

The Opioid Public Health Emergency and Older Adults

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December, 2017

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Executive Summary

Opioid use disorder can affect people of all ages; racial, ethnic, sexual and gender minorities; income classes; and geographic areas. Older adults are among the groups affected by this problem because they often use prescription opioids to cope with painful chronic conditions, such as arthritis, or procedures, such as surgery. As a result of chronic pain, older adults may use prescription opioids for a long time, which presents a risk for developing an opioid use disorder. In addition, as people age, medications affect them more strongly and are slower to leave their systems so the side effects of opioids can be severe. Among the risks that older adults who use opioids face are death, hospitalization, and use of emergency departments.

Prescription opioids are not the first line treatment for chronic pain and there are many effective alternative treatments for this condition. Experts have reviewed the available evidence on efficacy of opioid use and found that opioids are moderately effective for pain relief for periods of three months or less and that other therapies can help manage pain.

The National Aging Network has opportunities to educate older adults about opioids and connect them with helpful resources when they seek to reduce or eliminate use of the medications and obtain treatment if they have developed an opioid use disorder. Education resources are available from the Centers for Disease Control and Prevention (CDC) and the Substance Abuse and Mental Health Services Administration (SAMHSA). Among the treatment resources are federal programs, like Medicare, which covers various treatments for substance use disorders. Medicaid treatment coverage is available too, with the extent of it varying by state and jurisdiction. Veterans may also have access to treatments for the disorders and to non-opioid treatments for pain through the Veterans Health Administration.

Many states have taken action to address the opioid public health crisis, often with grants from the CDC and SAMHSA, and in partnership with the Aging Network. As of 2015, 13 states had educational programs they targeted to older adults. The Network could look to federal resources and state and local innovations for ideas when addressing the challenges of the opioid crisis among older adults.

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1.0 Introduction

Generally, opioid use leads to euphoria, drowsiness, and slowed breathing, as well as reduced pain (Surgeon General, 2016). Some people who use this substance can develop an opioid use disorder. Opioid use disorder symptoms include: a strong desire for opioids; an inability to control or reduce their use; failure to meet work, school, or home obligations; continued use despite social or interpersonal problems; use of larger amounts over time; development of tolerance; much time spent obtaining and using opioids; and withdrawal symptoms, such as anxiety, muscles aches, nausea or vomiting, diarrhea, fever, and insomnia (American Psychiatric Association, 2013). Unfortunately, many regard a substance use disorder as a personal moral failing that occurs due to inadequate willpower (Altman et al., 2012). However, research shows that substance use disorders are chronic, complex brain diseases with related behaviors, and the disorders may involve recovery and recurrence (U.S. Surgeon General, 2016; Altman et al., 2012).

Opioid use disorder can affect people of all ages; racial, ethnic, sexual and gender minorities; income classes; and geographic areas. Older adults are among the groups affected by this problem because they often use prescription opioids to cope with painful chronic conditions, like arthritis, or procedures, such as surgery. Like anyone else, if older adults use prescription opioids for a long time, they risk developing an opioid use disorder. Long-term opioid therapy is defined as use of opioids on most days for more than 3 months (Dowell et al., 2016)

This issue brief provides background information about opioid use among community dwelling older adults, opioid use disorder, and evidence-based treatments for the disorder. The brief describes federal guidelines for prescription opioid use, and therapeutic alternatives to opioids for people who experience chronic pain, evidence-based practices for treatment of opioid use disorder, and recovery support services. After providing this information, the issue brief describes federal resources and state and local innovations that address opioid use among older adults. Our Network partners could look to these resources and innovations for ideas when addressing the challenges of the opioid public health emergency¹.

Several important issues are outside the scope of this issue brief. Experts agree that people who are dying or have cancer may need opioids, so we do not address these populations here. In addition, we do not address opioid use among adults with disabilities aged 18-59 because we could not identify any nationwide data for this population. There is a critical need to address this gap.

¹ On October 26, 2017, the Department of Health and Human Services declared that a nationwide public health emergency exists due to the opioid crisis.

2.0 Opioid Use and Older Adults

Increasing age often comes with painful and chronic conditions such as degeneration in bones, joints, and muscles (Molton and Terrill, 2014). About 40 percent of older adults report pain, compared to 30 percent of the general population (Le Roux et al., 2016). In addition, some older adults have accumulated experiences involving trauma, which can result in anxiety and depression. Furthermore, loss of loved ones and erosion of social roles can occur with age and so can disability. These challenges can make older adults, like people of all ages, prone to relying on opioids and other substances such as alcohol to ease emotional and physical pain in their daily lives.

In addition, opioids have a stronger impact on older adults because bodily processes slow as people age. Older adults also tend to be using multiple medications, which can interact with opioids and cause serious side effects. For example, older adults who use opioids and take an anti-anxiety medication, such as a benzodiazepine, can experience slow respiration to the point of death, depending on dosage levels. Complicating this situation is that older adults with a substance use disorder, such as an opioid use disorder, may have symptoms similar to those of depression, delirium or dementia (Maree et al., 2016).

All of these considerations make opioid use among older adults a complex challenge. This section first provides available data on older adults' opioid use and then describes the particular risks this population experiences because they are older.

