Drug Diversion Webinar, Nov. 10, 2016
Q&A

What do you consider ' significant loss' that should be reported to DEA? A single dose with no trend noted would not be reported? ***In my previous practice, anything larger than two dosage units would be reported on the DEA form 106. If you are noting a trend of single doses missing this should trigger a more robust investigation, possibly in coordination with local law enforcement. Once there is identification of theft, the amount should be quantified and reported immediately. If theft is not able to be proven but the trended amount meets your self-determined "significance" threshold, you should report on the DEA form 106 of the significant loss and steps being taken to prevent future loss.***

Do you find real time EMR to ADC comparison versus retrospective review more effective? ***In our experience there is not one best method but rather a combination of approaches. Just like running an anomalous usage report should not be the only tool in your tool kit. Real-time review can be a good tool in cases where you want to closely monitor an individual's activity. This approach may be too myopic to monitor the entire organization. Retrospective review is often helpful to identify trends and paint a clearer picture.***

Will the audio be available for us to get other interested parties (couldn't attend today) engaged? ***The slide presentation will be made available on our website as well as the audio recording. An email will be sent to registered individuals when they are made available. Others may register after the webinar to access content.***

Drug screening is costly. Is there a method to recognize potential drug users outside of drug screening? And are there certain departments that are more likely to divert than others? ***Aside from drug screening, a robust staff education program regarding drug diversion as well as recognition of signs and symptoms of impairment are critical aspects to a comprehensive program. When it comes to drug diversion anyone can be involved, it comes down to access and opportunity. Anesthesia, Emergency Medicine, and Psychiatry providers have been cited in several sources as having the highest rates of addiction followed by nursing and pharmacy.***

The opportunity to perform random drug screens are impacted by some state regulations. ***When implementing your drug diversion program it is very important to include all stakeholders and understand relevant laws and statutes.***

Would you consider blind count mandatory in all areas? ***Yes, we firmly believe blind counts should be standard of practice in all locations. Pharmacy can assist end users by making sure automated cabinet pockets limit the number of dosage units needing to be counted for ease of the end user.***

Do health systems/hospitals conduct drug testing upon hire -- ours currently does not and I am curious if many others do? Just for staff who are considered 'high risk' and have access to controlled substances? ***In our experience, most hospitals do conduct drug screening as part of the initial employment process. We have found that random drug screening is not standard of practice and in fact very few hospitals have implemented this type of program. We are in support of random drug screening with risk stratification based upon level of access and frequency.***

Can you also dive into reporting diversion cases, especially with police reports? Most cases only involve a very small amount of drug loss in dollar amount that is not sufficient to be considered as petty theft. ***We suggest meeting with local law enforcement to be integrated into your drug diversion program. Even though most cases involve minimal dollar amounts, theft of***

controlled substances in most jurisdictions is a felony. You may be able to work with law enforcement to hold off the conviction in lieu of successfully completing treatment.

I work in the public sector and having a hard time creating a drug diversion response team. Many perceive that it is not necessary in "our" world. I'm trying to introduce the culture change through baby steps. What would you suggest I begin with? Drug diversion is a problem in every organization. ***We suggest calling a meeting of stakeholders to review and discuss the numerous case examples of significant events around the country involving DEA actions as well as patient harm. The DEA has become increasingly active, even in the VA hospitals (note Fort Wayne VA investigation). Education of stakeholders is the key first step followed by a thorough evaluation of your internal gaps and risk points.***

Any data to support standard deviation thresholds as predictor of diversion discovery? ***Very little is published on this topic. As noted in our presentation, like in treating a patient, don't just treat the numbers. We will also refer you to our article "Drug Diversion: What's Behind the Numbers" where we discuss the need to understand fully how analytic software gathers data and how the "numbers" are reported. We also recommend only using the standard deviations as a guide post. In our prior practice, approximately 60-70% of individuals outside of 2 standard deviations repeated on subsequent reporting periods.***

