal Register* of the notice announcing the availability of the draft guidance. Submit written comments to the Division of Dockets Management (HFA-305), Food and Drug Administration, 5630 Fishers Lane, rm. 1061, Rockville, MD 20852. Submit electronic comments to <http://www.regulations.gov>. Identify all comments with the docket number listed in the notice of availability that publishes in the *Federal Register*.

For questions regarding this document, contact Patricia Bernhardt at patricia.bernhardt@fda.hhs.gov, or at 301-796-6136.

Nirav R. Shah, M.D., M.P.H.
Commissioner

Sue Kelly
Executive Deputy Commissioner

January 13, 2014

Re: Off-label Use of Glucose Meters

Dear Laboratory Director:

As laboratory director, you are jointly and severally responsible with the owner for the maintenance and operation of the clinical laboratory (Article 5, Title V of New York State Public Health Law). This includes testing that is performed at the point-of-care (POCT) or as part of a health fair or other community screening event.

The US Food and Drug Administration (FDA) is responsible for approving medical devices, including glucose meters, based upon the performance characteristics established by the manufacturers (validation data) and submitted by the manufacturers to the FDA.



Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 15-11-CLIA

DATE: November 21, 2014

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Directions on the Off-Label/Modified Use of Waived Blood Glucose Monitoring Systems (BGMS)

Memorandum Summary

- **“Off-Label Use” of BGMS:** Using a test outside of its Food and Drug Administration (FDA)-approved/-cleared intended use, limitations or precautions, as indicated in the manufacturer’s instructions, is considered “off-label use.” “Off-label use” applies whether the test is waived or non-waived and it means that the test is considered modified and therefore defaults to a high-complexity test under the Clinical Laboratory Improvement Amendments (CLIA) regulations. This will require all laboratories using the device for an “off label use” to meet all applicable CLIA high-complexity requirements.
- **Surveyors Will Document Off-Label Use:** If any non-compliance is identified, a written statement of deficiencies (Form CMS-2567) will be issued and followed up using standard operating procedures and timeframes found in the applicable regulations and guidance documents.

Laboratory Test Limitations

- Lab tests are not fool-proof!
- There is no “perfect” device, otherwise we would all be using it!
- Any device can and will fail under the right conditions
- Those conditions are listed in the limitations section of the package insert, policy and training materials

ACCU-CHEK® Inform II

Test Strips and 1 Code Key

PROFESSIONAL USE

Cat. No. 05942861001

Limitations

- The ACCU-CHEK Inform II test strips are for testing fresh capillary, venous, arterial, or neonatal whole blood. Cord blood samples cannot be used.
- Hematocrit should be between 10–65 %.
- Lipemic samples (triglycerides) in excess of 1800 mg/dL may produce elevated results.
- Blood concentrations of galactose >15 mg/dL will cause overestimation of blood glucose results.
- Intravenous administration of ascorbic acid which results in blood concentrations of ascorbic acid >3 mg/dL will cause overestimation of blood glucose results.
- If peripheral circulation is impaired, collection of capillary blood from the approved sample sites is not advised as the results might not be a true reflection of the physiological blood glucose level. This may apply in the following circumstances: severe dehydration as a result of diabetic ketoacidosis or due to hyperglycemic hyperosmolar non-ketotic syndrome, hypotension, shock, decompensated heart failure NYHA Class IV, or peripheral arterial occlusive disease.
- This system has been tested at altitudes up to 10,000 feet.

Current Vanderbilt Glucose Procedure

12.0 PROCEDURE LIMITATIONS

12.1 Patient hematocrit should be between 10–65 %. Samples outside this hematocrit range will yield inaccurate results.

12.2 Lipemic samples (triglycerides) in excess of 1800 mg/dL may produce elevated results.

12.3 Blood concentrations of galactose >15 mg/dL will cause overestimation of blood glucose results.

12.4 Intravenous administration of ascorbic acid which results in blood concentrations of ascorbic acid >3 mg/dL will cause inaccurate glucose results.

