The Lewin Group
Promising Practices for Meeting the Needs of Dually Eligible Older Adults with Substance Use Disorders
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Kristin Corcoran: Thank you. My name Kristin Corcoran, and I'm with the Lewin Group. Welcome to today's webinar on meeting the needs of dually eligible older adults with substance use disorders. Next slide.

Today's session will include a 60-minute presenter-led discussion, followed up with 30 minutes for question-and-answer among the presenters and participants. This session will be recorded. A video replay and a copy of today's slides will be available at resourcesforintegratedcare.com. The link to the website is provided at the bottom-right of each slide.

The audio portion of the presentation will automatically stream through your computer. Phone lines for this presentation are also available. To access that number, you can click the black Phone widget at the bottom of your screen.

Should you have any questions now or throughout the presentation, feel free to enter them into the Q&A feature on the platform. We will be addressing your questions for our speakers at the end of the webinar. Next slide.

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You'll see on this slide that we've laid out the various credit options. If you are a social worker, you can obtain Continuing Education credits through NASW if you complete the pre-test at the beginning of the webinar and complete the post-test at the end.

CMS is also offering CEUs and CMEs for other individuals looking to obtain credits for attending this webinar. To obtain these credits, you must complete the post-test through CMS' Learning Management System.

Additional guidance about obtaining credits and accessing the links to the pre-test and post-test can be found within the Continuing Education Credit Guide in the resource list on the left side of your screen or at the Resources for Integrated Care website. Next slide.

This webinar is supported through the Medicare-Medicaid Coordination Office, or MMCO, at the Centers for Medicare & Medicaid Services. MMCO is developing technical assistance and actionable tools based on successful innovations and care models such as this webinar series. To

learn more about current efforts and resources, please visit our website or follow us on Twitter for more details at @Integrate_Care. Next slide.

At this time, I'd like to introduce our speakers. Our first speaker, Dr. Louis Trevisan, is an associate professor of psychiatry at Yale University. Our second speaker, Dr. Nicole MacFarland, is the executive director at Senior Hope Counseling. Elizabeth Baumann is a case manager at the Council on Aging of Southwestern Ohio. And Sherri is a consumer who will talk about her lived experience with a substance use disorder. Next slide.

On this slide, you will see our learning objectives for today's webinar. We hope that you will learn about unique characteristics of substance use disorders among dually eligible older adults; be able to recognize effective strategies for screening substance use disorders and helping older adults transition from assessment to treatment; recognize how to provide tailored treatment, recovery support services and community resources; and identify new opportunities for collaboration. Next slide.

We are going to start today's webinar with a few poll questions. Then we will move into the presenter-led discussion, followed by Q&A and evaluation questions at the end of the webinar.

Now we will move into the poll questions. Our first question is, In what setting do you work? All right, let's see the results.

Okay, so it looks like about 70% of people work in the health plan setting, and about almost 10% work in a community-based organization.

Our second question is, Which of the following best describes your professional area? All right, we'll give it a few more seconds and then see the results.

All right, almost half of the webinar participants are health plan case managers or care coordinators, and we also have almost 10% of participants are health plan administration or management.

So now I'm going to turn it over to Dr. Trevisan.

Louis Trevisan: Hello. Next slide, please.

Substance use disorders among older adults are a growing concern. The Baby Boomers, or the so-called Silver Tsunami, is upon us, and people who were born between 1946 and 1964 make up a large part of our population. They were of course exposed to much more substance use than previous generations, and you can see that the population of 50 and older with substance use disorders has doubled since 2006. Next slide, please.

The dually eligible older adults are at least 2.5 times higher in terms of substance use disorders than Medicare-only. This is very significant. The other issue is that people who are older have more physiological problems, more chronic health conditions, and they may have more cognitive

impairment. The takeaway is that dually eligible older adults are at an increased risk. Next slide, please.

We're going to be talking about three main substances here. They include alcohol, opiates and tobacco. That doesn't mean that we can't pay attention to the other drugs that are evident, including amphetamines, benzodiazepines and marijuana, most notably.

Alcohol is something that is commonly misused or used among this older generation, although it's decreasing. It was higher. It's now about 14.5% of older drinkers consume alcohol at a level above the recommended limit, which is over 65 is one drink per day for either man or woman. And then, 3% of older adults have an alcohol use disorder. Next slide, please.

In terms of opiates, you can see that 35% of adults that are aged 50 or older with chronic pain are misusing their prescriptions, and many of them have been started on opioid prescriptions. As many of you know, this is an epidemic in our society at this point. Dually eligible beneficiaries specifically have higher rates of opioid use, more so than Medicare-only, and you can see the statistics there on the slide. Of note, between 2006 and 2015, among dually eligible adults 55 to 64, 28.1% were using opioids. And in older, it's up to a quarter of the population. Next slide, please.

The use of tobacco among older adults is also a problem, and 14% of older adults used tobacco in the past 12 months. Now, this is lower than in past years, but it still presents quite a significant public health problem and for the individuals that do use tobacco. Dually eligible beneficiaries are much more likely to smoke cigarettes and tobacco than Medicare-only beneficiaries. Next slide, please.

When diagnosing substance use disorders in older adults, it's important to note that the diagnostic and statistical manual is geared towards younger adults, so please pay attention to this slide in terms of looking at the things that older folks may present with. They're not the classic things. Strictly using DSM-5 criteria for older adults may not reveal problematic substance use. They may no longer be working in the workplace. They're living at home. Not getting out. They may not be driving, so there's no driving errors noted or DUIs. They may not be cognizant of the fact that they are drinking more. Their withdrawal symptoms may be less pronounced than younger folks.

Usual social indicators of impaired function are missing in older adults, so it's important to pay close attention to many social aspects of their lives and medical aspects of their lives. Next slide, please.

This slide is interesting because it reminds me of my mom telling me a story once when she was in her early 80s, saying that when you get older, it's not for the faint of heart. She said things start getting more difficult. It's more difficult to get around physically, do things that you used to be able to do. And it adds a lot of stress. People tend to be a little bit more isolated.

I mentioned to her, I said, "Gee, you should join the senior center," and she said, "Well, that's for the old people." So not only do they suffer some of the consequences of getting older in terms of

the psychosocial and physical aspects, but their head is still thinking that they're 28, many of the times. So it's important to be sensitive to this issue. Next slide, please.

