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## What Is the Impact of Kentucky's Pharmacy Recovery Network?

Benjamin Paul Clark  
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# **What is the Impact of Kentucky's Pharmacy Recovery Network?**

Benjamin Paul Clark, PharmD/MPA Candidate

Spring 2010

## Section I. Executive Summary

**Problem Statement:** This capstone will focus on Kentucky's Pharmacy Recovery Network (PRN). In general, professional recovery networks are organizations that act as a liaison between professional state boards and the health professionals who are dealing with substance abuse and addictions that sometimes result in negative consequences to that individual and/or their profession. Instead of a "one-strike and you are out" approach, these organizations recognize that there is a disease process occurring. Thus, as opposed to engaging in strictly punitive measures, a rehabilitative approach is chosen to allow the health professional an opportunity to recover and successfully reenter into their profession. The research question this study seeks to answer is, "What is the impact of KY's PRN program? A secondary analysis will explore how KY compares with Ohio.

**Research Strategy:** A retrospective analysis of data from the KY PRN clients from 2000-2009 was conducted. The main point of interest focused on relapse rates or, alternatively, success rates and successful reentry back into the practice. Descriptive statistics were used to characterize the study group. Six variables were used for purposes of predicting relapse. Anecdotal data was obtained from Ohio's similar recovery program.

**Major Findings:** The average number of cases per year for the Board was 8. The average age of Kentucky Pharmacists who were treated was 43 years old with a majority being male. The mean time of being licensed before treatment was 16 yrs. The most popular substance abused was a mixture of opioids and/or benzodiazepines (48%). The overall relapse rate was 22%, with 4.2% of cases having 2 relapses. Of the cases that relapsed, 50% relapsed within 2 years of rehabilitation. Logistic regression was performed using relapse as the dependent variable and age, gender, number of years held license, and type of treatment as the dependent variables. Treatment in an inpatient facility is associated with statistically significantly more relapse. KY and OH appear to be similar in rates of relapse based upon anecdotal reports from OH.

**Recommendations:** Further studies should examine the incidence and prevalence of Pharmacists' substance addiction rates and measure the impact of PRNs. Better data collection is recommended in order to account for certain risk factors that can predict which impaired pharmacists are at the highest risk for relapse. In the current model, treatment within an inpatient facility appears to predict a higher rate of relapse. Further data analysis, preferably with additional data, should be conducted to confirm this preliminary finding. Comparison with other states' recovery programs would help to measure the success of KY's PRN.

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**Section II. Statement of the Problem**

This analysis is designed to examine the impact of Kentucky’s Pharmacy Recovery Network (PRN), a program which is designed to help drug and/or alcohol impaired pharmacists and pharmacy students recover from their addiction and regain successful transition back into the profession of pharmacy. A secondary analysis will compare Kentucky’s program with Ohio. Before my discussion of Kentucky’s PRN impact, I will first define addiction and highlight addiction rates that have been published. Next, the discussion will describe the background of Pharmacy Recovery Networks. An overview of their general structure and function will be discussed. I will highlight some of the data from past surveys that discuss various Pharmacy Recovery Network success rates. Finally, this discussion will conclude with description of Kentucky’s PRN structure. Data from 2000-2009 describing pharmacists who have been clients of the PRN network will be presented. A comparison of Ohio’s program will also be described.

**What is Addiction**

The American Medical Association (AMA) defines physician impairment as “any physical, mental, or behavioural disorder that interferes with the ability to engage safely in professional activities.”<sup>1</sup> According to Carinci et al, physician impairment is most often used to refer to substance use disorders.<sup>1</sup> This same terminology also is pertinent to other healthcare professions such as pharmacy. Substance use disorder can be subdivided into two inter-related categories of “substance abuse” and “substance dependence”.<sup>1</sup> According to the author, substance abuse is defined in terms of adverse consequences involving failure to meet family, school, and work-related obligations. An example of this is when the abuser puts themselves in physically dangerous situations, for instance driving a car while impaired, which often results in legal problems. Despite these consequences the abuser continues to use the substance.<sup>1</sup>

Substance dependence can be defined as addiction in many cases. The addiction component manifests as physiologic (i.e. becoming tolerant to the drug, needing more of drug for effect, withdrawal symptoms when drug is removed) and behavioural problems (i.e. preoccupation with the use of the substance, “cravings” or excessive desire for drug) related to a maladaptive pattern of substance use.<sup>1</sup> The American Society of Addiction Medicine further describes addiction as a primary, chronic, and neurobiological disease with associated psychosocial, environmental, and genetic factors that influence the development and manifestations.<sup>1</sup>

According to Carinci et al, several theories have been promoted to explain the reason health care providers develop substance use disorders, but there has been no definitive cause identified. According to the authors, the cause of substance abuse and impairment is no different than the general population.<sup>1</sup> Three factors that are believed

to add to the additional risk to health care providers are genetic and personality factors, stressful lifestyle and work environment, and easy access.<sup>1</sup> While Carinci and colleagues make this case with regards to physicians, the same types of stressors can easily be seen in the profession of pharmacy, along with the added potential danger of having access to controlled substances readily at hand on the shelves of their work space.

### **Health Professional Addiction Rates**

Professional impairment amongst healthcare workers, whether it be from the abuse of controlled prescriptions or alcohol, is a serious public health issue not only affecting the professionals, but also their families, colleagues, and patients.<sup>1</sup> Negative consequences resulting from professional impairment include negative impact on their profession as well as jeopardizing the integrity and quality of patient care.<sup>2</sup> The National Institute on Drug Abuse estimates that 8% to 12% of healthcare workers have substance abuse problems.<sup>2</sup> Specific to the pharmacy profession, a survey from McAuliffe et al, cited often in the literature, showed almost half of the pharmacists (46%) and two thirds of the students (62%) reported using a controlled substance at some time without a prescription; 19% and 41%, respectively, used one within the past year.<sup>3</sup> Several factors to consider before making inferences from this survey are that it was conducted in 1987 and was only based on respondents from the state of New England. Other data estimate that 11% to 15% of pharmacists, at some time in their career, are confronted with alcohol and/or drug dependency problems, with the median age for recovering pharmacists to be 43 years.<sup>2</sup> According to McNeas and colleagues, chemical dependency is the number one disabling illness for the medical professions.<sup>4</sup>

