2023 HEALTHTRUST UNIVERSITY CONFERENCE

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Deconstructing Diversion Investigations in the Ambulatory Surgical Center (ASC): Case Examples From Discovery to Final Reporting

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Meet the Presenters

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Disclosures

- The presenters have no real or perceived conflicts of interest related to this presentation

Note: This program may contain the mention of suppliers, brands, products, services or drugs presented in a case study or comparative format using evidence-based research. Such examples are intended for educational and informational purposes and should not be perceived as an endorsement of any particular supplier, brand, product, service or drug.

Learning Objectives

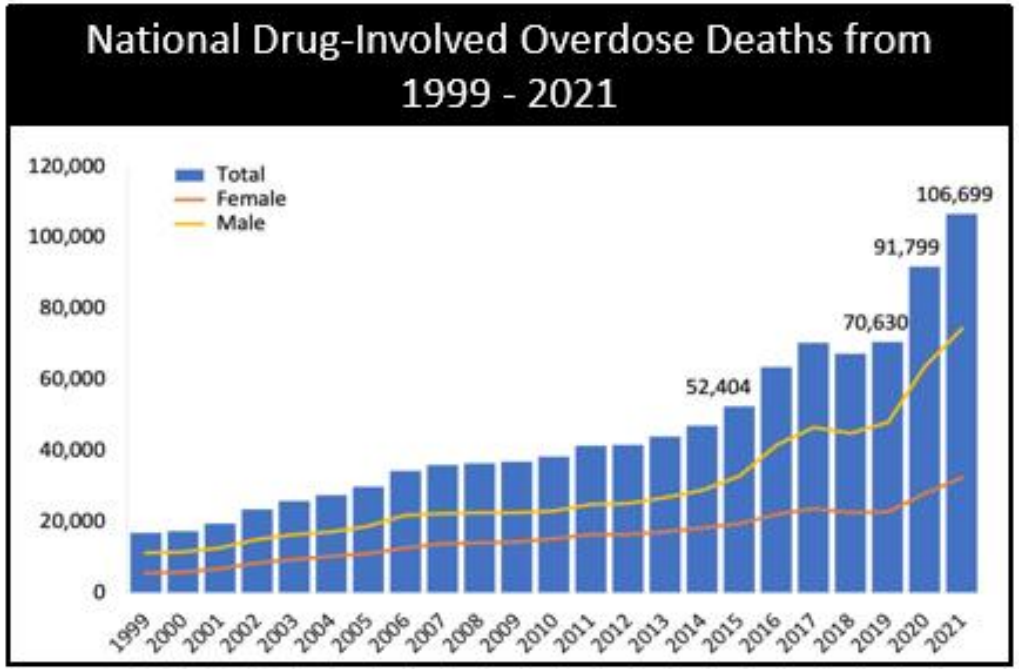
At the end of this session, participants should be able to:

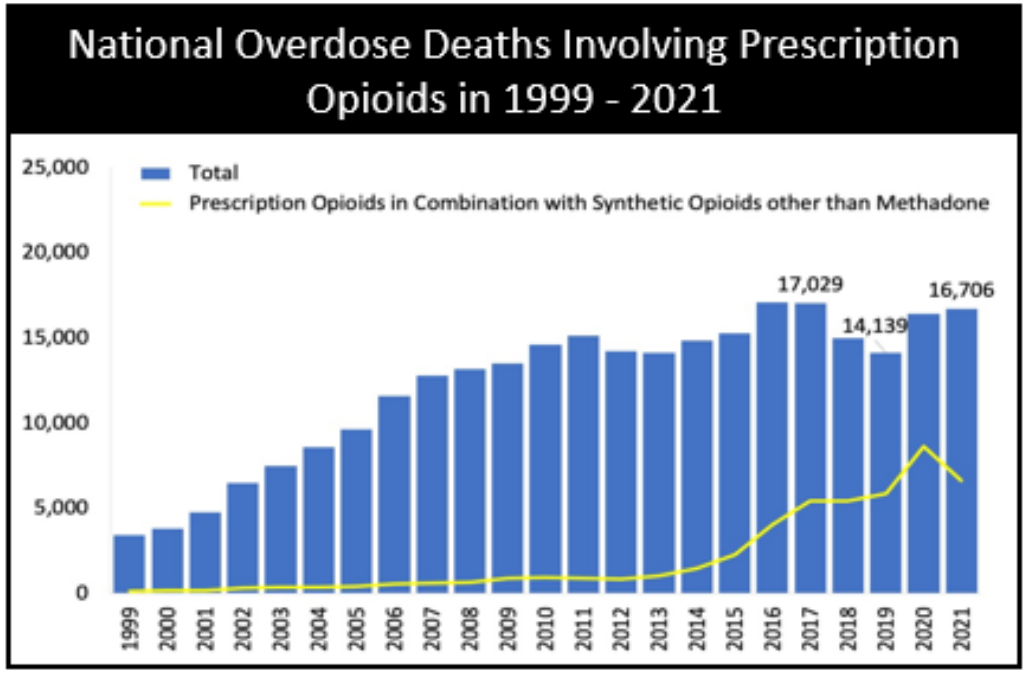
- Recall current state of opioid abuse and rates of abuse in healthcare professionals.
- Recognize examples of diversion cases that have occurred in ASCs and how the events were approached by members of the Medication Diversion team.
- Identify strategies to apply during a medication diversion event.