Those people who are supporting older adults should look more closely at the indicators and signs of substance use disorder beyond and in addition to conducting formal screenings. Covering physical, cognitive, social and psychiatric issues, being aware of those, is very important. I had a patient here who we videotaped for another seminar once who was in recovery for alcohol use disorder but was on methadone for pain, and he was in his late 60s. He was having breakthrough pain, and he didn't want to tell his doctor here at the VA where I work, so he went to a private doctor and got extra OxyContin.

Well, he didn't really become sedated, but what happened was it started interfering with his memory. He'd forget to eat or he wouldn't eat enough, and he was diabetic and he would bottom out on his sugar, and he would pass out. So this was a—it's important to make sure that you cover all the aspects with people that are older. Next slide, please.

The Center for Substance Abuse Treatment recommends that screening for substance use disorders be a part of the routine medical visit for everyone over the age of 60 years. The alcohol screens that you can see up there, including the CAGE, the AUDIT-C and the SMAST-G, are all excellent tools. The SMAST-G can be given if somebody's waiting in the waiting room. It's a pencil-and-paper, yes-no questions, 10-question paper assignment, and can give you good indication of what's going on. The AUDIT-C is a current evaluation of how people are drinking, and CAGE is historical. So you get quite a bit if you use several of these. You get quite a bit of coverage.

Tobacco is most often detected by just asking the patient or the client is usually very willing to talk about their tobacco use.

Opioids, you can ask about those, too, but the screening told for older person's potentially inappropriate prescriptions, which is validated in elderly population, along with the SMAST-G, the STOPP is easily accessible online and can help you look at not only opioids but other potential interactions and inappropriate use of prescriptions in the elderly. Next slide, please.

Some tips to take to the bank, basically, when you're working with older folks is don't be confrontational. You can ask them directly sometimes. You have to sort of feel it out. But a non-confrontational approach works much better than a confrontational approach about substance use.

Refer to their overall health issues and promotion of health. Above all, don't be judgmental. This will certainly turn somebody off, especially if they're older, and they don't want to talk about their issues if they feel like they're being judged.

One of the ways to ask for it is, "Are you having any unexplained medical issues? Could these symptoms that you're having be caused by your substance use?" Just be careful in terms of your approach and try to be more conversational and less confrontative. Next slide, please.

Getting from screening to treatment and how to engage older adults is something that can be a little bit tricky and nuanced, but it often works. Many older folks really do like talking to health care providers and caseworkers and docs, and so, suggesting that they try something new after asking them about their substance use can often help. I have an elderly guy who was drinking five or six drinks a day, and he's in his 70s and he was not doing well, isolating and doing that kind of thing. I asked him to start going to the senior center, and he actually—he wasn't my mother, so he decided to take my advice, and he went. He started riding his bike, and now he's up to riding five miles a day, and he's cut down to a couple of drinks a day.

So screening and then engaging in treatment involves a nuanced approach of trying to weave it into their everyday life and health. Next slide, please.

Treatments and interventions for substance use disorders among older adults are important. These approaches apply across all three substances that we're talking about and can be used for other substances as well that we mentioned earlier.

Different treatments work for different people. There's no special adaptation for motivational interviewing or motivational enhancement to older adults. You just have to make sure that they're cognitively aware and able to function well enough in order to converse and figure out how alcohol or other drugs interferes with their life and what's good and what's bad about it, that kind of thing.

Use a slower pace with older folks that have cognitively slowed presentations or have minimal cognitive impairment, but please be aware that you may get some pushback from folks who take offense to that. But above all, be deferential and try to work with them around that. Next slide, please.

For drinking alcohol, there's several approaches that work very well, including brief intervention for at-risk drinking. This often works very well in the clinician's office, a caseworker's office, a doctor's office, to sit with them two or three times in successive visits for 10 to 15 minutes and talk casually and provide education or assessment about their use of alcohol in particular.

Developing motivational strategies helps. Older folks, while you don't want to confront them, they do take advice from the doctor and from health care providers much more seriously than younger folks, and it's unclear why that is, but they do seem to respond better to advice.

Be supportive of their efforts and forgiving and non-judgmental if they're struggling or if they have slips. This is all part of normal recovery from any substance use. It's hard for people to be totally abstinent right off the bat. Next slide, please.

This is just an acronym. I'm not an acronym-type person, but it helps people remember what to do in a brief intervention. It's titled FRAMES. You can see what the letters stand for: Feedback, Responsibility, Advice, Menu of options. I don't know why anybody would need to be reminded to be empathic, but maybe they just needed to do that to round out FRAMES, remind you to try to put yourself in their position and understand what life is like for them as well. But it's useful to help you remember in the situation. Next slide, please.

Pharmacological treatments, this is my specialty. I'm not going to go into a lot of detail here. You can see that there are useful medications for the three substances that we're talking about listed on the slide. Note, though, that it's not just medication-assisted treatment that works. It should be combined with non-pharmacological treatment. Talking, being supportive, helping with the meds, helping understand the medications and how they work. And above all, when you're using these medications, if you're a prescriber or if you're somebody who's working with them, you want to make sure that they start on a low dose of the medication and know that there's a possibility that they will interact with some of the other medications that they're on. Next slide, please.

Key takeaways for tailoring services to older adults with substance use disorders.

Diagnosis and screening. Dually eligible older adults are at an increased risk of experiencing substance use disorders and the associated adverse outcomes. They're really the most vulnerable.

Look for indicators beyond the classic Diagnostic and Statistical Manual 5. This is purely a classification instrument. What you need to do is get to know the patient, the older person—excuse my use of the word. I'm an old-fashioned guy sometimes. But make sure that you look at physical, cognitive and social aspects of their lives.

Recognize that physical health conditions may be a side effect of substance use. Always suspect substance use. Next slide, please.

Engagement strategies. Build rapport. Discuss substance use. Don't be judgmental. Substances are around. They're everywhere. People have been using them all their lives, and this particular generation had big exposure in the younger days. If a cognitive impairment is evident, ask them to repeat back what you've said to them. Make sure they understand what's going on.

Brief interventions work. Advice seems to work for older folks. And combining pharmacological and non-pharmacological treatments works best.

