

P.O.L.

Insight

A Continuing
Education
Publication for the
Physician Office
Laboratory

In This Issue:

- *Venipuncture:
Pediatric
Phlebotomy*
- *Ergonomics &
Aging*
- *PT Referral*
- *PT Evaluations*

2008-B

Issue 52

Accreditation Statements

AAFP Physician's Proficiency Testing Program has been reviewed and is acceptable for up to 12 Prescribed credits by the American Academy of Family Physicians. AAFP accreditation begins 3/3/08. Term of approval covers three events offered within one year from this date with option for yearly renewal.

The American Academy of Family Physicians is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

The American Academy of Family Physicians designates this educational activity for a maximum of 12 *AMA PRA Category 1 Credit(s)*[™]. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Credit may be claimed for one year from the date of this event.

AAFP-PT is approved as a Provider of continuing education programs in the clinical laboratory sciences by the ASCLS P.A.C.E.[®] Program. AAFP-PT is also an approved provider for California clinical laboratory licensees under the P.A.C.E.[®] Program. The level of instruction for this event is basic. This event is worth 4 P.A.C.E.[®] Contact Hours.

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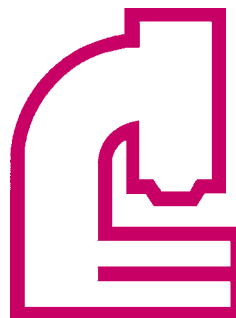


Table Of Contents

- Fear & Loathing in the Pediatric Phlebotomy Chair 4
- Ergonomics & the Aging Workforce 7
- Interpreting Your AAFP-PT Evaluation 10
- PT Referral: Are You Sending Out to Trouble?? 12
- CME Questions 14-16
- CME Test Sheet 17

2008-B CME Answers

1.	A	13.	B	25.	A
2.	B	14.	A	26.	B
3.	B	15.	B	27.	A
4.	B	16.	B	28.	D
5.	B	17.	A	29.	A
6.	A	18.	A	30.	B
7.	C	19.	A	31.	C
8.	A	20.	D	32.	B
9.	A	21.	B		
10.	D	22.	B		
11.	D	23.	A		
12.	A	24.	D		

To earn the CME, answer the questions included with this issue of the *Insight*, using the form included, or submit the test online at www.aafp.org/pt – click on Continuing Medical Education.

CME Learning Objectives

Following completion of the self-instructional material, the participant will be able to:

1. Employ strategies to reduce anxiety in pediatric patients; discuss the efficacy of topical anesthetics for venipuncture pain reduction; and describe the effect of parental positioning on the perception of pain during pediatric venipuncture.
2. Recite the 20-20-20 Rule; list 3 ways to diffuse light sources; describe the proper position of a computer monitor screen; list the 3 B's to lower stress; and identify the most common body part cited for missed work days.
3. Identify key parts of the AAFP-PT Evaluation.
4. Recognize an improper PT referral; describe consequences of referring PT samples: and discuss methods for avoiding PT referrals.

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P.A.C.E.[®] Due Dates and Course Codes

Event 2007-C	September 30, 2008	254-003-07
Event 2008-A	February 27, 2009	254-001-08
Event 2008-B	May 31, 2009	254-002-08

Fear and Loathing in the Pediatric Phlebotomy Chair

By Dennis J. Ernst MT(ASCP),
Director, Center for Phlebotomy
Education

Everyone likes to be remembered for something. But when it comes to drawing blood from children, it's better to be forgotten. Researchers say that up to 20 percent of the population is predisposed to needle phobia; all they need is a triggering event... like a venipuncture that goes badly. So how do we become forgotten? We strive to reduce pain and anxiety in our younger patients. Fortunately, researchers have uncovered a multitude of strategies and remedies to help us.

Positioning and distraction

One study measured the effectiveness of parental positioning on the child's level of fear. The authors concluded that children who were seated on a parent's lap and were distracted showed less fear than the children who were not.⁽¹⁾ Researchers also found that forcing a child to lay flat during a venipuncture procedure was likely to result in crying, panic, and struggling whereas positioning the child in a secure parental hug with close physical contact did not.

The "cough trick"

Researchers in Germany showed that when adult patients were told to cough at the time the needle is inserted, they rated their level of pain as significantly lower than when the cough was not induced.⁽²⁾ The authors speculate this mechanism works by the activation of pain-inhibitory pathways due to increased pressure in the subarachnoid space during the cough. Will this technique work as well on children as it did on the adults in the study? It's intriguing enough to require further study.

