ACCEPT

Addiction & Co-morbid Conditions: Enhancing Prevention & Therapeutics

How to Join:
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For attendance, purposes please text the following code: HEBNOQ to 608-260-7097

Session Date: Friday, May 16, 2025

Didactic Topic and Presenter:
Caring for Older Patients with Substance Use Disorders

Laurel Bessey, MD
Assistant Professor, Department of Psychiatry
University of Wisconsin School of Medicine and Public Health

Content Experts: Sheila Weix and Joe Galey

- 12:15 PM: Attendance text-in – Introductions
- 12:25 PM: Case Presentation
    - Presenter: Kelly Eagen, MD - *Assistant Professor, Department of Family Medicine and Community Health, Associate Program Director, Addiction Medicine Fellowship*
- 1 PM: Didactic Presentation
    - Presenter: Laurel Bessey, MD
- 1:15 PM End of Session

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Interprofessional Continuing Education Partnership
UNIVERSITY OF WISCONSIN-MADISON
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School of Nursing
School of Pharmacy

ECHO ACCEPT
Addiction & Co-morbid Conditions: Enhancing Prevention & Therapeutics 2025
Caring for Older Patients with Substance Use Disorders 5/16/2025
Didactic Presenter: Laurel Bessey, MD
Case Presenter: Kelly Eagen, MD

Provided by the University of Wisconsin–Madison Interprofessional Continuing Education Partnership (ICEP)

Intended Audience:

Nurses, Nurse Practitioners, Pharmacists, Physicians, Physician Assistants, Pharmacy Technicians, Psychologists, Social Workers, Patient/Caregivers, Students

Objectives:

- Describe the scope of the problem of substance use disorders in older adults
- Recognize the importance of screening for substance use disorders in older adults
- Describe evidence-based strategies for treatment and management of opioid and alcohol use disorders in older adults

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Randall Brown	RSS Chair	No relevant financial relationships to disclose	Yes	12/4/2024
Nada Rashid	RSS Coordinator	No relevant financial relationships to disclose	No	1/15/2025
Kathleen Maher	RSS Coordinator	No relevant financial relationships to disclose	No	12/9/2024
Ritu Bhatnagar	Planner	No relevant financial relationships to disclose	Yes	12/9/2024
Paul Hutson	Planner	usona (Independent Contractor - Consultant), Midwest Pharmacokinetic Consulting, LLC (Independent Contractor - Consultant), Otsuka America Pharmaceutical, Inc. (Independent Contractor - Consultant), Tryptamine Therapeutics (Independent Contractor - Consultant)	Yes	12/4/2024
Susan Mindock	Planner	No relevant financial relationships to disclose	No	12/7/2024
Sheila Weix	Planner	No relevant financial relationships to disclose	No	12/12/2024
Kellene Eagen	Planner	No relevant financial relationships to disclose	No	12/4/2024
Joseph Galey	Planner	No relevant financial relationships to disclose	No	12/12/2024
David Leinweber	Planner	No relevant financial relationships to disclose	Yes	12/4/2024
Laurel Bessey	Presenter	No relevant financial relationships to disclose	Yes	4/29/2025
Kelly Eagen	Presenter	No relevant financial relationships to disclose	No	5/12/2025

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Case Presentation

Kelly Eagen, MD
UW Health

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Case Introduction

- 51y female with PMHx of idiopathic pulmonary fibrosis, asthma, depression, history of pulmonary embolism on anticoagulation, OUD in sustained remission on methadone, AUD in sustained remission who was transferred from an outside hospital for expedited lung transplant evaluation.

- Primary question for discussion:
  What should be considered for patients on methadone for OUD when being evaluated for lung transplant?

