The Lewin Group
Supporting Older Adults with Substance Use Disorders
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Caroline Loeser: My name is Caroline Loeser, and I'm with the Lewin Group. Welcome to the webinar, ***Supporting Older Adults with Substance Use Disorders***. This is the second 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 a discussion among the presenters and participants.

This session will be recorded and a video replay and a copy of today's slides will be available at www.resourcesforintegratedcare.com. 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.

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This webinar is supported through the Medicare-Medicaid Coordination Office 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 you can follow us on Twitter for more details. Our Twitter handle is @Integrate_Care.

At this time, I'd like to introduce our moderator. Carol Regan is a Senior Advisor to Community Catalyst Center for Consumer Engagement and Health Innovations and has over 30 years of experience with national and state-based public policy and advocacy organizations. Carol?

Carol Regan: Thanks Caroline, and welcome everyone. We are so pleased to be introducing this really important and timely webinar. Community Catalyst has been working with the Lewin Group and the Medicare-Medicaid Coordination Office and the American Geriatric Society now for many years on developing a series of educational webinars on Geriatric Competent Care. This is part of our commitment to work across the country to ensure quality care for dually eligible Medicare-Medicaid beneficiaries enrolled in the Financial Alignment Initiative and Demonstrations.

Today's webinar has four really great speakers who will cover a number of topics. Let me start by introducing the faculty who you can see in front of you. We'll start with Dr. David Oslin is a Professor of Psychiatry at the Philadelphia Veterans Affairs Medical Center and the University of Pennsylvania Medical Center. He is the Director of the Mental Illness, Research, Education, and Clinical Center and the Chief of Behavioral Health at the Philadelphia Veterans Medical Center. In addition, both organizations support research on comorbidity and integrated care, respectively.

He is the author of over 75 research publications and 30 chapters, books, or editorials. His research portfolio includes studies aimed at improving access to behavioral health intervention care, improving treatment outcomes for addictive disorders, and the study of pharmacogenetics. Specific projects have included an adaptive treatment study of Naltrexone to develop strategies for maintenance treatment and non-response to treatment. Additionally, Dr. Oslin continues research on the implementation and dissemination of evidence-based practices for integrating primary and mental health care.

Our next speaker after that will be Dr. Jessica Gregg, who received her undergraduate degree from Stanford, her medical degree from the University of New Mexico, and her Doctorate in Medical Anthropology from Emory. She is board certified in Internal Medicine and Addiction Medicine and is a practicing physician with IMPACT, which is the Oregon Health Services University's Addiction Medicine Consult Service. She is also the Medical Director for OHSU's Addiction Medicine Clinic and Associate Program Director for the Addiction Medicine Fellowship.

Her previous work has included work on social medicine curriculum, which places OHSU internal medicine residents and physicians in Safety Net clinics.

She served as a Medical Director for Substance Use Disorder Services, an agency that serves adults impacted by homelessness, poverty and addictions, and serving as the Medical Director of the Health Professionals Services Program, which is Oregon's statewide confidential monitoring program for health professionals. She has also published widely on addiction and the current opioid crisis.

Then, I will turn it over to Ann Giazzoni who is a licensed social worker and a supervisor in case management at the University of Pittsburgh Medical Center (UPMC Health Plan), and combined clinical and management backgrounds. She oversees the case management process for the Rapid Emergency Department Outreach Pilot, which is a program that ensures case management intervention within 24 hours of an emergency department visit for an overdose.

In her work, Ann manages complex, co-occurring medical behavioral health and substance use case management programs for high-risk populations. Her focus is on providing person-centered integrated care for people needing assistance navigating physical and behavioral health systems. Ann has her Master Social Work (MSW) degree from the University of Pittsburgh and her Master's of Business Administration from Point Park University in Pittsburgh.

As you can see, we have an incredible list of faculty. Finally, I welcome Carol Prudhomme, who is consumer from Rhode Island, who will share her recovery story.

I just want to quickly share with you the learning objectives for this webinar. We hope that through this you'll learn a lot about the types of substance use disorders, the epidemiology, and the magnitude of this problem among older adults. The benefits and risks of substance use and how it could lead to abuse; to find the association between substance use disorder and comorbid mental health issues; and then looking at various treatment options and the need for care coordination.

Then, this what we're going to try to cover here. We've gone through the polls. We're going to start with talking about alcohol use, turn it over to opioid use, and then talk about how we support older adults and caregivers and their families struggling with substance use disorders. We'll then close up with a consumer perspective and then really look forward to the half an hour of questions and answers at the end, so we can answer some of your questions. Then, we have an evaluation at the end.

Thanks so much and now let me turn it over to Dr. Oslin.

Dr. David Oslin: Thank you and thanks for all of those on the webinar today. It's really exciting to talk about this topic. I've had sort of a lifelong passion of working in this area. I wanted to start by just talking about how substance use is a little different in older adults. This is kind of a compilation of the literature and some of my thoughts about it.

When we see people in their 60s and 70s who have a substance use disorder, there are a number of things that we need to think about clinically that are just different. From a health perspective, older adults are clearly more likely to be on medications, so the issue of polypharmacy as well as interactions with alcohol with any of a number of medications is a really important piece. Alcohol has the most drug-drug interactions of any medication we use. It just interferes in a number of ways with a lot of the treatment we do.

There is limited time to address substance issues in a lot of settings. The average primary care provider spends something on the order of about 90 seconds evaluating mental health disorders in a primary care setting of their 10 minutes that they have. There are just different biological susceptibilities. It takes less alcohol to have more impairment in older adults and there are a number of biologic reasons for that that we don't have time to go into today.

In terms of presentation, pain is a very strong correlate to substance use in older adults. So managing people's pain, either arthritic pain or other musculoskeletal pain is an issue that is a

feature in managing patients. Cognitive impairment is something that has to be managed and dealt with. I'll show a slide later that group therapy has to be really thought of carefully in an older adult. Somebody with very mild cognitive impairment may not be able to really participate in group the way it's intended. They may get some of the social aspects out of it, but may not cognitively process much of the information.

