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OPIOID USE DISORDER CASE MANAGEMENT GUIDE

The challenge of healthcare professionals is to confront the growing impact of opioid abuse on health and well-being while preserving the fundamental role of opioids for the treatment of pain and human suffering.

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OPIOID USE DISORDER CASE MANAGEMENT GUIDE

SECTION ONE: Understanding Opioid Use Disorder

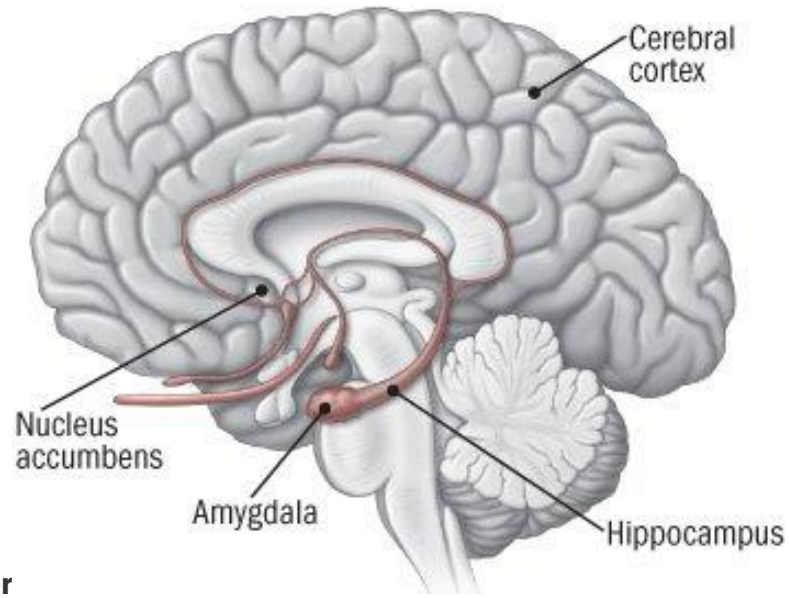
The abuse of opioids such as heroin, morphine, and prescription pain relievers is a global problem that affects the health and the social and economic welfare of societies. It is estimated that 2.1 million people in the United States suffer from opioid use disorder related to prescription opioids, and another 467,000 are addicted to heroin. Overdose deaths related to opioids have quadrupled since 1999.

Opioid medications effectively treat acute pain and help relieve chronic pain for some patients although the use of opioids to treat chronic non-cancer pain is not universally accepted. The number of individuals suffering from chronic pain in the US is estimated at 100 million and for some, treatment with opioid analgesics may be appropriate. Unfortunately, many patients who use long-term prescription opioids will eventually develop a substance use disorder.

The challenge of healthcare professionals is to confront the growing impact of opioid abuse on health and well-being while preserving the fundamental role of opioids for the treatment of pain and human suffering.

Physiology of Addiction

Controlled substances such as opioids, benzodiazepines, sedatives and tranquilizers stimulate the "reward" center of the brain. The nucleus accumbens, or reward center, is a cluster of nerve cells lying underneath the cerebral cortex. When the brain registers pleasure, whether it be in the form of food, sex, monetary reward or from psychoactive drugs, the neurotransmitter dopamine is released. All drugs of abuse, from nicotine to heroin cause a powerful surge of dopamine in the nucleus accumbens. Use of opioids floods the nucleus accumbens with dopamine leading to addiction. The hippocampus lays down memories of the pleasurable experience and the amygdala creates a conditional response.[1]



Brain's Reward Center *(Fig. 1)*

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Opioid Use Disorder

The Diagnostic and Statistical Manual of Mental Disorders revised the terms substance abuse and substance dependence for its 5th edition in 2013. The DSM-V now refers to these as substance use disorders further defined by levels of severity and by specific substance. A diagnosis of substance use disorder occurs when use of alcohol and/or drugs results in clinical and functional impairment like health problems, disability, or inability to meet obligations at work, school or at home. The level of severity of the substance use disorder will guide treatment recommendations. The DSM-V now specifies opioid use disorder.

