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Case Managers on the Front Lines of Opioid Epidemic Response

Advocacy, Education, and Empowerment for Users of Medical and Nonmedical Opioids

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ABSTRACT

Purpose: The purpose of this article is to examine how case managers, taking a holistic, patient-centered approach that is grounded in advocacy, have a crucial role to play in the opioid crisis response. This includes providing education, support, and resources to prevent misuse of and addiction to opioids prescribed for pain management and intervening with more resources to help combat the nonmedical use of prescription opioids and heroin.

Primary Practice Settings: In addition to case managers in acute care, workers' compensation, and palliative care, who have frequent contact with patients who are prescribed opioid medications for pain management, all case managers may interact with patients and support systems/families who are directly or indirectly impacted by opioid use, misuse, and addiction.

Implementations for Case Management Practice: The broad scope of the opioid epidemic necessitates individualized interventions to address the multiple needs of individuals. The case manager, particularly one who is board-certified, has the expertise and knowledge to assess individual needs, identify treatment and other resources, and provide education and support to the patient and family/support system. In addition, given the complexity and life-or-death consequences associated with the opioid crisis, a timely and comprehensive approach is essential, bringing together multiple disciplines in health care, public health, addiction, pain management, social work, mental health counseling, pharmacology, and case management.

Key words: *acute care, addiction, care coordination, case management, case management process, case manager, code of professional conduct for case managers, Commission for Case Manager Certification, ethical practice, ethics, interdisciplinary team, mental health counseling, opioid crisis, outpatient, pain management, palliative care, workers' compensation*

Opioid misuse is a national epidemic that claims the lives of more than 115 people from opioid-related overdoses daily (National Institute on Drug Abuse, 2018a). This crisis affects urban, suburban, and rural populations, with an estimated 2.1 million people (2016 figures) identified as having an opioid addiction (U.S. Department of Health and Human Services [HHS], 2018). Understanding of the complexity of the opioid crisis has evolved over time. Early responses to the crisis focused largely on reducing the nonmedical use and abuse of opioids. Kolodny et al. termed this a "misattribution of the opioid crisis" that resulted in "stymied efforts to address the crisis" such as to prevent and treat opioid addiction among both medical and nonmedical users (Kolodny et al., 2015, p. 564). More recently, efforts have concentrated on controlling access to opioids and monitoring their use in pain management, as well as greater education of providers and patients, alike. For example, the Centers for Medicare & Medicaid Services (CMS) has proposed new policies regarding opioid access, such as allowing Part D plans to require certain beneficiaries to obtain opioid prescriptions from specific prescribers or pharmacies (CMS, 2017).

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With this fuller understanding of the opioid epidemic, the result is a battle to be waged on two fronts: preventing misuse of, and addiction to, opioids prescribed for pain management and intervening with more resources to help combat the nonmedical use of prescription opioids and heroin. Case managers, with their holistic patient-centered approach grounded in advocacy (Commission for Case Manager Certification [CCMC], 2015), have crucial roles on both fronts. The broad scope of the epidemic necessitates individualized interventions to address the multiple needs of individuals. Such actions may entail more education and follow-up with patients who are prescribed opioids to control severe pain, including a specific plan for the feasibility of transitioning the patient from opioid to nonopioid pain management to discuss with the patient and the prescriber. Other interventions may be required as people who are addicted to nonmedical opioids, including heroin, enter the health care system because of complications linked to opioid use or as a comorbid factor that led to hospitalization.

Given the complexity and life-or-death consequences associated with the opioid crisis, a timely and comprehensive approach is essential, bringing together multiple disciplines in health care, public health, addiction, pain management, social work, mental health counseling, pharmacology, and case management. The use of opioid pain relievers by employees with severe workplace injuries covered by workers' compensation has led some employers to establish their own guidelines to reduce opioid risks (Disability Management Employer Coalition, 2017). Public health advocates are addressing drug use as a behavioral health issue, requiring evidence-based prevention, treatment, and recovery approaches. As Kolodny et al. observed: "Just as public health authorities would approach other disease outbreaks, efforts must be made to reduce the incidence of opioid addiction, identify cases early, and ensure access to effective treatment ...Coordinated efforts from federal agencies, state agencies, health care insurers, and health care providers are required to address the needs of millions of Americans... " (Kolodny et al., 2015, p. 569). Across the health and human services spectrum, the case manager, particularly one who is board-certified, has the expertise and knowledge to assess the individual's medical, psychosocial, behavioral, and functional needs, identify treatment and other resources, and provide education and support to the patient and family/support system (CCMC, 2015).

