2018 NCSBN Discipline Case Management Conference - Catch Me (If You Can): The Impaired Provider Video Transcript

Event
2018 NCSBN Discipline Case Management Conference

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- [Rodrigo] So, good morning. We still have everyone's attention? You got your coffee in? Everyone's pumped up and ready to go? So thank you guys for having us first and foremost.

And anytime we can escape from the Midwest and come out here, this is great. So thank you guys for the invitation. We're going to share our story today. And I try to limit how much Claudia talks because once they hear her, they don't want to hear my story anymore. So I pull it back a little bit, pull it back. So we have a story to tell and our story has merged into a lot of different perspectives that we want to share with you today.

So we put our story and we bring all our skeleton bones out of the closet in the hopes of generating some discussion, pushing the agenda on some issues, and having an open dialogue. So we're not asking everyone to agree with us or disagree with us, but we're just hoping that we can have a conversation and move some of these agendas forward. So we talk to you today from experience, personal experience on some of the things that we went through, and now we're on the other side as providers.

So we have this facility that we deal with healthcare professionals, the impaired healthcare professionals. So I'm going to talk about that a little bit. But I want to tell you about Catch Me If You Can. We had a story that we wanted to tell six years ago and it was called The Impaired Provider. Nobody wanted to hear TheImpaired Provider. I was begging, "Please, we got a story. We can help some people.Please, let us tell our story."

So a police officer in Southern Indiana, J. Fredricks, he says, "I got a perfect group for you. They want to hear about this Impaired Provider, but can you change the title to Catch Me If You Can? And

I said, "That actually sounds pretty good, right?It generates some discussion it generates some thought." So I had no idea who I was talking to. It turns out I was talking to the National Association of Drug Diversion Investigators.

That was my audience. So we're talking about addiction to these investigators at a casino in a bar, right? The irony to that. So this pops up on the screen in one of the Southern Indiana finest police officers with the Stetson and his cowboy belt. He said, "Well, we going to catch you boy. We're going to catch them all." That's what they said.

So we got introduced as the "Live specimen." You know, he was rubbing his hands, he said, "This is the 'live specimen' I was telling you about." And we're going to share that with you today. So how do I go from a nurse to running a treatment center program, right? It's a big jump and we're going to fill in those gaps for you today. I've been a nurse since 1996. I've been doing anesthesia since 2004.

I had a little bit of a break in anesthesia for about a year and I've been doing it again for the past six years. I'm currently the chief anesthetist at the group that I work for. So somewhere along the way, we were compelled to start this treatment program for healthcare professionals and that stemmed completely out of experience that I went through. Last month, we were awarded the Alternative to Discipline program for the State of Indiana.

So we're now holders of the contract that are going to be managing the Impaired Nurses program in the State of Indiana. So as far as Claudia goes, this is about one-tenth of her accomplishments. Her most challenging accomplishments was dealing with me for the past 15 years and she should have a couple more titles just for that alone.

She's a nurse. She's been a nurse since 1996. She's also a licensed addictions counselor, and she does counseling for families and for children and the UPSTART program that we talked about in the grade schools, identifying the dual diagnosis early on when they're in fifth grade and sixth grade instead of when we're seeing them in the treatment center as grown adults, that precipitates into a full-blown addiction.

So that's what we're here to talk about today. And she is really the driving force behind the impaired nurses program. Admittedly, because I have a character flaw called codependency and I believe the nurses and I feel sorry for the nurses. And then we bring in the heavy hitter over here and she said, "No, no, no. It has to be done a certain way. So that's a little bit about us and about our story. I want to tell you a quick story before we get into it.

We have four children. She has two. We have two a blended family. Our oldest daughter is 21 years old. When she was…you guys probably believe I have a 21- year-old but not her, right? So we get that all the time and it's actually her daughter. I'm not kidding.

I'm not kidding. So when we're together they're like, "You guys are sisters?" And then I come around the corner and they're like "Wait a second.Something's not right here. Grandpa or something?" Anyway, so she was going to college. She's a senior now at Purdue Lafayette. And before she went to college, she had to get her wisdom teeth extracted, okay?

So she gets her wisdom teeth. She has the evaluation for the physician. She goes to the doctor. She meets the nurses. She meets the physician who's going, "Yeah, you got to get them taken out. Here's your prescription to get your labs done. Got to get your labs done the next day." So the next day we go back into the clinic and she signs up. She gives the registration.

She turns over her insurance card. She meets three or four other people. She gets her labs drawn. The next day NPO all night just like she's supposed to, she goes to this outpatient surgery center meets the recovery room nurse, the pre-op holding nurse. She meets the anesthesia provider, nurse anesthetist who's going to put her to sleep for this, the surgeon, financial accountant. She met everybody. It was just at this time that Claudia and I turned and walked away.

We didn't say very much, right? It's like the nurse who has to be the patient. How hard is that, right? It's like, "The vein is right there.Stop poking me." We know too much as nurses. So very quietly, we saw them wheeling our daughter away to surgery and Claudia and I ended up in the lobby. -

[Claudia] So we're in the waiting room and our palms are sweating. We're anxious. We're nervous. We're both in healthcare so we probably shouldn't be that nervous because we know what's going to happen. But we were so nervous and we started thinking about all the people she came in contact with over the past couple of days. And we knew statistically speaking that one to two of the people that she came in contact with was struggling with substance use disorder.

They were either coming in hangover, they were thinking about their next fix, or maybe they were impaired. If we were lucky, it was the lady who took her insurance card, or maybe the greeter, the person who greeted her when she walked in the door. But if we're not so lucky, maybe it was the nurse who took her to surgery or the anesthesia provider who put her to sleep, or, God forbid, it was the surgeon who was operating on our kid.

It's all, as you guys can see, it's all a really a game of chance.

- So this is repeated every single day, right? Every single day when we go to the hospital this is repeated. What kind of game of chance are we playing? The public? What kind of game is the public playing? What kind of game of chance? We always say this is the biggest secret that's not talked about in healthcare industry, right?

We're talking about addiction rates in the general population. It's the leading news story in almost every news channel, but what about the healthcare industry, right? So we know over the course of years and much data and research and experience that this has happened at a much higher rate in the healthcare industry. So why is that? Why is that? Why do we think that in the healthcare industry it's happening more?

Getting any ideas why this is happening at a higher rate? - [Together] Access.

- Access? Who said access? Everybody said access, right? Give me another reason. Why else has this happened? - [Woman]

Stress.

- Stress. Oh, man, how many times have we heard about that, right? Stress in the nursing field, absolutely. Yes? - [Woman 2] Sometimes we hear about that nurses get injuries from, like, lifting patients and stuff.

- Absolutely. A legitimate injury, stress, access, expert knowledge and how to use these medications. And here's my favorite one. How many nurses do we have? Do we have a majority of nurses here? We have any nurses here? All right?

How many tee ball games did you guys miss because you had to stay your extra shift, right? How many? How many times were you angry and frustrated that you had to stay for the patient not do what you want to do? So there's an acronym in the treatment side and the treatment side of things when we're telling people, "If you don't want to relapse, keep an eye on these things because these things are opening the door to relapsing." It's called HALT, hungry, angry, lonely, and tired. How many times during your shift are you hungry, angry, lonely, or tired?

Right? Compounding this over and over again. Now you have access. Now you have an injury. Now you know how to use this medication. And it's this perfect storm that's happening every day. So before we jump into exactly how much this is happening in the healthcare industry, let's take a look in general population.

So if you can indulge us for a little bit of audience participation on the next couple slides. Let's do this, let's pretend that this is the United States. This room is representative of the United States. All the people in the United States are represented right here in this room.

- Okay. So let's have the table in front of me, all the people to the left stand up. Would you guys just stand up? Thank you.

- All right. Get your heart rate up a little bit.

- There you go. Well, all of you standing represent the people…you guys all represent people that know someone. So you're affiliated somewhere, one way or another. You know someone with substance use disorder. So now if I can have these two rows here sit down. All the tables in these two rows. You guys can sit down.

Okay, thank you. Now, all of you represent the people that know someone personally. Maybe it's a neighbor, it's a family member, it's a friend, a colleague, someone. You're not living with them, but you know them. Now, if I can have the two front tables sit down. Now, all of you represent someone who suffers with substance use disorder.

Maybe you're the airline pilot, the teacher, the lawyer, the nurse, the surgeon. You're someone who's struggling every day with this awful disease.

- You were just randomly selected, by the way. We didn't see you guys. It was just completely random.

- It was just random.

- Unless you know something or…- Now everybody else can sit down. All of you represent the people that live with someone. You live with someone. You go home to an addict every day. Maybe it's your sister, maybe it's your mother or your son or your daughter, but you live with someone. I remember early on when Rigo was in the throes of his addiction, my colleagues at work with tell me how excited they were to go home because they wanted to have dinner with their families and they wanted to spend time with their kids.

And I remember at the time, that was the worst part of my day, going home to the unknown, not knowing what I was walking into. Was I walking into someone overdosing or was I walking into some stability at home? It was the hardest part of my day.

- She makes it sound so bad. It is and I remember she said that very clearly. And I'll tell you a quick story. So we're going to go into the story a little bit more so that you understand this, but I was at the treatment center and they would give you passes to go home if you met the certain criteria to get these passes.

