Past Event: 2023 APRN Roundtable - Catch Me (If You Can): The Impaired Provider Video Transcript

Event
2023 APRN Roundtable

More info: https://www.ncsbn.org/past-event/2023-mym

Presenters
Rodrigo Garcia, MSN, MBA, APN-BC, CRNA, RN, Chief Executive Officer, Chief Anesthetist, Parkdale Center for Professionals;
Claudia Garcia, MBA, CADAC II, LAC, RN, Chief Operating Officer, Community Outreach Coordinator, Parkdale Center for Professionals

- [Rodrigo] Good afternoon, and thank you for inviting us to join you this afternoon. We sincerely appreciate it. You know, on the way here Claudia and I got nervous, nervous, like we have done hundreds of times when we're presenting this content, we get nervous about something that you may not expect or may not have anticipated.

It's not because we're not prepared for the content. It's not because we have stage fright or apprehension speaking. It's because something much bigger than that. But to explain that a little bit more detail, we have to go back in some time. Twelve years ago, to be exact, it was about 2012. I had been out of the treatment program for about a year and I was still currently unemployed. Claudia was working tirelessly to keep the family together, to keep the finances together, and we had so much professional uncertainty and personal uncertainty.

We really didn't know what was going to happen next and where we were going to go. However, we know that we wanted to tell our story. We had been through a lived experience, a trauma of sorts that we thought was going to be very helpful if other people could hear that story as well. So, we got the idea that we wanted to put this out in front of as many people as we can and see what happens. We started making some phone calls, and as you can imagine trying to get on stage as an opioid-addicted anesthesia provider with a family member, it wasn't a very exciting possibility for a speaker for many folks.

We had a lot of, "Thank you, but no thanks. That's not exactly what we're looking for." And then we came across this gentleman who to this day is one of our good friends, and he said, "You know, I have the perfect venue for you to speak at. I heard your story, it is very compelling. I like you two as people. I'd like to invite you to come and be one of the keynote speakers at our presentation for our conference."

We said, "Phenomenal. We'll do it." The organization happen to be an organization that was of individuals, a group of individuals that was tasked with investigating diversion in healthcare.

They worked for hospital systems and their sole purpose was to find the diversion amongst healthcare providers and help mitigate some of those consequences that happen with that. So, as a result, we drove about five hours to this venue and we're off stage feeling nervous, just like we did this morning when we were coming on stage. And he gets on stage to introduce us and he says, "Ladies and gentlemen, I'd like to introduce you to this live specimen. This is the live specimen I've been talking to you about."

Now, as you can imagine, we were both very taken aback by that and a little bit curious as to who exactly were who they were talking about, even though we knew it was us. And as we get on stage and the title of this presentation, "Catch Me If You Can," pops up on the screen behind us, we hear one of the gentlemen in the back of the room with a Stetson hat and the cowboy buckle. He stands up and he says, "Oh, we're going to catch you. We're going to catch all of you."

And it was at that moment that we knew what we were going to be facing if we continued on this journey. It was much more than addiction and mental health. It was stigma and the way culture and the way society views addiction amongst healthcare providers and mental health against healthcare providers. To this day, we still feel some of that. And I tell you this for this reason, if during the course of this presentation, you feel a little uncomfortable, you have some disagreements, it may hit a nerve the wrong way in some certain aspects.

That's okay. That's very welcome. And it's very normal. Our goal for this presentation is to generate discussion, to stimulate conversation, and to move the needle forward for our organization and for our colleagues in regards to mental health and addiction within our profession. And with that, my name is Rodrigo, and this is Claudia.

We've both been in the healthcare profession as direct care providers in the field of nursing in some regard for over 40 years, collectively. There's a line that you see on this screen here, this yellow line and everything above that line seems to be so simple, intuitive to me today. And Claudia has always had this part correct. It's what's really important. I'm a husband and a father, and that's what I associate myself as today.

And Claudia has always seemed to have that order correct. She's a mother and she's a wife. Everything else is our day job. This is what we kind of do day by day. And that's all it is at this point. We're co-founders of Parkdale Center, which is a behavioral health and mental health treatment center for healthcare providers, professionals. We work with a couple of state monitoring programs to make sure that we can help assist nurses as they re-enter the profession after they have an experience with mental health or with substance use disorder as well.

One of the things that we didn't expect getting into this profession is that we now consult for hospitals and we help them identify and mitigate any kind of risk and fallout in terms of the impaired healthcare provider. So, we're getting this firsthand perspective of a lot of different areas when it talks to substance use disorder, mental health, and the healthcare provider. I think to start this conversation, we want to tell you a story about one of our children.

She is now on her own and she's working as a social worker. But as she was leaving high school, going into college, there was an area that she had to get addressed before she went off to school. The same

kind of rite of passage that most kids that age do. And that's removal of her wisdom teeth. Now, what does that have to do with what we're talking about today?

You'll soon find out. She had to go get her evaluation first to get her wisdom teeth extracted. And we took her there to the hospital and she got her evaluation done. She met with the nurse. She met with the billing coordinator, of course. She met with about four or five people and they said, "Yep, these teeth need to come out. They need to do it before you go out to college. So, what we're going to do next is send you to get your labs done, your pre-op paperwork."

So, the next day we show up at the laboratory and she met about three or four people that day as well. They drew her blood. They got her insurance card. They did some pre-op work for the surgery that was scheduled a couple of days later and then sent us home. A couple of days later, we showed up for the surgery and we got there early and we met another handful of individuals.