Situational and individual factors

Researchers in England found significant reductions in pain and fear when psychological intervention strategies were used during venipuncture procedures.⁽³⁾ Such interventions include;

- Articulating the actual steps of the procedure to both child and parent(s) prior to performing the venipuncture;
- Explaining what the child might feel, sense, smell, see, and hear;
- Recognizing that the mere application of topical anesthetics can serve as early warning of an imminent venipuncture, and generate anxiety;
- Parental involvement including support and distraction;
- Engineering the event to be a collaboration between phlebotomist and child rather than for the child to simply be subjected to the procedure.
- Not placing the pediatric outpatient in the drawing area for a prolonged time prior to the procedure, which exposes the child to procedural cues that remind him/her of the imminent event.

Though not specified in the study, the use of smaller 23-gauge needles instead of 21-gauge can also reduce the discomfort pediatric patients feel. Because nearly everyone experiences their first venipuncture as children, that first experience becomes their perception of what every subsequent phlebotomy will be like. Smaller needles can minimize the pain in a way that psychological intervention cannot.



Topical anesthetics

Although adults typically tolerate venipunctures without agony, pediatric patients require an extra measure of patience, compassion and strategies to reduce the pain of the procedure, or at least the perception of pain. Are topical ointments and treatments effective in reducing venipuncture pain? Can they be a substitute for good technique and an empathetic approach? Studies show they might... and they might not.

One of the most widely prescribed pharmaceutical interventions to the pain of venipuncture is a mixture of lidocaine and prilocaine, often marketed under the brand name EMLA® (AstraZeneca Pharmaceuticals). Many studies have found EMLA to be effective.^(4,5,6,7) However, it requires at least an hour of application prior to the procedure, affecting the convenience of outpatient applications. Researches in Wales, UK found 4% amethocaine to act faster and be more effective than EMLA in minimizing venipuncture pain in pediatric patients between 1 and 15 years old.^(8,9)

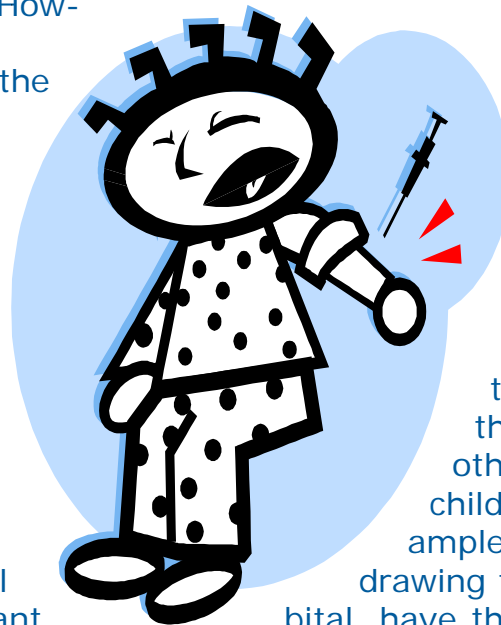
The *British Journal of Anesthesia* reported a successful reduction in pain during infant heelsticks using a tetracaine patch.⁽¹⁰⁾ Ninety-three percent presented little or no pain as opposed to 35 percent who had the placebo placed.

Researchers evaluating a low-tech solution to pain reduction measured the effect of applying ice to the intended puncture site 10 minutes prior to puncture.⁽¹¹⁾ The authors found no significant effect. A three-fold reduction in pain was observed when Lidocaine iontophoresis (LI) was

used (i.e., the delivery of the anesthetic without needles into the tissue with a low-level electric current).⁽¹²⁾

Best practices and specimen quality

Whether the solution is psychological, pharmacological, or as simple as a well-timed cough, best practices suggests minimizing the trauma of the procedure and maximizing the quality of the specimen. Preserving specimen integrity is particularly challenging when the child is anxious or combative. Having a parent or assistant stabilize the patient's arm is essential to all pediatric venipunctures. One should never assume the child who presents as calm and accepting will remain so once the needle is inserted. Being prepared for sudden movements by



immobilizing the arm at the wrist and beneath the elbow helps assure the needle will remain in place throughout the duration of the draw. If the parent is cooperative, position the child on his/her lap and instruct the parent to wrap one arm around the child's torso, impeding movement of the free arm. The parent's other arm can support the child's elbow or wrist. For example, if the phlebotomist will be drawing from the child's right antecubital, have the parent wrap his/her left arm around the child's chest, restricting movement of the patient's left arm. The parent's left hand can be positioned to provide support beneath the child's right elbow. The parent's right hand can secure the child's right wrist. Alternatively, an assistant can secure the right wrist while the parent secures the left arm and right elbow.