So week number one, I put in for my pass to go home and the counselor said, "Are you crazy? You just got here. You're not going home." So I call Claudia up and I said, "You can believe these SOBs, they won't let me go home. They don't know who I am," right? She's like, "Stay there. Do your work. Get the work done that you need." Week number two came and I said, "I need to go home. You know, I got to cut the grass." And they're like, "You're not going home." So I called Claudia and I said, "They won't let me go home.

I got to cut the...The kids want to play…" She said, "You didn't cut the grass when you were here and the kids…what do you want to cut the grass now for all of a sudden?" So this happened. Week number three I asked. "Nope, you're not doing it." Week number four came and went. "Nope, you're not going. You're staying right here. Staying put," right?

Ten and a half weeks I stayed put. So week number four I called her up and I said, "I'm completely beside myself, Claudia. I think I'm going to sign out AMA.They won't let me come home. I need to come home.I need to see my family. I need to do this." And I'll never forget she said this and we hear it almost every single time with family members, she said, "Rigo, I want to tell you something. This is going to sting a little bit. The world does not revolve around you, Rigo," right?

I'm like, "It doesn't?What?" No, you know, it stung a little bit. And she goes, "As a matter of fact, some parts of it get better if you're not in it." Yeah, right? I was, "So what do you mean by that?" And she said, "Your patients are safer.The kids are happy. They not wondering why you're not paying attention to them.I'm not worried about you coming home overdosed. Everybody's better because you're not in their life right now. Stay there and get it fixed."

Right, harsh, right? Deserved, but well deserved. So that's what we're talking about here. So how does that happen? How does that happen? I didn't wake up one day and say, "God, you know, this heroin thing sounds pretty good. You know, I'd pass that under bridge a couple times.Maybe if I just roll up under that bridge and shoot up this heroin, maybe we can start that."

So let's talk about what we're facing. This is what we're facing here. It blows my mind every time I see the statistics. I've been doing this for years now, 80% of the world's opiates is prescribed right here in the United States, right? Ninety percent of the world's hydrocodone is right here in the United States, and 80% of the world's amphetamines. People ask us all the time, "What's the next thing we need to be watching out for with our healthcare providers, with our children?"

Amphetamines. There's absolutely no doubt. This is the one that's going to sneak up on us and make opiates look like child's play, right? So you take all the industrialized countries in the world and you rank them and who diagnoses ADD, ADHD the most? We're number eight out of all the industrialized countries, but we're number one prescribing 80% of the world's amphetamines. What is the rest of the country do?

What is the rest of the world doing for pain? What is the rest of the country doing or the rest of the world doing for ADD, ADHD, right? So think about that. We were in Ghana, Africa about three years ago. We were on a medical mission. We were doing surgery for the folks in one of the villages there. And they would line up four days before the Americans were coming for free surgical services.

The hospitals literally had dirt floors in some of the rooms and was very…if there was a thing as Fourth World country, this was Fourth World country not third world. So we get there and these people are lined up for miles waiting. So our first two days all we did is triage, triage, triage, triage, triage. And we can't do real big cases, right, but we can do like the light pulmo. We can do a lot of hernias. We can do tons of goiters.

We did a lot of those. One to two out procedures, very fast recovery time, and it would change their lives, right? So I remember at the end of the second day…and the hardest part of that trip was saying, "We're booked.We can't take anymore." Because you got two miles of patients waiting to come in and see you, right? So we finished up our first day of surgery, 16-hour day, and this gentleman is walking and he has an abscess in his gum.

It looked like a pool ball, like a pool table ball. It was huge on his face. And he said, "Can you take care of this?" And we said, "We can't take care of it. We don't have…" And I said just in passing in the hallway. "Unless we cut it right now. Unless we do it right here." And he said, "Yeah, do it right here. This is perfect." And I'm like, "It's going to hurt."

He goes, "It does hurt. Do it here." So I grabbed one of the surgeons and I retracted his cheek and the surgeon slice him, squeezed him, packed him with IOTA foam gauze and instantly it went down, right? And my eyes teared up when we were doing this and I said, "Didn't that hurt?" And he said, "Hell yeah, it hurt.You put a needle in my throat, of course it hurt."

But the point is, what's our acceptance of pain in this country? Right? What's our tolerable levels of pain in this country? I'll tell you one quick other story here. When I was a new grad out of school and I was going to save the world one epidural at a time, right? One epid...Every angry, upset pregnant woman that comes into the…I'm going to be their savior, right?

And I got called back on every single one. I got this little tiny spot right here. I had standing orders, "Don't ever mess with a pregnant woman." She told me that, right? "Don't ever mess with them. You

give them what they want.You make them comfortable because you'll never understand this." "I got pain, it's just in this one spot." And I said, "All right.We'll pull the epidural back we'll dull this [inaudible].We'll change your position. We'll try some things and we'll lay you on your side."

Two hours later, baby's moving down. "I got a little bit of pain down here." And I'm like, "What's your pain?" "It's like kind of like a 3 out of 10. It's horrible." So this went on over and over and over again. Then one of the old timers told me, "You've setting yourself up for failure, right? How many perfect epidurals have you had?" And I said, "Maybe 20% works perfectly."

All right, that number just dropped down to 1%. So now when I go in there and say, "Oh, epidural, yeah. Pregnancy, this is going to hurt a little bit. What I'm going to do is start an epidural on you. The epidural, if I can get that 10 out of…" They always say 12 out of 10. "What's your pain level?" "Twelve out of 10." And I say, "I get it.If I can get you to a 6 or 7 out of 10, that's pretty good. If I can get you to a four out of five, that's kind of unheard of but it has happened before."

And then this rainbow unicorn appears once in a while and you have 0 or 1 out of 10 pain. You should be praising the Lord for that one, right? I've never got called back ever since then. I've been doing it for five years now. Now when I go back and I speak with my new moms, "How was it?" "Oh, it was good. It wasn't that bad. It was like a 5 out of 10 pain but it wasn't that bad, just like you said."

Setting our expectations for our nurses and setting our expectations for our patients is crucially, crucially important. So let's talk about how we got here. How did we get here as a society? Let's take a guess at that. How do we get to the point right now where everyone's addicted to pain medication? Any guesses? What's that?

- [Woman 4] Pushed by big pharma. Yeah, big pharma had something to do with it. There's no doubt about that. I'll give you a hint. It was one of the vital signs.

- Pain. Right? Pain. Pain is the vital sign, right? We have become so accustomed to making sure that our patients are comfortable. I used to work in the emergency room when I started as a nurse in the inner city in Gary, Indiana, right? You've heard of that for nothing good I'm sure, other than Michael Jackson was there, but murder capital of the year time and time and time again.

So they were Medicare, Medicaid, indigent population. We would have a high incidence of sickle cell patients that would come in and they would say, "Hey, Rigo, good to see you again. Yeah, porta cat. Give me the usual, 50 of Phenergan, 50 of Demerol, flush it hard with the 20 CCs. And this time flush it hard so I can get that rush," right?

And I go to the doctor and I'd say, "Hey, Betty's back and she want..." "Give it to her," right? That's the first time in 1996 that I realized that if she's unhappy, if Betty is unhappy, she's going to report it. If she reports it, the hospital doesn't get reimbursed for their services, lost revenue. It's completely a money game.

Everybody gets what they want. Everybody gets what they want. So fast forward to a couple years ago, now we're starting to realize this overwriting of prescription medication, right? Everybody's addicted to it. What are we going to do? So the Attorney General in Indiana who asked us to sit on his Drug Task

Force committee was winning an award, Top Attorney General in the Country. And his agenda was pulling back the reins on the physicians overwriting these prescriptions.

So he wins this award, and he comes back to us, and we sit down. And Claudia says, "Congratulations, you have to be so happy." He said, "We just opened Pandora's Box and these people don't even realize it." She said, "Well, what do you mean? What do you mean by that?" "We have taken the physicians' right to prescribe and we haven't filled the gap. So now we're going to have a bunch of addicted people, including nurses with no prescriptions that are going to turn to heroin.And what have you been hearing about the past couple years, right, the precipitous rise in heroin use because of our good intentioned efforts to quell the prescription writing."

So that's how we got here as a society. Now that we know how we got here as a society we can start to walk it back a little bit and we're going to share a little bit of our story of how we got here, how we got here today.

- So Rigo and I met 14 years ago. We were both working in surgery. I was the charge nurse in surgery, and Rigo was the Chief Nurse Anesthetist. We were friends for a couple of years before we started dating. because we do have a blended family and we wanted to take our time. I remember early on in our relationship I noticed that Rigo was well-respected and he was driven and he was everyone's go-to person.

Everyone went to Rigo if they had a question about a medication. If the anesthesia provider needed help with the spinal, they were looking for Rigo. He was really doing a great job in his profession. After a couple of years, he decided to join a baseball league because he thought he was still young and in shape and he thought he could still do that.

- Easy. Easy.

- So he decides to join this baseball league. And I remember sitting there that day and I was sitting there just watching him play. He jumps up to catch a ball. He was at second base and I see that he inverts his ankle and he falls right on his ankle and it looked really ugly from far away and I knew right there, "Oh, wow, that's going to hurt." They take him off the field and we get home and I'm telling him, "You need to go to the ER.

