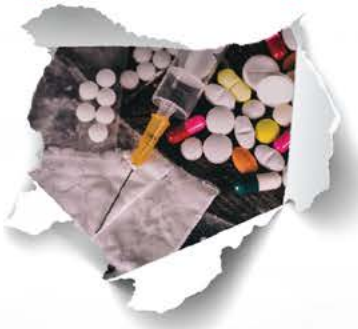
HEARTACHE, PAIN, AND HOPE:

Rural Communities, Older People, and the Opioid Crisis

An Introduction for Funders



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ABOUT OUR SPONSORS

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About Empire Health Foundation

Empire Health Foundation is a private health conversion foundation formed in 2008 through the sale of Deaconess and Valley Medical, a nonprofit hospital system in Spokane. Stewarding philanthropic assets totaling approximately $75 million, the Foundation invests in ideas and organizations that improve health access, education, research and policy to result in a measurably healthier region. Empire Health Foundation provides funding support in Adams, Lincoln, Ferry, Stevens, Pend Oreille, Whitman, and Spokane counties, and the Spokane, Kalispel, and Colville Indian Reservations. Learn more at **empirehealthfoundation.org**.

About Grantmakers In Aging

Grantmakers In Aging (GIA) is an inclusive and responsive membership organization comprised of all types of philanthropies with a common dedication to improving the experience of aging. GIA members have a shared recognition that a society that is better for older adults is better for people of all ages. For more information, please visit **GIAging.org**.

About Creating a Sustainable Network for the Rural Aging Movement

To accelerate and expand an emerging drive to improve the experience of rural aging, GIA is leading a three-year program, Creating a Sustainable Network for the Rural Aging Movement. GIA's work on the opioid epidemic, including this report, is part of this initiative. The initiative seeks to connect and support key players concerned with rural aging, share knowledge, expand the resources and services available to older adults in rural areas, and is supported by a grant from Margaret A. Cargill Philanthropies. For more information, please visit **GIAging.org/rural-aging**.

EPIDEMIC: A STORY OF PAIN

The opioid crisis is the story of many types of pain. It's about how well-meaning efforts to kill pain began to kill people instead. How chronic pain can hijack everyday life and medical care. How legal prescriptions can inadvertently lead patients to illegal street drugs. How individuals, families, even entire communities – particularly small and rural ones – can become collateral damage. Above all, how government, nonprofits, industry, and the medical profession must work together, considering the needs of many different kinds of people and tapping the ingenuity of experts and communities alike, to craft responsive solutions.

Opioids are the **most frequently** prescribed type of medication in the United States. They are painkillers that **include** codeine, morphine, OxyContin, Vicodin, Demerol, and methadone, as well as synthetic opioids like Fentanyl and Carfentanyl. Heroin, an illegal drug, is also an opioid.

Since the year 2000, an estimated 300,000 people have **died** of an opioid-related overdose. An **estimated** 2 million Americans have an **opioid use disorder**, and another 591,000 are addicted to heroin. (Opioid use has also become a powerful **risk factor** for heroin addiction.) ▶(See Box: Opioids by the Numbers.)

This document contains two major sections. The first, Places, People and Systems: Understanding the Problem, looks at the crisis arising from opioids in rural communities and, in particular, the damage it is causing in the lives of many older people. The second section, Governments, Communities, and Funders Respond, turns toward solutions, looking at a wide range of hopeful responses that governments, communities, and funders are already starting to put into place, and which cry out for scale and support.

It is telling that those who know the most about this problem are the most emphatic, such as Dr. Tom Frieden, who directed the Centers for Disease Control and Prevention (CDC) until early 2017. He has **called** the opioid epidemic, "one of the most heartbreaking problems I faced," **adding** that it is the only major aspect of American health that is getting "significantly worse."

FOR MORE BACKGROUND

For a more detailed look at the research and statistical background on this issue, please explore *Raising Awareness and Seeking Solutions to the Opioid Epidemic's Impact on Rural Older Adults*, prepared for Grantmakers In Aging by William F. Benson and Nancy Aldrich of Health Benefits ABCs.

To learn more, please go to **bit.ly/GIA_opioid_research.**

OPIOIDS BY THE NUMBERS

While awareness of the opioid problem is improving, **outcomes** are not. Most trends are still going in the wrong direction.

In 2015 alone, opioid-related overdoses **killed** more than 33,000 people. Nearly **half** involved prescription drugs.

To put that figure in perspective, the total number of recorded **homicides** in America in the same year was less than half as large. In its worst year (1995), **HIV/AIDS** took 43,000 lives. The entire Vietnam War **claimed** about 58,000 American lives.

PLACES, PEOPLE, AND SYSTEMS:
Understanding The Problem

Small Towns, Huge Impact

In rural America, the opioid toll is especially high. Rural America is noted both for its particular challenges and its quiet strength. The rural population is diverse, and is generally poorer and older than its urban neighbors. Many rural communities are tight-knit and self-reliant, their infrastructure and resources are often limited, and they are frequently overlooked in national debate and policymaking.

This has been a dangerous mix when it comes to opioids. No part of the country has been spared, but the opioid crisis has been particularly rampant in rural Appalachia, New England, and the Midwest. The six **states** with the highest drug overdose rates in 2015 were West Virginia, New Hampshire, Kentucky, Ohio, Rhode Island, and Pennsylvania. According to the **CDC**, for a variety of reasons, people in rural counties are nearly twice as likely to overdose on prescription painkillers as people in cities.

