“Nobody wants to wake up and face the world as an addict,” says Robert LoNigro, MD, MS.

But millions do, and substance abuse disorders (SUDs) remain severely undertreated, explains LoNigro, senior vice president and chief clinical officer at Envolve PeopleCare, part of the Centene Corporation. One recent study found that only about 5 percent of adults who misused prescription opioids in the past year, and just 17 percent of those with prescription opioid addiction, ever receive treatment.¹

That leaves many untreated. Nearly 10 million American adults—4.1 percent of the adult population—used opioid medications in 2012-2013 without a prescription or not as prescribed. This is up from 1.8 percent in 2001-2002.²


² Ibid.
You don’t need to know the exact numbers to know it’s an epidemic. “It’s been all over the news: Deaths from drug overdoses have jumped in nearly every county across the United States, driven largely by an explosion in addiction to prescription painkillers and heroin,” says Patrice Sminkey, CEO of the Commission for Case Manager Certification. The death rate from drug overdoses is climbing at a much faster pace than other causes of death; in fact, she points out, it’s being compared to the HIV/AIDS epidemic in the late 1980s and early 1990s.

The increasing misuse of prescription opioid pain relievers poses serious consequences beyond addiction, including pancreatitis, skin abscesses, endocarditis, neonatal abstinence syndrome and death. It often progresses to intravenous heroin use, increasing the risk for HIV, hepatitis C and other infections (for more on the heroin connection, see sidebar).

Professional case managers—nurses and social workers—are ideally suited to take on this epidemic and help support their patients, LoNigro says. Sminkey agrees: “We bring the expertise, experience, skills and compassion necessary to meet people where they are on the spectrum of care, and lead them to optimal health,” she explains.

Role of the case manager

The ability to consider the whole person—including the many factors that influence behaviors, such as history, family dynamics, psychosocial conditions, past traumas—is essential. But, because of how much time it takes to elicit information from the patient, it rarely happens in clinical practice, LoNigro says.

That’s why a case manager can play such a crucial role. What’s needed is something different from the traditional clinical relationship, he says. “Because the case manager is neither the prescriber of the opioids nor the purveyor of illicit substances, there is less reason for an individual to be evasive in responding to inquiries about these issues.”

It just takes the right touch. It requires respect and understanding. It requires delicacy. “There’s no magic to it,” he says.

Sminkey agrees: “If we have the right perspective, we will connect with many more people as case managers strengthen the expertise and resources needed to respond this crisis.”

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— ROBERT LONIGRO, MD, MS, SENIOR VICE PRESIDENT, CHIEF CLINICAL OFFICER, ENVOLVE PEOPLECARE

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The heroin connection

“...As Congress debates the merits of limiting doctors’ ability to prescribe opiates, those already addicted are turning to heroin for its lower cost and easier access,” Sminkey explains.

Four in five new heroin users started out misusing prescription painkillers. Consequently, the rate of heroin overdose deaths nearly quadrupled from 2000 to 2013. During this period, the rate of heroin overdose showed an average increase of 6 percent per year from 2000 to 2010, followed by a larger average increase of 37 percent per year from 2010 to 2013. Heroin overdose deaths among women have tripled in the last few years. From 2010 through 2013, they increased from 0.4 to 1.2 per 100,000.

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4. Ibid.
In addition, especially in an integrated setting, the case manager has access to subject matter expertise from behavioral health colleagues; this, LoNigro adds, facilitates a much more comprehensive approach to caring for the patient than can be achieved in most clinical practice settings.

“The opioid epidemic is forcing health care organizations to think differently about drug addiction and how we manage behavioral health issues in the health care sphere,” Sminkey says. “The crisis highlights the need of the professional case manager to know how to engage the full continuum of patient care, including medical, behavioral, community and social services.”

All in the family

Such a whole-person approach demands patience and good listening skills, but it also requires something else: a trusting relationship. Only then can the case manager gather the information needed to develop a care plan that can best meet the patient’s needs.

This plan needs to be developed in collaboration with the family, when possible. The family is particularly important, says LoNigro. Clearly, the effects of a substance use disorder are felt by the whole family. And likewise, the family can be a key to recovery. “Don’t underestimate the ability of family to support someone with a substance use disorder,” he says.

But there are other issues with which the family can assist. He identifies a few:

- The family context holds information about how SUDs develop and are sustained; it also holds clues as to what can influence treatment.
- Family systems theory and attachment theory models provide a framework for understanding how SUDs affect the family.
- Understanding a family’s current developmental stage helps inform assessment of impairment and determination of appropriate interventions.

Who needs help?