And that's it. Oh, if you're going to use medication, start low, go slow, but keep going until you're in a therapeutic range.

And that's it for me. What I'd like to do now is introduce—next slide, please—Dr. Nicole MacFarland, "Meeting the Needs of Dually Eligible Older Adults with SUDs: a Social Worker Perspective." Thank you.

Nicole MacFarland: Thank you, Dr. Trevisan, the Lewin Group and our audience today for calling into this WebEx. I am honored to be here today to discuss the topic of "Meeting the Needs of Dually Eligible Older Adults with SUDs: a Social Worker Perspective." Next slide, please.

Senior Hope Counseling Inc. was founded in 2002 by Dr. William Rockwood and Adrienne Rockwood, his wife. Senior Hope is an outpatient, non-intensive, freestanding SUD clinic

licensed by the Office of Alcoholism and Substance Abuse Services in Upstate New York, catering exclusively to older adults. Senior Hope serves approximately 120 older adults annually, including older adults who are dually eligible for Medicare and Medicaid.

We offer day and evening treatment programming with a focus on tailored treatment programs for older adults with substance use disorders. The services offered at Senior Hope are referenced on this slide. Next slide, please.

At Senior Hope, we feel that elders have done so much to pave the way for what we enjoy today in our society. They deserve to be revered and to be offered specialized treatment within environments that foster a culture of support and respect. We accomplish this by listening carefully to what older adults have to say, by acknowledging their current needs, by tailoring our approach to meet the unique needs of this client population with SUDs, and by being mindful of hearing, vision and mobility issues. We adjust treatment approaches accordingly, like talking slower for those with cognitive impairments and by offering larger print for those with vision impairments. Next slide, please.

It is important to complete a full psychosocial assessment when an older adult arrives at a facility, to determine if they are in need of treatment and what level of treatment, if needed, may be appropriate. Early onset is use that began prior to age 40 and may have been due to early childhood trauma. Generally these individuals have a basic understanding of their substance use disorders and exhibit high levels of substance-related physical health needs due to their long-term, harmful behavior.

There may be a higher need for collaboration with primary care providers and for screening of adverse childhood experiences, known as ACEs, that took place prior to age 18, which may have set the stage for long-term use of substances.

Late onset is use that began after age 40 years of age. Usually the older adult began using substances due to life stressors. For example, loss of a partner, retirement or a new diagnosis. There may be a greater need to identify and tailor treatment towards stressors that may have precipitated increased substance use. Next slide, please.

Comorbidity is a serious common concern among older adults with SUDs. It is important for practitioners to identify any psychiatric symptoms the older adults may have. Dually eligible older adults are more likely to have comorbid conditions and may require additional comprehensive services and supports.

Awareness of comorbidities can allow practitioners to provide more comprehensive services to older adults with SUDs. An example of a screening tool for depression is the PHQ-9, which can be very helpful in determining if the older adult requires a more comprehensive psychiatric evaluation by a psychiatrist. Next slide, please.

Providers caring for older adults should receive training to recognize the normal aging process and its effects on substance use disorders, including substance tolerance changes and possible indicators of an SUD. Normal aging is experiencing some sensory changes such as hearing and

vision changes, mild cognitive changes such as slowed thought process, and age-related sleep pattern changes like needing less sleep.

Normal aging is not experiencing depression, severe cognitive impairment, debilitating chronic diseases and frequent hospitalizations. The more familiar a practitioner is with the signs of what the normal aging process looks like, the more helpful this can be with treatment programming. Next slide, please.

In order to assess an older adult for SUDs, it is important for the practitioner to complete a comprehensive assessment to identify history of SUD, assess needs and determine the appropriate level of care. This can be accomplished by building a rapport and developing a trusting relationship prior to and during the assessment.

Assessing for adverse childhood experiences can be very helpful in considering the course of substance use disorder treatment. If an older adult has experienced trauma prior to 18, it can be helpful for the practitioner to be aware of this so that treatment planning during their stay can be tailored to meet those needs.

If relevant, discuss how SUD and related behaviors may be impacting their adult children and grandchildren. This can motivate older adults to engage in screening and treatment. If relevant, invite caregivers to join the assessment and follow-up sessions to provide insight and help determine appropriate level of care.

Ask for permission to communicate with others involved in the older adult's life to gather more information.

Senior Hope Counseling uses the Level of Care for Alcohol and Drug Treatment Referral known as LOCADTR, which is a validated assessment tool. This tool can be very helpful to providers during assessment to identify if the client can benefit from outpatient treatment or may be in need of a higher level of care. Additionally, providing information on available services via discussion with peers who have already engaged in services can be instrumental in helping the older adult to feel more comfortable with the treatment and demystify what the program is all about. Next slide, please.

CBT is an evidence-based, psychotherapeutic approach to identify and alter sequences of thinking, feeling and behaving that led to problematic substance use, and has outperformed nicotine replacement therapy for older adults. Cognitive behavioral therapy can be useful for addressing patterns tied to adverse childhood experiences and may be of value in supporting adults dealing with common stressors of aging.

Older adults may benefit from a structured instructional approach due to more common memory challenges. Reading or listening to key takeaways twice, with larger text or enhanced audio, can additionally be very helpful. Learning through multiple methods, both audible and visual, such as using blackboards or flip charts. Additional time to process new content is also very helpful.

For more information, see the Substance Abuse Among Older Adults Treatment Improvement Protocol, TIP, Series 26.

During this last year, I was asked to be a field reviewer for a newly developing SAMHSA TIP that will provide the most updated, evidence-based approaches to helping practitioners work with older adults with SUDs. It is due out for publication later this year, and I strongly encourage everyone to reach out and receive a free copy. Next slide, please.

Older adults may believe that they are alone in dealing with their SUDs, but peer support programs may help to normalize their experience and reduce isolation and stigma. The Senior Hope's alumni program is comprised of successful graduates of the outpatient SUD program for older adults. Successful graduates can stay in touch with their peers who are at a similar life stage, continue to receive support and begin to support others. Senior Hope also offers a peer-run AA meeting for older adults who engage in weekly support groups with one another. Next slide, please.

If possible, group older adults together into age-specific cohorts. As some members may be experiencing cognitive changes, slow the pace of meetings. Repeat content, and use enlarged text to account for visual deficits.