Your ankle is swollen. It's purple. It looks bad." "No, I'll just walk it off.I think I'll be fine." So we waited overnight. He wakes up in the morning in excruciating pain. He's like, "I can't even feel my leg." I said, "We need to go to the ER."

We go to the ER and the doctor starts doing some X-rays and they tell him, "Your ankle is broken. You need surgery." He was in so much pain. They prescribed an opiate. They gave him Vicodin. They said, "Take this. We need the swelling to go down a little bit, then we're going to have to operate on you." That was the first time Rigo had ever taken an opiate.

I remember he went home and he was in so much pain. He kept popping these Vicodins. He has his surgery and he's still popping these Vicodins. And I remember while he was at home, they told him, "You're going to have to be off for a couple of weeks. You going to go through some physical rehab,

you're going to take this medication, and then you can come back to work. You can come back in a walking boot or something, but take some time off." I remember while he was at home, he was so moody, so irritable.

He was not the guy that I knew prior to this accident. He just was so different. We're looking at probably 30 days after his injury. And now he's ready to get back to work. So he gets to back to work and I'm so excited to see him get back because I wanted the old Rigo to come back. The one that was at home, he was irritable. He was moody, he was mean, and he was isolating.

He didn't want to do anything. So he gets back to work and I'm excited to see this new guy come back and the old Rigo never came back. I started to notice that he was isolating more and more. He started wearing long sleeves. And he was doing things just out of the ordinary. And one day I remember we were in the kitchen and I'm looking at him and I see marks, what looked like track marks on his arms.

And at that moment I knew he was in trouble. He was in trouble and he was doing drugs. I knew that. And at the time, I did what I thought was the best thing to do. I started talking to his colleagues. I said, "Hey, I think Rigo's in trouble. I think he's maybe using drugs." I didn't want to put him in jail but I wanted him to get out of practice.

And I started talking to everyone but nobody would listen to me. So then I start telling Rigo, "Rigo, you're not right. You need to go get some help. There's help for you out there. I'll help you." "No, you're paranoid. I'm fine. I'm fine." Well, after a couple of months, this went on for months. I prayed every single day that somebody would help him.

Finally, he was intervened on, and he was removed from practice. And he was sent off to a treatment center. It's probably the first time in months that I was able to sleep at night, because I knew he wasn't going to hurt anyone or hurt himself. And I remember thinking to myself, when I was home alone, when he left, I'm sitting there in my bed thinking, "Wow, how did I get here? What are the chances that I would be in love with an addict? How does that happen?"

- So chances, right? We've heard that twice already. What are the chances that that's going to happen? We hear that story every day, every single day when a nurse checks into our facility or a pharmacist or a physician. We hear a variation. You change the injury, change the prescription, change the hospital setting, but it's always the same.

It's always the same. I don't want to get her off the hook that easy because I have to tell you a quick story. You see I'm full of these stories but I get so excited when I have a captive audience that has to stay here for an hour so I got another one for you and another one. So with the injury, I go to the hospital, right? And how many moms do we have in here? Moms? Okay, good.

You guys are going to love this story. So the way that they determine whether you need surgery is they'll stress the joint. So the orthopod came in and he took my ankle and he goes, "This is going to hurt a little bit." And he's stressing it and he's saying, "That's a grade one tear, that's a grade two tear." And I'm coming unglued. The pain was absolutely excruciating. And he goes, "I think this is grade four."

And I'm like, "How do you know?" And he said, "I popped it right back out of the socket." And he goes,

"Yep, it's a great four tear.You need to have surgery." I blacked out. I literally blacked out. Never blacked out before but I blacked out. And I know I blacked out because when I woke up they were kind of poking fun. "Oh he's a lightweight and they're wrapping my ankle at the same time.

So the surgeon leaves and I tell Claudia, "That was the most excruciating pain." Can you guys relate to that? Yeah, it's the most excruciating pain I've ever had in my entire…I got to about there in the sentence and she says, "Try having a baby. All right, done." Not even with that do I get credit.

But let's talk about chance and let's see how much this is really chance. So we're going to go through these things really quickly. And I promise we're going to keep this open for conversation and discussion at the end. If you guys have any questions as we kind of get into it now, please raise up your hand, redirect us, ask questions, and we'll get into it. So this is not a thing of chance. There's five reasons why we have an impaired professional.

This is the part that might sting you a little bit. The top two, you guys can't do anything about. The discipline committee, the boards of nursing, the compliance officers, the Attorney General. You can't do anything about it except understand that it's part of the equation. But this is the part about the impaired professional and why it happens. Reasons number three, four, and five, we all have some fault in this here.

This is all part of our fault of why this can happen. Why is me as an anesthesia provider can divert medication from the hospital and provide care to patients for a long time? One and two, I'll take that, three, four, and five were the people around me. So this discussion today is to focus on all of these, but really look at three, four, and five, right?

Don't get any feelings hurt. This is our experience. This is our recommendations. And let's talk about it. What can we do here moving forward, right? So you guys are the experts. You guys here in this room are the last line of defense between protecting the public, right?

You have to make decisions that are going to keep the public safe. And if it's within your organization to help the nurse, that's great too, but we have to protect the public. How many of you think that you can identify an impaired professional at home? You guys are getting the reports at the end of the road, right? You guys get it at the end. This nurse did this. Boom, boom, boom, boom, boom, boom, boom.

How many of you think that you can identify the nurse who is impaired at work? What do you think that person is going to look like, that nurse is going to look like?

- So let's say we had a nurse who is taking 50 to 60 Vicodins a day and coming to work, or maybe they were taking 5000 micrograms of fentanyl once or twice a day. What do you think that person would look like at work if you were looking for them?

- IV.

- What do you mean IV?

- You got IV user, right? IV user nurse.

- So what do you think they would look like? Maybe you think they would…tired maybe? Kind of disheveled?

- Any suggestion? Any guesses?

- Any guesses?

- Tired? Come on, guys. You guys are the ones here that have to find this nurse. You know they're out there. You got a stack of reports from the pharmacy saying something's not right. - [Man]

Irritable.

- Irritable?

- Irritable?

- Withdrawn?

- Maybe not, maybe pretty normal. [inaudible].

- I think you should have been at this table up here.

- Yes. You're correct. And that's what makes it so difficult because sometimes we're looking for that disheveled person. We're looking for that person that's not coming into work. The person that's staying at home that's just being irresponsible and Rigo was none of these, which is why I didn't know he was addicted for so long.

Because he went to work every day. He was at work. I never saw him falling asleep at work He was the complete opposite.

- So the [inaudible] Recovery Center, if you know us, if you don't, they're in Atlanta, Georgia, and they're the oldest professionals program for healthcare professionals in the country. So they did a study in 2011 and we've emulated this study and it's an ongoing thing that we do at Parkdale and we've given this information over and over again. We've seen a couple of studies that mirror this with the exact same results.

So we did something pretty simple, but the information we're getting is fantastic. So when our addicts come to us, in the throes of addiction, we don't ask them, "Rigo, tell me how wonderful you are?" Because I'd be like, "Tell me how much time you have because I got a lot to say." But we ask the family members. So we'll ask Claudia, "Describe Rigo for me," right?" We'll ask the coworkers, "Tell me about your coworker."

We'll ask the sons and the daughters, "Tell me about dad." Describe dad for me, right. And this is what we found. They're intelligent. They graduated in the top 25% of their class. These impaired providers are well-respected. They have advanced degrees.

They hold positions of supervision. They are the top performers. They're normal. Not only are they normal, here's something that might send a shutter down your spine, "I won an award, an Employee of the Month Award in the morning and I got escorted off the facility in the p.m. shift," right? They are the top performers. You know who was most upset that I got caught at work?

Who do you think was most upset? Yeah, my coworkers. They're like, "Now we got to work weekends and holidays. Rigo's working all of them," right? "Who's going give us a break now? Rigo gave us six a day." They were the most upset that I got caught. And this is what's happening, we're looking in the wrong spot for them.

So when I tell you the characteristics of what you're looking for, we just have to turn…we're not looking for the one. By the time you find them overdosed in the bathroom, it's too late. By the time that you see the physical symptoms that we teach our kids about, right, when we're walking down the street and we pull our kids closer and we put our purse on the other arm because there's someone dirty and disheveled and a brown paper bag.

That's not what we're looking for here when we're talking about the impaired professional. They're very, very, very functional. So let's look at a couple case studies. I put a couple of these case studies in here because I think it's going to be important for you guys to play along and just think about what you guys would do in this situation if you were presented. These are real cases. When Claudia talked about 5,000 mcgs of Fentanyl and 60 Vicodins and 500 milligrams of Demerol and 300 milligrams of morphine a day, these are patients that we've treated and they walk in just as alert and oriented as anyone of you here.

So a case study number one, think about what you guys would do here. This nurse has been a nurse for 12 years. They suspected a diversion and they asked her to self-report to the Board of Nursing and the Alternative to Discipline program in their state. They got a one year RMA and a one year contract with the Alternative to Discipline program and everything else was circumstantial. They kept their job. One year later, they suspected diversion again.

This is step number two, so the nurse resigns her position. She got a new job. Guess what? Suspected of diversion. Drug screen was positive. She was able to talk her way out of treatment. "I got this back injury.It just one time and I borrowed a friend's prescription." I'm sure you guys have heard it all at this point.