2.1 Data on Older Adults' Opioid Use

Several data sources describe older adults' use of opioids and show that many are at risk for or already have an opioid use disorder. While the numbers vary due to data source, they tell a similar story – older adults use opioids at high rates and over the long-term; some of these adults have acquired opioid use disorder.

- The Centers for Disease Control and Prevention's (CDC) analysis of data from the National Health and Nutrition Examination Survey, 2007–2012 found that the rate of opioid analgesic use in the past 30 days was 7.9 percent for those aged 60 and over, compared to 4.7 percent for those aged 20–39 (Frenk et al., 2015). The same study found that women aged 60 and over were more likely to use opioids than their male peers (8.6 percent vs. 6.9 percent).
- Data from the National Health and Nutrition Examination Survey (1999 – 2014) show that those aged 65 and older were 25.4 percent of long-term² users of opioids (Mojtabai, 2017).
- Data from the 2012–2013 National Epidemiologic Survey on Alcohol and Related Conditions – III found that 2.2 percent of adults age 65 and over reported non-medical use of prescription

² 90 days or longer

opioids during the past 12 months and 5.0 percent did so during their lifetimes (Saha et al., 2017). Among older adults, 0.4 percent were diagnosed with opioid use disorder in the last 12 months and 0.5 percent of them had such a disorder during their lifetimes.

- Data from the 2002 and 2014 National Survey on Drug Use and Health showed that non-medical opioid prescription drug use during the past 12 months doubled among those aged 65 and over in that 12-year period (0.4 percent vs. 0.8 percent) (Altman and Weakly, 2017).
- Medicare beneficiaries (aged and disabled) have among the highest and fastest-growing rates of diagnosed opioid use disorder at more than 6 of every 1,000 beneficiaries (CMS, January 2017).
- Nationally, one-third of Medicare Part D beneficiaries or 14.4 million people had at least one opioid prescription in 2016, with over 500,000 beneficiaries using very high amounts of the medication (DHHS/OIG, 2017). These patterns vary by state. Alabama and Mississippi had the highest proportions of Part D beneficiaries with at least one opioid prescription, at 46 percent and 45 percent, respectively.

2.2 Risks Associated with Older Adults' Opioid Use

When they use opioids for pain, older adults face a special set of challenges because of their generally reduced metabolism, excretion, and physical reserve, and more frequent use of drugs that can interact negatively with opioids (Chau et al., 2008). As people age, medications affect them more strongly and are slower to leave their systems. The opioid side effects that older adults and others may experience include: nausea and constipation; urine retention; central nervous system effects (sedation, mild cognitive impairment, respiratory depression); increased sensitivity to pain; as well as cardiovascular and endocrine system effects.

Among the risks related to older adults' opioid use are: injury, death, hospitalization, and use of emergency departments. Their service use rates vary across the country.

- Opioid use among older adults can result in excessive sedation, respiratory depression, and impairment in vision, attention, and coordination, as well as falls (SAMHSA, 2012).
- Older adults with opioid use disorder appear to be at a higher risk of death compared to younger adults with the disorder. A study using data from the Veterans Affairs' health care system found that veterans aged 50 and older with opioid use disorder were twice as likely to die as younger veterans with the disorder (Larney et al., 2015). The highest risk of death among these older veterans was for accidental medication-related deaths. In addition, older veterans with opioid use disorder had higher rates of suicide and violent death compared to their peers without the disorder.
- Side effects and opioid use disorder can lead to hospital use. In 2011, on an average day, 80 adults aged 65 and older visited the emergency department for problems with narcotic pain relievers and seven older adults' visits involved heroin (Mattson et al., 2017).

- Older adults' opioid-related use of hospital and treatment center services increased sharply from 2005 to 2014. For example, inpatient stays rose 85 percent for those aged 65 and older (Weiss et al., 2017). Emergency department visits for this group rose 112.1 percent during the same period.
- Opioid-related use of emergency departments and inpatient stays vary widely across the states (Weiss et al., 2017). In 2014, 13 states had the highest rates of opioid-related inpatient stays among older adults; these states concentrated West of the Mississippi River in the continental United States (US). Rates ranged from 133.9 per 100,000 in Wyoming to 599.9 per 100,000 in Oregon. Emergency department visit rates ranged from 40.2 per 100,000 in New York to 112.6 per 100,000 in Arizona.

3.0 Chronic Pain and Appropriate Treatment

Given the risks to older adults and the availability of effective alternatives, prescription opioids are not the first line treatment for chronic pain (Dowell et al., 2016). Chronic pain³ may develop from acute pain that cannot be or is not managed well or from chronic conditions (NASEM, 2017). Those with chronic pain often have multiple conditions and reduced quality of life (Molton and Terrill, 2014). Severe chronic pain is related to poor health and increased use of health care. There is little disagreement that treatment is critical; however, available evidence does not support the long-term use of opioids for treating chronic, non-cancer pain (NASEM, 2017). Rather, the CDC and others have reviewed the available evidence on efficacy of opioid use (Dowell et al., 2016) and found that opioids are moderately effective for pain relief for periods of three months or less, but generally not for long-term use. This section describes chronic pain and treatment alternatives, along with the CDC's opioid prescription guidelines (Dowell et al., 2016).