DSM-V Opioid Use Disorder Criteria:

1. Taking opioids in larger amounts and for longer than intended
2. Wanting to cut down or unsuccessful attempts to quit
3. Spending a lot of time obtaining opioids
4. Craving or an ardent desire to use opioids
5. Repeatedly unable to carry out major obligations at work, school, or home due to opioid use
6. Continued use despite persistent or recurring social or interpersonal problems caused or made worse by opioid use
7. Stopping or reducing important social, occupational, or recreational activities due to opioid use
8. Recurrent use of opioids in physically hazardous situations
9. Consistent use of opioids despite acknowledgment of persistent or recurrent physical or psychological difficulties from using opioids
10. Tolerance as defined by either a need for markedly increased amounts to achieve intoxication or desired effect or by a markedly diminished effect with continued use of the same amount *(Does not apply for diminished effect when used appropriately under medical supervision)*
11. Withdrawal manifesting as either characteristic syndrome or use of opioids to avoid withdrawal *(Does not apply when used appropriately under medical supervision)*

Severity of the opioid use disorder is determined by the number of the above criteria a patient exhibits:

- 2-3 criteria = Mild Opioid Use Disorder
- 4-5 criteria = Moderate Opioid Use Disorder
- 6-7 criteria = Severe Opioid Use Disorder

Opioid Prescription Drug Misuse

Many patients use opioid medications as prescribed by their physician for the management of acute or chronic pain. Prescription drug misuse occurs when an opioid medication is used outside the manner and intent for which it was prescribed. This includes:

- ✓ Overuse or misuse of opioid medications
- ✓ Use of opioid medications to get high
- ✓ Sharing or selling opioid medications
- ✓ Obtaining opioid medications from non-prescribing sources
- ✓ Use of opioid medications with alcohol, illicit substances or other controlled substances

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Risk Factors

Many factors can influence an individual's likelihood of developing a substance use disorder. Risk factors are characteristics at the biological, psychological, community, and cultural levels that precede or contribute to negative outcomes.

Risk factors may be variable, meaning they can change over time. Variable risk factors include income level, peer group, adverse childhood experiences, and employment. Risk factors can also be individual, for example, a genetic disposition to addiction or prenatal exposure to alcohol.

The following are risk factors for development of a substance use disorder (such as opioid use disorder)[2]:

- ✓ Parents who use drugs or alcohol
- ✓ Family history of mental illness
- ✓ History of child abuse or maltreatment
- ✓ Poor parental involvement
- ✓ Neighborhood poverty or violence
- ✓ Absence of a faith-based connection
- ✓ Absence of school-related activities, hobbies, or other interests
- ✓ Lack of economic opportunity

The following additional risk factors are associated with increased risk for opioid overdose[3]:

- ✓ Long-term use of opioids
- ✓ Identified substance use disorder
- ✓ Presence of a mental health disorder including depression or post-traumatic stress disorder
- ✓ History of legal problems or incarceration
- ✓ Being of the white race *(even though clinicians tend to more closely monitor black patients)*
- ✓ Age less than 45 years

SECTION TWO: Case Management Assessment

Case managers play an important role in the identification, assessment and ongoing care and management of patients with opioid use. The recommendations in this guide for assessment, care planning and monitoring have been developed with the recommendations made by CMSA's Standards of Practice for Case Management. Many patients using opioids have other complex medical and behavioral health conditions. Use of an integrated approach allows case managers to address opioid use in the context of the patient's full medical and behavioral needs. Case Managers trained to address medical and behavioral complexity are more successful in gaining the trust and engagement needed to implement holistic, condition-changing interventions for improved outcomes.

The first step in the case management process is to gather patient-related and patient-reported information to identify risk factors and create a care plan. Patients with suspected or known opioid use should have a detailed clinical assessment for substance use disorder conducted by a physician or nurse practitioner.

The following tables outline information that should be included in the case management assessment. This information should be shared with providers and will help the case manager to guide patients to develop goals and create interventions to work toward recovery.

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Patient Reported Information	
History of Substance Use	• Substance(s) type (include prescription drugs, alcohol or other substances) • Frequency of use • Most recent use • Past participation in treatment
Mental Health History	• Diagnosed conditions • Medications prescribed • Any signs or symptoms • Participation in treatment
Social History	• Family relationships • Support system • Employment • Other social relationships, i.e. friends, peers
Patient Perception of Substance Use	• Perception of substance use as a problem? • If yes, what are the resulting consequences? • Interest in change? • Readiness for change?

Data from Independent Sources	
Review Medical Records *(if available)*	• Review current and previous treatment plans • Identify comorbidities • Identify other involved providers
Review Claims History	• Other medical or behavioral diagnoses • Frequent ED use or hospital admissions
Review Pharmacy History	• Number of pharmacies utilized • Other medications prescribed • Prescription fill history
Consult with Other Treating Providers, (*as appropriate)*	• Conditions treated • Adherence to treatment regimen • Response to previous treatment

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Case Management Assessment Tools

There are easy assessment tools that case managers can use to gather and score some of the information included in the above tables. This guide will discuss the CAGE-AID, NIDA Quick Screen, and the Opioid Risk Tool for Self-Assessment.