If you are unable to offer groups specific to older adults, ask group leaders to be mindful of preferences that some older adults may share, including limit the profanity used, talk slower, and promote understanding of older- versus younger-adult challenges. For example, mobility and hearing issues for older adults versus workplace challenges for younger adults.

Older adults benefit from groups with smaller size, 15 or fewer older adults, ideally. Due to more likely hearing loss, visual loss and mild cognitive changes, smaller groups increase chances for older adults so they can fully participate in the conversation.

Encourage older adults to visit peer support groups prior to discharge from treatment to promote continuity and begin learning from their peers. Try more than one meeting before deciding whether it is a good fit. Next slide, please.

Appropriate community support can increase engagement in substance use disorder treatment and bolster its effectiveness through a focus on needs of the whole person. Community supports may include Meals on Wheels, transportation, social clubs, employment services, housing support, legal services, self-help groups and aging-in-place villages.

Tips for coordinating with community supports include finding out from the client what kind of support is most important to them. Reaching out to local and state departments on aging and requesting information about available resources can be very valuable. Developing memoranda of understanding and partnership agreements for referrals with key community organizations is very helpful. At the time of intake, ensure that information can be sent and received with the older adult's primary care provider by asking them for a release of information. Actively link older adults to community supports and follow up to see if the linkage has been made. Where

appropriate, involve caregivers or family members if the client is receptive to that involvement. Next slide, please.

It is important to help older adults structure their lives and plan activities that give him or her a sense of meaning and purpose. It is important to assist the older adult in finding age-specific SUD services in their respective communities, and it is also important to talk with older adults, and caregivers with consent, about removal of substances from the living environment.

Determine if the older adult is safe or needs additional services or supports. For example, a more supportive, supervised living environment may be needed.

Work with the older adult to develop a relapse prevention plan with phone numbers of supportive people and resources available to help them through their immediate needs, should they feel a relapse coming post-discharge from your facility.

Offer guidance to caregivers on potential SUD signs and symptoms, such as unexplained bruises, confusion and isolation. It is helpful for practitioners to become familiar with senior services in their communities and with their state guide to finding services for older adults. Next slide, please.

Here is a case example of a Senior Hope counseling client, Ms. S. Ms. S., a 57-year-old female with alcohol use disorder, cannabis use disorder and depression, presented for treatment. The practitioner built a rapport with Ms. S. and then delivered the adverse childhood experiences questionnaire. Ms. S. disclosed early childhood sexual abuse for the first time, which led to substance use to cope with emotional distress.

The development of a treatment plan with Ms. S. was based on her personal goals, which helped Ms. S. become engaged in her treatment. Treatment consisted of individual and group sessions with an emphasis on CBT to help Ms. S. realize that her childhood sexual abuse was not her fault. Over time, Ms. S. was able to address her underlying trauma and move forward with her recovery.

In conclusion, I would like to share how important it is to custom-tailor your approach to meet the unique needs of older adults who are often struggling with co-occurring issues. By listening carefully to what the older adult is sharing during the initial assessment and offering age-specific services to meet the needs of this vulnerable population, we can help our elders suffering with SUDs and co-occurring issues move towards greater quality of life, which is truly what they deserve at this later stage of life.

And now, it gives me great pleasure to introduce our next speaker, Elizabeth Baumann, LSW, case manager, Council on Aging of Southwestern Ohio.

Elizabeth Baumann: Thank you, Dr. MacFarland. Hello. I'm Elizabeth Baumann. I'm a licensed social worker with Council on Aging of Southwestern Ohio. I'm currently a case manager working with older adults who are dually eligible waiver beneficiaries. Council on Aging is a non-profit organization dedicated to enhancing the quality of life for older adults,

people with disabilities, their families and caregivers. We promote choice, independence, dignity and wellbeing through a range of services that help people remain in their homes for as long as feasibly possible.

We work to ensure the members are in the least-restricted environment through coordinating and collaborating with physicians, providers, behavioral health services and the SUD services. I will be discussing case management tips to working with older adults with substance use disorders, and then I will give specific examples that exemplify these tips. Next slide.

The first tip I have is that communication is key. This may seem like common sense, but it can either make or break success with the client. Substance use may be part of the older adult's life, but it's not necessarily who they are. There are many things that make up an individual, such as their wants, desires, where they've been and where they see themselves going. This is not any different working with older adults.

How we speak with our older adults builds the foundation for progress. Recognize and learn your members' interests, and remember them. Let them know you care about more than just talking about their substance use.

Have something to fall back on when the communication slows. Do some research on their interests and hobbies, ensuring you have commonalities to speak about that will keep communication flowing. Use these interests and commonalities as a way to begin a discussion about their substance use.

An example I think of is saying something as simple as, "I saw the Reds game was on last night. Is this something that triggers you to drink while you watch the game?" Communication promotes engagement. Next slide.

There may be some resistance upon initial contact and difficulty in reaching a member for follow-up. Communication may be guarded. There are some strategies for building rapport. The first step I have is to send a personalized greeting card upon enrollment, with your business card enclosed. Put a face to a name. Ask the older adult questions to understand their views on engagement and their expectations. Did they enroll in the program, expecting to only have contact when they call you? Do you need to clarify your contact guidelines?

Talk about their preferred means of communication and their schedule. Many older adults struggle to sleep well at night and may not be avoiding engagement, but you may be catching them at an inconvenient time.

Some older adults may not be ready to address their substance use disorders as well. Meet them where they are. Determine their definition of the problem and work on addressing that first. Work on what they see as needing to change. Is it something such as their living situation? Their income? These goals and efforts may ultimately lead to them realizing a change related to their substance use is needed. Having a goal of saving money, for example, and discussion may lead to the individual realizing how much money they've spent on alcohol. I'll give a good example of this in my case studies later in the presentation.

After engagement and readiness to change, there may be additional barriers to overcome such as their literacy. Next slide.

Do not assume that your older adult members or any of your members are literate. Illiteracy does not equal unintelligence. Some individuals may have had to drop out of school and provide for their family. It is okay to ask an older adult about their literacy abilities. Most will feel relieved that you've taken the time to ask.