Despite proper positioning, an unexpected struggle can lead to an insufficient vol-



ume of blood for testing, underfilled tubes, and compromised specimens. When underfilled, the ratio of blood to additive within the tube decreases, resulting in an excessive concentration of additive. This is not a problem when the additive is a clot activator, but if heparin, sodium citrate, or EDTA is in excess, the impact on the test result can be significant.

Tube manufacturers add a carefully calibrated amount of additive to each tube so that when they are completely filled, they preserve and prepare the specimen for testing without altering the test result. Underfilling tinkers with this delicate chemistry. Best practices instruct us to fill all tubes to their stated volumes. There's no guarantee accurate results can be obtained from underfilled tubes.

Collectors who anticipate lesser volumes can prevent the inaccurate results that short samples risk by stocking their trays with a wide variety of tube sizes, including lower-volume pediatric tubes. Instead of having only 4 mL tubes within reach, have 1.8 mL tubes available just in case. Should the child lose composure before the draw is complete and a syringe is in use, the collector can distribute the lower-than-expected volume of blood into smaller tubes, filling them completely. Should a tube holder be in use during a draw that is prematurely interrupted, the time saved in using smaller tubes can be the difference between a successful collection and the need for a repeat puncture.

There are a multitude of other variables and techniques that can improve the quality of the pediatric specimen and minimize the trauma of the procedure on both ends of the needle. Those who draw from this precious patient population know full well the chaos that can result. When collectors approach pediatric patients with compas-

sion, empathy, skillful technique, and a wide variety of supplies, the experience can be uneventful. In fact, if you master pediatric phlebotomy, what you are likely to be remembered for is being forgotten.

Adapted by the author from a series of articles that originally appeared in Phlebotomy Today (www.phlebotomy.com)

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Ergonomics and the Aging Workforce

By Terry Jo Gile, MA Ed. MT(ASCP),
"The Safety Lady"[®]
www.safetylady.com

As the Baby Boomers reach retirement, many are opting to remain on the job. Some want to retain their health benefits beyond Medicare. Some have not saved for retirement and need the money. Some are just lonely with their family scattered and want to stay connected to their extended "family". Regardless of the reason, having an ergonomic plan in place is very important especially to the aging workforce. The issue becomes an even greater concern when injuries beget injuries. For example, if a 60 year old with degenerative arthritis in the knee bumps it or twists it at work it becomes more painful and the employee may need a knee replacement. Determining eligibility for workers' compensation will be an issue.

According to the Bureau of Labor Statistics, the back is the most frequently cited part of the body requiring days away from work. Preventing back injuries that may cause herniated discs is a priority for employers faced with rising workers' compensation costs and reduced productivity.

In some environments, employees perform their duties while seated 50%–75% of the time. Task chairs that have a minimum of four-way (and preferably six-way) adjustability are best. The back of chair should be able to move to 110 degrees. In a slightly reclined position, the chair starts to work for the body, reducing seated muscle activity and disc pressure in the lumbar region.

The top of the monitor screen should be at eye level and directly in front of you with the distance from your eyes and the screen between 18 and 26 inches. Screens that swivel horizontally and tilt or elevate vertically are ideal because they

allow the monitor to move into a comfortable viewing angle and avoid glare. This is helpful for employees who wear bifocals.

According to Jeffrey Anshel, Optometrist and author of *Visual Ergonomics in the Workplace*, a too-close monitor can contribute to night-time blindness, a condition that makes focusing at regular or faraway distances difficult after a long day of up-close reading. As scary as that sounds, it is very easy to prevent. Here is what you can do:

- Lower your computer's monitor and tilt the screen upward. It is easier for your eyes to read at a lower height because it allows a more natural focus.
- Practice the 20/20/20 rule. Every 20 minutes, take a 20 second break to focus on a spot 20 feet away. You'll give your eyes a break and allow them to readjust to a distance beyond your screen.
- Follow the three B's to lower your stress levels
 - Take frequent **B**reaks
 - Concentrate on **B**linking to moisturize your eyes
 - Remember to **B**reathe