There are just a number of issues that happen as we get older. We have less structure to our day, because we may not have family duties or jobs to do and have poor health habits. There is anxiety and depression and suicide is clearly a higher prevalence rate in older adults. All of those are important in terms of ascertainment in thinking about older adults.

An important issue for me in taking care of older adults is really thinking about generativity or purpose. This is often a struggle for many older adults in terms of what are they doing with their life as they age. It's just an important piece to assess and think about.

In terms of dually eligible patients, there is some more unique stuff. Basically, dually eligible beneficiaries are sicker and have more negative health habits, if you will. I think everybody probably realizes that and it's just a more vulnerable population.

This is just to frame us a little bit. I realize that we're going to have a focus on opioids today. Tobacco really still predominates as the substance that is most frequently used in older adults. We don't have a lot of older adult-specific smoking campaigns, but older adults do benefit from tobacco cessation. Because they've been smoking a number of years, the prevalence rate is still actually fairly high.

Alcohol then is the next most common. It's more common than prescription medicines. The range varies for all of these substances depending on the site you're in; depending on your population frame of reference so to speak. So higher rates in an ER, lower rates if you go to a community event of some sort and just have normal healthy folks if you will. Any setting that's a healthcare setting these rates are actually going to higher.

Psychoactive prescription drug misuse is about 2% to 4%. The illicit substances in terms of use disorders are still actually pretty uncommon. Kind of special note about marijuana, we actually don't know a lot about the prevalence rate of marijuana use in 2018 among older adults compared to what it was before a lot of legalization. There's no real active or contemporary data there.

The same comorbidities exist in older adults that do in younger adults, but there are some caveats here. Cognitive impairment clearly is one of those caveats in the middle here. Suicide is clearly one of those things that we take special note of in older adults. Suicide rates are most elevated in older adults, particularly White men and that still is the case.

An older adult who has an alcohol use disorder, whether that's mild, moderate or severe alcohol use disorder, has about three times greater likelihood to have a comorbid other mental health disorder. It's just so important to assess and include in the treatment planning the assessment of comorbidities.

There are two caveats here for depression. One is that we've done a lot of work and if people really want their depression to get better or their PTSD for that matter, they need to be abstinent. There's a pretty direct relationship to lack of abstinence and poor outcomes for depression.

The other caveat is that there's a strong belief among a lot of providers that if you treat depression or treat the comorbidity, that the substance use will decline. There's actually almost zero literature for that. You really have to treat both problems, and it's in some ways more important to treat the substance use disorder. Because the chances of the other mental health disorder getting better are almost zero if you don't treat the substance use disorder.

Clinicians often get this a little backwards. We see a lot of patients on anti-depressants with no treatment of their alcohol use disorder or other substance use disorders. That's a really important factor. Treat the substance use is the punch line.

This is just an interesting study that we did asking people who are not actively in treatment who clearly had alcohol use disorder problems, and most of them moderate to severe alcohol use disorder. While almost all of them said that they needed to cut down and they recognized that drinking was a problem for them, a lot of them had real misgivings about going to an outpatient treatment program; not perceiving that they need treatment in a formal treatment program.

This really begs the question of how do we take treatment to patients who don't see addiction treatment programs as something that is viable for them. We'll come back to this. You will see there's a smattering of other reasons. I think it's important to realize that patients have some anxieties about coming to formal treatment programs and we really need to think about how to utilize services that can be delivered at AAAs or primary care settings or other settings. I saw that there's a number of AAAs on the call.

What are we looking for in a patient? Again, it sort of depends on the setting. In general, we want to know about drinking really at any level, particularly for treating them for other health problems. People who are drinking more than about one standard drink per day, or who drink more drinks on given days, so we call that binge drinking. Some of my patients binge-drink every day, so it doesn't mean cyclical drinking. It just means drinking far more on a given day.

For older adults and the third bullet is huge. There are a lot of medications that are impacted even by the glass of wine at night. It's fairly negatively impacted. Coumadin is a great example that you just can't drink with it. It doesn't mean that you have an alcohol use problem. It's just you should not combine alcohol and Coumadin.

In addition to drinking and the issues related to just drinking, which could mean moderate drinking as above, we look for people who have clear-cut addiction. To me, that means people who have issues of control, issues of craving, or impairments in some form or aspect of their life.

This is just to remind us of what a standard drink is and you can read that on your own there. I used to have a moustache, but that is not a picture of me. This slide just gives you a quick pocket card of what a standard drink is. When I teach residents, I often tell them or we have a little

discussion about writing in the chart that the patient drinks a 6-pack. After we do the exercise, we do the math about what a 6-pack could be. A 6-pack can actually be anywhere from about four standard drinks to about 15 standard drinks depending on the size of the can of beer. Writing a 6-pack the punch line is that that's not very helpful to your colleagues or the patient.

This is a quick screener that you can use pretty much anywhere. It's been validated in older adults, younger adults, men and women, whoever. I don't know about kids, so it's three questions. It's very simple to use. It's a self-assessment. It can be done over the phone. It can be done in the waiting room. The next slide talks about the scoring. It scores from 0 to 12. A positive here means somebody that you want to have a discussion with around their drinking. It does not mean they need an addiction treatment program. It's a 2 or a 3 for women. The higher the score the more likely they are going to need more formal treatment; the higher the score the more severe the drinking is.

We'll talk a little bit about primary care approaches, so the reality for us in the gerontology area is that most patients go to see primary care, but they don't always go to see mental health. There are validated methods of treating patients or giving patients an intervention in primary care. Brief advice, if done properly, is a very valid modality. It takes some training to do. Referral management relates to the idea that what is said in primary care actually so much dictates whether a patient will come see me as a psychiatrist. There are ways to do that and to be successful at it and to counsel people. We've been able to do pharmacotherapy for alcohol use disorders in primary care very successfully.

The thing for everybody on the phones to remember is that like depression care, substance abuse care can be delivered in a quality way in primary care. In fact, it's the place that most patients are actually seen. Thinking about how to deliver appropriate services there is something that I'm fairly passionate about.