### **Section III. A History of Recovery Networks**

To understand the history of recovery networks, it is necessary to look back to the 1930s. Dating back approximately eighty years ago, Alcoholics Anonymous emerged from a concern for workers with alcohol impairment.<sup>5</sup> According to Pooler, et al, early attempts to help the workforce were the origins of what are now known as employee assistance programs and colleague assistance programs.<sup>5</sup> In the decades between the 1940s and 1970s, these programs became professionalized. They moved away from the Alcoholics Anonymous “self-help” models, which relied on volunteers, to organizations that employed professionals.<sup>5</sup> Addiction in health professionals was not a major focus during this time, although there was evidence of concern with nurses who were addicted as early as the 1950s.<sup>5</sup> It was not until the 1970s that formalized concern for all health professionals came into being. According to Pool et al, three major societal changes contributed to this shift in awareness: 1) high profile figures who engaged in unethical behaviour receiving national attention (e.g. the Watergate scandal); 2) increase in litigation surrounding professionals who had engaged in unethical behaviour or harmed clients; and 3) the growing public realization and outcry over these issues as the media highlighted these problems.<sup>5</sup> With the public perception shifting to holding professionals accountable, professional organizations and licensing bodies became aware of the need to develop ethical guidelines that would address these issues either by punitive or rehabilitative responses as a result of unethical professional decisions (i.e. impairment).<sup>5</sup>

In the 1970s, the first professions to address impairment were medicine, psychology, and law.<sup>5</sup> From the empirical studies on impairment that were conducted by these professions came the development of policy and practice standards as well as



colleague assistance programs to assist those professionals who were practicing impaired.<sup>5</sup> By the 1980s, there was widespread support by professional organizations and state associations for physicians and nurses.<sup>5</sup>

As pharmacy impairment became more evident and demands for the issue to be addressed came to the forefront, the profession started to respond. In 1982, the American Pharmacists Association (APhA) acknowledged that substance abuse was an issue within the profession<sup>2,6</sup>. In 1982, APhA House of Delegates adopted a two-part policy statement on impaired pharmacists. The House of Delegates recommended that pharmacists not practice while impaired and that programs be established to provide counseling, treatment, prevention, and rehabilitation for pharmacists and pharmacy students.<sup>4</sup> Other organizations such as the American Society of Health System Pharmacy (ASHP) and the National Association of Boards of Pharmacy (NABP) eventually developed policies and guidelines supporting activities aiding impaired pharmacists and students.<sup>4</sup> For example, in 2000, the APhA formed the "APhA Addiction Practitioner Interest Group," whose mission is to foster greater awareness and understanding of addictive disease as a public health issue and promote treatment and recovery from addictive illnesses through education, advocacy and peer support.<sup>8</sup> Out of these movements and guidelines from various pharmacy organizations and state boards resulted the Pharmacy Recovery Networks (PRNs).<sup>2</sup>

By 1985, seventeen states had initiated a PRN. By 1987, this number increased to 38 states, and in 1990, 43 states had a PRN.<sup>4</sup> Many states and state boards now have similar PRN programs, which assists their pharmacists with recovery from addiction. Presently, all 50 states have some sort of PRN or physician recovery group in place.<sup>(2,7)</sup>

## **What are PRN networks**

A PRN is a confidential program which provides assistance in the early recognition, intervention, and treatment of substance abuse among affected pharmacists, pharmacy students, and in some states, pharmacy technicians.<sup>2</sup> PRN programs do not provide treatment but do assist with the referral process, monitor pharmacists' recovery and compliance, and act as a support structure for the person in recovery.<sup>9</sup> Additionally, for pharmacists who have broken state laws through their illness (for instance, stealing controlled substances from their employer and self-medicating), the PRN can serve as an advocate when the pharmacists are summoned by their State's Board of Pharmacy.<sup>9</sup> Many PRNs are also protected from liability as a result of laws being passed on their behalf.<sup>9</sup>

Each state has a state board of pharmacy with a stated purpose to protect the public. Alcohol and drug abuse that affects pharmacy practice and patient care is an offense that requires board action.<sup>5</sup> According to Pooler et al, the [law-enforcing] ability can lead to little incentive for rehabilitative action and instead, more punitive action, despite most states having laws in place allowing health professionals to seek treatment without discipline.<sup>5</sup> Additionally, as is sometimes the case, Board members are not trained in addictions, which may further increase the likelihood of punitive action being taken.<sup>5</sup> Pool et al, argue that licensing boards are not ideal entities to facilitate pharmacists in recovery because of their punitive approach to broken laws.<sup>5</sup> Finally, according to George and colleagues, not sanctioning a pharmacist and using a nonpunitive route of dealing with the issue increases the likelihood that pharmacists will refer themselves and their impaired colleagues for intervention.<sup>13</sup>

If an impaired pharmacist seeks help (self-referred) from his/her PRN, most programs require that pharmacist to sign a five-year confidential contract which covers a wide variety of items, including restriction from chemical substances/alcohol, release of medical records, treatment plan, random urine screenings, assigned attendance to inpatient or outpatient rehabilitation facilities, group therapy, mandatory meetings, and penalties for relapse.<sup>9</sup> If a pharmacist self-reports and does not break his/her contract, the pharmacist's board of pharmacy is not notified about the problem.<sup>9</sup> An exception to this is if a patient was harmed or if state laws were broken as a result of the impairment. In this case, the pharmacist's Board of Pharmacy is notified and a formal complaint is made which leads to an investigation and possible fines, agreed orders, or license suspension depending on the severity of the offense. If an agreed order is signed the pharmacist would then work with the PRN for monitoring and assistance with recovery. If the self-referred pharmacist is noncompliant after entering the PRN contract, most states require the PRN to report the impaired pharmacist to the Board of Pharmacy.<sup>9</sup> A survey conducted by McNeese et al, showed that only 20% of pharmacists actually self-report themselves.<sup>2</sup> The literature does not describe other states' methods, but in Kentucky when pharmacists are reported by someone else to be impaired, the Board refers them to the PRN for assistance with treatment while an investigation takes place.

Funding for PRN or similar programs come from state pharmacy licensing fees or other funds appropriated by state government and licensing boards. According to Young, in 2003 Kansas' program received \$30,000 from state licensing fees and Maryland's recovery program received \$89,000.<sup>9</sup> Some states receive funding in the form of monthly

fees charged to clients and donations from state professional organization, or a combination of both--license fees and client fees .<sup>5,9</sup>

There are some states that have a recovery network that is open to different health fields. For instance, Michigan was the first state to develop a comprehensive program that serviced multiple licensing boards in the mid -1990s. The program is titled “The Michigan Health Recovery Professional Program”.<sup>5</sup> In 1995 it covered 18 different professions.<sup>5</sup>

### **Are PRNs Successful?**

Measuring the success for PRNs can be done by a number of factors, some of which are harder to analyze than others. From the literature, the most common indicators used are relapse rates or abstinence rates. Random urine drug screenings are used as a proxy for determining abstinence. Another indicator is reentry into the profession. There is a paucity of data for treatment success of recovering pharmacists.<sup>11</sup> Most of the literature involves surveys. From one survey, success rates as high as 85% have been quoted.<sup>2</sup> Another survey conducted in 1988 by McNees et al, reported that 88% of pharmacists successfully completed treatment and returned to practice.