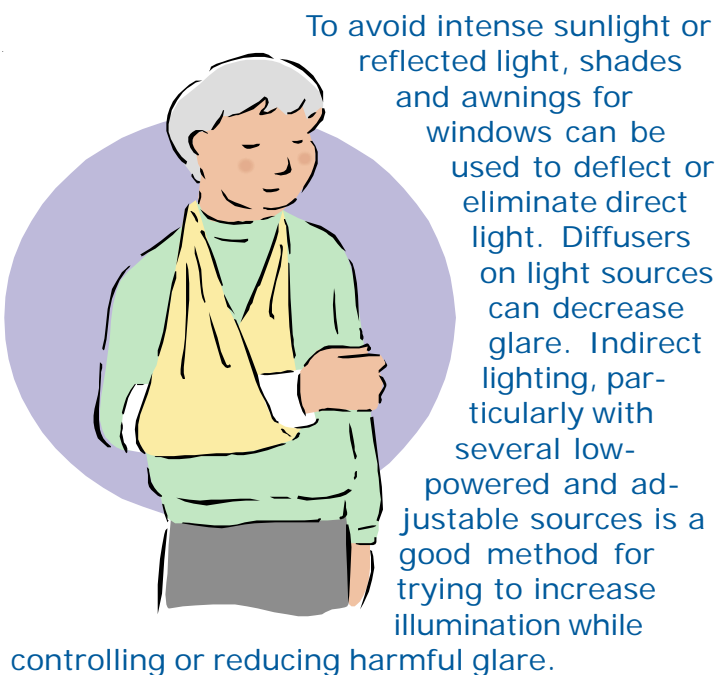
Computer Vision Syndrome (CVS) is the result of spending a large amount of time working at a computer terminal. Some common symptoms may include eyestrain, blurred vision, dry irritated eyes, double vision, and headaches. Visual symptoms may occur due to prescription eyewear that is not designed for computer use. Computer glasses can make a world of difference in comfort level while using a computer. They can correct blurred vision and relieve symptoms, such as eyestrain and burning. Most people wear glasses or contact lenses that do not correct the intermediate zone at all. Reading glasses correct near vision only,



and bifocals correct only near and far vision. Even lenses that do correct the intermediate zone, such as trifocals and progressive lenses, have only a small portion for the intermediate area, not nearly large enough for comfortable computer work. Users without appropriate eyeglasses may try to compensate for blurred vision by leaning forward, or by tipping their heads back to look through the bottom portion of their glasses. Both of these actions can result in sore necks, shoulders, or backs. Encourage employees to visit eye care professionals regularly, and inform them of computer-related work. Utilize desktop software applications that enlarge the contents on the screen, making it easier to read and reducing eyestrain.

As employees age, proper lighting becomes important. Ambient or daylight can be used when it is available. Task lighting should be no more than 3 times brighter than ambient light. Flat screens are helpful or you can turn off overhead lights or take out some of the fluorescent bulbs to reduce light. In a 4 bulb light fixture remove the middle two, if possible.

Employers should be aware that poor eyesight can cause slips, trips and falls, which often result in fractures and lengthy time off the job for older workers. Keep walkways free of debris and install nonslip flooring.



Frequent breaks and changes of position may help avoid repetitive motion problems such as carpal tunnel syndrome (CTS). Instead of a 15 minute break every four hours try a 5 minute mini-break every hour to allow stretching of the muscles. CTS is one of the most common job-related injuries, and if not properly treated, can cause irreversible nerve damage and permanent disability of varying degrees especially in phlebotomists and transcriptionists. If your practice has a laboratory, repetitive motion injuries can also occur during routine procedures such as pipetting, working at microscopes, operating microtomes, and using cell counters.

Physician offices rarely operate 24 hours a day, however, physicians see patients who do work on off shifts and they need to ask the appropriate questions to discern if the symptoms are related to an ergonomic illness. According to a 2004 study by Circadian Technologies in Stoneham, MA, employees on the night shift have an increased risk of cardiovascular disease, gastrointestinal disorders, obesity, diabetes and sleep apnea. They are also prone to increased absenteeism, turnover, on-the-job injuries such as needlesticks and technical errors. In a 2006 study published by the American College of Occupational and Environmental Medicine (ACOEM), 38% of employees experience low levels of energy, poor sleep or a feeling of fatigue. The study says that fatigue was more common in women than men, in workers over the age of 50, and in jobs with decision making responsibility. Employees with fatigue averaged 5.6 lost hours per week. The National Institute of Occupational Safety and Health (NIOSH) suggests 20 minutes of aerobic exercise before work can help employees wake up, feel energized and keep the heart in shape.

Here are some additional tips for keeping older employees safe on the job:

- Use caution when placing older workers in jobs requiring operation of equipment with which they are not familiar. If this cannot be avoided, proper training is a must and give them extra time to adjust to the change.



