



# Diversion: Your Guide to Identification and Prevention

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and can you detect the diverters?



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# Four Case Studies on Diversion Prevention

By Jerry Siegel, PharmD, FASHP, and Ryan A. Forrey, PharmD, MS

**E**ffectively addressing drug diversion is a challenging pursuit for hospitals throughout the United States, but failure to do so can easily jeopardize patient safety. Although it is common to believe that one's own hospital is an exception—since diversion could never happen here—this is certainly a misconception. The exact prevalence of drug diversion is unknown, because the deceptive and secretive nature of the problem, as well as health care institutions' reluctance to acknowledge lapses in medication security, makes quantifying its pervasiveness difficult. However, recognizing that drug diversion is occurring at your hospital is the first step toward preventing it.

To develop an effective diversion-prevention program, one must gain an understanding of who diverts, what drugs are the most common targets, which areas of the hospital are most likely to be targeted, and when and why diverters misdirect drugs. A program that addresses all of these points is most likely to be successful. At the Ohio State University (OSU) Wexner Medical Center, our diversion-prevention program—named Code N (for narcotics)—emphasizes the urgency of combating diversion. The key functions of the Code N program are enabled via a team of practitioners that quickly convene if evidence indicates a diversion scenario is in progress. The team comprises the director of pharmacy, the director of nursing, and representatives from risk management (the department responsible for calling the code), human resources, hospital security, hospital administration, as well as the manager of the discipline or patient care area under review. This team will meet within 24-48 hours of the discovery of potential diversion to review evidence and determine if a course of intervention is necessary. The success of this program is highly dependent on the multidisciplinary nature of our team and the rapid rate of response.

## Who May Become a Diverter?

Anyone with access to desirable drugs—controlled substances, high-cost medications, and other drugs deemed valuable—may become a diverter. In any case of diversion, patients, their families, physicians, pharmacists, nurses, technical staff, and others are put at risk. In health care settings that comply with secure medication storage requirements, diversion detection and prevention efforts focus primarily on staff with access to that storage.

### CASE REPORT: The Unexplained Empty Vial

While cleaning under the bed of a discharged patient in the medical/surgical unit, housekeeping found an empty sufentanil

vial. The director of pharmacy was perplexed as to why this medication was found in this location, as it is never stocked or dispensed outside of the pharmacy and was not administered to the discharged patient. Suspecting diversion, she began an internal investigation and found no anomalies, despite careful review of administration records for the patient's medical/surgical unit nurses, the anesthesiologist, and the operating room and post-anesthesia care unit nurses.

Three weeks later, hospital security requested a review and identification of medications found in the belongings of Jane Doe, an employee being terminated for performance issues. The director of pharmacy identified several tablets and nearly empty vials of controlled substances in her possession. Jane Doe also tested positive for several controlled substances in a urine toxicology screen.

Five years prior, Jane Doe was hired as a third-shift pharmacy technician. After exemplary performance in that role, she obtained a nursing position in the medical/surgical department. However, after changing positions, her pharmacy access was not revoked, an oversight that Jane Doe eventually discovered. She began entering the satellite pharmacies after hours to remove used controlled substance vials from hazardous waste receptacles and obtained sufficient medication to inject herself by pooling multiple vials. Jane Doe was working in the unit the night before the empty sufentanil vial was discovered. Had Jane Doe's diversion been discovered prior to (or in absence of) her termination proceedings pursuant to her performance, she would have been offered treatment through the hospital. In this case, her diversion was reported to the police as well as the state board of nursing. Jane Doe was subjected to criminal charges and her license was suspended pending successful completion of a rehab treatment program.

## Access to Medications

A comprehensive diversion-prevention program should focus on nurses, pharmacists, anesthesiologists, and pharmacy technicians—practitioners who regularly access medications as a function of their job duties. Many hospitals design their diversion-prevention programs to address the nursing staff first because of the sheer size of this workforce. Nurses who administer drugs daily, and may perceive drug availability due to poor or nonexistent workplace controls, have twice the normal rates of drug misuse.<sup>1</sup> Knowledge of drugs has not been shown to prevent addiction among nurses, but rather to promote self-medication. Nurses who are abusing drugs often cite the nature of their work as a

component driving their addiction. Contributing factors include<sup>2</sup>:

- Stress
- Access to controlled substances
- Belief that medications are safe, efficacious, and helpful
- Caregiver burnout
- Belief that their training and knowledge of controlled substances can protect them from addiction

Some hospitals and risk managers are wary of sharing cases of confirmed diversion, as they can create a negative perception of the hospital. Regardless, it is essential that drug abuse education be emphasized in the training of all health care practitioners and that all employees be made fully aware that a stringent diversion program is in place at the institution and that it will be strictly enforced. Knowledge about addiction does not prevent the pharmacologic action of the agents. Thus, from a management standpoint, we have to temper staff from working excessive overtime and beware of proffering rewards and accolades for doing so. Working long hours may be a root cause of diversion as long hours ensure continuous access to drugs.

### Controlling Access

When medication access is no longer appropriate for a given employee, for whatever reason, procedures must be in place to remove that person's access to the electronic medical record, ADCs, and any form of electronic security (such as badge readers) that grant physical access to a restricted space. To enable this, establish a process whereby departments notify the information technology (IT) data security group (or its equivalent) of upcoming employment transfers or terminations daily or whenever they occur; immediate or urgent terminations should be communicated rapidly as well. Moreover, the IT department must notify the department requesting an access change after the user's access has been revoked. Implementing enhanced technology to coordinate and synchronize these notifications with minimal human intervention is key. Integrating ADC systems into the institution's user database can increase control and decrease the risk of invalid users retaining access to controlled substances. However, even advanced systems cannot prevent all instances of unauthorized access, so continuous vigilance is required.

When an employee transfers from one position to another within the hospital, medication access must be re-evaluated prior to the move. Because the human resources department often manages transfers, rather than IT data security staff, coordination and early warning can be challenging. Our hospital requires a background check for all employees before initial hire and at the time of each transfer. Coupling an access review with a background check is an effective method to formalize a systematic procedure for medication security.

The pharmacy department also must conduct a regular audit of all pharmacy users' access to secured medication storage areas. Ensure that support and ancillary employees (such as office assistants or clerks) whose job descriptions do not include medication handling do not have access to medication storage areas.

## What Drugs Are Targeted for Diversion?

Opioids are the most commonly diverted medications in the health care setting by far, but narcotics are not the only drugs at risk of diversion. The choice to divert one drug over another is contingent on the goal of the diverter, as well as whether the drug is stolen for personal use or to sell to others.

### Diversion for Personal Use

Diversers who redirect products for personal use tend to begin with less potent oral agents, such as acetaminophen with codeine or acetaminophen with hydrocodone, as access and inventory of these DEA Schedule III drugs is often less restricted compared with Schedule II drugs. As the diverter's tolerance to the narcotic grows, the diversion pattern is likely to intensify. Schedule II and injectable opioids may become the next target.

In an anonymous study of drug misuse among nurses, 20% of those surveyed admitted to misusing one or more prescription substances. Easy access was highly correlated with drug misuse. Among these practitioners<sup>1</sup>:

- 60% used an opioid
- 45% used a tranquilizer
- 11% used sedatives
- 3.5% used amphetamines
- 1.9% used inhalants

### Diversion for Sale

An individual who is diverting opioids for sale typically focuses on oral, brand name medications with the highest street value, such as OxyContin and Percocet, or their generic equivalents. Controlled non-opioid medications that may be diverted for sale include the sedatives ketamine and midazolam (see **SIDEBAR** on page 7).

### CASE REPORT: No Perceived Problem

An inpatient charge nurse called the pharmacy ADC manager to report that furosemide 20 mg tablets were out of stock twice in one week. ADC records indicated that an inventory of 15 tablets should have been in the machine, but the pocket was empty. The ADC manager refilled the pocket and reviewed the usage reports, finding that the furosemide pocket had been refilled six times in the last three months. One particular nurse had been working every day that the furosemide stock had been refilled. Upon questioning, the nurse admitted that she had an eating disorder and had been taking the furosemide to assist with weight loss. She did not think that taking the diuretic would be a problem because, in her words, it was just furosemide, not a narcotic. In this institution, all diversion was treated equally, regardless of the substance being diverted. The hospital reported the nurse to the police for theft, as well as the state board of nursing. She had to appear before the board and ultimately had action against her license, which remained a permanent part of her professional record.



## Where Does Diversion Occur?

Diversion can occur in numerous areas of the hospital; consequently, more than one approach is required for prevention. Quite often, diversion occurs at the patient's bedside.

- **Substitution:** A common method of drug substitution is to replace a patient's prescribed opioid with another agent, such as saline or sterile water. An injection of sterile water will provide a sting (a feeling similar to an injection of the medication), but no therapeutic effects, so the diverter may sedate the patient with diphenhydramine or lorazepam to mask the lack of analgesia. Sometimes the diverter will not remove all of the opioid but dilute it so the patient receives partial pain relief. In one instance, the antipsychotic medication haloperidol was substituted for a diverted opioid.
- **Improper Charting:** Diverters will often put forth considerable effort to identify patients who can be used to cover for their diversion. Non-verbal patients, or those whose reports are considered unreliable, may have difficulty reporting inadequately controlled pain. For patients who are able to respond to a simple pain scale, improper charting may be used to obfuscate the reason for a dosage increase. The diverter will then administer the original dose to the patient, while keeping the remainder for personal use (see **TABLE 1**).