We met some of the nurses, the anesthesia provider who would be providing services that day. We met the surgeon, of course, the nurse, the recovery room nurse. And we had all of our instructions for how we should take her home and care for her on that day. And it was at that moment that Claudia and I realized something as they're wheeling our daughter off to surgery.

- [Claudia] So, while we were in the waiting room, we were both anxious and nervous, probably more anxious and nervous than we should have been, especially since we're both in healthcare. We're both nurses. We understand what takes place in surgery. But we were really nervous. And what we realized was that we started thinking about all the people she came in contact with, and we knew statistically speaking, that one to two of the people that she came in contact with was struggling with a substance use disorder.

They were either coming in hungover, they were actively using, or maybe they were looking for their next fix. If we're lucky, it was the person who took her insurance card or the person who greeted her at the door. But if we're not so lucky, maybe it's the surgeon or the anesthesia provider or the nurse who's taking care of her. And as you can see, it's really all a game of chance. So, we want to talk to you today about six different things.

We want to talk to you about our story. Why we're here today and why we're doing what we do. Also, we want to talk to you about substance use disorder in America, substance use disorder in the profession, and is addiction a disease or is it a choice? Also, managing the impairment of a healthcare worker. So, what do you do if you're the one struggling with a substance use disorder? Do you know how to get help?

Or if your colleague needed help, do you know what you would do? And the last one is the provider wellness. How do you take care of yourself and what should you do to take care of yourself?

- So, to get this started, we want to start telling you a little bit more about our story. And I think this is going to make a lot more sense when we get through it to you, and we tell it as our story. But this story has been repeated so many times across the country. And just at the treatment center alone, we've heard the same story 3500 times now with healthcare providers who have gone through a very, very similar...

We tell people all the time if you change the name of the hospital and the facility, you change the precipitating event, the rest of the story is the same with healthcare providers. You can almost lay them

right on top of each other. So, before Claudia and I met, I'll tell you the background for me because this is a very similar background.

I grew up in what would be considered middle America and mom, dad, brother, sister, white picket fence, private school education, everything seemed to be the American dream, so to speak. It took me a long time to realize how significant this part was, but it was so significant that it took me about 25 years to undo it. But I was primed and conditioned from a very young age to realize that my accomplishments and my successes to me correlated with my acceptance and my approval.

And even in some cases, to the love that I received growing up. In other words, the better I did, the more I did, the more I succeeded, the more I felt accepted, the more I felt loved. And it was something that it was early on very easy for me to do. I'll just do a little extra and I'll get a couple extra hugs and a couple extra pats on the back. That situation had played out repeatedly throughout my life.

I went to an accelerated program in nursing school and I graduated with my first degree, my bachelor's degree, at the age of 20. I spent the next eight years what I would describe on this...it was this very chaotic, super speed climbing the corporate ladder through the nursing profession, picking up as much accolades and awards and certifications and training as I could.

I experienced the trauma E.R., and the ICU, and the neuro ICU. I went on to anesthesia school and became a nurse anesthetist in 2004, and this was as fast as I could and as high as I could. I took on some roles at the university, being a clinical preceptor and an instructor. And the first time I remember catching my breath, ironically, was at the end of that eight-year run when I could finally take a big, deep breath and I landed as a chief anesthetist at a hospital in a surgery center.

And that's where I met Claudia.

- So, Rodrigo and I met working in surgery. And one of the things that I noticed early on about Rodrigo was that he was well liked, well respected. He was everyone's go-to person, highly intelligent. And I remember he was the one that would always get the Employee of the Month award. And there were times where he would get the award months in a row. And, you know, after a few years of dating, Rodrigo decided to join a baseball league.

And I remember this particular situation, this day like it happened yesterday, because little did I know that it would forever change our lives. Rodrigo was playing a baseball game. He jumped up to catch a ball and when he came back down, he landed on his ankle. From a distance, I knew he was in trouble. I saw the way he landed on his ankle.

His ankle swelled up immediately. We went to the E.R. While we were in the E.R., they gave him some opiates. That was the first time Rodrigo had ever taken an opiate. They gave it to him obviously for the pain. But we found out that he had torn all the ligaments on his ankle and that he was going to require some extensive surgery. They told him he had to wait a few days, so they kept him on opiates for a few days until the swelling was down.

Then they did the surgery and he was on opiates as well. Then he went through physical rehab and also was on opiates. So, he was on opiates for a few weeks. And I remember during this time, even when he was home and he was just going through his rehab, he was different. Rodrigo was quiet. He was withdrawn. He was irritable.

He was disconnected from the family. But of course, at the time I thought, "Well, it's because he just had a major surgery. He's going through a lot." One of the things I noticed was that he was going through his medication really fast. At one point, his physician had given him a prescription for four days of pain medication. He went through it in two days. And as a nurse, I thought, "Well, he obviously needs stronger medication or more." So, we're calling the physician.

We're getting more medication for him. But this went on for weeks and weeks. And after about six weeks, it was time for Rodrigo to get back to work. And I was super excited because I thought, "Well, if he gets back to work, maybe the old Rodrigo will come back. He'll be connected again, happy, social, and all the things that I loved about him would come back." So, here it's time to get back to work. He's back at work and I noticed right away that he was different at work.