- Redesign jobs to eliminate physically challenging tasks. Use good planning, material handling aids and automation to eliminate manual lifting.
 - Avoid making older employees perform strenuous work in hot/humid or cold environments. As we age the skin becomes thin and less resilient and susceptible to bruising.
 - Organize the work station to avoid lifting or reaching above shoulder level.
 - Minimize equipment and background noise. What you might consider as music may be very distracting for an older worker.
 - Provide color contrast in stairs and other changes in elevation. This will draw attention to the change and make the surface easier to identify. Use primary colors and not pastels that are hard for older employees to see.
- Encourage employees to get exercise. Employers can counter the effects of aging by implementing wellness programs. Employees can improve their health by engaging in as little as 30 minutes of moderate activity each day.
- Finally, talk to your mature staff and get their feedback. Ask them what can be done to make their job more comfortable. Often they will have a simple and easy to adapt solution that will help others in your practice.



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■ Interpreting your AAFP-PT Evaluation

Participating in proficiency testing involves much more than just adding some extra tests to your workload a few times each year. The process begins when you receive your test kit and perform the tests, followed by recording your results and submitting them to your PT provider. However, the PT cycle isn't complete until you've received your evaluation, reviewed the results and, if necessary, implemented a corrective action plan.

According to CLIA'88 regulations, laboratories are required to review and evaluate proficiency testing performance. This review (and documentation of that review) is part of the duties required of the Laboratory Director. Although most reviewer's eyes naturally go first to the Pass/Fail column, your evaluation also gives you valuable statistical information, the acceptable range or response(s), and the opportunity to compare your performance with other labs using the same or similar methods or instruments. The evaluation also includes the CMS Performance Summary for regulated analytes, including a cumulative report of performance for the most recent three testing events.

You can view and obtain a copy of your AAFP-PT Evaluation at your convenience by logging in to PT Central and selecting "Reports" on your home page. This option to view on-line is available to ALL participants, including those who submit results via fax.

For more information about how the evaluations are prepared, definitions of commonly used PT grading terms, and suggestions for reviewing your evaluation, see pages 8-10 of the AAFP-PT Handbook. For tips on investigating PT failure, refer to pages 10-11 and the Corrective Action Checklist on pages 24-25 of the Handbook.

Your AAFP-PT Evaluation report has a new look! The following is a brief description of the key components.

- 1 **Participant Demographic Information** — Name, location, contact information, AAFP ID#, CLIA #, and COLA # (if applicable)
- 2 **PT-Central Login Information** — Web address to enter PT Central, laboratory login name and password.
- 3 **Regulatory Agencies** — agencies or persons designated to receive your PT results.
- 4 **Modules/Specimens List** — a listing of all modules and specimens received for this event.
- 5 **Analyte Results** — Results for specific analytes and instruments.
- 6 **Laboratory Results & Grade** — Submitted results and Pass or Fail grade.
- 7 **Analyte Statistics** — Acceptable ranges, standard deviation, coefficient of variation
- 8 **Comparison Group** — Identifies the comparison group for grading.
- 9 **CMS Score** — Percentage of passing grades for regulated analytes to be reported to CMS and included in the CMS Performance Summary report.



Your AAFP-PT Evaluation

1

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Proficiency Testing Evaluation

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 Attention: Debbie

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 OC-1, RS-(1-5), UA-1, UDS-1, UM-1, VAD-(1-2), VP-(1-5), WPT-1

Test/Your Method(s)	Spec	Your Result	Target Mean	Group SD	Your SDI	Acceptable Range	Group*	Comments
Module: 614, Auto Diff II								
Subspecialty: Hematology								
CMS Analyte Score: 100%								
White Blood Cell Count in 10 ⁹ /L								
Abbott Cell-Dyn 1800 1								
HD-1	3.5	3.6	0.40	-0.25	3.1 - 4.1	SG	Pass	
HD-2	19.0	18.7	1.23	0.24	15.9 - 21.5	SG	Pass	
HD-3	22.6	22.0	1.92	0.31	18.7 - 25.3	SG	Pass	
HD-4	7.7	7.9	0.90	-0.22	6.7 - 9.1	SG	Pass	
HD-5	4.4	4.3	0.59	0.17	3.7 - 4.9	SG	Pass	

Test/Your Method(s)	Spec	Your Result	Target Mean	Group SD	Your SDI	Acceptable Range	Group*	Comments
Module: 614, Auto Diff II								
Subspecialty: Hematology								
CMS Analyte Score: 100%								
Lymphocyte in percent								
Abbott Cell-Dyn 1800 1								
HD-1	29.30	32.17	1.787	-1.61	26.81 - 37.53	SG	Pass	
HD-2	39.40	42.02	2.949	-0.89	33.17 - 50.87	SG	Pass	
HD-3	39.80	41.84	2.785	-0.70	33.48 - 50.20	SG	Pass	
HD-4	29.40	32.07	2.969	-0.90	23.16 - 40.98	SG	Pass	
HD-5	31.70	34.18	2.463	-1.01	26.79 - 41.57	SG	Pass	