12.5 If peripheral circulation is impaired, collection of capillary blood from the approved sample sites is not advised as the results might not be a true reflection of the physiological blood glucose level. This may apply in the following circumstances: severe dehydration as a result of diabetic ketoacidosis or due to hyperglycemic hyperosmolar non-ketotic syndrome, hypotension, shock, decompensated heart failure NYHA Class IV, or peripheral arterial occlusive disease.

12.6 This system has been tested at altitudes up to 10,000 feet.

12.7 Refer to Accu-Chek Inform II strip package insert for complete listing of limitations and interfering substances

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- This system has been tested at altitudes up to 10,000 feet.
- The performance of this system has not been evaluated in the critically ill.

This limitation is new
as of December 2012
for all glucose meters!



Definition of Critically Ill

- No universal definition of critically ill exists
- Critical illness is any disease process which causes physiological instability leading to disability or death within minutes or hours.(1)
- All inpatients, by virtue of their hospitalization, may be considered “critically ill”. So, critically ill patients are not just those patients in the ICU
 - Consider the OR, ED, Trauma, Sepsis, and others
- CMS and FDA indicate that the definition of what constitutes “critically ill” must be defined by each institution.

The BGMS that have been cleared by the FDA as waived for home use were originally designed as consumer devices, intended for use in monitoring glucose levels in an individual patient diagnosed with diabetes. However, over time, the use of BGMS has expanded to include use in healthcare facilities and, in turn, use in patient populations that the manufacturer's studies and performance standards, which were used to evaluate these BGMS for home use, did not address.

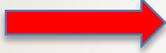
Manufacturers' Instructions

The CLIA-certified laboratories must read and follow all of the manufacturer's instructions for waived test systems, including BGMS. This includes any instructions that the manufacturer may include regarding the system's intended use, limitations and precautions. Note that manufacturers' instructions vary in format, and some information may be found in different sections. Moreover, manufacturers' instructions may be updated or changed, and instructions

This means that, when the manufacturer's instructions contain limitations indicating that the BGMS has not been evaluated or cleared for use in critically ill patients, the use of BGMS on critically ill patients will be considered "off-label" use, and, for purposes of the CLIA regulations, will automatically default to high-complexity testing. Facilities may continue to use their waived BGMS on patients as long as they are following the manufacturer's instructions.

Revised Vanderbilt Glucose Procedure

12.0 PROCEDURE LIMITATIONS

- 
- 12.1 The manufacturer, Roche Diagnostics, has indicated that the performance of the Inform II meter has not been evaluated in critically ill patients. For the purpose of point-of-care glucose testing, Vanderbilt has defined and interprets this “critically ill” testing limitation such that use of the Inform II meter is prohibited for testing in patients with any of the following conditions:
- 12.1.1. Hematocrits less than 10% or greater than 65%.
 - 12.1.2. Triglyceride levels greater than 1800 mg/dL.
 - 12.1.3. Blood concentrations of galactose >15 mg/dL.
 - 12.1.4. Intravenous administration of ascorbic acid resulting in blood concentrations of ascorbic acid >3 mg/dL.
 - 12.1.5. Use of capillary blood collected by fingerstick in patients with peripheral circulation impairment to include severe dehydration resulting from diabetic ketoacidosis, hyperglycemic hyperosmolar non-ketotic syndrome, hypotension, shock, decompensated heart failure NYHA Class IV, or peripheral arterial occlusive disease.
 - 12.1.6. Cord blood samples
- 
- Do not use the ACCU-CHEK Inform II for testing patients exhibiting any of these conditions. Instead, collect venous or arterial blood and send to the clinical laboratory for testing with STAT orders as indicated
- 12.2 This system has been tested at altitudes up to 10,000 feet.
- 12.3 Refer to Accu-Chek Inform II strip package insert for complete listing of limitations and interfering substances