But again, he had been off for a while, so it made sense. But this went on for weeks and weeks and months and months. And after about six months, I realized that Rodrigo was struggling and he was having a hard time with something. At the time, I didn't know what it was, but when I figured it out that he was struggling with addiction and he needed help as a colleague and as a loved one, I didn't know what to do.

I did everything in my power to get him help just the best way that I knew. But I didn't know a whole lot back then. So, I did what I could. And, you know, eventually, after a few weeks, he finally ended up in a treatment center. He was escorted out of the facility at work. He was there one day and he was gone the next.

Everything just happened so fast. But as a healthcare worker and as a loved one, I was left just at a loss of words because I had no idea how we even got here. Like, how does this happen to someone? As Rodrigo described, someone who came from a very good family, someone highly educated, and how does addiction come into our home? Like, why does this happen?

- The worst part about that time was that on the surface it looked like bad decisions. And there certainly were some bad decisions. It looked like a character flaw maybe. It looked like poor willpower, no willpower at all. But underneath the surface, and there's just like one scratch underneath the surface, it was filled with shame, and guilt, and remorse, and worry, and fear.

And it had become probably the exact opposite of the way that I was raised. Like as long as you do good things, you're going to get a lot of love and now you're doing bad things, nobody's going to love you. That was the thought process during that whole time, which was, you know, even 12 years later now is difficult to wrap my head around that kind of feeling of being in that kind of space.

But nonetheless, the whole event and this whole traumatic event, because it truly was a traumatic event, and it lasted about nine months. And when I say it lasted nine months, it meant from the top of the professional and personal mountain where I was, in a sense, the golden child. And I felt like the golden child and the people around me treated me like I was the golden child, to this replaceable, go off to the side.

You get everything that's coming to you kind of position as a nurse. I had a hard time wrapping my head around how it could go from the top to the bottom so quickly, and which leads us to believe that there has to be more than just because I took a prescription for an injury, this has happened. There has to be more. Not everybody that takes a medication, an opiate, for example, becomes addicted to the medications. So, why is that?

And to understand that at the very basic root level, we have to trace this all the way back to the beginnings, all the way to where this starts. We know it starts in one of two places or two roads. Think of it as two roads eventually converging. A precipitating event will help that convergence like an injury or a prescription. But these two roads are our lived experiences, our personal experiences, the way that we were raised.

And the second road is culture and society, and how the United States treats this and how our profession treats this and thinks of it, and how society treats it and thinks of it. And unfortunately, a large percentage of us as healthcare providers will have these roads converge, and that's when these decisions are made.

And we're going to talk about that a little bit. What does substance use disorder look like, and how prevalent is it in the United States currently?

- So, what we know is that one in three people personally know someone with a substance use disorder. So, these are our friends, our co-workers, our colleagues, maybe our neighbors. And 1 in 7 people, so about 15% live with someone with a substance use disorder. So, these are our parents, our children, our spouses, our loved ones.

And my heart always goes out to this population because that was me not too long ago. And I remember how envious and jealous sometimes I was of my colleagues when they used to end their days. They used to tell me how excited they were to end their day and go home to their families, and spend time with their kids and their spouses, and do homework, and all the things you do as a mom and as a parent. And sometimes for me, it was the scariest part of my day because I didn't know what I was walking into.

Was I walking into someone who was sober? Was I walking into chaos or maybe an overdose? And 1 in 10 people, so about 10% of the population meets the DSM-5 criteria for a substance use disorder. So, now these are our doctors, our nurses, our pharmacists, and all the other occupations and all the other people that suffer from this disease.

- So, when we're trying to figure out why did this happen and how did we get to this point, you don't have to look too far back in time to be able to trace this back when we're looking at the United States and the problems with substance use disorder and how that parlays over into the healthcare industry as well. So, you look at things like the infamous fifth vital sign. I was a very young nurse when I first had this intuition that there was something around this that wasn't really kind of sitting right.

And the stories would go like this or my recollection of the events at that time was like this. Every weekend we would have the same group of people. When I was working in the emergency room, patients, they would come in and they would almost ask what they wanted. I worked in an inner city, a very high acuity, a very noncompliant patient population, and a high incidence of sickle cell.

So, the same group of people would come in and they would say, "I need 50 milligrams of this, please, and make sure you flush it. And if you wouldn't mind, please use the portacath that I have here." And I thought that was odd the first couple of times I heard it, and I would take it back to the attending in the emergency room and say, "Well, I'm looking at her. It doesn't look like she has that much pain, but she's saying that her pain is off the roof and this is what they want."

And physician, without hesitation would say, "Well, that's what you give them. Go ahead and give it to them. It'll be fine. Treat them every week, just give them their medication." I always thought that was

odd. And I also thought it was odd that there was an assessment part about pain. Even if the differential diagnosis didn't include a pain component. They came in for COPD, they came in for asthma. We had to not only chart but assess their pain control at that time.

And it wasn't until months and months later that I realized that the patients already knew that as well. The patients knew that by being satisfied with their request for pain, that would have a direct correlation into what their satisfaction reports would be off of their visit. And then it took me months after that to realize that the insurance companies would look at those satisfaction reports and determine reimbursement for the hospitals.

So, you can see that this correlation of pain is the fifth vital sign, patient satisfaction, financial incentive, insurance reimbursements all tied together. And I had started to notice, like a pot of water starting to bubble, that this was going to be something, this was going to be significant.