Normalize adding this into your conversation. Rather than just saying, "Can you read?" maybe consider asking them, "Would you like me to read this with you? Do you need assistance filling this out?" This will also strengthen rapport.

Compliance with appointments is the next barrier that we can face. Next slide.

Dually eligible older adults with substance use disorders may need assistance attending their treatment appointments. They may not ask unless you prompt them. because they've previously worked independently, they go to their appointments on their own. They've not needed the help that they need now.

They may struggle cognitively as well or have literacy barriers on top of potentially not being sober, which contributes to why they need someone to accompany them to their medical appointments. Attend appointments with them if possible or schedule time to call in on speakerphone.

They may need assistance managing appointments and pickup times. They may need someone to act as a notetaker, especially if they are not sober. This will prevent missing vital information and provide reminders post-appointment.

They may need additional mobility supports in and out of the appointments.

Help them engage their support system to alleviate these barriers. Questions such as, "Do you have family or friends who would be willing to ride with you and assist you during your appointment? Is there anyone that would be willing to meet you at your appointment and take notes for you? Can I help you call someone to inform them of your appointment?" Next slide.

Coordinating with the care team. Don't assume knows how to or feels comfortable advocating for themselves. Older adults may have recently lost support systems who previously have helped them, such as their spouse. Some older adults may have many questions they are unsure how to word to a physician or may think they aren't important enough to ask.

Help support independence and self-advocacy. Help the older adults schedule and prepare for their appointments, such as scheduling, writing down appointments. Do they have a planner? Do they need help writing the appointment in the planner?

This slide lists wonderful examples of questions you can potentially ask your patients that you work with.

Assist with making a list of questions to take to their appointment and ask their provider, such as specific questions they have to ask, "Would you like me to help you write them out and put them in your planner so you have them when you get there?" Next slide.

The next step I have is to hold care team collaboration meetings with the older adult present. It can hinder your rapport with an older adult if you are consistently having conversations with providers or physicians about the older adult's treatment without them present. Call the physicians together if you have a question. Place the doctor's office on speakerphone so that the older adult can hear the full conversation. The older adult is the center of the care team and has a choice and control over his or her own care and care team recommendations.

Engage the caregiver in helping build the care plan and attending care collaboration meetings as well with the older adult's permission.

Share the care plan during care collaboration meetings and ask for input into the assessment and goals. An example of this is an older adult wanted to complete detox from home rather than a facility, which can be dangerous. I simply faxed the care plan to the older adult's physician and requested the physician step out the goal of detoxing from home into specific steps for the older adult to follow, providing guidance and supporting the individual's choice for treatment. Next slide.

Now will be focusing on a few case studies for dually eligible older adults with substance use disorders. I will be providing ground-level tips and tricks which have worked for these specific cases but can be generalized and adopted to fit many older adults working through substance use disorders. I'll be relating two case studies back to the engagement strategies that I just reviewed.

The first case study we will look at we will call Mrs. M. Mrs. M. is a 72-year-old dually eligible female. Mrs. M. has been diagnosed with moderate opioid use disorder, with her substance of choice being Percocet. Mrs. M. also has other health-related conditions, such as arthritis, COPD as well as frequent constipation. Next slide.

What I'll focus on first is communicating with Mrs. M. Addressing substance use negatively can shut down communication and openness. Rather than saying, "Mrs. M., I see you have problems with overtaking your pills," try saying some things such as, "How are you managing your medication? How can I help support you in sticking with your medication schedule? Do you have a pill organizer for each day of the week? Is it hard for you to read the labels on your medication bottles?"

We mistakenly shut down communication without even knowing we did it with something as simple as how we phrase a question. How we intend for someone to take a question or comment and how it's received are not always aligned. Next slide.

The next barrier I had with Mrs. M. was engagement. Upon enrollment, Mrs. M. would not answer the phone or open the door for me. The resolution I came to was this: I completed a drive-by to her home and left a flyer on her door with my business card, which had my photo on it so Mrs. M. would recognize my face.

I then called from a non-private office number. Many older adults are fearful of answering private calls as many telemarketers as well as medical supply companies scam-call older adults. Notify the older adult that your number will show as private if it does.

These strategies were successful, and I was able to gain contact with Mrs. M. Next slide.

Coordinating with Mrs. M.'s care team. Mrs. M. reported concerns of having her Percocet dosage reduced but felt fearful of discussing it with her physician. This could lead to issues such as buying the Percocet off the market and a potential for overdose.

The resolution I came to was this: During a home visit, I inquired as to whether Mrs. M. would like me to facilitate the conversation between her and her physician. I called the physician's office and placed the office on speakerphone, informed them that the older adult was present for the call and had some concerns with her dosage of medication she would like to speak with the physician about.

She continued the conversation, but I was present for support. Through this, the physician did not adjust her medication level, as she hoped, any further but was able to discuss her opioid use disorder with the physician, and the doctor gave her supports that were available. This maintained rapport between the physician and the patient. Next slide.

Transportation barriers are very common. Pill counts generally occur randomly and are monitored and initiated by the pain clinic directly to ensure compliance with medications prescribed. Mrs. M. could not attend random pill counts due to mobility issues and lack of transportation, but transportation for Mrs. M. required a three-day scheduling notice and was not able to give that for a random pill count.

The resolution I came to was calling the pain clinic with Mrs. M. and arranged for a home health nurse to come in her home for a pill count. This was not previously offered by the pain clinic. Sometimes coming up with resolution requires case managers to be resourceful and creative. Next slide.

My next case example we will call Mr. P. Mr. P. is a 75-year-old dually eligible male with an alcohol use disorder. He has other health-related conditions of fatty liver disease, lower GI resections, hypertension, Type 2 diabetes, arthritis and tongue cancer in remission. Next slide.

Mr. P. was not openly communicating with me and restricted info that he provided. I needed to build rapport with him. I noticed that Mr. P. had a bike sitting by his living room door during a home visit. When communication wasn't flowing, I said, "I see you have a bike. Do you enjoy riding?" He started talking to me about the bike, which led into him telling me that when he feels

like drinking, he takes the bike ride to get his mind off drinking. Every time I go to his house now, I ask him, "Hey, have you had any enjoyable bike rides lately? Tell me about them."

Notice what your older adult is wearing. Notice their surroundings if you're in their home. Look for topics to converse about that could build rapport. Next slide.