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850



Center for Clinical Standards and Quality/Survey & Certification Group

DATE: March 13, 2015 **Ref: Temporary Withdrawal-S&C: 15-11-CLIA and Reissuance as Draft, with Draft Clarifications**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Reissuance of S&C 15-11 As DRAFT ONLY – FOR COMMENT
Off-Label/Modified Use of Waived Blood Glucose Monitoring Systems (BGMS)

We are temporarily withdrawing S&C Memorandum 15-11, which was previously issued on November 21, 2014, and reissuing it in draft-only form in order to:

- Obtain more feedback regarding the use of waived BGMS, the environments in which BGMS are currently used, and any issues that hospitals and other providers have identified with such use;
- Promote added education regarding the current CLIA requirements.

Use of Glucose Meters for Critically Ill Patients

This white paper includes an overview of glucose meter limitations with practical advice for use of glucose meters in critically ill patients



CLINICAL AND
LABORATORY
STANDARDS
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Options to Address CMS Changes

- Proposed Policy Change
 - Least disruptive
 - No change in practice, staff already trained and doing this
 - Meets letter of the regulatory change by defining what “critically ill” means for this device – the pkg insert limitations – so not testing under “off-label” uses
- Change to a meter cleared for “critically ill” use
 - Caution, no meter is cleared for use of capillary samples in critically ill patients!
- Stop using glucose meters for “critically ill” patients – use an “alternative” method
 - Require more costly Blood Gas testing
 - Core lab testing with delays in results that could impact care
- Use glucose meters “off-label”
 - CLIA high-complexity testing with required validation in critically ill patients
 - Consequences for staff educational background, licensure (med director), and ongoing documentation.

What is Risk?



CLSI Document EP23

- *Laboratory Quality Control Based on Risk Management; Approved Guideline (EP23-A™)*
- James H. Nichols, PhD, DABCC, FACB, Chairholder of the document development committee
- EP23 describes good laboratory practice for developing a QCP based on the manufacturer's risk mitigation information, applicable regulatory and accreditation requirements, and the individual health care and laboratory setting.

Industrial Risk Management

- Manufacturers consider potential for errors and address how these hazards are mitigated or reduced in FDA submissions based on “use-case scenarios”
- Use-case scenarios describe real-world examples of how one or more people interact with a device
- For example:
 - A POCT device may be taken to the patient’s bedside, or
 - A sample may be collected and transported to a device
- These two scenarios have different workflows and present different opportunities for error or risks!

IQCP History

- CLIA 88 requires 2 levels of QC each day of testing!
- Newer lab devices offer internal and engineered control processes that make daily liquid QC duplicative and redundant.
- IQCP allows laboratories to develop a plan that optimizes the use of engineered, internal control processes on a device and balances the performance of external liquid QC without impacting safety!
- CLSI EP23 introduces industrial and ISO risk management principles to the clinical laboratory
- CMS adopted key risk management concepts to develop the IQCP option for quality control
- IQCP replaces 2003 EQC options currently in place.

New IQCP

- Two levels of liquid QC required each day of testing

OR

- Laboratory develops an IQCP:
 - Balance internal control processes with external controls
 - Reduce frequency of liquid QC to minimum recommended by manufacturer
 - Maximize clinical outcome, available staff resources and cost effectiveness in the lab

Individualized Quality Control Plan



Risk in the Laboratory

- There is no “perfect” laboratory device, otherwise we would all be using it!
- Any device can and will fail under the right conditions
- A discussion of risk must start with what can go wrong with a test (errors or nonconformities)
- Lab tests are not fool-proof!

Where is the Risk in the Process?



What Could Possibly Go Wrong?