I've been in the industry since 1996 as a professional nurse and I have seen this continue to increase. And when is this going to stop? The momentum is continuing to increase in that direction. I think we've done a little bit better job with that fifth vital sign of pain to add some more objectivity or at the very least, not associate that directly or indirectly. however you look at it, with financial incentives for the physicians and for the hospitals and for the providers, which is a very dangerous road that we've been on for the past 30 years or 40 years, as you can see.

So, if you look at that, what has that done? If you're looking at that as the starting point, what has that parlayed into today? What are we being experienced today? Well, what it has turned into is this whole idea of our society as a society of consumption. We're a consumer society today. So, when we look at 80% of the world's opiates are prescribed in the United States and 90% of the world's hydrocodone is prescribed in the United States, it begs to ask the question, what is the rest of the world doing for pain management?

Claudia and I were very recently in a medical mission in Africa, and it was an incredible experience. And the most incredible thing was the people that we met there. They were just so grateful for... Despite materialistically not having very much, they were more grateful than any population than we had ever worked with. They knew that we were coming to do surgery, free surgery for this very, very underserved community up in the mountains.

And they lined up four days or five days before, it was a first come, first serve. So, Claudia and I spent the first two days with our team doing pre-op assessments. We just wanted to set up the schedule and see who was going to be eligible for these services. At the end of that two days, our surgery schedule was set for two weeks. There was still a large gathering of people waiting for a cancellation so they can fill in the spot. At the end of that first surgical day, which was our third day there, it was a long day.

It was about a 20-hour day if I remember correctly. And I remember Mr. Martin, who was one of the locals. He kind of worked his way through the crowd and he came up to us and he said, "I have this abscess, dental abscess." And it was so big it was closing off his eye. And the pain, it was evident. He said, "Can you do something about that?"

And I said, "Well, we don't have a spot on the surgical schedule and if we take you back now, we might have a rush at the door of people trying to get in and do this." And just then one of the residents who was with us on our team walked by and he said, "I could just do it right here." And it was literally an

incision, some suction, some pressure. And the whole procedure took about four, five minutes. But during the course of it, his eyes started watering because he was in obvious pain.

And my eyes started watering because he was in obvious pain. And at the end of it, he takes a step back and Mr. Martin looks at us and he gives us his big, beautiful smile and he hugs us and he thanks us. And I said, "Mr. Martin," it really took me back if you remember. I said, "Mr. Martin, didn't that hurt?" And he said, "Well, of course, it hurts. You put a knife in my face. And of course, it hurt."

And then the next thing that he said changed my perspective on all of this. He said, "The pain is the same in the U.S. as it is in Africa. We just think of it differently here. We just think of pain differently here. And that really set into motion a series of events that would change the way that I practice and the way that I talk to people about their expectations and how pain should fit into their lives and when is enough, enough, and when is not enough.

It was very profound to hear at that time. When we're looking at overconsumption in this country, you can look at another classification of medications as well, the amphetamines. Eighty percent of the world's amphetamines is prescribed here in the United States. And when you look at statistics like 1% of prescribing, practitioners prescribe 25% of the prescriptions for opioids and 50% of the total dosages for opioids, we know that there is an inherent problem with the overriding of the prescriptions as well.

So, all of these things are kind of compounding and factoring and creating this perfect storm for healthcare providers. And there's a reason why healthcare providers are suffering from this profession, in this profession, with this regard in a lot of different areas. Claudia's going to paint a picture or two of some of the typical APRNs and RNs that we have worked with in the treatment center side, and the dosages and the amounts, they may seem shocking to you and surprising to you.

And they are to us as well. But we can say through personal experience and through my personal experience and through going through this several thousand times, these numbers are really accurate. And it's going to be your job to think about what does this look like if this is your colleague?

- We've treated nurses who have been taking 20 to 30 Vicodin pills a day, some 300 milligrams of morphine IV every day for 6 months. So, these are people that we've treated. And sometimes we think as providers that if we're in the hospital, that we would be able to notice someone who's that impaired, right?

Because this is a lot of medication. Even when we first started, when we got in this field, I couldn't believe the amounts that we were hearing. At first you think, "Well, there's no way that someone can naturally take that much." But unfortunately, there is a way, right? With tolerance. So, when you look at that, you know, sometimes we think, "Well, what are we really supposed to be looking for when we're looking for someone in the workplace or even if it's a loved one? What are some of the classic things that you're looking for, right?"

So, you're looking at things like someone being disheveled, right? You think, well, obviously if someone's coming to work with that much medication on board or if they're drunk with alcohol, they're going to be disheveled. Maybe they might not be able to hold a job. They might lose their job, right? Because they're coming in late. Maybe they're looked at as being irresponsible, degenerates. We hear that a lot, criminals because maybe they're stealing from work, or dirty, right?

They're not keeping their hygiene up. They're coming to work with their hair messy or they're just not keeping up their hygiene because they're too sick. Well, this is one of the reasons that I didn't figure out that Rodrigo had an addiction problem early on was because Rodrigo didn't fit this profile. He was the complete opposite.

He came to work every single day. There were days where he came in early. He stayed after. He picked up call. He was always at work and he was always giving people breaks. And he was our overachiever. Like I mentioned earlier, he was getting awards every month sometimes.