### CASE REPORT: Too Much Information

The pharmacy department set up a phone hotline to enable anonymous reporting of suspicious behavior. The call is recorded and will trigger a page to the narcotics manager. The manager can then alert the pharmacy manager on-call for review and potential action. The intent of the hotline is for immediate reporting of a caregiver impaired while on duty or in the act of diversion.

The hotline received a tip that a nursing unit manager had improperly removed a controlled medication from an ADC that was intended for a patient who had been discharged that day. The ADC had been set to automatically remove patients from the profile eight hours after discharge. When questioned, the manager stated that the patient was coming back to the hospital to pick up the medication. An inventory of the ADC revealed that the manager removed numerous 4 mg syringes of hydromorphone, which is not a medication that would be given to a discharged patient. A search of her office and locker found no evidence of the diverted medication. Further investigation revealed that she had been injecting diverted opioids into grapes and eating them in plain sight of her staff.

The manager had received diversion prevention training, and therefore knew how to run reports and determine if certain activities would be detected. As a manager, she had access to four ADC units. She deduced that if she removed opioids from more than one unit, the standard deviation (SD) report would not compile all of her activity, but instead compare activity on each unit separately. By keeping her activity on each unit less than 2 standard deviations (SD), she could stay below

the 4+ SD that would have triggered an investigation. This incident drove home the fact that no one is above suspicion and that caution must be applied in how we train and how much we train. The facility should be cognizant of not providing the means by which to divert.

Be aware that while training personnel in how to identify diversion, you could be inadvertently providing information that teaches methods for successful diversion. Interestingly, in this instance, the pharmacy department's training program provided the nurse manager with the information that allowed her to divert, while the hospital's anonymous diversion hotline assisted in uncovering her diversion. Nevertheless, educating staff to be observant and vigilant will improve diversion detection and prevention.

## Why Do Medical Professionals Divert?

It can be difficult to understand why medical professionals would risk their years of training, professional reputations, and personal livelihoods to engage in drug diversion. However, addiction knows no bounds, and anyone can develop a substance use disorder. Among all drug users, most are functioning in the community and nearly 66% are employed.<sup>3</sup> Furthermore, an estimated 10% to 20% of nurses have substance abuse problems,<sup>4,5</sup> and they tend to abuse prescription drugs instead of street drugs.<sup>6</sup>

### CASE REPORT: The Supernurse

Monthly reports from the controlled substances vault showed that a registered nurse on one of our patient care units had a 3+ SD use of controlled substances compared with fellow nurses in the same time frame. Further investigation revealed that this nurse was the only one who gave several patients acetaminophen with oxycodone after charting their pain scales. Review of the charts showed that the highest doses were always removed, and no doses were wasted. The unit's head nurse vouched for the nurse in question, saying he was one of the most well-respected and reputable nurses in the department. She insisted that this nurse was beyond reproach—never taking vacation, always volunteering to work overtime, and available whenever someone called in sick.

Because never wanting to be away from work—where there is access to narcotics—is a potential red flag for diversion (see **TABLE 2**), the decision was made to interview this nurse and ask for an explanation for why his utilization patterns were notably different than his peers. For confidentiality, we interviewed him in a conference room outside his own unit. The nurse denied any wrongdoing and was insulted that we were questioning him. (That reaction was not surprising, as denial is common in substance use interventions.) After he regained his composure, we again asked him to explain the high volume of use and the unusual usage pattern. He emphasized how concerned he was for his patients and that he did not want to see them suffer, unlike some of his colleagues who encouraged patients not to use narcotic pain medication.

When the head nurse questioned his judgment in always offering patients the highest dose, the nurse said that he always removed the highest dose, and if all tablets were not used he

would save them for later. We then inquired why he did not follow policy and waste the medication per protocol, and the nurse replied that he did not want to waste other nurses' time and throw away viable medication. The next question was whether or not he sometimes forgot he had the drugs and accidentally took them home after his shift, which he strongly denied. As he became increasingly upset, he was asked how long had he been taking medications from the unit and why he was taking them. At this time, the nurse finally confessed to diverting the drugs. He said he had received prescription pain medications several years ago for a work-related back injury, but that his doctor had refused to prescribe additional narcotics when he would not take time off from work for physical therapy. One day a patient only wanted one of the two tablets offered, so he took the other tablet. Because no one seemed to notice, this became his method for diversion. He apologized profusely, but explained that using the pain medication was the only way he could get through a shift. As his addiction increased, he volunteered to work more often. He rationalized that his ability to keep working was in the best interest of the hospital. This nurse was placed in a rehabilitation program.

## Technology to Monitor for Diversion

In our experience, automated surveillance programs detect about one-half of diversions that are discovered; the other 50% are revealed through direct observation and tips reported to the pharmacy. Although not a substitute for human instinct and evaluation, technology is a vital component of any diversion-prevention program.

**Automated Dispensing Cabinets (ADCs):** To prevent diversion in the operating suite, accountability requires accurate record keeping for dispensing and waste. The use of ADCs may assist with dispensing accountability, but reconciliation of the inventory is essential.

**Spectrophotometry:** Some institutions use spectrophotometers to perform a qualitative assay of returned narcotics, as these devices can detect a wrong drug, diluted drug, or missing drug. It is important to be aware of the limitations of these devices, as they cannot detect all types of drugs. When staff is aware that a spectrophotometer is being used, this may deter diversion, but spectrophotometry is only one tool in a comprehensive diversion-prevention program. Keep in mind that a diverter may research which narcotics the spectrophotometer cannot detect. To increase the odds of detection, run random, unpredictable sample assays, and also assay all suspicious returns, whether late, left behind, or returned with missing information.

High-performance liquid chromatography (HPLC) is required to do a quantitative analysis of returned narcotics, but HPLC is beyond the scope of many pharmacies. Waste samples for HPLC must be sent to a toxicology laboratory for evaluation, a process that can be time-consuming and costly.

**Diversion Monitoring Software:** Diversion-monitoring systems can be useful to screen for variations in utilization. However, for this software to be effective, the pharmacist or technician must be trained to accurately interpret the results. For example, screens set

## Indicators of Medication Diversion by Staff

**TABLES 1 AND 2** were developed at OSU to help guide the Code N team in making decisions about interventions. When reviewing the evidence from software reports, dispensing, and charting, these additional tables help determine the behavioral practices of the suspected diverter. The more Yes answers that are prevalent, the more likely the suspect is diverting medications and an intervention will be planned.

### TABLE 1

## Patient Care Indicators

Inconsistent or incorrect charting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Displays inconsistent work quality with times of high and low efficiency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Offers to medicate other nurses' patients on a regular basis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Obtains larger dose of narcotics when the ordered dose is unavailable, then documents the remaining amount wasted	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Requests to care for specific patients	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Illustrates specific narcotic use with patients under his/her care	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
His/her patients reveal consistent pain scale patterns or complain that narcotics are not having the desired effect (especially when administered PRN) only on that shift	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

## TABLE 2

### Behavioral Indicators

Isolates self from others, eats meals alone, avoids staff social events	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Frequent, unexplained disappearances during shift	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Often shows up on off days to finish work or retrieve forgotten items	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Frequently volunteers to work extra shifts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Frequently spills or wastes narcotics	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Chaotic home/personal life	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Refuses to comply with narcotic diversion investigational procedures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

## SIDEBAR

# Diversion for Sale

**Diversion of controlled substances for sale occurs in hospital settings**, but is less common than diversion for personal use. Dealing in narcotics often requires large quantities of controlled substances to meet customers' demands. In a patient care area, high-volume diversion should trigger even a basic surveillance system early on.

Larger-scale diversion is more likely to occur in a hospital when the same person orders and receives the inventory. Other diversion-for-sale schemes involve robbery rather than passive diversion. Robberies have increased at outpatient and retail pharmacies as access to prescriptions for controlled substances has become more restricted. Therefore, outpatient pharmacies should be aware of this potential threat.

A proactive diversion program should not focus exclusively on controlled substances, because non-controlled medications of high value also may be diverted. Diversion may occur during shortages (eg, ciprofloxacin tablets during the anthrax scare of 2001) or where health care workers' access make certain agents tempting (eg, fluconazole tablets or diuretics).

to detect all users at 1+ SD of variance from the mean will return hundreds of false-positive reports, making follow-up impossible. We have found the monthly reports of all users with a threshold of 3+ SD narrows the reports to a more manageable sample group. Each user with 3+ SDs then must be investigated to determine if a reasonable explanation exists for the higher utilization. Although this report works for unit-based users, float nurses may avoid accurate screening unless they themselves are compared as a user group.