3.1 Appropriate Chronic Pain Management

Evidence shows that effective chronic pain management may involve stepped therapy (NASEM, 2017). Stepped therapy is a patient-centered approach involving potentially more than one technique. It emphasizes treatment goals and progressive modifications of treatment if the goals are not reached. Randomized controlled trials have demonstrated stepped therapy's effectiveness compared to usual care in terms of reduced pain-related disability, pain interference, pain severity, increased patient quality of life, and reduced costs (NASEM, 2017). Techniques, which could be part of stepped therapy, include cognitive-behavioral, physical/rehabilitation, pharmacologic, or interventional therapies (NASEM, 2017). Related techniques include acupuncture, exercise, and mindfulness meditation. Some techniques, such as massage and cognitive-behavioral therapy compare favorably to usual care for back

³ Experts define chronic pain as "pain lasting 3 or more months, or beyond the time of normal tissue healing" (NASEM, 2017).

and neck pain. Many of the treatments that do not involve medications are poorly reimbursed, if at all, by third-party payers (NASEM, 2017).

Self-management can be part of stepped therapy (NASEM, 2017). The concept is to help the individual manage the consequences and lifestyle changes related to living with a painful, chronic condition. Coping with these conditions includes accepting the presence of painful conditions, exercise, relaxation and other techniques to improve function. One program – the Chronic Pain Self-Management Program (CPSMP) – was effective in reducing pain in two randomized-controlled trials (LeFort et al., 1998). Participants in the program experienced significant improvements in pain, dependency, vitality, aspects of role functioning, life satisfaction and in self-efficacy and resourcefulness. Some Aging Network partners offer this program. Rehabilitation programs also use self-management techniques for chronic pain and have been shown to reduce pain and depression and increase the likelihood of return to work (Brendbekken et al., 2017; Ehde et al., 2015).

If a person with chronic pain needs medication, opioids are not the only option. A number of non-opioid medications can treat pain, with each having specific uses, benefits, and risks to the patient (NASEM, 2017). Examples include: nonsteroidal anti-inflammatories, anti-depressants, anti-epileptics, and capsaicin creams and patches.

3.2 Guidelines for Opioid Prescriptions

The CDC developed opioid prescription guidelines for chronic pain (Dowell et al., 2016). These guidelines are for providers serving community-dwelling people aged 18 and older who have pain lasting beyond the time their tissues heal or chronic pain. The guidelines recommend nonpharmacologic and non-opioid pharmacologic therapy alternatives to opioids for chronic pain. If providers prescribe opioids, these medications are more likely to be effective if they are integrated with nonpharmacologic therapies. People with chronic pain can benefit from nonpharmacologic therapies such as exercise and cognitive behavioral therapy. The guidelines also recommend that providers discuss with patients the benefits and risks of opioids, along with treatment goals for pain and function before patients start taking the medications. Providers and patients should also agree about when opioid therapy should stop. Providers should periodically review this agreement with patients and discuss the risks and benefits associated with continuing the opioid prescriptions. The CDC also recommends that providers evaluate patients for history of substance use disorder, consult state prescription drug monitoring programs, and offer evidence-based treatment for those with opioid use disorders.

4.0 Long-Term Opioid Use and Treatment

Despite the existence of these guidelines, alternative pain treatments, and lack of hard evidence about opioids' efficacy, long-term use of opioids exists due to patient and provider factors. Some providers still prescribe opioids for long-term use (NASEM, 2017). Some may do this, in part, because of the false belief that risk of opioid use disorders is low. Providers received marketing materials suggesting this was the case in the 1990s and beyond (NASEM, 2017). Providers may prescribe opioids, without

knowing about or considering pain management alternatives, or they may not have information about their patients' use of opioids. Patients may develop tolerance for prescription opioids and need more over time to relieve their pain. Opioids also produce feelings of pleasure and contentment so people who use them initially for pain may take higher amounts over time or self-medicate for stress, anxiety, depression, or other behavioral health conditions. As a result of these circumstances, there are chronic pain patients who receive opioids at high doses or under inappropriate circumstances (NASEM, 2017), likely with harmful side effects. These patients may need treatment for opioid use disorder.

4.1 Treatment for Opioid Use Disorder

If a person does develop a disorder, scientific evidence shows that substance use disorders, including opioid use disorder, can be treated effectively and recovery is possible (Surgeon General, 2016). Treatment requires a comprehensive, interdisciplinary set of solutions, which include: treating a person's individual needs, including pain control; providing readily available treatment, including medication-assisted treatment for opioid use disorder; ensuring sufficient length of treatment; and providing any necessary behavioral therapies.

The scientific literature strongly supports medication playing the central role in treating an opioid use disorder (NASEM, 2017). Current evidence-based guidelines recommend the use of medication-assisted treatment, which combines medication with counseling or other supportive services (VA/DOD, 2015; ASAM, 2015; Dowell et al., 2016). The data show that medications can lead to clinical improvements for patients and improvements in their quality of life (NASEM, 2017). Counseling may help people recover, but research does not support using counseling alone (NASEM, 2017). According to available evidence, the longer a person receives medication-assisted treatment, the better their health outcomes (NASEM, 2017).