Current State of Opioid Abuse

Melissa Culbreth, MSSW, LMSW
Director of Medication Compliance, HCA Healthcare

The Opioid Epidemic





Since 1999, more than 932,000 people have died from a drug overdose

In 2020, opioids resulted in an estimated 75% of drug overdoses

Over 56,000 people died from synthetic opioids in 2020

Sources: The Drug Overdose Epidemic: Behind the Numbers. Centers for Disease Control and Prevention. June 1, 2022. Accessed May 18, 2023.
Drug Overdose Death Rates. National Institute on Drug Abuse. February 9, 2023. Accessed May 18, 2023.

Substance Abuse in Healthcare Professionals & Impact to Patient Care

Substance Abuse in Healthcare Professionals

- Estimated 10–15% of healthcare professionals will misuse substances
- Healthcare Professionals versus General Population:
  - Unique patterns
  - Disproportionate misuse of prescription drugs compared to street drugs
  - Tendencies occur based on the medications readily available
  - Drug diversion in the healthcare setting is difficult to measure

20%
Nurses admit to misusing one or more prescription drugs

19%
Pharmacists reported controlled substance use without valid prescription

17.6%
Physicians reported controlled substance use for self treatment

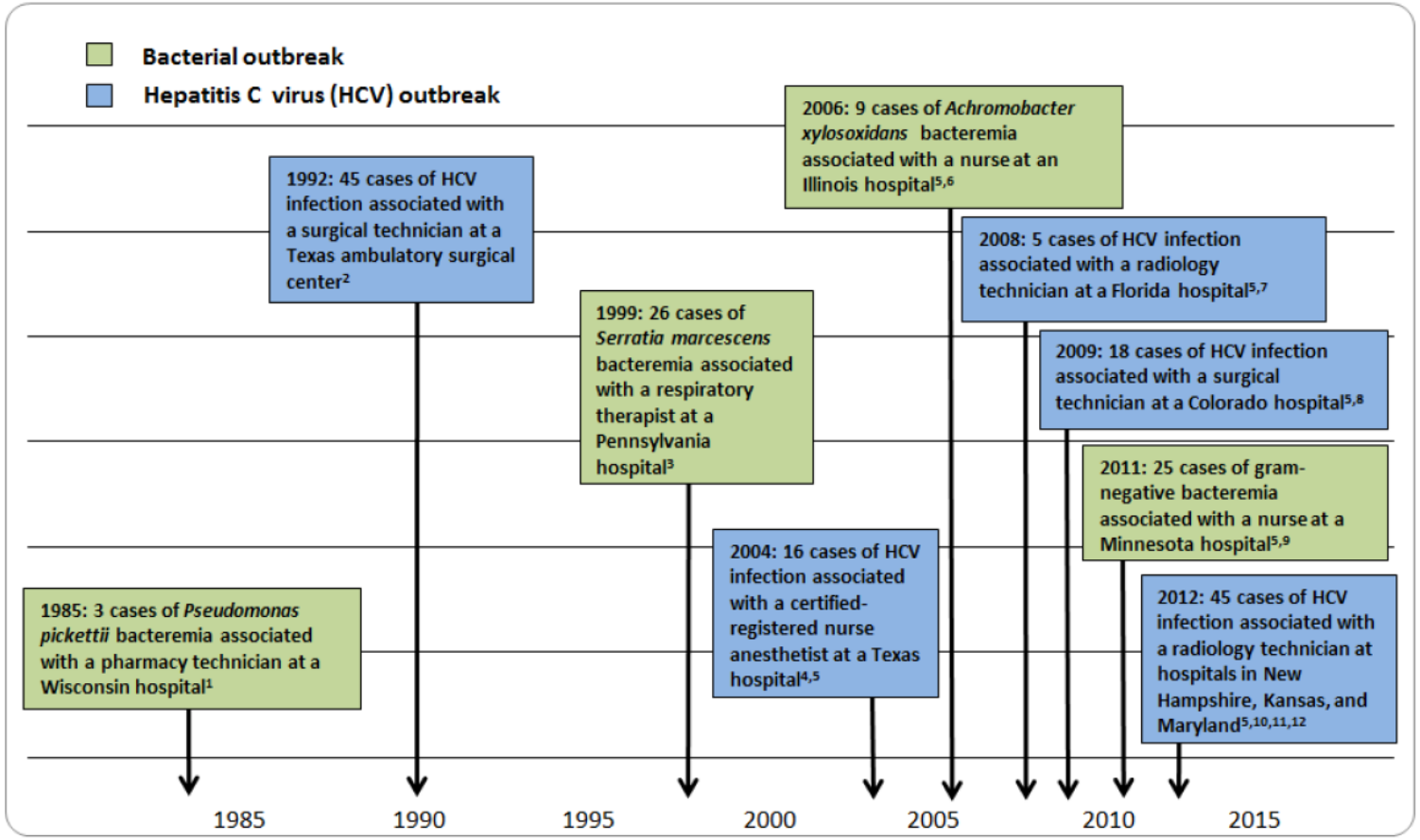
Sources: Nyhus J. Drug diversion in healthcare: Prevention and detection for nurses. American Nurse Journal. Volume 15, Number 5. May 2021.
Baldisseri MR. Impaired healthcare professional. Crit Care Med. February 2007; 35(2 Suppl):S106-16
McClure SR, O'Neal BC, Grauer D, et al. Compliance with recommendations for prevention and detection of controlled substance diversion in hospitals. Am J Health-Syst Pharm. 2011; 68:689-94