This is actually a trial we did on delivering behavioral health care into a primary care setting using care managers; mostly nurses or social workers or psychologists. This Step Care Approach is identifying people with mild to moderate disease, about a lot of comorbidities, treating them in primary care with an emphasis on measurement-based care. Providing decision support; emphasizing self-management, and having visits over not having visits, and that's really what the telephone comment relates to.

If patients aren't able to come for a visit or are on vacation, you can still do a visit. You can do it over the telephone. Patients love it, particularly older patients and it's quite effective. We've done some research in this area and shown that this model is actually more effective than sending people to specialty care, because more people engage in the model. It really has to do with being able to engage patients where they are and where they want to get treated.

This was a study we did of older adults in terms of thinking about peer support groups, AA mostly, and it just shows that for some older adults it's a little harder to attend that traditional mode of treatment. They are a little less likely to attend AA, a little less likely to get a sponsor, a little less likely to provide after-care. This is after going through a residential treatment program and this is actually the Hazelden Betty Ford Program.

They really were indoctrinated, if you will, into the model of peer support, but still struggled. I think there are a lot of issues there; transportation, people not wanting to be in groups, people having a little bit of cognitive impairment; not being able to get much out of group. It just all needs to be part of the assessment and not something that is an automatic.

This is just a plug that you can do pharmacotherapy in older adults. There are four medications, three that are FDA approved and one that is used a lot, but not FDA approved. My two go-tos are Naltrexone and Topiramate on this list. I use very little Antabuse and very little Acamprosate. Acamprosate is a three-time-a-day medication and then patients are already taking a lot of meds. That's not a friendly thing to add on to. This is just an option. There's not a lot of difference in using these drugs or medications in older adults and they're very effective.

This is just an example of a primary care patient, kind of a typical patient just to give you a flavor on how this might work in a primary care setting. It could apply to a AAA or other settings as well. This is a 59-year-old guy with arthritis, diabetes and hypertension, who says to his primary care doctor he's having trouble sleeping and he's missed work a couple of times. He's gotten into some increasing arguments with his wife. He doesn't raise alcohol as an issue.

The primary care visit in this setting automatically screens people. He had a PHQ-2 and an Audit-C score. The Audit-C was a 9, which is relatively high. He was in a rush so he wouldn't stay and talk to anybody. In this particular practice that is a really practice, the nurse reaches out to him and talks to him on the phone.

The behavioral health provider, the nurse or the social worker, looks over the chart and calls the patient and talks about treatment options, talks about Audit-C score. He agrees to cut down initially and they have a couple of phone calls. The behavioral health provider has a supervising psychiatrist that they go to. Because the patient struggled a little bit, they actually talked about Naltrexone. The patient ended up being willing to do that and you do that continually in follow up.

In this case, the psychiatrist does not prescribe the medication. What happens is the behavioral health provider, or the social worker, goes back to the primary care doctor and makes the recommendation. It's up to the primary care doctor to agree with that or not and to start the medication. Often with the support the provider is quite comfortable doing that. This patient did quite well, as a lot of them do.

I guess I've covered a lot of this. There are a couple of more visits and there's education as part of the plan of his behavioral activation in terms of trying to get him to do some exercise, to step down his alcohol use, and actually engage family. That's a big one in trying to get them to talk to their family. He does that and he actually gets a lot better. That's just a flavor of how this might work in another setting and a really fast introduction alcohol use disorders in older adults.

I'm pleased now to introduce Dr. Gregg, who is going to move us through opioid use disorders.

Dr. Jessica Gregg: Thank you, and that was terrific. Let's jump right in, and I'm going to talk about opioid use disorder among older adults. As I'm sure you're all aware, the United States is in the midst of an opioid crisis. Opioids led to more than 42,000 deaths in 2016, and 40% of all opioid overdose deaths involve prescription opioids. In fact, drug overdose is now the leading cause of death for Americans under 50 years of age. What about Americans over 50? How is the crisis affecting them?

They haven't escaped. Opioid misuse among adults age 50 and older in 2014 was higher than all years between 2002 and 2011. The population of older adults who misuse opioids is projected to double from 2004 to 2020, from 1.2% to 2.4% based on current trends and the increase in the older adult population.

I think sometimes older adults are ignored in this crisis, because across age groups in 2014 adults age 50 or older were the least likely to misuse opioids in the past year; while young adults age 18 to 25 were the most likely. Even though the proportion of older adults who misuse opioids is relatively small compared to young adults, the National Survey on Drug Use and Health and the data above suggests that opioid misuse is increasing significantly among older adults and they are suffering the consequences.

Why is this happening? Why are opioid use disorders increasing among older adults? Some of it is just numbers and our population is getting older. In the 1950s, less than 10% over the country was older than 65. That share will more than double to 23% by 2060. Many of those individuals will have had experience using prescription opioids and illicit opioids. Their opioid use and potentially their opioid use disorder will have begun when they were younger. If they survive to 50, they're going to be faced then with the dual challenges of aging and addiction.

In addition to that and in addition just to numbers, many older adults experience pain as they age. Getting older just hurts, and as an aside, dual eligible older adults also tend to have lower levels of family support and financial resources in comparison to beneficiaries covered by Medicare-only, making the range of options available for pain management likely more limited.

To get more specific about pain, 60% to 75% of older adults suffer from a chronic pain disorder and the incidents of chronic pain increases with age. This is likely one of the main drivers behind the finding that one in three recipients of Medicare Part D received a prescription opioid in 2016, with more than 500,000 beneficiaries receiving high dosages and that average dose far exceeding the manufacturer's recommended amount.

Even if a person didn't develop a use disorder as a younger adult, he or she has ample opportunity to develop one later. Of note, dually eligible beneficiaries have approximately two times' higher rate of co-occurring substance use disorder and chronic pain relative to beneficiaries with Medicare-only; and about six times higher rates relative to adults with disabilities who have Medicaid-only. They are particularly at risk.

Opioid use and opioid use disorder is clearly a problem among older adults. To be clear, that doesn't mean that no older adults should receive opioids. You should receive them if they're indicated. The use of opioids, particularly at higher dosages and particularly over a longer period

of time carries risks. It carries risks inherent in the drugs themselves; so sedation, constipation, falls, and overdose.

