The Lewin Group
Promising Practices for Meeting the Needs of Dually Eligible Older Adults with Schizophrenia
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Evan Vahouny: Thank you. My name is Evan Vahouny, and I'm with The Lewin Group. Welcome to today's webinar on meeting the needs of dually eligible older adults with schizophrenia. This is the fifth session of our 2018 Geriatric Competent Care Webinar Series.

Today's session will include a 60-minute presenter-led discussion followed up with 30 minutes for Q&A among the presenters and participants. This session will be recorded. A video replay and a copy of today's slides will be available at https://www.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 our webinar.

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You will 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 pretest 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 credit for attending this webinar. To obtain these credits you must complete the post-test through CMS's Learning Management System.

Additional guidance about obtaining credits and accessing the links to the pretest and post-test can be found in the Continuing Education Credit Guide in the Resource List on the left side of your screen or at the Resources for Integrated Care website.

This webinar is supported through the Medicare/Medicaid Coordination Office, or MMCO, at the Centers for Medicare and Medicaid Services. MMCO is developed tactical assistance and actionable tools based on successful innovation 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 at Integrate_Care.

At this time, I'd like to introduce our speakers for this webinar.

Our first speaker, Dr. Naila Azhar, is an Assistant Professor of Psychiatry and Supervising Attending at the Schizophrenia Outpatient Clinic at UConn Health. Our second speaker, Tracy Beavers, is a Care Manager at CareSource Ohio. Ann Marie Luongo is a Program Manager at Advanced Behavioral Health, Inc. And Heidi is a family caregiver who will talk about her experiences with her brother.

On this slide you will see our learning objectives for today's webinar. We hope that you will learn about common symptoms of schizophrenia among dually eligible older adults; be able to recognize effective treatment options; identify practical tips and strategies; and identify new opportunities for collaboration.

I am now going to pass it over to Dr. Azhar to start off our presentation.

Naila Azhar: Thanks, Evan. Thanks for the introduction. Greeting to all participants and to everyone who is listening.

So, first slide presents data, prevalence data. While 3.6% of all individuals are 65 or older, and this number might seem lower to you, but put this in perspective of a world that's aging, world population is aging, and demographics are changing. World's older population is growing at an unprecedented rate of 8.5%, and this percentage is projected to jump to nearly 17% by 2050. So, while 3.6% of individuals with schizophrenia are 65 and older, this number is expected to increase.

The table on this slide that gives you a breakdown of behavioral health conditions among dually eligible adults and compares it with Medicare-only beneficiaries. As you can see, the rate of schizophrenia and psychotic disorders among persons who are dually eligible for Medicare and Medicaid is 7%. And if you compare it with the patients who are only Medicare beneficiaries, this rate is 1%. And this has implications on resource allocation.

This slide focuses on signs and symptoms of schizophrenia. Schizophrenia is a syndrome, which means it's a cluster of signs and symptoms. Recognizing multiple dimensions of this disorder and associated impaired occupational and social functioning is key to identifying patients who suffer from this disease and key to be able to help them.

Signs and symptoms of schizophrenia are generally grouped into several dimensions, and these are positive, negative, disorganized, and cognitive dimensions. Positive dimension basically means that presence of something that's normally not present in a normal population, for example, seeing things which are not there or hearing voices that are not there, or think false beliefs, so auditory hallucinations, real hallucinations, and delusions.

Negative dimension is absence of something that's normally present, and this includes spontaneity in speech, emotional responsiveness. When human beings talk to each other there's a change in their voice or their tone, depending upon the emotional content of the conversation, and you can also see a change in their affect. And in patients with schizophrenia you sometimes see flattening of the affect is a term that's mostly used. So they have monotonal speech and they have lack of emotional responsiveness.

Disorganization basically is displayed as the person's behavior or his speech. So disorganized behavior can show up as people who are not dressed up appropriately. They might be stripping their clothes. They might be randomly urinating or defecating on the floor. And their speech might also be disorganized, which means that they might be losing train of thought while they are having a conversation, or they might be jumping from one topic to another topic, or might include unnecessary irrelevant details into the conversation.

Psychomotor immobility would manifest as almost like inability to move. People might be sitting at the same spot, staring into space for a long time.

Cognitive dimension is an important dimension, because it means that people would have difficulty understanding instructions. They would have problems with working memory and in terms of attention.

These are general symptoms, right? So how are these symptoms reflected in older patient population? So, as people grow older, positive symptoms and disorganized symptoms, they improve. So there will be less auditory hallucinations and less disorganization, like people not dressing up properly. But they would have more negative symptoms, which would include loss of interest, problems with the verbal expression, problems with the empathy. And there might also be some soft neurological sign which can impair their motor functions. And there is like a cognitive decline in older patients with schizophrenia. So positive symptoms get better, but negative symptoms and cognitive symptoms, which are highly correlated to functioning and quality of life, get worse.

So, next slide basically emphasizes the point that schizophrenia is like a chronic disease model, and like diabetes or any other chronic disease, so most of the people would have comparative stability with some residual symptoms, but it would be interrupted by psychotic symptoms which might need inpatient hospitalization. So stress, poor diet, nonadherence to medication, or other medical problems can cause this decompensation.

This slide captures early onset schizophrenia and compares it with late onset and very late onset schizophrenia. Typical presentation of schizophrenia starts at an early age of 17 or 18 years, and these people would have like disorganization and would have problems with speech and their behaviors. And in comparison people who have late onset schizophrenia have better premorbid functioning, which means they were relatively doing okay before the disease started. So their expression of emotions might be better, and their social functioning might be better.

Now, compare this with very late onset schizophrenia like psychosis, which means the age of onset after 60 years. These people mostly have mock delusions, which are very distressing for these patients. They typically describe these beliefs, which are persecutory in nature. People might think that other people are after them. They are trying to poison them. And they have difficulty trusting other people, which includes their family members and healthcare providers.

