2005

Drug Demand Reduction
Strategic Planning Session
Areas of discussion

Outsourcing Threat:

What risk do we currently have for an unsolicited proposal from private industry to do all drug testing and replace the military drug testing program? We can argue some distinct advantages:

- We can make rapid changes to cutoffs and drugs to be tested without involving contract negotiations and increased costs?
- We have military leadership that can relate to and is accepted in military courts as being a part of the system not just doing the job for a buck.
- Judges, panel members and military lawyers have respect for the military drug testing system that would be lost with contract testing.

But with our current situation we may not have the lowest cost per sample:

- We need to make every lab efficient and low cost.
- Do we have excess capacity that is increasing our costs?
- Do we have too many labs?
- What is the optimum number for any increase in testing or surges in workload?
- How can we overcome excess capacity?
- How can we reduce cost per sample?
- What impact would bottle opening and pouring/sampling systems do to cost?
- Would this system improve the forensic identification of samples?

Standardization:

Standardization will be the theme at the next Joint Service meeting in San Antonio. Some examples where lack of standardization is affecting the effectiveness of the program are:

- A single set of DoD discrepancy codes.
- No two labs accomplish screening in the same manner. We have 1,2 & 4 point calibration and some use a K factor. Attempts to send opens samples to the labs for QC were not a success. We need to make decisions on how each screen is accomplished and set accepted standardized procedures. PCP or THC may be easy. AMPs may be difficult.
- Differences in the degree of use and application of the LIM system.

IT and Automation:

Cost of LIMS programmer, based on one previous month with overtime would be $260,000/yr. The employee does not get this much, probably somewhere around half that amount and it does include overtime (about 55 hr/wk). Would it be more cost efficient to have GS employees by finding or moving FTEs to USAMITIC? There of course would

be other problems with command and control of GS employees in an organization that we don't own or control.

Where do we go with Crab Quant vs Target DB? There is a working group that will have a plan for long-term replacement. Do we need to be concerned about the timeframe established? More money, more programmers, will produce faster results. What is the plan if there is a problem outside of our scope of knowledge with the Target DB?

Infrastructure and Equipment:

A substantial investment has been made at the Fort Meade Lab to maintain NLCP certification. Currently the lab is expending an inordinate amount of effort to maintain this certification for only 23,000 Army civilian samples. Do we NLCP de-certify Fort Meade or do we work to shift more DoD agency work towards Fort Meade?

Services continue to purchase equipment without consultation with DoD/AFIP. Is this a problem? If so, what do we do to fix the problem?

Is there anything else that we can do with the drug labs? I.e. chem./bio testing of urine, blood or other collected material. We have forensic toxicology background and the only military mass production laboratories in the system. Would it be beneficial to market these capabilities?

Technical and Production Issues:

What drugs should we have in our panel? Oxycodone is above the historical trigger point (0.25%) for 100% testing. Benzodiazepenes may also need to be included in routine testing. Can we replace Barbiturates or is that not a politically correct direction? Is there a reason to have rotational drugs? Or should we consider preparing a request for staffing and funding for 100% testing of all drugs at all times? How many do we miss with the rotational drug testing currently being done?

Why can't the system support the workload? Why do outside experts make a living testifying for the military drug testing, Drs. Narish Jain, Don Fredricks, Carl Selavka, Ashraf Mozayani, etc.? Is there any way to capture this cost and transfer it to a lab for expert witnesses? Traditional thought in drug testing has been that the last step in drug testing is the court case. If we do all the collection testing and reporting but can not represent the case in court then we are not doing our job. How do we fix this?

The LCOs play a critical role in the certification of a correct final result. Many of the errors in our system over the last few years have been because the LCO(s) have failed to recognize a problem on final review. There is becoming an over dependence on the LIMS system to answer all checks of the data. The LIMS can assist and flag areas, but is not the final answer. How can we arrange the workloads on the LCOs so that they are not always every day in the "hot seat"? Is there too much pressure on them?

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Numerous times over the last few months there have been attempts to contact drug labs? Many of these attempts have ended with an answering machine and no return phone call? Some of these attempts have ended a phone ringing with no answer at all? On one occasion 7 different phone numbers were unsuccessful in reaching the lab. We should be customer oriented and always have someone answer the phone during business hours?

Progress toward sound quality assurance programs has been made in a few of the labs. How do we expand this across all the labs?