IT TAKES A COMMUNITY: Project Lazarus

Project Lazarus is based on two ideas: that drug overdose deaths are preventable, and that all communities are ultimately responsible for their own health.

Established in 2008 in rural Wilkes County, North Carolina, by Fred Wells Brason II, a former hospice chaplain, Project Lazarus offers help to individuals and training to communities and clinicians. It emphasizes tailoring responses to local needs and building broad coalitions that include emergency room physicians, local hospitals, primary care doctors, faith-based programs, and law enforcement.

"I say [to communities], 'I can help you, but I can't do it for you," **says** Brason, a 2012 Robert Wood Johnson Community Health Leader award **recipient**.

Early results were stunning, including a 69 percent drop in overdose deaths.

The program then **received** $2.6 million in 2013 from the Kate B. Reynolds Charitable Trust to broaden and adapt the work statewide. Administered by **Community Care of North Carolina**, the North Carolina Office of Rural Health, and the Foundation for Health Leadership and Innovation, similar strategies were employed across all 100 North Carolina counties, the Cherokee Nation, and the U.S. Army's Wounded Warrior Program at Fort Bragg.

In June 2017, North Carolina unveiled a statewide **Opioid Action Plan**.

WHEN EVERY MINUTE COUNTS:
Access To Antidotes

Opioids kill by depressing respiration – the user may pass out, breathe too slowly, or stop breathing altogether. Death can be prevented with a prompt dose of the antidote naloxone, or Narcan.

Naloxone can be given by injection (the fastest and most effective way) or by nasal inhalant, but only 13 U.S. states allow emergency responders with anything less than the most advanced qualifications to give it by injection. These individuals are rare in rural counties.

The CDC has **recommended** training Emergency Medical Technicians (EMTs) at all levels and helping basic EMTs get advanced certification.

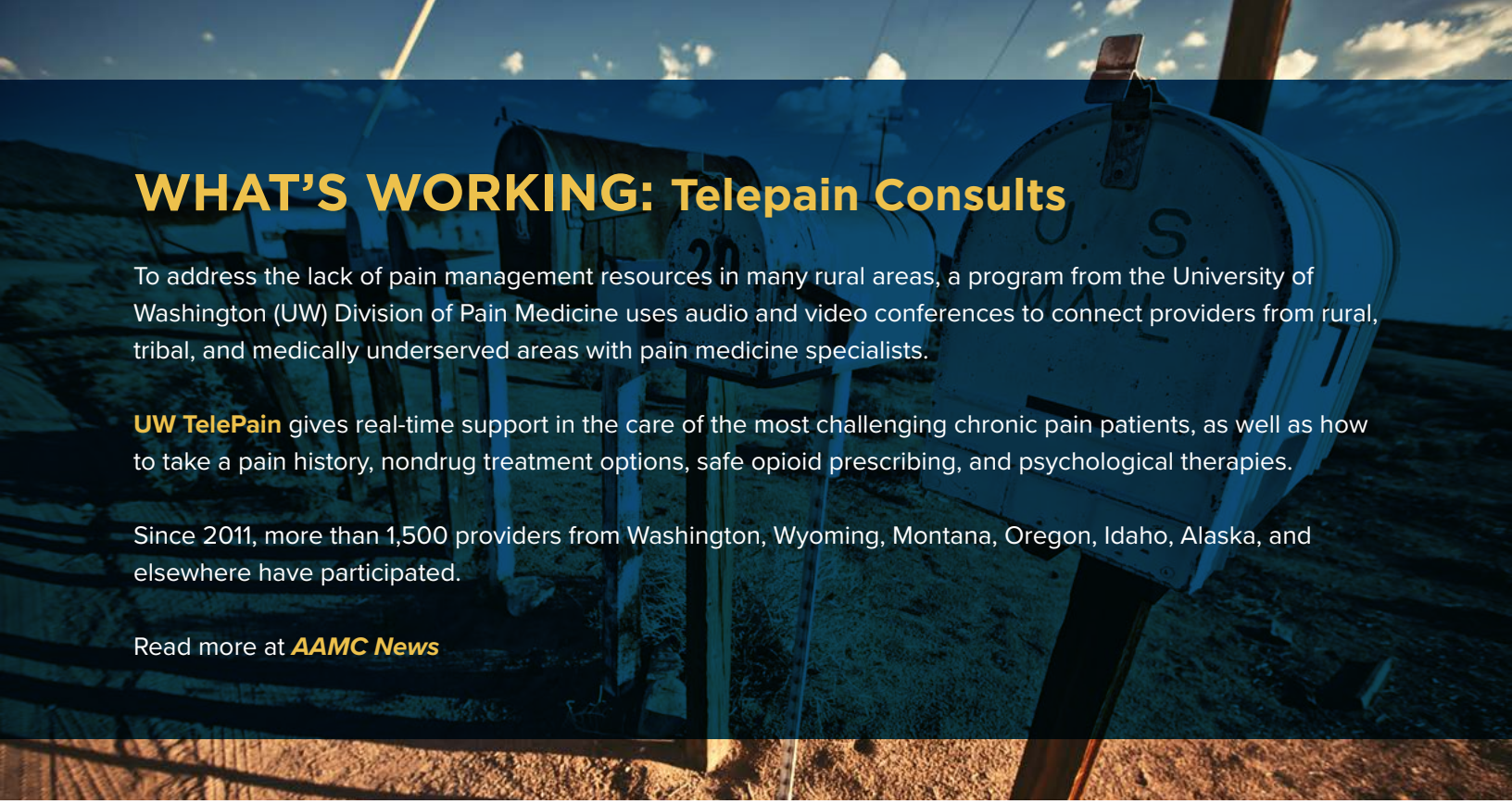
Other efforts to make antidotes more available are found in:

- **Maryland,** where all public schools and institutes of higher learning must stock Narcan and have trained personnel.
- **Kentucky,** where free kits and training are available to the public through the **Kentucky Harm Reduction Coalition**.
- **West Virginia,** one of several states to launch needle exchange programs for heroin users.
- The 31 states with **Good Samaritan** laws that provide legal immunity to anyone who uses 911 to call in an overdose, and
- States where naloxone is **available** in pharmacies without a prescription: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, and Wisconsin.