You can see partition delusion mentioned over here. Partition delusion means that they have this belief that structures that normally act as barriers to protect them and barriers against movement,

sight, and sound, like walls, floors, and ceilings and doors, they are permeable, and they believe that other people can see them. They can steal their stuff. They can harm them. And they can even sexually assault them.

Next two slides talk about unique characteristics of older patients with schizophrenia. As people grow older, we said that the psychotic symptoms improve. Most of the hospitalizations in older people with schizophrenia are not because of psychotic symptoms, but they might be because of the physical problems that they are experiencing, because of the medication side effects, or because of the cognitive problems.

So there's a greater risk of most side effects of antipsychotic medication in older people, and there are more movement disorders, as well, in older people. And we can talk a little bit more in the question-and-answer session about this. So, older people with schizophrenia have more hospitalizations because of physical issues, and they are more sensitive to side effects of medication, and they have more cognitive problems.

Another unique characteristic of older patient population is cognitive issues. And it's extremely important to be able to differentiate between a person who has cognitive problems, either because of the side effects of the medication or because of depression or just because of the progression of the disease, from those patients who are developing Alzheimer's dementia, right? So, what is the difference? The difference is that people who are developing dementia, their cognitive loss is very progressive and is very -- sharp decline. And if you are suspecting that a person might be developing dementia it's important to be able to refer the person for neuropsychological testing.

Next two slides focus on specific challenges that one might face while you are treating and caring for older adults with schizophrenia. And these people tend to have more complex needs. So these patients have comorbid medical problems. There will be problems in their mobility. And these patients, we just mentioned that they have more delusional thinking and paranoia or difficulty trusting their providers. And they have not only difficulty trusting them, but they have cognitive problems. That means they have difficulty understanding the interactions with their teams.

And there might be physical side effects of the medications that they are taking. These people are more prone to develop these side effects, for example, orthostatic hypertension, which means that their blood pressure falls when they stand. They might be feeling dizzy, so there might be fall risk and other risks of psychotropic medication.

And just because of the chronic nature of this disease these patients will be more socially isolated. Their spouse might have died. And there's also caregiver burnout because it's a chronic condition. They might have adult children who have left the house, or the spouse might be getting older and not able to take care of these older adults. So these problems are specific in older adults with schizophrenia, and we need to keep in mind a plan how to take care of these issues while we are treating patients, older patients, with schizophrenia.

In addition, older patients might underreport some of the symptoms. I can go into detail in question-and-answer session, but these people have a high tolerance to pain, and they have cognitive problems. And the healthcare system is also fragmented. What does that mean? That means that they might be getting neuropsychiatric care somewhere else. Medical care might be provided at another spot. And case management and care coordination teams are not as integrated as we need them to be.

Last but not least, and very important, and I've seen this multiple times in my experience is that there's a bias against people kind of even among physicians. There's an attitude problem. So people are not seen as patients. They are sometimes seen as schizophrenia patients. So it's extremely important to be able to do a thorough assessment of these patients and identify what are some of the comorbid medical issues and be able to do a thorough physical examination in an older patient. It can help narrow down differential diagnoses. And sometimes some of very critical issues can just be missed because a patient is agitated and you don't want to do a thorough physical exam on them. So you can give some medication to the patient and do a thorough medical examination for these patients.

So let's move to the next slide, please. So next six slides focus on complicating factors in comorbid medical conditions. These factors in comorbid medical conditions are either specific to older patients with schizophrenia or they're more prevalent in this patient population. And as a treatment provider, as a team member, it's important to be able to identify these comorbid conditions and to be able to screen for these problems.

So, what are some of these problems? Obesity is more common. Diabetes is more common. Hyperlipidemia, coronary artery disease, myocardial infarction, mobility-related problems, which includes joint degenerative diseases like osteoarthritis, they are more common in this patient population. They might also have cataracts. And long-term smoking can cause other medical issues, as well. We are going to focus on metabolic syndrome, depression, and substance use disorders in the next few slides, because these are very important, and they can impair functioning of the patient and they can cause problems with treatment for these patients.

So let's focus on -- this is Slide 19 -- let's focus on metabolic syndrome. Metabolic syndrome is a cluster of conditions, which includes increased blood pressure, high blood sugar, excess body weight around the weight, abnormal cholesterol and triglyceride level. And these patients, older patients, are already at a higher cardiometabolic risk for developing myocardial infarction and other related disorders. So it's extremely important to be able to use a screening tool to identify high-risk older adults and be able to modify modifiable risk factors.

In my clinic, I have a screen that I use. I collect information at the baseline and then at regular intervals. It's extremely important to be able to monitor cardiometabolic factors using a screen at baseline and at regular intervals to reduce the cardiac risk for these patients.

Another important thing is that it's the responsibility of the psychiatrist to regularly update medical history, because new medical problems might start, and just because our systems, our healthcare system, is not integrated, there might be problem with communication. So it's extremely important to periodically update medical history and all the medical problems that the

patient is having, and also update current medications, which might be interacting with the medications that the patient is getting.

Another important complicating factor, a comorbid condition which is unique to this patient population, is depression. Depressive symptoms are more common in patients in dually diagnosed -- in patients who are dually eligible, and they experience depressive symptoms, which can take the form of subclinical depression or schizoaffective disorder or major depressive disorder, and it's extremely important to have a screening tool to screen for depressive symptoms in this patient population. A commonly used very easy screening tool is PHQ-2, and it's available, and a score of 3 points or more on PHQ-2 has a sensitivity of 83% and a specificity of 92% to find a major depressive episode.

Depressive symptoms among older adults with schizophrenia contribute to great admissions and increased number of hospital days, which increases the cost of treatment and also cause distress for the patient and their families. It's very important to not only routinely screen for depressive symptoms but also screen for suicide risk, as this risk remains higher in older adults with schizophrenia because they might be having command auditory hallucinations, and it's important to be able to identify that risk and to be able to change medications accordingly.