They didn't do anything but give her an increased time in her contract for the monitoring. Three months later, she was found overdosed in the bathroom, she was arrested, charged with a felony, a suspension on her license, and mandated into a 60-day treatment center for health care professionals. At the time we put this slide together, she now has two and a half years of documented clean sobriety, right? So you can see how this happens.

So who's at fault here? Who's partly culpable? I think we can say that this was managed probably incorrectly from the very beginning, right? So there's a lot of people at fault. Ultimately it was her fault for taking the pills. So Dr. Gabor Mattei who is a addictionologist in Vancouver, has treated more heroin addicts than anybody else in the Western Hemisphere, he coins it like this, "Although the initial act of

ingestion is voluntary, cessation of the addiction is not."

Is that something we could buy into? So we don't have to split hairs on is this a disease or is this a choice? Because we can have a whole another discussion on that. But the first time I took that medication when I came back to work after three months of being on prescription medication and it was 7:00 in the morning and I started to feel a little bit icky, and then after my first case I'm like, "God, my back's starting to hurt now." And then by 11:00 I had, excuse the graphicness of it, the nausea and the vomiting and the diarrhea like something's not right.

I come back after three months and now I have to take off work because I get the flu. Who gets the flu? So I crawled out to my car and I had one more Vicodin pill that was left in there. I had a couple in there and I took one. And within 20 minutes, not only did I feel good but I felt better. That was the initial act of ingestion. That was the moment that I knew I was physically dependent on that.

So I made the decision, "This is my choices now.You got some prescription. It's a prescription. You had a pain.It's a legitimate pain. You know how to use this.You know how you feel about addicts, Rigo. They're week and character flaws and you don't look like an addict. So keep taking the medication.Wean yourself off, and in a couple weeks this will all be behind you.If you need another prescription, you got a lot of buddies, they'll write you another prescription and no harm, no foul, right?You're not hurting anybody."

Or I could say the exact opposite that the nursing profession teaches us. "I need help. I need someone to take care of me. I need to take some time off. I'm an addict. I need to go into a treatment center. I get anxiety now, I've already been through that but I get anxiety now if that I had to do that. We're not trained as nurses and healthcare professionals to take care of ourselves, right?

We talked about that earlier. We sacrifice tee ball games. We stay late. We come an early. We do things that we don't want you to help others. But when it's time to help ourselves, we're not really good at that. So this is case study number one.

We're going to talk about a couple more. You can't do anything about the way the patients look, right? Accessibility and necessity. Just stop using. Stop drinking, right? I'm going to divorce you, just stop, just stop. If it was that easy, we wouldn't have an addiction.

And I want to talk about that a little bit. How much is this pull? How much is this pull? How much are you getting pulled to do this? So when Claudia is saying, "You're about to get arrested and fired, and I'm about to divorce you and the kids don't want you and you look like crap.You've lost 100 pounds. Maybe not 100, but. You've lost some weight here." Why can't you just stop, right?

That's the million dollar question of why can't you just stop? Well, let's talk about that. We're going to take you back real quickly to Nursing 101 where we're talking about the little bit of physiology and this is all we're going to talk about here. So there's two parts of your brain. And this is how we explain it to our kids, because it's so important. So an upstairs brain and the downstairs brain.

And you can think of it like that. The upstairs brain is your prefrontal cortex. This is the one that separates us from all other mammals, this prefrontal cortex. This is the higher learning part of your

brain. This is the part that has your personality. This has your consciousness of decision-making. So if you really want to do something but it's illegal, the prefrontal cortex says, "Hey, you probably shouldn't do that. That's not going to be a good idea."

That is driven by…it's like this thing that's in your psyche all the time telling you do this, do that subconsciously. No one tells us, "Hey, listen, if you don't eat for 72 hours, you're going to start having some physiological effects." It just says, "You're hungry. It feels good. Eat something." And every time you eat, this VTA area, this nuclear accumbens gives you a reward so that you do it again, right?

So you get a little reward. You eat that cake, it feels good. Next time it remembers, eat that cake again. So this part right here, the nucleus accumbens and the VTA sits right next to an area of the brain called the hippocampus. The hippocampus is responsible for memory. So you remember what feels good and what doesn't. The last safety check that you have physiologically is this prefrontal cortex.

And this is like the last filter. It'll say, "Okay.It feels good. You need it. You've done it before.Should I do it though? Is this right or is this wrong?Should I do this?" That's where it's at. There's an actual connection between the two. There's a physiological connection like a railroad track. You can see it depicted as that black line right there that connects the two. That connection, this is God's cruel joke, He doesn't…that connection is not fully developed until you're in your early 20s, right?

And if you're a man, it might never get developed. He's nodding because he knows. He's like, "Yeah. I'm still waiting for that to happen." So when your kids are like, "What were you thinking? Why would you do that?" Our seven-year-old was on top of the hill in the cul de sac that we live on and he wanted to go downhill with his shirt off on a skateboard into cross traffic.

And we're like, "Listen, player, you've never even been on a skateboard.What are you doing?" But his primitive part of his brain was telling him, "It's going to feel good. The wind, the sunshine, the excitement, it's going to feel good." He wasn't thinking about what was going to happen. This is what happens with these drugs, alcohol, phonography, sex addiction, internet gaming, which is now diagnosable and treatable, right?

Social media on the phone. This is what happens, it breaks that connection completely. So when she says, "I'm going to divorce you if you don't stop," the thing that's overwhelming my brain is, "Do it. Do it. Do it. Do it. It doesn't matter.It's not making any connection." The only thing that repairs that connection, the only thing that repairs that connection is sustained sobriety.

That's it. You got to stay away from it long enough now. I'm seven and a half-years sober and I can see the insanity of the things that I was doing before. But when I was going back into treatment, I said, "Was it really that bad? I mean, I wasn't hurting anybody.I'm just myself." So let's talk about how much this pull is, all right? The good thing is, is that you can get a dopamine reward for a lot of things that keep us alive and keep us moving forward.

You hug your kids, you get 50 mcgs of dopamine. Reading and laughing and smelling flowers, food, sex, meaningful relationships, they all give you enough dopamine to reward that behavior to do it again. So think about that, right? Two hundred mcgs is the highest dopamine that you're going to get on this page. Everything under 200 is enough to sustain humanity.

It rewards you to eat. It rewards us to protect each other. It rewards us to have social groups and laugh, to hug our kids and nurture them and raised them, to procreate, to eat. It rewards us at a 200 mcg or lower dopamine and that's enough. So now you start talking about some of these exogenous neurotransmitters like tobacco that gives you 300 or alcohol that gives you 350.

So they're getting jaundice, and they're getting anxieties and their liver, you can palpate and you can see pulsating and you tell them, "You're going to die." They're getting twice as much reward from that alcohol than they are from anything else that they can take naturally. How many people have tried to stop smoking or tried to tell your patients to stop smoking, right? We know what that does, you're going to die.

We know that shaves years off your life and there's consequences associated with that, but when they're getting 300 mcgs of dopamine, that's not easy to do. Let's talk about some of these addictive things. There's cocaine, 400, 450 for opiates, and then the kiss of death, the amphetamines, methamphetamines, 1,200 mcgs of dopamine every time they take a hit, right?

I was getting 450 mcgs of dopamine every time I took a Vicodin, every time I shot up the Fentanyl, 450 mcgs. Telling people just to stop doing it is not going to cut it. There's no way. It's physiologically impossible. So this is where it starts to shift a little bit, right? So, you know those two things you can't do anything about, just know that it exists.

Characteristics number one, know what you're looking for, right? You're not looking for the degenerate. And number two, this is more than just willpower alone. There's a physiological reason why just say no doesn't work, right? So let's talk about how it starts to affect us. What can we do about it? We're talking about enabling.

Enabling behavior. Claudia was an expert enabler.

- Oh, I was. Today I work as a drug alcohol counselor. And what I find in my experience with families is that the home families struggle. They enable the behavior. The work families also do the same thing. I remember when Rigo was in the throes of his addiction, I enabled his behavior. I would wake him up every morning to make sure he was on his way to work and that he wouldn't be late so that nobody would know.

When he was at work, while I was trying to do all my charge nurse duties, I would do rounds on his patients. Sometimes I would peek through the OR windows just to look to see if he was there or if he was awake or if the patients were okay. I remember I was so sick myself that I started going into recovery room and checking on patients to see if he was withholding medication, just so that I can see if patients were having pain.

I remember when Rigo left the facility and he was gone, it took a couple months for me to start talking about what happened with some of our colleagues. But I remember asking some of his colleagues if they knew he was using and every single person I asked said they did. And then I started asking, "Well, why didn't you say something?" And they all said similar answers, "He's a nice guy. I didn't know the options. I didn't know who to call.I didn't want to put him in jail. I didn't want to see him destroy his

family and his career. He's a really good guy.I know he cares about these patients."

But nobody in the facility knew what to do, including myself. Had I known then what I know now, I would have reported him to our Alternative to Discipline program but I didn't know that that was even an option. Instead, we both lived with pain and suffering and, you know, we were compromising, you know, patient care and everything else just because we weren't empowered to report someone.

So it really does affect everyone.

- Everybody knew too. Everybody knew that I was in trouble and she asked them when she went back to work and they all knew. They all knew. What do you do? What do you do when you're faced with that situation? Right? You don't want to be wrong.