The role of the professional case manager in the opioid crisis has been emphasized for years, particularly in pain management (Carter, Watson, & Sminkey, 2014). The multifaceted role of the professional case manager to carry out the goals of the Triple Aim—improving the experience of care, improving the health of populations, and reducing the per capita cost of health care (Berwick, Nolan, & Whittington, 2008)—showcases how professional case management can address the opioid crisis with interventions such as more in-depth education for patients to further the goals of decreasing the risk of opioid misuse and providing access to services for those affected.

Understanding Opioid Use, Abuse, and Addiction

Case managers today, regardless of practice setting or specialization, cannot afford to be naïve about the opioid crisis. Starting in the late 1990s, with the assumption that patients could be prescribed opioid pain relievers without significant risk of addiction, health care providers began prescribing them at greater rates. Emergency department visits involving misuse or abuse of prescription opioids increased by 153% between 2004 and 2011, and admissions to substance-abuse treatment programs as a result of prescription opioids increased by more than four times between 2002 and 2012. Between 2000 and 2014, the rates of death from prescription opioid overdose almost quadrupled, and in 2015, more than 33,000 individuals in the United States died from opioid overdose (Compton, Jones, & Baldwin, 2016). More recently, in 2016, 11.5 million people misused prescription opioids; heroin users numbered an estimated 948,000 (HHS, 2018). Overdose deaths because of opioid pain reliever abuse occur most frequently in adults ages 45 to 54 years, whereas the 55- to 64-year-age group saw the greatest increase in deaths because of overdose over the past decade. White women ages 55 to 64 years experienced the largest increase in accidental opioid overdose deaths (Kolodny et al., 2015). Moreover, in a study of heroin users who sought treatment between 2010 and 2013, the vast majority who became abusers after 1990 did so with prescription opioids. Nearly all in the study (94%) reported using heroin because prescription opioids were significantly more costly and difficult to obtain (Cicero, Ellise, Surratt, & Kurtz, 2014). In another study of heroin use by those in and not in treatment, nearly 80% of heroin users reported first using prescription opioids (National Institute on Drug Abuse, 2018a). Given the pervasiveness of the epidemic, case managers must recognize that the individuals they serve and the families/support

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systems with whom they interact may be directly or indirectly affected by the opioid crisis. As HHS Secretary Thomas Price stated in a recent speech, "That's what's so important to understand about this challenge. It knows no bounds. Americans of every creed, color, and class are caught up in this crisis. No corner of our country has escaped this scourge." (HHS, 2017, p. 2). Case managers are aware that suspending judgment and keeping an open mind are vital to maintaining open communication with patients who may more willingly admit to illicit opioid use if good rapport exists with the case manager.

Understanding Opioids and Addiction

Opioids are a class of drugs that include prescription pain relievers such as oxycodone, hydrocodone, codeine, morphine, and fentanyl, among others, as well as illegal drugs such as heroin.

Opioids interact with opioid receptors on nerve cells in the brain and nervous system to relieve pain and produce pleasurable effects. Drug overdose is the leading cause of accidental death in the United States. (Rudd, Seth, David, & Scholl, 2016).

In response to the opioid crisis, actions have been taken by a variety of involved parties on the federal and state levels, as well as among health care organizations, health plans, providers, and other clinicians and professionals. HHS, for example, has set five major priorities to respond to the opioid crisis: improving access to treatment and recovery services, promoting use of overdose-reversing drugs, strengthening understanding of the epidemic through improved public health surveillance, providing support for research on pain and addiction, and advancing better pain management practices (National Institute on Drug Abuse, 2018a).