From a thorough literature search, I was able to find reported data from South Carolina’s recovery network. Unlike states with recovery programs for specific health professionals, for example, recovery networks specific to pharmacists (PRNs), South Carolina operates an umbrella organization to cover most health professionals (i.e. Counselors, Medical Examiners, Physicians, Nurses, Physical Therapists, Dentists,

Pharmacists, Veterinarians, etc.) referred to as the Recovering Professional Program (RPP).<sup>5</sup> Data were collected from 2000 through 2008. During that time period, 1,292 professionals were evaluated, treated, and/or monitored by RPP. Of the 1,292 professionals, there were 811 who had been discharged from the program while the other 472 were still currently being monitored (i.e. the 5 year contract period was still active). Of the 811 who were discharged, 429 (53%) successfully completed the program or did not require monitoring. The other 225 (28%) were noncompliant and 33 (4%) were not able to be contacted or had incomplete data. Because RPP did not follow professionals past discharge, there was no data to show how many went back into practice. Additionally, 114 (14%) of the professionals who were evaluated elected not to go through the program (noncompliant). Looking at the data specific to the 72 pharmacists that completed discharge, 41 (57%) of them successfully completed the program or did not require monitoring. Thirteen pharmacists refused to participate in the program, 3 were deceased, and 4 were not able to be contacted or had incomplete data. Excluding these pharmacists, and looking at the 52 that participated in the program, the data suggest that 78% (41 of 52) successfully completed the program or did not require monitoring.

A retrospective cohort study of 292 healthcare professionals enrolled in the Washington Physicians Health Program (WPHP), an independent post-treatment monitoring program, showed 218 (74%) of professionals remained abstinent. Interestingly, this study had a potential follow-up period of 10 years (i.e. the data was from 1991 to 2001) for professionals that entered closer to the year 1991. Just like the RPP previously mentioned, the WPHP assisted many types of health professions; pharmacists made up less than 2% of that sample. With the paucity of data available,

looking at relapse rates, according to Domino et al, virtually every study of dependency among health care professionals is limited in its conclusions because most studies have short follow-ups, limitations in statistical methods, and variable intensity of monitoring.<sup>10</sup>

#### **Section IV. Research Design**

The data for this capstone were collected from Kentucky's PRN database consisting of a list of addicted pharmacists who were known to the Kentucky Board of Pharmacy and followed by Kentucky's PRN from years 2000 – 2009. The pharmacists were known because they either broke a state law as a result of their addiction or broke their original PRN contract within five years of being followed by the PRN. Additional units of analysis were procured from the files kept by the Board of Pharmacy. Other collected data included the following: gender, age at time of impairment, relapses (if it occurred), current license status (active, inactive, deceased, unknown), number of years holding a license before impairment, type of practice (retail, independent, hospital, long-term care, unknown), substance abused (opioids and/or benzodiazepines, alcohol, combination, other, unknown), and treatment facility (inpatient, outpatient, not required, unknown).

I attempted to compare Kentucky's PRN with Ohio's similar program as a secondary form of analysis. The following data were collected for comparison: PRN governing Board (freestanding or under State Board), Board of Directors (yes, no), "is a PRN codified in state statutes?" (yes, no), funding source, penalty, years pharmacist are monitored, percent of pharmacists licensed in the state being monitored by a PRN, and relapse rates.

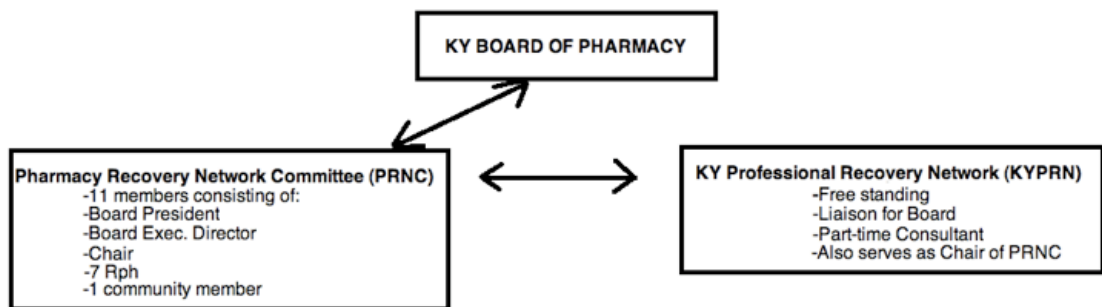
## **Section V. Analysis and Findings**

### **Kentucky's PRN**

According to information from Kentucky's Board of Pharmacy, the beginnings of Kentucky's recovery initiatives can be traced back to 1986.<sup>12</sup> At that time there was a committee formed under the name- Pharmacists Helping Fellow Pharmacists (HELP). The committee evolved over the years because of concerns of liability.<sup>12</sup> In 1998, with the help of KPhA's support, legislation was passed (KRS 315.126) (Appendix 1) that added a \$10 fee and started what then was called the Impaired Pharmacist Committee (IPC).<sup>12</sup> The \$10 fee was to be utilized for funding the operation of the IPC. In 1999, legislation 201 KAR 2:250 was passed (see Appendix 2). This regulation allowed the Board to use a consultant to assist with the IPC and monitor impaired pharmacists and interns. The consultant is required to be a licensed pharmacist in Kentucky. The regulation also defines the 11 members who serve on the IPC. For instance, the Board of Pharmacy President, the Executive Director of the Board, the Chair of the Pharmacist Recovery Network Committee (PRNC), and eight other members, seven who are pharmacists and one member from the community, reside on the committee. Currently, the chair of the committee is also the consultant for the Board. The committee reviews petitions from pharmacists seeking to have their license reinstated and gives the Board its recommendations. In 2005, the revised legislation 201 KAR 2:250 went into effect changing the name of IPC to the PRNC.

The Kentucky Board of Pharmacy is currently contracted with a freestanding organization incorporated by Brian Fingerson who runs the Kentucky Professionals Recovery Network (KYPRN) (from above, Mr. Fingerson is also the Chair of the PRNC).