“Opioid prescribing levels for rural areas are traditionally higher than for urban areas,” explains Fred Brason II, executive director and CEO of Project Lazarus, a community-based opioid intervention program in North Carolina. ▶(See Box: It Takes a Community: Project Lazarus)

“Due to travel distances and the types of occupations in rural areas, a physician is more likely to prescribe opioids,” Brason adds. “In our area, my dairy farmer has to get up tomorrow morning. He doesn’t have time to go over to Winston-Salem or down to Charlotte for some kind of invasive treatment. So the opioid keeps them going.” ▶(See Box: What’s Working: Telepain Consults)

Despite having some of the biggest challenges, rural communities have some of the least recourse. The lifesaving medication naloxone (or Narcan), which can reverse an overdose, is less available in rural areas, and long distances often interfere with timely emergency treatment. Only 10 percent of opioid addiction treatment resources nationwide are located in rural areas, and only 11 percent of rural patients seeking addiction treatment receive evidence-based Medication-Assisted Treatment (MAT). ▶(See Box: When Every Minute Counts: Access to Antidotes)



WHAT'S WORKING: Telepain Consults

To address the lack of pain management resources in many rural areas, a program from the University of Washington (UW) Division of Pain Medicine uses audio and video conferences to connect providers from rural, tribal, and medically underserved areas with pain medicine specialists.

UW TelePain gives real-time support in the care of the most challenging chronic pain patients, as well as how to take a pain history, nondrug treatment options, safe opioid prescribing, and psychological therapies.

Since 2011, more than 1,500 providers from Washington, Wyoming, Montana, Oregon, Idaho, Alaska, and elsewhere have participated.

Read more at ***AAMC News***

Aftershocks: Beyond Addiction

It is also essential to recognize that the repercussions of this epidemic stretch far beyond the harm to addicted individuals. The opioid crisis has caused community-wide aftershocks — in child welfare, elder abuse, public safety, criminal justice, the workforce, the economy, caregiving, housing, and, of course, health care.

The National Advisory Committee on Rural Health and Human Services **declared** in 2016 that "widespread drug abuse inhibits the growth of industry, increases the difficulty in attracting new residents, and creates bleak futures for current residents." Their chilling conclusion: "Ongoing prescription opioid misuse and heroin abuse pose a threat to the future of rural America."

Opioids and Rural America: A Problem That Is Getting Older

An important but frequently forgotten cohort in this crisis is older people living in small towns and rural areas. There are approximately 10 million people age 65 and older living in rural America today, and one out of four older Americans **lives** in a small town or other rural area. While people 65+ do not suffer the highest rate of opioid overdose deaths, they certainly are not immune, and opioid misuse and abuse **skews older**.

As a group, older adults often have multiple chronic conditions, take a lot of medications, and have high rates of chronic pain. In rural areas, work-related injuries from physically demanding jobs like coal mining and farming happen often, resulting in chronic pain. The physiology of aging can alter how people react to powerful narcotics, and cultural and generational sensitivities may stop people from seeking help (which may be scarce anyway.) ▶(See Box: "One Size Does Not Fit All": Senior-Centered Therapy at Senior Hope)

These are all drivers of the emerging **evidence** that Medicare patients have some of the highest and fastest-growing rates of opioid use disorder, including related **hospitalizations** increasing by 10 percent per year.

"Opioid misuse by older adults is very common in this region, largely due to poor health literacy and misunderstanding of the medication itself rather than a blatant desire to abuse," explains Ashley Merritt, PharmD, with Parkland Health Mart Pharmacy in rural Ironton, Missouri. "They also have very little understanding of serious side effects like respiratory depression and potential signs of an overdose."

At present, the age group most heavily affected is adults ages 45 to 55, but it is worth noting that unless something changes soon for this age group, they are likely to continue struggling into their sixties and seventies.

In the **words** of Nora Volkow, PhD, director of the National Institute on Drug Abuse, "Baby Boomers' histories of illicit drug use, and their relatively tolerant attitudes toward it, along with the fact that they now comprise nearly 30 percent of the nation's population, have raised the stakes on understanding and responding effectively to drug abuse among older adults."

"ONE SIZE DOES NOT FIT ALL": Senior-Centered Therapy at Senior Hope

Senior Hope Counseling in Albany, NY, is one of the few senior-only addiction treatment centers, offering support groups, addiction and trauma therapy, and Medication-Assisted Therapy for opioid addiction.

Because "one size does not fit all," Senior Hope therapies reflect the needs of an older population.

Older adults who have tried groups that included younger patients say they are uncomfortable with the profanity that is common, and that they feel like "mom" or "dad," who had to focus on helping others instead of their own needs.

