



**DIABETES IN SPECIAL & VULNERABLE POPULATIONS:
A NATIONAL LEARNING SERIES**

**Diabetes Continuum of Care: Using
Behavioral Health and Substance Use
Disorder Integration to Address Older
Adults with Cognitive Impairments and
Diabetes**

Tuesday, April 9, 2019
8am HT / 11am PT / 1pm CT / 2pm ET

Welcome!
We will begin in a few minutes.



Diabetes Continuum of Care: Using Behavioral Health and Substance Use Disorder Integration to Address Older Adults with Cognitive Impairments and Diabetes

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ABOUT THE SERIES

Diabetes affects more than 30 million people in the United States. Multi-tiered efforts to prevent, treat and manage diabetes are critical in reducing the burden of diabetes, particularly for medically underserved racial and ethnic minority populations. In addition to higher prevalence, ethnic and racial minority patients with diabetes have higher mortality and higher rates of diabetic complications.

To combat and continue the national conversation around diabetes, 13 National Cooperative Agreement (NCA) organizations have partnered to create a four-part national learning webinar series to engage health centers, Primary Care Associations (PCAs), and Health Center Controlled Networks (HCCNs) to increase foundation knowledge of effective strategies to prevent, treat, and manage diabetes among special and vulnerable Health Center Program patients.

This year's national learning series is focused on co-morbidities associated with diabetes (e.g., oral health, behavioral health, substance abuse disorders, obesity, and social determinants of health). This series complements with HRSA's working draft of the "Diabetes Clinical Change Package" (to be published this year).

Register for the National Learning Series today at diabetes.aapcho.org.

WEBINAR FACULTY

NATIONAL COOPERATIVE AGREEMENT (NCA) ORGANIZATION PARTNERS

Association of Asian Pacific Community Health Organizations

Corporation for Supportive Housing

Farmworker Justice

Fenway Health

Health Outreach Partners

MHP Salud

Migrant Clinicians Network

National Center for Equitable Care for Elders

National Center for Farmworker Health

National Center for Health and Public Housing

National Health Care for the Homeless Council

National Network for Oral Health Access

National Nurse-Led Care Consortium

School-Based Health Alliance

FOR MORE INFO ON OUR NCA PARTNERS, VISIT [DIABETES.AAPCHO.ORG](https://diabetes.aapcho.org).



Diabetes Continuum of Care: Using Behavioral Health and Substance Use Disorder Integration to Address Older Adults with Cognitive Impairments and Diabetes

NCA FACULTY



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Chief Medical Officer of
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Christine Riedy, PhD, MA, MPH
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for Elders