The KYPRN works with other professional organizations with impairment, such as, dentistry, veterinary medicine, respiratory care, and physical therapy, but also has a part-time paid position serving as liaison between the PRNC and the Kentucky Board of Pharmacy for impaired pharmacists and interns who are seeking treatment or are in recovery. For the purposes of this discussion, the PRN refers collectively to the combined efforts of both the KYPRN and the PRNC. Mr. Fingerson is also a licensed pharmacist in Kentucky, which meets 201 KAR 2:250 requirements (Figure 1). KYPRN is not a certified counseling organization and therefore does not participate in the diagnosis and treatment of impaired professionals. The KYPRN working with Kentucky’s PRNC helps to facilitate impaired professionals with finding treatment and aftercare programs. According to Mr. Fingerson, “The [PRNC] serves as a source of information for people seeking help negotiating their way through the discovery of their disease, treatment, aftercare, and petition for reinstatement.”<sup>13</sup>



**Figure 1. Organization Structure of Kentucky's Recovery Network**

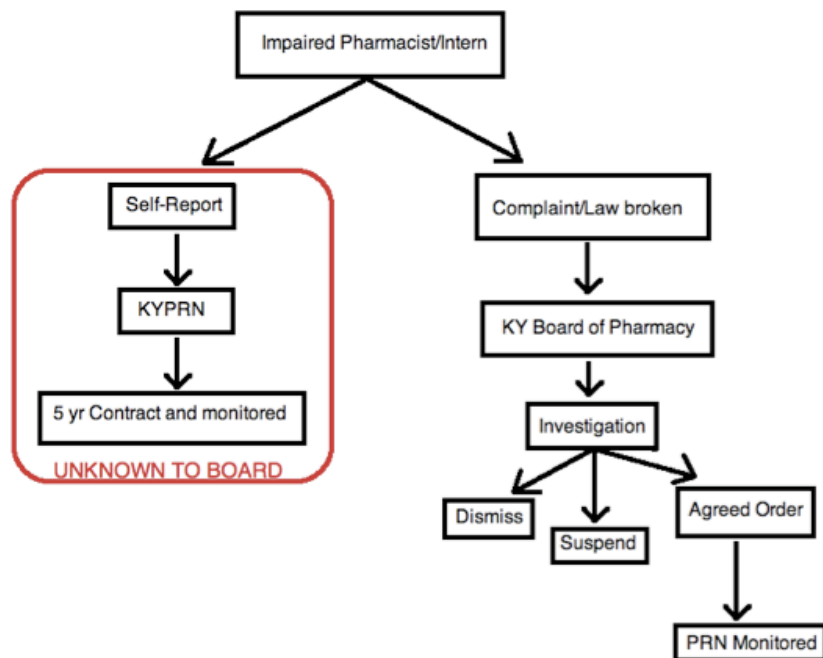
Kentucky’s PRN works very similar to other PRNs in Section III. A pharmacist or pharmacy intern licensed in Kentucky can self-refer if they feel they have an impairment problem as a result of misuse or abuse of alcohol or drugs, or both. If a complaint to the



Board is made that a pharmacist is impaired and no other complaint is made, that information is forwarded to the KYPRN consultant and that pharmacist will not go in front of the Board for discipline if they agree to terms set by the KYPRN including a contractual agreement with KYPRN (see Appendix 3). The contract between the Pharmacists and the PRN is very detailed in its requirements. The contract allows the KYPRN Director to monitor the pharmacist for 5 years. It requires the client to attend a certain number of meetings in AA/NA per month. In addition, the agreement requires the client to obtain a sponsor and requires clients to abstain from alcohol and all mood-altering chemicals; random urine drug screens are required throughout the contract period and any missed test is reported to the Board. Any violation of the contract may lead to the Director of the KYPRN reporting them to the Board. The Director of Kentucky's PRN describes recovery programs in the following way:

“One of the benefits of having a [Professional Recovery Network and Pharmacy Recovery Network Committee] in Kentucky is accountability for the person trying to stay clean and sober. Clients learn during the earliest parts of their treatment that recovery from substance abuse disorder is a one-day-at-a-time affair. There are many components to a clean and sober lifestyle. The Kentucky Pharmacist Recovery Network has a contract with each client that gives specifics of what to do to maintain that type of lifestyle... This gives the person accountability.”<sup>13</sup>

If a pharmacist or intern has other complaints issued against him/her as a result of impairment (i.e. stolen medications from employer, public harm from impairment, etc), then that constitutes a formal complaint. The pharmacist must go through an investigation process and through a hearing with the Board with three possible outcomes that can result: the case can be dismissed, their license can be suspended, or the pharmacist may have the option of signing an “agreed order” (figure 2).



**Figure 2. Flowchart of Impaired Pharmacist through KY's PRN: Self-report vs. Formal Complaint**

That agreed order, according to Mr. Fingerson is very similar in scope to the KYPRN contract (personal communication). One main difference is that while the pharmacist has an active case with the Board, their license is on probation with possible limited practice restrictions along with possible fines and other stipulations. This is assuming that he/she was given the option to sign an agreed order. Pharmacists that have agreed orders with the Board are still followed and monitored by the PRN.

## Results

This analysis observed only the known Pharmacist cases to the Board. In other words, these are the cases that have undergone a formal hearing with the Board of Pharmacy. Pharmacy intern cases were excluded from the analysis. Impaired pharmacists monitored by the KYPRN who have self-referred to the PRN and those who

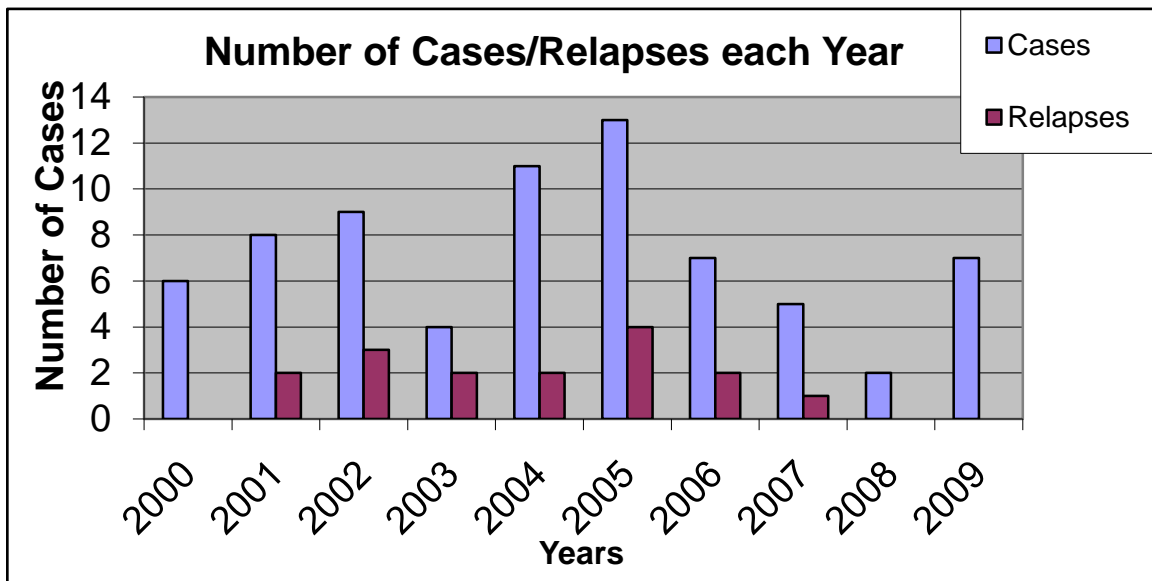
have not had a formal complaint to the Board against them are not included in this analysis due to data being less complete for these two groups.