Obtaining Patient Feedback on Pain and Pain Management

The case management process, which seeks to gather feedback from patients about their care, concerns, and questions, is a frontline intervention in understanding the individual's experience of pain and pain management strategies. This includes asking questions such as:

- Is the individual taking any pain medications?
- Is the prescribed pain medication working? What is the relief level?
- Does the individual or family/support system have questions or concerns about pain? (Case Management Body of Knowledge, 2018)

The goal is not to eliminate opioid use altogether, but to promote safe and focused use in specific clinical scenarios including palliative care, advanced cancer-related pain, and in certain situations in which alternative pain treatments have failed. This requires a care plan, including a drug transition plan, that is reviewed by both patients and care providers. In primary care, it may be the patient who undergoes surgery and who is prescribed an opioid to manage pain. Pain is a health factor (Carter et al., 2014) that has been identified as a poorly addressed clinical and public health problem. The safe use of prescription opioids is needed to control pain. Severe pain from injury, surgery, or disease requires a comprehensive pain management approach that may include the safe and well-monitored use of opioids. The Joint Commission has issued standards to guide accredited health care organizations in developing policies and procedures to improve patient care and safety. The Joint Commission's standards, revised effective January 2018, require hospitals to have a process to address pain assessment, as well as a process based on clinical determination to treat patients' pain and/or refer patients for pain treatment. These treatments may include nonpharmacologic or pharmacologic approaches. In addition, hospitals must have a process for clinicians to reassess and respond to patients' pain (The Joint Commission, 2018).

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The presence of pain and pain management strategies are part of case management assessments of patients (Carter et al., 2014). Case managers also engage in medication reconciliation, with the goal of identifying and monitoring medications taken by the patient to determine necessity, improve safety, avoid adverse drug affects, and prevent overprescribing. In addition, case managers who coordinate care among multiple providers play an important role in helping guard against potential opioid misuse that may occur if the patient is provided with multiple prescriptions for controlled substances. Collaborating with the patient's pharmacist may help ensure that the patient is receiving only the intended amount of the opioid prescribed by provider.

Case management involvement in responding to the opioid crisis extends in many other directions as well. Case managers in acute care, emergency departments, and other hospital and outpatient settings increasingly encounter individuals in health

crisis whether directly because of opioid misuse and addiction, or those whose health is otherwise compromised by opioid abuse. Case managers who specialize in disability management and workers' compensation often interact directly with individuals who have taken or are currently taking opioid pain relievers, and whose safety on the job and in transit to the workplace must be assessed. Employers are encouraged to ensure that their health care and absence management programs align with organizational goals to provide their workforce with a safe and healthy environment. This includes review of drug screening and drug-free workplace policies, health and wellness programs and strategies, disease management, and stay-at-work and return-to-work policies.

A Case Management Approach to Opioid Abuse

Among the many roles case managers play in addressing the opioid crisis, two that stand out across multiple practice settings are communication and education, specifically to educate patients and their families/support systems about the risks of opioid abuse and to address risk reduction. The case management process looks at individuals with empathy for their particular challenges and circumstances, suspending judgment and avoiding assumptions. Engagement relies on advocacy, which is the heart of case management practice (CCMC, 2015). Advocacy enables engagement with patients, whether they are being newly treated for pain or whether they are longer-term medical or nonmedical users of opioid prescription pain relievers or other substances, including heroin. Although engagement with patients regarding opioid use will vary based on individual circumstances, a commitment to open and candid communication, education of patients and their families/support systems, and identification of risks are essential elements of all interactions.

In acute care settings, for example, patients who are scheduled for surgery (such as cardiac, orthopedic, or major abdominal procedures) will likely require opiate medications during the immediate postoperative period. With such scheduled patients, case managers can begin working with the patient during the preoperative phase of care planning. During this phase, the patient's current pain management regimen is assessed, including past or current use of opioids. The case manager, working with the patient and the provider, develops and implements a pain management plan as part of the overall care transition plan to ensure that the individual is transitioned from opioids to other medications for controlling pain according to his/her individual needs. This may also involve preoperative collaboration with anesthesiologists or other pain specialists. In the case of trauma, such as vehicular accidents or vehicle-pedestrian incidents, it is often difficult to assess the patient's medication history in advance of emergency surgery. During the postoperative period, the patient's pain management and care transition plans must be reviewed and updated as appropriate. Furthermore, this information must be transferred in a timely manner to the next level of care as part of a transition plan. This communication should be clear and concise to support the patient's pain management and transition plan.

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Engaging With Candor, Building Rapport

Case managers possess specific communication skills, including their use of motivational interviewing techniques to identify the individual's current health status and challenges, as well as his/her goals (Tahan & Sminkey, 2012).