Regardless of the method or tools used in assessment, the following tenants should always be observed:

1. Use empathic and truthful communication
2. Take a nonjudgmental stance
3. Start with broad questions when assessing use of prescription medications:
    a. What do your medications mean to you?
    b. How helpful have your medications been to you?
    c. Have you ever had any bad experiences from your medications like side effects, problems in your social life, legal problems?
    d. Have you ever taken pain medications for any reason other than pain?
    e. Do you ever take pain medicines to help you sleep or relieve stress?

CAGE-AID

The CAGE-AID assessment tool consists of 4 simple yes/no questions. An answer of 'yes' to two (2) or more of these questions indicates risk and the need for further evaluation. This tool can be used for any substance including opioids. The case manager can customize the questions to include the specific substance used by the patient. For example, "Have you felt you ought to cut down on the number of Percocet taken every day?"

Have you felt you ought to cut down on your drinking or drug use?	Yes	No
Have people annoyed you by criticizing your drinking or drug use?	Yes	No
Have you felt bad or guilty about your drinking or drug use?	Yes	No
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?	Yes	No
Score	Yes answers: ____ / 4	

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National Institute on Drug Abuse (NIDA) Quick Screen

The NIDA Quick Screen tool is step one of a larger NIDA Modified Assist Tool. The quick screen is an easy tool to identify patients who are at risk for addiction from alcohol, tobacco, prescription drugs, or illegal.

NIDA Quick Screen Question: **In the past year, how often have you used the following?**					
	Never	**Once or twice**	**Monthly**	**Weekly**	**Daily or almost daily**
Alcohol **For men:** 5 or more drinks per day **For women:** 4 or more drinks per day					
Tobacco products					
Prescription drugs for non-medical reason					
Illegal drugs					

Scoring:

- If the patient answers 'Never' to all of these questions the screening is complete and there is no need to asses further.
- If the patient answers 'Yes' to daily or almost daily drinking, the patient is an at-risk drinker.
- If the patient answers 'Yes' to tobacco use, the patient is at risk and a smoking cessation discussion should occur.
- If the patient answers 'Yes' to use of non-medical prescription drugs or use of illegal drugs additional evaluation is required.

The NIDA Modified Assist Tool is a more in-depth assessment for patients who are identified by the NIDA Quick Screen. It is a more time intensive assessment and is typically used as part of a clinic visit. The instructions related to the screening tool are detailed. If this tool is used, please access the tool from the link provided to score appropriately.

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The next set of questions assess lifetime use of drugs:

In your lifetime, which of the following substances have you ever used?	**Yes**	**No**
Cannabis		
Cocaine		
Prescription stimulants		
Methamphetamine		
Inhalants		
Sedatives or sleeping pills		
Hallucinogens		
Street opioids		
Prescription opioids		
Other: specify		

Scoring:
If the answer to any of these questions is 'Yes' additional physician assessment is required.

The next set of questions is related to recent drug use. This assessment provides a score that will indicate the severity of risk.

Ask the following for each drug mentioned in the lifetime use assessment: *(circle the appropriate response as reported by the patient)*					
	Never	**Once or twice**	**Monthly**	**Weekly**	**Daily or almost daily**
In the past 3 months, how often have you used _____? (insert drug name)	0	2	3	4	6
In the past three months, how often have you had a strong urge to use _____?	0	3	4	5	6
In the past 3 months, how often has your use of _____led to health, social, legal or financial problems?	0	5	6	7	8
In the past three months, how often have you failed to do what was normally expected of you because of your use of _____?	0	5	6	7	8

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For the next 2 questions, ask for all substances ever used:			
	No	**Yes, but not in the last 3 months**	**Yes, in the past 3 months**
Has a friend or relative or anyone ever expressed concern about your use of _____?	0	3	6
Have you ever tried and failed to control, cut down or stop using _____?	0	3	6
Ask the next question if the patient mentions ANY drug that might be injected, including those in the 'Other' category. *(This can include steroids)*			
	No, never	**Yes, but not in the last 3 months**	**Yes, in the past 3 months**
Have you ever used any drug (including steroids) by injection? *Indicate you are referring to non-medical use.*			
Add all the numbers for a Substance Involvement Score. If the patient reports use of injectable, non-medical drugs in the last question, the patient should be advised to be tested for HIV/Hepatitis Score: _____			

Scoring:

Score > 27	High Risk	- Advise provider of results - Provide feedback on screening results - Assess readiness for change - Facilitate treatment referral - Offer continuing support
Score 4-26	Moderate Risk	- Advise provider of results - Provide feedback on screening results - Assess readiness for change - Discuss referral based on results and clinical judgement - Offer continuing support
Score 0-3	Low Risk	- Reinforce abstinence - Offer continuing support

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Opioid Risk Tool for Self-Assessment

The Opioid Risk Tool is a self-reported screening tool that can be conducted and scored in less than one minute. If categorized as high-risk, patients have a higher likelihood of future abusive drug related behavior. This tool is appropriate for both male and female patients but should **not** be used in a non-pain population.