Another important complicating factor and a comorbid condition is substance use disorder. Prevalence of substance use condition among persons with schizophrenia is significantly higher than the general population. Although oral substance use becomes less common as older adults with schizophrenia age, which means that some substances like cocaine might be less frequent in this patient population, however, tobacco use and alcohol use remain very high. It's extremely important to choose a screen that's very sensitive and specific to screen for substance use disorders in this patient population.

There are two screens that I wanted to talk about. One of them is AUDIT-C. It basically is three very easy questions. And options are 0, 1, 2, 3, 4. This is a very good screen, and research has shown that it's very effective in screening for alcohol use in this patient population. There is another screen, which is short, Michigan Alcoholism Screening Test. The advantage, and there's a geriatric version which has 10 questions, the advantage of using this screen is that it has 10 questions but the answers are yes and no.

So it's very important to be able to screen patients with the schizophrenia, older patients with schizophrenia, for alcohol and tobacco use disorders. Why is it important? It's important because it can complicate treatment. Also, some of extrapyramidal symptoms, which are tremors, dystonia, akathisia, which is restlessness, they are more -- and also Parkinson-type symptoms -- they are more prominent in people who have comorbid substance user disorder. And older adults already are particularly vulnerable to side effects of these -- of antipsychotic medications, and if they also have substance use disorder these very distressing symptoms can become a problem. And the likelihood of reversing these potentially debilitating symptoms diminishes with age.

So, how do we screen and manage substance use disorder? An evidence-based intervention is brief screening, brief intervention, referral for treatment. Brief intervention consists of a screening followed by one to five sessions of advice, education, and motivational interviewing. It

has shown a lot of evidence in reducing I'll call related problems in older adults. And the intervention can be delivered in a medical setting or in older adult homes or in other aging service sites.

Some of the other programs that can help is intensive outpatient program. You have to understand this older patient population has their own specific needs, so the recommendations that you are making should be tailored to meet their personality and their needs. Nicotine use is very common in older adults. It's extremely important to explain it to the patient that there's an interaction between smoking and metabolism of antipsychotic medications.

And two medications, clozapine and olanzapine, increase the metabolism, or have an increased metabolism if you're smoking, and you might need a higher dose of these medications. It's very common to see that people are asymptomatic when they are discharged. They start smoking, and some of the symptoms come back. So it's extremely important to explain that to the patient.

Next slide is an assessment checklist. In our busy practices it's important to use this checklist to be able to systematically review current medical problems and to be able to complete assessment for these comorbid medical issues. This next slide tells you -- gives you a checklist and tells you how to access this checklist.

So, antipsychotic medications, in terms of treating patients with antipsychotic medications, more is not good. Patients as they grow older their body's ability to handle medications is diminished. There are changes in the permeability of blood-brain barrier. There are changes in receptors and changes in receptor occupancy, which makes older people more vulnerable to the side effects of these medications. It's extremely important to start with the lowest possible therapeutic dose, and in some patients you might actually be able to stop the medication, as well.

So, incrementally review the need of antipsychotic medication and consider reducing the dose. Some patients are on an anticholinergic medication. These medications are used to treat side effects of antipsychotic medications. In older patients the anticholinergic medication can cause a lot of problems. It can cause constipation. It can cause blurred vision. It can cause memory issues. So if it's possible you should try stopping anticholinergic medication. So, in summary, it's better to use lower doses of medication, start with the lowest possible dose, and use an incremental dosage decrease, and try using second-generation antipsychotics as compared to first-generation antipsychotics.

Because these antipsychotic medications have cardiometabolic side effects, it's important to monitor these side effects by using an instrument. Like you can have an assessment at the baseline and then regular screening for blood pressure, body weight, and glycemic control to see that these patients are not having metabolic side effects.

Fall risk is an important thing that needs to be monitored, because these medications can cause orthostatic hypertension, and they can cause falls, which can lead to long hospital days and a lot of distress for the patients. So you have to keep patient on fall risk precautions. It's important to have some parameters, which means that hold medication if blood pressure falls below 90 or 65,

or if the patient is dizzy. So it's very important to have these parameters and to be able to communicate it to the team taking care of the patient.

Mobility can be affected by these medications, as well. It's important to have a physical therapist regularly assessing the patient, especially making an assessment before a patient is discharged from the hospital.

It's important to understand when you are making a treatment plan for the patient that although the need for medication is reduced there is improved outcome by using psychosocial interventions. The goal of this treatment intervention is to improve functioning, to improve living, learning, working, and socializing of the patient, because these older patients tend to be more socially isolative, and they have cognitive issues and a problem with skills. So cognitive behavioral social skills training has shown to be very effective in improving community functioning and giving hope to these people.

Another very effective psychosocial intervention is functional adaptation skills training. Intervention is for individuals about 14.

And next slide gives you details of components of functional adaptation skills. So it has seven components: medication management, social skills, communication skills, organization and planning, transportation, and financial management. So this is very specific. It focuses on specific skills that are problem areas in this older patient population. So they are very -- it is very targeted and has shown to be very effective in improving quality of life and improving outcome for older patients with schizophrenia.

Some other psychosocial nonmedication treatment interventions in older patients with schizophrenia are support and pschoeducation for caregivers. So, caregivers have a very important role in terms of outcomes, disease outcomes. Caregiver stress is very common, and there are several programs that healthcare givers deal with the caregiver distress. They work with them to assess their needs, their specific problems, and they also help the caregivers kind of have additional help so that they can have some break and they can focus on regaining their strength.

Many middle-aged and older people are interested in volunteering. However, there are few occasional rehabilitation programs. Some older people can be involved in an organized manner in different phases of such programs at a pace and at a time that is appropriate for their needs. It would include at least three steps, which is Step 1 would be initial assessment for person's job skills, and help -- a collaborative process to help with a job search, and time unlimited follow-up to support these patients while they're working on the worksite.

