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Return-and-disposal programs commence at health systems

Reminding patients to dispose of expired and leftover medications is no longer enough for some health-system pharmacists. They're looking at the next step: offering patients a central location to bring those medications for proper disposal.

Since fall 2006, seven of the clinic-associated Group Health Cooperative pharmacies in Washington state have each had a medication-disposal bin in their public area, said Shirley J. Reitz, associate director of pharmacy clinical services.

The bins, Reitz said, are part of a statewide pilot program involving the consumer-governed HMO.

She estimated that her pharmacy warehouse, in the first six months or so of serving as Group Health's central bin collection site, took in 110–120 5-gal-buckets' worth of unused medications.

In San Jose, California, 429-bed Good Samaritan Hospital held what it called a "safe drug drop" at the pharmacy on March 6 during National Patient Safety Week.

Publicity for the event included a notice in the city's major newspaper.

"We had 144 gallons of medication collected" in eight hours, said pharmacy director Wayne D. Adachi.

Included in that collection was one supply of medication reportedly dating back to 1981 or so, he said.

People emptied their containers of medications into plastic storage bags, Adachi said, and then a pharmacy technician dumped the bags of tablets and capsules into 1-gal pharmaceutical waste bins.

"When the line got fairly long, I was out there collecting medications as well," he said.

Adachi said the pharmacy locked the bins and sent them for destruction by a firm that incinerates pharmaceuticals.

"We're exploring with the city of San Jose to do this on a regular basis," he said.

"We're going to be putting in a locked disposal box that will be outside of the pharmacy" so that people can drop off expired medications without assistance.

The March 6 event, he said, consumed the pharmacy technician's entire eight-hour workday.

Medication return-and-disposal programs are "still in an infancy stage," said Maria D. Spencer, director of state government affairs at ASHP.

Few programs have actually started, she said.

But such programs apparently are just what the federal government wants to see.

The Bush administration on February 20 issued new guidelines for the proper disposal of unused, unneeded, and expired prescription drugs.

Consumers, according to the guidelines, have the following options:

- Take advantage of community take-back programs that allow the public to bring unused pharmaceuticals to a central location for proper disposal,
- Remove unused prescription medications from their original containers and throw the loose medications in the trash,
- Mix prescription medications with an undesirable substance, such as used coffee grounds or cat litter, and put them in impermeable, nondescript containers to further ensure that those medications are not diverted, and
- If the accompanying patient information specifically instructs so, flush prescription medications down the toilet.

In issuing the guidelines, the administration said they were designed to reduce the diversion of prescription medications and also protect the environment.

Washington state's board of pharmacy and department of ecology are part of the pilot program with Group Health.

Known by the acronym PH:ARM, for "Pharmaceuticals from Households: A Return Mechanism," the 2006–08 pro-

gram is testing two return-and-disposal models.

One model relies on clinic and community pharmacies and is intended to serve residential users, school districts, child-care facilities, hospice patients' families, and hotels, according to a brochure prepared by the Washington State Department of Ecology.

The other model is designed for residents of nursing homes.

Final disposal of the unused medications under both models is by incineration.

The incinerator where these medications go is different from where Group Health sends its waste, Reitz said.

"The only thing that we take back into this program is stuff that's been dispensed to a patient," she explained. "And once it's been dispensed to a patient, it falls outside a lot of the hazardous-waste regulations. It becomes patient waste or home hazardous waste rather than medical hazardous waste."

The buckets received at the pharmacy warehouse are moved to a secure, locked area, Reitz said. There, workers from Group Health, the state board of pharmacy, and the ecology department's solid-waste program gather periodically to open about 50 buckets, inspect them, and remove anything inappropriate for incineration, such as big aerosol cans.

"Asthma inhalers are fine," she said. Aerosol antifungals and hair sprays are not.

Despite signage on the disposal buckets and advance notice, some patients do deposit things that should not be there, Reitz said.

Controlled substances, she said, are absolutely forbidden in the pilot program because it lacks a waiver from Drug Enforcement Administration (DEA) regulations.