## Conclusion

Potential diversion opportunities in a health care setting are too numerous for any one individual or technology to monitor effectively. Successful prevention and detection must rely on multiple strategies, and the following have demonstrated effectiveness:

- Incorporate dispensing by users within the pharmacy department in routine diversion-monitoring programs
- Connect time-keeping (clocking-in) devices with ADCs so that access to dispensing systems outside of an employee's work hours can be prevented or more easily detected
- Link pain scale charting to dispensing devices to better correlate higher doses of medication with the patient condition and nursing documentation
- Use bedside bar coding and bar code dispensing to facilitate tracking and detection of discrepancies

- Retrieve data from the EHR on uncharted doses dispensed and review these unreconciled medication reports for trends
- Work with IT data security to program financial/billing systems to identify cases of dispensed but uncharted controlled substances or other medications targeted for diversion

Utilizing multiple diversion-prevention strategies will best ensure diversion is effectively detected, addressed, and prevented at your hospital. While a percentage of hospital staff will always seek to divert drugs, developing and implementing a comprehensive, robust diversion-prevention program is the most effective tool to combat this ongoing challenge. ■

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# A Systematized Approach to Combat Drug Diversion

By Steve Carlson, RPh, MHA, and Andrew F. Corsaro

**I**t has been well publicized in recent news reports that prescription drug abuse is a major and growing problem in the United States. For the first time, deaths from overdoses of prescription opioid pain relievers have exceeded deaths from heroin and cocaine combined.<sup>1</sup> Data shows that rates of drug abuse among health care workers are comparable to the general population, and thus remain a significant issue for health care facilities. The major difference between the general public and medical professionals is the accessibility of a large source of controlled substances, leading to illegal removal from the health system for the purposes of self-administration, selling, or supplying to others. To combat this national crisis, a systematic, collaborative process to manage drug diversion is a necessity in every health system.

In an effort to ensure patient safety and reduce the likelihood of drug diversion, Northeast Georgia Medical Center in Gainesville adopted its current drug diversion policy and procedure (P&P) in 2006, and made additional modifications in 2010. Our goals were simple: To ensure patient safety and improve the security of our facility and its employees by preventing the abuse and diversion of controlled substances.

**To determine whether someone is being truthful or deceptive requires much more than simply relying on common sense or an understanding of normal and abnormal human behavior.**

## **Institute a Diversion Policy and Procedure**

Just as local municipalities may not place a traffic light at a dangerous intersection until an accident occurs, some health care facilities may not see the need to adopt an institution-wide, comprehensive drug diversion P&P until a dangerous incident transpires. However, it is important to have a policy in place prior to having a problem, as neglecting to institute a P&P leaves hospitals vulnerable. Pharmacy leaders must be knowledgeable about all suspected diversion cases

in their facilities and must be active participants in the collaborative process to detect, confirm, and address diversion.

While fitness-for-duty policies—including drug and alcohol policies—are fairly standard in most organizations, drug diversion policies are not as common. When developing a P&P, involve a multidisciplinary team from all affected departments, including pharmacy, security, human resources, employee health, EAP, and administration. Effective drug diversion policies must define the methods used in the investigation of suspected diversion. In addition, a drug diversion policy should contain the following elements:

- The definition of drug diversion
- Fitness-for-duty policy
- An appropriate chain of contact when diversion is suspected
- A system that facilitates timely recognition of any diversion of controlled substances, as well as a procedure to quickly identify the individual responsible for diversion
- Requirement of staff to report suspected drug diversion immediately to his or her department director or manager, as well as a requirement to treat such information as confidential and take all responsible steps to protect the confidentiality of the information and the identity of the individual furnishing information, to the extent allowed by law
- Chain of command for reporting drug diversion, both within the institution and to the appropriate local and federal authorities, if necessary
- Involvement of facility security and police, if necessary

Any member of the team should be able to get the group together to discuss an instance of suspected diversion. Our team, nicknamed Code D, is led by the director of pharmacy. It is important to identify and document the responsibilities of each member. As the team is being formed, each participant needs to understand and agree on his or her individual responsibilities, as well as the procedures of the team as a whole. For example, the team members responsible for conducting interviews of suspected diverters, as well as where and when these interviews will typically take place, should be predefined and delineated in the P&P.

## **Develop Monitoring Methods**

Automated reports are an excellent method of using technology to document cases of suspected diversion. As such, automated dispensing cabinets (ADCs) are a common means of securing controlled substances and oftentimes are capable of using software

to analyze usage patterns for diversion. Data extraction software is available that works with any manufacturer that analyzes usage and presents anomalies up to 0.5 standard deviations from the mean (see **FIGURE 1**). The data extraction software can be used both as a screening tool and as a confirming tool.

In addition, a well-defined process that identifies weekly counts and reviews all discrepancies, PCA and epidural usage, and OR processes should be developed. Additional security measures, such as the placement of cameras in strategic locations, should be considered as well.

**Interview Process**

In many cases the suspicion of drug diversion may only be supported by statistical analysis and circumstantial facts such as observed behaviors and personal life challenges (for signs and symptoms of drug addiction, see **TABLE 1**). Although this information is very important to support an internal investigation, there is nothing more concrete than a confession.

When an interview is warranted, a few essential factors must be considered: preservation of evidence, creating an environment where truth barriers are removed, asking questions to determine truth or deception, and balancing employee relations when asking hard questions. The interview should be a complete surprise to the employee and start with a supervisor escorting the employee from their department to the site of the interview. Because the employee will ask where they are going, be honest and state that the pharmacy department needs to speak with them regarding some medication practices. The location of the interview should be someplace unfamiliar to the employee, quiet, and void of distractions. It is vital during this first step that the supervisor escorting the employee go directly to the interview room and not allow for unobserved stops in locker rooms and/or bathrooms. If the employee is in possession of diverted medications, he or she will likely try to get to a private location to discard the evidence.

Upon their arrival at the interview room, the employee should be handed off to one or two interviewers who are unfamiliar to the employee. Experience has shown that it is easier for people to tell the truth to those they do not know than to someone they have a prior relationship with. To preserve transparency in the process, we recommend video recording the interviews, with the employee’s consent, so that what transpires is not misrepresented later.

Start the interview by introducing the interviewers and asking the employee some general questions about themselves, ie, name, department, and phone number. This is where the analysis of their behaviors will start and the signs of truth and/or deception will present themselves. For example, most people will be nervous during this initial phase of the interview process. You may notice them sitting with their arms and legs crossed in a barrier posture, or sweating and shaking with heavy respiration. A person who is being honest and truthful will show a decrease of these symptoms as the interview progresses. On the other hand, someone who is lying will become more nervous and display continued symptoms over the course of the interview.

Asking specific questions will allow you to gauge how honest the person is willing to be with you. Try to focus on their verbal (speech), nonverbal (body language), and paralinguistic (how fast

they answer, is their behavior consistent with their response) behavior. The following questions are commonly asked during the interview process:

- Why do you think you are being interviewed today?
- How do you feel about being interviewed on this topic?
- The reason for the interview is to find out why you are pulling an unusually high volume of narcotics, which to us is an indication of diversion (describe diversion). Are you taking these narcotics for yourself and not giving them to the patients? If you are, it is important that you tell us that now.
- Can you give us an explanation as to why your usage is significantly higher than others on your floor?
- Do you have coworkers who can vouch for the rationale behind the high volume of drugs that you are pulling?