Tailoring Treatment for Older People

Here are some of the features that can make counseling and treatment more age-friendly:

- Staff with experience with older people
- Group sessions that are small, with people of similar age
- Strategies for coping with depression, isolation, retirement, and loss of a spouse
- Marital and family involvement/therapy and case management
- Special therapy as needed, such as trauma survivors group
- Recognizing the role of shame and other hurdles to seeking help
- Facilitators speaking loudly and slowly
- Age-related, large print materials in the waiting room
- Transportation provided, if possible
- An accessible location for non-ambulatory patients
- Link people to community services (transportation, housing, mental and physical health)

A GRANDMOTHER'S STORY:

"There was no way we were gonna let our grandson end up in foster care"

For my 50th birthday, I got a two-year old. You see, my daughter and her boyfriend had a beautiful little boy named Francis, but they got caught up in drugs.

It started with the pain medication she was given after Francis was born, and it just got worse.

When you're my age, you don't expect to start all over again raising a grandchild. But there was no way we were gonna let our grandson end up in foster care.

My story isn't unique. This epidemic has devastated communities all over the country. It doesn't discriminate against age, race, gender, or income. It affects all of us.

— *Pamela Livengood of Keene, New Hampshire, **spoke** at the 2016 Democratic National Convention*

Victimized Without Taking a Single Pill

Addiction is only one of many ways that older people are hurt by the opioid epidemic. In tight-knit rural communities, older people are often drawn into the struggles of addicted children, friends, and extended family, which can turn their own lives upside down. ▶ (See Box: A Grandmother's Story)

The increasing number of grandparents raising the children of addicted parents in "grandfamilies" has paralleled, and is likely driven by, the growth of the epidemic, according to **experts** at nonprofits such as **Generations United**.

An older adult living in public housing who tries to shelter or support an addicted child or grandchild risks eviction under anti-drug use **regulations** from the Department of Housing and Urban Development.

An observed rise in elder abuse and financial exploitation is also attributed to the opioid crisis. The Boston Globe **reports** that, as more adult children with addiction problems are moving back in with their parents, the older people can become easy targets for financial, physical, and emotional abuse, and reports of elder abuse cases in Massachusetts have **increased** by 37 percent in the past five years.

Oversharing Opioids

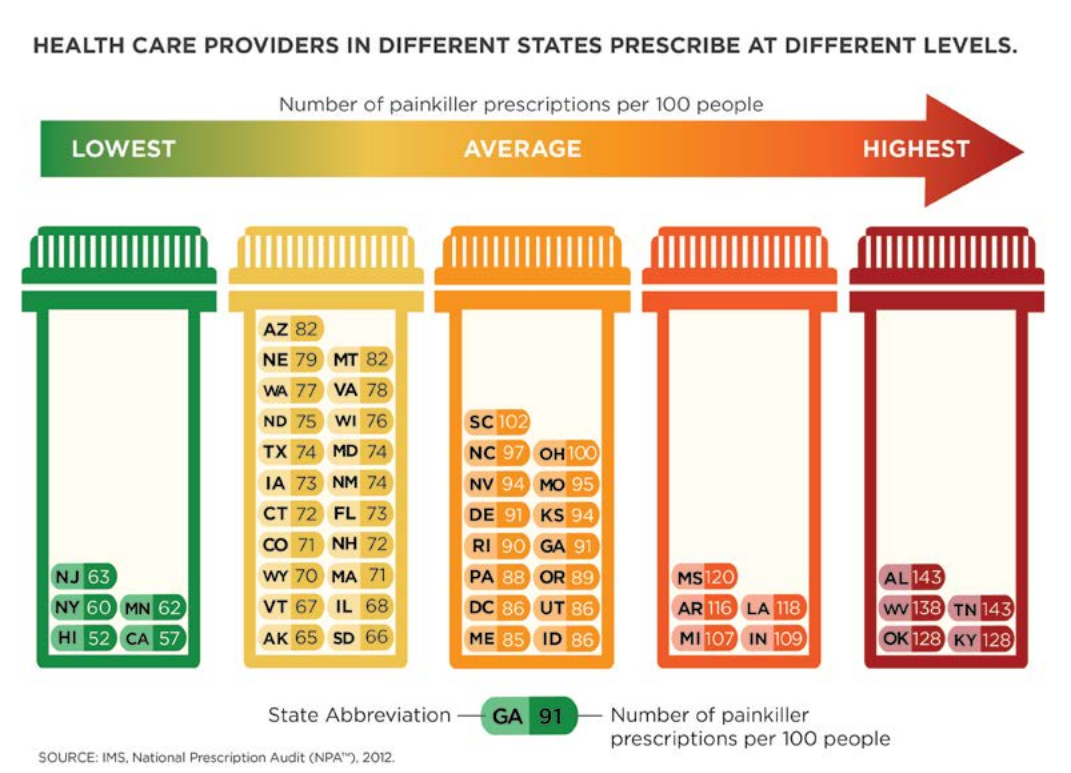
Older people who have opioids prescribed by their doctors can inadvertently increase the flow of drugs to others.

Ill-advised pill sharing among older people is **common**, especially in small and lower-income communities – an example of mutual support run amok. “Drug sharing is extremely common in rural areas; it’s just what you do. We’re a very friendly society in rural America. We hoard everything, we keep everything, we share everything,” says Fred Brason of Project Lazarus.

Drug diversion and theft happen, too, and the mere presence of powerful drugs can feed the problem by making access all too easy for family members. “We’ve had seniors bring in all their medications in a paper bag, and found that many weren’t sure what they were taking or what it was for,” says Carol Wright Kenderdine, assistant vice president for Mobility & Transportation at Easterseals, Inc. and co-director of the National Aging and Disability Transportation Center. “They also didn’t know how many they had, so they had no idea that pills were missing.”