In 2012, 259 million prescriptions were written for opioids. It’s no surprise, then, that case managers who work with patients with chronic pain will eventually encounter those with SUDs. Overall, says LoNigro, 10-20 percent of those prescribed chronic opioids exhibit aberrant use and behaviors. In 2014, almost 2 million Americans abused or were dependent on prescription opioids. As many as one in four people who

LoNigro offers a list of some of the many things a case manager can do to help SUD clients:

| ✓ | Routinely assess for SUD problem and refer the individual to a specialty clinic for further assessment or treatment when indicated. |
| ✓ | If a problem is identified, educate about SUD, treatment, recovery and relapse. |
| ✓ | Explore the impact of SUD on client and the family. |
| ✓ | Know the structure of the family that the individual you are working with comes from (i.e., blended family, single-parent family). |
| ✓ | Know the developmental stage of the family that the individual you are working with comes from (family with teenagers, aging family). |
| ✓ | Provide treatment referrals for family members (children, spouses, adult parents) where appropriate. |
| ✓ | Coordinate with school systems to help clients access school-based services, after-school care and tutoring. Help parents advocate in the school system for their children if psychoeducational/neuropsychological testing is needed, or with the development of an Individualized Education Plan. |
| ✓ | Facilitate referrals to specialized courts if indicated: adult drug court, teen drug court, family court. |
| ✓ | Educate clients with SUDs about pregnancy prevention and provide education about risks of drug exposure on a fetus. |
| ✓ | Inform about AA, NA for the patient with an SUD, and Al-Anon, Nar-Anon, Alateen for family members. Provide location and times of meetings in their area. |
| ✓ | If there are safety issues with regard to children or the elderly, child protective services or elder protective services referral may be needed. |
| ✓ | Ask questions about whether the current living situation is physically safe or if there have been past or present incidences of domestic violence. |
receives prescription opioids long term for non-cancer pain in primary care settings struggles with addiction.  

Addiction to prescription painkillers is no respecter of class, wealth or family background, says Sminkey. It is a problem in large cities and in rural communities. But it is more common in some populations than in others. A recent report found rates of prescription opioid misuse were highest among men; people with annual incomes of less than $70,000; those previously married; and people with a high school education or less. People who’ve had an alcohol use disorder are nearly twice as likely to develop an opioid addiction as well.

LoNigro offers a few other characteristics of patients at higher risk for substance use disorder. They include a history of opiate abuse and/or treatment, history of prior SUD treatment, presence of serious mental illness (including obsessive-compulsive disorder and attention deficit hyperactivity disorder), family history of substance use disorders and a history of preadolescent sexual abuse.

**Taking action**

It’s not always obvious who is at risk or who has already become addicted. Case managers may be the first to notice something is awry—not just with patients, but also with prescribing patterns. It’s important to speak up, he says, but be tactful—and tactical. Don’t simply confront a physician: Come in with evidence and explain what needs to be changed.

Patients at high risk for SUDs need to be cared for differently, he says. Developing treatment agreements with the patient is an excellent tool. Other approaches include limiting the intervals between visits, controlling the supply of medications, counting pills and even conducting urine drug screens. Again, he asserts, it comes back to family. “To the degree possible, include the patient’s support network in your monitoring effort.”

**Special considerations: the elderly**

Even though they are not necessarily at high risk, older patients need special consideration, too. “Given the variable response, and potential increased sensitivity, to opioids, older patients should ‘start low and go slow,’” he says. That means low doses with longer intervals between dose increases when considering treatment efficacy.

Nausea and vomiting are more common in older patients, as is opioid-related constipation; he recommends liberal use of laxatives.

Perhaps most important, identify all the medications the patient is taking. This is important for all patients but critical for the elderly, who generally take more medications than younger people do. In particular, it’s essential to avoid mixing opioids with benzodiazepines and other respiratory depressant medications.

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8. ibid

9. One resource he recommends is at www.scopeofpain.com. SCOPE of Pain is a series of continuing medical education/continuing nursing education activities designed to help you safely and effectively manage patients with chronic pain, when appropriate, with opioid analgesics.

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**“To the degree possible, include the patient’s support network in your monitoring effort.”**

— ROBERT LONIGRO, MD, MS, SENIOR VICE PRESIDENT, CHIEF CLINICAL OFFICER, ENVOLVE PEOPLECARE
Addressing the pain: alternatives to opioids

There are a number of excellent guidelines available regarding the appropriate treatment of pain. LoNigro offers a basic overview. In addition to other—non-opioid—medications such as NSAIDS, anti-convulsants, antidepressants and topical agents, there are several approaches.

Physical therapy can include exercise, acupuncture, orthotics, transcutaneous electrical nerve stimulation and such basic modalities as heat, cold and stretching. Behavioral approaches include cognitive behavioral therapy, acceptance and commitment therapy, treatment of mood and trauma issues, meditation and counseling. Other possibilities include nerve blocks, steroid injections, trigger point injections and pumps.

When evaluating these options for a patient, consider consulting with physiatrists or pain management experts. Do what it takes to understand the cause of the pain. When in doubt, he says, call in specialists such as orthopedists or neurologists.