**TABLE 1**  
**Signs and Symptoms of Drug Addiction<sup>2</sup>**

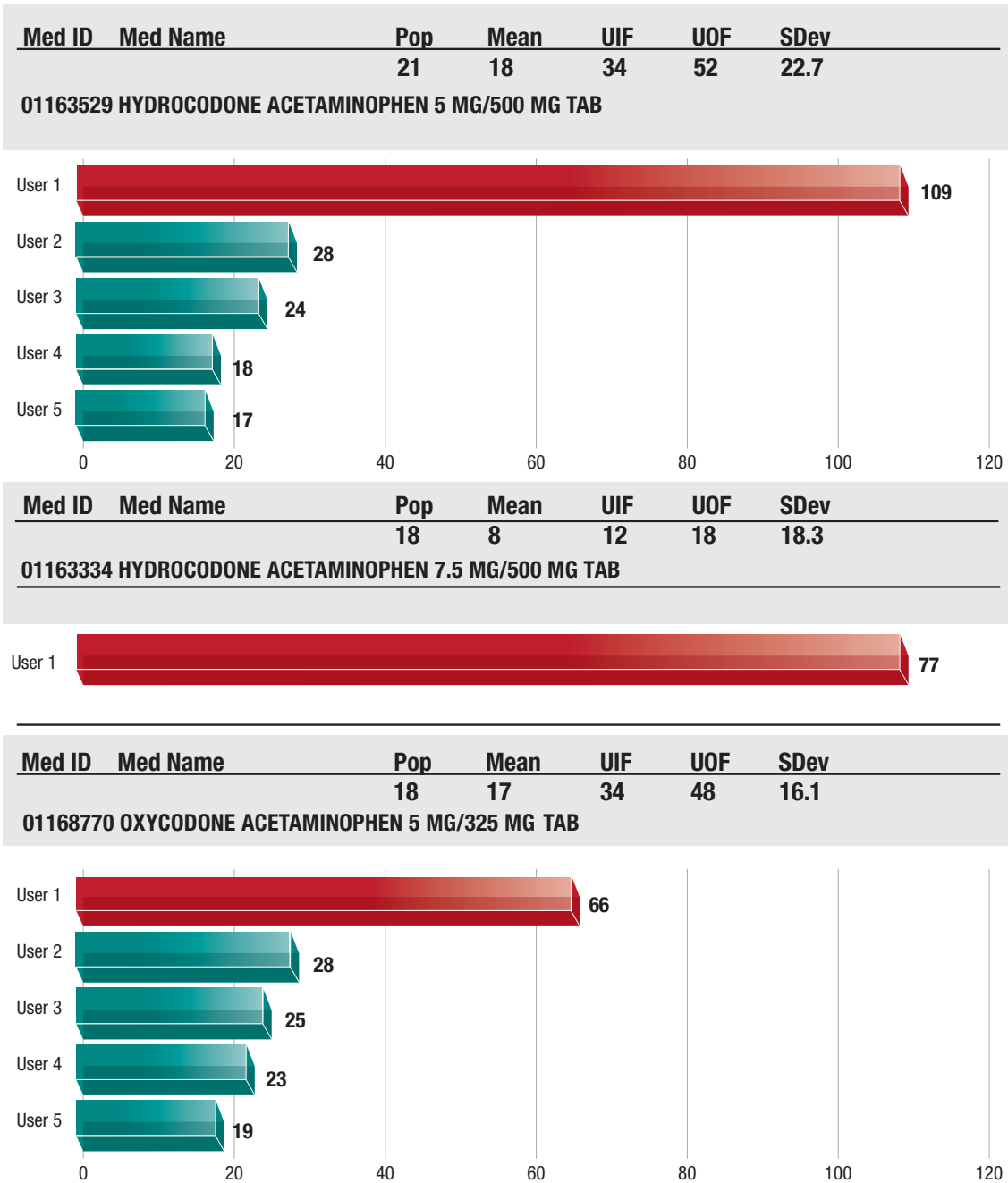
Work absenteeism—absences without notification and an excessive number of sick days
Frequent disappearances from the work site, having long unexplained absences, making improbable excuses, and taking frequent or long trips to the bathroom
Excessive amounts of time spent near a drug supply. They volunteer for overtime and are at work when not scheduled to be there
Unreliability in keeping appointments and meeting deadlines
Work performance which alternates between periods of high and low productivity and may suffer from mistakes made due to inattention, poor judgment, and bad decisions
Confusion, memory loss, and difficulty concentrating or recalling details and instructions. Ordinary tasks require greater effort and consume more time
Interpersonal relations with colleagues, staff, and patients suffer. Rarely admits errors or accepts blame for errors or oversights
Heavy “wastage” of drugs
Sloppy recordkeeping
Progressive deterioration in personal appearance and hygiene
Uncharacteristic deterioration of handwriting and charting
Wearing long sleeves when inappropriate
Personality change—mood swings, anxiety, depression, lack of impulse control, suicidal thoughts or gestures
Patient and staff complaints about health care provider’s changing attitude/behavior
Increasing personal and professional isolation





- Is there any reason why another employee would name you as someone who would divert drugs?
- When we complete this investigation, and pull all the necessary data and interviews together, how do you feel this investigation will be resolved?
- Are you taking any prescription medications? Is there any reason that a fitness-for-duty test performed after this meeting would show a scheduled narcotic in your system?
- What do you think should happen to an employee who is caught diverting narcotics?
- Do you think the police should get involved with internal drug diversion in our organization?
- Do you think that someone found diverting drugs deserves a second chance under any circumstances?

**FIGURE 1**  
**Anomalous Usage Report Example**



Pop, population; SDev, standard deviation; UIF, upper inner fencepost, UOF; upper outer fencepost.

To determine whether someone is being truthful or deceptive requires much more than simply relying on common sense or an understanding of normal and abnormal human behavior. Uncovering deception often takes training and repetition to master. Many companies offer this kind of training for a wide array of industries. To effectively use this interview approach it is highly recommended that an investment be made in training programs for pharmacy and security leaders who are responsible for uncovering diversion.

Without a systematized approach, **hospitals are vulnerable to major drug diversion and subsequent public and legal repercussions.**

### Follow-up Steps

If the employee confesses to diversion, certain steps must be taken. Have the employee complete a written statement at the conclusion of the interview, detailing the nature and scope of the diversion. Conduct a search of the employee's belongings as defined by organizational policy, and have the employee escorted to employee health or the ER for a drug screen panel. Inform the employee that he or she is now on administrative leave without pay until the screen returns and the team meets to review the case findings.

Different facilities will have various perspectives on the rehiring of employees who have completed a program and can prove they are no longer using and diverting medications. Although some facilities may hire back these employees, Northeast Georgia Medical Center has adopted a zero tolerance policy, meaning that we do not hire these employees back. We regard our commitment to safe patient care our top priority.

### Reporting Requirements

Depending on your state's requirements, reporting to the state licensure board may be required, in addition to both state narcotics agents and local authorities. If there is a substantial loss, the DEA must be notified.<sup>3</sup> It is also a requirement to report any diversion to the CEO of the health system.

### Conclusion

Drug abuse is a significant problem in the United States. With the comparable rates of addiction among health care workers, the potential of drug diversion occurring in our health systems is a constant issue. A vigilant approach is required to help prevent, monitor for, and investigate drug diversion. The ideal method is multidimensional, and includes explicit policies, detection methods, investigation processes, and an organizational culture of readiness. Without a systematized approach, hospitals are vulnerable to major drug diversion and subsequent public and legal repercussions. ■

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# Investigate and Manage Suspected Drug Diversion

By Ashley Tortorici, PharmD, and Bill Turner, RPh

**R**egulatory agencies surveying hospitals have high expectations of pharmacy departments when it comes to monitoring the use, and potential diversion of, controlled substances. To meet those expectations, facilities should require internal audits to help identify clinicians with unusual dispensing patterns that might be indicative of diverting controlled substances. When unusual patterns are identified, the challenging work begins—investigation, and in cases of proven diversion, confronting the diverter and reporting these events to the appropriate agencies.

Palomar Pomerado Health is a public hospital district in northern San Diego County, California, that includes the 319-bed Palomar Medical Center in Escondido and the 107-bed Pomerado Hospital in Poway, as well as two long-term care facilities. The hospital district has had a very clear policy regarding the inappropriate use, possession, and/or sale of alcohol, drugs, and other substances that can adversely affect an employee's job performance and patient safety. However, a policy defining the procedure for monitoring controlled substance medication use, and the process for investigation and reporting of proven incidents of diversion, was not in place. Pharmacy leadership's concerns about the absence of a clear policy and procedure (P&P) were amplified by a mock regulatory surveyor's comments that such a process was lacking and should be developed immediately.

**Anticipating a political maelstrom trying to obtain other disciplines' buy-in, we sought the involvement of the district's corporate compliance officer, who is responsible for ensuring compliance with state and federal law.**

**In our facility, we listen to our employees carefully** and keep an open mind regarding possible diversion, but concern also needs to be expressed when an employee's usage patterns are suspicious.



Reinforcing this idea, an alarming incident occurred in one of our hospitals in which nursing management pursued an investigation of a suspected nurse diverter on their own without consulting the pharmacy until near the conclusion of the analysis. Leading up to the inquiry, pharmacy had been auditing the nurse's unusual activity and reporting it to nursing management, but this sharing of information was not reciprocal, and pharmacy was left out of the ensuing investigation. Diversion is a significant employee and patient safety concern, and cannot be handled in a vague or unclear manner. To remedy this, we sought to develop a definitive, guiding P&P protocol to ensure all staff members are aware of the steps that should be taken when diversion is suspected.

## Developing a Hospital-wide Policy and Procedure

The pharmacy leadership group initially struggled to define the best approach to developing comprehensive P&Ps. Anticipating a political maelstrom trying to obtain other disciplines' buy-in, we sought the involvement of the district's corporate compliance officer, who is responsible for ensuring compliance with state and federal law. Initially our medication safety pharmacist contacted other hospitals in the area to see if they would be willing to share their drug diversion P&Ps for reference. The pharmacy department used the responses to help create a template for the initial draft of the drug diversion protocol. Our lead automated dispensing cabinet (ADC) technician, who is an expert on ADC functionality, was instrumental in outlining the auditing process for the initial draft.

Once this draft was created, a multi-disciplinary group was formed to edit and revise the document. This group included individuals from a variety of departments, including the corporate compliance officer, the medical staff manager, a chief nursing executive, a human resources representative, the managers of both our pharmacy departments, and the medication safety specialist. One of the challenges in creating the document was that the group was tasked with encompassing not just nursing, but the management of diversion in all departments of both of our hospitals, as well as our two long-term care facilities. The templates we received from other hospitals typically covered audits for the nursing department only, so we spent a significant amount of time researching how to make our P&Ps appropriate for all areas in all our facilities. After receiving initial feedback from the group, pharmacy worked on the draft protocol for several months through completion. The document that was ultimately created describes how diversion can be mitigated through the auditing of pharmacists, pharmacy technicians, physicians, and nursing, as well as staff in our long-term care facilities. (See Sample Policies and Procedures.)