He had great patient satisfaction reviews. So, he was our overachiever, but we didn't know it. A lot of us didn't know. So, when we think about this, what should we be looking for? If we're looking at the healthcare system, if you're looking for someone at work or you think someone might be struggling, let's take a look at what we should be looking for.

- So, the Talbott Recovery Center, which is the oldest treatment provider for healthcare professionals in the country, did a report in 2014, and we emulated that same study at Parkdale in 2018. It's a very simple study. We asked the loved ones and the co-workers and the family members, "Describe for us your loved one, your healthcare provider who is impaired. Describe for us them. Tell us about them. Tell us what they look like."

And this is what they look like. This is the cheat sheet. If you want to know which provider is going to be at risk, this is what it is. They're intelligent, they're well-liked. They graduate in the top 25% of their class, they're supervisors, they're directors. They have advanced degrees. They're in positions of power and authority.

This is on the surface of what this looks like. So now, again, not everyone who has these characteristics is going to become addicted or have a problem with substance use disorder. But these are very, very common characteristics. And as Claudia alluded to, these are the things when you look at them on paper and you see their performance and their behaviors and they're coming in early and they're taking all the breaks and they're winning awards, that may cause you to have a second doubt of, "Are they doing something? Are they not? Is this just my imagination? I don't want to be wrong. I'm not going to say anything. It's not my problem. It's their problem."

All of those things that are kind of compounding the decision-making that Claudia and thousands of people that were in Claudia's position are faced with every day. So, when we're looking at the healthcare providers and the APRNs, and I say APRNs especially because there's a different level of access, there's a different level of supervision, there's a different level of ability to obtain the medications and a different level of stress in a lot of cases.

So, when we're looking at the risk factors and why is it more prevalent in healthcare providers as opposed to the general populations, it's for the following reasons. Healthcare providers and being a healthcare provider is a risk factor in itself. It's a high stress job. You have access to medication. You have knowledge and the ability to use the medications and you know how you need to use these medications.

So, it's that combination. And we're talking about these two parallel roads. This is the professional roads that's running parallel with society's role. So, on society's side on the outside, we know what culture is going to think and society is going to think. We know all about the stigma and we know about the

incidences and the prevalence of SUD, substance use disorder, accessibility, opioids, addiction. We know all of that.

It's just sitting there waiting. And then on the professional side that's running parallel, we have access to these same medications. We have a profession in an organization maybe sometimes self-imposed of a desire to not want to ask for help or not being able to ask for help or not having permission to ask for help. And then like we've talked about, it's this precipitating event that joins these two roads and that's when the substance use disorder or the struggles with mental health or the overconsumption of medications, that's when that occurs.

So, one of the things that we do often when we're treating patients and this is very, very telling in our profession as nurses, when we're treating our patients after a substance use disorder and we do a whole track on relapse prevention track, we preface the entire program, the relapse prevention program, with stay away from this acronym. This acronym is HALT, H-A-L-T, and we develop an entire program to enable them and to empower them to stay away from this acronym of HALT.

And what that stands for is hungry, angry, lonely, and tired. So, those are oftentimes precursors to that thinking that says, 'I'm hungry, angry, lonely, and tired. I sure could use a..." Fill in the blank, a drink, another pill, whatever you want to put in that blank. And we spent a lot of time saying, hungry, angry, lonely, tired are precursors to the next step, which is the bad decision of starting to use something.

So, now think about the nursing career and think about your last time that you felt hungry, angry, lonely, or tired. I spent just about three years of my residency feeling like that every day. I think it was a prerequisite in a lot of cases. Those were my days as nurse and I have many, many days as a nurse where I felt that. Today we work really hard to make sure that we stay out of that area because that is certainly a risk factor of that.

We are working with and we have worked with many hospitals in the past and this is a really interesting finding that we've come across. So, when we discover impairment at work, when we discover diversion at work, so in other words, healthcare providers who are taking medications from the hospital for self-use, either diverting them from a patient or taking extra from the pharmacy or from wherever, or not wasting their medication and using that for self-use.

We've developed with a Community Health Network about a 60, 65-point questionnaire. Now, it's in its infancy stage now, but what we're seeing with those results and our partners that are doing a phenomenal job at this, is very surprisingly, the common characteristics of those profiles. Very little of them have to do with drug-related activities like overconsumption, taking more medication out of the pharmacy, mismanagement in the charting of your dosages that you're giving.

Three of the top five have nothing to do with diversion from the hospital. It talks about things like have you had a recent traumatic event? Yes. Do you feel more stressed? Yes. So, it's these social things. It's these personal things, it's these well-being things that are leading into being precursors to why people have a subsequent problem with addictions or mental health in the workplace.

One of the surprising risk factors that we have seen in the past couple of years is COVID. Now, who would think that COVID has anything to do with what we're seeing in terms of substance use disorder and mental health in our profession? Well, we don't have to speculate too much because we have this blueprint that's played out in front of us. And if we look back into the events that happened on 9/11, we can see this step-by-step repetition of history of what's happened.

So, if you recall those events of September 11th, we remember right afterward these first responders were rushing into these buildings and there were levels of heroism that we've never seen before. We stood on the sidelines and we applauded them and we thank them and we put them on commercials and we pinned superhero capes on them and we thank them for their service. Well, after time and everything kind of got back to normal, the attention and the spotlight wasn't on them anymore.