Falsely Decreased Glucose Results

- Complaint from an ICU of sporadic falsely decreased glucose results
- Immediate repeat test on same meter, gave significantly higher “clinically sensible” values
- Inspection of unit found nurses taking procedural shortcuts to save time
- Bottles of test strips dumped on counter in spare utility room
- Some strips not making it into trash, falling back on counter and being “REUSED”

Risk of Error from Open Reagents

- Glucose test strips exposed to air for as little as 2 hours have been shown to cause -26% bias.¹
- Strips left on counters pose risk of reuse, leading to falsely low results.
- Some meters catch reuse and “error” preventing a result. Other meters do not!²



1. Keffer P, Kampa IS. *Diabetes* 1998; 47; abs 0170.
2. Silverman BC, Humbertson SK, Stem JE, Nichols JH. Operational errors cause inaccurate glucose results. *Diabetes Care* 2000;23:429-30.

What Have We Learned From Our IQCPs?

order - written LA

Sample - verbal - Signed As procedure
 Unselect DEFAULT Panel (what's ordered) → Audit documentation
 green top tubes → score CAT (icing comment if not) → Training/comp
 all others hep syringes → check balanced hep syringes
 phlebotomy - Blood Gas Samples → Allen's test documented Reli-serv → Train/comp
 puncture → Flush lines - Contamination? → After Analysis result -
 venous in ED → central venous lines - (mixed w/arterial) → Not verified
 lines → flushed? → go back to nurse verify source re collection

verify source prior to analysis

mixing - Train/comp - Results? (No Delta Crit Care/CL)

Clots - Train/comp } iQM

Bubbles - Train/comp } iQM

Drugs - Train/comp } iQM

Patient ID - Name on Sample = req Train/comp
 use label at bedside - not on GEM
 label sample
 preprint/labels at bed → matching req → match order → Print barcode → barcode → Scan Analysis

Analysis → **DELAY** - Backup plan in use
 Re-analysis of sample w/ cap off -
 Cartridge - iQM - QC
 Calibration - CUP - refrig / 8 mar RT logs
 Temp Ship → ✓ CUP in logs
 on-instrument → iQM disables test - aspirates sample
 expiration → iQM
 volume of sample → short sample - iQM
 Power Failure → on UPS - deactivates cartridge @ 20 mins
 Inject mystery fluid - cell saver - Train/comp
 operator lock - out - Train/comp
 trouble shooting - manual elec iQM

Post → **Results** - interface
 Need to accept result → down → resubmit after reconnects
 Print/Call

PVP/6 mo linearity - Train/comp
 PT correlations

QCP
 MAN Recount
 - PCS - B - 30 mins / room
 A - 4 hrs
 D - 12 hrs
 C - 24 hrs
 - CVP - on new cartridge → man set
 Train/comp - Temp monitoring Ref/AT
 orders - deleted tests
 Tube Types / icing comments
 Sample Source Procedure
 PT ID
 Sample Collection - Allen's
 Mixing
 INTERFERENCES - Bubbles
 Clots
 Drugs
 Delay - Reanalysis sample
 Sample Application
 Mystery Fluids
 Operation/Troubleshooting
 Calling - cartridge replace
 RVP / 6 mo cal / lin check
 Access to GEM web
 PT - mode, Technique
 Disinfection

QA
 - Error Flags
 QC
 Sample
 bill ← iQM - cartridges
 Test # replace
 Corrective Action Report
 Short samples
 critical samples
 Service Calls
 PT
 Validations
 PT correlations

Reference Ranges - Alert System
 Critical Results - night person

What Have We Learned From Our IQCPs?

- Processes on different units were not uniform
 - Some units complained that they couldn't print a barcode for blood gas specimens until after sample collected. (because order hadn't been communicated to lab and blood gas system) staff created workarounds, skipped steps, labeling sample at analyzer rather than at bedside
 - In reality, workflow issue that simply required some retraining. Staff print order entry barcode, then match to order/requisition at bedside, collect and label at bedside, scan at analyzer
 - Simplified uniform process hospital-wide, safer for pts

What Have We Learned From Our IQCPs?

- Devices not setup uniformly
 - IQCP development revealed that operator lockout used for most devices
 - One model of POCT coag device was not setup with operator lockout – compliance concern, anyone can test!
 - Corrected problem
- Harmonized use of lockout across devices.
Discrepancy was discovered by multidisciplinary meetings and communication about practices!