This new P&P outlined the steps pharmacy should take to monitor diversion, who should be contacted when diversion is suspected, and what outside agencies need to be notified when diversion is confirmed. The pharmacy department prints a report that compares ADC activity versus controlled substances safe activity at least every three days, looking for any suspicious patterns. This report allows the auditor to compare the narcotics removed from the narcotics safe to those delivered to the ADC stations, as well as other medications that have been returned or expired. If discrepancies are discovered and cannot be resolved, the pharmacy manager or supervisor is notified.

## Managing Diversion in Specific Hospital Departments

### Operating Room

Diversion monitoring in the OR requires a distinctive process. To monitor anesthesiologists, pharmacy runs an ADC charge/credit report at least weekly to investigate discrepancies between narcotics pulled

## Sample Policies and Procedures for the INVESTIGATION AND REPORTING OF DRUG DIVERSION

### I. PURPOSE:

The intent of this procedure is to identify persons responsible for monitoring drug diversion and execution of appropriate reporting and disciplinary actions.

### II. DEFINITIONS:

*Proactive Diversion Report:* This report identifies diversion trends in the early stages through statistical analysis. All users falling outside of standard dosing practice (by three standard deviations or more) for a nursing area appear on this report.

### III. TEXT / STANDARDS OF PRACTICE:

#### Professions Monitored by the Pharmacy Director or the Pharmacy Designee:

##### A. Pharmacists and Pharmacy Technicians

1. An automated dispensing cabinet (ADC) versus controlled substances safe Compare Report will be printed and reviewed as least every three days for all activities during the previous day(s) which will compare narcotics removed from the narcotic safe to delivery to ADCs, narcotic returns, and wastes. The pharmacy-designated employee running the report will attempt to resolve discrepancies, but any unresolved discrepancies will be reported to the pharmacy manager or supervisor, who will be responsible for further investigation of the discrepancy.

##### B. Anesthesiologists

1. An ADC Charge/Credit report or similar ADC activity report will be utilized on at least a weekly basis to investigate discrepancies between narcotics pulled from the OR ADC to the anesthesia records for an individual anesthesiologist. Actions that will be researched include removal of anesthesia bags, additional removal of narcotics from ADCs, and documentation of narcotics administered and wasted.

##### C. Nursing

1. A Proactive Diversion Report or an Anomalous Usage Report will be printed by pharmacy and reviewed by the pharmacy manager (or designee) monthly, as a screening tool for ADC users that have removed larger than normal quantities of controlled substances. Pharmacy will review the previous month's findings by Day 7 of the following month.

##### D. Long-term Care

1. Any discrepancy in controlled substance counts is reported to the director of nursing immediately. The director of nursing investigates and makes every reasonable effort to reconcile all reported discrepancies while nurses remain on duty. The director of nursing documents irreconcilable discrepancies in a report to the administrator.

**Reporting to outside agencies will be coordinated by the corporate compliance officer, pharmacy, and the investigating manager/medical staff leader.** Questions from outside agencies should be referred to the pharmacy manager (or pharmacist in charge) or investigating manager. No documents with protected health information may be distributed to outside agencies until approved by the corporate compliance officer.

To view this sample P&P online in its entirety, visit [www.pppmag.com/DiversionPolicy](http://www.pppmag.com/DiversionPolicy)





## One Approach to Uncovering Diversion

**One successful technique pharmacy employed recently to thwart a diverter was to visit a patient who had just been given a controlled substance medication and qualitatively gauge pain relief.** The nurse suspected of diverting had signed out two oral pain medications for a patient, but as a result of pharmacy's discussion with this patient, it was discovered that he had not received any oral medications for pain. The patient did not, however, complain of pain, since he had recently received a parenteral dose of pain medication.

This fact sparked our interest and we consequently learned a trick this diverter had used: his usage patterns of parenteral medications for his patients were higher than average, and it was discovered that he treated his patients with those medications and then signed out potent oral pain medications for that same patient to divert for himself. He most likely justified his actions to himself by attending to his patients with potent injectable medications, believing then that it would pose no observable danger to the patient to divert the oral drugs prescribed for them—obviously a dangerous and unacceptable practice. When confronted with the evidence, he admitted to having a problem and was referred to rehab for treatment.

from the OR ADC and the anesthesia records for an individual anesthesiologist. The auditor reviews actions that include the removal of anesthesia bags, any additional removal of narcotics from the ADC, and documentation of narcotics administered and wasted. When discrepancies are identified, the pharmacy designee contacts the individual anesthesiologist(s) to resolve them. If discrepancies cannot be resolved in this manner or a concern is raised about possible impairment or diversion, the chair of the department of anesthesia is contacted in writing.

### Nursing

To monitor for nursing diversion, pharmacy runs a proactive diversion report out of the controlled substances safe or an anomalous usage report out of our dispensing analytics system at least monthly. These reports allow the auditor to identify ADC users that have removed larger than normal quantities of controlled substances. The reports are populated according to nursing unit, so the nurses that are compared are ones caring for patients of the same acuity, and thus should be administering about the same amount of controlled substances. If an ADC user has been statistically identified as being three standard deviations above the mean for narcotic withdrawals, an ADC transaction report will be reviewed for that individual. A manager also may request such reports at any time in the event of questionable employee behavior or other indices

of suspicion. When reviewing these reports, the auditor focuses on key points, such as excessive discrepancies, excess or lack of waste with the same witness, removals from multiple ADCs, and anything else that seems unusual. After pharmacy review, the reports are sent with a cover letter to the appropriate manager with a brief assessment of any findings the pharmacy has identified. Our policy is to allow 10 days to review the materials and reply back to pharmacy. To ensure follow-up, a copy of the cover letter is kept in the pharmacy.

The nurse managers can respond in one of two ways. They can sign and return the cover letter, which would mean that their review did not lead them to believe the individual was diverting. They also can request, in writing, additional time or reports to further monitor the individual in question. In this situation, pharmacy would consider this an ongoing investigation and a pharmacy designee and the nursing manager would continue to monitor the individual with closer scrutiny until the individual is cleared or there is enough information to confirm diversion. If diversion is identified, the nursing manager must notify pharmacy of the names of the diverted drugs and the number of doses known or suspected to be diverted. The manager also should include any pertinent information on how the diversion occurred.

If the employee refuses to admit that he or she has a problem or if the diverter was found to be selling controlled substances to others, **we are more likely to report the diversion to law enforcement.**

### Long-term Care

In our long-term care facilities, any controlled substance count discrepancies are immediately reported to the director of nursing, whose responsibility it is to investigate and attempt to reconcile all reported variances while the nurse in question remains on duty. The director of nursing documents irreconcilable discrepancies in a report to the administrator; any apparent criminal activity must be reported to the pharmacy manager with oversight of the respective facility, the administrator, and the consultant pharmacist.

### Steps Taken When Diversion is Suspected

When diversion is suspected, the multidisciplinary group outlined in the P&Ps is contacted to help facilitate the investigation. The investigative team understands that the risk resulting from diversion is very high, both to patients and staff, and thus ultimately to the



entire district. The institution's risk manager is notified right away, through a quality review report, when there is potential impact on patient care. Human resources is also contacted to guide the proper flow of investigation and to protect the employee's rights. The pharmacy manager also may decide to revoke the individual's access to ADCs when appropriate. If a physician is suspected of diversion, the chair of the physician's department is notified. Last of all, the pharmacy billing technician needs to rectify any billing issues related to drug loss or theft if a patient was charged for a medication that he or she did not receive.

### Interviewing the Suspected Diverter

When investigating suspected diversion, at some point the employee must be interviewed about their unusual controlled substance usage patterns. Their reactions to questioning can vary widely. An initial inquiry before conclusive evidence is addressed offers an opportunity for the employee to present their side of the story. In our facility, we listen to our employees carefully and keep an open mind regarding possible diversion, but concern also needs to be expressed when an employee's usage patterns are suspicious. Sometimes it turns out there is a good reason for odd usage patterns, and the employee should be given the opportunity to refute the possibility of diversion.

However, if the diversion evidence is more conclusive, our experience has been that employees respond in one of two ways: they admit they have a problem and ask for help, or they quit their jobs. Our hospital culture supports helping those that admit they have a problem, so these employees are typically directed to our employee assistance program, which usually refers them to a rehab program. Employees are given the opportunity to self-report to the state board of their profession; however, the investigative team follows up to ensure that this happens.