Medical & Behavioral Health Diagnosis:	Current Medications:
• Idiopathic pulmonary fibrosis • Asthma • h/o pulmonary embolism on anticoagulation • Depression • Opioid use disorder in sustained remission • Alcohol use disorder in sustained remission	• Home O2 • Methadone 110 mg daily (at OTP) • Albuterol (INH) • Budesonide-formoterol (INH) • Ipratropium-albuterol (INH) • Apixaban • Benzonatate • Mycophenolate • Prednisone • Acetaminophen • Ferrous sulfate • Calcium/Magnesium/Vitamin D • Saline nasal spray • OTC cough medications

Substance Use

- History:
  - Initial treatment of back pain and foot fracture with rx opioids ~ 15 years ago. Pain inadequately controlled and patient sought out additional unprescribed opioids. Denies insufflation or injection. PCP subsequently discontinued opioids due to taking unprescribed and the patient sought care with methadone at an opioid treatment program. She has been on methadone for ~ 13 years.
  - In 2013, pt's father died and she started using alcohol heavily for ~ 1 year, reflecting that she was dealing with unprocessed grief. She sought residential treatment. Denies any regular or heavy alcohol use since. Reports 1 drink (wine) on holidays/major events.
  - Denies past/present other substance use.

- Treatments:
  - Methadone (current)
  - Outpatient counseling at OTP (current)
  - Residential treatment: ~ 2014 for alcohol use disorder

OUD treatment history

- Engaged in treatment ~ 13 years ago on methadone
- In another state, achieved monthly take-homes
- Dose:
  - Maximum: 140 mg
  - Self-driven taper to 60 mg
  - Returned to 110 mg after father died
- Moved to WI → transitioned to Q2week take homes due to WI regulations
  - Prefers to dose weekly to minimize random call-backs for toxicology testing
- Per OTP medical director and counselor, no concerns for substance use, very stable and well supported in treatment

Social History:	Family History:
• Housed with husband and 14 year old daughter • Owns her home • Two adult children outside of the home • From Wisconsin • Homeschools child • Former nurse • Drives	• Father with IPL • No substance use history

Patient strengths & protective factors:	Risk factors:
• Supportive and engaged family (husband, adult children, mother) • Strong supports at opioid treatment program • Spouse with SUD also in sustained remission • Motivated to parent adolescent • Well controlled moods • Significant insight into stressors, moods, substance use	• Deteriorating physical health • Rural geography (further from tertiary care services and

Labs

- January 2025: (outpatient transplant eval initiated)
  - PEth: not detected

- April 2025: (inpatient expedited transplant eval)
  - UDT: all negative (amphetamines, benzodiazapines, cannabinoids, cocaine, opiates)
  - PEth: 38 ng/mL
  - HCV Ab: non-reactive
  - HCV RNA: not detected
  - HIV Ag/Ab: non-reactive
  - EKG QTc: 439 ms

PEth (phosphatidylethanol)

- Direct alcohol biomarker detected in serum
- A phospholipid metabolite of ethanol incorporated into membrane of RBCs
- Produced via non-oxidative metabolism
- Results:
  - Less than 10 ng/mL.....Not detected
  - Less than 20 ng/mL.....Abstinence or light consumption
  - 20 - 200 ng/mL.....Moderate consumption
  - Greater than 200 ng/mL.....Heavy consumption or chronic use
- Interpretation
  - Window of detection: 2-4 weeks
  - Significant interpersonal variation

Patient Goals & Motivations for Treatment

- To obtain a lung transplant
- To live, be healthy and physically able to enjoy life and be with her family and care for her daughter
- Remain abstinent
  - Open to tapering methadone over time but has insight into a rapid taper not being feasible or recommended

Proposed Diagnoses

- Opioid use disorder in sustained remission on methadone

- Alcohol use disorder in sustained remission
  - Recent alcohol use not meeting criteria for active use disorder

SUD considerations related to lung transplant

- Lung transplant for a patient on methadone had never been done before at this institution

- Sought out experiences of other institutions
  - Not common!