Economic need is another factor. Although there are no hard data on seniors selling their opioids, Brason has seen it happen and works to educate communities about the risk. “We have had situations of seniors selling their medications, mainly through their grandkids, to supplement their Social Security,” he says.

Excess supply can also drive misuse. So-called “pill mills” take hold when locally owned pharmacies in small towns have an economic incentive to fill prescriptions even when they may seem excessive or suspicious. A powerful **piece** in *The Atlantic* magazine catalogued how the tiny city of Manchester, Kentucky – population 1,500 – is home to 11 drug stores, most of them independent, and most selling little besides prescription drugs.



Residents of small towns with limited access to health care may also be reluctant to admit or act on the fact that a local doctor is writing too many prescriptions. ▶ (See Box: Prescribing PDMP (Prescription Drug Monitoring Programs)

PRESCRIBING PDMP
(Prescription Drug Monitoring Programs)

"Doctor shopping" refers to patients wanting more opioids than their prescriber will give them, and looking elsewhere. A 2011 **analysis** shows that more than 22,000 Medicare Part D beneficiaries (out of a total of 29.5 million), who were neither cancer nor hospice patients, participated in "doctor shopping" by filling prescriptions from at least four providers, in at least four different pharmacies, and that the prescriptions were well above the recommended dose.

One response – which the CDC **called** "among the most promising" – is statewide databases called Prescription Drug Monitoring Programs (PDMPs). These are now in every state except Missouri (where a single state senator – a physician – has **blocked** legislation for years.)

The databases can help prescribers and pharmacists identify patients with more than one source of pain prescriptions, but not all physicians have gotten trained to use them and not all states require physicians and pharmacists to check the list before prescribing or filling an opioid prescription.

"433 Pain Pills For Every Man, Woman, and Child in West Virginia"

Powerful marketing by pharmaceutical companies — considered a significant driver of the epidemic — has focused hard on rural communities. One of the most dramatic examples is captured in this **excerpt** from a 2016 Pulitzer Prize-winning series by reporter Eric Eyre of the Charleston *Gazette-Mail* in West Virginia:

> *Follow the pills and you'll find the overdose deaths.*
>
> *The trail of painkillers leads to West Virginia's southern coalfields, to places like Kermit, population 392. There, out-of-state drug companies shipped nearly 9 million highly addictive — and potentially lethal — hydrocodone pills over two years to a single pharmacy in the Mingo County town.*
>
> *Rural and poor, Mingo County has the fourth-highest prescription opioid death rate of any county in the United States. [...]*
>
> *In six years, drug wholesalers showered the state with 780 million hydrocodone and oxycodone pills, while 1,728 West Virginians fatally overdosed on those two painkillers, a Sunday Gazette-Mail investigation found.*
>
> *The unfettered shipments amount to 433 pain pills for every man, woman and child in West Virginia.*

Minorities Report: An Intergenerational Approach

American Indians and Alaska Natives have some of the highest **rates** of opioid overdose for all ages, at 6.2 deaths per 100,000 people — nearly **equal** to non-Hispanic whites. More specific data (e.g., by age) is relatively scarce; considering the elevated risk, this alone probably needs attention.

For other minority groups, such as African Americans, Hispanics, and Asians, opioid overdose rates are notably lower. (The reasons are not well known, although there is some **evidence** that African Americans in particular may receive fewer painkillers from providers, even in emergency situations.)

Some tribes are fighting back. The Cherokee Nation has filed a **lawsuit** against producers and distributors of opioids, and the Indian Health Service now **requires** all its providers to check the Prescription Drug Monitoring Program before writing an opioid prescription longer than seven days, as well as **equipping** all Bureau of Indian Affairs law enforcement officers with the overdose antidote naloxone.
▶(See Box: Prescribing PDMP (Prescription Drug Monitoring Programs)

While focusing primarily on the health of younger people, tribes are turning to their older generation for help. **IAMNDN** (I AM Indian Native Drug-free Nations), headquartered in Lawton, Oklahoma, seeks to reduce youth addiction with an intergenerational approach, promoting increased dialogue between younger tribal members and tribal leaders with the motto "Culture is Prevention." IAMNDN's message is unflinching: "Historically to be Native was synonymous with alcoholic, drug addict, loser, stupid, ignorant and unemployed. IAMNDN is going to challenge the stereotypes of old." Activities include cultural clubs and a behavioral health summit that has received **funding** from the federal Substance Abuse and Mental Health Services Administration (SAMHSA.)

WHAT'S WORKING:
Academic Medicine Reaches Out to Rural Providers

In rural eastern Colorado in 2016, only one health care provider had the waiver required to prescribe buprenorphine, the drug used in Medication-Assisted Therapy (MAT) for opioid addiction. It wasn't enough.

"We now have a group of people with opioid use disorder who are our neighbors — farmers, ranchers, businesspeople, and their kids," says Jack Westfall, MD, a family medicine practitioner and associate dean of rural health at the University of Colorado (CU) School of Medicine Anschutz Medical Campus.

CU School of Medicine received a $3 million, three-year federal grant to train primary care physicians, nurse practitioners, physician assistants, and office staff about opioid use disorder and MAT and to offer the buprenorphine waiver course free online. It is already offering a free, in-person training.

"[The academic medicine community] has to be the torch on the hill that sheds some light," says Dr. Westfall, who is also the principal investigator for the grant. "We're developing a curriculum for the whole primary care practice, for the front office, nurses, providers, and billing staff. Everybody participates in the care of the patient."