### Reporting Diversion to Outside Agencies

Once diversion has been confirmed, a number of agencies are contacted and made aware of the case. At our facility, the corporate compliance officer, the pharmacy department, and the investigating manager are all involved at this stage. The investigating manager is responsible for making sure a report is filed with the individual's licensing board (ie, nursing, medical, or pharmacy). Pharmacy is tasked with reporting to the Drug Enforcement Administration and to the pharmacy director and chief executive officer, per policy. Pharmacy is also responsible for reporting to local authorities, if appropriate. Whether to include law enforcement is always a tough decision faced by our team. If the employee refuses to admit that he or she has a problem or if the diverter was found to be selling controlled substances to others, we are more likely to report the diversion to law enforcement.

### Maintaining Diversion P&Ps

To help enforce the drug diversion P&Ps, the pharmacy department works closely with nurses and anesthesiologists to help them understand and best manage the monitoring process for controlled substances. Pharmacy provides in-services for nursing staff to help

them recognize the danger to patients introduced by employee controlled-substance diversion. Pharmacy managers educate nurse managers and anesthesiology leaders, and present the results of audits, including compliance percentages, at their leadership and section meetings.

**One policy that is difficult to enforce** is the 10-day turnaround time for follow-up with nurses having greater than three standard deviations above the mean for narcotic removals.

One policy that is difficult to enforce is the 10-day turnaround time for follow-up with nurses having greater than three standard deviations above the mean for narcotic removals. As further proof of the problem, an external auditor validated poor compliance with the 10-day turnaround window. To remedy the situation, the pharmacy shared these results with nurse leaders and managers. Education has improved compliance with the 10-day window, but continual reinforcement remains necessary.

### Conclusion

Due to the inherent dangers that employees misusing or abusing prescription drugs bring to patients, facilities, and themselves, hospitals need to have clear, well-defined P&Ps in place to manage these difficult situations. The document should not only include steps for uncovering diversion, it also should contain steps to take after a case of diversion has been verified. A multidisciplinary, investigative team approach is critical to promoting ideal communication among departments when diversion is suspected or validated. Ultimately, the safety of the patient is paramount, and this principle should guide all investigations and actions taken when responding to possible drug diversion. ■

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# The Legal Ramifications of Diversion Prevention

By Ralph J. Frank Jr, RPh, MPH, and Barbara T. Burke, JD, RN, MS

**D**rug diversion represents a significant public health concern across the United States and estimates of prescription medication misuse suggest a problem of greater magnitude than illicit drugs. Nonmedical uses of opioid pain relievers alone are projected to cost insurance companies upwards of \$73 billion annually in health care costs.<sup>1,2</sup> Furthermore, in 2009, 1.2 million ED visits were related to misuse or abuse of pharmaceuticals.<sup>1</sup> Hospitals present the greatest potential for diversion of prescription medications because medication inventories are abundant and are spread across numerous system access points, including medication rooms and automated dispensing cabinets (ADCs). Further complicating the problem is the higher rate of prescription drug abuse noted in health care workers when compared to the general public due to their increased access to these substances on a regular basis.<sup>3,4</sup>

Within a hospital, pharmacy holds a fundamental responsibility for managing all medications throughout the facility, and ensuring the safety and security of patients and staff when it comes to medication use. Furthermore, pharmacy bears responsibility for ongoing oversight of medication supplies to facilitate early detection of adulteration, abuse, or diversion. Numerous regulatory agencies mandate this responsibility, including the Drug Enforcement Agency, state boards of pharmacy, and accreditation bodies such as The Joint Commission.

## Design an Effective Diversion Prevention Program

Diversion routinely involves three basic medication types or classes: high-cost medications intended for resale, performance-enhancing medications, and controlled substances. Regardless of the class of medications involved, a multi-tiered and carefully designed surveillance system is essential to the early detection and resolution of diversion. The most successful programs employ multifocal strategies for surveillance, detection, and remediation and are based on the contributions of a multidisciplinary team. Likewise, program objectives, goals, as well as policies and procedures (P&Ps) must be clearly defined and well publicized in order to be effective.

Written P&Ps should provide clear direction and lines of authority for the reporting, investigation, and resolution of diversion episodes, as well as managing those individuals involved in diversion. The term diversion must be clearly defined and sufficiently broad to include future classes of medications. P&Ps must instruct all employees of their responsibility to report any suspected diversion or suspicious activities and also must define the chain of command for reporting and investigating such claims. It is equally important to outline the individual responsibilities of the chain's hierarchy. Although the chain of command will vary according to

the size and other characteristics of each institution, the following positions are commonly included:

### **Staff Member's Direct Supervisor**

Oversees activities of those under his or her span of control, including monitoring for behavioral changes, signs and symptoms of diversion, anomalous changes in inventory levels, and detection of abnormal activity

### **Director of Pharmacy**

Is accountable to senior administration, regulatory authorities, and licensing bodies for the activities of the pharmacy department as it relates to diversion, and its adherence to performance and conduct set forth in policies and regulations

### **Human Resources Representative**

Develops and executes policies governing behavior within the institution

### **State/Federal Drug Control Authority Representative**

Ensures that hospital pharmacies adhere to regulations set forth in statutes and investigates deviations from accepted standards of practice

## Employee and Data Surveillance

Observational monitoring of staff by supervisors can lead to early detection of common physical and emotional signs and symptoms of substance abuse. Documentation of these observations over time creates a contemporaneous record of potential diversion, but this documentation must be objective, detailed, and whenever possible, corroborated by another supervisor. Suspicion should be raised when any of the following are noted:

- Erratic attendance, tardiness, and unanticipated absences
- Increased confrontation with coworkers
- Unpredictable mood swings
- Secretive behavior such as leaving for unknown reasons without prior notice
- Inappropriate clothing for the environment/time of year
- Behavior suggestive of impairment such as tremors, slurred speech, or unsteady gait
- Unexpected changes in lifestyle or affluence

Effective diversion prevention also requires regular surveillance of medication inventory as well as ongoing review of ADC transaction reports for changes in patterns of use or dispensing. To assist these

efforts, several effective computer applications are available that automatically monitor all controlled substance transactions. Monitoring discrepancy reports from ADCs and proof-of-use sheets, along with correlating drug destruction reports with dispensing activities, can provide early insight into potential diversion activities.

### If Diversion Is Suspected

The central mission of hospitals is to protect and promote the safety and welfare of their patients and staff. As such, hospitals are expected to serve as patient advocates and have a moral and ethical (as well as legal) obligation to adhere to mandates set forth by statutes and regulatory agencies, including monitoring for illegal and unprofessional behavior. Keep in mind, individuals accused of diversion are entitled to the presumption of innocence until proven guilty. They also have the right to a notification of alleged charges, to view evidence presented against them, and to legal representation. The rights of the hospital in cases of diversion or suspected diversion are largely dictated through internal policies regarding theft and fitness for duty. Therefore, policies should be in place to address as many contingencies as possible without constraining the organization with cumbersome detail. Such policies should clearly define drug diversion within the context and scope of the organization's operation, responsibilities for reporting of diversion, the manner of disposition of diversion allegations, the reporting cascade for diversion events, as well as the manner of involvement of external authorities.

The hospital's policy, as well as state laws, should dictate the role of substance abuse testing. Hospitals that engage in substance abuse testing must have a comprehensive written policy that is uniformly applied to all employees. In states where reasonable suspicion testing (see **SIDEBAR**) is allowed, adherence to the criteria authorizing this manner of testing must be followed, and the institution's policy must clearly delineate the consequences of refusal to test. A copy of this policy should be provided to all employees for review prior to commencement of duties.

When testing is permitted, the suspected diverted medication must be considered in order to select the best test methodology (eg, urine vs blood). In order to avoid challenges to test integrity, specimens must be collected under a strict chain of custody and a confirmatory test methodology equivalent in accuracy to gas chromatography or mass spectroscopy should be employed. Hair testing has limited utility due to its inability to detect the presence of a specific drug at a discrete point in time.

### Interviewing a Suspected Diverter

Interviews conducted for suspected episodes of diversion must be carefully prepared and structured. The accused should be escorted directly to the interview site by their direct supervisor without any stops en route, and the interview should take place in a private, quiet location away from the subject's workplace. Interviews should be conducted as close in time to the alleged diversion as possible, but only after sufficient evidence has been collected and is ready for presentation. Evidence should be based on objective sources to the greatest extent possible, and all interviews should be disclosed and

## Reasonable Suspicion Testing

**There are a variety of circumstances under which an organization may require a drug test and reasonable suspicion is among the most common:**

Reasonable suspicion testing is similar to, and sometimes referred to as probable-cause or for-cause testing and is conducted when supervisors document observable signs and symptoms that lead them to suspect drug use or a drug-free workplace policy violation. It is extremely important to have clear, consistent definitions of what behavior justifies drug and alcohol testing and any suspicion should be corroborated by another supervisor or manager. Since this type of testing is at the discretion of management, it requires careful, comprehensive supervisor training. In addition, it is advised that employees who are suspected of drug use or a policy violation not return to work while awaiting the results of reasonable suspicion testing.

Courtesy of the US Department of Labor: <http://www.dol.gov/elaws/asp/drugfree/drugs/dt.asp>

maintained as confidential proceedings. The accused should be informed of his or her rights including the right to legal counsel.