SUD considerations related to lung transplant

- High dose methadone
  - Drug-drug interactions post-transplant
  - Potential for QTc prolongation
  - Concern for respiratory sedation in a high-risk pulmonary patient
  - Challenges related to post-op pain control
- Recent detected PEth
  - Result not entirely consistent with reported alcohol use
  - Also uses mouthwash and cough syrup?
  - PEth ≠ active AUD
- Stigma

DSM-5 Substance Use Disorder ("Addiction")

- Tolerance
- Withdrawal

} Physical Dependence ≠ Use Disorder

- Larger amts/longer periods than intended
- Persistent desire/failed attempts to quit/control use
- Much time obtaining/using/recovering
- Important activities sacrificed
- Continued use despite known adverse effects
- Failure to fulfill major obligations
- Recurrent hazardous use
- Craving
- Ongoing use despite interpersonal problems

2-3 = mild
4-5 = moderate
≥ 6 = severe

Proposed Treatment Plan

- Addiction Medicine participated in "Selection Committee" to advocate on the part of the patient regarding her candidacy for lung transplant

- ADM recommendations:
  - No SUD-related contraindication to transplant
  - Peri-operative management:
    - Anesthesia to utilize nerve ablation for opioid sparing pain regimen
    - Additional opioids to be used as needed PRN pain
    - Methadone
      - Convert methadone PO: IV (2 mg PO : 1 mg IV) while intubated
      - Recommend splitting total dose to take advantage of analgesic benefit of methadone (40/30/30)
      - As tolerated, consolidate dose back to Qday dosing by discharge

Proposed Treatment Plan

- Post discharge
  - Pt to remain local to hospital for 1-2 months
  - Patients can guest dose at a local OTP for up to 30 days
  - If > 30 days, formally transfer OTP (and then transfer back when returning to hometown)
  - Pt to continue counseling with OTP
  - Pt aware of additional resources including social work and support from transplant team

Hospital course

- Uncomplicated transplant
- Pain well controlled
  - Transitioned back to qday methadone 2 weeks post-op with hydromorphone for pain at bedtime
- Discharged to local hotel with family
- Transferred OUD care to local OTP
- Discharge with naloxone

Discussion:

- Primary question:

  What should be considered for patients on methadone for OUD when being evaluated for lung transplant?

Caring for Older Patients with Substance Use Disorders

Laurel Bessey, MD

Assistant Professor, Department of Psychiatry

University of Wisconsin School of Medicine and Public Health

May 16, 2025

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2024 Universal Activity Number (UAN): JA0000358-0000-24-009-L01-P; JA0000358-0000-24-009-L01-T

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Learning Objectives

- Describe the scope of the problem of substance use disorders in older adults
- Recognize the importance of screening for substance use disorders in older adults
- Describe evidence-based strategies for treatment and management of opioid and alcohol use disorders in older adults

Substance use disorders in older adults

- Over 4.6 million older adults with SUD in 2023
- Increasing compared to prior years (about 1 million in 2018)
- Alcohol Use:
  - 65% of OA report exceeding alcohol intake recs weekly
  - 10% report bingeing 5+ drinks/sitting
- Opioid Use 2013-2015:
  - Population age 55+ grew ~6%
  - Age 55+ seeking tx for OUD grew ~54%

While many older adults have aged with their SUD, some will develop SUDs later in life

SAMHSA. 2023 National Survery on Drug Use and Health
Grant et al. Prevalence of 12-Month Alcohol Use, High-Risk Drinking... *JAMA psychiatry.* 2017
Huhn et al. A hidden aspect of the U.S. opioid crisis…. *Drug and alcohol dependence*. 2018

Alcohol use in older adults

- Compared to younger adults older adults experience…
  - Higher BACs with equivalent dose of alcohol
  - More impairments including cognitive impairment
  - Increased risk of falls
  - Increased risk of hospitalization

No more than 3 drinks/day

No more than 7 drinks in 1 week

National Institute on Alcohol Abuse and Alcoholism (NIAAA)
Lehmann & Fingerhood. Substance-Use Disorders in Later Life. N Engl J Med. 2018

An “invisible” population

- Older adults less likely self-report a problem with alcohol use and to ask for treatment than younger patients
- Provider beliefs/attitudes towards older adults can lead them to NOT screen for alcohol misuse