Read more at AAMC News

When the Road to Recovery Is Too Long

Medication-assisted Treatment (MAT) is the standard of care for people trying to end an opioid addiction, but it can be hard to find in rural places. The FDA-approved medications for opioid addiction treatment are methadone, buprenorphine, buprenorphine/naloxone, and injectable naltrexone — all of which are regulated in different ways.

Buprenorphine/naloxone is the first medication for opioid dependency that can legally be prescribed or dispensed in physician offices. (To decrease the likelihood of diversion and misuse, buprenorphine is typically given in the United States as buprenorphine/naloxone — a combination drug.)

Allowing physicians to dispense buprenorphine/naloxone has significantly increased access, but hurdles still exist. Physicians must have at least eight hours of training to obtain the Drug Enforcement Administration (DEA) waiver needed to prescribe it and, as of 2015, only 3 percent of primary care physicians had the **waiver**. In fact, most U.S. counties had no physicians with waivers, meaning that more than 30 million people had to travel out of their county to get evidence-based care to fight opioid addiction.

(Note that buprenorphine/naloxone is not the same drug as naloxone, which is used to reverse overdoses and is available in many places without a prescription.) ▶(See Box: What's Working: Academic Medicine Reaches Out to Rural Providers)

NIH CALLS FOR "ALL SCIENTIFIC HANDS ON DECK"

Calling the opioid problem "staggering but not hopeless," National Institutes of Health (NIH) director Francis Collins and National Institute on Drug Abuse (NIDA) director Nora Volkow **called** in May of 2017 for increased basic research on three fronts:

- More and better medications for overdose reversal;
- New and innovative techniques and medications for addiction treatment; and
- Safe, effective treatments to manage chronic pain.

This includes what has been called the "Holy Grail" of pharmaceutical research–a non-addictive opioid.

Animal studies have shown good results from compounds called biased agonists that produce pain relief without the "high" and without depressing breathing. Other research is looking at non-opioid approaches like cannabinoids, sodium channel blockers, gene therapies, and brain-stimulation technologies.

The leaders also announced that NIH will partner with pharmaceutical industry leaders to cut in half the time it takes to develop new treatments.

Not all reaction has been positive: "This is a complex bio-psycho-social disease," opioid expert Anna Lembke, an assistant professor of psychiatry and behavioral sciences at Stanford University, **told** the *Chronicle of Higher Education*, "and these interventions really are only looking at the biology piece."

How Did We Get Here?

It is a cruel irony that the opioid epidemic started, to a large extent, with legitimate prescriptions. A critical question is why.

One factor was a change in medical philosophy. In 1995, the notion of pain as a "fifth vital sign" was introduced and rapidly taken up by institutions as influential as the Veterans Health Administration and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Clinical practice soon followed, as an excellent retrospective **article** in *Clinical Therapeutics* explains: "patients report pain and expect their providers to respond."

The problem: most physicians were not trained accordingly. The new standards, the article explains, "exposed serious deficits in provider education and training in pain assessment and management."

At the same time, aggressive marketing by pharmaceutical firms pushed the idea that opioids could be effective but not dangerous. This campaign drew heavily on two strikingly small pieces of **evidence** – one of which was not even a study but a brief (one paragraph) and old (1980) **letter to the editor** of the *New England Journal of Medicine*.

Official prescribing guidelines also began to change, including those from the American Geriatrics Society, which **advised** its members in 2009 that "all patients with moderate to severe pain or diminished quality of life due to pain be considered for opioid therapy, which may be safer for many seniors than long-term use of [medications like] NSAIDs and COX-2s."

It has been called a perfect storm. Given that the source of most opioids is a licensed physician, some critics even resist the term "abuse." "Calling it an abuse problem suggests the cause is bad behavior — people abusing dangerous drugs to get high. While it's true that some people got addicted from recreational use, many also became addicted taking opioids exactly as prescribed by doctors," **says** Andrew Kolodny, co-director of the Opioid Policy Research Collaborative at the Heller School at Brandeis University and co-founder of Physicians for Responsible Opioid Prescribing.

"Policymakers wanted to stop so-called 'drug abusers' but were ignoring the problem of overprescribing," he adds. "It was all focused on preventing kids from getting into grandma's medicine chest, but no one was looking at why every grandma now had opioids in her medicine chest." ▶(See Box: NIH Calls for "All Scientific Hands on Deck")

Under increasingly intense professional and media scrutiny, that has begun to change. The former Surgeon General, Vivek Murthy, MD, launched a campaign called **Turn the Tide** that provides extensive resources and guidance for health care providers, and the CDC also released **new prescribing guidelines** in 2016 that called for more limited use of opioids, particularly for chronic pain.

It is important to note, however, that chronic pain remains a troublesome problem, particularly for older people and many rural residents. For that reason, these conclusions were not universally cheered by geriatricians. ▶(See Box: The Problem of Chronic Pain in Older Adults)

This concern is reflected in a major **report** sponsored by the Food and Drug Administration (FDA) and released by the National Academies of Sciences, Engineering and Medicine, which outlines a strategic response to include weighing societal, not just the individual, impacts of opioids; increasing investment in treatment for the millions who have opioid use disorder when reducing lawful access to opioids; giving universal access to evidence-based treatment for opioid use disorder in a variety of settings, including hospitals, criminal justice settings, and substance-use treatment programs; and removing federal, state, and other programmatic impediments to full coverage of FDA-approved medications for treatment of opioid use disorder, among others. ▶(See also Policy Prescriptions)

State and local governments, including Ohio, **West Virginia,** Illinois, New York, Washington, California, and the **Cherokee Nation** are also beginning to push back, with measures including **court cases** against pharmaceutical producers. While it is early days for this strategy, there is some precedent: in 2007, Purdue Pharmaceuticals (the producers of OxyContin) **pleaded guilty** to criminal charges that they misled regulators, doctors, and patients about the drug's risk of addiction, and paid a near-record $600 million in fines.