With candid communication and the building of rapport, case managers can engage in honest discussions around medication use, including opioids. Patients may admit to being confused about multiple medications. Or, active users may reveal their opioid dependence, particularly if they are facing surgery or are experiencing medical complications because of opioid use. As case managers engage in these discussions with patients, remaining objective and nonjudgmental is paramount.

Individuals receiving unscheduled treatment in acute care settings may also include patients who are admitted because of the direct effect of opioid usage. Some cases may involve overdoses of opioid pain relievers or heroin, including paramedic response and use of overdose-reversing drugs, such as naloxone, which is designed to rapidly reverse opioid overdose and comes in autoinjection and nasal spray forms (National Institute on Drug Abuse, 2018b). Others may require acute care treatment because of the consequences of opiate use, which may include infections of the skin, wound(s), or blood. Further complications may occur if intravenously administered antibiotics are required because oral counterparts are not available or not as effective. The patient's veins may be compromised by intravenous drug use, such

as injecting heroin. Continuing antibiotic treatment postdischarge may be difficult if the individual does not have a home context in which to receive treatment or a family/support system to help coordinate ongoing treatment. Because many infusion companies will not take an IV drug abuser on service, because they would then have a direct mainline through which to inject drugs, continuing treatment in the community may not be possible for these patients. Early assessment of the patient and the support system regarding the long-term treatment plan is essential. Frequent reassessment, as the patient responds to hospital-administered medications and treatment, can further clarify options for the discharge plan. Collaboration with a clinical social worker or clinical case manager throughout hospitalization is also essential.

Acute Care for Active Users

Case managers in acute care settings such as inpatient, emergency departments, and outpatient may encounter individuals who are actively misusing and/or addicted to opioid pain relievers or heroin. As part of medical treatment, the hospital-based case manager, often working closely with social workers, addiction specialists, and others, can present options for addiction treatment. Ultimately, as with every aspect of patient-centered care, it is the individual's decision of whether to cease using. The individual may not have insurance or financial resources to cover the cost of inpatient addiction treatment and recovery programs. Community-based programs and support groups are another alternative. But participation in addiction recovery begins with the person's choice. If the person chooses to pursue a recovery program, he or she must personally learn the parameters of the program in order to participate.

When an individual who has been prescribed opioids leaves the acute care setting, oversight of the individual's response to treatment is often limited to periodic follow-up visits with the health care provider. This limited supervision could potentially lead to missed cues or "red flags" involving opioid misuse. Case managers specializing in disability management and workers' compensation are uniquely positioned to assess and monitor the individual's prescribed treatment plan and intervene when there are signs that an individual could be misusing, abusing, or be addicted to opioids.

A Team Response

The complexity of these cases exceeds the ability to discuss here each potential scenario in-depth. However, a common approach utilizes the expertise of the interdisciplinary team composed of a case manager, social worker (which may include a case manager-social worker dyad that specializes in trauma or specific surgical procedures), as well as physicians, nursing staff, pharmacists, and other clinicians. In some acute care settings, physicians with palliative care expertise and acute care specialists such as anesthesiologists may provide valuable expertise and input on pain management and transitioning patients from opioids to analgesics and other medications such as muscle relaxers. Within the medical community and academic medicine, there is greater recognition of the role of the addiction medicine specialist. For example, in 2016, the American Board of Medical Specialties recognized addiction medicine as a new subspecialty. Sokol of the Addiction Medicine Foundation observed, "Such acknowledgment shows that the academic medicine community is committed to approaching addiction as a treatable disease and not perpetuating the stigma of addiction as a moral failing, bad behavior, or a crime" (Sokol, 2017, p. 2). Board-certified case managers, too, in their role as advocates and with the obligation to empower patients "in a matter that is supportive and objective" (CCMC, 2015, p. 4) are also required under ethical standards for professional case management to address the needs of the individual without judgment.

Pharmacists are a wealth of information about medications, possible side effects, and medication interactions and should be included on interdisciplinary teams addressing opioid use. Addiction and other behavioral health issues require the expertise of mental health counselors and other behavioral health specialists who can both inform the team and be a resource for the individual and family/support system. Counseling and other supportive services may be available through an employee assistance program (EAP), such as those offered by many employers as part of their health and wellness benefits for employees and their dependents. These services may also be available through the patient's health care benefits package. There may also be resources available in the community.