The Food and Drug Administration has approved three drugs for medication-assisted treatment related to opioid use disorder (NASEM, 2017). Methadone and Buprenorphine reduce opioid cravings and withdrawal symptoms; and Naltrexone can reverse some of opioids' effects. Methadone is available through specialized outpatient treatment programs that the Substance Abuse and Mental Health Services Administration (SAMHSA) regulates and generally requires daily visits due to the medication's dispensing requirements. The law states that only physicians, nurse practitioners and physician assistants can prescribe Buprenorphine after obtaining a waiver from SAMHSA and the Drug Enforcement Administration. These practitioners are encouraged to provide psycho-social treatment and they have limits on the number of patients they can serve at any one time. Naltrexone has somewhat different effects than Methadone and Buprenorphine. Naltrexone may reduce cravings for opioids and the medication has little potential for abuse. If a person relapses and uses an opioid, Naltrexone can prevent the feeling of getting high. Any health care provider who is licensed to prescribe medications can prescribe Naltrexone. A fourth medication – Naloxone – is the standard of care for treatment of opioid overdose (NASEM, 2017). This medication blocks the effects of opioids and reverses respiratory and central nervous system problems associated with overdose. Naloxone is available in community settings in many states.

5.0 Federal Strategies to Address the Opioid Crisis

In 2017, the Department of Health and Human Services (DHHS) released a five point strategy to address the opioid crisis (DHHS, 2017). Those strategies are:

1. Improving access to prevention, treatment, and recovery services, including the full range of medication-assisted treatments.
2. Targeting availability and distribution of overdose-reversing drugs.
3. Strengthening our understanding of the crisis through better public health data and reporting.
4. Providing support for cutting edge research on pain and addiction.
5. Advancing better practices for pain management.

The federal government has many programs and policies that address this five point strategy. This section focuses on reducing demand through education and referral to opioid use disorder treatments because these strategies are consistent with Aging Network services.

5.1 Education

People appear to know little about opioids so providing education about the drugs is critical (NASEM, 2017). CDC guidelines (Dowell et al., 2016) recommend that people receive education about the risks and benefits of opioids, available pain management alternatives, and the responsibilities that patients and health care providers have for ensuring appropriate and effective use of opioids. The CDC (2014 and 2017) describes appropriate educational messages:

- Avoid taking prescription painkillers more often than prescribed.
- Dispose of medications properly, as soon as treatment is complete, and avoid keeping prescription painkillers or sedatives around.
- Store opioids in a secure place where others cannot get them.
- Help prevent misuse by not selling or sharing prescription medications. Never use another person's prescription medications.
- Get help for substance use problems by calling the SAMHSA Treatment Locator at 1-800-662-HELP.
- Call Poison Help 1-800-222-1222 with questions about medications.

Additionally, CDC has developed an awareness campaign, [Rx Awareness](#), which tells the real stories of people whose lives were torn apart by prescription opioids. The campaign is designed to: 1) increase

public awareness that prescription opioids can be addictive and dangerous, and 2) decrease the number of people who use opioids recreationally or overuse them.

SAMHSA and the Administration for Community Living (ACL) (2012) point to additional educational messages for older adults and their families and SAMHSA has [related resources](#):

- Use the correct opioid dose and only for as long as prescribed.
- Ask about possible side effects and when to report them.
- Read all medication-related information received before starting a new medication.
- Inform doctors and pharmacists about all medications used, including those sold over-the-counter, and about any alcohol use.
- Inform the doctor if a medication is not working. Other medications or nonpharmacologic approaches may be appropriate before opioid doses are increased.

5.2 Treatment

In addition to educating older adults about pain management and risks of opioid use, the Aging Network can inform them and their families, if appropriate, about coverage and availability of treatment for opioid use disorder. Medicare beneficiaries have access to certain treatments, while Medicaid beneficiaries' access depends upon their states' programs. In addition, the Department of Veterans Affairs (VA) has a comprehensive approach to pain treatment and opioid use available to older Veterans in its health system.

5.2.1 Medicare

Medicare covers certain medically necessary services when a beneficiary needs treatment for an opioid use disorder (CMS MLN, 2017) through various benefit categories, including:

- Diagnostic services
- Inpatient treatment and related professional services and medications
- Intensive outpatient psychiatric day treatment program, which is an alternative to inpatient psychiatric hospitalization or outpatient treatment, with medications that are not usually self-administered
- Counseling by a licensed professional, individual or group psychotherapy with state-licensed mental health professionals, and family counseling necessary for benefit of the patient
- Occupational therapy and individualized activity therapies that are not primarily recreational or diversionary

- Patient training and education related to the patient's care and treatment of the diagnosed psychiatric condition
- Drugs and biologicals that cannot be self-administered and are furnished for therapeutic purposes

Medicare covers another benefit - Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services (CMS, 2017). SBIRT is an early intervention for people using substances, which provides an effective intervention designed to prevent the unhealthy consequences of substance use. SBIRT can also help those with a disorder enter and stay in treatment. Primary care providers can use SBIRT services to screen and assist people who may not be seeking help for a substance use problem, but whose use of it may compromise their ability to successfully handle their health, work, or family issues.