Key Topics

 Smoke free public housing

 Community collaborations

 Behavioral health, e.g., trauma-informed care


 QI/QA, e.g., diabetes, childhood obesity, opioids, emergency preparedness, etc

 Social determinants of health

www.nchph.org





Key Topics

 Achieving health equity for older adults of all races & socio-economic levels

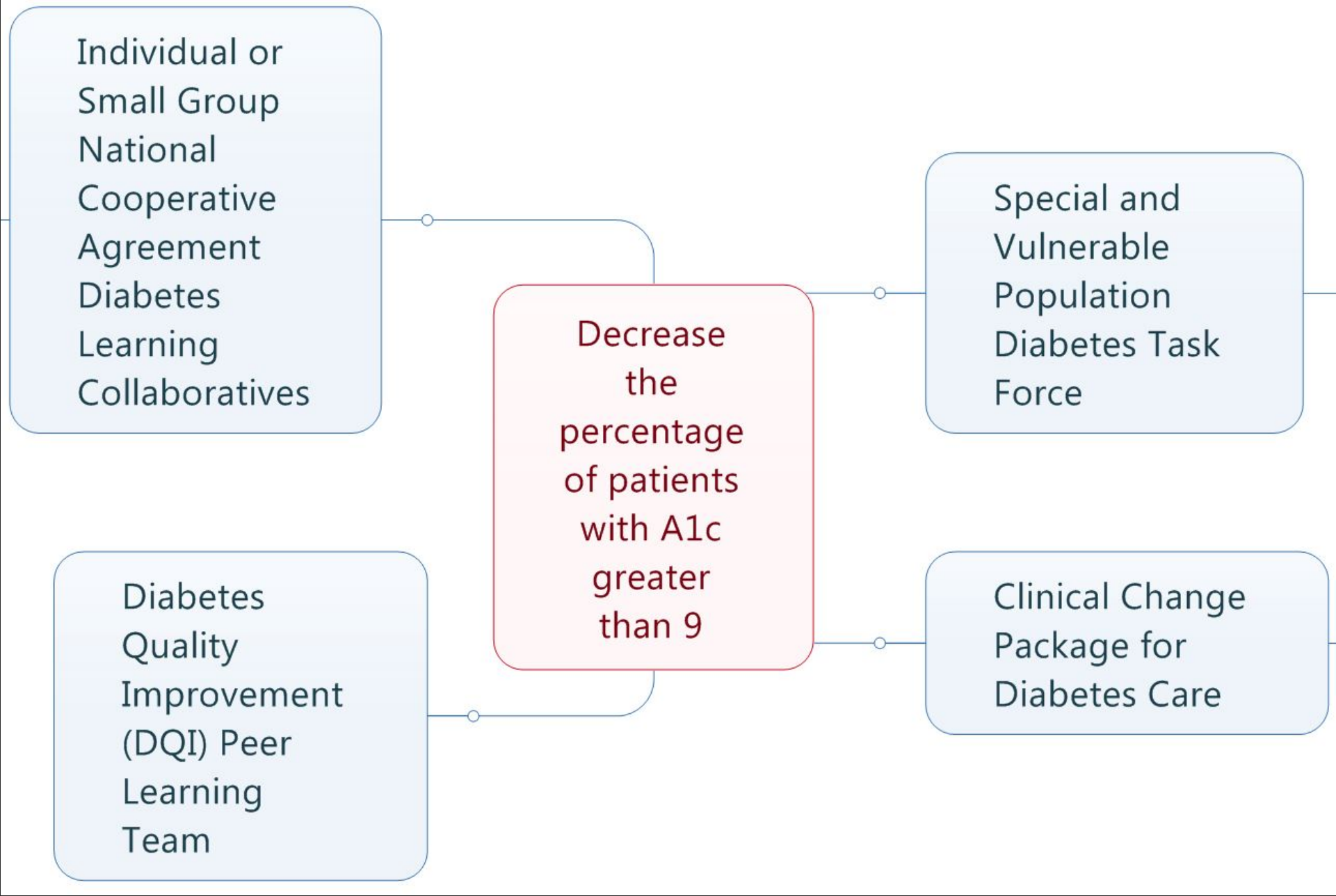
 Improved access to health care

 Behavioral and oral health integration

 Improved knowledge of self- management of chronic conditions

 Connecting and engaging older adults to community / enabling services

<http://ece.hsdm.harvard.edu/>



HRSA Funded Diabetes Activities 2018-2019

Strategic Partners' Technical Assistance Strategies to Prevent and Manage Diabetes

Improving Health Systems & Infrastructure

EHRs with Diabetes Modules

Diabetes Informatics

Health Information Exchange (HIE) & Telemedicine

Patient Centered Medical Home (PCMH)

Use Patient Portals

Optimizing Provider & Multidisciplinary Teams

Team Based Care

Promote National Standards

New Techniques for Early Detection Screening

Case Management

Sharing of Diabetes Management Promising Practices

Eye, Foot, Dental, & Kidney Screening

Provider Counseling of Patients

Facilitating Behavior Change in Patients

CHW Directed Patient Education

Lifestyle/Self-Management

Promote Physical Activity and Healthy Diets

Address Childhood & Adult Obesity

Increase Patient Health Literacy



Diabetes Continuum of Care: Using Behavioral Health and Substance Use Disorder Integration to Address Older Adults with Cognitive Impairments and Diabetes

LEARNING OBJECTIVES

- 1) To understand the prevalence of substance abuse among patients with diabetes and describe a collaborative model for treatment in a health center setting
- 2) To explore a clinical perspective on behavioral health and substance use disorder integration for patients with diabetes, in particular medication adherence
- 3) To identify resources to address substance use disorder among older adults with cognitive impairments



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TODAY'S SPEAKERS



Elizabeth A. Davis, MD
Chief of Adult Medicine
and Medical Director of
Addiction Treatment
Program



Saria El Haddad, MD
Director of Partial
Hospitalization, Dual
Diagnosis



Christine Riedy, PhD, MA, MPH
Principal Investigator /
Program Director





Housekeeping



The screenshot shows a GoToMeeting application window with a menu bar (GoToMeeting, File, Edit, View, Window, Audio, Help) and a title bar (Waiting to view AAPCHO Meetings's screen). The main content area is a white slide with the text:

Talking:

Webcams Zoom

Viewer Window


AAPCHO Webinars
Organizer: AAPCHO Meetings | Presenter: AAPCHO Meetings

On the right side, there is a GoToWebinar Control Panel with the following sections:

- Audio:** Includes radio buttons for "Computer audio" and "Phone call".
- Dial:** +1 (213) 929-4232
- Access code:** 596-982-507
- Your audio PIN:** 84
- Talking:** Includes a status indicator and a "Problem dialing in?" link.
- Questions:** A section with a text input field labeled "Type question here." and a "Send" button.
- Footer:** AAPCHO Webinars, Webinar ID# 422-451-107, and the GoToWebinar logo.



Questions & Comments

- Questions can be submitted via the **GoToWebinar 'Questions' screen** at any time
- We will address questions and comments at the end of the webinar
- Webinar slides and video recording will be emailed to all participants after the end of the webinar
- Interact with us on Twitter  @AAPCHotweets and use **#DiabetesNationalLearningSeries**

The screenshot shows the GoToWebinar interface with two panels highlighted by a red border. The top panel is the 'Audio' control window, which includes a 'Sound Check' indicator, radio buttons for 'Computer audio' (selected) and 'Phone call', a 'MUTED' status with a microphone icon, and dropdown menus for 'Transmit (Plantronics Savi 7xx-M)' and 'Receive (Plantronics Savi 7xx-M)'. A volume bar is also visible. Below the audio panel, it says 'Talking: Liz Davis'. The bottom panel is the 'Questions' window, featuring a large question mark icon, a text input field with the placeholder '[Enter a question for staff]', and a 'Send' button. At the bottom of the interface, it displays 'Webinar Housekeeping', 'Webinar ID: 608-865-371', and the GoToWebinar logo.