What Have We Learned From Our IQCPs?

- Device/reagent shipments check-ins are inconsistent
 - New cartridge shipments = analyze 2 levels QC each site
 - New lot of cartridge = 2 levels QC on all i-stats
 - QC each i-stat monthly, 2 levels of QC on all i-stats
 - 6 mo cal verification = 3 levels x 3 (triplicate) x each i-stat
 - 6 mo correlation = 10 patients per i-stat
- We QC the i-stats, but chemistry is in the cartridge not the analyzer! Each site receiving different lots of cartridges at different times and not performing QC across all lots each month!

What Have We Learned From Our IQCPs?

- Revised based on IQCP
 - Low, normal, high QC are same vials as in linearity set, so analyzing 3 levels QC is same as a 3 level linearity check!
 - Reduce replicates and emphasize on cartridge lots
 - Consolidate shipments (ie life-flight 7 locations), central shipment, validation then distribute cartridges to sites
 - Each shipment, 3 levels of QC
 - New lots, 3 levels of QC, 5 pts old lot to new lot, 1 i-stat
 - Monthly 3 levels of QC each cartridge type, 1 i-stat at each site documents cartridge viability at site storage and satisfies 6 month linearity (already done each month)

What Have We Learned From Our IQCPs?

- Before: (QC the device)

– Shipments =	10 shipments/yr x 2 QC x 7 sites =	140 tests
– Lot validations =	5 x/yr x 2 levels x 8 meters =	80 tests
– QC monthly =	2 QC x 8 i-stats x 12 mos =	192 tests
– 6 mo cal-ver =	8 i-stats x 3 levels x 3 reps x 2x/yr =	144 tests
– 6 mo correlations =	10 patients x 8 i-stats x 2x/yr =	<u>160 tests</u>
	TOTAL =	716 tests

- After: (QC the reagent)

– Shipments =	4 shipments/yr x 3 QC x 1 site =	12 tests
– Lot validations =	QC shipment, max 4x/yr x 5 pts x 2(old/new)	40 tests
– QC monthly =	3 QC x 7 sites x 12 mos =	252 tests
– If additional lot:	3 QC x 7 sites x 4 mos	84 tests
– 6 mo cal ver and pt correl already done monthly QC/lot val =	<u>0 tests</u>	
	TOTAL =	304/(388) tests

What Have We Learned From Our IQCPs?

- i-Stat IQCP now controlling the reagent not the device
- Improved quality - Operators now perform all the required testing – before the POCT staff would analyze linearities and perform 6 mo comparisons!
- Enhanced efficiency – fewer cartridges required for non-patient testing, saves cost and resources
- Better quality assurance of cartridges – QC each lot of cartridges monthly (the i-stat has internal checks)!

Benefits of Developing an IQCP

- Promotes multidisciplinary communication and collaboration
- Identifies weaknesses in the testing process
- Uncovers discrepancies between sites, allowing for harmonization of workflow and operations
- Establishes rationale for actions – why we do specific activities – like QC and what hazards are addressed
- Improves efficiency and saves costs

AACC Government Affairs Committee Capital Hill Visits

- The value of laboratory testing
 - Role in patient care
 - Who are laboratory specialists?
- Test harmonization
- 21st Century Cures – LDT position statement
- Newborn screening and children's health



AACC Capital Hill Briefing 10/14/2015

- Precision Medicine vs Personalized Medicine
- Direct to Consumer Testing
- Test Harmonization



Summary

- Many hot topics in lab regulations are current concern
- Glucose meters in critically ill patients. Use glucose meters within the package insert limitations, otherwise must perform studies to prove validity and reliability of results in those patients (off-label use)
- Developing an IQCP provides many benefits!
- I want to thank and acknowledge Courtney Lias and Alberto Guitierrez (FDA) and Karen Dyer (CMS) for borrowing several slides