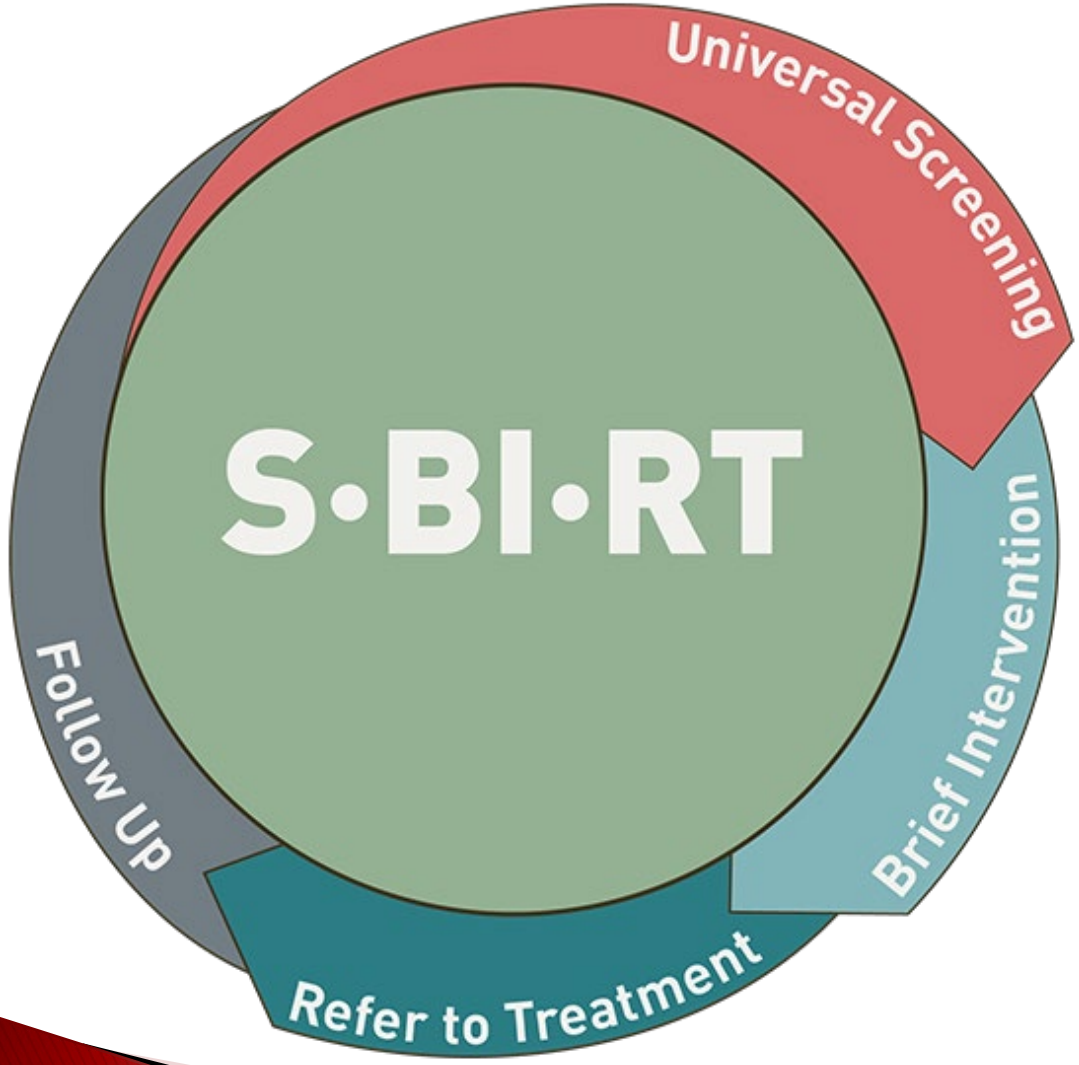
“They are never going to change”

“I don’t want to be disrespectful given his age”

“It’s not causing them issues”

“At his age it’s normal to forget things”

“Not enough time”



SAMHSA TIP 26: Treating Substance Use Disorder in Older Adults

Treatment Improvement Protocol 2020

Project ECHO
University of Wisconsin

Screen all adults age 60+ for substance use/misuse

ANNUALLY

and

WHEN LIFE CHANGES OCCUR

Screening tools for alcohol use disorder in older adults

- Alcohol Use Disorders Identification Test (AUDIT)
  - Cut off for older adults: ≥5 for AUDIT; ≥4 for AUDIT-C
  - Improves sensitivity from 48% to 85%
- CAGE/CAGE-AID questionnaire:
  - Variable sensitivity in older adults
  - Older adults less likely to have someone at home to"annoy" them about their drinking
  - Poor at identifying binge drinkers

Aalto et al. *International Journal of Geriatric Psychiatry.* 2011; 26, 881–885.
Han et al. *Clin Geriatric Med.* 2018 Feb;34(1):117-129

Short Michigan Alcoholism Screening Test (SMAST-G)

Short Michigan Alcoholism Screening Test–Geriatric Version (SMAST-G)

Source: University of Michigan Alcohol Research Center. Reprinted with permission.