CME/CNE Accreditation Available

- Please complete the post-webinar survey at the end to indicate whether you would like to receive CME/CNE units or a certificate of attendance.
- Please indicate whether you'd prefer an electronic or hard copy of your certificate.
- For questions, please contact Martha at malvarado@migrantclinician.org.





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An Integrated Model for Treating Adult Patients with SUD and Diabetes Mellitus

Elizabeth A Davis, MD

Objectives

- Provide context, background statistics to understand the scope of substance abuse in the USA and in our health center
- Describe a collaborative model for substance abuse treatment in a federally qualified community health center
- Discuss the impact of chronic disease and mental status on management of SUD

Diabetes Prevalence, General Population

- www.samhsa.gov USA 2010

Demographic	Number of People	Percent of Population
>20 years old	25.6 million	11.3%
>65 years old	10.9 million	26.9%
Non-Hispanic Whites > 20 years old	15.7 million	10.2%
Non-Hispanic Blacks > 20 years old	4.9 million	18.7%

- An estimated 33% adults will have DM in 2050
- Medical expenditure costs for patients with DM are 2.5x those for patients without DM
- Those with DM and MI account for the most ER visits and hospital readmission

SUD and Mental Illness in the United States

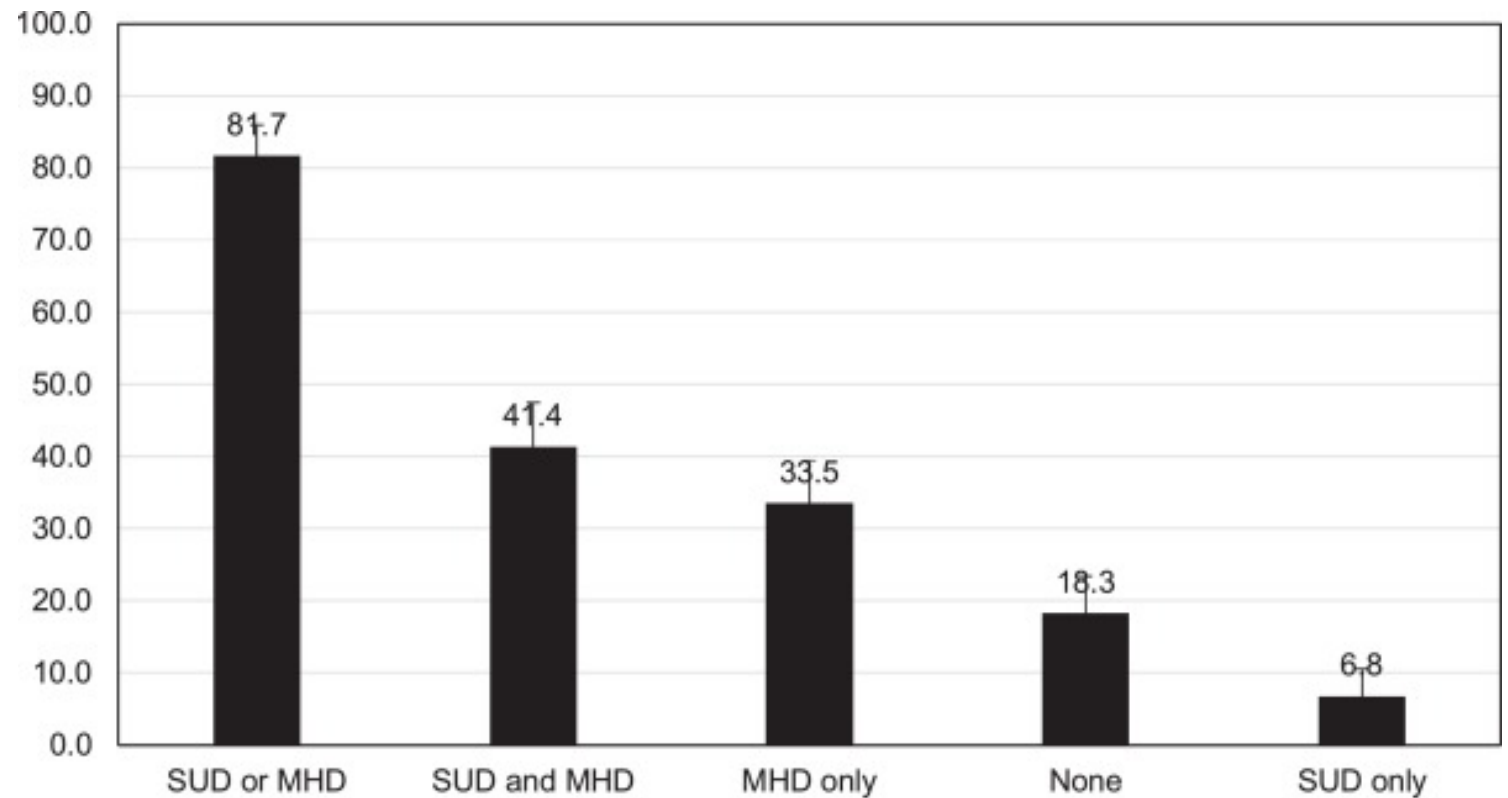
- 18% adults ≥ 18 years old have experienced MI
 - Approximately 20% of patients with MI have SUD
- 9% adults ≥ 18 years old have SUD
- 3.4% adults ≥ 18 years old have both MI and SUD

What is the Prevalence of SUD among patients with DM?