THE PROBLEM OF CHRONIC PAIN IN OLDER ADULTS

Chronic pain, defined as non-cancer pain that continues three to six months or past the time of normal tissue healing, is notoriously difficult to treat. In its 2011 Report, "Relieving Pain in America," the Institute of Medicine **characterized** it as a "disease in its own right."

It is also distressingly common in older people, **affecting** as many as half, including up to 80 percent of nursing home residents.

While the long-term safety and effectiveness of opioid treatment for chronic pain remains significantly **under-researched**, some geriatricians are concerned that new **prescribing guidelines** from the CDC and measures like the Prescription Drug Monitoring Program may make it harder for physicians to get some older people with chronic pain the help they need.

"I think the policies and procedures we are putting in place are going to increase the well-established and sizable number of older people who do not have pain adequately treated," **says** Cary Reid, PhD, MD, associate professor and director of the Office of Geriatric Research in the Division of Geriatrics and Palliative Medicine at Weill Cornell Medical College, and director of Cornell's Translational Research Institute on Pain in Later Life.

"We need to recognize that the line between palliative care and chronic disease care can be blurry in older patients. The goal is to mitigate pain so patients' quality of life is improved."

GOVERNMENTS, COMMUNITIES, AND FUNDERS RESPOND

Funders Versus Opioids

Perhaps it is because the problem has been fast-moving and complex, but the philanthropic response to the opioid crisis, particularly with regard to the challenges and impact on older, rural people, has been limited. In the view of ***Inside Philanthropy***, "the number of funders working the opioid problem is not nearly as great as one would expect."

Here is a sampling of foundation-backed initiatives:

- **The Conrad N. Hilton Foundation** has worked in the substance use field for decades; the biggest funder in the field, it allocated more than $11 million in 2016, with a focus on youth, prevention, and early intervention efforts.
- **The California Health Care Foundation** has supported the **California Opioid Safety Coalitions Network**, which provides data mapping, information resources, professional education, clinical research support, and coalition building through multiple in-state **grants**.
- The GE Foundation made a $15 million Boston-based grant, including support for a **"hack-a-thon"** to bring together 250 innovators across public health, engineering, business, and design to develop solutions to the opioid epidemic.
- The **Cardinal Health Foundation** has granted over $6 million through its Generation Rx program since 2009, including prescriber education and drug take-back programs.
- **The Laura and John Arnold Foundation** awarded $1 million in grants in 2016, with a criminal justice focus.
- Columbus Foundation in Ohio issued a **"Critical Need Alert"** to donors for increased training for providers and first responders, an evidence-based community mental health campaign, a new website, expanded crisis phone number, and the launch of the first-ever professional Chat Now service.
- The Community Foundation of New Jersey has **funded** the **NJ Connect for Recovery** phone line staffed by trained peer counselors.
- The Robert Wood Johnson Foundation was a leading funder of substance abuse work, investing **some $700 million** from 1986 to 2009, when it pulled back from the field. The Foundation also maintains an active interest in broader rural health issues, including support for NORC at the University of Chicago's **Profile of Tribal Health Departments** and a new **grant** announced in June 2017 providing $730,000 to Campbell University in North Carolina to fund the Rural Philanthropic Analysis. This **study** is designed to create, identify, and enhance new ideas and insights to improve the practice and impact of charitable organizations when it comes to supporting healthy, equitable rural communities.
- The New York State Health Foundation has funded projects including the **Essex County Heroin and Opioid (ECHO) Prevention Coalition**, a multiagency collaboration in upstate New York.
- The Community Health Network (Indiana) has **provided** pain management education and public classes where attendees receive education about overdose, treatment, how to administer naloxone, and one free naloxone kit.

Other programs tackling various facets of the opioid and addiction crisis have received funding from:

- The New Hampshire Charitable Foundation — $142 million for its **Substance Use Disorder Portfolio**.
- **Interact for Health**, based in Cincinnati, Ohio, and serving 20 counties in Ohio, Kentucky, and Indiana, has distributed overdose reversal kits to families and hosted a 2015 Regional Opiate Summit.
- Lutheran Foundation (Indiana), whose **Look Up Initiative** is a web-based resource designed to reduce stigma and provide mental and behavioral health information, including two crisis connections (an 800 # and a text-to-chat component).
- The Porter County Community Foundation (Indiana), whose grantmaking to the Frontline Foundation **focuses** on youth substance abuse.
- The **Health Foundation of Greater Indianapolis**, for testing, treatment, and syringe exchange services for an opioid-related HIV/AIDS outbreak.
- The Richard M. Fairbanks Foundation, which **awarded** $700,000 to Project POINT, providing patients revived from opioid overdose with high-quality treatment and wraparound support for recovery; and $376,000 to Ascend Indiana, a workforce development initiative for behavioral health focused on addiction treatment.
- The Foundation for a Healthy Kentucky and Interact for Health, whose work has included funding a **statewide health poll** and the **Inside Opioid Addiction** coverage by KET Kentucky Public Television's Health Three60 series.

Policy Prescriptions

The opioid crisis involves a high degree of regulation, government involvement, and a central role for public programs, making policy an even more important tool than usual. Many actionable policy prescriptions have been put forward and some key examples are offered below. (For more details, please refer to this excellent **policy brief** from the National Rural Health Association.)