	Yes (1)	No (0)
1. When talking with others, do you ever underestimate how much you drink?		
2. After a few drinks, have you sometimes not eaten or been able to skip a meal because you didn't feel hungry?		
3. Does having a few drinks help decrease your shakiness or tremors?		
4. Does alcohol sometimes make it hard for you to remember parts of the day or night?		
5. Do you usually take a drink to relax or calm your nerves?		
6. Do you drink to take your mind off your problems?		
7. Have you ever increased your drinking after experiencing a loss in your life?		
8. Has a doctor or nurse ever said they were worried or concerned about your drinking?		
9. Have you ever made rules to manage your drinking?		
10. When you feel lonely, does having a drink help?		

TOTAL SMAST-G-SCORE (0-10) _____

Specific for older adults

- +2/10: problematic drinking
- +5/10: sensitivity of 91-93% for alcohol use disorder

Blow et al. The Michigan Alcoholism Screening Test Geriatric version…*Alcohol Clin Exp Res. 1992*
Hirata et al. Validity of the Michigan Alcoholism Screening Test (MAST)…*Am J Geriatr Psychiatry.* 2001

Severity of Dependence Scale

- Assess severity dependence of CNS depressants
- Cut off older adults: ≥ 6 for detecting misuse
- Sensitivity of 76%

Question	Never / almost never	Sometimes	Often	Always / nearly always
1. Did you think your use of (drug) was out of control?	0	1	2	3
2. Did the prospect of missing a fix (or dose) make you anxious or worried?	0	1	2	3
3. Did you worry about your use of (drug)?	0	1	2	3
4. Did you wish you could stop?	0	1	2	3
	Not difficult	**Quite difficult**	**Very difficult**	**Impossible**
5. How difficult did you find it to stop or go without (drug)?	0	1	2	3

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Cheng et al. *BMC Geriatrics.* 2019; 19:174

Assessment after Screening

- Share results with patient
- If positive get more information:
  - Medical and psych history
  - Substance use history
  - Frequency of use and route of administration
  - Check PDMP
  - Past attempts to stop use and response to treatment
- Physical exam if needed
- Refer for treatment if needed

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- Tolerance
- Withdrawal

} Physical Dependence ≠ Use Disorder

- Larger amts/longer periods than intended
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A problematic pattern of substance use leading to clinically significant impairment or distress **at least 2 within 12-month period**:

Table 1. Use of DSM-5 Criteria for the Diagnosis of Substance-Use Disorder in Older Adults.*

DSM-5 Criterion	Application of Criterion for Older Adult
Substance taken in greater amount than intended	Older adult may be impaired using the same amount taken when younger
There is persistent desire or unsuccessful effort to cut down or control use	Older adult may not realize use is problematic, especially with long-term use
There is excessive time spent to obtain, use, or recover from the substance	Same
There is craving for the substance	Same
Repeated use leads to inability to perform role in the workplace or at school or home	Role impairment is less pertinent; older adult may be retired and may be living alone
Use continues despite negative consequences in social and interpersonal situations	Same
Valued social or work-related roles are stopped because of use	Effect of substance use on social roles is less obvious if older adult is no longer working
Repeated substance use occurs in potentially dangerous situations	Same; older adult may be at increased risk for impaired driving
Substance use not deterred by medical or psychiatric complication	Same; medical consequences can be serious, including confusion, falls with injury, and psychiatric symptoms
Tolerance develops: increasing amount is needed to obtain effects	Symptomatic impairment may occur without an obvious need for increasing the amount
Withdrawal syndrome occurs or patient takes substance to prevent withdrawal	Withdrawal syndrome can occur with more subtle symptoms such as confusion