Mark each box that applies:	**Female**	**Male**
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Prescription drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Prescription drugs	5	5
Age between 16-45 years	1	1
History of pre-adolescent sexual abuse	3	0
Mental health disorder		
ADD, OCD, Bipolar, schizophrenia	2	2
Depression	1	1
Score		

Scoring:

- ≤ 3 = minimal risk for opioid abuse
- 4-7 = moderate risk of opioid abuse
- ≥ 8 = elevated risk of opioid abuse

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Assessing Readiness for Change

The opioid risk assessment process identifies the challenges of abuse, but the willingness and ability to address the challenges must also be determined. Before the care planning process can begin, case managers must assess patients' motivation and readiness to change.

One tool for evaluating readiness to change is the transtheoretical model as developed by Prochaska.

Stages of Readiness for Change:

Pre-contemplation	The patient is not concerned about the opioid use and sees no reason to change behavior.
Contemplation	The patient is beginning to realize that opioid use might not be a positive health choice and is considering making a change.
Determination	The patient has decided to reduce or stop the opioid use.
Action	The patient is stopping opioid use.
Maintenance	The patient has reduced or stopped opioid use.
Relapse	The patient has returned to opioid use.

Understanding patient readiness for change will drive interventions in the care plan. The stage of change has no reflection on the length of recovery. Some patients come to treatment highly motivated and are ready for action-oriented interventions. Others will need motivation at the outset to be able to move toward action-oriented interventions. Individuals in the pre-contemplation or contemplation stages should be targeted with Motivational Interviewing to help them come to the realization that a change is necessary and ultimately to the decision to initiate a change.

Motivational Interviewing:

Motivational Interviewing (MI) has demonstrated efficacy in substance use disorders. MI is a psychotherapeutic approach and communication method designed to help patients explore and resolve ambivalence which can then lead to behavior change. MI is best applied when there is a specific behavior identified for change.

Opioid addiction is a chronic, progressive condition characterized by cycles of abstinence and relapse. The cycles are reflective of patient motivation to initiate and maintain change. It is important to accept that individuals will vacillate in their levels of motivation. In the relapse setting, MI can be used by the case manager to nonjudgmentally redirect patients to consider reinstituting positive behavior changes.

MI is a powerful tool because it is easily integrated into various settings and can be effectively used by case managers who work with patients telephonically. If you are unfamiliar with MI or do not feel confident in your abilities to conduct these types of conversations, a course in MI would be recommended. Please see the Resource section of this document for information on a MI course created specifically for case managers offered by CMSA.

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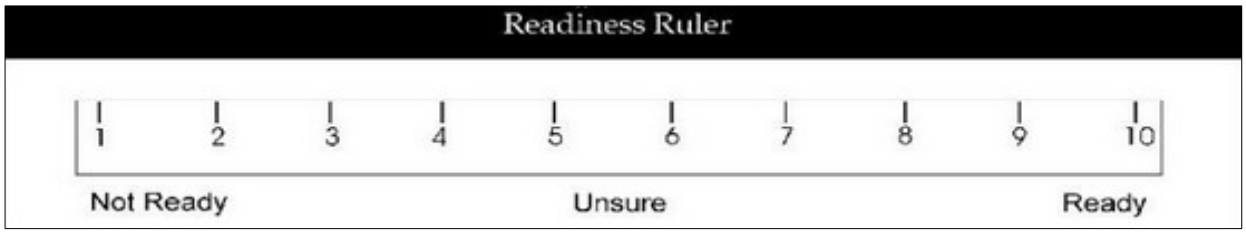
Readiness Ruler:

The Readiness Ruler is another tool that can be used to evaluate readiness to change. This tool can also be used as a Confidence Ruler when the individual is ready to make a change.



(Fig.2)

When discussing making a change, the patient is asked, "On a scale of one to 10, how ready are you to _____?" Based on their rating, additional questions are then asked.

For example:

For a score of 1-3: "What would it take for you to score a 5 or 6?"

For a score of 4-6: "What has influenced you to score a ___? What is needed for you to be more ready for change?"

For a score of 7-10: "What has happened to make you feel ready to change?"

SECTION THREE: Care Planning and Case Management Interventions

Success in addressing an opioid substance use disorder includes early identification and interventions that target multiple factors. Physicians order treatment for the patient, but it is case managers who assist, support, facilitate and coordinate the specifics of the treatment plan. To create a care plan that effectively supports patients' adherence to a treatment plan, case managers must be aware of treatment options for opioid use disorder.