So, what we have seen since then in the immediate aftermath of that is with that first responder group of individuals, increases in divorce, increases in addiction, alcoholism, suicide, bankruptcy, domestic violence, all of the above. We saw that immediately afterward because of the trauma that was associated with that and the lack of maybe insight and the lack of support and care and resources.

So, now we have this thing that happened in a couple of years ago of COVID, and we've done the exact same thing. It was a traumatic event for our country. But these first responders equivalent, which is our healthcare providers, are running back into the hospitals. And we don't know if there's enough PPE and protective gear, but they run in any way. We don't know what they're bringing home to their family, but they do it anyway.

So, as we stand on the sidelines, the best that we can do is pin superhero capes on them and put them on commercials and thank them and applaud them and be gracious for them. And now we're seeing everything kind of settle down and getting back to normal. And we are probably the first stop on the treatment center side because what we're seeing is with our healthcare providers, an increase in mental health issues, an increase in depression, an increase in substance use disorder and addiction and alcoholism, an increase in divorce, and increase in domestic violence.

And it's just getting started now. And it's behooved all of us collectively to stop this now, stop this as fast as we can and do our part to at least recognize that this is a thing that's happening. We've had more people at the center that come in that say, you know, everything was fine up until COVID. And then they tell us their experience.

It was like they're barely holding it together with all the normal stresses of life and family and job and occupation and patience and responsibility. And they get this one little push with the COVID and it's pushed them over into areas that they never expected. And they're saying the exact same thing that I've said, the exact same thing that Claudia said, the exact same thing that thousands of our patients have said is, "I didn't think it was ever going to happen to me. I never thought that this would be me."

And we've heard that time and time again. So, as we look into our profession and more specifically advanced practice registered nurses, I like to think of them as the heartbeat of the nursing profession in a lot of regards. It's the specialty programs that allow us to provide incredible services in the realms of anesthesia and education and midwifery and nurse practitioners.

It is such an important avenue to be able to provide services to our patient population. So, what does that look like in terms of addiction and mental health, and substance use disorder? And what are we seeing? So, you can see by the numbers here that if you look at that 15%, there should be a lot of people, advanced practice registered nurses that are receiving help and receiving treatment.

But we know, unfortunately, that's just not the case. So, what that tells us is what are we seeing? Anecdotally, what are we seeing on the front lines? And what that tells us is that there's a lot of people out there that are currently suffering, a lot of APRNSs that are currently struggling unnecessarily that

don't have to. Now, there's a couple of data points here that we have hard numbers on and that you can extrapolate into your specific profession or your specific arena.

So, we monitor some of the nurses that are entering back into the field of practice in Indiana and West Virginia. We monitor them after they've had a substance use disorder. So, we already know that they've had a problem or they've had an issue. So, what we know is that in Indiana, for example, there's 400 nurses that were monitoring after 100,000 plus nurses in the state of Indiana.

If you look at that 10% to 15%, we can relatively say that there's 10,000 to 15,000 nurses that should be having a problem with substance use disorder. We have our eye on about 400 of them currently in the state of Indiana. So, out of those 400, the overrepresentation, because of the reasons we mentioned before, about 23% of them are APRNs.

So, out of that total population, almost one in four of them are APRNs because of the stress and the access and the medications that they have available to them. So, if you look at it in terms of that, what the take-home message is that this is happening a lot. It's out there, but very few APRNs and very few nurses and healthcare providers are receiving the help and the treatment that they need.

So, now back to the age old adage of, is this a choice or is this a disease? You know, when we do this presentation live, we pull the audience and we can see, you know, 90% of the audience will say it's a disease. But we do see a lot of hesitation in raising your hand to this as a choice. I think they probably may feel that, but they don't want to raise their hand entirely. So, I like the way Dr.

Gabor Maté, who is an addictionologist in Canada, how he says it. He says, "Although the initial actor ingestion is voluntary, cessation of the disease process is not." What that means is it was my choice to take that pill the first time. And then after I realized that I may have a substance use disorder, it was my choice to take that pill the second time. But after the disease process took over it was certainly not my choice anymore.

Bigger things were in play to answer that question of is it a disease or is it a choice? We have to look at some of the neurobiology of the addiction. What does this look like? As you can remember, we'll talk about the reward pathway system. And I put this...we talk about this because we want to really illustrate how much of a pull this is, how much of a choice this really is not.

And we're looking at the reward pathway system and we're talking about why can't people just stop? Why can't providers just say no? I knew that I had a problem. I knew I needed some help like all our providers do. But what was pulling so hard about it? So, when we're looking at a choice versus a disease, I want to just reflect on a primary disease that you're familiar treating, anyone in your specialty that you're treating, diabetes, high blood pressure, eclampsia, preeclampsia, anyone of those diseases.

And you look at our differential diagnosis list of parameters and you'll see that they're the same for addictions. There's a prognosis, there's signs and symptoms, there's a treatment plan, there's a care plan associated with it. There's medications that may or may not work for it. The relapse rates are similar. The cure rates are similar.

The treatment is similar. So, if you look at addiction and you compare it to any other primary disease, they check off all the same boxes with almost the same data points on each one. Something to consider when you're trying to toil in your head, is this a disease or is this an addiction? When we're looking at

how much of a pull, how much is this addiction pulling to make these decisions that are unethical, immoral, or irrational, but they keep doing it?