It carries risks in terms of addiction. Medicare beneficiaries have among the highest and fastest growing rates of diagnosed opioid use disorder in the country at more than 6 of every 1,000 beneficiaries. From 2005 to 2014, individuals age 65 and older experience an increase in inpatient stays related to opioid use and that was an 85% increase, and emergency department related opioid use that was related to opioid use at 112.1% increase. In 13 states, when comparing across age groups, the highest rate of opioid related inpatient stays was among individuals age 65 and older.

Opioid use disorder and misuse of opioids among older Americans is clearly a problem, but what do you do? In addition to more judicious prescribing, we need to recognize and treat opioid use disorder when it exists. In the interest of time, I'm going to refer you to the CDC Guidelines for prescribing guidance and I'll focus the rest of my talk on how to know when use becomes disordered and what to do when it's diagnosed.

First, let's review how we diagnose substance use disorders. We use the Diagnostic and Statistical Manual, or the DSM. The version now is the DSM-5, which provides a standardized way to understand substance use disorders and mental illness. According to the DSM-5, there are 11 criteria that determine whether or not use is disordered. Let's go ahead and review them.

The first four are: taking in larger amounts or for longer than intended; unsuccessful efforts to cut down; spending a lot of time obtaining the substance; and craving or strong desire to use the substance. When I think of these four, I kind of clump them as the criteria that reflect craving and compulsion.

The next five are: recurrent use resulting in a failure to fulfill major role obligations; continued used despite recurring social or interpersonal issues due to use; important activities given up or reduced; recurrent use in physically hazardous situations; and persistent and recurrent physical or psychological difficulties from use. I think of these as sort of the consequences of loss of control criteria.

There are two more criteria that only sometimes count; and that's tolerance and withdrawal. Some substances when they're used appropriately lead to tolerance, meaning you need more of that substance to achieve the same effect. If you take away, a person experiences withdrawal, meaning that they feel sick when the substance is removed. But that doesn't always mean that somebody's addicted to that substance. If I leave this webinar and I'm hit by a bus and I break a bunch of bones in my body and I'm in the hospital for two months getting morphine every day, I'll develop tolerance to that opioid and I will need more to achieve the same pain control over time.

If I'm discharged from the hospital and I don't have an opioid taper, I'll enter withdrawal. That doesn't mean I'm addicted to that morphine. That means that my body is dependent on it. Now, if I leave the webinar and I start ordering morphine on the Internet for two months and I take it

every day, I will also develop tolerance to that morphine and I will also enter withdrawal if I stop taking it. In that case because I'm not using it in a prescribed way, those two criteria count.

Now in the 11th criteria we can diagnose opioid use disorder. A mild disorder is when someone meets two to three criteria; moderate four to five; and severe is six or more. Once we have diagnosed we can treat. Treatment approaches for substance use disorders used to be dominated by abstinence-based approaches, and abstinence meaning both don't use or drink at all, but also don't take medications that might help you not do those things. However, medications to treat opioid use disorder have repeatedly been shown to decrease substance use; increase retention and treatment; and to decrease mortality among individuals with an opioid use disorder. They're really important to use, when indicated.

The first that I'm going to talk about is Methadone. It comes in a liquid or a pill form and it's a full agonist at the opioid receptor. What that means is that it sits on the receptor in the brain and activates it fully. It's like morphine, or Oxycodone or heroin, but it has a very long half-life so it sticks around at a steady state, and with regular dosing a patient doesn't get euphoric but his or her cravings are blocked. It's only possible to prescribe Methadone to treat an opioid use disorder from an opioid treatment program, or what people often call a Methadone Maintenance Clinic.

A doctor cannot prescribe it from his or her clinic when it's used to treat addiction. They can use it for pain, but not for addiction. Studies on the Methadone for opioid use disorder have demonstrated significantly decreased drug use and decreased mortality from opioid use disorder among patients treated with Methadone. It also leads to decreases in new infections with HIV, hepatitis and decreased criminality.

Buprenorphine is a partial agonist at the opioid receptor, which means that it occupies that same receptor as the other opioids that only activate it partially. The patients generally get no euphoria, but their cravings are blocked. This medication can be prescribed from a doctor's office, but prescribers have to obtain what's called a "data waiver" that is a special license to prescribe it. It takes 8 hours of training and then you can get that license. They're limited in the number of patients they can treat. The first year they can treat 30, the second year if they apply they can treat 100, and then if they have a few special criteria after that they can treat 275 patients. This medication also cuts mortality by over half from an opioid use disorder.

Those were the opioid agonists. Extended release Naltrexone is another effective tool to use. It was approved in 2010 for opioid use disorder. It blocks opioid receptors. In this cartoon, the red is the Naltrexone blocking the receptor and the light green are opioids trying unsuccessfully to kind of land on that receptor. It's an injection that lasts a month and it has demonstrated efficacy in reducing return to illicit opioid use, increasing treatment retention, and reducing opioid craving.

The last medication I want to talk about is Naloxone. This is a medication that reverses overdose. It comes in multiple forms as you can see on the screen. Walley and colleagues in Massachusetts demonstrated that communities that have Naloxone distribution from multiple different types of sites have significantly decreased overdose rates. Coffin and colleagues demonstrated that when providers in primary care clinics in San Francisco prescribed Naloxone along with their opioid

prescriptions, their patients on long-term opioids had 46% fewer opioid-related ER visits per month in the first six months after receipt of the prescription; and 63% fewer after one year when compared with patients who did not receive Naloxone. It is an incredibly important lifesaving medication.

Let's put this all together with a case study. Diana was a 65-year-old female, who was taking about 20 Hydrocodone tablets a day, which she obtained from multiple providers in ERs when they met her. She stated that she started using pills about 15 years' prior to meeting me after she broke her leg skiing. She found that the pills not only helped her acute leg pain, but they also eased some chronic shoulder pain and surprisingly to her eased her anxiety related to her work and her marriage as well.