Medication Diversion: Impact to Patient Care

Physicians at Roswell Park Comprehensive Cancer Center reported **six of their patients** contracted a bacterial blood infection after a nurse replaced an opioid medication with tap water

Study conducted by the Mayo Clinic found that around **28,000 patients** have been put at risk for contracting Hepatitis C over a 10-year period because of medication diversion

U.S. Outbreaks Associated With Drug Diversion by Healthcare Providers



Source: U.S. Outbreaks Associated with Drug Diversion by Healthcare Providers, 1983 – 2013. Center for Disease Control and Prevention. January 4, 2012.
Mann B. Some Health Workers Suffering From Addiction Steal Drugs Meant for Patients. NPR. October 5, 2020.

Assessment Question #1

Approximately what percent of healthcare professionals will misuse controlled substances during their career?

A. 20–30%
B. 5–10%
C. 15–20%

Assessment Question #1 | Answer…

Approximately what percent of healthcare professionals will misuse controlled substances during their career?

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B. 5–10%
C. 15–20%

Diversion Opportunities in the ASC

Lea Schilit, PharmD, CPh, MS, RD
Assistant Vice President, Clinical Pharmacy Services
HCA Ambulatory Surgery Division—East Region

What's wrong with these pictures?

Source: Photos property of Lea Schilit, PharmD, CPh, MS, RD
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Risks in the Ambulatory Surgery Center Setting

- Limited technology/automation
  - Electronic health records
  - Automated dispensing machines
  - Barcode medication administration
- Predominately paper charting
- Manual auditing
- Fast-paced environment
- Controlled substances (CS) immediately available
- Narcotic waste and reconciliation process
- Contracted and at times inconsistent staff

Methods to Divert in the ASC

Methods of Diverting

- Diverting pharmaceutical waste
- Switching out syringes
- Tampering and substitution
- Diluting medications
- Diversion from patients
- Blatant theft
- Falsification of documentation of medication administration

Examples

- Pretending to waste and then pulling syringes from sharps bin
- Bringing water bottles into OR and squirting CS into the bottle instead of wasting
- Tampering with vials and then gluing the tops back on using surgical glue
- Pocketing CS waste syringes in pockets and switching out with syringes of saline
- Pocketing vials of CS when the count was off to falsely correct the count
- Taping sleeves of CS tablet cards together to make all the same height after removing tablets from the card
- Diverting the CS in anticipation of the surgeon routinely ordering it for the patient
- Knowing the center didn't have cameras and pulling narcotics out of the medication safe for personal use than falsifying other patient charts as if the medication was administered to them
- Using fanny pack and putting vials/medications into it to bring to other centers
- Taking CS from surgery center and caught using them in hospital

How many of these examples have you seen in your own facilities?