Next slide is a summary slide that captures tips for treating older adults with schizophrenia. And a take-home message is that when it comes to medication use the lowest dose of antipsychotic medication that's possible. Use second-generation antipsychotics rather than first-generation antipsychotics. Adjust medications if needed during hospitalization to reduce the fall risk. Monitor for physical impact of psychotropic medications, especially monitor for metabolic syndrome. In terms of care delivery, psychiatrists should keep medical history and medications up to date and coordinate with the primary care physician or the geriatric clinic.

And it's extremely important to understand that there are specific presentation and comorbid problems in these patients, and they have many medical problems, and it's important that we take a very careful approach and avoid overlooking medical problems that might be contributing to the presentation, clinical presentation, in older patients with schizophrenia.

Also use targeted screens to assess for comorbid conditions. We spoke about screens for substance use disorders, AUDIT-C, and for depression PHQ-2. Also assess for suicide risk. And use ample instructions. Use ample instructions and use repetition to ensure understanding. But older people have cognitive issues. They have difficulty understanding instructions. So use simple instructions and use repetition.

Also make appropriate referrals. We mentioned dementia, which is sometimes seen in patients with schizophrenia, so it's important to screen for cognitive problems and refer the patient for neuropsych testing if you are suspecting that a person, a patient might be having dementia, make referrals to prevent social isolation and support social skill development. Use psychosocial interventions to improve social functioning. And, extremely important, watch for caregiver burnout. And link them to resources that are available to support them.

That's the end of my presentation. I will move to the next presenter and hand it over to Tracy.

Tracy Beavers: Thank you. Good afternoon. Welcome and thank you for attending today. First slide, please. CareSource MyCareOhio is an administered healthcare plan for dually eligible beneficiaries registered for Medicare and Ohio Medicaid insurance.

CareSource MyCareOhio encourages choice and self-helped. It gives support so members can stay independent. The approach is member-centered care by coordinating healthcare with other determinant needs. For the purpose of his webinar, the terms care manager and case manager will be synonymous. A care manager is an advocate who works through the healthcare system to coordinate a member's needs. This is done through face-to-face and telephonic contacts.

Care managers provide single point of contact for members to assist with all aspects of member care, including, but not limited to services, benefits, and claims. Care managers coordinate with providers and community organizations to address the needs related to physical and behavioral health as well as address the social determinants that affect health, such as housing, transportation, and nutrition.

Everyone sets up their interdisciplinary care team, or IDCT, a little differently. Here at CareSource our interdisciplinary care teams include the member, the care manager, the primary care provider, the behavioral health provider. It also includes anyone else the member chooses. The IDCT could also include the member's family, their pharmacist, a caregiver, their pain management provider, or any healthcare provider the member chooses to include. Even if the member chooses not to include any other providers in the formal IDCT process, the care manager should keep open lines of communication with most, if not all, providers. Remember to document any and all communication.

IDCT focuses on individualized care and is led by the member's care manager, with an emphasis on the member's individual needs and self-led goals. With each member's interaction, focus on consistent and effective messaging. Medication taken as prescribed will help manage member's psychiatric symptoms. Repeat this message at every medication review. But remember that medication adherence is a member choice. It is a fine line between consistent reminder to take medication as prescribed and what a member may consider to be pressure to do something he or she may choose not to do.

Because symptoms more common in older adults with schizophrenia are apathy, abnormal movements, and greater deficits in learning, your member may need additional repetitive education about their medication -- why, when, and how to take their medication. Continue to focus on educating your member about the positive benefits of medication adherence.

The chart on this slide shows some of the most challenges that people diagnosed with schizophrenia face. These challenges only become increasingly more difficult as the person ages. The left side lists some frequent trials your member may experience, and the right side of the chart shows opportunities for you to assist your member.

The healthcare effectiveness data and information set, also known as HEDIS measures, is a widely used set of performance measures in the managed care industry. These measures were developed and maintained by the National Committee for Quality Assurance and are the guidelines that are used to ensure that members are receiving quality healthcare.

Remind your member when specific HEDIS measures are due, and assist them in scheduling appointments and transportation. Common gaps in care are colonoscopies, Pap smears, mammograms, eye exams and dental exams.

Dealing with conflict is a challenge for most people. To help the older adult diagnosed with schizophrenia, remind them, one, to recognize and deal with their own family first; two, to recognize each situation they deal with is different; three, to recognize that being assertive does not mean they have to be aggressive; four, to focus on good behaviors -- what they focus on they get more of; five, to remember that if they lose control they lose, period. Remember that you do not have to be manipulated. If your member loses control and attempts to draw you into the conflict, do not take the bait.

Follow up with your member several days before their scheduled appointments and again on the day of the appointment. Ensure that they are up and getting ready. Help remove barriers such as transportation. Older adults with schizophrenia are prone to canceling follow-up appointments that are important for monitoring antipsychotic medication use.

Age-related memory issues, memory problems relate to polypharmacy and multiple comorbid diagnoses make the older adult with schizophrenia an unreliable historian. Get medication reconciliation sheets to help member recall medication lists, and attend new provider appointments with member when you are available.

This slide continues to list opportunities for you to assist your member with addressing the challenges they face with everyday life. Poor community function is the individual's difficulty to integrated unaided into society with the stigma and limitations associated with schizophrenia. With help, your member can overcome the challenges of limited, unlimited support, low income, poor community function, low health literacy, difficulty communicating, persistent negative symptoms, comorbidities, polypharmacy, and poor physical health.

Opinions differ from one person to another, and what one person sees as a great encounter may not measure up for your member. This is critical in the older adult with schizophrenia, because this is a chronic, debilitating mental disorder characterized by distortions of thinking and perception. A central element of schizophrenia is psychosis, which means having an abnormal perception of reality. In addition to this abnormal perception of reality, as the member with schizophrenia ages additional life challenges, such as hearing loss, vision loss, and decreased mobility, intensifies the abnormal perception of reality.