Why is that? If you're looking at just the dopamine levels, you can see here how much of a pull this is every time they have a decision. "Do I go home and I hug the kids, and I play with the kids outside, or do I have one more drink or one more opiate, or one more whatever it is," you can see what they're going up against.

A physiological tug of war, a neurobiological tug of war that's changing the plasticity of the brain. They lose that frontal cortex, the ability for that frontal cortex to make these decisions. So, over the course of the addiction, the driver of the machine is not the frontal cortex anymore.

It becomes the reward pathway system that is reflex reward, fix, manage, and control, flight or fight. It's all buried right in that center. And that's why it's so hard. So, now that we know that it's a disease that is surrounded by some poor choices, at least initially, how do you manage it when you come across it? How are you going to manage this back into your little corner of the world where... This is where Claudia lived, she knew something was wrong.

My colleagues and my co-workers knew something was wrong. But how do you manage it in a system that currently does not advocate for a linear approach to treat the impaired healthcare provider?

- And one of the things that you can see that's really interesting when it comes to nursing is that there really isn't a one-way path, unfortunately. Sometimes you have to deal with the licensing board. Sometimes you have something to do with the office of the Attorney General. Maybe it's a legal issue. The ATD, that's the Alternative to Discipline program. So, maybe that's the monitoring program for your state.

Sometimes you have to work with them first, or sometimes you go there and you don't need treatment or vice versa. There's treatment center issues as well. Sometimes you have to deal with the treatment center to find out what your next recommendations are. But when you look at this, just this illustration here, you can see how it's so confusing, it's so difficult to figure out what's your path back to work or even your path back to sobriety. There are just so many different options that every state, depending on where you live, if you live in Indiana versus you live in West Virginia or Texas, everyone does things so differently that there isn't one way to do it.

Unfortunately, we get patients that come into our treatment center that want... They heard from another colleague from a different state that they did certain things to get back to work. But unfortunately, you really have to follow what your state says. So, I think that's where the confusion happens sometimes, is that we don't know sometimes what the right answers are. You know, when Rodrigo went through his addiction, I didn't know. I knew about a lot of these things, but I didn't know who I called first, right?

If I had known back then what I know today, I would have called our Alternative to Discipline program day number one. The second that I realized that Rodrigo was in trouble, I would have called. Instead, I was chasing Rodrigo around. And, you know, if you're someone who's who has experience with addiction, you don't chase somebody around who has an active addiction because they're going to deny it. It's very hard as a loved one to intervene that you do need to get other people involved.

But I didn't know those things, so I chased them around, tried to get them the help that I thought I was trying to do, but it just never worked. So, that's, you know, just to finish up this one here, it's just...it's very complicated. And unfortunately, there is no one way to do things.

- And if you take this list and it's a very complicated decision tree, it really is. So we broke it down here on this slide. You take that same list with those same options and you think of it as a pendulum. If you do too much of one, it's going to be a very punitive, non-therapeutic, non-beneficial way to address it. And if you swing the pendulum too far the other way and it becomes too treatment-centric and treatment-focused, and it almost appears to be a little bit coddling, it's not beneficial and it's not therapeutic and it's not effective.

The pendulum is sitting right in the middle and who to call you can see is highlighted there. First of all, the institution will have mandatory reporting requirements and sometimes that includes some legal entities. There's no getting around that. You have to do that. And from the treatment recovery point of view, that's actually a good thing. A little bit of a consequence is not a bad thing at all. And then the Alternative to Discipline programs, if you're fortunate enough to be in a state that has an Alternative to Discipline program, that can make the complete decision tree simplified for you, because their obligation and their role is to then contact the next people who need to be involved, whether it be the board of nursing or the office of the Attorney General for further investigation.

So, think of these decisions as you're making as a pendulum. And when you look at this slide, it really kind of shows you if you get too far one way, who you're going to be calling first, if you get too far the other way, neither one of those are going to be therapeutic or beneficial to you, to the institution, to your patients, to your provider who is suffering and struggling. So, our strong suggestion and advice after working with nearly every alternative program and board of nursing across the country, is to keep that pendulum in the middle, maintain and support your mandatory reporting requirements, fulfill those reporting requirements absolutely.

And then help your colleague out by doing the right thing and making that right call to the right person. It's not to eliminate the need to have consequences or accountability. As a matter of fact, it's the best way to do it to ensure accountability. We know what works. We have the formula. And I don't mean we, I mean historically throughout the industry, we know what works.

We know what doesn't work. And this is the very quick cheat sheet on how to manage the impaired healthcare provider.

- So, what we know is if someone goes through a detox, meaning they stop using drugs, maybe they start, they stop on their own, they just decide to stop using one day, or maybe they go into a treatment center for withdrawal management, or they're incarcerated and they're forced to stop using. We know that they have a 10% success rate, so 90% of these people will still relapse.

They'll go back to using. Now, if someone detoxes, they stop using and we add some type of structured stability where they're being monitored. Maybe it's the Alternative to Discipline program. Maybe they're doing drug testing, maybe they're the ones making sure they're staying compliant.

Now, as you can see, the numbers go up, now they have a 60% success rate, but unfortunately, 40% will still go back to using. Now, if they go through detox, they stop using and they get treatment. And treatment might be a facility that can treat their addiction, but also their depression and their anxiety. And they also are doing the monitoring. So, they have all three pieces.