And I'd become an expert at taking people down the rabbit hole with me, right? She wants to divorce me, well, I'll call her bluff. She's not going to divorce me, right? You know, I threatened American with Disabilities Act and the ACLU and everyone that I could threaten if the hospital wanted to come and pursue me. But the people that enabled me cared about me the most, and they wanted me to succeed.

And this is where we start seeing it, this is our…we get locked into the way we used to do things. We consult for hospitals now and we go in there and we give them this spreadsheet, this incredible spreadsheet and we do an investigation. We go through their departments and we review their policies and we talk to their staff and we tell them, "This is how the diversion is happening and this is what you need to do and we offer it to hospitals. And more hospitals, 9 out of 10 hospitals say, "No, thank you. We're okay.We don't need that information. We're good."

Why is that? Because they've been doing…they've paid an attorney 2,000 hours of attorney fee salaries to write these policies, to implement it, to train, and to have someone come in there and say, "You might be doing things wrong.Let's take a look at it a little differently." So this perception of loss, I'm going to lose all my investment. I'm going to lose all my policies. I'm going to lose all this stuff is more of a driving force than just cut your losses and to try things differently.

And that's really kind of what we hope to kind of open the eyes on today is maybe we're not doing things the right way, maybe we're not doing things as good as we can be doing things. So this potential loss, we see it in the stock market every day, right? You put in $50, you're making $100, you're like, "Yes, I'm doing good." It's down to $90, "I'm going to stay in, I'm going to ride this out." It's down to $80, "I'm going to keep it in there because it's got to go back up."

Now, you're at $50, "Oh, it's breakeven.I haven't lost anything." Now it's $40. "I don't want to lose $10. It's going to go back up. I'm going to stay," right? And then it's down to zero and you're in gamblers anonymous because you're trying to chase that. This is what happens all the time. Dr.

Harry Beigerman [SP] is a professor of Business at the Harvard School of Medicine and this is what he does every single year since the late 1970s. He'll take out a $20 bill. I'm going to do this one of these days. And he'll say, "I'm going to auction off this $20 bill. There's two rules to this, you go in increments of $1 and the last two people that are in have to both pay," right?

So think about that. Who wants to buy this $20 bill for $1? I would hope everyone's hand raises up, right? Two dollars, $3, $4, $15, $16, now everyone starts laughing. They don't want to be the last two left in this game, right? Eighteen and $19.

I'll buy that $20 bill for $20. The $19 guy is saying, "I'm not going to lose $19, I'd rather lose one.So I'm going to bet $21. I can't just break even here.I could get out now and lose $20. I'd rather lose $2. So I'm going to bet $22." This game goes on, and on, and on. He donates the money to charity. He's never donated less than $200 to charity since the 1970s. Getting ingrained in the way we do things because of this perception of loss is a bigger motivating factor than the change to the positive.

Let me give you another example of how this works on a bigger scale. 1970s the Vietnam War was just wrapping up and 20% of our servicemen were addicted to heroin. They're coming back to the country and President Nixon said, "We're going to have an army full of zombies coming back here addicted to heroin. Let's put some money into this war on drugs."

They put $300 million in 1970 into the war on drugs. You can see in 1985, it shot up through the roof. What happened in 1985 around that time that the money you just open up the bank account to this war on drugs? Just say no, right? We just talked about that, just say no doesn't work. We know that.

But 1985 we've said, "Just say no. Just say no, kids, just say no." One point five trillion dollars as of 2010. Look at that bottom line though. That's the addicted percent of the general population in the United States. It has not changed, yet we continue to put money in areas that we know are not going to work.

So your next question is, "Where are we putting this money at?" This is where we put it, Sixty percent is prosecution, punitive, punish them, take their license away, make an example out of them, report them to the Attorney General. Those natures. Ten percent of border patrol, 5% we're going to go after the dealer, 15% specifically to the Just Say No campaign. Look at that 10%. This is what we absolutely 100% know that works.

And it all gets bundled up in the smallest piece of the pie there. Treatment, education, prevention, reentry, medically assisted treatment, aftercare support, family counseling, Early Start programs, all of these things that we know work is what we're spending the least amount of money on. Any questions so far about that?

Let's look at case study number two here. This is advanced practice. So it's a CRNA. She had a legitimate prescription for Vicodins, legitimate prescription. However, she was taking more than she should have and she was running out. So at the end of the month, she was diverting Vicodin pills from the hospital. They saw some suspicious activity.

They did the drug screening and it came positive for Vicodins and she said, "You know what? I need help. I need help.It's true." She could have just said it was her prescription but she said, "I need some help. Please give me some help." So she voluntarily admitted herself to a treatment center and she got the right kind of help that she needed for her profession. The treatment center, as we do when they come to us, the requirement is you will report yourself to somebody, the Board of Nursing or the Alternative to Discipline program.

So when they come to us, even if they're under the radar, they will be on the radar by the time they leave us. So she reported to them and she went to the Alternative to Discipline program. There were no legal. The hospital did not want to pursue and there was no termination. She got a three-year probation on her nursing license with a three-year recovery monitoring agreement with the Alternative to Discipline program. She exceeded all their recommendations.

This one sounds great, right? It sounds legit. It sounds like they did everything they were supposed to do, right? So we're going to let you guys think about that case for a minute and we're going to come back to that here just in a minute. Inadequate interventions. This is number four. This is our fault again.

I just want to take a poll here. How many of you have the ability or in your policies you deal with CRNAs nurse anesthetists? How many of you through your nursing organization deal with nurse anesthetists? Okay, about half the room here deals with nurse anesthetists. How many of you out of half the room there…if you keep your hands up just for one second here, how many of you treat your nurse anesthetists different than your nurses?

Okay, more than half of the room went down. Okay, so we're treating our nurse anesthetists. So out of you that still treat nurse anesthetists differently, how many of you have a three-year or a mandatory time off of work of one year? How about two years? Okay, that's everybody. So the point is you have somebody who's a floor nurse who might see one or two patients and they're alert and they're oriented or you have somebody like me in the throes of a severe addiction with keys to the pharmacy.

I am the stop check. I am the stop check. I'm the final say. I order the medication from the pharmacy and I tell what gets given and it's up to me to be...So that's my profile. The other profile is an LPN who stole a couple pills. And in many states, we get treated the exact same way. Does that put a little shudder down your...

It should. Inadequate intervention. People ask me all the time, "Rigo, how were you able to get back to practice because I'm from North Carolina and I got to wait two years? I'm from Texas and I got to wait one year as a nurse and then one year off of anesthesia. I can't get back to work. How did you get back to work? What was the biggest factor?

It was the state that I was in. It was the biggest factor. It didn't matter what I did or who I told or who was monitoring me, it was the state that I was in. So these loopholes are throughout the country. Inadequate interventions. We know what works. We have the magic formula.

We have 50 years of the federal government and historical speaking and data and research and what doesn't work. The benefit of realizing what doesn't work is we know what works. This is what works.

- So what we found is if someone goes through detox, meaning they just stop using drugs, they stop. Maybe they stop on their own at home or they go to a treatment center for detox or maybe they're incarcerated but they stop using. We know that they have a 10% success rate. So 90% of those people are still going to relapse at the one year.

Now if we have someone who stops using, they go through detox and then now they're being monitored.

Maybe they're being monitored through The Alternative to Discipline Program, or maybe it's the Board of Nursing or the court system, but someone is holding them accountable. Now, they're at the 60% success rate. So 40% of them are still going to relapse. Now, let's look at if they stop using. They go to treatment.

Treatment being whether it's an inpatient facility or dual diagnosis center that can treat their addiction and their anxiety and their depression and then they're still being monitored. At the one year mark, they're at 85% success rate now. At the three-year mark, they're at 90%. And if we can get them to five years, now they're at 95%.

I know a lot of states are now moving over to the five-year monitoring programs because they know that that's what works. They have a better chance of staying sober if they're accountable and they're going through some type of structured treatment longer.

- So if you think about this metaphoric pendulum that's swinging back and forth. And this is really the problem why we can't all get on the same page is because it's either I'm punitive and they punished and they need to be made an example for their indiscretions or, you know, they're sick and it's a disease and let me hug them and leave them alone and be nice to them. Well, the answer is in the middle, right?

They're sick and it's a disease. There's no doubt about that and we could spend eight hours talking about the science of addiction. It's an absolute physiological change in their brain and it's a disease. But with that comes consequences for their indiscretions. They have to be held accountable. Sometimes it's legal. Most of time it's with the board.

Sometimes they lose their profession. When I was discharging from the program my counselor said to me, "Listen, Rigo, if you want to get back to work in anesthesia ever again, you got to finish this program.You go to do urine drug screens for five years, monitored urine drug screens for five years. You to take some time off of work. You better be volunteering and giving some time back and showing some gratitude. You have to come back to my aftercare program once a week for the next two years, right? There's a lot of things you have to do."

And I said, "I don't think it's fair. I mean, I don't think I should have to do all…why do I have to do all that?" And he took his glasses off and he leaned forward he said, "We have options.You don't have to do that." And I said, "Now we're talking. You don't know who I am. Give me the other option." And he said, "You don't have to be a nurse. That's your option because Rigo, being a nurse is not your right.Get that out of your head right now. Being a nurse is a privilege and if you want to keep that privilege, you better work for it."