Understanding Opioid Use Disorder Treatments

If significant use or abuse of non-prescription or illegal opioids is determined, medically-assisted withdrawal and treatment may be required. For those with a long history of prescribed opioid use for chronic pain, tapering in conjunction with non-pharmacological interventions is recommended by the CDC. These include a recommended taper of the opioid use in conjunction with interventions such as counseling to manage anxiety, physical therapy modalities, relaxation techniques or other behavioral therapies. Opioid taper in pregnant women is of significant concern because withdrawal symptoms can result in spontaneous abortion.

Following the completion of medically supervised withdrawal, Medication Assisted Treatment (MAT) plus psychosocial treatment is recommended. The tandem treatment is more effective that MAT alone, or psychosocial treatment alone. Patients who complete MAT are more likely to achieve opioid abstinence[4].

Medications used in MAT are methadone and buprenorphine. Opioid agonist therapies with methadone or buprenorphine reduce the effects of opioid withdrawal and reduce cravings. They have also been shown to increase treatment retention[5].

Naltrexone is an extended-release injectable medication that reduces the risk of opioid relapse and helps control cravings. It is particularly useful for people exiting a controlled setting where abstinence has been

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enforced such as jail or residential rehabilitation or in situations where maintenance with an opioid agonist is not available or appropriate.

Examples of Psychosocial Interventions:

- ✓ Addiction Counseling
- ✓ Self-help groups
- ✓ Narcotics Anonymous
- ✓ Methadone Anonymous
- ✓ Medication-Assisted Recovery Services
- ✓ Cognitive Behavioral Therapy
- ✓ Mindfulness-based relapse prevention with Acceptance and Community Therapy
- ✓ Contingency Management

Building the Care Plan

Care plan development requires the establishment of clear cut goals that aim to reduce or eliminate use of opioids. Care plans for opioid use disorder are created based on patient readiness for change and commitment to recovery. A care plan may initially address helping a patient to take first steps in changing patterns of opioid use, or can be geared toward supporting a patient in maintaining treatment and/or abstinence.

Case managers provide care plan goals and interventions to best to support patients in whatever stage of change they are in to help them to move toward to recovery. Keep in mind that for patients dealing with chronic pain, abstinence may be an unrealistic goal.

Case management strategies and interventions may include:

- ✓ Outline the risk of addiction even when taking medications prescribed by a physician, especially if taken for an extended period of time
- ✓ Outline the risks of aberrant drug-taking
- ✓ Get patient agreement to take opioid medication ONLY as prescribed
- ✓ Do pill counts with the patient
- ✓ Monitor prescription fills
- ✓ Limit medication prescriptions to one provider and one pharmacy
- ✓ Include family/support system in the development of the goals and interventions
- ✓ Address social issues that may be contributing to the use disorder
- ✓ Obtain patient agreement for urine toxicology screening when following up with the treating physician (and communicate this with the physician's office)

The development of a care plan for opioid use disorder will require significant customization and focus on the patient. As you can see from the assessment process, the goals and interventions can vary widely based on the patient's use, history and readiness to change. It is important to understand that the intensiveness of treatment waxes and wanes over time based on the patient's ability to maintain recovery.

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Sample Care Plan addressing long-term use of prescription opioids for pain management:

Challenges	Goal	Interventions
Long-term use of prescription opioids	Reduction in opioid use	- Establish current opioid dosing/use - Assess pain rating - Evaluate functional status: what activities can the patient do; what helps relieve pain/what exacerbates pain - Facilitate medically supervised opioid taper - Facilitate non-pharmacological therapies
Concern/fear related to withdrawal symptoms and increased pain	Taper with effective pain management	- Establish the patient's readiness to change and willingness to participate in treatment - Monitor medically-supervised taper (pill counts; monitor utilization) - Monitor patient's response to taper (pain rating, signs of withdrawal) - Encourage use of non-pharmacological interventions - Report any progress or complications to treating physician
Activity is limited due to pain	Improved physical function	- Continue to support non-pharmacological pain management interventions - Continue to support and facilitate behavioral interventions - Evaluate improvement in function (ADLs and IADLs) - Evaluate pain rating with activity

SECTION FOUR: Tips for Working with Pregnant Women Before and After Delivery

Opioid use during pregnancy is a major public health concern that has implications for both the mother and her child. Opioid use is associated with complications of pregnancy including placental abruption, fetal growth restriction and preterm labor[6]. Babies who are exposed to opioids in utero may experience neonatal abstinence syndrome (NAS), which is post-natal withdrawal characterized by excessive crying, hyperactive reflexes, diarrhea, vomiting, rapid breathing, seizures, and tremors. According to the Centers of Disease Control and Prevention (CDC), incidence of NAS increased 300% between 1999 and 2013[7]. Pregnant women with an opioid use disorder require additional treatment and case management considerations.

