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Institutional diversion: A well-kept secret

by John J. Burke

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The incidence of healthcare facility drug diversion in the United States has long been a fundamental problem that has not been properly addressed over the past decades, although there appears to be some light at the end of the proverbial tunnel on this critical issue. At the heart of the issue has been the reluctance by healthcare facilities to properly report these crimes.

First, I want to make sure that I define what I mean when I say drug diversion. There are multi-paragraph explanations on the definition, but I have always chosen to confine myself to a simple explanation: Any criminal act involving a prescription drug.

A wide range of criminal offenses fall into this category; however, this article will focus on the typical crimes that are committed when a healthcare professional illegally secures medication for their own use, meaning medication ordered for a patient that the healthcare professional takes out of the legal path for their own use. Virtually all these offenses are due to self-addiction, and only in very rare instances would these drugs be procured for resale.

A bit of history

I first became acutely aware of the problem when I was fortunate enough to head up and form the Cincinnati Police Division's Pharmaceutical Diversion Squad (PDS) in late 1990. Although very few police agencies were involved in the investigation of pharmaceutical diversion in those days, even fewer had a subspecialty of diversion issues that occurred in healthcare facilities.

PDS was fortunate enough to select a detective for the squad who had some experience in investigating institutional diversion. He certainly assisted us in the startup of this specialty, but we quickly became aware that the Ohio Board of Pharmacy also had a legion of pharmacists who had prior health facility experience, who were responsible for investigating these kinds of offenses for the state board.

These pharmacists quickly became invaluable and a necessary part of the team in investigating these crimes. They were able to provide our detectives with the experience to detect potential violations that could lead to the identification of a perpetrator. Reviewing paperwork in those days, and finding violators without the assistance of software that is available today, was a true art. Only later did software become available that allows health facilities to more easily find potential outliers that many times leads to a person involved in diversion.

Hospitals

As we introduced ourselves to each of the hospitals and the many long-term care (LTC) facilities, the response

was mixed. Ohio has one of the more compliance-friendly regulations and laws involving diversion, including this specialty, but it didn't stop some of the legal departments from pushing back on our interest in trying to press into their world. Because the Ohio Board of Pharmacy (OBP), along with the Drug Enforcement Administration (DEA), held the licensure key to these health facilities being able to administer prescription drugs, we ultimately prevailed, except for one hospital group.

This group, led by the security director who had considerable power in their facilities, was openly defying the law in not reporting diversion immediately to law enforcement as required by the State of Ohio. This came to an end when on Christmas Eve an agency nurse was caught diverting medication and the offense was not reported. A confidential phone call was made to our office, detailing the offense and the scheme to cover it up.

Not reporting these offenses was a crime in Ohio, and I made a trip to the security director's office to advise him that we were considering arresting him for this violation. We didn't want to arrest him and cause the hospital group much embarrassment; we simply wanted him to comply with state law and federal regulations. Although embarrassed, he agreed to comply in the future, and we were, for the most part, receiving these incidents in a timely manner afterwards so we could investigate them and prosecute if the act was criminal.

Long-term care

The LTC facilities were a different problem. They were owned by any number of people, and the management styles were just as diverse. Many of the owners resided outside of Cincinnati and were almost impossible to contact, or we were blocked by their legal counsel.

The answer to this compliance issue was that each of these nursing homes of course administered controlled substances that they received from supplying pharmacies. There were three major ones in our city, along with a few mom-and-pop pharmacies that provided prescription drugs to some neighborhood LTC institutions. All these pharmacies had to be licensed by the OBP and the DEA to function.

The three major supplying pharmacies were extremely cooperative. One employed a young pharmacist who was incredibly adept at recognizing the diversion inside each facility. She was not only very skillful in her detection work, but she contacted us immediately, and we collaborated with her and developed many cases.

Estimating the size of the problem

Over the years I have had the news media ask me repeatedly to give them a sense of this problem across the United States. I routinely told them that I had no idea, since so much of it was unreported. Eventually I decided to take data I had from the Cincinnati Police Division experience and roughly try to figure out the expected problems all over the country.

Since we arrested about 50 nurses per year on these offenses in Cincinnati, I simply took the population of our city at that time (about 400,000) and, along with the approximate U.S. population, came up with the fact that there should be about 102 arrests per day and over 30,000 per year in America! This surprised me, as the number is staggering to say the least, but nonetheless it is the best estimate I can determine. Although the number may seem high, it is likely a low estimate, because there is no way that we caught every offender. It should also be noted that Cincinnati was not a haven for these kinds of offenses; the problem was just getting special attention.

So what number is reported? The answer is not easy, other than to say far less than 30,000+ offenses! Some data put out recently by Protenus[1] would indicate that they found, through media reports and other avenues, a little over 300 incidents in 2017. Assuming the Cincinnati statistics are correct, that's about three days' worth of reporting and further reveals that these incidents are grossly underreported.

With this premise in mind, that means that thousands of incidents are not reported properly, which indicates that innocent patients are negatively impacted by addicted caregivers, and addicted healthcare workers are not getting rehabilitation opportunities in a timely manner. As those addicted reach for higher and higher levels of drugs to satisfy their habits, successful rehabilitation becomes more difficult. That's if they don't have a tragic ending before their rehabilitation can be mandated.