The interview is best conducted by individuals with whom the accused is not familiar, and may include a human resources representative and/or representatives from the state pharmacy regulatory body; the pharmacy director or a designee may also be present. The interview team should meet prior to the interview to designate a lead investigator, plan the interview strategy, and coordinate evidence for a seamless presentation. The interview team should include a trained interviewer, as the correlation of physical, verbal, and cognitive responses during the interview process can provide critical clues regarding guilt or innocence. Behavioral changes and changes in speech, body language, and posturing during the interview contribute to a global picture. Interviewers should watch for increases in rates of perspiration and respiration that do not resolve during the course of the interview, as well as listen for contradictions of previously submitted statements. It is important to understand that a determination of truthfulness relies not only on these observations, but also requires the extensive training and practice in their interpretation that a trained interviewer can provide.

An experienced interviewer is able to interpolate data and information from disparate sources into a global framework through which to assess the guilt or innocence of the alleged diverter. Data gained from statistical review of dispensing, administration, and inventory control records must be considered along with direct and indirect observations, and knowledge of the suspect's personal life in order to create a comprehensive profile upon which to structure the interview questions and direction. Although considerable expertise may be developed through ongoing participation in this genre of interview, advanced techniques may be obtained and refined through participation in commercial interviewer training opportunities.

### Weighing the Evidence

Proceeding with only circumstantial evidence of diversion is difficult, and great care must be exercised if this course of action is chosen. It is inadvisable to proceed with interviews or disciplinary proceedings unless there is a factual, solid basis for the allegations. All collected





## Polygraph Testing

**The Employee Polygraph Protection Act of 1988 (EPPA) generally prevents most private employers from using lie detector tests,** either for pre-employment screening or during the course of employment.<sup>5</sup> Employers generally may not require or request any employee or job applicant to take a lie detector test, or discharge, discipline, or discriminate against an employee or job applicant for refusing to take a test or for exercising other rights under the EPPA. There are, however, certain exemptions when polygraph use is acceptable. The Act permits exemptions for polygraph testing of certain employees of private firms who are reasonably suspected of involvement in a workplace incident, such as theft, embezzlement, diversion, etc, that resulted in specific economic loss or injury to the employer. When polygraph examinations are allowed, they are subject to strict standards for the conduct of the test, including the pretest, testing, and post testing phases. Polygraph examiners must be licensed and bonded or have professional liability coverage. The Act also strictly limits the disclosure of information obtained during a polygraph test. Keep in mind, the admissibility of polygraph testing varies from jurisdiction to jurisdiction; some states allow results by stipulation while other states completely ban it.

diversion evidence, whether witness observations or data, should be meticulously verified. Whenever possible, obtain observations directly from the witness or supervisor, avoiding secondhand recounts of events. Obtaining supporting data from objective sources, such as ADC counts, lends credibility to the case and helps eliminate claims of subjectivity.

If a suspected diverter claims his or her innocence, what happens next depends upon the strength of the evidence. If the evidence is strong enough without a confession, the case should be pursued. If not, the evidence should be revisited for possible alternative explanations. Should the evidence continue to be compelling although insufficient for a solid case to be made, and the suspect continues to work, surveillance and monitoring for subsequent events should continue, and supervisors should consider assigning the employee to roles with less accessibility to high-risk substances.

Should the accused admit guilt, immediately suspend employment if permitted through HR policy. Hospital and patient security must be protected; therefore, it is crucial to immediately revoke this employee's access to all secure locations and informational systems through inactivation of all passwords, and confiscation of all work-related identification cards, work materials, and keys. Ask the accused to provide written narrative documentation of all activities surrounding the incident. If available, offer him or her the option of assistance for drug abuse rehabilitation. Ultimately, there is no statutory obligation to provide rehabilitation services to an admitted diverter who seeks help. Nevertheless, it is good practice to provide assistance to individuals involved in diversion. Sudden unemployment with no

source of income may cause the diverter to resort to further criminal activity to maintain their lifestyle. Without the option of rehabilitation, the problem is not resolved but merely displaced.

### Concluding Steps

The state board of pharmacy should be notified as soon as a diversion episode has been positively identified. All proceedings involving diversion investigations and interviews should be treated as confidential information, with only authorized individuals notified of the outcome. This includes, at a minimum, the board of pharmacy, the human resources representative, the director of pharmacy, and the hospital CEO. Should a suspected but unproven diverter leave your facility and seek employment elsewhere, human resources policy should clearly define what information may be provided to outside employers on reference checks, keeping in mind that the presumption of innocence remains. Many hospitals have a policy to only verify an individual's dates of employment.

Whatever the outcome, a rigorous diversion prevention program, supported by clear and responsible P&CPs and diligent surveillance and enforcement will not only ensure your facility's compliance with state and federal regulations, but will help protect your institution's staff and patients from the risks of impaired practitioners. ■

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# Addressing Substance Abuse in the Pharmacy

By Wallace Cross, BS Pharm, MHS, CADC

**T**he public consistently ranks pharmacists as being among the most honest and ethical of all professional groups.<sup>1</sup> Therefore, it might be surprising to learn that one in nine, or about 11% of pharmacists, suffers from addictive disease (AD) at some point in their career.<sup>2</sup>

The combination of easy access, job stress, and a host of other factors conspire to make nonmedical prescription substance abuse a problem in the pharmacy setting.

However, it is promising to note that pharmacists are generally more successful at recovery than the population at large and than other groups of health care professionals. Fortunately, numerous opportunities exist for confidential, successful treatment, including facilities that specialize in treating health care professionals. Greater awareness of treatment programs and education about AD that begins in pharmacy school are the keys to illuminating the problem, treating addicted pharmacists, and protecting the public at large.

**Fortunately, numerous opportunities exist for confidential, successful treatment, including facilities that specialize in treating health care professionals.**

## Risk Factors Unique to Pharmacists

Sheer access and exposure to prescription addicting substances may explain why substance abuse is more common among pharmacists than among the general public. In fact, pharmacists may have the highest risk work setting of any professional group when it comes to AD.

It is not uncommon for pharmacists to be responsible for filling enormous numbers of prescriptions daily, often without adequate help. The high number of opportunities to make mistakes can lead to high levels of stress and, ultimately, job dissatisfaction.<sup>3</sup>

Job stress, added to ready access to highly addictive substances in an environment that often tolerates self-medication, can make diverting medications seem innocuous. If a layperson develops

**TABLE 1**

## DSM-V Criteria for Substance Use Disorder<sup>1</sup>

In the latest version of the DSM, *Substance Use Disorder* is the diagnosis used instead of the previous diagnoses *Substance Abuse* and *Substance Dependence*. To be diagnosed with substance use disorder, the patient must meet at least two of the following 11 criteria for the diagnosis. Meeting two to three of the criteria indicates mild substance use disorder, meeting four to five criteria indicates moderate, and meeting six to seven indicates severe.

### Diagnostic Criteria

- Continuing to use opioids despite negative personal consequences
- Repeatedly unable to carry out major obligations at work, school, or home due to opioid use
- Recurrent use of opioids in physically hazardous situations
- Continued use despite persistent or recurring social or interpersonal problems caused or made worse by opioid use
- Tolerance as defined by either a need for markedly increased amounts to achieve intoxication or desired effect or markedly diminished effect with continued use of the same amount
- Withdrawal manifesting as either characteristic syndrome or the substance is used to avoid withdrawal
- Using greater amounts or using over a longer time period than intended
- Persistent desire or unsuccessful efforts to cut down or control opioid use
- Spending a lot of time obtaining, using, or recovering from using opioids
- Stopping or reducing important social, occupational, or recreational activities due to opioid use
- Consistent use of opioids despite acknowledgment of persistent or recurrent physical or psychological difficulties from using opioids
- Craving or a strong desire to use opioids

<sup>1</sup>American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.



SIDEBAR 1

Treatment Facilities that Specialize in Treating Health Care Professionals

Betty Ford Center  
Rancho Mirage, CA  
www.bettyfordcenter.org

Farley Center  
Williamsburg, VA  
www.farleycenter.com

Hazelden  
(multiple locations)  
www.hazelden.org

Pine Grove Behavioral Health and Addiction Services  
Hattiesburg, MS  
www.pinegrovetreatment.com

Presence Behavioral Health (formerly Resurrection)  
Chicago, IL  
www.presencehealth.org

Professional Renewal Center  
Lawrence, KS  
www.prckansas.org

Rogers Memorial  
Milwaukee and Oconomowoc, WI  
www.rogershospital.org

Talbott Recovery Campus  
Atlanta, GA  
www.talbottcampus.com

TABLE 2

Signs of Addictive Disease in the Workplace

Changes in behavior in the workplace are often exhibited by those with addictive disease.