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Supportive and Honest Communication

It is especially important to remain non-judgmental when working with pregnant women who are using or misusing opioids. Many people have strong opinions about the use of opioids during pregnancy and the potential effects on the unborn child. It is crucial to put personal feelings and opinions aside in order to work openly and honestly with patients to achieve the best possible outcomes for both the mother and baby. Most of these women already feel shame or guilt related to their opioid use. Any perception of disapproval or judgement could hinder their willingness to participate in case management or seek appropriate prenatal care.

When talking to pregnant women who are currently using opioids, remember to stick to the facts. Give them a factual description of the implications for their pregnancy and their baby. Avoid scare tactics or downplaying the situation. These women need an accurate and factual description of what to expect.

What to expect:

- ✓ Frequent drug testing both during and after pregnancy
- ✓ Decreased pain tolerance in labor and postpartum
- ✓ Increased pain medication needs during delivery - epidural anesthesia is often a good choice for these women
- ✓ Involvement of child protective services: this does not always happen, but an early, factual discussion provides a chance to talk about fears and develop a plan
- ✓ Presence of withdrawal symptoms or NAS in their newborn

Case management strategies and interventions during pregnancy:

- ✓ Screen all pregnant women for both prescription and non-prescription opioid use. Women taking prescribed opioids need to know that their baby may suffer withdrawal symptoms.
- ✓ Screen for sexual trauma and PTSD. Encourage engagement with mental health services if screen is positive. This population has a high incidence of sexual trauma, and childbirth can be a triggering event.
- ✓ Educate about warning signs and symptoms of preterm labor and premature rupture of membranes.
- ✓ Encourage development of a support system during pregnancy to provide help after the baby is born. Connect women who do not have a support system with home care, outpatient mother-baby treatment, or other resources as early as possible.
- ✓ Encourage creation of an emergency action plan (e.g., transportation, childcare, crisis resources)
- ✓ Reinforce the treatment plan for women who are receiving medication assisted treatment (MAT). Women are often highly motivated to abruptly quit opioid use during pregnancy, but withdrawal is not recommended during pregnancy because of the high risk, and dire consequences, of relapse during this time. Help women to understand that supervised medication substitution is the safest option during pregnancy.
- ✓ Discuss signs and symptoms of NAS early in pregnancy as well as strategies to ease the baby's symptoms. Explain that babies who were exposed to opioids but don't "officially" have a NAS diagnosis can still be very fussy after birth and may need additional comfort measures.
- ✓ Ask about relapse at every contact. If you don't ask she probably won't tell you.

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Post-Partum

The postpartum period is overwhelming in the best of circumstances. For women who are coping with opioid recovery and who have a fussy, symptomatic infant who won't sleep, the initial month after delivery can be devastating. Case management interventions for these women should focus on relapse prevention and on strategies to comfort their babies and relieve symptoms of NAS.

Case management strategies and interventions following delivery:

- ✓ Closely monitor for signs of relapse. Women are at particularly high risk of relapse postpartum due to multiple stressors, including changes in insurance coverage and access to care, demands of newborn care, exacerbation of underlying mental-health conditions, and the stress of involvement of child protective services and the threat of losing custody of the child.
- ✓ Provide education and options for contraceptive use, including immediate postpartum long-acting reversible contraception, to minimize the risk of unplanned pregnancy. Unintended pregnancy rates for women with substance use disorders are considerably higher than the general population[8].
- ✓ Screen for postpartum depression and connect patients to appropriate mental health services as needed.
- ✓ Encourage breastfeeding for mothers who are on MAT. Women should not breastfeed if they are currently using street drugs or using opioids outside of a medically supervised program.
- ✓ Teach strategies for soothing babies and reducing symptoms of NAS:
  - Hold baby with skin-to-skin contact as much as possible
  - Keep baby in a quiet space and minimize bright light or stimulation
  - Provide small, frequent ad-lib feedings
  - Swaddle baby in soft, light blankets
  - Offer a pacifier

SECTION FIVE: Ongoing Case Management and Relapse Prevention

Forty (40) to 60% of patients will relapse within one year of initial treatment[9]. Substance use and addiction must be viewed as any other chronic condition requiring long term case management support. A continuing care model is recommended for the ongoing management of opioid use disorder, especially in patients with chronic pain, or those with addiction.

Care plans require modification as you work with patients, moving from implementation of initial recovery interventions through prevention of relapse. Communication with treating providers is essential. Individual patients vary in their clinical needs. The intensiveness of case management monitoring will depend on the individual patient, clinical condition, and risk of relapse.