SUD and Medical Comorbidities among High Risk Patients with Severe DM over 2 year period

• Wu et al, *Drug and Alcohol Dependency*, 2018 May

- Top 10% risk score for poor outcomes
- SUD: alcohol, tobacco, drugs
- MHD: mood, anxiety, psychosis, cognitive d/o, sleep
- Strong association between DM and COPD
- SUD and MHD higher levels of ED visits and hospitalizations



Substance use disorder (SUD) and mental health disorder (MHD) diagnoses, %

N=263

Relationship Between DM and Substance Abuse

Reciprocal Impact

- Insulin Resistance linked to MI (schizophrenia, depression), independent of impact of medications or behavior
- Severe psychological distress among those with DM is 2x as high as it is among those without (depression rates twice as high)
- Person with depression has 60% chance of developing DM

Linkage between particular substances and DM

- Metabolic Impact

- Ecstasy, ketamine, cocaine use can trigger acute diabetic symptoms (hyperglycemia)
- Heroin associated with increased risk of insulin resistance
- Hepatitis C infection may induce insulin resistance
- Alcohol
 - binge drinking without eating leads to hypoglycemia
 - drinking without starvation associated with development of hyperglycemia
 - alcohol related hyperglycemia results in ketoacidosis, a medical emergency
 - alcohol +/- DM is a major cause for pancreatitis which worsens hyperglycemia
- MJ associated with lower prevalence for DM

Multifactorial Impact on Cognition

- Age, SUD, MI, DM independently impact cognition
- Augmentation of risk when all three involved
- Cognitive compromise has negative impact on behavior, capacity to learn, and judgment
- Risks for infection and ischemia further impact cognition
- May increase risk for medication and substance misuse
- Management must be multidisciplinary and supportive with case management and outreach as a prominent feature

Best Way to Care for Complex Patients

Overdose Death Rates

- National vs State of Massachusetts
-

65,000 overdose deaths in 2016 (CDC), twice as many since 1999

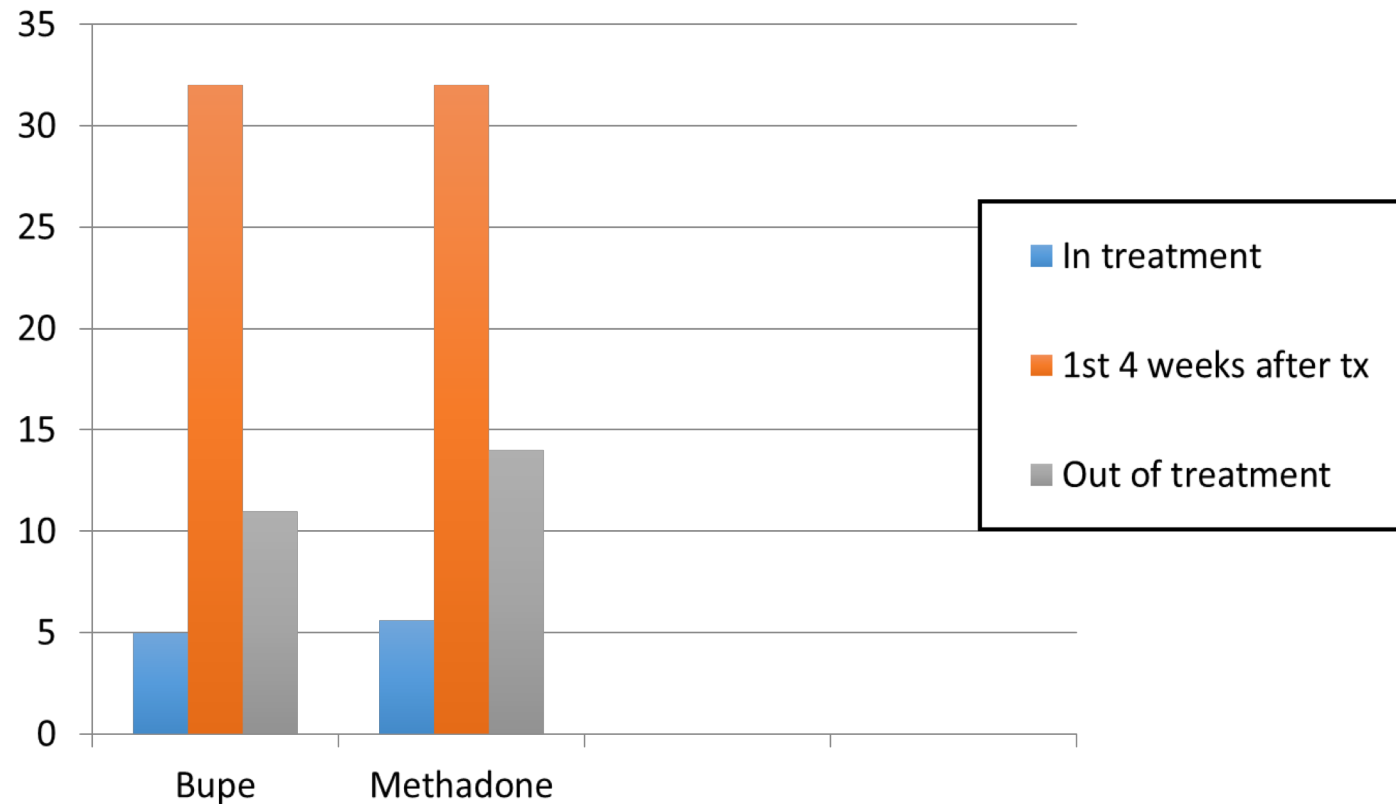
Only 1 in 10 actually receive treatment for their SUD