Test/Your Method(s)	Spec	Your Result	Target Mean	Group SD	Your SDI	Acceptable Range	Group*	Comments
Module: 614, Auto Diff II								
Subspecialty: Hematology								
CMS Analyte Score: 100%								
Granulocyte in percent								
Abbott Cell-Dyn 1800 1								
HD-1	62.8	60.4	1.92	1.25	54.6 - 66.2	SG	Pass	
HD-2	52.3	51.2	1.53	0.72	46.6 - 55.8	SG	Pass	
HD-3	52.3	51.3	1.31	0.76	47.4 - 55.2	SG	Pass	
HD-4	61.6	60.4	2.72	0.44	52.2 - 68.6	SG	Pass	
HD-5	57.7	57.1	1.97	0.30	51.2 - 63.0	SG	Pass	

Test/Your Method(s)	Spec	Your Result	Target Mean	Group SD	Your SDI	Acceptable Range	Group*	Comments
Module: 614, Auto Diff II								
Subspecialty: Hematology								
CMS Analyte Score: 100%								
Red Blood Cell Count in 10 ¹² /L								
Abbott Cell-Dyn 1800 1								
HD-1	2.80	2.82	0.227	-0.09	2.65 - 2.99	SG	Pass	

Print Date: 5/29/2008
 * PG - Peer Group MG - Method Group SG - Special Group AG - All Method Group GO - Gross Outlier
 Part No.: PTER Page: 1 of 11

3

4

5

6

9

2

7

8



■ PT Referrals: Are You Sending Out to Trouble??

Proficiency testing is a form of external quality control for your laboratory. It is designed to provide a snapshot of your overall testing performance. Therefore, it is not surprising that the CLIA'88 regulations specify that testing must be done in a manner that mimics a patient sample and that the testing must actually be performed by the laboratory that is submitting the results. That seems quite straightforward and unlikely to cause difficulty for compliant labs.

However, what happens when the normal process for handling a patient specimen involves sending the sample to a reference or off-site laboratory for confirmatory or follow-up testing? This very common practice is perfectly acceptable for patient samples, but doing the same thing with a PT sample can land you in deep trouble with regulators. The authorities are often notified of possible violations by reference laboratories, who are legally required to report receiving a PT sample for testing. Laboratory inspectors are well-aware of when PT testing events are occurring and are trained to check samples logs at both the referring and receiving facilities looking for suspicious samples or fake patients.

Referring a PT sample for testing can trigger serious consequences, including loss of laboratory license, immediate loss of ability to receive Medicare/Medicaid reimbursement, and loss of the Director's ability of own or operate a laboratory for up to two years. This part of the law has no "wiggle room". There is no distinction made between *inadvertent* and *intentional* referrals. It applies to both *regulated* and *non-regulated* analytes. Although several lawsuits have challenged the enforcement of this rule, the courts have sided with CMS in every case to date.

Unfortunately, even the most careful lab can easily run afoul of the law. Here are a few situations to watch out for:

- Your lab only reports colony counts and routinely sends out any growth >100,000 CFU/ml to a reference lab for identification and antimicrobial susceptibility testing. Before leaving on maternity leave, your long-time lab tech thoroughly instructs her replacement on this protocol. During her absence, a PT event arrives. The temp carefully follows the standard procedure and sends the PT sample out for "ID and sensitivity".
- Your large group practice has a second office across town. Your hematology instrument is down today for unexpected maintenance. The analyzer in the other office is working fine, so it is decided to send all samples there. Your PT results are due today, so the PT samples are included in the batch travelling to the other facility.
- In a small town, two physicians' offices share the part-time services of a single laboratorian. In the morning, he works for Dr. A and performs the PT testing. In the afternoon, working for Dr. B, he also tests their PT. Dr. B's analyzer has been acting up and the results don't look very good.
- Recognizing that he's working with the same sample, the employee opts to report the better results from Dr. A's office for both labs.
- A poorly performing employee is being terminated. Before leaving, the disgruntled worker places a fake note in the PT folder indicating that the neighborhood hospital lab was



consulted and PT results compared before being reported. (True story!)