She told me when she started using the pills she took about 5 a day, but that she was taking more now to achieve the same effect, bringing her up to the 20 a day. She also told me that she had tried to cut down about two years' prior, because she was getting tired of the effort around having to get the pills, but as she tapered she felt really sick. She's had some diarrhea. She was anxious. She was restless, so she started increasing again. She told me that her husband hates it when she takes the pills, because she kind of spaces out and that he'd be angry if he knew how many pills she was actually taking.

Her primary care physician discovered these multiple prescriptions, alerted the other providers, and sent her for an evaluation with me and that's how I met her. On my exam, she met the criteria for a severe opioid use disorder. She'd been unable to cut down. She spends a lot of time obtaining the opioids. She craved it. She had a strong desire. She talked about how she would beg for pills from her providers. She continued to use despite social and interpersonal problems with her husband. She had tolerance and she experienced withdrawal.

We started her on Buprenorphine, which alleviated her cravings and it also helped her shoulder pain. She was not interested in treatment for substance use disorder or for formal treatment, but she was open to individual and marriage counseling that touched on that use disorder and touched on some of the other stressors that contributed to her desire to use. She's been attending those sessions regularly. She also got a Naloxone kit.

Just a quick summary, opioid use disorder affects older adults and the issue's growing and it's deadly. We diagnose substance use disorders using the DSM-5 criteria and we have medications that treat opioid use disorder and they're lifesaving. We need to use them. Thank you, and now I'll turn it over to the next speaker.

Ann Giazzoni: Thank you, this is Ann Giazzoni. I am the Program Manager for Physical Health and Behavioral Health Integration with UPMC Health Plan. Thank you all for joining today. From the little survey you did at the beginning it sounds like many of you are social workers and work in managed care. The presentation today, hopefully, will be helpful in the work that you do.

I want to talk about substance abuse in older adults and also family factors. It's very important to understand the family dynamics of substance use disorder. If that's something you've never had training on, I would highly encourage you to learn about the family dynamics of how substance

use relates to a family. There's a lot of negative stigma out there and it's a barrier to getting help for older adults. It's also important to know how a family views substance use. For example, if they view it as a medical condition versus if they view it as a bad moral character or they're just not trying hard enough, there's going to maybe be a little more resistance to getting help.

There's a lot of loss and grief and denial associated with substance use disorder. If you combine this with older adults and the loss of independence, and also with losing friends, and if they've experienced any trauma in their life and things like that, it's very important to understand the family situation in which they live.

Also, substance abuse can be generational. It can be there with their children, maybe even in the family that they grew up in. We see older adults taking care of their grandchildren because their children are now have possibly had a fatal overdose. There's a lot of stress on older adults and it's very important to understand the family factors of that. For the loved ones of the person with a substance use disorder, looking at mutual support programs for them; Al-Anon, Nar-Anon.

There are many out there in the community and maybe where you live that are helpful supports and can be very educational about why their loved one continues to use. If they're trying to seek help, just stopping use doesn't make everything better. These educational programs and mutual support programs are very helpful for family members of the person trying to seek help.

There are two types of onset that are important as well. There's early onset of substance use concerns that are before the age of 65, and late onset of substance use concerns, which would be at 65 or more. With early onset you're looking at a higher incidence of physical and psychiatric concerns. Maybe they've burned a lot of bridges, so there are not a lot of supports. Substance use is long term and maybe they've had periods of where they were abstinent, but you can see many relapses.

You also see with early onset many attempts at treatment versus later onset. It might have been something that was related to a medical condition that they received opioids or started combining with drinking and things like that. They might still have some supports and they might be related more to stress or grief and loss of independence. Maybe they've never tried drug treatment before, so it might be just some educational piece for them.

We're going to talk about Fred a little bit. Fred is dually eligible. He has Medicare and Medicaid. He is a 66-year-old White male. He has an early onset of substance use disorder. The reason why I picked early onset versus the late for my piece example is because my guess is that similar to my work someone like Fred makes up possibly a large portion of your caseload. He has multiple issues going on at the same time. It might even be sort of this chaotic situation; multiple risk factors going on. Someone like Fred may take up your whole day as someone you're trying to help.

Fred has visited the emergency room several times for drug overdoses over the past six months. He was recently admitted for an infected abscess and he admitted that this was an injection site of IV heroin. He has chronic medical conditions including hepatitis C, CHF and COPD. I just wanted to highlight the hepatitis C, because many of our Baby Boomers have hepatitis C and

they don't know it. This is a very important thing to screen for is hepatitis C, because as we know now there is a cure for hepatitis C.

With Fred some of his psychosocial situation is that he receives Social Security and food stamps. He is dually eligible for Medicare and Medicaid. He says that he has a brother, but only calls him in case of an emergency. It doesn't sound like a great support. He also has an ex-wife and you can leave a message there if you need to reach them, so not a great support there either. For transportation, and this is a very important thing to assess, and he either walks or takes the bus and so not very reliable transportation. For food he goes to either a soup kitchen or he uses food assistance.

Housing is a huge issue for someone who has a lot going on. He is technically homeless, but he says he can stay with friends occasionally and his ex-wife will sometimes let him stay there if it's really cold outside. He uses her address for his mail. This is an important aspect, because getting to know Fred I learned that, yes, he has an address but it's not where he lives on a regular basis. He really has nowhere that he lives on a regular basis. It's important to assess all of these things and ask Fred about his housing. Yes, he might have an address, but he doesn't really live there so that's a risk factor for him.

As we're assessing someone like Fred, some tools to use are the NIDA, where there's a quick screen and then there's the Modified ASSIST to assess what his substance abuse is. There is also the ASAM, which helps for placement criteria of what level of care someone could be in. Also, additional assessments could be for social supports; housing, finances, transportation. A lot of these are psychosocial factors, population health factors that are very important to get the full picture of what's going on in Fred's life.

What kind of interventions are going to work with someone like Fred with a very chaotic situation and lots going on. It's very important that it's person-centered. What was going to work with Fred may not work with someone else. Also, when he's ready to take action and he says, I really need some help. I can't live like this anymore. Take those rapid interventions so that he can really gain help when he's ready.

Motivational interviewing techniques are very effective at assessing a person's readiness to change. Getting educated on motivational interviewing can be extremely helpful. Also, again assessing the family involvement and having his family involved can be a protective factor. For example, maybe there are new grandchildren in Fred's life. That might be something that might be a motivator for him to change and to start taking some steps in more healthy behaviors.