Increased absences
Tardiness
Long bathroom breaks
Mysterious disappearances
Morning grogginess
Generally seems “different”
Stays late for no apparent reason
Becomes confused easily
Increased problems in personal life
Appears more unkempt than previously
Looks/sounds mildly impaired for short periods
Appears distant/hard to reach emotionally
Comes to work on days off and “helps out” for short periods

diarrhea, a coworker might suggest purchasing an over-the-counter remedy or seeing a doctor; however, if a pharmacist complains of diarrhea, a colleague might suggest taking a few Lomotil. Mention of a splitting headache may result in a recommendation for Fiorinal. Muscle or back pain from weekend activities might lead to Monday morning Vicodin. Pharmacists may begin rationalizing the drug-taking behavior by thinking, *At least I was able to stay at work and not go home sick.*

Other factors that can place health care professionals at high risk for abuse include<sup>4</sup>:

- A genetic predisposition to addiction (ie, a family history of dependence)
- Long work hours and shift work
- Feelings of invincibility, or believing that being knowledgeable about the pharmacodynamics of potentially addictive medications protects against addiction

- Social factors, including a lack of peer, academic, or occupational discouragement for prescription diversion
- Comorbid mental disorders or medical conditions, particularly those involving chronic pain

Inadequate training and education about addiction adds to the risk of pharmacists developing AD. Most pharmacy schools teach little about the subject. They may touch on the pharmacology of an addicting agent, but seldom delve deeper. Pharmacy schools should teach students about the psychological and biological aspects of addiction, the criteria for the condition (see **TABLE 1**), and the options available for recovery and treatment. Students should learn that confidential treatment programs exist, and they should know how to get help if required.

In addition, pharmacy workplaces should have pamphlets readily available that discuss AD and detail where employees can go for a confidential chemical dependency assessment (usually free

of charge). One way to find a treatment center is to visit the site of the Pharmacists Recovery Network (PRN; [www.usaprn.org](http://www.usaprn.org)), a unique network dedicated to helping addicted pharmacists and pharmacy students. Moreover, information is available at [www.drug-rehab.org](http://www.drug-rehab.org), a non-profit group that provides referrals to treatment programs in all 50 states. (For additional treatment options, see **SIDEBAR 1: Treatment Facilities that Specialize in Treating Health Care Professionals.**)

### Conscientiousness Leads to Reticence

Pharmacists tend to be extremely conscientious about their jobs and the responsibility they have to the health of their patients. This feeling, combined with the fear and shame of losing their license and/or livelihood, may make them more reticent than other health care professionals to seek help. Additionally, the problem may be easier for them to cover up, as it is uncommon for pharmacists to use IV or illegal drugs, and they seldom obtain drugs from anywhere other than their workplace. In fact, hydrocodone is most commonly the pharmacist's drug of choice.

Many pharmacists are unaware that they can get help for AD confidentially. Allowing pharmacists to come forward confidentially helps minimize risk to the public. Most pharmacists believe that coming forward and requesting assistance will mean the end of their career, but pharmacists should be aware that HIPAA guidelines strictly prohibit private treatment programs from discussing any patient with anyone. PRN programs can potentially report a pharmacist who refuses to comply with treatment or after-care protocols to the pharmacy board, but pharmacists should be assured that PRN programs give pharmacists every opportunity to succeed at recovery.

### If You Suspect a Colleague Has Addictive Disease

If a coworker is exhibiting a number of the signs listed in **TABLE 2**, and you suspect AD, a first step might be to contact PRN or any pharmacist recovery program. Once you have done so, you can approach the addict with the information that you contacted a confidential treatment program and that they are now aware of the situation. Explain that the only way to avoid repercussions is for the addict to contact the program for help voluntarily. If the coworker does not, he or she will be reported to the pharmacy board.

Most recovery programs are based on the 12 steps made famous by Alcoholics Anonymous (AA). In fact, most programs require a minimum of three AA or Narcotics Anonymous (NA) meetings per week. Most also require working with a sponsor and participating in a health professional's after-care or Caduceus group. Some require individual therapy.

Treatment programs commonly begin with an active treatment phase lasting approximately 6 to 10 weeks. Although some are

#### SIDEBAR 2

### Portrait of a Typical Pharmacist Addict

**Mary is a 28-year-old, divorced single mother with a four-year-old daughter.** She works the day shift as a pharmacist on the inpatient unit in a large suburban hospital. The hospital provides a day care center where she can leave her daughter while she works.

Mary suffers from chronic lower back pain and has a prescription for Vicodin, which she has progressively taken in larger and larger doses. She begins suffering fairly serious withdrawal symptoms whenever she tries to cut back.

Feeling afraid, overwhelmed, and unable to manage her job and care for her daughter, Mary began diverting Vicodin from her workplace. She was successful for six months, but Mary's diversion was eventually discovered. Her hospital offered her a last chance contract, which stipulated that if Mary sought professional help and followed through with all of the treatment recommendations, she could retain her job.

Mary was referred to her state's PRN Program, which referred her to a recovery facility specializing in treating health care professionals. Mary successfully completed an eight-week treatment stay and began the facility's two-year aftercare group therapy program (once per week). Mary also complied with frequent, random urine screens, three AA/NA meetings per week, and a regimen of monthly Vivitrol. Because Mary remained fully compliant with all of the recommendations made by the treatment facility and the PRN Program, she was not reported to the pharmacy board in her state.

Today, Mary has been successful in her recovery for over five years and has completed all of her monitoring obligations, but continues to invest in her AA/NA program by attending her regular weekly AA/NA meetings and meeting regularly with her AA/NA sponsor.

designed as complete inpatient programs, many are termed *boarded partial hospitalization programs*. For example, in the program at Presence Behavioral Health, patients live in apartments across the street from the treatment facility. This allows them to maintain some independence when they are not in treatment sessions and attend AA or NA meetings in the evenings.

Most after-care programs last about two years and involve weekly group therapy sessions, as well as ongoing AA or NA meetings. Following participation in after-care, participants often have certain practice restrictions and should expect to be monitored in the workplace for five years. Because almost three-quarters of pharmacists who have ADs are addicted to opioids,<sup>4</sup> one of the conditions for returning to work may be that the pharmacist takes the opioid blocker Vivitrol. Other restrictions might be that the pharmacist is not allowed to work alone or do shift work.

Participation in a pharmacy assistance program is an extremely strong predictor of successful recovery. One study reported that those pharmacists who were not engaged in a pharmacy

assistance program were 10 times more likely to relapse than those who participated.<sup>4</sup> Interestingly, workplace setting may play a role in job retention. Pharmacists working in community settings—most notably for large pharmacy chains—were far more likely to be terminated than pharmacists working in hospitals or other settings. After identifying their addiction, 75% of community pharmacists, 29% of hospital pharmacists, 17% of students, and 50% of pharmacists from other settings were terminated from their positions.<sup>4</sup>

Because almost three-quarters of pharmacists who have ADs are addicted to opioids, **one of the conditions for returning to work may be that the pharmacist takes the opioid blocker Vivitrol.**

### Pharmacists are Successful at Recovery

Pharmacists are generally more successful at recovery than the population at large and than other groups of health care professionals, such as physicians and nurses (see **SIDEBAR 2**). In fact, in the previously discussed study involving 116 addicted pharmacists, 87% remained abstinent at the end of a two-year follow-up period, as confirmed by random urine screens, clinician observation, and participant self-reports.<sup>4</sup> The study found that being single, as opposed to married, was associated with a higher risk of relapse, as was having a personality disorder, having a prior treatment history, having alcohol as their drug of choice, and not

being fully invested in the 12-step recovery program throughout the follow-up period. Notably, although alcohol is not the drug of choice for most pharmacists, it is associated with a three-time greater risk of relapse for those who abuse it compared with those who do not abuse it.<sup>4</sup>

Part of the reason for the high success rate among pharmacists seeking treatment is the tendency to abuse opioids rather than other agents, which makes the use of naltrexone possible. Naltrexone seems to help protect against relapse. The risk of relapse was eight times greater in pharmacists not prescribed naltrexone than among those using the agent.<sup>4</sup> In addition, pharmacists tend to be more compliant with treatment than other health care groups.

### Light at the End of the Tunnel

Although certain aspects of the pharmacy profession place pharmacists at high risk for AD, confidential, effective treatment is available. Treatment programs tailored specifically to pharmacists offer promising results and the best hope of a return to work.

It is important to remember that even after recovering pharmacists return to the workplace, the high-risk environment mandates attention to return-to-work issues and to ongoing support. Education that begins in pharmacy school and building awareness about the problem remain the best lines of defense. ■

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## Diversion Prevention Resources

A harsh reality is that drug diversion is more prevalent than we want to admit. However, it's critical for the safety of patients and the integrity of the health care institution to proactively address this issue. We trust you will find this compendium of articles a valuable resource, and hope it will trigger conversations at your institution about how to best tackle drug diversion.

For additional resources about drug diversion, please visit our website:  
**[www.omnicell.com/DiversionCentral](http://www.omnicell.com/DiversionCentral)**

You will find resources such as:

- Webinars
- Blogs
- Videos
- Educational tools
- Events

### Do you have a plan for preventing and detecting diversion?

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*"I have identified some diversion cases in as short a time as three days after the diversion started . . ."*

Kimberly New, JD, BSN, RN  
Diversion consultant and educator  
Pandora user

**Please contact us at 855-306-7926 to learn more about how Omnicell can help you with diversion prevention.**

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