Tampered Vials in the ASC

Source: Photos property of Lea Schilit, PharmD, CPh, MS, RD
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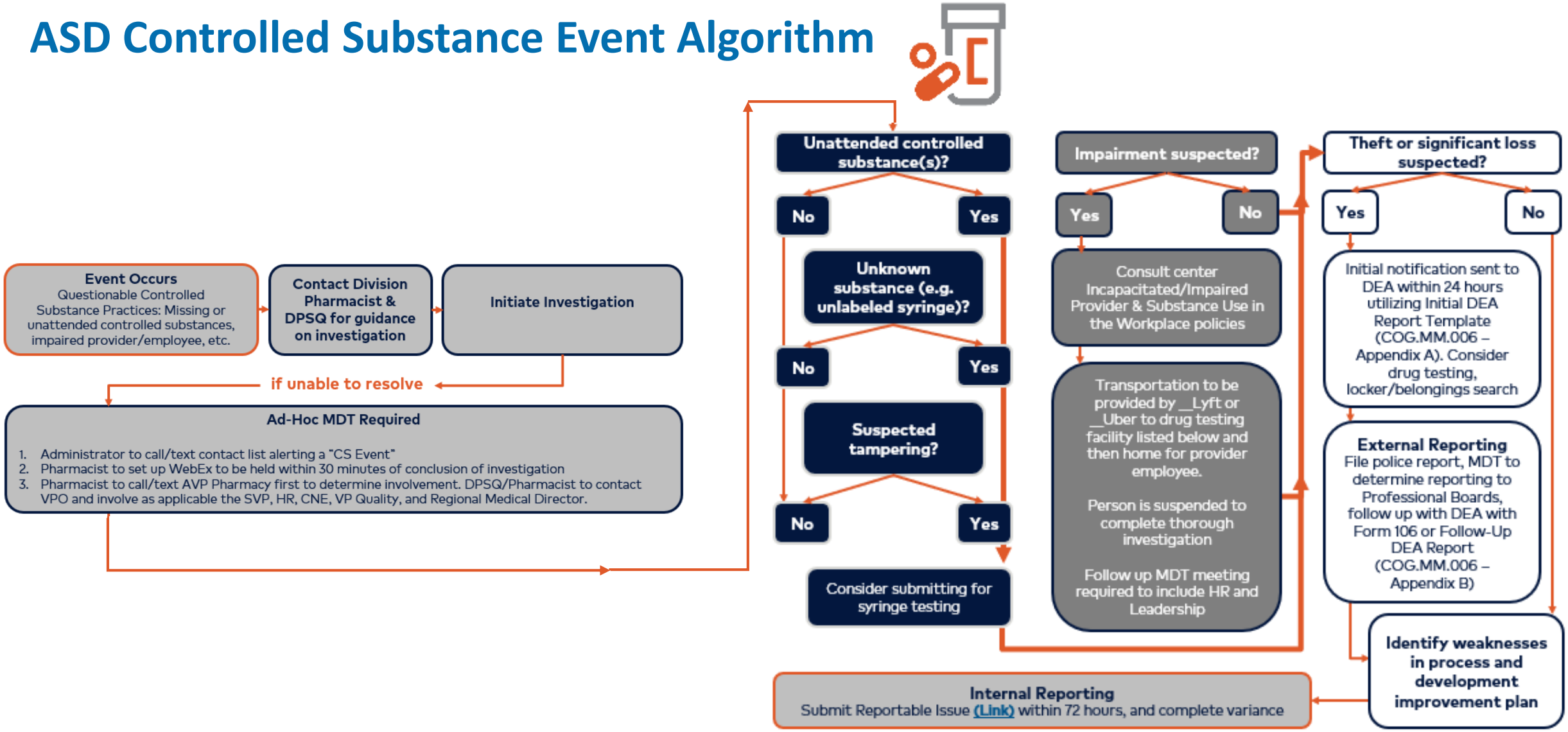
Controlled Substances Algorithm

ASD Controlled Substance Event Algorithm



Diversion Case #1 & Lessons Learned

Jason Ehrlinspiel, Esq.