From 2000-2009, there were 72 clients (Table 1) that were monitored by KYPRN, with an average of 8 cases per year with a range of 2 to 13 clients per year. Figure 3 shows a graphical representation of the cases each year and the number of relapses each year. The overall relapse rate for those 72 clients was 22% (16/72). 4.2% of cases (3/72) had >1 relapse. Of the cases that relapsed, 50% (8/16) relapsed within 2 years of rehabilitation (Table 2). These data were analyzed using Microsoft Excel 2008 version 12.2.4 Microsoft Inc.

The percentage of male clients was 70% (51/72); as of March 2010, 52% of pharmacists in Kentucky were male. The mean age of clients was 43 years old (range of 23 – 63 yrs old) with a standard deviation of 11 years. The mean time of licensure before entering a PRN agreement was 16 yrs (range of 1 to 39 yrs), with a standard deviation of 11 years (Table 3). The type of practice most pharmacists came from was chain pharmacy, 55% (45/72) (Table 4). The most popular substance category abused was the combination of opioids and benzodiazepines, representing 48% of the sample (35/72) (Table 5). The treatment facility most often utilized was inpatient, 47% (34/72) (Table 6). The percent of pharmacists whose license was still in active status was 63% (45/72) (Table 7). These data were analyzed by PASW STATISTICS Version 18, IBM Inc.

Year	Total Cases	Relapses
2000	6	0
2001	8	2
2002	9	3
2003	4	2
2004	11	2
2005	13	4
2006	7	2
2007	5	1
2008	2	0
2009	7	0
Total	72	16

**Table 1. Data from 2000-2009 showing Cases and Relapses per year**



**Figure 3. Histogram representing the number of cases and number of relapses for each year**

<b>Time Span (in yrs) for Relapse</b>		
<b>Years passed</b>	<b>Total Cases</b>	<b>Percent of Cases</b>
<1yr	3	18.75%
1yr	5	31.3%
2yr	2	12.5%
3yr	1	6.3%
4yr	2	12.5%
5yr	3	18.8%
	16	

**Table 2. Table depicting the amount of time in years before each relapse**

<b>Gender</b>	<b>Frequency</b>	<b>Percent</b>		
Male	51	70.8		
Female	21	29.2		
<b>Age</b>	<b>Minimum</b>	<b>Maximum</b>	<b>Mean</b>	<b>Std Deviation</b>
	23 yrs	68 yrs	42.6	11.6
<b>Yrs Held License Before Impairment</b>	<b>Minimum</b>	<b>Maximum</b>	<b>Mean</b>	<b>Std Deviation</b>
	1	39	16	11.4

**Table 3. Gender, Age, and Years held license at time of impairment**

Practice Type	Frequency	Percent
Chain	40	55.6
Independent	12	16.7
Hospital	9	12.5
Long Term Care	2	2.8
Unknown	9	12.5

**Table 4. Percentages of Four Different Areas of Pharmacy Involving Impaired Pharmacists**

Drug Abuse Choice	Frequency	Percent
Opioids +/- Benzos	35	48.6
Alcohol	5	6.9
Combination of Alcohol and Opiods/Benzos	12	16.7
Other illicit	12	16.7
Unknown	8	11.1

**Table 5. Drug Abuse Choice of 5 different categories**

Treatment Facility	Frequency	Percent
Inpatient	34	47.2
Outpatient	13	18.1
Not Completed	10	13.9
Unknown	15	20.8

**Table 6. Types of treatment facilities used by pharmacists**

License Status	Frequency	Percent
Active	45	62.5
Inactive	21	29.2
Decease	3	4.2
Unknown	3	4.2

**Table 7. License status of Impaired Pharmacist as of March 2010**

Using PASW STATISTICS Version 18, a mixture of Chi-square and independent samples t-tests were performed to determine whether relapse could be predicted by, or at least shown to be related to, the other variables of interest. Relapse was not related to client gender ( $\chi^2 = 0.173$ ,  $p = .678$ , ns), age ( $t = 1.228$ ,  $p = .224$ , ns), or choice of agent for drug abuse ( $\chi^2 = 2.544$ ,  $p = .637$ , ns). In addition, the years a license was held before relapse ( $t = 1.638$ ,  $p = .107$ , ns), current license status ( $\chi^2 = 5.290$ ,  $p = .152$ , ns), type of treatment facility chosen for rehabilitation ( $\chi^2 = 5.271$ ,  $p = .153$ , ns), and type of pharmacy practice ( $\chi^2 = 2.588$ ,  $p = .629$ , ns) all failed to show a significant relation to whether the pharmacist experienced relapse.

A logistic regression was performed in order to determine if relapse could be predicted by gender, age, type of treatment facility (inpatient versus outpatient), type of drug abused, and years held license (table 8). The results show that predicting relapse is

difficult. Neither gender nor age of pharmacist predicts relapse. The length of time in practice also does not predict relapse, and the 12 of 72 cases in which length of time in practice could not be ascertained are not different from other cases. Type of drug—alcohol, opioid and/or benzodiazepine, or a combination—also does not predict relapse, so no particular addiction appears to be more or less difficult to treat. Treatment in an inpatient facility is associated with statistically significantly more relapse. The

Variable	dy/dx	Std Err.	Z	P>{z}	[95% C.I.]	X
Female	0.0325268	0.12524	0.26	0.795	[-0.21 - 0.28]	0.292
Age	0.0009471	0.00622	0.15	0.879	[-.011235 - .013129]	42.55
Years Held License	-0.0082213	0.00713	-1.15	0.249	[-.022188 - .005746]	13.33
Yrs Held Lic_dummy variable	0.0330924	0.19513	0.17	0.865	[-.349346 - .415531]	0.1666
In-Patient Treatment*	0.252	0.12084	2.08	0.037	[.01489-.488557]	0.4722
Type of Drug Opiod/Benzo*	0.341	0.27374	1.25	0.212	[-195039-.87799]	0.0694
Type of Drug Alcohol*	0.173	0.18024	0.96	0.337	[-.180234-.52628]	0.1666
Type of Drug Combination*	0.0777	0.176568	0.44	0.66	[-268351-.423836]	0.1666
Type of Drug Other*	0.167	0.27122	0.62	0.538	[-.364459-.698699]	0.111
Time	-0.0211861	0.01899	-1.12	0.265	[-.058402-.01603]	4.208
(*) dy/dx if for discrete change of dummy variable from 0 to 1						

**Table 8. Logistic Regression Predicting Relapse**

pharmacists in inpatient treatment are 25 percentage points more likely to relapse, which is quite large given that only 22% overall relapsed.