Disability management specialists and workers' compensation case managers offer expertise in the assessment and monitoring of opioid prescriptions and usage after an injury, illness, or surgery. Disability managers and workers' compensation case managers cannot prescribe or direct care, but frequently will have access to medical and pharmacy records to facilitate claim processing and payments. This is necessary because medical documentation must support impairment in an individual's functionality and the inability to perform work in order for an income replacement claim to be paid. Without medical documentation to support a physical or cognitive impairment, a worker's compensation or short/long term disability claim may be denied and/or referred for further review.

During this process of claim review, a case manager may identify potential red flags in the medical

records and/or case management documentation that could point to signs and symptoms of opioid misuse, abuse, and/or addiction. Examples of red flags may include evidence of multiple health care providers who prescribe medications for the patient, frequent changes in providers, lack of response to the prescribed treatment plan, lack of change to the treatment plan when recovery has plateaued, and/or increasing dosages and or refills of opioid prescriptions. If such warning signs are identified, the case manager may request additional clarification and information from the treating health care provider or suggest that the patient access community-based resources or EAP services, if available and appropriate for his or her needs.

Education and Advocacy

When patients are prescribed any medication, and particularly one as strong and potentially addictive as an opioid pain reliever, the case manager must help ensure that the individual understands what medications he or she is taking as well as the potential side effects, while monitoring for contraindications with other medicines, including existing prescription pain relievers. The dosage and duration of the prescribed medication should also be communicated in language that the individual and family/support system understand. Tools and resources for enhancing patient education include written instructions in plain language (and, when necessary, translated into the person's primary language) and information from reputable websites such as the Centers for Disease Control and Prevention and the HHS. The case manager may collaborate with a home health agency to ensure a post-discharge home safety evaluation is completed, the results of which need to be shared with the patient, family/support system, and provider(s).

HHS Five Priorities to Respond to Crisis

The HHS has identified five major priorities in response to the opioid crisis:

1. Improving access to treatment and recovery services
2. Promoting use of overdose-reversing drugs
3. Strengthening understanding of the epidemic through better public health surveillance
4. Providing support for cutting-edge research on pain and addiction
5. Advancing better practices for pain management (HHS, April 2017)

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Advocacy, engagement, education, and communication advance the empowerment of patients, particularly with regard to having honest and upfront conversations with physicians and other caregivers about their care, current medication use, new prescriptions, and pain management needs. Empowerment also opens the door to conversations with patients and families/support systems about recovery and rehabilitation, including the availability of such resources, options covered by their insurance plans, and the parameters of participating in these treatment and recovery programs. For both the patient and the family/support system, community-based resources such as support groups and 12-step programs can help those impacted by addiction. Alternative therapies such as yoga, meditation, acupuncture, and mindfulness may also be viable options for those interested in pursuing them as a lifestyle change to help control pain and support behavioral changes associated with addiction recovery.

Conclusion

Alone, case managers cannot possibly solve the opioid crisis. They are, however, integral parts of interdisciplinary teams across the health and human services spectrum. Case managers' response to the crisis begins with a commitment to being educated about all aspects of the crisis, the roots and extent of the opioid epidemic, and the need to focus intervention and treatment on both medical and nonmedical users of opioids. As the hub of interdisciplinary

As the hub of interdisciplinary teams, case managers are also uniquely positioned to access resources that can address the multifaceted issues intertwined in the opioid epidemic: the experience of pain and need for effective pain management; the importance of education of patients and families/support systems to identify warning signals of opioid misuse and addiction; and delivering comprehensive care and treatment to address the holistic needs of patients with opioid use disorder.

teams, case managers are also uniquely positioned to access resources that can address the multifaceted issues intertwined in the opioid epidemic: the experience of pain and need for effective pain management; the importance of education of patients and families/support systems to identify warning signals of opioid misuse and addiction; and delivering comprehensive care and treatment to address the holistic needs of patients with opioid use disorder. At the heart of this approach is the commitment to advocate for patients and their families/support systems. In this way, case managers are at the center of a multifaceted and multidisciplinary approach to addressing the opioid crisis individually, one case at a time, and as a population health crisis.