Mr. P. also didn't feel that he had an issue with substance use and didn't want to work on it. The resolution that we came to: I was able to come to helping him come up with goals that he prioritized as important. He told me he wasn't happy with his budget and wanted to have more spending money at the end of the month, so we broke down his budget to see where he was spending his money. I gave him a transaction form to fill out for the month and look at.

Due to this, he realized how much he was spending on alcohol. He then began to realize he had a substance use disorder without me directly telling him. Next slide.

Mr. P. was also religious and attended communion in which wine was served. He wanted to participate without indulging in alcohol. We ended up coming up with a resolution of I sat down in his home with him, and I assisted him in writing an anonymous letter to the church, requesting to have a second option of grape juice for communion. I also helped him come up with a backup plan of bringing a bottle of grape juice to service when he knew communion was going to be served. Next slide.

I worked very diligently to coordinate with Mr. P.'s care team. I requested to share his care plan, which included a goal of attending AA meetings per week, with his physician. The physician called to ask me and Mr. P. if we could add a goal of cutting back on half of a glass of alcohol a day to improve his GI function. This included the physician in Mr. P.'s goal related to substance use disorders and allowed for engagement with the physician and added another support system for Mr. P. to lean on when he needed it.

We really should be creating a person-centered care plan with older adults that is centered around their individual goals, not necessarily the goals that we have for our older adults. Next slide.

Some key takeaways that I really want to highlight are engagement and communication. Learn your members' individual interests. Remember them. Let them know you care more not just about their substance use disorder but also about their individual person.

Meet older adults where they are. Determine their definition of the problem and work on addressing that. It typically will build into building rapport and then working on the issue at hand.

Ask them about their literacy abilities. Just because we can read, we shouldn't assume that others can.

The next key takeaway is care coordination. Help older adult members to schedule appointments and attend if possible to take notes and support follow-through. Assist older adults in developing

questions to ask their care provider, and hold care team collaboration meetings with the older adult present. Many physicians want to be involved in the care and not just at the doctor's appointments. They'll call you and they'll talk to you on the phone. Just don't be scared to share with the care team.

I want to thank everyone for your time, and now our consumer speaker, Sherri, will speak.

Kristin Corcoran: Sherri, are you still with us?

Sherri: Yes. Can you hear me? Hello?

Kristin Corcoran: Yes. You can go ahead. Thank you.

Sherri: Okay. My name is Sherri, and I am an addictions counselor. I have a Bachelor's degree in biology and chemistry, and I work at an addictions center. A little about me. I was born into a family that was a typical '50s family. My father owned his own business; my mom was a stay-at-home mom. Just before my third birthday, a man walked out of the psychiatric hospital, came into our home and murdered my mother in front of me.

My father sent my brother and I away to England where my mother's family lived, and I was sure that he sent us away because it was my fault that my mother was dead.

When we returned from England, we stayed with my father's parents. My grandfather would get me drunk and molest me.

My father remarried a woman who hated me and who was very abusive. By the time I was five, all I wanted to do was die. I felt that every problem in the house was because of me and everybody would be happy if I was gone.

My stepmother taught me to hate myself. I was an ugly, stupid, no-good, rotten piece of garbage. The abuse got so bad that my father had to send me away to boarding school, where I learned about drugs and alcohol.

In a way, the drugs and alcohol saved my life. It was the first time I had had friends and I didn't want to die.

In time, I became involved with substance abuse, and I tried to kill myself when I was 20 by intentionally overdosing on heroin.

I tried to put my life together after this, but I couldn't keep away from drugs and alcohol. In 2010 I was given a DWI and spent two months in jail.

At this point, I'd had enough. I wanted to stop drinking and using. I went to AA meetings in the jail and realized that I could not continue abusing myself, that I needed to be clean and sober.

It's been a long road, but I haven't had a drink since. Maintaining sobriety has not been that hard. I went to a program at Senior Hope where I learned how to be an older adult with a substance abuse problem.

My best advice for clinicians is to listen carefully to the clients. Ask questions. And, most importantly, give them positive feedback. Tell them they're important. They should be proud of themselves for all their work, that they deserve a good life, that they can achieve anything they want, that they're not bad people, just made bad choices.

I find that giving back to the community is a great way to maintain sobriety. I've brought AA meetings to a local detox unit, and I've brought AA meetings to the correctional facility. The more I give, the stronger my recovery becomes.

Clients need to believe that they're special and important. I encourage people to find a sponsor and get involved in the 12-step program. Keep in touch with other sober people and stay away from people, places and things that can cause triggers.

The most important thing, I find, to help people is to teach them to love themselves. I'm not unique, and I have worked hard to recover from substance abuse. I went back to school and completed my [TASC], which is an addictions counseling program. I'm very happy that I may help others to achieve their goals.

Thank you very much for listening.

Kristin Corcoran: Thank you so much, Sherri. And thank you, Dr. Trevisan and Dr. MacFarland and Elizabeth, for your presentations. With that, we now have a few minutes for questions from the audience.

At this time, if you have any questions for our speakers, please submit them using the Q&A feature on the lower left side of the presentation. Type your comment at the bottom of the Q&A box and press Submit.

Our first question is for Elizabeth. What are some of the most effective ways to help older adults maintain their recovery over time?

Elizabeth Baumann: Thank you for your question. I think just being part of a person's life, working with our older adults frequently, checking in on them not just on your scheduled contact routine, which most of us have a normal schedule we have to check in, but check on them more often. Call them just to see how they're doing. Most people really appreciate that, especially our older generation that may not have other support systems. I would say that is probably the number one tip I have.

Kristin Corcoran: Thank you, Elizabeth. Dr. MacFarland, do you have anything that you would like to add?

Nicole MacFarland: Yes, I think another tip would be to engage caregivers that are involved with the older adults. They provide a comprehensive overview of traditional perspectives that the older adult may not have shared, so that the practitioner can be well poised to provide services to support that elder SUD client.

Kristin Corcoran: Thank you, Dr. MacFarland. Our next question is for Dr. Trevisan. How does the information that you've presented on screenings and intervention fit with the SBIRT model?