"There are regulatory issues at the large incinerators [regarding] controlled substances," Reitz said. "And so what they want is an attestation from us before they would accept [household pharmaceutical waste] that there are no controlled substances in these buckets. Well, unless we are willing to go through every bucket

and look for controlled substances, we cannot attest to the fact that there are no controlled substances in it.”

Reitz said the state board of pharmacy requested the federal waiver in March.

A DEA spokeswoman said the agency does not comment on pending requests for waivers.

Adachi said Good Samaritan did not accept controlled substances at its return-and-disposal event.

“Nor did we accept needles and syringes,” he said. “However, people did bring them, and then we ended up collecting those as well” for disposal.

Good Samaritan’s return-and-disposal event, timed to coincide with National

Patient Safety Week, also served as an opportunity for the pharmacy to kick-start its medication reconciliation program, Adachi said.

Physicians on staff, he said, had already received wallet-sized medication history cards to give to patients for them to complete and bring to Good Samaritan when hospitalized.

The pharmacy technician who helped people dispose of their expired medications gave out the wallet-sized cards in return, Adachi said, and referred medication questions to a pharmacist.

—Cheryl A. Thompson

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ED physicians offer solutions for boarding

The only cure for emergency department (ED) boarding—a practice in which admitted patients are held in hallways and other ED areas until inpatient beds become available—is to “get rid of it,” said Sandra Schneider, an emergency physician at Strong Memorial Hospital in Rochester, New York.

The “worst” decision hospital EDs ever made, she told an audience on May 1 at the 2007 American College of Emergency Physicians Leadership and Advocacy Conference in Washington, D.C., was to allow inpatient units to leave admitted patients waiting in the ED areas.

Schneider advised EDs that do not currently board patients to not start the practice.

EDs were initially charged with providing care to the sick and injured, said Schneider, chair of the department of emergency medicine at the University of Rochester School of Medicine. However, over the past two decades, the patient

loads for EDs have expanded to include other populations, she said.

When Congress passed the Emergency Medical Treatment and Active Labor Act (EMTALA) in 1986, EDs became responsible for providing care to the poor and uninsured.

EMTALA requires hospital EDs to medically screen all persons seeking emergency care, regardless of their ability to pay, and provide the treatment necessary to stabilize those determined to have an emergent condition or, if the facility does not have the capability, transfer the patient to another hospital.

“And we accepted that,” Schneider said. “Although some of our departments got a little crowded for a little while, we did that, and we took these people into our arms and embraced them and took care of them.”

In recent years, hospitals began allowing primary care physicians to send their patients to EDs for laboratory tests and x-rays.

“And we did this willingly,” Schneider said. “We recognized we could take care of these patients better and faster than most other places, and we said ‘OK.’”

But, she said, when health systems began relying on EDs to board admitted patients as a way to ease capacity problems in inpatient units, that “crushed the system.”

Schneider compared EDs to a busy restaurant where people come in, take a seat, but never leave.

“And they sit there for breakfast, and they sit there for lunch, and they sit there for dinner,” she said. “You can’t make business, and there’s a line out the end trying to get in.”

But, she said, the lack of access to a seat in a restaurant means that the patron does not get to have a meal. The lack of emergency care could mean the difference between life and death.

One way hospitals can alleviate the problems of boarding until they can completely stop the practice, Schneider said, is to create a temporary “bed czar” who is responsible for finding available beds in inpatient units.

Hospitals should also ensure that housekeeping services move quickly to have rooms ready for newly admitted patients, and facilities should ensure that operating room schedules are well-balanced to help alleviate capacity problems in inpatient units.

Hospitals must also stop the practice of diverting ambulances when their inpatient units and EDs are full, Schneider said.

“Ambulance diversion doesn’t work” to solve the problems of overcrowding and boarding, she insisted.

According to the Institute of Medicine, which issued a series of reports in June 2006 detailing the problems of the nation’s overburdened and underfunded emergency care system, an ambulance is diverted once every minute of every hour of every day.

Schneider said her ED was able to solve the problem of ambulance diversion at her facility by creating a 24-bed observation unit in 2004, which has since nearly doubled in size.