A brief look at the funding distributed to the PRN yielded the following: There are 4,518 registered pharmacists in the state of Kentucky as of March 20<sup>th</sup>, 2010. Because of the \$10 fee that is added to the yearly renewal of licenses, there is approximately \$45,000 in funds that are to be used for the PRN every year. Assuming eight “known” pharmacists per year are monitored by the PRN, this yields \$5,500 dollars per year for each pharmacist. Because each contract is for five years, this would be equal to approximately \$28,000 dollars of funds that can be used to help an addicted pharmacist recover. This analysis does not include the “unknown” pharmacists (i.e., those who have not undergone a formal hearing with the Board of Pharmacy) who would most likely require the same amount of attention and monitoring. The majority of the funds are used to pay the salary of the Director of KYPRN for his work in helping addicted pharmacists and interns throughout their recovery. The funds are also used to reimburse mileage for the 11-member panel of PRNC and pay for approved conferences that focus on issues surrounding addiction and recovery.

A secondary goal of this capstone was to compare KY’s PRN with OH’s similar program. Unfortunately, Ohio did not maintain a database that tracked its recovering pharmacists, so no strong conclusions can be made. It is worth noting from Ohio’s response some of the information given. Ohio does have a board of Directors. Ohio’s recovery organization is freestanding and separate from its Board. It is codified in its statutes. One difference that is noted, Ohio does receive its funding from renewal license fees in comparison with Kentucky. It charges its clients monthly fees and receives some funding from various pharmacy organizations and Continuing Education conferences. Ohio has approximately 13,000 registered pharmacists, three times as many as Kentucky.

According to OH's Director, since 2000 approximately 120 pharmacists have been treated and 16 have relapsed. This would be approximately 13% (16/120) relapse rate, very similar to Kentucky (11% to 22%). Comparing the percentage of Kentucky and Ohio's pharmacists who were under contract with the PRNs since 2000, OH monitored approximately 1% of its pharmacists (120/13,000) while KY monitored roughly 1.6% (72/4,500), accounting for the 70 "unknowns" that were not including in the analysis it would be closer to 3% (142/4,500) for KY.

### **Conclusions and Limitations**

There are several limitations to this analysis that should be addressed. As stated in the results section, the analysis only looked at the "known" pharmacists. According to the Director of KYPRN, there are approximately 70 pharmacists/interns who, during the period of 2000-2009, have not been known to the Board (i.e., no formal hearing with the Board of Pharmacy). Factoring this group of recovering pharmacists/interns into the data would essentially double the sample size as well as decrease the relapse rate by half (22% → 11%). As previously stated, those who are "unknown" to the Board and only working under a contract with KYPRN, are made known to the Board should they relapse. This analysis did not account for the fact that some of the 72 known pharmacists were once unknown to the Board and relapsed (thus making them "known" to the Board). The analysis was based on the assumption that all 72 pharmacists originally were relapse-free. However, according to the Director of KYPRN, there were a small number of pharmacists who were "unknown" and then reported to the Board because of violating the KYPRN contract. This suggests that Kentucky's relapse rate is probably between 11%-22%. In a more positive light, another way to explain this is that Kentucky's PRN

has 78% to 89% success rates, which is impressive in the field of addiction medicine. In attempts to make comparison to other populations, looking at abstinence rates in low-income mothers in New Jersey, the best rates were approximately 50% in the study after a 24 month follow-up.<sup>14</sup> Another study looking at an urban clinical sample showed that only 52% had maintained remission after 12 months.<sup>15</sup> There are certainly many other factors that can be attributed to this by comparing the populations' demographics, education, employment status, coexisting mental disorders, and arguably what a pharmacist has too loose (i.e. higher than average salary). Regardless of these many other contributing variables, KY's PRN success appears noteworthy.

In terms of defining outcomes for this program, a look at the percent of recovering pharmacists who have reentered the profession is warranted. Looking at the number of pharmacists with an active license is used as a success indicator. From the analysis, 62% of the current recovering pharmacists are practicing with an active license. Approximately 30% of pharmacist licenses are inactive, which means that their license was suspended or they never renewed it. Assuming the 4% of deceased and 4% of "license status unknown" pharmacists successfully entered back into the profession, this equates to a 70% success rate for KY's PRN. From this small sample size, this is lower than the 88% success rates that previous surveys describe.

Another limitation to this study is the span of time that occurs to capture a relapse. From this analysis, because almost 20% of the pharmacists who relapsed did so at >4 years after their contract, the clients from years 2006-2009 may be falsely decreasing the relapse rate. Continuing to keep and store records for Kentucky's recovering pharmacists would help to mitigate this limitation.

One interesting point to be made from these data is the average age at which pharmacists are entering into a contract with the PRN: 42 years old. This is comparable to surveys from the literature highlighting 43 years old. This reflects the chronic nature of addictive diseases and possibly illustrates that many professionals can go for a long time before they ever seek treatment or are eventually caught.

Looking at the results of the logistic regression, which suggests that impaired pharmacists who seek inpatient treatment are 25% more likely to relapse, seems counter-intuitive at first glance. In theory, an inpatient facility would provide more intensive treatment and perhaps yield better outcomes or result in no change at all. One explanation could be that those pharmacists who enroll in inpatient treatment facilities are the more complicated cases to treat and therefore have the higher likelihood of relapse. Whether this indicates that the cases are inherently harder to manage or that treatment is unsuccessful cannot be differentiated in the present data, but the difference is quite large. As a policy recommendation then, the pharmacists with the more difficult addiction cases may need more intense treatment than they are currently receiving.

Other studies looking at health care professionals have shown that the risk of relapse was increased with those who used a major opioid or had a coexisting psychiatric illness or a family history of a substance use disorder, and having more than 1 of these risk increased the likelihood.<sup>10</sup> Developing a database for state PRNs that track these factors could be used for validating these results as well as being used to be more proactive for relapse for pharmacists who have increased risk.