5.2.2 Medicaid

State Medicaid programs' coverage of opioid use disorder treatment and supportive services varies across the country (MACPAC, 2017). Services include screening and early intervention, medication-assisted treatment, and Naloxone use. Coverage varies because many of the following services are optional: counseling, services provided by licensed clinical social workers, targeted case management, medication management, clinic services, prescription drugs, and peer and recovery supports. However, states that expanded Medicaid to the new adult group must cover mental health and substance use disorder services as an essential health benefit. In addition, the Mental Health and Addiction Equity Act applied to Medicaid in various ways requiring mental health and substance abuse services be covered in the same manner as medical/surgical services.

- Thirty-four states and the District of Columbia covered some part of screening, intervention, and referral in 2012.
- All states cover at least one of the three medications for treating opioid use disorder: methadone, buprenorphine, and naltrexone.
- Twenty-four states covered some type of psychotherapy, and 39 states and the District of Columbia covered some other type of therapy in 2015.
- Fourteen states covered some form of peer support for substance use disorders in 2015.
- Twenty-six state Medicaid programs listed Naloxone or its equivalent on their preferred drug lists or made at least one formulation available without prior authorization in 2016.

In addition to providing benefits, state Medicaid programs are using available options to address opioid use disorder (MACPAC, 2017). These include the: Section 1115 waiver; Section 2703 health homes option; the state plan rehabilitation option; and Section 1915(i) state plan option for home-and community-based services.

Medicaid also can cover alternatives to opioid treatment for pain management (MACPAC, 2017). In 2016, 12 states were encouraging or requiring the use of pain management therapies, such as non-steroidal anti-inflammatories, corticosteroids, antiepileptics, and antidepressants, cognitive-behavioral therapy, and exercise therapy.

In November 2017, CMS added to these options by releasing a State Medicaid Directors' letter about use of Section 1115 demonstration waivers (CMS, November 2017). States can design and must evaluate programs to improve access to high quality, clinically appropriate treatment for opioid use disorder and other substance use disorders. States can offer the "continuum of services to treat addiction to opioids or other substances, including services provided to Medicaid enrollees residing in residential treatment facilities."

5.2.3 Veterans Affairs (VA)

The VA has a comprehensive approach to addressing opioid use disorder for patients in its health system called "S.T.O.P. P.A.I.N." (VA, 2017). This acronym stands for:

- S - Stepped Care Model -it encourages a continuum of care from onset of pain through treatment. Self-management is part of this through participation in such groups as Narcotics Anonymous and through counseling. Treatment programs are available and involve primary care, and other medical specialists.
- T - Treatment alternatives/complementary care - this expands the availability of evidence-based treatment options, such as acupuncture, yoga, and progressive relaxation.
- - Ongoing monitoring of opioid use- this involves tracking and monitoring individual use of and risks of opioid therapy.
- P - Practice Guidelines - they provide clear and comprehensive evidence-based recommendations for practitioners to minimize harm and increase safety for patients requiring substance use disorder treatment and opioid therapy.
- P - Prescription monitoring - VA targets specific education in real time to providers and patients. The VA's tools enable identification of potential problems, educational targeting, and tracking of progress.
- A - Academic Detailing - one-to-one peer education program for front-line providers on practice, resources, opioid safety, and comparisons of providers' practice to those of their peers.
- I - Informed consent for patients - VA requires an informed consent process prior to long-term opioid therapy so that patients know the risks of opioid therapy, discuss opioid interactions with other medicines, and review safe prescribing practices such as urine drug screens.

- N - Naloxone distribution - education of providers on Naloxone distribution to veterans on long-term opioid therapy.

6.0 SAMHSA and CDC Funding of State and Local Activities

In addition to the availability of treatment under Medicare, Medicaid, and the Veterans Administration, many states have taken action to address the opioid public health crisis, generally with grants from SAMHSA and CDC, and often in partnership with the Aging Network.

As of 2015, 48 states' drug and alcohol agencies reported that they had state task forces involving a variety of stakeholders to address prescription drug misuse, and 48 had public education initiatives about the risks of opioids for the general public (Wickramatilake, 2017). Thirteen states had educational programs they targeted to older adults, which involved printed materials, internet campaigns, multimedia presentations, and other methods.

6.1 SAMHSA Funding

State governments administer SAMHSA's behavioral health grants through single state agencies. One of these grants is the Substance Abuse Prevention and Treatment Block Grant. These grants require state matching funds and support a publicly-funded substance use disorder prevention, treatment and recovery system in every state. Twenty percent of funds must go toward prevention. Single state agencies:

- Plan, organize, deliver, and monitor critical services in each state
- Promote quality by setting standards and collecting and reporting data
- Promote coordination across state government
- Maintain ongoing relationships with provider community

In Spring 2017, SAMHSA awarded \$485 million in grants through the State Targeted Response to the Opioid Crisis Grant Program (SAMHSA, 2017). The 21st Century CURES Act authorized these grants. Their purpose is to increase access to treatment, reduce unmet treatment need, and reduce opioid overdose related deaths through the provision of prevention, treatment and recovery activities for opioid use disorder (OUD). Two-year grants were awarded to all 50 states, the District of Columbia, four U.S. territories, and the free associated states of Palau and Micronesia. Some states have identified older adults as a priority population for their efforts.

