



Summary of ACL Stakeholder Discussion: Opioid Public Health Emergency

March 7, 2018

Introduction

Vicki Gottlich described the Administration for Community Living's (ACL) issue brief on the opioid public health emergency as part of an ACL series of issue briefs that promote independent living in the community for older adults and people with disabilities. The emergency is a priority for the Administration, Department of Health and Human Services (DHHS), ACL, and every operating division has a role in addressing the emergency. Across ACL we are working together to determine how best to help our aging and disability stakeholders and this meeting will be helpful to this effort. The meeting is a product of a collaboration among ACL's Center for Policy and Evaluation, the Administration on Aging, and the National Institute for Independent Living and Rehabilitation Research (NIDILRR), along with other colleagues across ACL.

Attendees introduced themselves and gave their organizational affiliation. In addition to ACL staff, 16 stakeholders attended the call:

- 2 stakeholders represented national organizations primarily serving older adults;
- 3 stakeholders represented national organizations primarily serving people with disabilities;
- 3 stakeholders represented national organizations serving both older adults and people with disabilities;
- 2 stakeholders represented regional centers primary serving older adults; and
- 6 stakeholders represented regional centers primary serving specific populations of people with disabilities [intellectual and developmental disabilities, serious mental illness, spinal cord injury, traumatic brain injury, burn injury].

Shannon Skowronski, one of the co-authors of ACL's issue brief, summarized it and emphasized that the opioid emergency affects people of all ages and types. While ACL found data on opioid use among older adults, data on younger people with disabilities were not readily available. Regarding older adults, as people age, their absorption of and reactions to opioids change and older adults are more likely to experience chronic pain and take multiple medications that may interact with opioids more than other age groups. While stepped therapy is the preferred approach to pain management, reimbursement for alternatives to opioids can be very limited. DHHS has a five-point strategy to address the opioid emergency.¹

Sarah Ruiz, one of the co-authors of ACL's issue brief, discussed NIDILRR's Request for Information on people with disabilities and opioid use. She said the impetus for the Request for Information was the paucity of data on people with disabilities. NIDILRR heard from a wide range of stakeholders and learned a great deal from the "grey literature," which indicates that opioid use affects people with disabilities due to their conditions and health care access challenges. NIDILRR will produce a report based on this Request for Information in two months.

¹ The strategy was unveiled in April 2017 <https://www.hhs.gov/about/leadership/secretary/speeches/2017-speeches/secretary-price-announces-hhs-strategy-for-fighting-opioid-crisis/index.html>

Clarifying question about the presentations:

- What is the definition of opioid use disorder in the ACL issue brief? The definition appears in the introductory section of the issue brief and it paraphrases the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition definition of opioid use disorder, by describing symptoms of the disorder.² Authors clarified that long-term use of opioids is not automatically considered an opioid use disorder.

General discussion

The below table summarizes common themes during the two hour stakeholder meeting and examples of those themes.

Theme (# of times mentioned)	Examples
Dual diagnosis (3)	<p>-There are large populations who have a dual diagnosis. For example, serious mental illness and intellectual and developmental disabilities: 35% of people on Social Security Disability Insurance (SSDI) have a serious mental illness and 30% of those with intellectual and developmental disabilities have such illnesses.</p> <p>-Every state has state-operated programs that provide services for people with mental health challenges, intellectual and developmental disabilities, and alcohol/drug abuse and these programs serve dual diagnoses. It is critical to integrate substance abuse and mental health for meaningful coordination across the silos at the state level.</p>
Education (8)	<p>-Eldercare Locator (www.eldercare.gov) could be a useful tool to educate the aging and disability networks on medication safety and opioid use disorder.</p> <p>-There's a need for a curriculum on safe medication use that can be easily integrated into existing health education programs.</p> <p>-There's a need for vehicles to disseminate research through knowledge translation to constituents.</p> <p>-Some community organizations provide guidance on safe disposal locations and provide medication reconciliation. How can this be expanded?</p> <p>-A current Administration on Aging program - Chronic Pain Self-management program - has updated their curriculum and now provides an appendix on opioid use and tapering.</p> <p>-Need for provider education about differences in how to respond to pain in disability populations</p>
Prevalence (5)	<p>-Data is needed on what populations are successfully using opioids. What are their characteristics?</p> <p>-There's a need for information on older adults with SCI and opioid use and their outcomes.</p> <p>-Some single site data comparing pain interference in people with burn injuries, traumatic brain injury, and spinal cord injury suggest that patients with burns have higher pain at 1 year. Could opioid use be a problem for people with burn injuries?</p> <p>-Several clinicians observed regional differences in pain medication prescribing patterns. How do factors such as payer mix contribute to these differences?</p>