Once someone like Fred is ready and says, I think I'm ready. I need some help. Having a face-to-face intervention is really helpful. Know the resources in your area as clinicians, as helpers, and who can get face to face. When is the next time Fred's going to be going to the doctor? Does he have a way to get there? Is there someone who you can mobilize to go and meet Fred where he is? Is there home health that would be willing to go and see him? I've had home health agencies that were willing to go to a homeless shelter to see someone, so knowing which the best face-to-face help is important.

We also have community paramedics that are very helpful in our area in Pennsylvania and they may have a similar program where you are. Peer-recovery specialists are such a wonderful asset in recovery. They have lived experience in recovery. They can get a special certification as there is a certified peer-recovery specialist training that they can complete. They can really meet that person where they are and say, I understand what you're going through. I've been there. That is very effective in engaging someone in treatment and also maintaining them in treatment.

Having expert staff is very important in care coordination. The care team and the components of that care team are very important that they are skilled in many areas. Many people access a clinical situation for substance abuse. Does that medical staff having training in substance abuse? Is there someone on staff who has that ability to assess and care for them; whether it be in a primary care office; whether it be in an emergency room? Many of you work for managed care organizations on this call today and we can see lots of utilization that can be really helpful to pass along to anyone who might help that person.

Staff who can facilitate admissions to detox and rehabs and not just give phone numbers; if you give someone who is still using a phone number and say here's a phone number to medication assisted therapy; here's a phone number to treatment, that's good, but often making that phone call with them is much more effective. The chances of them following up might be slim.

When you think about your own organizations, how are you hiring? Hire that staff person who has lots of experience in lots of different areas to help them remove barriers. We don't want to transfer people and like I said just give phone numbers. We need those staff people, those clinicians, the peer navigators, the peer recovery specialists to really have at their fingertips the resources that are needed. For example, Fred has a mobile case manager and that person can go right to wherever Fred is and connect him with substance abuse services, either inpatient or outpatient, and also medication assisted therapy.

For treatment recourses, again, having staff with the knowledge of the criteria for different treatment options and what's in your specific area. What medication addiction treatment is out there? There's also a mobile app through SAMHSA that's really helpful. Dr. Gregg also talked about Narcan and Naloxone to treat overdoses. This is very important. Hopefully, first responders have these things. There's a way also to get them for free a different places in your community.

We need to have a person-centered recovery process, so to engage that person. Maybe they're not ready for treatment, but maybe they will help you with the fact they're going to be evicted. You're keeping that person engaged with helpers. You're keeping that person talking with you. That in itself can be a success so that eventually a trusting relationship can be formed.

Mutual support programs, again, we talked about Alcoholics Anonymous, Narcotics Anonymous (Al-Anon, Nar-Nan) for family members of that person seeking treatment.

This is the Surgeon General's Advisory on Naloxone and opioid overdose, so you can read that. It's very important to use Naloxone. It can save a life. Be prepared. Get Naloxone and save a life.

Our next presenter is a consumer and I'll pass it along to Carol.

Carol Prudhomme: Hello. My name is Carol, and I'm a recovering alcoholic, and I'm from Woonsocket, Rhode Island. Thank you for inviting me today to briefly share my story with you. I got into recovery after many years, because basically I had lost everything I had and lost myself along the way. Whenever I had even $2.50 in my pocket, I would get a drink; not food. If I didn't have the money, I'd find a way to get it. I'd panhandle or do anything to make the $2.50. I was panning and I got my money through cash for alcohol.

One day I was hitting up a house. A police officer pulled up in his cruiser and he ticketed me. I was still drinking pretty heavily, and when I went to court they wanted $125.00 and I just did not have it. So I went to jail; a good thing, because I could have a warm bed and three meals a day. When I got out of jail, I went back to living under the railroad tracks. For food I'd go through the dumpsters at Kentucky Fried Chicken. Sometimes the workers at a nearby Chinese restaurant helped me with food.

Living on the street was hard during the winter and I came down with frostbite. The old folks who lived across the street from me hadn't seen me all day, so they came over and saw I was in the tent and that I couldn't move and I couldn't walk. So they called Rescue and got me to the hospital and first thing they thought I was numb and drunk and they put me in the drunk ward.

They took blood and they saw I was sober and they admitted me for seven days; really for me it was like being at a four-star hotel. When I left the nurses knew me and they sent me home with clothes and Dunkin' Donuts' cards and cigarettes. I started going to a program in Woonsocket where they had doctors' services and a lot of folks hung around there to talk and stay inside where it was warm. Every Friday we got together to talk. It started with 5 and grew to 30. A lot of people were trying to stay sober.

Then I met Diego, my peer recovery specialist, through someone else at the family shelter and he got me into a detox program at a local hospital. Once I got over the withdrawals, I went to live at Amos House and started really working the program. Diego checked in on me every week and he would bring me things. He'd take me to my medical appointments and help me get on disability. I have coverage through the Neighborhood Health Plan and they have been really helpful. I didn't realize how sick I was, but they have taken care of me from getting my inhalers to my – I can't say the word, but my breathing Nebulizer machine – and even my eye doctor.

I also get RIPTA bus tickets that help me get to my recovery groups. I am now in Phase 2 of my program. I'm in independent living; my own room, my own bathroom and I have a caseworker. What I would like to tell all of you who are trying to help people like me is what I needed. I needed someone to be my advocate and that was Diego. I needed housing, so I had a place to go after detox and not back to the streets.

I needed medication that I could afford, like my insulin, and I needed help with transportation, which I did get through the help of the advocates and through the program I'm in now, which has been very helpful. I can say a lot for the Amos House and the programs that have gotten me

where I am today. Without these programs, there'd be a lot more deaths in this world. Thanks for listening and I hope my story will help others.

Caroline Loeser: Carol, thank you so much for sharing your story with everyone today, and thanks so much to our other speakers: Dr. Oslin, Dr. Gregg, and Ann. This has been really informative, and thanks for joining us today. With that we actually 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 of the presentation. Put your comment at the bottom of the Q&A box and then press Submit to send it. We've had a couple of questions come in throughout the presentation.