That's the message that needs to be sent and that's the strong message that we send. And that's the first time I'd ever thought of, "What do you mean it's not my right?" It's not. It's not. I drive an hour and a half to work right now and in the in the boondocks of Indiana corn country and it's boring, but I take care of that job and I protect that job and I love that job and I'm grateful for the job because it's the best privilege that I can do is to help somebody else when they're sick now.

So why don't we do this if we know this is what works? Why do you think we don't do this? And it's just a question here. I'm not asking you to answer, just to think about that. Why don't we do this? If we know

this is what works. If we can add in a little bit more accountability, like you stole medicine, you might get a misdemeanor, right?

You stole medicine twice, now you can't be a nurse anymore. So pepper in the appropriate amount of accountability with this, but we know stop them from using, put them in an appropriate treatment center, and then monitor the heck out of them for three to five years. That's what's going to get you sober nurses. This is why that doesn't work because when you get the nurse who's in trouble, everybody wants a piece of their hide, right?

And everyone has an agenda and everyone has a policy and everybody has requirements and everybody has things that they want to do. And very rarely do we talk to each other. We were talking to a couple folks last night and we asked them a question, they said, "I'm not sure that's the Alternative to Discipline's job, that's what they do. We're the Board of Nursing and we don't do that."

Well, why not? Why aren't we all on the same page here talking together? The Board of Nursing, the Office of the Attorney General, any law enforcement who wants to get wind of this like the whole room of NATI [SP] who wanted to re-arrest me five years later. Alternative to Discipline report, the employer for anesthesia providers or the like, the NBC RNA who certifies me to practice anesthesia.

They have their own credentialing. Credentialing at the hospital and most communities. The Office of the Inspector General, the Practitioner databank, the treatment center, and the angry wife who has her own list that is more harsh than any of the other ones that I had to go through. So this is why it doesn't work. We got too many people involved in trying to make these decisions. Let's go back to that case study number two.

This is what the resolution of that nurse was. While the employer by their policy said, "We got to report you to the Office of the Attorney General. I'm sorry, we have to do that. Who then in turn reported her to the DEA. The Office of the Attorney General did an investigative report and reported to the DEA. The Board of Nursing put a three-year probation. These are color-coded because the things that are in black didn't affect her ability to go back to practice.

The things that are in orange on this screen here, she had a little trouble getting back to practice. But the things that are in red, she's never going to practice again in anesthesia. So The Alternative to Discipline Program gave her a three-year monitoring agreement. The legal side fell out as a felony. She stole medication. It's a felony it was commuted down to a misdemeanor.

Her NBCRNA did not give her a certification to practice. They put her on a provisional which means if you're going to credential this person that come to practice, it's provisional meaning you might want to call and ask us the details of this. It's like a probation on the nursing license, that kind of thing. The credentialing at the hospital reported her to the National Practitioner Data Bank because that's what they have to do.

You're familiar with the National Practitioner Data Bank, right? That's one of those things too. Well, who's going to ensure you? Which insurance companies are going to reimburse you if you're on that list? And then the Office of the Inspector General because here was a felony, they were alerted and this nurse was placed on the Office of the Inspector General list, which means they can't practice anywhere for a

period of five years that takes federal funding, Medicare, Medicaid, TriCore, Native American insurance plans.

So essentially they're dead in the water. This nurse has been 100% compliant, voluntarily admitted into the program. This is one example of many. So now when this gets out in the public and you have a nurse and she's sick and she knows she's sick, she knows she needs some help and you ask them, "Why didn't you just report?Why didn't you just ask for help?"

Well, the last nurse that asked for help ended up on a federal exclusion list or in jail, right? These are the reasons why. Last one here and we're going to open it up for questions, expert knowledge. This is 100% on the responsibility of all of us in this room here. You have to learn more about this, the impaired nurse, the impaired professional. You're always going to be one step behind. You know who policies and procedures work for?

Policies and procedures at your hospitals, policies and procedures with your Boards of Nursing. Those are perfect. They work. They work 90% of the time for the 90%of the people that are not the addicts, right? Because Claudia reads a policy and it says, "Don't take drugs." She's like, "Pretty clear, black and white." And I go, "Well, what exactly is a drug? What does that mean? What does that mean?"

Because my policy and procedure said, "We can call you in for a urine drug screen if we suspect something, right? And they spelled it out. So they called me in and they said, "Rigo, we're going to need you to do a urine drug screen for us." I said, "I'm not doing a urine drug screen." And they said, "Well, why not?" And in my head I was thinking, "Because I just shut up 10 minutes ago. That's why not."

But they said, "Well, why not?" I said, "Because I don't have to." They said, "Yes, you do." I got the CEO and head of pharmacy and security and the police and Claudia…I'm going to lose points for husband of the year of award because I didn't say this part. Claudia was the charge nurse in the surgery department that I was diverting from. So she was there and she saw it all the time, right, and she was there during this meeting.

And they said, "We need you to do a drug screen right now." And she said, "Please just do it.Just come on, get the help that you need." And I said, "Actually, in your policy and procedure manual on substance abuse page three, paragraph two, line seven," exactly, "it says that I need three discrepancies in a six-month period on my charting to be asked to do a random drug screen. Show me my discrepancies in my charting and I'll do a drug screen for you."

You can imagine how unhappy they were, right?

- But we changed the policy the day after.

- Yeah. It is known as the Rigo policy at the hospital. But these are the things, right? You're always going to stay one step behind. We do entire presentations on that. While you guys are at home sleeping, resting on the safety of your policies and procedures and that you have people looking and you have security cameras, the addict is thinking, "How am I going to get my next one because I need it? It's not because I want to hurt anybody, because I physiologically need it."

There's some of these substances that will shut down your body and kill the host if you don't get it like alcohol, like benzodiazepines. Opiates, just make you feel like you want to die, but you're not going to. But there are some of these things that if their body doesn't get it, it will shut down and kill the body. So these are a couple of things.

They're always one step ahead. Urine drug screens. We do a two-hour presentation on how to…I'm sure there was Jeannie with Affinity here. And you're going to hear from Barry this afternoon with Affinity Testing, but we do a two-hour presentation on how to cheat your urine drug screen tests, right? Fascinating information. I'll tell you a little bit about that as a teaser. So they say we're going to take a look at that and we're going to make sure…and this is historical.

They've changed a lot of this significantly. We're going to look at your urine drug screen and it's dilute. We can't accept this. It's a dilute sample. Try it again. I said, "All right." So they would go and they get vitamin B12 tablets from the pharmacy and they will make that fluorescent yellow urine, dilute it down with a liter of water before they test.

Now they have a dilute sample that's like nuclear reactor glowing yellow. I said, "Okay, well, it's good I'm taking vitamins." "Well, we're onto you on that. We're going to have to test for some more things because now it's coming back to dilute. So let's look at some of the natural body spill offs. So let's look at other things like creatinine," right? So now they go to the health food store.

They take creatinine powder and they overdose it and they take vitamin B and they overdose that and they wash it down with five liters of fluid and now they're catching that spill off. Temperature's put. They're doing everything perfectly. They got onto that. So now they're doing complete urinalysis panels in addition to that Well, someone figured out we don't have to pass the test, we just need to buy some more time.

We just need to buy some more time. So a little salt in the fingernails and after you give the sample and you swirl your finger around in the salt, it will adulterate the test. So they'll call you up and they'll say, "Hey, we found a foreign substance in there. You got to come back in tomorrow or something." Well, you already know that. You get three extra days. Now you got to wash your hands and it's observed. So bleach on the drawstring does the same thing, right?

One step ahead. We can talk about this all day. It's one step ahead. And as a matter of fact, when they tighten up their policies and they get this information and they tell us now you got to wash your hands, I got the blueprint. I know what you guys are going to do. So I do something different. This is a perfect case in point to the next one.

Fentanyl is illegal. Fentanyl got stopped at the border from China. It can no longer come in. U-47700 can be bought off the internet today because it's an isomer of Fentanyl. They change one molecule and call it something differently. It's completely different. One step ahead.

We talked about the policies and the procedures. Reversing a marked increase and this should scare all of you healthcare professionals in the abuse of propofol, right? Very difficult to detect. Very small margin of error. You know how we're catching our people on propofol? How do you think we catch them on propofol? They're dead.

They're dead, or they're in the bathroom and they're passed out. That's how we're catching people that are using propofol and these are your nurses. It's not testing scheduled. We talked about that, the mass spec machine. We did a presentation for 300 nurses in the state of Indiana. We said, "How many of you guys have a mass spectrometry machine?"

And 300 proud hands went up, right? You understand what that is? That means if they send the fluid back, they put it through this machine. It emits some light rays through it, and it'll tell you what it is. It'll you what it is. Three hundred proud hands went up. And we said, "How many of you have a quantitative or a qualitative one? Who has a quantitative one?Tell us about that."

Two hundred and ninety-nine hands went down because either they didn't know or they didn't have it, but the addicts know. There's no reason why six floors down in the bowels of surgery, I should know what kind of machine they have upstairs in the pharmacy but I did because that means is she going to be able to tell that there's fentanyl in the syringe that I'm going to send back or she going to be able to tell that there's 47.35 mcgs of fentanyl? It made all the difference in the world because now I'm sending 20 CC's of normal saline with one drop of fentanyl that the machine is picking up of, "Yeah, there's fentanyl in here."