MA experienced one of the largest growths in overdose deaths
Rate more than doubled from 2013-2016
Attributed to Fentanyl

MA saw a 4% decrease in deaths in 2017
Medicaid expansion, narcan education, MAT, resource availability

Overdose mortality rates

- Sordo et al 2017, Simon et al



Relapse approaches 90% within 1 month after stopping Buprenorphine.

Rate of death from OD in the first month after stopping MAT is 50%.

Models for Caring for Complex Patients

-
- Collaborative care: specific high risk populations within a co-located health center
 - Primary care clinic that includes an integrated behavioral health team, SUD specialists, HIV specialist, etc
 - Medical practitioners in a mental health clinic
 - Integration of primary care, Nursing, BH, disease prevention, case management, patient/staff education, community outreach
 - Medical Home, multidisciplinary team to address medical and social needs
 - Nurse care manager model
 - Developed in MA specifically for SUD treatment
 - Interfaces with primary care but has a specific supportive role
 - Low barrier treatment: easy engagement or open access with multiple ports of entry

SUPPORT Wellness Program

- SECHC Integrated Model
-

- **Employs all three models**

- Nurses that play a central role in managing the majority of SUD care
- Medical Home that provides fully integrated care with primary care providers who provide general medical care and primary prevention of chronic disease, case management, pharmacology specialization
- Specialty Care, capacity to treat HCV and HIV and BH problems

- **Fluidity of roles**

- all team members co-lead groups
- uniform training and shared philosophies of care
- Collaborative decision making

South End Community Health Center

- Boston, MA
-

• **Clinical Departments**

- Adult and Family Medicine
- Pediatrics and School Based Health Center
- Women's Health
- Integrated Behavioral Health and specialty Behavioral Health
- Dental
- Eye Care/Optical Shop

• **Total Patients (UDS 2017):13,966**

- Female: 57%
- Latino/Hispanic: 58%
- Better served in language other than English: 6,071
- 70% Medicaid/Medicare
- Percentage of patients who do not report their income bracket has increased from 35% in 2017 to 46% in 2018 (>50% patients live under the FPL)

• **Patients with DM, at least 700 of 8000 adult patients**

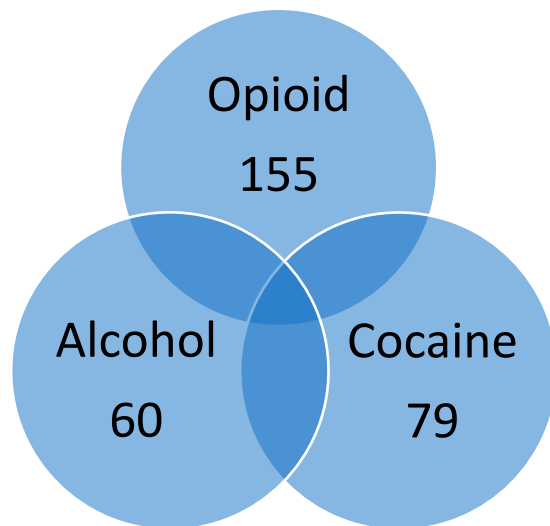
- 15 of 230 patients in SUPPORT Wellness Program have DM
- 10 of 230 patients are >65