Communication is both verbal and nonverbal. With the older adult diagnosed with schizophrenia, you may have to speak louder due to hearing loss. This can be misinterpreted by the member as anger. Vision loss also makes it more difficult to pick up nonverbal cues in communication. Speak clearly and calmly.

I have a 70-year-old with schizophrenia on my caseload who told me that the most important thing I have done for them is make them realize they are not a schizophrenic. They are a person that has been diagnosed with schizophrenia, and diabetes, and hypertension, and hyperlipidemia. But, most importantly, they are a person. Realizing that there are individuals that see beyond their disease has opened the world for them.

Schizophrenia has been observed around the world, in different races and cultures. It is a universal ailment. However, it is not always viewed the same in every society. I had an African-American older member with schizophrenia who told me his African diagnosis is [mafufunyana]. He believes that he is possessed by demons, and if he takes the medication that is prescribed by the psychiatrist he will not be able to control himself and the demon will take over his body and control his actions. His family supports his decision not to take medication.

Asian Americans with schizophrenia tend to have very close family ties and frequently live and work with other family members. These close-knit families are apt to serve as overseers and help the older adult diagnosed with schizophrenia with medication reconciliation and symptom management on a daily basis. This helps the member with schizophrenia with medication compliance.

Building member-centered care plans must include the member's input. What is important to them? Take time with your member during assessments to ask them questions to determine what is important to them. Seeing a psychiatrist may not be a priority to your member if they are 60 years old and have never been treated for their schizophrenia. Realistic goals based on a member's need are addressed in a focused assessment. Help guide your member to set realistic and obtainable goals. A realistic goal for someone who's never set goals for themselves before

may be as simple as remembering to take their medicine every day. Each care plan should be as individualized as the member. Do not copy from another person's care plan.

Address goals with each meaningful contact with your member. Keep in mind that the older adult with schizophrenia may be slow to show progress on their integrated care plan. Make sure there is documented input from the member's primary care physician or behavioral healthcare provider and all members from the TBC Team.

When your member is in a psychotic phase they will be suffering from hallucinations and delusions. They may also be living with depression. Depression is a mood disorder that frequently coexists with schizophrenia and which also needs to be treated. Watch for symptoms of depression in older adults that have been diagnosed with schizophrenia.

You can use assessment tools to help you with this, such as the PHQ-2 and the PHQ-9. Always follow through with what you say to your members. If you tell a member that you will call them back later on the same day, do not forget to call them back. They will always remember that you promised to call them but did not. Broken promises are hard to recover from and cause broken relationships between a case manager and the older member with schizophrenia. In all things, remember that this is your member's health, and the preferences regarding their care are ultimately theirs alone. It's their life and their choices.

Motivational interviewing is a therapeutic approach that attempts to move an individual away from a state of indecision or uncertainty and towards finding motivation to make positive decisions and accomplishing established goals. Motivational interviewing is not a way of misleading your member into doing what you want them to do, but rather a way of talking to your member that helps resolve their mixed insecurities and ambivalent feelings.

Keep in mind that the older adult with schizophrenia may not have answers that seem appropriate to your open-ended questions. Your summaries may not be an adequate representation of what they were trying to represent to you and may become a source of frustration for your member. Be aware of the situation if this happens and limit your responses.

OARS is an acronym used in motivational interviewing to represent core interviewing skills. OARS stands for open-ended questions, affirmations, reflections, and summaries. This slide represents a few examples of interactions between you and your member.

Many older adults with schizophrenia have limited support. You can assist them with wraparound support, warm lines and contact phone lines or volunteer staff listening lines that members can call anonymously to talk to a peer counselor even if member is not engaged in behavioral health services. Member support may not be family, but may include friends, neighbors, religious acquaintances, or even hired caregivers. Engage supporting caregivers with member permission on the IDC Team. Encourage them to attend therapy sessions with the member to learn about the disease progression, expected prognosis, and how to prevent caregiver burnout.

The annual care team meeting, this is not always held at one time. Information is gathered from all providers and members of the care team. Information is disseminated by the care manager and reviewing with the member. You may be communicating with providers and the care team member more frequently than once a year in a less formal manner, but the IDCT meetings are documented formally.

Older adults diagnosed with schizophrenia have a higher rate of mortality related to comorbidity, a sedentary lifestyle, and increased smoking. The extent and consequence of medical comorbidity in older persons with schizophrenia are generally not fully appreciated.

Consider factors specific to older patients with schizophrenia. One, persons with schizophrenia may under-report symptoms because the disorder may increase the pain tolerance. Two, deficits in cognitive processes may diminish the patient's insight about medical as well as psychiatric illnesses. Three, neuroleptics may reduce pain sensitivity. Four, nonadherence with treatment regimens for physical illness may be high. And five, long-term use of antipsychotic medications may cause diabetes, coronary artery disease, and Parkinson's disease.

Schizophrenia can affect individuals of all ages. Facilitating transitions for older adults with schizophrenia must consider the effects of age on the body during the progression of the illness. Positive symptoms of schizophrenia are likely to become less severe, then early substance becomes less common, and mental health functioning time and again improve. Hospitalizations are more likely to be due to physical problems rather than psychotic relapses.

When elderly patients with schizophrenia are hospitalized for psychiatric illnesses versus medical illness, they likely will experience long inpatient stays. Elderly patients may be admitted for a duration of up to 6 months for the first psychiatric admission. Generally patients have poor family support, which can be one of the main contributing factors for length of stay.

With each transition it is essential to support the older member with schizophrenia with a medication review and reconciliation. Be sure to evaluate medication interactions, review information with member, and notify provider. Review discharge information received from the discharge planner with member and caregiver, if member has one. Reach out to the new provider with an invitation to participate on the IDC Team. Educate the member and caregiver on the diagnosis, medication, vaccination, and their benefits. With each new life change, a new assessment can be completed for your member. This will help establish your member's current social determinants and necessary requirements.