Dr. Oslin I'm going to start with a question that came in earlier in your presentation. I know you touched on this briefly, but will you elaborate a little bit more on what you mean by "generativity?"

Dr. David Oslin: Yes. It's a term from Erikson's developmental stages of life, and it roughly translates into purpose. The notion that I feel like I know why I'm living and know what I'm doing and what role I'm playing in my stage in life. As working adults, our purpose often is our existing families and our work. As we get older, those things we retire and they subside.

Some people are very good at picking up hobbies or having grandkids, which is also a hobby, but some people really struggle with this. It is part of what leads to suicidal thoughts, but it's also part of a loss that can lead to increase in substance use. Hopefully, that helps and it's a nice way – if you want to go back and read some Erikson – it's a nice way of conceptualizing some of the psychodynamic issues that affect us as we age.

Caroline Loeser: Thank you for that added context. Dr. Gregg, I'll turn to you next for a question that came in during your presentation. The question is many older adults have chronic pain and need opioids, but do not misuse the opioids. How can you tell when a patient will misuse the opioids? Is it the length of time they are on one or the type of opioids specifically?

Dr. Jessica Gregg: That is a great question. There are a couple of things. We do have risk tools before starting someone on an opioid and that doesn't indicate somebody's high on the risk tool or risk of opioid use disorder or opioid misuse. It doesn't mean that you don't necessarily prescribe the opioids, but you might be more vigilant about the rapidity of the taper and making sure that it's being taking as prescribed.

That's a different scenario than having a patient who has been on opioids for a long period of time and now we're becoming much more vigilant and much more aware of the extent of opioid use disorder and the deadliness; how dangerous it is to our patients. I think people are really struggling with this, because on the one hand in good faith they prescribed to patients in pain, and in good faith those patients took opioids and are still on them. Now, we're recognizing the downside.

My approach is generally if somebody has been on opioids for a long period of time and they've been taking them as prescribed and they haven't suffered real consequences from that use, and

those consequences can be things as varied as decreased bone density, increased depression, and increased fatigue. A lot of times we put patients on opioids and we're not paying attention to all the side effects.

Let's say that we have a patient who has had minimal side effects, is taking them as prescribed and has been on them for a long period of time. I don't take those patients off of their opioids just because we're now much more aware of the dangers. I will often, if they're on higher dosages above 90 morphine equivalence, and say let's get you down to what we consider a safer dose, because the risk of overdose and the risk of other consequences is lower on lower doses. I mean it's the importance of primary care and long-term relationships to do that. Those are the contexts in which those tapers or non-tapers or assessments of opioid use are best done.

Caroline Loeser: Great. Thank you, Dr. Gregg.

Dr. David Oslin: This is Dr. Oslin. Can I just add that the other thing to emphasize is the concurrent use of alcohol or Benzodiazepines, which also markedly raises people's risks for death at even lower doses.

Caroline Loeser: Thank you, Dr. Oslin.

Ann, I have a question that came in during your presentation. I think you touched on this a little bit during your case study with Fred that perhaps you can go into a little bit more detail. The question is that you talked about the importance of supporting members with social supports and then the importance of having an interdisciplinary care team and having family support as well. What do you do for older adults who live alone and may not have a family or a support system?

Ann Giazzoni: That's a really good question. I think that many older adults do live alone, and assessing what is out there for them that they could quality for. For example, our dually enrolled members may have an eligibility for long-term support services, which is a caregiver in their home. Are there things where they could be getting support in their home so they could maintain their independence in their own home, which is where a lot of people want to be maintained and not living in a nursing facility.

Knowing what the person is eligible for to gain social supports when they do not have family and also possibly what mobile mental health or substance abuse treatment could be obtained in their home. Again, having that knowledge of what's available to them and what do they qualify for and having that expertise is very important.

Caroline Loeser: Thank you, Ann.

Dr. Oslin, I'll turn back to you and this came up during your portion of the presentation when you talked about the different servings of alcohol. The question is that the information you provided asks about six or more drinks of binge drinking and the definition looks like four or more. This individual is also seeing the number five for the number of drinks. He wants to know if there's a current standard definition used across healthcare settings for binge drinking.

Dr. David Oslin: That's a great question and actually there's a superb article that just came out in Lancet on drinking that questions a lot of this as well. I think my slide shows this as more than four, which would be the same as five or more and so first you have to look at that. I think you will see a little bit of confusion between different things and for us and research we use five or more, which is greater than four as the standard.

The Lancet article I just referenced actually raises questions about whether drinking over one standard drink per day doesn't increase your risk and they did not find a gender difference and they didn't find an age difference. The risk for lots of negative things started at one and then rose exponentially as you increased, which is a little bit different than what the US is actually recommending right now. That Lancet article was a compilation of a lot of European data. That's a great question. The reality is you're trying to get at heavy drinking in a day.

The other things that I would say about this to trainees is that none of us carry an I&O sheet around in our pockets. We don't really monitor how much we drink. Often people know how much they buy, but the notion that people keep track of ounces is a little bit crazy. If I were to ask any of you guys to tell me how much coffee you've had each day over the last two to three weeks, you'd soon see how hard that is to do. We're just trying to get really close to the truth and as that slide showed not a very large drink when it really is not what they're talking about. We're trying to have a common language here with our patients.

Caroline Loeser: Thanks, Dr. Oslin.

Carol, I just wanted to let you know that we have a lot of comments coming in through the Q&A just thanking you for sharing your story and congratulating you on your success. I wanted to share that with you.

Carol Prudhomme: Thank you.

Caroline Loeser: Ann, this question probably can go to you. The question is if you could recommend resources to use for accessing readiness to change or motivational interview techniques.

Carol Prudhomme: There's so much help out there, but it's not very well put out there in the right way. It scares a lot of people. They think that going to a detox that everything's going to be done and they're going to go right back out there and everything's going to be easy. There are a lot of homeless people. Like I said, I lived in a cave. I've been out there like I said. The thing is that you've got to have more outreach people out there to help these people.