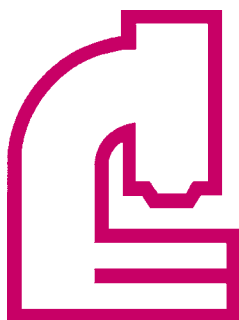
All of the above would constitute violations under CLIA. Other examples include running the same sample multiple times or having several employees run the sample and discussing or comparing results.

These practices are only permissible if it is also standard (i.e., documented) procedure for handling patient samples.

If any of the scenarios above sound like they could occur in your office, how can you protect yourself?

- Most PT referrals are the result of “well-intentioned misunderstandings”. Employee education is your best defense against this type of error. Procedures for handling PT samples should be part of all new-employee training and a written policy against referring PT samples should be placed in your Standard Operating Procedures. The policy should be reviewed and signed by employees annually.

All PT programs provide a “Specimen referred” or “Test not performed” reporting option. Use these codes to indicate that a sample would normally be sent out for further testing, and then stop short of actually sending the sample.



- To avoid the “accidental” referral, consider color coding or otherwise differentiating PT samples. Scheduling supervisory personnel to be on hand during a PT event can also help catch a PT sample before it is inadvertently bundled into a reference lab courier box.
- Handle PT samples with the same confidentiality as a patient sample. This means not discussing results with co-workers or over after-hours drinks with your buddy who happens to work in another lab. Avoid using PT samples for employee training or competency testing until the results have been submitted and graded.
- If your laboratory uses the services of an outside consultant, be aware that allowing the consultant to perform your PT testing or submit your results may also constitute a violation, if the consultant has access to results of multiple laboratories.

The CLIA regulations are the law and it will require an act of Congress to change them. This is not likely in the foreseeable future. CMS is committed to enforcing this component of the rules, and has issued additional guidance to their inspectors regarding this topic. Judy Yost, Director of CMS Laboratory Services, recently commented that a “plethora of cases” have already been discovered. Make sure that your laboratory isn’t one of them.

REFERENCES

www.cms.hhs.gov/CLIA/downloads/Dear%20Colleaguefinal.pdf

Lusky, K., *PT Referral raising red flags with CMS*. CAP TODAY. Vol 22, no. 3, March 2008.

2008-A CME Questions

The material necessary to review to answer the following questions may be found in this issue of the *P.O.L. Insight* and the *AAFP-PT Handbook* or on the AAFP-PT website (<http://www.aafp.org/pt> and click on Continuing Medical Education). The Test Sheet may be found on page 16 of the *P.O.L. Insight*. The Accreditation information may be found on the inside cover of this issue.

1. True or False: a child held by the parent and distracted is less likely to cry during venipuncture.
 - A. True
 - B. False
2. What percentage of the population is reported to be needle-phobic?:
 - A. 5%
 - B. 20%
 - C. 50%
 - D. 90%
3. True or False: Asking a child to lie flat during venipuncture is the preferred position.
 - A. True
 - B. False
4. True or False: The topical anesthetic, EMLA, is convenient for in-office use due to its rapid effectiveness.
 - A. True
 - B. False
5. The "cough trick" is a technique for:
 - A. using magic to distract the patient
 - B. inducing a cough to decrease venipuncture pain
 - C. improving visualization of veins
 - D. none of the above
6. True or False: The mechanism for the effectiveness of the cough trick is thought to be due to activation of pain-inhibition pathways.
 - A. True
 - B. False
7. The preferred needle size for pediatric phlebotomy is:
 - A. 15 gauge
 - B. 21 gauge
 - C. 23 gauge
 - D. 50 gauge
8. True or False: An anxious or combative child may result in compromised specimen quality.
 - A. True
 - B. False
9. True or False: Immobilizing the child's arm is essential to successful pediatric venipuncture.
 - A. True
 - B. False
10. Strategies for reducing pediatric venipuncture pain include:
 - A. explaining the process to the child
 - B. involving the parents
 - C. avoiding a prolonged wait in the drawing area
 - D. all the above