Louis Trevisan: Thank you for the question. SBIRT, or Screening, Brief Intervention and Referral to Treatment is the acronym, basically when you screen somebody, as I tried to indicate, using the AUDIT-C or the CAGE or the SMAST-G, the STOPP, or just most often older adults, if you just ask them and want to talk about it in a motivational interviewing way, you can screen them for their substance use.

I would try brief interventions at first if it appears that their substance use is moderate or mild, and if it doesn't work, then you would refer to treatment. I would always encourage—and Sherri did remind me and I didn't mention it earlier—that 12-step programs are very important. They provide a community. It doesn't work for everybody, but it does give a lot of support, and the sponsors are very dedicated. There are groups that cater to older adults as well.

SBIRT is Screening, Brief Intervention and Referral to Treatment. So you screen them, and then you try to do a brief intervention, and if that doesn't work, then you refer to treatment and support them as much as you can.

Kristin Corcoran: Thank you, Dr. Trevisan. Our next question is for Sherri. What advice would you give to a caregiver that is providing care for an older adult with a substance use disorder?

Sherri: I think it's very, very important that the clients believe in themselves and that they are confirmed that they are good people. I think seniors need to work with other seniors so that they have a community. But most importantly is the caregivers need to listen and hear and work with the person on their level.

Kristin Corcoran: Thank you, Sherri. Our next question is for Dr. MacFarland. What does the treatment timeline and process look like for an older adult at Senior Hope Counseling, and what is the typical treatment progression?

Nicole MacFarland: Thank you for that question. At Senior Hope, we do our utmost to custom tailor our approach to meet the unique needs of each individual. The average length of stay is anywhere from six months to nine months. We have over half of our patient population struggling with co-occurring disorders, and in those cases, individuals may benefit from a longer stay with us.

Treatment includes individual and group sessions, family intervention and involvement, and certainly case management and referral.

So really, some individuals may be there for a shorter period of time, and others may benefit from a longer stay with us. We are a non-intensive outpatient treatment facility located in Upstate New York.

Kristin Corcoran: Thank you, Dr. MacFarland.

Nicole MacFarland: You're welcome.

Kristin Corcoran: The next question is for Elizabeth. What advice would you give to a case manager who's working with an older adult that is resistant to substance use treatment?

Elizabeth Baumann: The best tip I have is just to meet them where they are. Throughout the presentation, we talked about members that are resistant and may not even recognize that they have a substance use disorder yet. I would just start with what they see as a problem. Like I talked about, see what they see as a challenge. Is it their income? Is it where they're living? A lot of times, even with examples of people being evicted, why are they being evicted? Why are their finances low? What are the barriers they're coming into? I've had members be evicted and they don't know why, and then they turn around and they realize that it's because they've been drinking excessively in the hallways or they've not been following the rules of the place that they're living.

So just meeting them where they are, that's definitely the first thing you should do. Thank you.

Kristin Corcoran: Thank you, Elizabeth. The next question is for Dr. Trevisan. How does screening for substance use disorders differ for older adults compared to younger adults?

Louis Trevisan: This is a good question. I think that it needs to be a little bit more conversational. It needs to be couched in the idea of how somebody's life is moving along and their medical issues, their psychosocial issues that they may have or they may bring up. Screening should be a warm, empathic way of engaging the older person in talking about substances, whether or not they're using them or not, and if they are, how they're using them. Rather than just a check the box off.

And that speaks to a couple other things I wanted to say about this. Clearly it takes a little bit of time, so sometimes fast-paced primary care doctors may not feel that they can do that, and they need to have somebody in their office that helps them with these kinds of issues.

And stigma needs to be thrown out the door. Substance use disorders or issues are not things that are indicating bad character. These are good people, as Sherri says. These are wonderful people. Many of them have incredible talents and things to give back to the world, and if we can help them with their substance use, they do really, really well.

So I think getting to know them and taking a little bit of time with them really helps you understand that this is not a characterological flaw. This is an issue that—substances are very

addicting. They can be very problematic for almost anybody, as we've seen with the use of chronic pain medications.

So I would say being gentle, being non-confrontative, non-judgmental, and getting to know who they are and what they bring to the table. Because they've had a long life. They've got stories. They've got things that they can educate you about.

So I would use that kind of approach with an older adult rather than—and you can do that with young people, too, but sometimes it's a little bit more cut and dried with them. Thank you.

Kristin Corcoran: Thank you, Dr. Trevisan. The next question is for Elizabeth. Our care managers and social workers work exclusively telephonically. Do you have any telephone-specific tips that you can share?

Elizabeth Baumann: I would say just listen to what the person is calling in about first and build off of that. If they are calling in under the influence, it may be different; you may be able just to kind of meet them where they are and only discuss the things that they have to talk about. But being able to just to listen to them and listen to their concerns and build off of that I think is something that maybe, "Hey, it sounds like you may be having an issue right now. Would you like me to call somebody for you? Can I three-way call somebody in to get you some help on the line?"

Being able to use that three-way call function is really important. I do home visits specifically, but I do do some telephonic calls, so being able to just to say, "Hey"—instead of, "I'm going to hang up and call somebody for you," "Let's call together." I think that's going to build rapport and that's going to be able to get them the immediate help that they have. Thank you.

Kristin Corcoran: Those are great tips. Thank you, Elizabeth. Our next question is for Dr. MacFarland. How do you encourage older adults to attend support groups? How do you pique their interest?

Nicole MacFarland: We pique their interest by encouraging them to talk with their peers. Oftentimes when they're able to talk with their peers, whether it be in the waiting room or just an initial introduction, it helps to start to demystify the experience of outpatient treatment and all that's involved with that.

During the seminar, I talked about our peer support groups and our alumni program and our self-run AA meetings, and there's something very special that happens when you have peer-to-peer communication. A lot of times older adults, this is their first experience being in an age-specific treatment program, and they may have some reluctance, and so by being able to talk with one or more peers, they start to realize that engaging in the groups and starting to open up and share can be a really positive experience and help them move towards greater recovery. So this is something that we offer at Senior Hope.

Kristin Corcoran: Thank you, Dr. MacFarland. Sherri, the next question is for you. When did you decide that it was time you wanted to address your substance use disorder, and was there any particular reason behind your decision?