One enormous but unsettled policy question is the future role of Medicaid and Medicare. Rural older adults are more likely to be **dual eligibles** and are at higher risk of opioid misuse. Medicare's present coverage of services for mental health, behavioral health, and substance abuse disorders is, in the **analysis** of the Center for Medicare Advocacy, "not as extensive as its coverage for other services."

Medicaid currently **pays** for about 1.2 million adults to receive treatment for opioid misuse. The stakes are high, and the question of how efforts to change or cut the program would alter coverage and health outcomes remains a topic of vehement debate.

A sampling of other policy prescriptions:

- Expand access to substance use treatment services, particularly those offering expertise in working with older adults ▶(See Box: Reducing Stigma: A Legacy of First Lady Betty Ford)
- Expand and increase training of the substance use workforce in rural communities ▶(See Box: What's Working: Growing the Workforce with CARS)
- Improve the capacity of rural EMS systems to respond to opioid overdoses
- Support and scale up existing successful programs, including telehealth
- Expand publicly funded rural transportation options to make treatment and other supports more accessible to older people
- Expand and improve services to prevent, detect, and end elder abuse and financial exploitation (which are chronically underdiagnosed and underfunded), such as Adult Protective Services, ombudsman programs, social work and health care provider training, and legal assistance
- Improve legal options and financial assistance for grandfamilies affected by opioids
- Support and maximize use of the National Family Caregiver Support Program
- Support private programs like Kinship Navigator programs for custodial grandparents
- Expand and improve prescriber and medical **education** about opioids and chronic pain
- Promote use of evidence-based prescribing guidelines (e.g., smaller doses, shorter durations, alternative medications)
- Promote policies that respect and address the higher chronic pain needs of older adults
- Strengthen state prescription drug monitoring programs (PDMPs) and sharing of prescription information across state lines
- Encourage substance use treatment as an alternative to incarceration for opioid users
- Increase basic and clinical research into better opioids and better alternatives
- Provide education and promote use of non-opioid treatments (e.g., acetaminophen, NSAIDS, COX-2 inhibitors, anti-convulsants, epidural injections, anti-depressants)
- Provide education and promote use of nonpharmacologic treatments (e.g., Cognitive Behavioral Therapy, exercise therapy, biofeedback and neurofeedback, brain, spinal cord, and nerve stimulation, complementary medicine, yoga, meditation, acupuncture)

REDUCING STIGMA:
A Legacy of First Lady Betty Ford

Image Courtesy of Betty Ford Center

A very public **story** of recovery belongs to former First Lady Betty Ford, who had alcoholism and also became addicted to opioids in the early 1960s after a pinched nerve. Following a family intervention in 1978 (a year after leaving the White House), she became a recovery advocate noted for her openness and honesty.

"I liked alcohol," she **wrote** in her 1987 memoir. "It made me feel warm. And I loved pills. They took away my tension and my pain."

Now the **Hazelden Betty Ford Foundation** offers programs focused on older adults, such as **Recovery@50Plus**.

The program addresses age-specific addiction issues, the importance of rediscovering purpose and meaning in life, and "the stigma of addiction and the impact of shame on recovery."

CONFRONTING THE CRISIS:
An Opportunity for Funders and All of Us

The American opioid situation offers grounds for both hope and concern, with plenty of room for constructive action. While the opioid prescription rate has **begun** to slow, the death rate has actually been **rising**, several states have **declared** a state of emergency, and Americans still **consume** far more opioids than people in any other country in the world.

The damage to rural communities has been outsized, and there is a great need to enlarge the frame of reference for this problem. Rural communities are home to many older people and are aging faster than the rest of the country. The harm to rural older people is not limited to addiction, so the solutions can't be limited to this, either.

Even more important is ensuring that needed changes in prescription practices do not unleash yet another wave of unintended consequences. In a worst-case scenario, these could include driving desperate people to less expensive street drugs, and stripping older people with chronic pain of their options for relief.

WHAT'S WORKING:
Growing the Workforce with CARS

In rural, culturally and ethnically diverse New Mexico, the **Community Addictions Recovery Specialist** (CARS) program is using telehealth and in-person training to train paraprofessionals – medical assistants, community health workers, health educators, and peer support specialists – to provide clinical support, health education, and evidence-based behavioral interventions, with a focus on alcohol and opiate addiction.

CARS is part of **Project ECHO** (Extension for Community Healthcare Outcomes), a multi-disease telehealth program that focuses on medically underserved areas. Created at the University of New Mexico by Dr. Sanjeev Arora, it now operates in 23 countries and through academic medical centers in the United States, the Department of Veterans Affairs, and the Department of Defense. In 2015, Project ECHO **received** a $14 million expansion grant from the GE Foundation.

Because of how complex and multi-faceted the problem is, many communities have not been able to formulate a comprehensive strategy that leads to a long-term grant request or funder relationship, says Allen Smart, who worked extensively on the opioid problem while vice president of programs and interim president at the Kate B. Reynolds Charitable Trust and now serves as project director for rural philanthropy at Campbell University in Buies Creek, North Carolina. Yet the potential for a catalytic contribution from the philanthropic sector is tremendous. “What we need to do now is demand that funders take on the charge of becoming really familiar with the research and the most promising practices.”

Commitment, creativity, ingenuity, and coordination between government, funders, nonprofits, and the medical community will be needed if we are to make meaningful progress toward meeting the needs, and indeed, saving the lives, of individuals and communities in pain.

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