SAMHSA also administers the Medication Assisted Treatment for Prescription Drug and Opioid Addiction program which expands access to medication assisted treatment by providing grants to states with the highest rates of treatment admissions for opioid addiction. Twenty-two states currently have these

grants and, in September 2017, SAMHSA awarded \$35 million dollars in these grants to six states (Altman, 2017).

SAMHSA also provides a number of funding streams that can be used to expand access to naloxone (Altman, 2017). States are able to use State Targeted Response to the Opioid Crisis funds to purchase and distribute naloxone, and some states are also using a portion of their Substance Abuse Block Grant funds for opioid overdose prevention activities. SAMHSA is currently providing \$11 million per year in Grants to Prevent Prescription Drug/Opioid Overdose Related Deaths to 12 states. These grants are also being used to train first responders on emergency medical care to be rendered in an overdose situation and how to administer naloxone as well as how to purchase and distribute naloxone. In September 2017, SAMHSA awarded \$46 million in grants, which the Comprehensive Addiction and Recovery Act authorized. Under this Act, grantees in 22 states will provide resources to first responders and treatment providers who work directly with the populations at highest risk for opioid overdose.

6.2 CDC funding

As of 2017, 44 states and Washington, DC are working on public health prevention efforts aimed to build state, local, and tribal capacity; support providers, health systems, and payers; empower consumers to make safe choices; partner with public safety; and conduct surveillance and research. Through the [Overdose Prevention in States](#) effort, CDC is working with 45 state health departments and Washington D.C. to provide scientific expertise, enhanced surveillance activities, and support resources. Among the many activities this program funds are efforts to:

- Report non-fatal and fatal opioid overdoses more quickly, identify hot spots, and rapidly respond with targeted resources
- Identify risk factors for fatal overdoses
- Share data with key stakeholders also working on prevention activities
- Share CDC's [Rx Awareness](#) communication campaign to increase awareness and knowledge among consumers about the risks of prescription opioids.

CDC's Overdose Prevention in States effort includes three programs that equip states with resources needed to address the epidemic. The three programs are: [Prescription Drug Overdose: Prevention for States](#), [Data-Driven Prevention Initiative](#), and [Enhanced State Opioid Overdose Surveillance](#). The resources and information from these programs help combat prescription and illicit opioid use and overdose and is the heart of the CDC's work on the opioid epidemic.

6.2 Aging Network Innovations

The Aging Network has been working with its partners at the state and local levels to address the opioid public health emergency. The examples in this section are designed to inform the entire Network about

possibilities they might consider. This section contains descriptions of innovative programs in four states: Arizona, Colorado, Nevada, and New Hampshire.

Arizona's State Targeted Response grant is focused on "Increasing prevention and treatment activities to reduce opioid use disorders and opioid-related deaths" (State of Arizona, 2017). Under this goal, there are three objectives for older adults:

- Objective 2.4: By August 31, 2017, a total of 20 Area Agencies on Aging staff will be trained in two evidence-based programs - Wellness Initiative for Senior Education (WISE) and Mental Health First Aid.
- Objective 2.5: By April 30, 2019 increase health care empowerment and medication management by WISE Program participants, as measured by pre-post program evaluations.
- Objective 2.6: By April 30, 2019, increase awareness of unique risk factors and warning signs of mental health problems in adults over the age of 65 by Mental Health First Aid for Older Adult participants, as measured by pre-post training evaluation.

In October 2017, the **Colorado** State Unit on Aging and the State Department of Public Health and Environment, in collaboration with the U.S. Drug Enforcement Administration, partnered in the *National Prescription Drugs Take Back Day*. Their efforts were intended to discourage misuse of opioids and other medications through the safe disposal of unwanted medications. Local health and human services agencies, including Area Agencies on Aging, provided outreach and education about the opioid crisis, and partnered with hundreds of drop off sites throughout the state to encourage older adults to dispose of unneeded medications (Colorado Prescription Take Back Program, 2017). The *2016 National Prescription Drug Take Back Day* netted over 900,000 pounds of prescription medications nationally (U.S. Department of Justice, 2016).

Nevada has also targeted efforts to older adults by using a multidisciplinary team to address opioid use disorder prevention and intervention among older adults (State of Nevada, 2017). The Nevada Department of Health and Human Services, Aging and Disability Services Division also is funding the University of Nevada, Reno, Sanford Center on Aging, Geriatric Medication Management program for individuals over 60 (Sanford Center on Aging, 2017). The program provides individuals with a comprehensive medication evaluation by a geriatric pharmacist – who then works with caregivers and prescribing physicians to recommend changes and address any potential safety concerns.

New Hampshire has a statewide program called the Referral, Education, Assistance and Prevention Program (REAP) (Pepin et al., 2014). REAP is supported through a partnership between New Hampshire Housing and three programs in that state's Department of Health and Human Services. REAP counselors, who are located in New Hampshire's ten community mental health centers, offer free and confidential, home-based counseling to adults age 60 and older, as well as to family members or caregivers with concerns about an older adult. Counseling is offered on a wide range of personal concerns: grief and loss, the use of alcohol or medications, medication safety, housing and safety concerns, and more. Last year, 2,117 individuals received assistance through REAP (Kinsey, 2017). In

addition, REAP counselors provide group education sessions in senior housing and other venues where older adults gather, and provide technical assistance to housing managers and other service providers in the Aging Network. REAP counselors have provided support for older adults at risk for or experiencing opioid addiction, as well as assisted older adults who have assumed primary caregiving responsibilities for grandchildren as a result of opioid abuse within the family.