Sherri: There had been many times that I was sick after drinking and swore I'd never drink again, but I never really followed through. It wasn't until I received a DWI and spent two months in jail that I realized that I had to make different choices in my life. By going to AA meetings in the jail, it reassured me that it wasn't impossible to be clean and sober.

The experience of being in jail for two months really made me strong in wanting recovery. I never want to have that experience again. It's horrible. And I don't have to ever have that happen again because I stay clean and sober.

Kristin Corcoran: Thank you so much, Sherri. The next question is for Dr. Trevisan. What can we do as care coordinators to assist members with medication? Have you found certain medications to be more helpful for older adults, that have less side effects?

Louis Trevisan: This is a great question. Medications for substance use disorders, particularly alcohol and opioids and tobacco, all really do help. I think for care workers or for caseworkers, the best thing to do would be to help them make sure that they're taking their medications in the right way. Medications are often misused or—medications in general, not just medications for substance use disorders. Medications like Suboxone or methadone—methadone is handed out and strictly controlled daily. Suboxone you can take home but would have to be monitored closely.

Naltrexone for alcohol and other medications that are listed there for alcohol, the care worker could really help monitor whether they're taking them the correct way or not. And if they're not, why not? And if they're having side effects.

So those are important issues. Medication compliance for this harm-reduction model for both opioids and alcohol and for tobacco are very important because they really reduce the possibility of overdose for opioids. They reduce the rewarding effects of alcohol when taken properly. And for tobacco, which is the number one public health concern not only for older folks but for lots of people, the varenicline and gum and patch all work. Of course, you need to do non-pharmacological treatments are well, and care workers can help support those initiatives and make sure that people are taking them right or taking them in the right situations.

Another important aspect of medication treatment is the use of naloxone spray or injections, which are now in many states over-the-counter, but we prescribe them and we teach people how to use them, and the care workers can teach them how to use them, too, because they can become important for somebody who has a slip. Often people who see other people who have overdosed or who have used and done—naloxone works very good and saves lives, and it should be out there.

But the care workers, I think spend time with the people and talk with the doctors. Feel free to call us and let us know how things are going when you do visit because this is a real all-out effort, I think, to work on making sure that we can manage these problems.

Kristin Corcoran: Thank you, Dr. Trevisan. The next question is for Elizabeth. What if your client fully admits to having a substance use disorder but is adamant that their primary caretaker be left out of their recovery process? How would you gently encourage the client to utilize that support system?

Elizabeth Baumann: Well, it is absolutely their choice as to who they wanted involved in their care team. I would let them know automatically that that is absolutely okay, we'll take it step by step on working through their substance use disorder, and really engage the supports that they are willing to start with.

I would just let them know that I would highly encourage the primary care provider being involved based on the fact that alcohol use or substance use can damage your organs. It can cause other long-term effects, or it could interact with the medications that they're using for their conditions.

I would just tell them that you're willing to facilitate the conversations with them if they are fearful of talking to the provider about it. I think that's a lot of the times what I see first is they're fearful of admitting that they are having an issue, especially if they've had the same primary care provider for a long period of time, that feeling that they're going to disappoint someone.

And I would just tell them, "Hey, if you would like me to, I can call the primary care provider and we'll discuss it." But don't push too much. The first time I would just say, "Okay, that's fine. We'll work on what we can," and then just kind of gently mention it about every other time you see them, "Hey, how are you feeling about your doctor being involved? Is there another doctor that we can work on getting involved in your care?"

I think that's probably the best way, but definitely meeting them where they are. Let them know they're in control of their treatment; otherwise, it's going to damage your rapport with them. It's going to kind of start to shut the walls down between you and the patient. Thank you.

Kristin Corcoran: Thank you, Elizabeth. The next question is for Dr. MacFarland. You mentioned using peer supports. How do you utilize their knowledge and skills in your centers, and how are they received by other team members?

Nicole MacFarland: Yes, with the alumni program, we decided to roll that out because we realized that just because individuals graduate successfully from the program doesn't mean they don't benefit from ongoing support as time goes on. So we have these successful graduates, and we offer them an opportunity to come together to share their experiences, not only with one another but, as you can see with Sherri, she is a true ambassador for the program and has often spoken in our groups with newer members to Senior Hope and in the community to share her experience and what worked for her and how wonderful she's doing with her recovery and wellness.

So there is a lot of strength associated with encouraging the peer support and helping this older population realize that they're not alone in their plight. A lot of times, the older generation shares with us that when they were growing up, there was so much stigma associated with addiction, with mental health issues, and the services were not in place like they are more so now with the younger generation.

So this is what's tied into initial resistance, and peer support can be instrumental in helping an older adult to engage and stay in treatment and move towards recovery and wellness.

Kristin Corcoran: Great. Thank you so much, Dr. MacFarland. And, Sherri, this next question is for you. Was there one person that helped you recover more than another? Who was it, and what did they do to impact your change?

Sherri: Believe it or not, one of the things that was instrumental is that I was ordered to go to drug court. I had to go each week to a meeting, and I had to go—whenever they called me, I had to be drug tested. That helped me at the beginning of becoming free and clear of drugs and alcohol.

But most important was my work with Senior Hope. I worked with other seniors who understood where I was coming from, and they taught me that I'm not a bad person, that I could achieve this if I wanted to.

So I think that the peer supports and the programs brought me to a place where I could stay clean and sober and function like a non-addicted person in society. The peer support has been essential in my being able to maintain sobriety.

Kristin Corcoran: Thank you so much, Sherri. That concludes our question-and-answer session. At this time, if you have any additional questions or comments, please email RIC@lewin.com. We'd also like to invite everyone to visit our website to view recordings of our upcoming webinars and our webinars that aired earlier this year. You can view the topics of these webinars on this slide.

The slides for today's presentations, a recording and a transcript will be available on the Resources for Integrated Care website.

At this time, the post-tests for the webinar are now open. Additional guidance about obtaining credits and accessing the link to the post-test can be found within the Continuing Education Credit Guide on this slide or at the Resources for Integrated Care website. Next slide.

Thank you so much for joining us today. Please complete our brief evaluation for our webinar so that we can continue to deliver high-quality presentations. If you have any questions for us, please email us at RIC@lewin.com.

Thanks again to all of our speakers. Have a wonderful afternoon, and thank you so much for your participation.