Looking at the secondary analysis of comparing KY with OH, from the anecdotal evidence given, on the surface, Kentucky and Ohio appear to be similar in their success

rates (~13% relapse rate for OH and 11% to 22% for KY). Again, because the data was anecdotal, a strong conclusion cannot be made. Comparing Kentucky's PRN outcomes with other states' recovery programs may be useful for increasing Kentucky's PRN impact on pharmacists in need of or who are in recovery.

One final question that arises from this analysis is where are all of the addicted pharmacists? Data on addiction rates of pharmacists is very limited and from older sources, but if the addiction rates hold true, in that 11 – 15% of pharmacists have substance use problems--Kentucky's PRN is running significantly under capacity and many pharmacists are under the radar. Perhaps it is a mixture of both, the age of pharmacists in this analysis being caught or admitting they have a problem is in the fourth decade of life on average; other studies have shown the median age to be 42. It could be that some pharmacists are never caught and never seek help. Further studies should be completed to gain a better understanding of the incidence and prevalence of substance abuse among pharmacists to better evaluate the effectiveness of a state's PRN program.

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## **Appendix 1. (KRS 315.126)**

315.126 Pharmacist recovery network committee -- Administrative regulations -- Assessment -- Confidentiality -- Reporting restrictions.

(1) The board shall establish a pharmacist recovery network committee to promote the early identification, intervention, treatment, and rehabilitation of pharmacists and pharmacist interns who may be impaired by reason of illness, alcohol or drug abuse, or as a result of any other physical or mental condition.

- (2) The board may enter into a contractual agreement with a nonprofit corporation, pharmacy professional organization, or similar organization for the purpose of creating, supporting, and maintaining a pharmacist recovery network committee.
- (3) The board may promulgate administrative regulations pursuant to KRS Chapter 13A to effectuate and implement the provisions of this section.
- (4) Beginning July 15, 1998, the board shall collect an assessment of ten dollars (\$10) to be added to each licensure renewal application fee payable to the board. This assessment shall be expended by the board on the operation of the pharmacist recovery network committee.
- (5) Members of a pharmacist recovery network committee, any administrator, staff member, consultant, agent, volunteer, or employee of the committee acting within the scope of his or her duties and without actual malice and all other persons who furnish information to the committee in good faith and without actual malice shall not be liable for any claim or damages as a result of any statement, decision, opinion, investigation, or action taken by the committee or by any individual member of the committee.
- (6) All information, interviews, reports, statements, memoranda, or other documents furnished to or produced by the pharmacist recovery network committee, all communications to or from the committee, and all proceedings, findings, and conclusions of the committee, including those relating to intervention, treatment, or rehabilitation, that in any way pertain or refer to a pharmacist or pharmacist intern who is or may be impaired shall be privileged and confidential.
- (7) All records and proceedings of the committee that pertain or refer to a pharmacist or pharmacist intern who is or may be impaired shall be privileged and confidential, used by the committee and its members only in the exercise of the proper function of the committee, not be considered public records, and not be subject to court subpoena, discovery, or introduction as evidence in any civil, criminal, or administrative proceedings, except as described in subsection (8) of this section.
- (8) The committee may only disclose the information relative to an impaired pharmacist or pharmacist intern if:
- (a) It is essential to disclose the information to persons or organizations needing the information in order to address the intervention, treatment, or rehabilitation needs of the impaired pharmacist or pharmacist intern;
  - (b) The release is authorized in writing by the impaired pharmacist or pharmacist intern; or
  - (c) The committee is required to make a report to the board pursuant to KRS 315.121. **Effective:** June 20, 2005

**History:** Amended 2005 Ky. Acts ch. 61, sec. 5, effective June 20, 2005. -- Created 1998 Ky. Acts ch. 531, sec. 1, effective July 15, 1998.

## Appendix 2 -201 KAR 2:250

### Pharmacist Recovery Network Committee.

RELATES TO: KRS 315.121(1)(d), 315.126

STATUTORY AUTHORITY: KRS 315.126(3), 315.191(1)(a)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 315.126(1) requires the Board of Pharmacy to establish a pharmacy recovery network committee (PRNC). This administrative regulation establishes minimum requirements for the establishment and operation of the PRNC. This administrative regulation specifies the manner by which the board's PRNC consultant works with the board in intervention, evaluating and treating a pharmacist or intern, and providing for continuing care and monitoring by the consultant through a treatment provider.

Section 1. The board's Pharmacist Recovery Network Committee (PRNC) consultant shall be a pharmacist licensee of the board. The consultant shall assist the Case Review Committee (CRC) and the PRNC in carrying out their respective responsibilities. This shall include working with the board's inspectors and investigators to determine whether a pharmacist or intern is in fact impaired.

Section 2. If a pharmacist or intern self reports impairment as a result of the misuse or abuse of alcohol or drugs, or both; or if the board receives a legally sufficient complaint alleging that a pharmacist or intern is impaired as a result of the misuse or abuse of alcohol or drugs, or both, and no complaint against the pharmacist or intern other than impairment exists, the reporting of any impairment information to the board shall be forwarded to the consultant and shall not constitute grounds for discipline, if the PRNC finds the pharmacist or intern has:

- (1) Acknowledged the impairment problem;
- (2) Voluntarily enrolled in an appropriate, approved treatment program;
- (3) Voluntarily withdrawn from practice or limited the scope of practice as required by the consultant, in each case, until the PRNC is satisfied the licensee has successfully completed an approved treatment program; and

(4) Executed releases for medical records, authorizing the release of all records of evaluations, diagnoses, and treatment of the licensee, including records of treatment for emotional or mental conditions, to the consultant. The consultant shall not make copies or reports of records that do not regard the issue of the licensee's impairment and his or her participation in a treatment program.

Section 3. (1) A treatment provider shall disclose to the consultant or board if applicable all information in its possession regarding the issue of a pharmacist's or intern's impairment and participation in the treatment program. Failure of the treatment provider to provide information to the consultant shall be a basis for the withdrawal of the use of the program or provider.

(2) If in the opinion of the consultant or PRNC, an impaired pharmacist or intern has not progressed satisfactorily in a treatment or recovery program, all information regarding the issue of a pharmacist's or intern's impairment and participation in a treatment or recovery program in the consultant's possession shall be disclosed to the board. That disclosure shall constitute a complaint.

Section 4. All information concerning a pharmacist or intern held by the consultant, PRNC, CRC, or board shall remain confidential.

Section 5. (1) The PRNC shall be comprised of eleven (11) members. The members shall include:

(a) The President of the Board of Pharmacy;

(b) The Chair of the PRNC;

(c) The Executive Director of the Board of Pharmacy; and

(d) Eight (8) other members, of which seven (7) shall be pharmacists and one (1) shall be a citizen member.