On this case study, the name has been changed to protect Gene's identity. Gene is a beneficiary dually enrolled in Medicare and Medicaid through CareSource, MyCareOhio. His past medical history includes paranoid schizophrenia, osteoarthritis, emphysema, and anxiety. He knows schizophrenia is a progressive disease and that he is afraid he is going to go be forced to take medication and that he would not be able to control his hallucinations.

He's a heavy smoker with a sedentary life, and at his time of enrollment he had not had established medical care for over five years. He's been dependent on his elderly sister's care for

his entire adult life. His medical and behavioral health conditions that he's been unable to leave his house, care for his home, or do simple tasks for himself.

Gene and his sister have been living on Gene's income. His sister has no income. Gene's utilities were hundreds of dollars overdue, with shutoff notices. In May of 2018 Gene's sister was hospitalized for four weeks, leaving Gene to care for himself. Gene had no children and no other family members to help him.

Gene's CareSource telephonic care manager referred him to the behavioral team. A focused assessment was completed and an integrated care plan with realistic, measurable goals was completed. Gene agreed to see a primary care physician, to think about seeing a behavioral healthcare provider, and was given wraparound support of a warm line, contact lines, crisis center information, and smoking cessation information.

He was also linked with local resources. Pantry goods and supplies were delivered to his home. Clothing was delivered to his home in appropriate sizes. He was given assistance with applications for rent subsidies and utility assistance. He was given help with utility bills from local churches. He was given help with the AT&T Access application for low-income internet.

Gene's current state is that he is actually able to live on his own now. He is no longer dependent on his sister. He feels like he is managing his schizophrenia and his medical condition in a way he is comfortable with. Gene's sister is now able to focus on her own health, and she is living a happier and healthier life, and they both feel that their life is more productive.

The focus of managed care is helping individuals to find their most satisfying life. Thank you. That's the end of my presentation, and I will pass it over to Ann Marie.

Ann Marie Luongo: Thank you, Tracy. Good afternoon. My name is Ann Marie Luongo, and I am the Program Manager for the Connecticut Mental Health Medicaid Waiver through Advanced Behavioral Health, Inc.

ABH is currently the fiduciary and credential agency for the mental health waiver in the state of Connecticut. So Dr. Azhar and Tracy have given you a lot of information today, so just going to follow up with some observations and some tips from running a program that provides direct care services to older adults with schizophrenia living in the community.

So, I think it's important to look at why some of our older clients with schizophrenia might not be attending appointments regularly. It's a big issue that we deal with in our program. And it's important to keep in mind that there may be many reasons why they're not always doing that, and it's not often clear. And instead of just quickly labeling clients as being noncompliant it's really important to do a little investigation and figure out what's going on.

Obviously some of the symptoms of their schizophrenia like paranoia and delusions can get in the way. But sometimes it's more practical things like transportation issues. Sometimes the Medicaid transportation doesn't always show up, or if it does show up they're an hour late, so

obviously that can get in the way. So it's really important to talk with your clients about what particular issues are going on and what's leading them to not attend appointments.

So we see a lot of our clients getting very anxious around attending doctor appointments. They're not sure how to explain themselves sometimes to the doctor, or if the doctor's going to understand what they're trying to get across. They also might be frightened by the doctor might do once hearing of some of their symptom, either medical symptoms or psychiatric. Many of the folks we work with have spent a significant time in institutions, and some of them are nervous about having to go back.

In Connecticut a lot of the institutions that were previously used to house individuals with serious mental illness, those buildings are now being used as outpatient facilities. So you can understand how some of our clients are quite hesitant to go to those buildings for treatment. Even sometimes driving on the grounds or driving by those facilities can cause a lot of anxiety for a client, so obviously a big factor in deterring some of our clients who are following up with their care.

Another issue that we come up with a lot is clients going to medical appointments and sometimes assumptions being made that their physical symptoms are related to their psychiatric illness. And this is also known as diagnostic overshadowing. Sometimes we're quick to judge that everything that's going on with our folks is related to their psychiatric illness, so maybe we might overlook some other issues that might be going on, and we might be missing something medical.

A case example that we worked with, an older gentleman who was living with schizophrenia. His symptoms were being quite well managed by medication, living in the community, in elderly housing, doing quite well, with services in his home. He began experiencing visual hallucinations, which was a new symptom for him. He had never experienced them before. His doctor increased his psychiatric medication, thinking that this was a new symptom. They tried that for a few times. He ended up in the ED a couple of times, a couple of times of inpatient hospitalization.

Eventually after they couldn't resolve the issue they ended up hospitalizing him for a longer period of time, taking him off all of his medications and restarting. Come to find out that the issue had to do with a pain medication that he was taking a fairly high dosage of and had for years, but obviously as he aged he wasn't able to tolerate the medication as well, and one of the side effects were these visual hallucinations he was having of children sitting in the corner of his living room in his apartment. So once that medication was reduced he was no longer experiencing those visual hallucinations.

So in order to help our clients work through some of these issues the most important thing is to build and gain trust. It's critical that we take the time to get to know our clients as a whole person, not just their diagnosis. Find out what's important to them, what their likes and dislikes are. Take an interest in what they find interesting. Once we're able to gain that trust and relationship with the client we can work on techniques that might help them deal with some of the fear and anxiety of attending appointments.

A lot of the things we try to focus on with our staff is guided imagery exercises, breathing exercises, relaxation techniques. And roleplaying also can be helpful in helping a client prepare for an appointment. A lot of times if they practice what they're going to say to the doctor with a staff they feel comfortable with and have a lot of trust with it's a good preparation for when they do actually attend the appointment with a doctor.