Senior Litigation Counsel, HCA Healthcare

Diversion Case #1 – FACTS

Who: *Registered Nurse*
What: *Engaged in suspicious behavior consistent with drug diversion*
Where: *Ambulatory Surgery Center*
When: *Discovered Early 2023*

Background

Mid-2022

- Spouse of RN's colleague contacted Administrator
- Expressed that colleague came home and made comments about her concerns for potential diversion by the RN
- Colleague interviewed: Shared RN left floor for long periods of time, frequented locker and restroom, and always took patients more likely to need strong narcotics

Incident #1

Late 2022

- RN found in Center after hours; attempted to take medical tubing
- Written up

Incident #2

January 20, 2023

- Another RN observes RN removing cellophane from fentanyl box
- Tries to replace cellophane after noticing other RN is observing

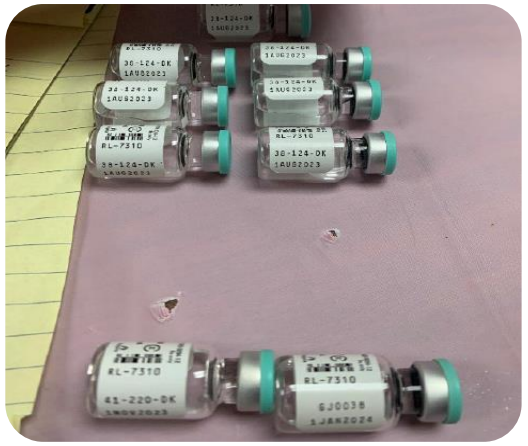
Incident #3

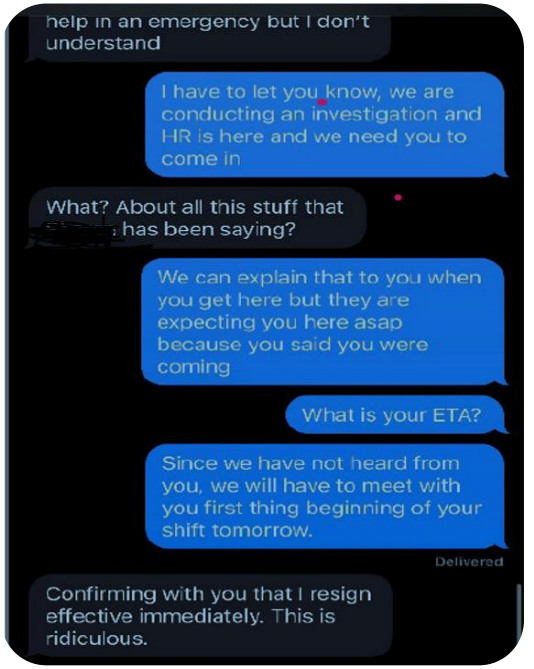
January 24, 2023

- Asks to pull pain meds for other RNs
- Fentanyl missing from pack; RN pulls vial from pocket; none of RN's patients had pain med orders
- RN found in narcotic cabinet later in day; cellophane removed from fentanyl box

Diversion Case #1 – INVESTIGATION

- Division Pharmacy Director notified 6 days after events
- Security camera implementation scheduled; not yet in place
- All fentanyl vials sequestered along with CS log book
- RN charts pulled for review
- Division Pharmacy Director inspected fentanyl vials ➔ vial tops would not spin – presumed tampering of vials
- MDT meeting immediately scheduled and leadership contacted RN to return to the Center
  - RN immediately resigned via text and did not return to the Center
- **60** vials sent off for content analysis; **37** returned with fentanyl levels at 2mcg/mL or below
- RN's locker was searched; nothing of concern found





Source: Rosa Milero, PharmD, BCPS

Diversion Case #1 – REPORTING & REMEDIATION

- Initial notification letter sent to DEA same day pharmacist notified of events
- RN's access to alarm code disabled
- All key access points to surgery center were changed
- Narcotic keys and medication room; keypad code changed
- Reportable Incident (RI) report filed with HCA Ethics & Compliance
- MDT determined highly probable threshold for diversion was met
- Local police report filed
- Boards of Pharmacy and Nursing notified
- DEA Form 106 submitted upon completion of investigation
- RN agreed to blood borne pathogen testing; results negative/non-reactive
- RN employment terminated; not eligible for rehire

Learning Opportunities

- Concerns reported by co-worker not taken seriously or immediately investigated
  - Missed opportunity to uncover diversion earlier in time
  - Missed opportunity to interview RN
  - Lack of missing medication is NOT mandatory to initiate a diversion investigation or to conclude diversion

- Delayed reporting to pharmacist and delayed MDT meetings after events took place negatively impacted investigation
  - 1 business day to submit initial notification to the DEA
  - Conservative View – clock starts running when reasonably suspect diversion, i.e. actively investigate

Polling Question #1

How long do you have to notify the DEA of a potential diversion/CS event?