So these are the things we're going to stay one step ahead all the time. So now that I've depressed everybody, what are we going to do about this? What are you going to do about this now, right? Hopeless and helpless. It's real easy guys. Characteristics. Accept what the addiction looks like.

This is the new face of the addiction accept what it looks like. As far as the accessibility, consider the compulsion. Just stop is not going to work. Just a slap on the wrist is not going to work. Just the punishment is not going to work. The enabling and the misdiagnosing, objective parameters. If they're using more than they did six months ago, if they're using more than the rest of them, if they're coming in early, if they're staying late, if there are objective parameters, then they're using.

Go with your gut instinct. Take the subjectivity out of it. Take it completely out of it. Inadequate interventions. We were talking here just right before the presentation. And one of the frustrations we talked about is I get them, I put them in the program, I'm monitoring them, and then they have a compact nursing license. They go to another state, right?

This is going to sting you guys because it stings me every time I say it because I'm always trying to prove myself worthy to be in a conversation with the physicians, right? So I'm nicer my patients, I am diligent with everything that I do professionally because I don't ever want them to say, "He's just a nurse," right? I want to be able to be competent in front of them. But they got this figured out. They're ahead of us light years on this.

So their states and their monitoring agencies and their boards and their treatment centers, they all work together. "Yeah, I'm a physician, I have a problem." Boom, pick a place on the treatment center. The treatment center will call us and tell us what's wrong with you. And when you can come back to practice and then we're going to lock you down for five years. This is where you work. This is how much you work.

These are your drug screens. One time you fail, you're out. You can't afford treatment center, don't be a physician. You don't want to do the work, don't be a physician, right? Right out of the bed. As soon as discharge comes, 85% success rates on the physician side because they're all talking together. So what we need to do, oligopolize the system.

Oligopoly, if you don't know it's like a gas station. They have them on four corners and I'm always looking for the cheapest one. "They're all the same price." That's what they say to each other is, "Let's not give them a loophole here. Let's all win at this game." And that's what our message is here for you, let's not be the weakest link treatment center, Alternative to Discipline if you're here, Boards of Nursing if you're here, compliance if you're here, law enforcement if you're here, let's not be the weakest link.

Let's all work together to get this right. Expert knowledge. Learn more, learn more. Invite us to come and talk to you and we'll teach you more and you'll teach us. That's the beautiful part about this. I want to leave you with one last thought, Claudia is going to leave you with one less thought. It's very, very important.

- While we were here presenting the past hour, hour and 15 minutes maybe, I have a watch, but three to four people have died of a drug overdose. Now we have three to four families and friends and coworkers and all these people that are going to be affected now. So just something to think about.

- As we sit here in the beautiful State of Colorado, which I think is so ironic that many years ago, they called it The Mile High State. I'm sure that doesn't fall on...and it's beautiful. But there's someone in the bathroom that's overdosed. That's probably going to come across your table at some point, if they're lucky, right?

There's a patient that's suffering from pain right now. There's a nurse that's overdosed in the bathroom. There's a surgeon who's practicing impaired. And the public and them and my daughter, we're all relying on you guys to get this right. So with that, we're going to leave up our contact information. That's our personal cell phone number. It's all yours.

Our email addresses, please contact us, call us, challenge us. You agree. You disagree. This is the only way we get better by hearing the other side and the other perspectives. So on that note, we both want to thank you for having us here today and - Thank you. we'd love to take any questions that you guys have. Thank you.

- That's okay. I can hear you.

- Can you go to the microphone, please?

- She was asking me about my suit if you didn't hear that. She's like, "Where'd that come from?"

- That's a great suit, [inaudible].

- Oh, thanks. - [woman 5] I was just wondering if you could tell us more about the Parkdale Center that you…Is it a treatment center or is it for monitoring or a combination?

- Sure. Yeah. Thank you. Thank you for that question. So, yeah, we're more than happy to tell you about that. So when we came through the treatment center, there were three things that were very problematic for us. Number one, why was it so hard to find a treatment center that treated professionals?

And why did I have to go to a professionals program, why not just the local community center or just somebody who was close and more affordable to me? That was a big problem. When I went through the treatment center, they did a good job. They got me sober, but there were a lot of things that we thought kind of if we could do a treatment center, we would do these things better. Number one, it was too expensive. It's far too expensive. And I even asked the counselor, and I promise you, I asked him, "If someone came up to the window and he wanted to get treatment but he got in trouble and he lost his job and he didn't have insurance and they turned him away and he was crying."

They said, "Why didn't you bring him in here?" He goes, "Why? He didn't have the money.He couldn't afford it." And I said, "But you're not paying any more for the light bill if he sits in that empty chair. This could save his life.Why do you charge so much?" And he said, "Because we can. You need to be back to work. You got a license. You're trying to stay out of jail.We can charge whatever we want." And that really resonated hard with us. So it was the cost.

Number two, the aesthetic environment that we were in, I was in a classroom, right? And when the door opened and I looked out the window, I'm like, "I want to be out there because this is making me more anxious being in this classroom eight hours a day. And then the third thing we get back home and Claudia didn't know what to do with me. It's like what do we do? You know, I mean, where's the help for her? I came back to work and they're like, "Good job, Rigo, you did it. You did it."

She was the hero in this. I wasn't the hero, right? I wasn't the one that kept the family together, who kept the lights on. She was. But there was nothing for her. So when we developed the treatment center, we started working ironically with the same people that investigated me, the Board of Nursing, the Alternative to Discipline program, and the Office of the Attorney General, and NATI.

And we said, "Let's make a center for professionals. Let's focus on healthcare professionals.Let's have a sub-specialty for anesthesia providers." And we worked hand in hand with these organizations including the ANA and Julie. Where's Julie at here? Julie writes with the ANA. She's here representing the national organization and she's really spearheaded this to get this right to make treatment affordable, to make it beautiful and feel good.

It's not supposed to be shameful, it's supposed to feel good. And as a result, we've treated probably more CRNAs than anybody else in the country. We've been open for three years. We've treated 400 healthcare professionals from all over the country, from some of your states. We get 45% from Indiana. We get 55% from around the country and this is where they come. And the reason is and I think there's a lot of good treatment centers out there guys.

I'm not bashing them. There's a lot of good treatment centers out there. But when they leave our treatment centers, Claudia and her team are going to work diligently with the support system at home, with the family members. And more importantly, we reach out to the Boards of Nursing. We reach out to the compliance officers. We reach out to the Attorney Generals and the employers and we'll say, "How would you like this nurse packaged up for you when you come back?"

And we're all in it together. So thank you for asking that question. We're located in Chesterton, Indiana. So if you drew a straight line between downtown Chicago and South Bend, Indiana where Notre Dame plays, we're right in the middle.

- And I do want to add, we are a dual diagnosis so we are able to treat anxiety, depression, and all that as well.

- They'll ask us, they'll say, "Rigo, why didn't you just go back to anesthesia and Claudia go back to nursing and you guys will make a pretty nice living and you won't have to drag your kids through this and be embarrassed?" And we had to think about that pretty hard, right? So, you know, six years ago when we started speaking, I said Claudia, "We can go back to nursing like they're all saying.

We can talk about us, our topic, and people aren't going to like us and they're going to think that I should be in jail maybe. They're not going to like the kids. And if I tell them I'm back in anesthesia, they may think that the system is broken, right? "How can you possibly be back into anesthesia?" We're going to lose friends. We're going to lose family. We're definitely going to lose money and we're going to lose jobs.

Or we can go back to anesthesia."And she said, "That first option sounds really good. Let's do that." She's just as sick as I am, right? So that's why we did it and that's why we do it here today. We needed to have the addiction to be able to do what we do today. That's why we do it. Thank you. Thank you for the question.

Yes, Ma'am. - [Woman 6] Claudia made a comment that it was like after the fact you learned about the alternative program that could have helped you earlier. That's something we're struggling about with is we have a small percentage in the alternative that self-report and how do we help communicate that? And also, are we expecting people with trouble to really know they need help?

- Yeah.

- I'll answer that question. I think it starts with the hospital systems where the hospital systems start maybe adding some CU, some competency, something where people are empowered and they understand that there's another way out, because you're right. Most people, when they're in active addiction, they're not going to ask for help. The numbers, I think it's 95% of people that go through addiction, don't ask for help.

There's only that 5% that see that their life is falling apart and they raised her hand and ask for help, but most people are not. It's going to be the colleagues, the bosses, and the friends, and the families that are going to push people towards treatment. We've been open for almost three years and we've never had…I don't think even to this point we have not had one person come in without being in trouble. Usually it's the wife is about to divorce them.

The work called, the Board of Nursing. Most of them are coming in because they're forced into treatment and their success rates aren't...they don't change if they don't self-report. It's just getting them into the treatment center. We can help give them that clarity so that they can see that they're sick because

they don't see that.

- We started with the nursing school. So our service work is going to the schools, the grade schools and high schools and in the nursing schools in particular. And the message that we leave all of them with after…the last thing we say to them is, "You 16 people in this room, you 30 people, you can never say you didn't know what to do. You've heard the stories, you got the education. You could never say like we did, 'I didn't know what to do."