So, something we can do as community-based providers, we want to give them a lot of choice and empower the client to make a lot of decisions around their medical care. These are folks who may not have been given these options previously. But we definitely now want to try to empower them to take control of their care. You want to work on a list of positives or benefits with them on following up with care. Help them decide how following up with services is going to benefit them. We're all more likely to do things when we can see the benefit of the action.

Remembering that sometimes going to a new doctor or a new facility can be overwhelming for our folks, so we try to introduce things gradually and let them build up a comfort level, showing them a website of the doctor office, maybe, so they can see a picture of the doctor. Sometimes we even drive by the office with the client so they can see where it is, take a stroll through the building before the appointment, things like that. And, again, you want to provide as much education as you can on medical issues. We want to be empowering the client to make their own decisions, so we want to make sure they have all their resources.

So, one of the most important things we focus on in training is that it's not always what we say but how we say it. Finding the right way to communicate with someone can be the difference between failure and success. So you want to really think about how you might say something to get the most positive result. And I just listed on this slide a few examples of just how maybe changing the phrasing of how you're saying something to a client can hopefully get a better response. So instead of saying you need to go to the doctor because you're having trouble walking maybe trying to point out a positive benefit of going to the doctor. So being able to get around better would make it easier to go to the park. So, again, just trying to find a phrase that may get a better response from the client.

So, in coordinating care for older adults with schizophrenia, it's important, again, to create a plan that includes both medical and behavioral health providers. Obviously there can be many different people working with our client, so you want to make sure everybody's involved, that everybody's on the same page. That of course is going to mean regular contact between all providers. Secure email is vital. Our program would not survive without it. So definitely something you need to make sure you have.

Again, you want to make sure you train as many staff as possible in motivational interviewing, not just so that they can more effectively communicate with their clients but also they can model those types of interactions when they're out with the client with other providers, so hopefully everyone can start working with our clients in a more effective manner. And, again, making sure their plan of care includes the whole person, and not just the nuts and the bolts. Our clients do better when they're active and social, so we need to help them with these goals by including that in their plans.

Again, you don't want to ask clients to just forget about some of those previous negative experiences they may have had when attending medical appointments or even psychiatric appointments. Some of those experiences may have not been comfortable. They may have been judged. They may have not been treated well. But we want to encourage them to learn from those experiences and build on that to become a better self-advocate. We want to encourage them to educate providers on their illness and so that they'll be able to request the treatment that they actually need. And, again, roleplaying can be very helpful on these types of situations in kind of helping clients go through a different scenario that they might've faced with a provider.

So my program's goal is to keep older adults with schizophrenia out of the nursing homes and in the community. So we always need to be focusing on what we can do to provide better outcomes. So you're going to want to examine all the home and community-based options that are available to our folks. With our population it's probably going to mean a combination of services from programs like Medicaid waivers like mine, also home healthcare agencies, and also accessing -- here in Connecticut we call them local mental health authorities, so whoever the community providers are that are providing the behavioral health services. Everyone's going to need to work together to really provide what our clients need to stay out of the nursing homes and stay in independent housing.

We want to make sure we look for secure housing where clients can age in place, and also in communities where they're going to be accepted. Investigating different medication management resources is important, utilizing devices such as electronic medication boxes, sometimes daily medication administration from home care agencies, and also maybe sometimes turning to intramuscular therapies to help those clients that might not follow through on medication on a regular basis.

Just some legal issues that we have to keep in mind in working with our folks in the community. Releases of information, so just keeping in mind that sometimes these can be difficult to get from our population. Sometimes our clients have a lot of fear or paranoia about signing documents, so sometimes that can play a role in making it difficult to communicate with other providers. The need to work with conservators of person and estate. Those terms may vary by state, but some of our folks have been assigned individuals to the probate court to help them make legal decisions, financial decisions. So obviously those folks are going to need to be a vital member of the team.

And keeping in mind laws and regulations around providing the least restrictive environment. A lot of states, including my own, have been through lawsuits because people with serious mental illness fought for the right to not have to live in nursing homes and wanted to live in the community, with supports, so making sure that we're doing everything possible to provide the supports in the community to keep people out of those long-term settings.

And being proactive with clients and helping them discuss behavioral health advanced directives, encouraging clients to make decisions about where they want to receive care, what they want, and who they might want to help make decisions on their behalf.

So, that's all I have for today. I thank you for your time. And I want to now turn it over to Heidi, who is a family caregiver.

Heidi: Hi. My name's Heidi, and I'm an RN with a bachelor's degree, and for the last 10 years I've been taking care of my older brother, Kurt, at home. He was a civil engineer who had a breakdown at work when he was 28, and he was diagnosed with paranoid schizophrenia and OCD. Kurt hears a single voice, neutral gender, and he basically hears it just about all the time, but the volume changes, depending on what the environmental and emotional triggers that are happening around him.

Several examples of these triggers that really increase his agitation are predominantly the number one thing that bothers him the most are female voices that argue, and the volume raises and decreases and surprise him. He doesn't have this type of reaction as much with men, but for some reason the women's voices really bother him. He could be in a restaurant or in a grocery store and automatically he assumes that people are directing comments toward him, and maybe because there are a lot more women in grocery stores than men this is part of the reason. But it's very difficult for him to get through certain areas of everyday living.

Any loud signs, from TVs to crowds to even family members when there's a larger group of people. He thinks a lot of comments are directed toward him, so when there's swearing, when there's negative feelings, he automatically thinks that he's done something wrong and he's the one at fault. And it makes him very paranoid, and he basically just starts to withdraw.

He's also not comfortable in dark rooms. He's not comfortable with anything having to do with the color of black. He has associated that with the Mafia, and, again, everybody's after him, and it's difficult to get him to just relax even in a darkened room.