Programs, such as those in Arizona, Colorado, Nevada, and New Hampshire point to some of the potential directions that states and localities can take to address long-term opioid use among older adults. In 2012, SAMHSA and ACL made the following additional suggestions to the National Aging Network (SAMHSA/AoA, 2012):

- Integrate screening and brief interventions into existing programs, such as medication reviews.
- Know the substance use prevention and treatment service providers in their areas and build relationships with them.
- Implement depression and pain management programs, such as Healthy IDEAS, PEARLS, and the Chronic Pain Self-Management Program, to address older adults' pain experience. For program descriptions please visit [The Evidence-Based Leadership Council](#). In 2017, ACL funded two grantees to focus on opioid use among older adults. The Utah Department of Health will be collaborating with stakeholders to offer the Chronic Pain Self-Management Program for patients misusing prescription opioids. In California, Partners in Care is collaborating with organizations to target adults with opioid addiction for enrollment in CPSMP workshops (ACL, 2017).

7.0 Conclusion

Older adults, like people of any age, are at risk of misusing prescription opioids and acquiring an opioid use disorder. Older adults are likely to receive prescriptions for opioids due to chronic, painful conditions that often accompany age. When this population uses opioids, they may experience particularly severe side effects because bodily processes generally slow with age. Fortunately, there are proven alternatives to opioids for pain relief. In addition, those who have opioid use disorder may benefit from the evidence-based medication assisted treatments that are available. The Aging Network and its partners can help older adults receive information about opioids and their appropriate use and can refer people to treatment programs. Many states and Aging Network partners have already begun to take steps in these directions.

References

- Altman B., personal communication. November 29, 2017.
- Altman, B., Weakly, E., *Spotlight on Older Adults and Behavioral Health*, Substance Abuse and Mental Health Services Administration Presentation on September 16, 2017
- Altman, D.E., Fineberg, H.V., Gold, M.S., Greenfield, S.F., Kabler, E.R., Lynk, M. and Sullivan, L.W., 2012. *Addiction medicine: Closing the gap between science and practice*. Columbia University, The National Center on Addiction and Substance Abuse, New York, NY.
- American Psychiatric Association. 2013. *Diagnostic and statistical manual of mental disorders (DSM-5®)*. American Psychiatric Pub.
- ASAM (American Society of Addiction Medicine). 2015. *The ASAM National Clinical Guidelines for the Use of Medications in the Treatment of Addiction involving Opioid Use*. Chevy Chase, MD.
- Brennbekken, R., Eriksen, H. R., Grasdahl, A., Harris, A., Hagen, E. M., Tangen, T. (2017). Return to work in patients with chronic musculoskeletal pain: Multidisciplinary Intervention versus Brief intervention: A Randomized Clinical Trial. *Journal of Occupational Rehabilitation*, 27(1), pp. 82-91.
- CDC (Centers for Disease Control and Prevention). 2017. *CDC Vital Signs July 2017*
- CDC (Centers for Disease Control and Prevention). 2014. *CDC Vital Signs July 2014*
- CMS (Centers for Medicare & Medicaid Services). January 5, 2017. *Opioid Misuse Strategy*.
- CMS (Centers for Medicare & Medicaid Services). March 2017. *Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services*.
- CMS/MLN (Centers for Medicare & Medicaid Services/ Medicare Learning Network). July 24, 2017. *MLN Matters, Medicare Coverage of Substance Abuse Services, Number: SE1604*.
- CMS State Medicaid Directors Letter # 17-003. November 1, 2017. *Strategies to Address the Opioid Epidemic*.
- [Colorado Prescription Take Back Program](#). 2017. Accessed November 1, 2017.
- Chau, D.L., Walker, V., Pai, L. and Cho, L.M., 2008. Opiates and Elderly: Use and Side Effects. *Clinical Interventions in Aging*, 3(2), pp.273.
- DHHS (Department of Health and Human Services). 2017. *Opioids: The Prescription Drug & Heroin Overdose Epidemic*.
- DHHS/OIG (Department of Health and Human Services/Office of the Inspector General). 2017. *Opioids in Medicare Part D: Concerns about Extreme Use and Questionable Prescribing*.
- Dowell D, Haegerich TM, Chou R. *CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016*. MMWR Recomm Rep 2016; 65 (No. RR-1):1–49.
- Dowell, D., Haegerich, T.M. and Chou, R., 2016. CDC guideline for prescribing opioids for chronic pain— United States, 2016. *JAMA*, 315(15), pp.1624-1645.

Ehde, D. M., Elzea, J. L., Verrall, A.M., Gibbons, L. E., Smith, A. E., Amtmann, D. (2015). Efficacy of a telephone-delivered self-management intervention for persons with multiple sclerosis: A randomized controlled trial with one-year follow-up. *Archives of Physical Medicine and Rehabilitation*, 96(11), pp. 1945-1958, 1958.e1-1958.e2.