Program Demographics

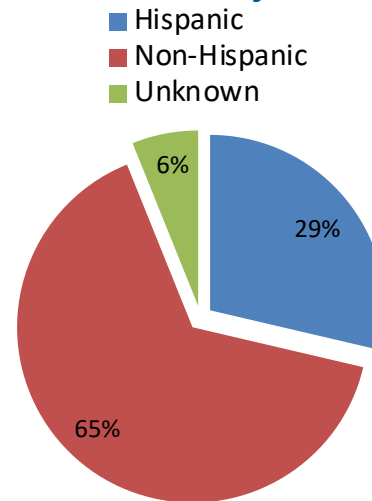
October 2016 - June 2018

Total Patients Enrolled 189

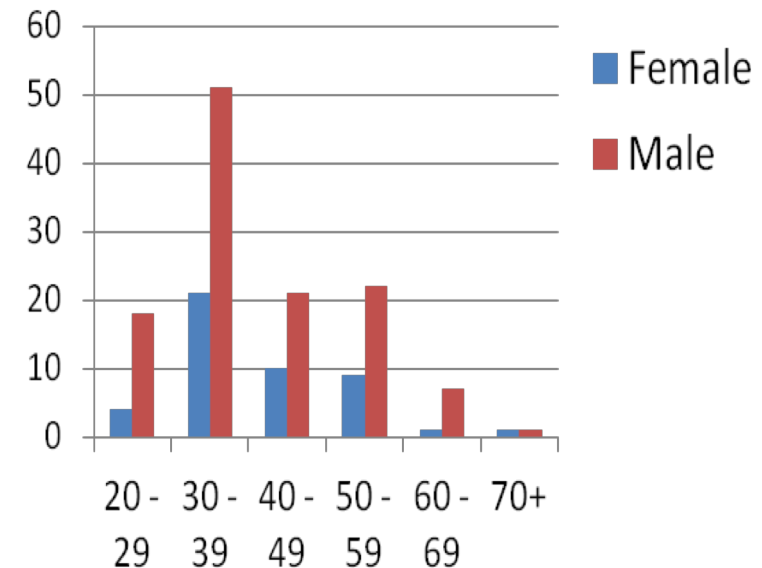
Substance Use Type



Ethnicity

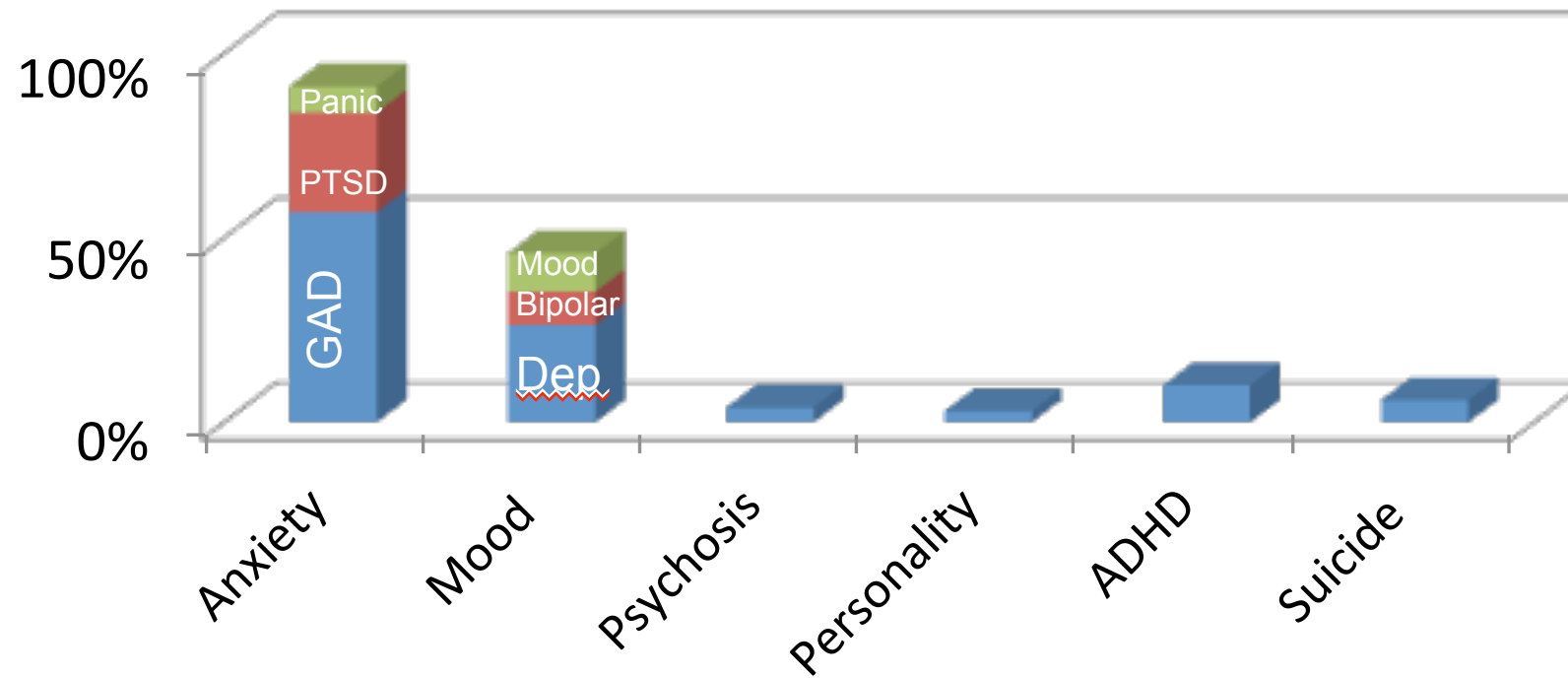


Gender by Age



Distribution of Mental Illness Diagnoses

October 2016 - June 2018



Treatment That Promotes Engagement

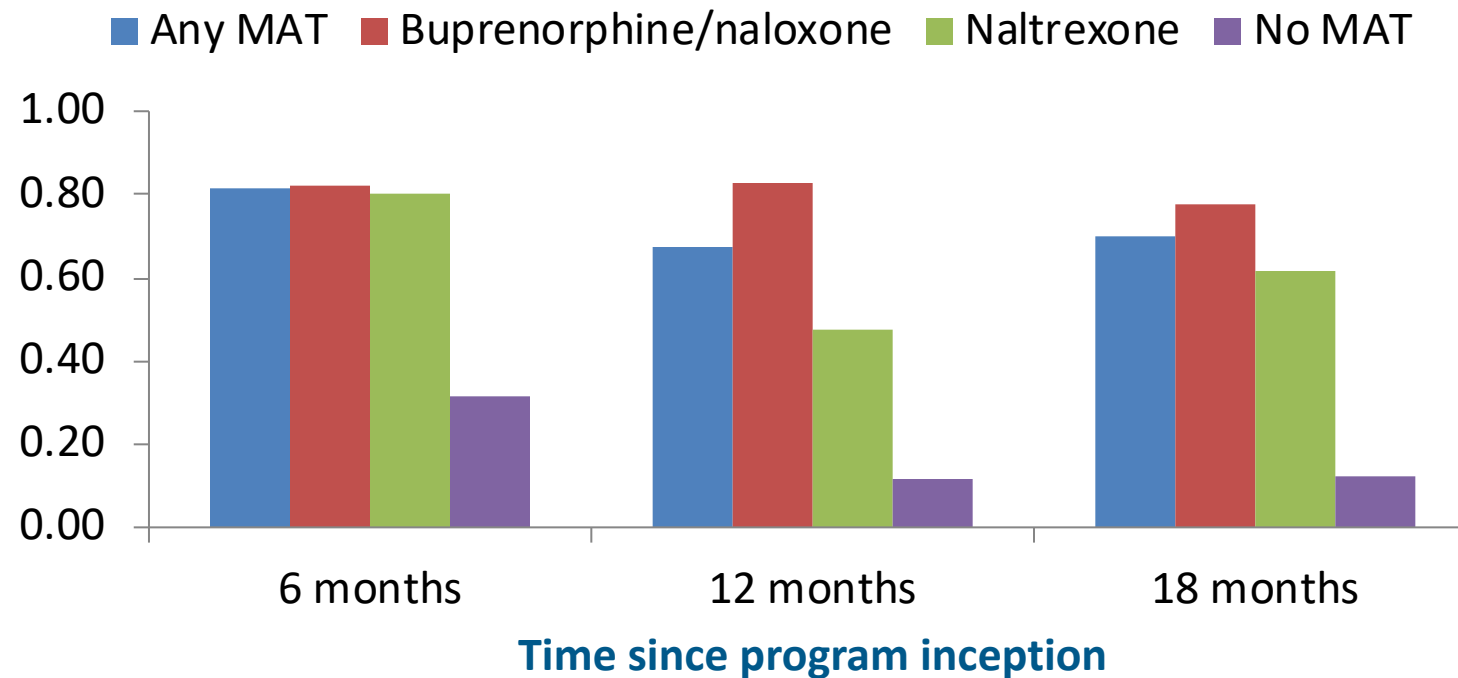
Primary Goals: Retention and Survival

-
- Impact of interventions on retention
 - Harm reduction strategies
 - Low barrier induction
 - Non-judgmental, open accessible care
 - Integration of medical and behavioral health model
 - MAT alone is insufficient for successful linkage to community resources, long-term recovery, and overdose prevention
 - Distinct Strengths
 - RN's with dual diagnosis experience
 - dually trained internist psychiatrist,
 - CM with background in HIV/AIDS resource linkage, STI screening, and LGBTQ youth advocacy
 - Developing a Peer Recovery Coach Program

OBAT Retention Rates

October 2016 - June 2018

Program Retention



Rewards of Caring for High Risk Patients with SUD

- Making successful and impactful connections with difficult patients
- Thinking outside the box when caring for complex patients
- Collaboration with multiple team members who support one another.
 - Never have to worry alone
- Number of connections with team correlates with overall retention.
 - Assumes trust is an essential factor
- Positive impact on patient overall health by treating medical conditions, psychological symptoms, and substance use.

Issues to address

- Stigma and the impact of medical treatment, patients receiving substandard care
- Funding for addiction programs can be a disservice to the overall care of complex patients who need holistic care
- Aging and SUD and the impact on managing chronic disease: monitoring cognitive decline, risk for delirium, risk for abuse
- Impact of SUD on complications associated with DM including infections (cellulitis, osteomyelitis), CVD, pain management, cirrhosis

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 - Yovannys Kenney
 - Yaritza Chavares, MA
 - Rachel King, MD
 - Perla Mercedes
 - Elizabeth A Davis, MD
 - Vanessa L Ryan, FNP
- Funding Sources
 - HRSA
 - SAMHSA
 - GE

SECHC SUPPORT Wellness Team





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MEDICATION ADHERENCE IN THE GERIATRIC POPULATION WITH SUBSTANCE USE DISORDERS AND COGNITIVE IMPAIRMENT

Saria El Haddad, MD

Medical Director, Dual Diagnosis Partial Hospitalization
Program, Brigham and Women's Faulkner Hospital