Kurt comes to have interesting versions of past history with the family, and sometimes this can be very difficult when other family members are hearing stories or passing on different discussions at any family gathering. And, of course, Kurt's versions are very in sway to making him be more positive and his memories being much happier than something that might not necessarily have happened in everyone else's memories.

He has a very set way of doing things. You cannot hurry him. You cannot change his routine. You have to plan around him. And there's a lot of difficulty with short-term memory, which we've heard in almost all of the previous discussions. He can leave clothes in the dryer. He can leave the stove on, anything from food not being put away to not taking his meds. And it can cause obviously a lot of negative feelings, because he can't cope without the meds.

I've basically kind of created a caregiver and provider-assisted list to help in what I feel would benefit people like my brother, and I think it's important for caregivers to find out what a person's comfort area is and to know that this is where they feel safe when their behavior is changing. And it's highly recommended to make sure that they are in their safe zone when they're upset.

Headphones often with soothing music or nature sounds can really help. We worked together to create a how-to booklet or using post-its for step-by-step, simple step-by-step reminders of how to do simple things like laundry, use your cell phone, CD player, because they're often forgetting.

Even listen to their delusional talk. When Kurt's alone is when his conversation gets going with himself, and you can actually learn what they're obsessing about when you listen.

And have a plan for the negative behavior. It's very important for every caregiver to really just stay calm. And you may need to raise your professional voice to get their attention and redirect them to a safer activity. And most important is to be patient. And sometimes that is the very hardest thing to do. But it really helps keep them calm when you're calm.

And also for caregivers it's really important to create your own support system. Talk to friends. Talk to family. You've got to be able to vent. You've got to be able to share your anger, get other ideas. Anything that will help you to help them.

And for providers, when addressing patients make sure you have their attention. Kurt was just in the hospital, and I know with -- every resident going through has so many patients on their mind and so much information to assess. But it doesn't do any good to assess when the patient is not there with you giving you any answers. Often when their eyes are glazed or they're staring at the floor or the ceiling they're not with you. Oftentimes you're going to have to touch them, and you're going to have to kind of push areas and palpate them to say does this hurt, is this what's bothering you.

Kurt always will tell you everything is fine. You can ask him. He could have black and blue marks all over, and he will tell you he's fine. But when you palpate the area it's not quite as calm, cool, and collected. I mean, he will then express that that hurts, and you have his attention, and he knows that you're there to provide help.

There are often -- speaking to a caregiver will greatly help to get a baseline for the way the patient normally acts. It's very rare for, in my experience, to have someone come up to me and ask me exactly how Kurt has acted at home. It's more the nursing staff, not so much the residents that inquire, and I've heard it I can't tell you how many times over the last several weeks that he was in the hospital, well, he's calm. Kurt's calm. This is great. He's ready to go home. Kurt's calm.

There's very little stimulation at the hospital. The rooms are quiet. Individual rooms. He's by himself. He has the TV whatever volume he wants. But unfortunately this isn't what normal life at home is. You have -- I have a son, and he has friends over. Kurt has friends that he does see. And that adds a lot of noise and a lot of physical and visual stimulation that Kurt is not reacting the normal way when he's in the hospital as when he is at home.

And they need to get a baseline. They need to understand that he doesn't seem quite normal. And, unfortunately, most of the time I don't think families realize that. Something that I feel would help them understand is the hospital provides pharmaceutical assistance so the patient will not harm themselves or others, then they're discharged. The patient's personal psychiatrist or group therapy sessions are what provide all other assistance.

People, I think, families expect patients to go home and be in the exact same emotional state as they were normally, as opposed to coming home and being just either so stoic because they're

overmedicated or frantic because everything was quiet at the hospital and so they could be calm and then they get home and they're overwhelmed. And the families need to realize that there are other caregivers that can help and assist, and the hospital is not the end all be all of care for their family. They need to look to the normal caregivers to help them.

And this basically is the end of my presentation. I thank you.

Evan Vahouny: Great. Thanks so much, Heidi, and thank you to our other speakers, Dr. Azhar, Tracy, and Ann Marie, for your presentations.

With that, we have a few minutes here for questions, and then I will close out with a couple last points. So we're going to try to do a real quick rapid-fire question here. So, for Dr. Azhar, and then if anyone else wants to very quickly weigh in, the question is how are the use of antipsychotic medications monitored, and what guidance is provided for their use, especially given the broader medical concerns about the use of antipsychotic medications among older adults?

Naila Azhar: Right. Extremely important question. There are standard protocols for treating older patients, and the standard is that they should be on monotherapy, which means one medication, and the lowest possible dose. So there are standard protocols that are kind of universal in this rule that older people need to be on one antipsychotic medication, and there are some guidelines for monitor metabolic side effects. So basic principles and standard protocols, that's how -- there is -- I guess the question, there's not a monitoring agency or something.

There are standard protocols and guidelines, and it's the responsibility of the practicing psychiatrist and psychiatrist in training to make themselves aware of these protocols and guidelines. So the protocol is start with the lowest dose of one antipsychotic medication, and try to see if you can lower the dose if the person is getting older, because our body's ability to metabolize this medication is reduced as we grow older.

Evan Vahouny: Okay, great. Thanks, Dr. Azhar, for that response.

I'm going to go ahead and close out now the webinar. Thank you again to our speakers for your presentations. We'd 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. And the slides for today's presentation, a recording, and a transcript, will be available on the Resources for Integrated Care website. The link to that URL is at the bottom right of the screen.

At this time the post-tests for this webinar are now open. Additional guidance about obtaining credits and accessing the links to the post-tests can be found in the Continuing Education Credit Guide in the Resource Guide on our left-hand side of your screen or at the Resources for Integrated Care website.

Thank you so much, again, to everyone for joining us today, and to our speakers. Please complete our brief evaluation for our webinar so that we can continue to deliver high-quality

presentations for you all. If you have any questions for us, please email us at RIC@lewin.com. Thank you again. Have a wonderful afternoon, and thanks so much for your participation.