A. Seven business days
B. One business day
C. 48 hours
D. 30 days

Polling Question #1 | Answer…

How long do you have to notify the DEA of a potential diversion/CS event?

A. Seven business days

B. One business day

C. 48 hours

D. 30 days

Diversion Case #2 & Lessons Learned

Michael Hicks, M.D.
Chief Medical Officer
HCA Healthcare Ambulatory Surgery Division

Diversion Case #2 – BACKGROUND

Who: *Anesthesiologist*
What: *Patterns of concerning behaviors and documentation practices consistent with drug diversion*
Where: *Ambulatory Surgery Center*

December 14, 2021

- Colleagues reported Anesthesiologist (Provider) had angry outbursts toward staff in Endoscopy room
  - MDT meeting immediately held:
    - Additional concerns: Drawing up fentanyl syringes ahead of cases and frequent restroom breaks
    - MDT advised a focus chart review from the day of outburst
      - High use of narcotics for short Endoscopy cases, but no pattern indicating diversion
      - Provider recently drug tested with negative results
      - MDT established plan to continue focus chart reviews

January 2022

- Provider resigned before review could be completed

April 2022

- Provider returned and reinstated

Diversion Case #2 – BACKGROUND (continued)

August 18, 2022

- Audit revealed four instances of discrepancies involving Fentanyl and Propofol between June & August 2022

August 29, 2022

- Provider was at facility and Administrator performed chart audit of day
  - Patient who received anesthesia by Provider arrived in PACU complaining of 10/10 pain requiring multiple doses of hydromorphone
  - Multiple discrepancies involving Fentanyl and Propofol between Anesthesia and Narcotic Administration records identified

August 30, 2022

- Another angry outburst between Provider and Surgeon

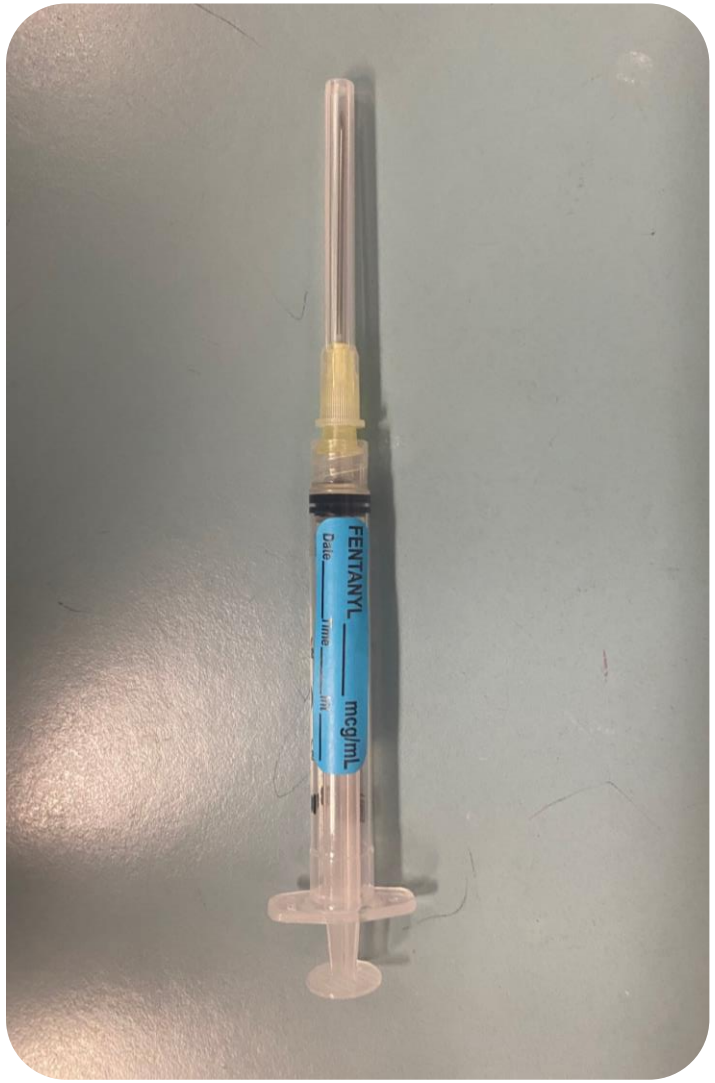
August 31, 2022

- Another Ad Hoc MDT meeting held and team recommended:
  - Provide counseling on documentation and CS handling
  - Reportable Issue (internal report) to be filed
  - Provider asked to submit to random drug test
  - Submit multiple random samples of CS waste for testing
  - Complete focused chart review for Provider
  - Discussed policy criteria for conducting personal belonging search for facility colleagues