Additional Resources for Case Managers

American Society of Addiction Medicine: www.asam.org

American Society of Regional Anesthesia and Pain Management: www.asra.com

American Association of Nurse Anesthetists: www.aana.com

Harvard Medical School Global Academy, series on pain and opioid treatment: https://leanforward.hms.harvard.edu/2018/02/01/the-orphaned-patient-treating-chronic-pain-with-opioids/

Society for Oncology Massage: www.s4om.org

References

Berwick, D., Nolan, T., & Whittington, J. (2008). The triple aim: Care, health, and cost. *Health Affairs*, *27*(3), 759–769. Retrieved from http://content.healthaffairs.org/content/27/3/759.abstract

Carter, J., Watson, A., & Sminkey, P. (2014, May-June). Pain management: Screening and assessment of pain as part of a comprehensive case management process. *Professional Case Management*, *19*(3), 126–134.

Case Management Body of Knowledge. (2018). *Obtain feedback regarding care and services*. Retrieved from https://www.cmbodyofknowledge.com/content/obtain-feeback-regarding-care-and-services doi:10.1097/NCM.0000000000000029

Centers for Medicare & Medicaid Services. (2017). *CMS proposes policies to lower the cost of prescription drugs and combat the opioid crisis*. Retrieved from https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2017-Press-releases-items/2017-11-16-2.html

Cicero, T., Ellise, M., Surratt, H., & Kurtz, S. (2014). The changing face of heroin use in the United States: A retrospective analysis of the past 50 years. *JAMA Psychiatry*, *71*(7), 821–826. doi:10.1001/jamapsychiatry.2014.366. Retrieved from https://jamanetwork.com/journals/jamapsychiatry/fullarticle/1874575

Commission for Case Manager Certification. (2009, Rev. 2015). *Code of professional conduct for case managers with standards, rules, procedures, and penalties*. Retrieved from https://ccmcertification.org/sites/default/files/docs/2017/code_of_professional_conduct.pdf

Compton, W., Jones, C., & Baldwin, G. (2016, January). Relationship between nonmedical prescription-opioid use and heroin use. *New England Journal of Medicine*, *374*, 154–163. doi:10.1056/NEJMra1508490. Retrieved from http://www.nejm.org/doi/full/10.1056/NEJMra1508490

Disability Management Employer Coalition (DMEC). (2017, September). *Reducing opioid risk through management and alternatives*. Retrieved from http://dmec.org/2017/09/10/problem-pain-reducing-opioid-risks/

Health and Human Services (2017, April). *Secretary price announces HHS strategy for fighting opioid crisis*. Retrieved from https://www.hhs.gov/about/leadership/secretary/speeches/2017-speeches/secretary-price-announces-hhs-strategy-for-fighting-opioid-crisis/index.html

Health and Human Services (2018, January). *The opioid epidemic by the numbers*. Retrieved from https://www.hhs.gov/opioids/sites/default/files/2018-01/opioids-infographic.pdf

Kolodny, A., Courtwright, D., Hwang, C., Kreiner, P., Eadie, J., Clark, T., & Alexander, G. C. (2015). The prescription opioid and heroin crisis: A public health approach to an epidemic of addiction. *Annual Review of Public Health*, *36*, 559–574. Retrieved from https://www.annualreviews.org/doi/full/10.1146/annurev-publhealth-031914-122957?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dpubmed

National Institute on Drug Abuse. (2018a, March). *Opioid overdose crisis*. Retrieved from https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis

National Institute on Drug Abuse. (2018b, January). *Opioid overdose reversal with naloxone (Narcan, Evzio)*. Retrieved from https://www.drugabuse.gov/related-topics/opioid-overdose-reversal-naloxone-narcan-evzio

Rudd, R. A., Seth, P., David, F., & Scholl, L. (2016, December). Increases in drug and opioid-involved overdose deaths—United States, 2010–2015. *MMWR Morbidity and Mortality Weekly Report*, *65*, 1445–1452. doi:http://dx.doi.org/10.15585/mmwr.mm655051e1.

Sokol, R. (2017). *Training future physicians to address opioid crisis*. Retrieved from Association of American Medical Colleges website: https://news.aamc.org/patient-care/article/training-future-physicians-address-opioid-crisis/

Tahan, H., & Sminkey, P. (2012, July-August). Motivational interviewing: Building rapport with clients to encourage desirable behavioral and lifestyle changes. *Professional Case Management*, *17*(4), 164–172. doi:0.1097/NCM.0b013e318253f029

The Joint Commission. (2018). *Pain management*. Retrieved from https://www.jointcommission.org/topics/pain_management.aspx

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