So it's 15 people at a time sometimes what we have to do to get them. - [Woman 7] And excuse me, let me tell you about NCSBN's products that we have to help educate the public. We have brochures on substance use disorder. We have brochures for managers. We have posters for the facilities that can be put in a break room or that introducing the topic.

We have free CEs and we have a wonderful video that can be used in the facility for education. But we need your help in getting that out to the facilities in your area. So you can order as many of them as you want free. And if you know a way to get them into the hospital, that would be fabulous because that can…the facilities need education before they come against a nurse that has a problem.

- So a couple more questions. We have the time.

- Yes ma'am. - [Kathy] Thank you, sir. First of all, congratulations on your sobriety and I don't think we gave you a round of applause for that.

- I appreciate it.

- And thank you to your wife for sticking to you…- Yeah, no kidding.

- …for doing that. I am Kathy Bores Hale [SP] Washington, D.C., now board staff. We have a lot of fight in our own team, loving fights, on how we approach nurses, or impaired practitioners. Some of us, you hear that you're too soft. You let these nurses off.

You get...they're hidden in these programs. And then we hear about the anatomy and physiology of the problem and how we need to help. Then we hear about interesting on your five issues there with about the misdiagnosis enabling but then about interventions. I want a little bit about interventions.

One of my concern is one of the first things that happen when I find when people are discovered in acute care or long-term care that they are terminated from their employment. So they have now lost their ability to maintain a living, they've lost their insurance coverage, continued their dignity, their profession.

How do you find a balance with intervention to help people to be successful so that when you look at the large number that we don't lose all these people out of the profession that need help during this process?

- That's an amazingly good question. Anybody from Ohio here? Anybody from the great State of Ohio? Okay, good. We could talk about them then. No, I'm just kidding. That's not the reason why.

And so in three different areas there we help go to hospitals when they say, "I got someone I think they're using. we need to do an intervention on them." So we help in that area primarily. We go into hospitals and we help them develop intervention teams where they can do this. And this all stemmed from the Cleveland Clinic in Ohio. So the way that they do it in the Cleveland Clinic in Ohio is that they changed the culture.

So that is the way you do it. We change the culture. We change the culture one family member at a time that we talked to, and now we changed it one treatment center patient at a time. We changed the culture. And we've been blessed now to have the Impaired Nurses program awarded to us. Now we're going to change in one state at a time. And if everyone can do that, this is how we change the culture.

So this is what they say. They make it very clear at the Cleveland Clinic upon new hires and upon monthly competencies and yearly annual competencies and they have the posters that Kathleen was talking about. They have resources and is available. And it's very, very, very crystal clear that we're a compassionate hospital. And if you guys need help, we're going to help you.

You could take some time off of work. We're going to get you the treatment that you need. We're going to protect your license and we're going to bring you back to work. But make no mistake about it. We also have this team over here that is dying to get their hands on you. They're investigating reports. They're pulling Pixus charts.

They're investigating. They're doing random drug screens. And if we find you, you're going to be on the front page of the newspaper, and we're going to put you there. So it's very crystal clear and their culture is changed. So statistically speaking across the country, 3% to 4% of people will get into a treatment center on their own.

They'll say, "The wheels are falling off.I'm really addicted. I'm not doing well. I need help." At the Cleveland Clinic, over 50% self-report into treatment and monitoring. So they come into treatment. They come into monitoring. And they sent us a bunch of nurses we've had. We send them back to Cleveland Clinic. And this is what they do, the complete opposite of what we're told to do.

They don't push them away. They bring them closer. They put them in a two-year contract. They say, "You can't moonlight anywhere else. You have to work these shifts with these people and do this many drug screens on this unit." What do you think happens at the end of that two years? They stay and then they tell the next person and then the next person asks for help and then they stay. The relapse rates are scraping the ground.

The retention rates are out the roof. So it's changing the culture and you do that at the Board of Nursing as well. We're going to help you if you ask for help. Make no mistake about it, we're going to come sniff you out. And when we find you, it's not going to be pretty. Thank you for that question. Yes, sir?

- [Jeff] I'm Jeff Ward. I'm the investigator and supervisor for Delaware's division of Professional Regulation. Nursing is one of our many wards. Part of my obligation is once a year I have to present to each board and discuss the disciplinary process. And just as a commentary, I have not learned that filter mechanism yet so there were times when something'll be said and, you know, words come out you're, "Oh, crap.That did come out and somebody's going to hear that."

The nursing board was discussing disciplinary actions. And one of the questions that came from the Board of Nursing's president was, "Well, if you're so good why can't you tell me where to start? Why don't we find where these nurses are coming from?" I was like, "No problem, I can do that." That was the part that I didn't expect him to hear.

And it was it was an interesting conversation. And what I was impressed by was the position of the nurses to recognize that they had a problem themselves. And I said, "We can find those nurses for you if you'd allow us." The vast majority of our nurses were coming to us with a problem, start with that legitimate prescription. I can show you who they are. Our licensure database is in the same server that our PMP is in.

So don't tell me I can't find it. Now, to my surprise, the board members started to discuss this seriously. Our Deputy Attorney General stroked. You know she's still recovering. But I was certainly impressed by the legitimacy of concern that the board members had themselves and their willingness to address the problem, finding that pool, identifying who those nurses were that were initially given that legitimate prescription, and let's identify who they are and follow them.

Give them the help they need before they even realize they need it. And there was a lot of discussion, as you've mentioned, about implied consent. You have no right to be a nurse. I had no right. My background was law enforcement. I had no right to be an officer. Once I became a paramedic in the aviation section, I signed an implied consent that would say that I could be randomly tested for opioids as long as I was in that unit.

I was randomly checked once a month. That's how random it was. But kudos to the nursing profession. You all take it very seriously. You take it much more seriously than law enforcement does. If I presented it to them, they would be, "No, no, no, no, you're not testing me. That's private." And the fact that you're willing to do that is, in your profession it truly should be recognized.

- Thank you for your comment. I appreciate that truly. Before we break for that, before we break, I want to share one last story with you. There was a personal story that we went through and I try to get through without getting choked up because it's such an emotional thing for me, but I think it's important that you guys hear this. It'll kind of tell you a little bit of our relationship and about where we're at. So I got off treatment. They told me I had to stay off of work for a year, primary breadwinner.

How am I going to stay off work for a year, right? It's tough. We have four kids and they're all in school. And besides the shame and the stigma, Claudia went back to work at the place where all this happened. So she went back and she faced it and I had a lot of guilt and shame about that alone. So I'm on the couch and I'm trying to go to recovery and I'm volunteering and I'm doing things around the house.

Every time she came home, there was dinner on the table and everything was mopped and swept and I was doing my part. And I'm like doing the math in my head and I'm like, "All right, I'm going to enjoy my sobriety and my recovery now, but in two or three months, the savings is going to be gone. The 401 (k) is going to be gone. We've already milked it out of our families and friends as much as we can. So what are we going to do? And she said, "Don't worry about it. I got you.

I got the family. Put it on my shoulders. So she picked up extra time. She was doing overtime. I felt bad about that. We get to month three or four, she picks up another job so now she's working two jobs, 70, 80 hours a week, right? That's what nurses do.

So she kept the family really together and she kept us moving forward. So month six she's like, "Just take care of yourself where you're going." I'm like, "But you're killing yourself." She's like just take care of yourself. I got this. And I'm like, "The money's gone. Where are we getting this from?"

She's like, "Just don't worry about it. You need to do this for you." Month number seven, now I'm getting anxious. I'm like, "It's just not adding up, Claudia. You got to tell me where this money is coming from." I'm like checking Craigslist thinking she picked up like a night job or something. I'm like, "What's going on here?" And so she's a pretty a girl. She can get some things.

But I said, "Something is not right here." So now it's like month 10 and I'm starting to apply but nothing was ever late. Everything was, you know, always on time. The kids had what they needed and she let me do whatever I needed to do to get well. And I said, "Claudia, you have to tell me. Please tell me where this money is coming from."

She said, "I'm going to tell you but I don't want you to get mad." And I said, "Whatever, whatever I just want to know." So she sits me at the table across. She holds my hand and she leans forward and she said, "Rigo, I want to tell you something, I'm going to be honest with you I sold the gold." The gold. We're Latinos, we got a lot of gold. The christening bracelets and the baptism and the quinceanera stuff, you know, all of this stuff here.

And I'm like, "Your dad gave that to you and all the kids' stuff," and I'm just instantly crying. I'm like, "I'm the biggest piece of, you know, whatever. I can't believe you would do that and I promise I'm going to make this up to you.And I'm going to buy you everything back. And if it's at the pawn shop, I swear to you, I'm going to go get it and I'm never going to mess up like this again."

And it was going on and on and on and I got that cry that…not the cute cry, but the ugly cry, right? That one, that cry. I had this ugly cry and I just barely caught my breath and she leaned into me and she grabbed my hand and she said, "I sold your gold. I have all of mine."

- Yeah, I still have my gold.

- Yeah. Plastic wear is what I wear today here. So sincerely from the bottom of our hearts, thank you guys for letting us entertain you and talk to you and share our message with you. And with anything that you guys need, we're completely at your disposal. So thank you again for sharing your morning with us.

- Thank you.