Frenk, S.M., Porter, K.S. and Paulozzi, L., 2015. *Prescription opioid analgesic use among adults: United States, 1999-2012* (No. 2015). US Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics.

Girard, C., June 22, 2017. *The Opioid Epidemic and Its Impact on Older Adults*, Presentation before the Administration for Community Living Regions 1 and II. Massachusetts Department of Public Health.

Kinsey, Jennifer. Older Adult Services Director at the Seacoast Mental Health Center and Director of the New Hampshire REAP Program. Personal communication with Shannon Skowronski on November 6, 2017.

Larney, S., Bohnert, A.S., Ganoczy, D., Ilgen, M.A., Hickman, M., Blow, F.C. and Degenhardt, L., 2015. Mortality among older adults with opioid use disorders in the Veteran's Health Administration, 2000–2011. *Drug and Alcohol Dependence*, 147, pp.32-37.

LeFort, S.M., Gray-Donald, K., Rowat, K.M. and Jeans, M.E., 1998. Randomized controlled trial of a community-based psychoeducation program for the self-management of chronic pain. *Pain*, 74(2), pp.297-306.

Le Roux, C., Tang, Y. and Drexler, K., 2016. Alcohol and opioid use disorder in older adults: neglected and treatable illnesses. *Current Psychiatry Reports*, 18(9), p.87.

Mattson, M., Lipari, R.N., Hays, C. and Van Horn, S.L., 2017. A day in the life of older adults: Substance use facts. *The CBHSQ Report: May*, 11.

Maree, R.D., Marcum, Z.A., Saghafi, E., Weiner, D.K. and Karp, J.F., 2016. A systematic review of opioid and benzodiazepine misuse in older adults. *The American Journal of Geriatric Psychiatry*, 24(11), pp.949-963.

MACPAC (Medicaid and CHIP Payment and Access Commission) *Report to Congress on Medicaid and CHIP, Chapter 2: Medicaid and the Opioid Epidemic*. June 2017.

Molton, I., & Terrill, A., 2014. Overview of Persistent Pain in Older Adults. *American Psychologist*, 69(2), pp. 197-207.

Mojtabai, R., 2017. National trends in long-term use of prescription opioids. *Pharmacoepidemiology and Drug Safety*.

NASEM (National Academies of Sciences, Engineering, and Medicine). 2017. *Pain Management and the Opioid Epidemic: Balancing Societal and Individual Benefits and Risks of Prescription Opioid Use*.

Pepin, R., Hoyt, J., Karatzas, L. and Bartels, S., 2014. New Hampshire REAPs results: Tailored outreach program assists older adults at risk for mental health conditions and substance misuse. *Generations*, 38(3), pp.68-74.

Saha, T.D., Kerridge, B.T., Goldstein, R.B., Chou, S.P., Zhang, H., Jung, J., Pickering, R.P., Ruan, W.J., Smith, S.M., Huang, B. and Hasin, D.S., 2016. Nonmedical prescription opioid use and DSM-5 nonmedical prescription opioid use disorder in the United States. *The Journal of Clinical Psychiatry*, 77(6), pp.772-780.

SAMHSA (Substance Abuse and Mental Health Services Administration). (2017). *Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health*.

SAMHSA (Substance Abuse and Mental Health Services Administration) and AoA (Administration on Aging). 2012. *Older Americans Mental Health Issue Brief 5: Prescription Medication Misuse and Abuse Among Older Adults*.

SAMHSA (Substance Abuse and Mental Health Services Administration). 2017. [State Targeted Response to Opioid Crisis Grants](#). Accessed on November 1, 2017.

Sanford Center for Aging. 201). [Medication Management Program](#). Accessed on November 1, 2017.

State of Arizona. 2017. [Arizona Opioid STR Project Narrative](#). Accessed on November 1, 2017.

State of Nevada. 2017. [Governor's Opioid State Action Accountability Taskforce](#). Accessed on November 1, 2017.

Surgeon General (U.S. Department of Health and Human Services (HHS), Office of the Surgeon General), *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*. Washington, DC: HHS, November 2016.

U.S. Department of Justice. 2017. [Drug Enforcement Administration \(DEA\) Prepares for Prescription Drug Take Back Day](#). Accessed on November 1, 2017.

VA (Department of Veterans Affairs). 2017. News Release. *VA Answers Governor Christie's Call on Opioids, Launches S.T.O.P. P.A.I.N Advice and Guidelines*, August 1, 2017

Department of Veterans Affairs and Department of Defense (VA/DoD). 2015. *VA/DoD clinical practice guideline for management of substance use disorders*. Washington, DC.

Weiss A.J., Bailey M.K., O'Malley L., Barrett M.L., Elixhauser A., Steiner C.A., *Patient Characteristics of Opioid-Related Inpatient Stays and Emergency Department Visits Nationally and by State, 2014*. HCUP Statistical Brief #224. June 2017. Agency for Healthcare Research and Quality.

Wickramatilake, S., Zur, J., Mulvaney-Day, N., Klimo, M.C.V., Selmi, E. and Harwood, H., 2017. How states are tackling the opioid crisis. *Public Health Reports*, 132(2), pp.171-179.

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