11. Effective topical pain-reducing methods include:
 - A. 4% amethocaine
 - B. ice packs
 - C. lidocaine iontophoresis
 - D. A & C only
12. True or False: A tetracaine patch has been shown to be effective in reducing the pain of infant heel sticks.
 - A. True
 - B. False
13. True or False: Short-filling a 4 mL tube is acceptable if insufficient volume of sample is obtained.
 - A. True
 - B. False
14. True or False: Small volumes should always be available when pediatric phlebotomy is performed.
 - A. True
 - B. False
15. Which part of the body is most commonly cited as a cause of missed work?
 - A. Head
 - B. Back
 - C. Feet
 - D. Legs
16. Task chairs should be able to recline to _____ degrees?
 - A. 90
 - B. 110
 - C. 120
 - D. 180
17. True or False: Task chairs should have a minimum of four-way adjustability.
 - A. True
 - B. False
18. The top of the computer monitor should be:
 - A. at eye level
 - B. slightly above eye level.
 - C. slightly below eye level.
 - D. several inches below eye level.
19. True or False: Working in a slightly reclined position reduces seated muscle activity and lumbar disk pressure.
 - A. True
 - B. False
20. To reduce stress:
 - A. take frequent breaks
 - B. blink to moisturize eyes
 - C. breathe
 - D. all of the above
21. True or False: The distance between the eyes and the computer monitor screen should be between 20-24 inches.
 - A. True
 - B. False



22. Task lighting should be no more than ____ times more bright than ambient light.
 - A. 2
 - B. 3
 - C. 4
 - D. 10
23. True or False: A too-close computer monitor can contribute to night blindness.
 - A. True
 - B. False
24. Symptoms of Computer Vision Syndrome include:
 - A. blurred vision.
 - B. headaches.
 - C. dry eyes.
 - D. All of the above
25. True or False: The 20/20/20 Rule calls for a 20 second break every 20 minutes to focus on an object 20 feet away.
 - A. True
 - B. False
26. True or False: Bifocals include a correction in the intermediate range to allow for computer use.
 - A. True
 - B. False
27. True or False: Carpal tunnel syndrome is one of the most common causes of work-related injury.
 - A. True
 - B. False
28. Reducing glare can be accomplished by using:
 - A. shades or awnings.
 - B. diffusers.
 - C. indirect lighting.
 - D. all of the above
29. True or False: Employees in the night shift are prone to ergonomic illness related to sleep disturbances.
 - A. True
 - B. False
30. True or False: The CMS Performance includes all the tests reported by the laboratory for all analytes.
 - A. True
 - B. False
31. Review of the PT Evaluation is the responsibility of :
 - A. the testing personnel.
 - B. the technical supervisor.
 - C. the Laboratory Director.
 - D. no one, it's not necessary to review results.
32. Referring a PT sample for outside testing is punishable by:
 - A. a fine.
 - B. loss of CLIA license.
 - C. a warning.
 - D. imprisonment



AAFP-PT CME Test Answer Sheet

ALL INFORMATION MUST BE COMPLETED TO OBTAIN CREDIT

2008-B (submit by May 31, 2009 to obtain credit)

Fill in the circles for the correct answers:

Please print:

Individual AAFP #: _____

(All participants in the AAFP-PT are now assigned a 7-digit AAFP number; AAFP-member physicians should use their AAFP-ID number; non-member physicians and laboratory personnel are assigned an ID number the first time CME is submitted)

Lab AAFP #: _____

(All labs enrolled in AAFP-PT are assigned a 7-digit AAFP number. The Lab ID number may be found on the Order Confirmation and on evaluations.)

Name (Last) (First) (Initial)

Street

City / State/ Zip Code

Fax Number

- Address or Fax change Name change

Select one if you are a physician:

FP IM
 PED OB/GYN
 Other

Select one if you are laboratory personnel:

MT MLT Nurse Practitioner
 RN LPN Physician Assistant
 Med. Assist. Laboratory Manager
 Laboratory Consultant Other

	A	B	C	D
1.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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6.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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11.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
25.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
26.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
27.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
28.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
29.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
30.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
31.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
32.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Evaluation: please fill in bubble between 1 & 5 – 1 denotes poor, 5 denotes excellent:

1. To what extent were the objectives achieved?
poor ① ② ③ ④ ⑤ *excellent*
2. To what extent did the AAFP-PT education program *content* relate to the program's objectives?
poor ① ② ③ ④ ⑤ *excellent*
3. Rate your overall degree of satisfaction with this education program.
poor ① ② ③ ④ ⑤ *excellent*
4. In what general area of laboratory practice would you like to receive educational materials? (please mark all that apply).
 - CLIA and/or regulatory. requirements
 - Good laboratory practices
 - Test Procedures
 - Technical Subjects
 - Business/Financial Aspects
 - Other, please specify _____



Return to: AAFP-PT Education Program
 11400 Tomahawk Creek Parkway
 Leawood, KS 66211-2672
 or Fax to 913-906-6079

Important: *Keep a copy of the completed form for your records. Documentation of CME hours earned is mailed to lab personnel in July and January. Allow 7-10 business days for requested transcripts.*