Diversion Case #2 – FACTS

September 6, 2022

- Random CS syringe test planned
  - Provider had one Propofol syringe and one Fentanyl syringe in Endoscopy Room
  - At end of a case, Provider handed RN one Fentanyl syringe and one Propofol syringe to waste (both labeled accordingly)
  - Provider was informed the Fentanyl syringe would be sent for testing
    - Appeared flustered and returned to cart, rummaging in drawer and his pockets
    - Appeared to open a new Fentanyl vial to draw into another syringe and label as Fentanyl
  - Provider attempted to give new syringe to RN, stating he accidentally gave her a saline flush at first (even though it was labeled as Fentanyl) and the newly-drawn syringe of Fentanyl was the correct syringe



Source: Photo property of Sonnia Zambrano, PharmD, CPh
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Diversion Case #2 – RESPONSE & REPORTING

September 6, 2022 (day of event)

- Administrator notified HR and Medical Director
- Ad Hoc MDT meeting held
  - No suspected impairment: Medical Director had Provider finish out day as there was no one to relieve him
  - Both syringes labeled as Fentanyl were sent for testing
- Provider refused drug test
- Provider declined to talk with Administrator and stated he was resigning at end of day
- Initial notification sent to DEA within one business day after consulting with in-house counsel

October 2022

- Syringe test results returned and MDT reconvened
  - First syringe result (initial syringe provided as waste): No fentanyl detected; confirmed with repeat analysis
  - Second syringe result: Concentration of 51.5 mcg/mL (within normal limits)
- Provider resigned his employment but did not resign privileges
- Summary of suspension was provided based on Governing Body approval
- MDT determined highly probable diversion
- Local police report filed, DEA Form 106 submitted, and Revocation letter sent to Provider by MEC
- Board of Pharmacy and National Provider Data Bank notified

Diversion Case #2 | Lessons Learned

- Involvement of Med Exec and Governing Boards when physician behavior is involved
- Identifying how many “strikes” a contract employee gets before they are asked to not return to the center
- Is there a back-up plan to have center anesthesia coverage in a case like this?
- Always complete a diversion investigation once started. No exceptions
- Missing medications are not necessary to trigger a diversion investigation

Steps a Medication Diversion Team May Use During a Diversion Event

Group Discussion

Steps a Medication Diversion Team May Use During a Diversion Event

- Controlled substance algorithm
  - Appropriation escalation of event notification: Pharmacist, SVP, VPO, CNE, Regional Medical Directors, HR, Division Patient Safety Quality Director
  - HR involvement for possible suspension during investigation
- Technology and automation
  - Review of camera footage during time of suspected event
  - Review of automated dispensing cabinet records
  - Check narcotic cabinets
- Investigating variations in practices
  - Trends in usage or wastage of controlled substances by a provider or nurse
  - Review of charts from day of suspected event and person(s) involved
  - Review of anesthesia waste logs, anesthesia records, nursing records, daily controlled substance logs
- Controlled substance syringe testing
  - Analysis of contents of syringe to test if diluted
- Urine drug screen, if applicable
  - Depending on half life of the diverted medication in question
  - Arranging transportation to testing facility
- Blood borne pathogen testing

Assessment Question #2

What are steps a Medication Diversion Team should recommend during a suspected diversion event?

A. Notification of appropriate persons of the event (e.g., HR, VPO, Pharmacist)
B. Controlled substance chart audits/review of controlled substance logs
C. Review of camera footage
D. Controlled substance syringe testing
E. All of the above

Assessment Question #2 | Answer…

What are steps a Medication Diversion Team should recommend during a suspected diversion event?

A. Notification of appropriate persons of the event (e.g., HR, VPO, Pharmacist)
B. Controlled substance chart audits/review of controlled substance logs
C. Review of camera footage
D. Controlled substance syringe testing
E. All of the above

Strategies to Apply to Decrease Risk of a Diversion Event

Group Discussion

Strategies to Apply to Decrease Risk of a Diversion Event

- Multi-disciplinary, Medication Diversion Team
  - Have a team in place that meets regularly
- Creating a controlled substance algorithm
- Technology and automation
  - If possible, have cameras at center
- Monthly controlled substance chart audits
  - Focus on different providers, nurses or controlled substances each month
- Diversion risk rounds
  - Round on staff quarterly; monitor for compliance
  - Observe practices, ask questions related to controlled substance policies and handling
- Processes for wasting controlled substances
  - Waste with a witness
  - Where are controlled substances being wasted?
- Ensure appropriate chain of custody
  - When handing off controlled substances
- Anesthesia narcotic boxes
  - How and when and by who are boxes/kits made
  - How are they distributed? Is anesthesia checking contents before accepting?
- Segregation of duties
  - Person who orders controlled substances should not receive them
  - Person who approves invoices should not have access to ordering
- Coaching and corrective action
- Annual diversion education
- Accountability, Duty to Report

Assessment Question #3

What strategies may be applied to decrease the risk of a diversion event at your center?