² For more information, see <https://www.samhsa.gov/disorders/substance-use>

Theme (# of times mentioned)	Examples
Treatment strategies (13)	<p>-Evidence from a recent Patient-Centered Outcomes Research Institute study on fibromyalgia suggests that cutting off opioids without appropriate psychosocial supports and pain alternatives results in loss in function, suicidal ideation, as well as marital and employment challenges.</p> <p>-There are no protocols for appropriate tapering strategies for coming off opioids for older adults or people with disabilities. Strategies must include pain management. Several recent studies by Beth Darnall at Stanford have shown success with involuntary tapering.</p> <p>-BRITE³ (Brief Intervention and Treatment for Elders) is aimed at substance abuse disorder and can be implemented by those in the aging or disability network. It can identify those at risk but there's not a lot of funding for the program across the country.</p> <p>-SBIRT⁴ (Screening, Brief Intervention, and Referral to Treatment) is a useful program that is reimbursed by Medicaid and includes an important piece on prescriber education.</p> <p>-Medication therapy management is a required program under Medicare part D and can identify those at risk.</p> <p>-Peer support recovery specialists have been shown to improve outcomes for people with dual diagnoses.</p> <p>-Extensive resources through Substance Abuse and Mental Health Services Administration (SAMHSA), Health Resources and Services Administration (HRSA), and the Agency for Healthcare Research and Quality (AHRQ) on integration of behavioral health and primary care. How can these care management protocols be used to address opioid emergency?</p> <p>-We do not know enough about older adults who appear in emergency departments with addiction and what strategies are being used (if any) to get these older adults into treatment. Medicare does not pay for outpatient treatment.</p> <p>-Children exposed to opioids in utero are more likely to experience developmental delays and these children are being referred to state programs but there is no long-term data on their trajectory or what treatments work for them. These children also sometimes experience trauma or neglect from a parent who is an opioid abuser.</p> <p>-NIDILRR model system programs (traumatic brain injury, spinal cord injury, burn injury) have been following trajectories post-injury for which pain medication are required. This information could inform training tools for consumers and also for primary care physicians who see people with spinal cord injury, traumatic brain injury, and burn injuries.</p> <p>-New research on people with spinal cord injury suggests there are personality traits associated with people at greater risk for opioid misuse. These same personality traits put them at greater risk for traumatic injury to begin with. Research needs to consider personality, behavioral, and environmental characteristics of users on a larger spectrum.</p>

³ <https://www.ncoa.org/resources/program-summary-brief-intervention-treatment-for-elders-brite/>

⁴ <https://www.integration.samhsa.gov/clinical-practice/sbirt>

Theme (# of times mentioned)	Examples
Unintended consequences (4)	<p>-One national organization spoke of “ripple effects” of the opioid emergency, such as growing number of grandparents raising grandchildren, suspected increases in elder abuse, etc.</p> <p>-People with disabilities often report problems with Medicaid paying for medically necessary services. Policy changes to Medicaid and tighter regulations on opioids have had a negative impact on people with disabilities trying to successfully manage pain.</p>
Unintentional deaths (2)	<p>-Recent published literature suggests certain groups (traumatic brain injury/spinal cord injury) may disproportionately experience unintentional deaths due to medications but this is not necessarily precipitated by an opioid use disorder.</p> <p>-Recent study suggests people with traumatic brain injuries are 10 times more likely to die from a medication overdose.</p>

What more do we need to know about OUD and older adults and people with disabilities?

- What treatments are people using for pain and how does that vary by region?
- What are the legitimate uses of opioids for older adults and people with disabilities and what do we know about people who are successfully using opioids?
- What is the prevalence of opioid use among people with mental illness and what is the impact on them? 35% of people on SSDI have a serious mental illness and 30% of people with intellectual and developmental disabilities have a co-occurring serious mental illness.
- What is the prevalence of opioid use among people with spinal cord injury and what is the impact on them?
- What percentage of prescription opioid deaths are due to unintentional poisonings? This a particular problem for people with traumatic brain injury because they often have difficulty managing opioids due to cognitive impairment. A 2015 study showed that 60 to 70% of those with TBIs are discharged from institutions with an opioid and this group is 10 times more likely to die of accidental poisonings than people in general.
- What are the results of older adults or people with disabilities losing access to opioids and not having access to other methods of pain management? One study found that 37% of those aged 50 to 70 who lose access to their prescription opioids experience suicidal ideation and their personal and work lives disintegrate.
- What are effective strategies to get older adults to recognize the risks associated with opioid use, and to taper them off opioids?
- Related to medication-assisted treatment, what are the barriers to treatment for older adults and people with disabilities? Medicare does not cover outpatient treatment and Medicaid coverage is uneven.
- What do we know about the secondary effects of the opioid emergency in terms of grandparents raising grandchildren, elder abuse, and effects on a person’s disability? Also, how do we best treat children who are exposed to opioids in utero and experience withdrawal and developmental delays after birth?