People out there are seeing it themselves. Talking about it doesn't really see it with the eyes. Now, when I go back to Woonsocket, Rhode Island and go see my doctors and stuff, I see it continuing. But when they see somebody like me and how far I've gotten, they're willing to try it. Again, but that one that makes it is what counts; if it's just one that can make it. Then, that one goes and word keeps going and you go to groups and you end up in meetings and you see people there; AA meetings, any type group meetings they come out. I can't say more about the meetings and not to be afraid to talk to your physicians.

Eventually, you're going to have them that have doubts, but it's because of your past and you can't blame a physician for that. You can't the blame the psychiatrist. It's just like me going off my disability because of my alcoholism, you know, they're throwing all of that in my face. I'm sober now, so why are you putting my past to me again. You know, I've been doing great. I am doing great and I plan on doing great. I don't look back. I live for the present and hope for the future. That's what I do, and with that have a good day everybody.

Caroline Loeser: Thank you, Carol, I really appreciate you sharing your perspective.

Ann, if you're still on, I don't know if you could comment a bit more on this question, specifically any resources that you might recommend for assessing readiness for change and motivational interview techniques.

Ann Giazzoni: Sure, and I just want to thank Carol for her comments. I think she's very inspirational and it kind of fits in with a motivational interviewing. SAMHSA has some nice information about motivational interviewing on their website. There are many trainings out there that you could search for in your local areas. Where I am employed, we have motivational interviewing as part of all of our onboarding of our new employees. SAMHSA would definitely be a great place to start learning about motivational interviewing and readiness for change.

Along with what Carol was saying recovery is a process and that motivation waxes and wanes. Having those support people who are skilled in motivational interviewing along the way, whether it be peer recovery specialists, social workers, even PCPs, to keep that person engaged in their recovery is so important to continue the motivation to change. Some of these are harder than others and we all need a cheerleader sometimes. Motivational interviewing has a great structure for that.

Caroline Loeser: Thank you, Ann.

We have a number of questions coming in, so we really appreciate the audience staying engaged and reaching out with your questions. The questions that we can't get to today I just want to let everyone know that we'll work on creating a question-and-answer document and we'll be posting that to our website. I think we have time for about one or two more questions.

For this question in particular, I'll open it up to everyone on the panel today. The question is what is the relationship of an adult's right to self-determination and their willingness or unwillingness to participate in substance use disorder treatment or care programs? They cannot be forced to participate, so how does one help individuals who no one knows are at high risk for abuse, neglect or substance use disorder?

Ann Giazzoni: This is Ann. From a clinician perspective, a case management perspective, they do have that right to self-determination and having that person at the center of their treatment is so important and understanding the recovery model and that that recovery is a process. Having that person engage with the helper is a success right there. Maybe they're not ready to stop their use or decrease their use, but they would like help with something else. They don't have enough

to eat, or their medical equipment broke and they need a new walker or whatever it is that they need.

They're willing to continue that relationship and I think that they're kind of leading the way and developing that trusting relationship is important for self-determination. I think Dr. Oslin mentioned that people have to be ready to change. It can't be forced. Having that relationship with that person is very important along the way. What do they want help with right now and taking that lead from them?

Dr. Jessica Gregg: This is Jessica Gregg. I would echo that with a specific example. I had a patient who did not want to stop using heroin, but actually was interested in some help with smoking cessation. So, we started with that and really didn't talk about heroin. Once he actually cut down on his smoking, he thought about other things that he might want to change. Eventually, we did get him on to Buprenorphine. He isn't using heroin, but that was absolutely of no interest to him when I first saw him.

I would also echo something that she said earlier about the peers. We have a peer on our team and so having a peer also not pushing that agenda, but able to support that patient in his smoking cessation first, and then sort of talking about his other goals was unbelievably important.

Caroline Loeser: Thank you both for sharing. I'll go ahead with one final question before we conclude for today. Dr. Gregg, this may be a question for you, but of course others please feel free to jump in. The question is how should we initiate a conversation with a pain management physician, who is prescribing a high dose of opioids for many years, to a family member, and suggest how this physician can reduce the opioid?

Dr. Jessica Gregg: I want to make sure I understand the question. It's a family member wanting to talk to a pain physician?

Caroline Loeser: Yes, I think that's what this question is getting at; maybe the family member having the conversation with the provider.

Dr. Jessica Gregg: First, it's important to talk to the patient, him or herself, because they have a right to know what's being said about them to their provider and to be able to say to the provider I don't want you to talk, or it is okay. I mean, that's their right. I think that's first and foremost what has to be dealt with.

If the patient is comfortable, then I think expressing a valid concern over a dosage and saying can we open that dialogue with the patient as well. It can't be a runaround. It doesn't happen through a backdoor.

Caroline Loeser: Thank you, Dr. Gregg. At this time if you have any additional questions or comments, please email us at RIC@Lewin.com. For more information, you can also find a list of resources related to supporting older adults with substance use disorder in the last few slides of this presentation.

Before we conclude, we also would like to take a few minutes to share more from the audience. We'd like to know within your particular discipline what else you would like to learn about substance use disorders. We'll give everyone just a couple of minutes here to enter your response using the Q&A feature. Thank you everyone for sharing. We'll definitely take this into consideration for any potential future work.

We'd also like to invite everyone to visit our website to view recordings of our webinars that aired earlier this year. These webinars include: Safe and Effective Use of Medications in Older Adults; Disability Competent Care 2018 Webinar Series; and Providing Culturally Competent Care: Meeting the LTSS Needs of Dually Eligible Beneficiaries.

The slides for today's presentation, a recording and a transcript will be available on the Resources for Integrated Care website shortly. At this time the post-test for this webinar are now open. Additional guidance about obtaining credits and accessing the links to the post-test can be found within the Continuing Education Credit Guide in the Resource Guide on the left-hand side of your screen, or at the Resources for Integrated Care website.

Thanks so much for joining us today. Please complete our brief evaluation of our webinar so that we can contribute to delivering high-quality presentations. If you have any questions for us, please email us at RIC@Lewin.com. Thanks again to all the speakers. Have a wonderful afternoon and thank you so much for your participation.