How do you monitor when certain users are routinely above the standard deviations based on patient's they care for? (Ortho post op) ***For individuals who fall outside the normal standard deviations your next step may be reviewing the transactional detail. For example, select a few patients and review the amount of drug given by the implicated nurse versus the others caring for the same patient. Does it look similar? Also compare withdraws versus administration and waste documentation for any gaps. You may also consider looking at withdrawals of other medications which may mask activity such as diphenhydramine and acetaminophen. These drugs may be given to the patient in lieu of the controlled substance they were supposed to receive.***

If you limit access to the narcotics storage area, how is a 24/7 department able to be efficient during times of sick calls and vacations on the off hours? ***Every department must determine what is appropriate access. The scenario posed is not an exception. If you have to loosen access then make sure you have more robust checks and balances as well as camera surveillance.***

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Do you have any recommendation for automated auditing process? (eg. marrying Pyxis® data to EHR documentation) ***Some hospitals have developed their own programs and spreadsheets to "marry" automated cabinet activity with EHR documentation. We are aware of an analytic software vendor who has developed the ability to combine this data as well as other external data sources. HelioMetrics has created Rx Drug Diversion Analytics™ which we feel is the next generation of analytic software.***

Every quarter we would review usage of controlled substances on each nursing unit and remove stock if not used/or not normally used. If a patient had a specific need and they went home, we would pull the drug also after they went home. ***Visante agrees with this approach to reduce access for medications and thus reducing opportunity.***

Do you have any suggestions of specific strategies to prevent diversion from continuous infusions that are already running, other than lock boxes or in addition to them? Continuous infusions present a challenge. Even though the IV bag itself may be locked, the IV line is still accessible. ***Staff education and awareness is key to identifying things out of the norm. For example, the IV***

room making continuous infusions ahead of predicted need. IV lines which leak or are dripping being noticed by the bedside nurse. These can be symptoms of drug being diverted.

We have experienced a great deal of push back from anesthesia regarding a 30 second auto-log out. They are saying it inhibits patient care. Thoughts? ***Communication and conversation with anesthesia providers is key in this situation. Work closely with your anesthesia champion to determine what is appropriate and co-manage the situation with providers. Also be cognizant of any relevant state rules and regulations (note: Ohio).***

Who should lead the investigation of a diversion? The controlled substance prevention officer? HR? Security? ***In our experience, Pharmacy usually takes the lead role with a Nursing colleague. That said, other organizations have Security or Compliance take a lead role. There isn't necessarily a right or wrong answer. We feel the key is making sure each team member knows their role and the sequence of investigation.***

What is the best way to deal with incomplete documentation of a narcotic to the patient? Counsel staff or investigate since outside of policy? ***Make documentation expectations clear by policy, then hold staff accountable in the same manner used for other policy deviations. If there is a trend you may wish to collaborate with pharmacy to investigate for other signs of potential diversion.***

Any suggestions about improving STDEV for full time/part time employees? The part time can look normal but works half as much. Have folks tagged the user name F for float, P for part time? ***We previously mentioned HelioMetrics analytic software which is able to integrate time and attendance records for this very purpose. Whomever is running and reviewing the proactive diversion reports needs to have a keen understanding of the areas being monitored as well as routine communication with area managers to understand these staffing situations.***

What recommendations do you have for testing waste. ***The first thing is to make sure that end users are aware you are testing for waste. A simple Brix refractometer can be used for analyzing most waste, except fentanyl. A more definitive approach is available through several vendors which perform essentially a mass spectroscopy analysis (more expensive). Some organizations have adopted periodic or "for-cause" analysis through an outside lab (most expensive).***

Would like to hear about ADC<-->EMR automatic review for diversion review (i.e. undocumented dispenses) ***Some hospitals have developed their own programs and spreadsheets to "marry" automated cabinet activity with EHR documentation. We are aware of an analytic software vendor who has developed the ability to combine this data as well as other external data sources. HelioMetrics has created Rx Drug Diversion Analytics™, which we feel is the next generation of analytic software.***

Interested to learn how Visante can help your organization? To schedule a call with Greg Burger or Maureen Burger, please contact Alana Columbo at acolumbo@visanteinc.com or call 703-625-6281.