What could be the roles of the Aging and Disability Networks in the opioid public health crisis?

- Disabilities can train providers, agencies, and Medicare Part C and D programs about pain management and safe medication practice and develop curricula that can be integrated with provider health education.
- The Networks could:
 - Make connections with mental health, primary care, and other providers who deal with the opioid emergency.
 - Disseminate programs and models, and relevant research to providers, and state and local health organizations.
 - Become more comfortable serving populations with substance use disorders
 - Promote collaboration and integration among Intellectual and Developmental Disability, Mental Health, Alcohol and Drug Abuse and Medicaid agencies on the emergency.
- Provide the following services:
 - Inform people about how and where they can store their medications and dispose of their unused ones. Use of the Eldercare Locator to identify safe disposal options would be important for older adults.
 - Offer chronic disease self-management and chronic pain self-management programs. Both programs are being updated with material on opioids.
 - Promote use of Screening, Brief Intervention, and Referral to Treatment , which is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.
- Reach out to health care providers (doctors, nurses, pharmacists) to educate them about the opioid public health emergency.

What recommendations are there for possible ACL activities related to the emergency?

- Use ACL clearinghouses, resource centers, and its communication systems to educate older adults and people with disabilities about the opioid public health emergency.
- Promote collaboration among disability research groups to share pain management strategies for people with different types of disabilities and to share this information with health care providers.
- Promote SAMHSA's training of peer recovery specialists to be more effective in the area of inappropriate substance use.
- Explore and help facilitate transitions from various types of health care coverage to Medicare. States, providers, and patients struggle with the breaks in coverage between Medicaid and private health plans and Medicare when it comes to pain management and opioid use disorder treatments.
- Determine what models pharmacists are using to work with the Aging and Disability Networks on substance and opioid use disorders to identify people who are at risk of same and disseminate those models.
- Promote education about pain management, opioids, and opioid use disorder treatment protocols at medical schools.

- Create a task force that cuts across disability groups and develop a strategic plan to deal with the emergency and produce a research plan.

Outstanding Research Questions

- How do we modify self-management protocols for people who have cognitive impairment? How does brain injury affect the success of treatment?
- What do health care providers need to know to treat their patients’ pain without resorting to opioids?
- What are the best alternatives to opioids to manage chronic pain for older adults and people with disabilities?

Suggest Actions

The table below summarizes requested actions by stakeholders.

Action Requested	Possible Strategy
Task Force on Opioids for Older Adults and People with Disabilities	-Led by ACL and including experts from federal partners, the task force could cut across disability types and develop a strategic plan.
Issue Brief on Cross-Cutting Lessons from NIDILRR’s Model Systems	-The Spinal Cord Injury model system has a similar effort underway and NIDILRR could present this first brief to the other model systems for expansion/refinement.
Best Practices in “warm hand-offs” between Medicaid and Medicare as individuals turning 65	-ACL could connect with Centers for Medicare & Medicaid Services on this area to understand if there are best practices to share with the network.
Information sharing across federal and state health care programs	-Work with Centers for Medicare & Medicaid Services to evaluate how to provide state Medicaid programs with timely information on Medicare opioid prescriptions as well as Medicare funded treatment for opioid abuse and addiction. This information could be shared for dual eligible individuals as well as retrospectively for those who are already Medicare eligible at the time of Medicaid eligibility.
Create ACL resource summarizing efforts across the federal government	-Create a “living document” summarizing efforts specific to the opioid emergency and older adults and people with disabilities to keep the network informed.
ACL partnership with professional organizations to understand current research projects	-NIDILRR currently partners with American Congress of Rehabilitation for several activities and could learn from their pain management group or have selected committees comment on results from the Request for Information.
Funding specific to the opioid emergency and people with disabilities	-ACL subcomponents to consider the potential for near- term funding on the opioid emergency.

Next steps

- ACL will summarize the meeting and circulate it to invitees and attendees for comment and clarification.
- ACL plans to learn from the input we receive from this group as we shape our response to the opioid public health emergency.

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