Lehmann & Fingerhood. Substance-Use Disorders in Later Life. *N Engl J Med*. 2018

Neuropsychological testing in SUDs

- Can be very helpful in identifying impairment and relative strengths by cognitive domain, pointing to etiologies of impairment
  - Ex: In alcohol related dementias (ARD) we see executive, visuospatial, and memory difficulties, but **spared** language function
- Usually try to optimize cognitive risks (like substance use) before testing
- Sometimes can be helpful to demonstrate the effects of use on cognition

Treatment of SUD in older adults

Older adults are l*ess likely to be screened, identified, and referred for treatment for substance use issues*

BUT OLDER ADULTS ARE

JUST AS LIKELY TO BENEFIT

FROM TREATMENT AS YOUNGER ADULTS

Canadian Guidelines on Opioid Use Disorder Among Older Adults (2020)

- Older adults should be screened for Opioid Use Disorder
- Threshold to admit older adult for opioid withdrawal management lower than for younger adult
- Opioid Agonist Treatment (OAT) is recommended when possible
  - First line: Buprenorphine-naloxone maintenance
  - Second line: Methadone if bup-naloxone is not tolerated
- If opioid agonist treatment contraindicated may offer naltrexone MAT
- Go slow, use lowest effective dose, monitor closely (sleep apnea, sedation, cog impairment, falls, etc.)

Project ECHO University of Wisconsin

Rieb et al. Canadian Guidelines on Opioid Use Disorder Among Older Adults. *Can Geriatr J.* 2020 .

Opioid withdrawal in older adults: It could be life threatening

- Opioid withdrawal using ultra-rapid opioid detox not recommended due to high risk for adverse events/death:
  - Electrolyte abnormalities from fluid loss
  - Arrhythmias
  - Deconditioning with prolonged withdrawal
- Induction onto an opioid agonist >>non-opioid treatment withdrawal management in older adults with an OUD
- If not available use COWS to monitor withdrawal and treat symptomatically
  - Clonidine (Alpha 2 agonists): appropriate to use, with BP monitoring
  - Loperamide and other anticholinergics –use with care
  - NSAIDs – use with caution
- Lower threshold to admit older adults for withdrawal

ASAM National Practice Guideline For the Treatment of Opioid Use Disorder: 2020 Focused Update

Rieb et al. Canadian Guidelines on Opioid Use Disorder Among Older Adults. *Can Geriatr J*. 2020

Buprenorphine > Methadone (for pain control and/or MAT in older adults)

- Generally, less sedating → less fall risk
- Less respiratory depression
- Metabolism stable (no ↑ in $t_{1/2}$) with aging
- Less cardiac risk than methadone (still some QT ↑)
- More readily available for LTC/homebound
- If on methadone maintenance plan ahead for transition of treatment

Nonpharmacologic Treatments for AUD in OA

- Motivational interviewing
- Social support (senior center)
- 12 step recovery groups (AA)
- Cognitive behavioral therapy
- Problem solving therapy
- Relapse prevention therapy

Pharmacologic Treatments for AUD in OA

- FDA approved medications for AUD have not been studied adequately in OA but they should be considered:
  - **Naltrexone**
  - **Acamprosate**
  - Disulfiram
- **Topiramate**, gabapentin
- Needs more studies: baclofen, varenicline, ondansetron

Lehmann & Fingerhood. Substance-Use Disorders in Later Life. *N Engl J Med*. 2018
Soyka et al. Pharmacotherapy of alcoholism…*Expert opinion on pharmacotherapy.* 2017
Kim et al. Practical outpatient pharmacotherapy for alcohol use disorder. *Drugs in context. 2018*

Summary

- Substance use disorders are increasing among older adults
- Older adults are just as likely to benefit from treatment but we can't treat them if we don't identify them via screening
- We all have beliefs about aging and competing priorities that may get in the way of universal screening
- Substance withdrawal in older adults may be life threatening
- Go slow, use lowest effective dose, monitor closely when using pharmacological treatment for SUD in older adults

Questions?