Despite a growing consensus that medication-assisted treatment is a successful strategy to tackle the country’s opioid epidemic, only a tiny percentage of those with SUDs are receiving it.

The closing gender gap

Although men are more likely to have a substance use disorder, that may be changing. Prescription pain reliever overdose deaths among women increased more than 400 percent from 1999 to 2010, compared to 237 percent among men.10 Men are more likely to die from an overdose, but that gap is closing, too.11 LoNigro points out women are more likely to have chronic pain, be prescribed prescription pain relievers, be given higher doses and use them for longer periods than men. Women may become dependent on prescription pain relievers more quickly than men do.

Medication-assisted treatment

One successful approach to addressing SUD, medication-assisted treatment (MAT), combines behavioral therapy and medications to treat substance use disorders.

Among the most commonly used medications are the following:

- **Methadone** fully activates opioid receptors to suppress withdrawal, block the effects of other opioids and reduce craving. This medication must be taken every day and has a high potential for abuse.

- **Buprenorphine** is a partial opioid agonist with lower risks of abuse, dependence and side effects compared with methadone.

- **Naltrexone** blocks the effects of opioids.12

Despite a growing consensus that medication-assisted treatment is a successful strategy to tackle the country’s opioid epidemic, only a tiny percentage of those with SUDs are receiving it.13 Limited availability of the appropriate medications contributes to this, but perhaps a bigger reason is the


12 The Substance Abuse and Mental Health Services Administration (SAMHSA) is an agency within the U.S. Department of Health and Human Services. It has a variety of resources on MAT: www.samhsa.gov/medication-assisted-treatment

stigma surrounding MAT. For his part, LoNigro believes in giving patients various alternatives to treat their addictions.

Some patients are on MAT briefly; for others, it’s a lifelong solution. It’s not clear why that happens, he says. “We don’t know enough about the physiology and neurobiology.” It’s likely that long-term treatment is less about the physical components and more about the behavioral components of addiction.

But integrating those areas remains a challenge as long as behavioral health and physical health remained siloed. An unfortunate side effect of these advanced medication therapies is that, because behavioral health “carve outs” remain commonplace in managed care, behavioral health remains segregated from physical health for the patients who might most benefit from integration of the two.

Rethinking the system

What’s needed is an integrated approach, argues LoNigro. “After all, the brain is still connected to the body, last time I checked.”

Sminkey concurs, and shares his dismay that, although the mind and the body are indeed connected, the way we deliver and pay for their care is not. She thinks the current crisis may ultimately change that fragmented approach.

“If nothing else, this epidemic has made it more apparent than ever that our physical health is only one part of the total health picture. We can’t ignore the social, behavioral, emotional and financial needs of those who present in the emergency room with drug dependency, or are flagged in a health plan database with an opioid abuse issue. A whole-person approach to case management and an understanding of the need for an integrated approach to care are the right places to start.”

The opioid crisis is a call to action, not only in terms of substance use disorders, but of behavioral health integration. “As case managers, we know how to optimize healing, paying special attention to the emotional and behavioral health needs of our clients,” she says. “Case managers, as community connectors and health care team members, must be part of the innovative thinking that will help turn the tide of opioid addiction.”

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About the Experts

Patrice Sminkey, Chief Executive Officer, Commission for Case Manager Certification

Sminkey comes to the Commission from URAC, where she most recently served as senior director of sales. Prior to that, she was senior vice president, operations and client management, Patient Infosystems in Rochester, N.Y. She brings a proven track record in operations management in small and large operations, multilevel services and cross-functional teams. She has extensive experience in client management and coordination, including marked improvement in client retention, timely and fiscally sound program implementation and an expanding book of business.

As chief executive officer, Sminkey oversees the management of all activities related to the Commission’s operations, including all programs, products and services; and the provision of quality services to and by the Commission. She is a direct liaison to the Commission’s Executive Committee. She works with CCMC’s volunteer leadership to evaluate and develop potential new products for implementation by CCMC, and she establishes and maintains communication and working relationships with other organizations, agencies, groups, corporations and individuals.

She holds a diploma of nursing from the Chester County School of Nursing.

Robert LoNigro, MD, MS
Senior Vice President, Chief Clinical Officer
Envolve PeopleCare

LoNigro is senior vice president and chief clinical officer of Envolve PeopleCare, a Centene corporation. Prior to that, he served in executive positions at CeltiCare Health Plan of Massachusetts and as chief medical officer of the New England Quality Care Alliance and of Tufts Health Plan. LoNigro maintains a part-time clinical practice as an inpatient consultant at McLean Hospital Southeast, where he oversees the internal medicine consultation service.

In addition to his medical education and practice, he also holds bachelor and master’s degrees engineering from Virginia Tech, where his interest in biomedical engineering and medicine was born.

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