Risk factors for relapse include[10]:

- ✓ Co-occurring psychiatric illness
- ✓ Sustained sleep difficulties
- ✓ Poor social support
- ✓ Low motivation for recovery
- ✓ Elevated levels of personal stress
- ✓ History of previous relapse
- ✓ Ongoing self-reported cravings
- ✓ Continued use of other drugs or alcohol early in treatment
- ✓ Continued influence of individuals not supportive of recovery
- ✓ Low motivation toward recovery weeks after treatment started

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Honest communication and clear expectations are essential when working with patients with substance use disorders. Establishing a trusted and non-judgmental relationship is crucial to maintaining patient engagement over time. Help patients understand that your primary role is to advocate for their needs and provide support, and part of that support includes working with the treating physician to reduce their risk for abuse, addition and overdose. Clearly communicate that any concern related to patients' safety or well-being will be communicated with the treating physician.

Prevention of Relapse

Prevention of relapse offers the best opportunity for long term success. Medically assisted opioid tapering and medically assisted treatment are important first steps, but patients must also be supported with behavioral interventions. Behavioral support helps patients learn how to recognize and address risks for relapse. There are two forms of 'relapse' that if not addressed may result in a physical relapse and return to active opioid use[11].

Emotional Relapse Risks

Educate patients about the early emotional warning signs such as anxiety, anger, isolation behavior, mood swings, or absence of participation in recovery activities. Help patients to recognize and acknowledge these feelings and behaviors in themselves or in their family or support system. Once identified, encourage learning and practice of relaxation techniques, which can be most effective. Reinforce with the patient the importance of self-care: adequate sleep and good nutrition to reduce stress which can exacerbate negative emotions.

Mental Relapse Risks

Patients may be thinking about using opioids and may feel conflicted about these thoughts. Let patients know that feelings of confusion or conflict are normal. Teach patients to recognize signs of mental conflict such as thinking about places and people involved in past drug use, lying to others, socializing with individuals involved in past use, or planning to use opioids. If allowed to go unchecked, these thoughts and feelings will only intensify which increase the risk of physical relapse.

Again, behavioral strategies are helpful interventions to reduce this risk. Encourage patients to discuss the urge to use opioids with a sponsor, or someone in their recovery group. Sharing can reduce feelings of loneliness and isolation and make problems or triggers seem less daunting. Encourage distracting activities like calling a friend, attendance at a recovery group meeting or appointment, or maybe something as simple as going for a walk. Most urges dissipate in 15-30 minutes, so participating in a distracting activity can mitigate the threat. But case managers should also understand that 30 minutes can seem like an eternity when battling the urge to use opioid drugs.

Help patients recognize their desire to use but establish a plan of what to do when these feelings arise. Help patients to identify which strategies and interventions work best for them. Remind them of the consequences they already experienced with use, or the potential consequences if they choose to use again. Make sure that patients have the number for a crisis line or trained counselor to call in case their usual strategies are not enough to overcome the desire for opioids.

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Case Management for Relapsed Opioid Use

Physical relapse, or returning to previous misuse or abuse of opioids, will occur if emotional and mental stressors go unchecked. Case managers play a crucial role in helping patients avoid relapse. Recognition of warning signs as well as developing and practicing strategies for relapse prevention are at the core of the care plan for members who are recovering from opioid misuse. Reassessments and care plan interventions need to include exploration of feelings and developing and individual plan for addressing situations of stress and temptation.

Sample care plan for on-going monitoring:

Challenges	Goal	Intervention
Risk of relapse	Sustained abstinence or reduced dosage of opioids	- Educate patient on the signs of emotional and mental relapse - Assess and monitor for signs of emotional and mental relapse: ask patient about feelings of anxiety, anger, urge to use - Support and facilitate recovery activities including counseling visits, group meetings, distracting activities

The treatment modalities outlined earlier still hold true for the patient who has relapsed. However, the case manager should carefully assess the contributors to relapse and find ways to address and eliminate these barriers. All supports must be explored, but most of all the case manager must be vigilant and prepared to address the challenges of a very fluid condition.