(2)(a) All members shall have the same rights, which include voting privileges.

(b) A member of the PRNC shall not be on the board, except the President of the Board.

(c) Any criminal conviction or disciplinary action by a licensure board against a proposed member shall be reported to the board prior to consideration for appointment.

(d) There may be no more than four (4) members in successful recovery on the PRNC.

(e) A pharmacist under a Pharmacist Recovery Network Agreement shall not serve on the PRNC.

(3)(a) A PRNC member may be appointed by the board a maximum of three (3), four (4) year terms.

(b) A PRNC member shall not serve more than (2) terms consecutively.

(c) After serving two (2) consecutive terms a PRNC member shall rotate off the PRNC for at least two (2) years.

(d) A committee member shall serve no more than twelve (12) years on the PRNC.

(e) The President of the Board, the PRNC Consultant, and the Executive Director of the Board membership on the PRNC shall not constitute a twelve (12) year term.

(f) Membership of the PRNC shall be selected by the board from a list of qualified candidates submitted by an interested individual or entity.

(4) A member of the PRNC who becomes impaired, relapses, has any criminal conviction, or has any disciplinary action by a licensure board shall immediately resign from the PRNC.

(5) The board by majority vote, with the recusal of the President of the Board, may remove a member of the PRNC for any of the following reasons:

(a) Refusal or inability of a committee member to perform duties as a member of the committee in an efficient, responsible, and professional manner;

(b) Misuse of the committee by a member to obtain personal, pecuniary, or material gain or advantage for the member or others; and

(c) Violation of any provision of KRS Chapter 315. (28 Ky.R. 1517; Am. 1793; eff. 2-7-2002; 33 Ky.R. 4201; 34 Ky.R. 229; eff. 8-16-07.)

## Appendix 3- KYPRN Monitoring Agreement

This agreement specifies the terms under which the Kentucky Professionals Recovery Network ("KYPRN") agrees to counsel with, aid, and monitor any professional within the program. This agreement is intended to clarify the terms of the agreement for the time specified. It is specifically designed to meet the needs of each individual and is uniquely suited to the individual. Copies of this agreement shall be provided to the primary care physician, the facility where undergoing treatment, and others as deemed necessary by the Director of KYPRN. The client indicates by the client's signature that the client read and understands the terms of this agreement.

I, , do agree to the terms of this agreement for a period of five (5) years or as long as I'm under an order by the Kentucky Board of Pharmacy whichever is longer.

I understand that all costs connected with my treatment, counseling, and testing in the program are to be rendered at my own expense.

I shall call the Director of KYPRN at least monthly. I shall provide my addiction story to the Director of KYPRN. I shall provide written monthly self-reports to KYPRN on the forms provided by the Director of KYPRN.

I shall attend AA or NA meeting no less than \_\_\_\_ times per two weeks (\_\_\_\_ meetings per calendar month, which shall include a minimum of \_\_\_\_per week) and shall provided the Board and KYPRN with written monthly reports of all AA/NA meetings. I shall get and use a sponsor approved by the Director of the KYPRN.

I agree to provide to the Director of KYPRN the name, address, and phone number of my primary care physician. Other physicians shall be on a referral basis from the primary care physician. Signing this document serves as an authorization to release all medical



records and/or patient information to the Director of KYPRN and authorizes consultation between any treatment provider and the Director of KYPRN. I agree that the information may be divulged to the PRNC and the Board of Pharmacy.

I understand that going back into practice, when/if that happens, shall put me back into a place where I may have used in the past. I understand that I must remain ever vigilant to avoid relapse.

I agree to **abstain** from any and all mood-altering chemicals (including but not limited to alcohol (i.e. ethyl alcohol or ethanol), marijuana, tranquilizers, inhalants, sedatives, stimulants, narcotics, opioids including tramadol, nalbuphine, soporifics, androgenic steroids, scheduled and/or unscheduled drugs, mood altering over-the-counter medications, herbals, dietary supplements, and any other known addictive drug) except as prescribed by my physician **and only after consultation with the Director of KYPRN**. If any mood altering and/or potentially addictive medications are required or recommended by my physician I shall notify the Director of KYPRN in advance and provide documentation of the need for the medication (i.e. copy of the prescription or note from the prescribing physician) within 3 days of receipt of treatment. If the need for medication is ongoing, I shall renew verification every 90 days. I shall update my medication list with the Director of KYPRN any time a new prescription or OTC is added. I shall not fill my own prescriptions. I also agree to avoid exposure to anything that may cause my drug test to be positive. In that regard I shall avoid such items as "hemp oil" "coca tea" and I shall not consume poppy seeds (which can be found hidden in curry sauces, breads, salad dressing, and in or on other foods). I shall not use ethyl alcohol in any form e.g.

- alcohol "free" wine or beer

- OTC drugs containing alcohol (e.g. cough syrups or other similar OTC drugs or supplements)

- Mouthwash or other hygiene products containing ethanol (e.g. sanitizing hand or body gels such as Purell)

- Foods or beverages containing alcohol (e.g. communion wine, desserts, vanilla extract, etc.)

- Any other form of ethyl alcohol

Intentional use of any of these products or medications without a physicians order is a violation of this agreement. **When you sign this document you give up the right to self-medicate with the exception of single entity OTC NSAIDS and Acetaminophen.**

I agree to obtain urine or other body fluid or hair samples for drug/alcohol screens at the discretion of the KYPRN, the Board of Pharmacy, or any other monitoring body. Production of these samples shall be observed. I shall provide copies of any results of all drug/alcohol screens – regardless of who ordered them –to the Director of KYPRN. I understand that it is my responsibility to obtain the permission of the Director of the KYPRN **prior** to any event e.g. vacations, travel, family obligations or other that may affect my availability for a screen. Accommodations for drug/alcohol screens during this period shall be at the discretion of the Director of KYPRN. Notice of approval for attendance at the event shall be provided in writing to the Board of Pharmacy (if under and Order) and the testing company **prior** to attendance. A missed drug screen shall be reported to the board.

I understand that changes of the practice sits or employer shall require **prior** approval of the Director of KYPRN if the client is not under a Board Order, and the Board or Board President if the client is under Board Order. I shall also notify the Director of KYPRN of any change in home address, phone number, or email within one week.

I understand that violation of any part of this agreement shall cause the Director of KYPRN to report such to the Kentucky Board of Pharmacy.

I agree to appear before the PRN Committee if requested, and it is my responsibility to make arrangements for appearance as ordered by the Board.

I agree to report to KYPRN any arrest, citation, or anything else that pertains to alcohol or drug use within 24 hours of its occurrence.

I agree to follow the terms of any after-care agreement signed by me following treatment at \_\_\_\_\_.