A. Creation of a Medication Diversion Team
B. Conducting diversion risk rounds
C. Monthly controlled substance chart audits
D. Diversion education to staff
E. All of the above

Assessment Question #3 | Answer…

What strategies may be applied to decrease the risk of a diversion event at your center?

A. Creation of a Medication Diversion Team
B. Conducting diversion risk rounds
C. Monthly controlled substance chart audits
D. Diversion education to staff
E. All of the above

References

- Centers for Disease Control and Prevention. The Drug Overdose Epidemic: Behind the Numbers. June 1, 2022. Accessed May 18, 2023. https://www.cdc.gov/opioids/data/index.html
- Drug Overdose Death Rates. National Institute on Drug Abuse. February 9, 2023. Accessed May 18, 2023. https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates
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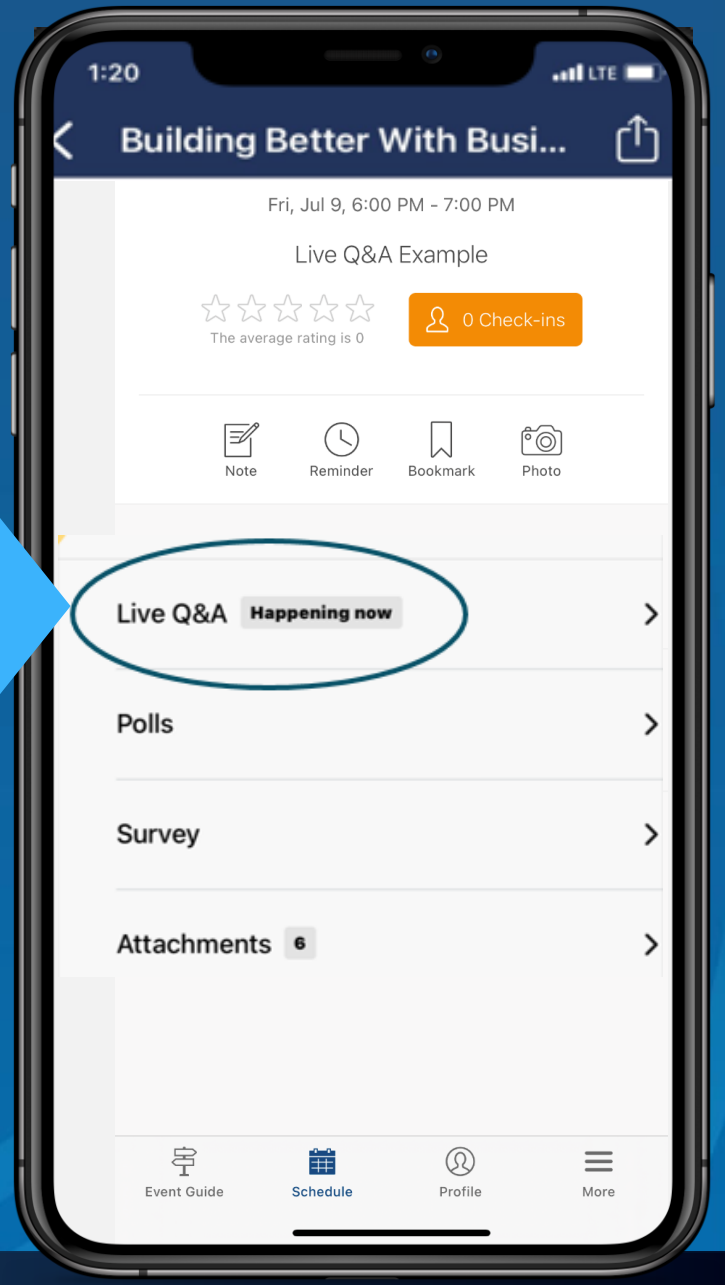
- Send in any time; Qs will be held until the end of the session



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Thank you...

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