SECTION SIX: Opioid Use Disorder Resources for Case Managers

RESOURCES

Assessment Resources:

1. CAGE-AID https://www.mhn.com/static/pdfs/CAGE-AID.pdf
2. National Institute of Health (NIDA) Quick Screen and NIDA-Modified Assist https://www.drugabuse.gov/sites/default/files/files/QuickScreen_Updated_2013%281%29.pdf
3. Opioid Risk Tool for Self-Assessment https://www.drugabuse.gov/sites/default/files/files/OpioidRiskTool.pdf
4. Readiness Ruler https://www.healtheast.org/images/stories/pathways/change_ruler.pdf

Treatment Resources:

1. CDC Pocket Guide to Opioid Taper https://www.cdc.gov/drugoverdose/pdf/clinical_pocket_guide_tapering-a.pdf
2. CDC Opioid Prescribing Guidelines https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm
3. Treatment for Substance Abuse Disorders https://www.samhsa.gov/treatment/substance-use-disorders
4. What Are Therapeutic Communities? *(NIDA)* https://www.drugabuse.gov/publications/research-reports/therapeutic-communities/what-are-therapeutic-communities

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5. Methadone Anonymous https://www.facebook.com/MethadoneAnonymous/?ref=page_internal
6. Self Help Groups and MMT http://www.mindspring.com/~ewestp/filecab/selfhelp.html
7. Management of Suspected Opioid Overdose with Naloxone by Emergency Medical Services Personnel Executive Summary https://effectivehealthcare.ahrq.gov/sites/default/files/cer-193-naloxone-executive-summary.pdf

Educational Resources:

1. Motivational Interviewing www.cmsa.org/products
2. Integrated Case Management Training www.cmsa.org/products

Pregnancy & Newborn Resources:

1. CDC Pregnancy and Opioid Pain Medications Fact Sheet https://www.cdc.gov/drugoverdose/pdf/pregnancy_opioid_pain_factsheet-a.pdf
2. Managing Neonatal Abstinence Syndrome https://www.jointcommission.org/assets/1/23/Quick_Safety_Issue_27_Sep_2016.pdf
3. Inpatient Pathway for Evaluation/Treatment of Infants with http://www.chop.edu/clinical-pathway/neonatal-abstinence-syndrome-clinical-pathway

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Author Biographies:

Kathleen Fraser, MSN, MHA, RN-BC, CCM, CRRN. Kathy is a Registered Nurse, a Certified Case Manager, Certified Rehabilitation Registered Nurse and Board Certified in Case Management with the American Nurses Credentialing Center. She holds a Masters' Degree in Nursing and also a Masters' Degree in Health Care Administration. Kathy has been a nurse for 39 years beginning with Hospital nursing which included Emergency Room, Labor & Delivery and as a Director of Nursing. Kathy became a Case Manager 24 years ago, creating the 1st Case Management Department for a national hospital, long term care company.

Kathy served a two-year term as the National President of Case Management Society of America from 2014-2016 and currently serves as the Executive Director of CMSA. She has served on the Role Delineation and Expert Panel Committees of the American Nurses Association Certification Council for Case Management. Over the past 23 years she has served 5 previous Chapter Presidency terms in Houston and is a past Houston/Gulf Coast CMSA Case Manager of the Year. Kathy is active with the National COPD Foundation and author of the CMSA CMAG on COPD. She also serves on the advisory for the NQF and as a board member of URAC.

In June 2016, Kathy was presented CMSA's prestigious National Case Manager of the Year Award. In recent years, she was also selected by SEAK, Inc. and the National Workers' Compensation and Occupational Medicine Conference as one of the "50 Most Influential People in Workers' Compensation and Occupational Medicine".

Rebecca Perez, BSN, RN, CCM has a Bachelor's Degree in Nursing and is a Certified Case Manager with extensive clinical and case management experience. Much of her case management career has been spent in the pursuit to hone skills to better communicate with patients, and to move them toward self-advocacy and improved health outcomes. She has been involved with the Case Management Society of America since 1997, holding both local and national leadership positions and honored with the 2013 National CMSA Case Manager of the Year award. She is a published author of professional articles, Case Management Adherence Guidelines and a co-author of the 2010 Integrated Case Management Manual. Rebecca was a developer of CMSA's Integrated Case Management training curriculum and was a master trainer for the program. She has created CMSA's newest Integrated Case Management Training Program to coincide with 2017 version of the ICM manual, providing advanced practical skills and training to case managers working with individuals with health complexity. Rebecca recently moved into the position as Director of Product Development for Fraser Imagineers and the Case Management Society of America. She also serves as the Executive Director for the CMSA Foundation. Past work experience includes 16 years in the acute care setting and 23 years of case management experience. Case management experience includes both direct patient contact and management for payors and a large managed care organization.

Most recent experience with a large managed care organization: working with the organizations health plans and quality/accreditation to ensure case management practice was performed according CMSA's Standards of Practice. A training curriculum was developed to achieve this as well as to ensure compliance with NCQA guidelines. Assisted the Corporate Quality and Accreditation department with audit guidelines, conducted file reviews with the health plans to review practice and compliance and assisted with comment on proposed Population Health and LTSS guidelines.

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