They stop using, they're doing treatment and they're being held accountable with some type of monitoring program. Now, you look at the numbers, with the 1-year mark, they're at 85% success rate. And now at the 3-year mark, they're at 90%. And if we can get them to 5 years, you can see the numbers are 95%. And that's really the goal is to get them there.

And, you know, a lot of Alternative to Discipline programs are now moving towards a five-year model where they are keeping them longer. And some of the things that they do while they're in this five-year contract, they're doing things like random drug screens. They're making sure that these people that have a substance use disorder, that they're being held accountable, that they're doing meetings, that they're well to go...and that they're fit for duty as well, right?

Because as a nurse, I want to make sure that my colleague, if they're coming back to work and they have a SUD and maybe they were diverting from the hospital, that they're safe to practice and that I don't have to worry about their patients being affected.

- So, part of the reason why I, for example, had to take a year off of work, my professional organization suggested and required that I did was to get to that 85% success rate after that first year out. So, why is that significant? That's the same rate as the general population. So, we talked about 10% to 15% of the general population has a problem, the substance use disorder. So, a year after work, after following these steps, would get me back into that ballpark.

And then statistically speaking, if you get them past the year mark, there'll be a much better statistical chance to take as opposed to hiring somebody completely off the street that you don't know anything about. You can see here that it's really important to incorporate some kind of monitoring or accountability. The nursing profession as a whole does a really, really nice job with this.

The challenge is it's not as uniform as it could probably be. So, when we're looking at these ATD programs or Alternative to Discipline programs, they're not disciplined, hence the name, Alternative to Discipline. They work with the boards of nursing to provide an alternative pathway as opposed to being disciplined. So, think of it as you get your one chance.

You get your re-entry program. You get this one chance to figure out the issue, work on the problem, display objectively sobriety and continued wellness, and continued health. So, this is a little bit of a busy slide. So, we'll keep this up there for you so you can kind of look through this. But on the left here, you can see there's three different types of programs that the state may or may not offer.

The first type is a third party, the third party who is contracted with the State Board of Nursing to provide this service for the nurses of that state. This is one physical step separation from the Board of Nursing. It allows the participant to enter the program voluntarily, and sometimes the boards of nursing won't even know about it unless the participant becomes non-compliant.

So, these types of programs are very successful. They provide the accountability, they provide the re-entry, they provide the advocacy, they provide a formal way to enter the program voluntarily and confidentially as well. The nurses in these programs do very well. The second type of program is where the Board of Nursing doesn't offer that typical alternative to discipline program, but they have an Alternative to Discipline track.

So, the Board of Nursing actually manages it and monitors it and says, "We're going to give you one chance. You do everything we ask you to do. This is your one chance to make the most of it." Final

point to make about this data. This information was extrapolated from the National Organization of Alternative Programs website. It's a kind of a work in progress.

It's an excellent resource if you want the updated list of programs and the types of programs that they have with the contact information as well. So, please visit that website and you can get the most updated. It's a very small percentage currently that do not offer an Alternative to Discipline program of some type, but it is changing almost monthly. So, visit that website.

Often, you'll get a lot of really good up-to-date information on that as well. So, now here we are. What do we do? What do we do with all this information and how do we start to make a difference individually and within our profession? So, if we're looking at the future of APRNs and wellness in terms of provider wellness, what does that look like? I can tell you just kind of anecdotally that every patient that comes in that we've treated ever from the beginning of our first patient in 2015 to currently, they have a characteristic that's in common with each other.

And we get asked this question a lot. Describe for us what your patients look like coming in. If I had to sum it up in one area, it would be balance and more particularly lack of balance. They don't maintain that balance in their life and they come in real heavy on one side of their professional and personal life. They're working way too much and they're not doing enough of this. And I have struggled with that personally for a very long time.

But that goes back to that first slide that we showed you is when I was unbalanced, everything underneath that yellow line in my introduction was the juggling, was all the plates spinning and Claudius seems to have this figured out since the very beginning. So, maybe you can share with us a little bit of what you do to make sure that you maintain your balance.

- So, for me, for myself, I do things like exercise, meditation. I spend time with my kids, with my family members. I make time for friends. Sometimes it's just walking my dog or just spending some alone time and really finding that healthy balance. We all have different versions of balance, but one of the most important things for me is just really taking the time out and being able to just unwind.

And I know that's a really hard concept sometimes, especially if you're a mother and a wife, and you work full time and you're in the nursing field, it's hard. Sometimes it's challenging to just take a time out. And one of the things that I've really done well, I'm really proud of myself for, is that I have learned to say no. And I think that was something that I had a really hard time doing when I was a young nurse over 20 years ago. But I always wanted to stay over and take call and help out, and sometimes in the profession we have to do these things, especially with the shortage that we sometimes feel obligated to do these things.

But there were so many times that I missed out on very important events with my kids because I couldn't say no, I couldn't say no to the patient who needed me or I couldn't say no to my colleague, but I missed out on a lot of things. And there's a healthy balance of yes and no, correct? I mean, we do have to help out when we can, but there are some times that you have to say no. And I think that's probably one of the harder things that I see in the profession is just saying no and feeling that no is a complete sentence.

We want to leave you with one last thought. Every 20 minutes someone in our country dies of a prescription drug overdose. Just in the time we were here today, three people have lost their lives. And as you can imagine all of the families and friends and just the people that have been affected by this. We thank you for your time.

And we are open for questions.