Instructor, Harvard Medical School

Adherence

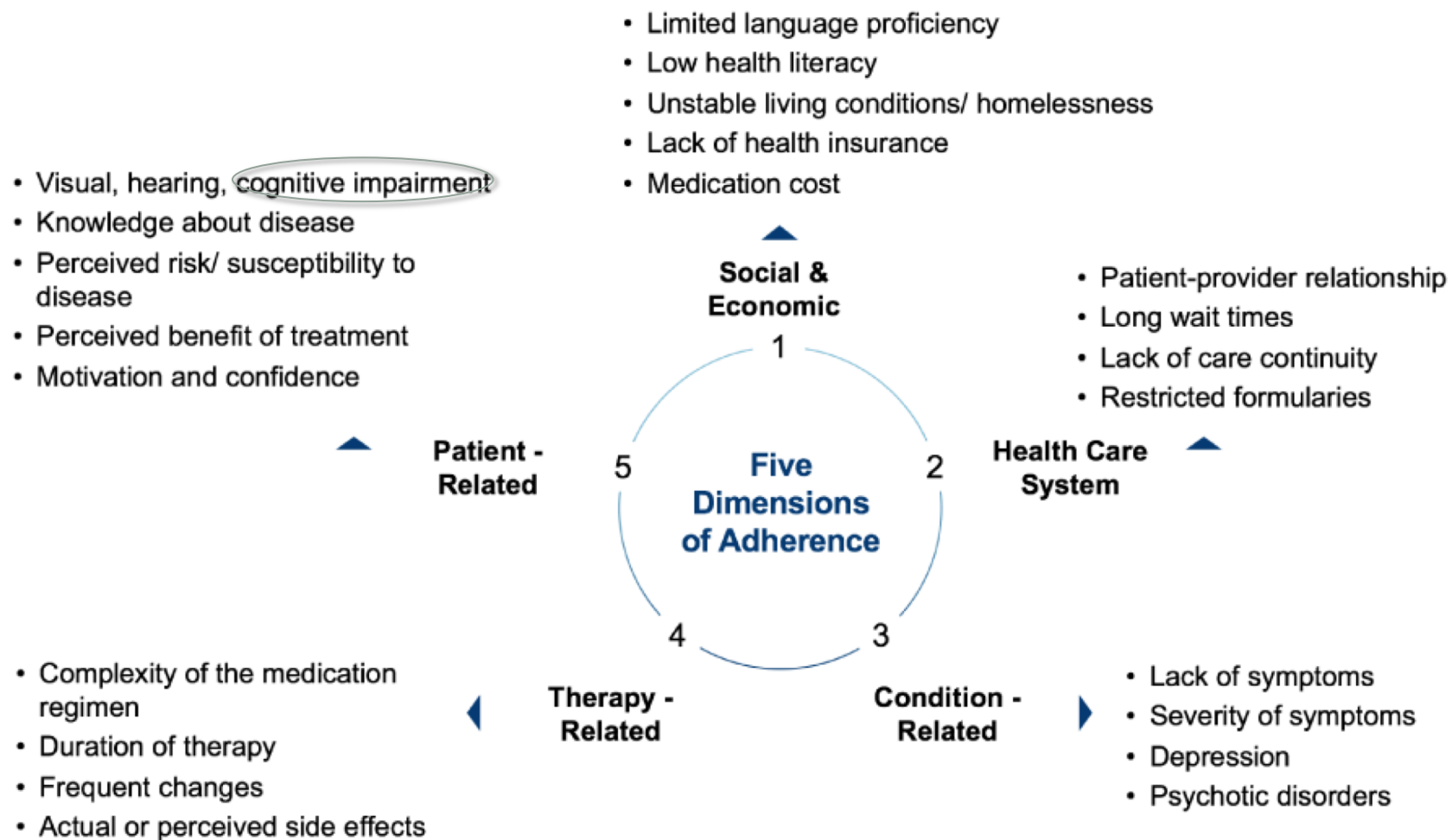
“...the extent to which a person’s behavior – taking medication, following a diet, and or executing lifestyle changes – corresponds with the agreed recommendations from a provider”

the World Health Organization

Medication non-adherence

- Taking less than 80% of prescribed doses
- Can also include taking too many doses
- Is associated with an increased risk for poor health, adverse clinical events, and mortality
- Low adherence, even to placebo, is independently associated with an increased risk of death ('healthy adherer' effect) (Simpson 2006).

Determinants of adherence



Source: Sabaté, Eduardo. Adherence to long-term therapies: evidence for action. World Health Organization, 2003.

Psychosocial stressors in aging

- Role and status change, especially retirement
- Income changes
- Physical health decline → polypharmacy
- Cognitive changes
- Widowhood
- Shrinking social networks
- Loss of independence

Clinical trials in the elderly

- Elderly people have a double risk of developing adverse effects than younger people.
- 20% of older people in Europe receive at least one inappropriate drug.
- 30% of hospital admissions among elderly people are caused by adverse effects of drugs.
- Frequency of side effects is seven times greater.
- Aging increases the number of drugs taken, and therefore, the possibility to develop an adverse reaction.
- Between 50% and 70% of the adverse reactions observed are preventable.

Until recently, elderly people, have been excluded from some randomized controlled trials without justification

The European research consortium PREDICT (Increasing the PaRticipation of the EIDerly In Clinical Trials) has compiled a charter for the rights of elderly people in clinical trials.

Barriers unique to patients with SUDs

- Co-occurring disorders
- Active drug use-> taking medications off schedule, missing doses, forgetting to take medication due to intoxication, running out of medications
- “ I don’t want to mix my meds with alcohol”

Barriers unique to patients with cognitive impairment

- Understanding new directions
- Living alone
- Scheduling medication administration into the daily routine
- Uncooperative patients

Interventional tools to improve adherence

- Behavioral interventions
- Educational interventions
- Integrated care interventions
- Self-management interventions
- Risk communication
- Packaging and daily reminders

In patients with cognitive impairment:

- human communication as a reminder vs non-human reminders
- Integrated intervention is more important: regular medication reviews, physician – pharmacist cooperation

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Substance Use Disorders (SUD) and Addictions among Older Adults in Health Centers

Fall 2018 Learning Collaborative (LC)



Overview of learning collaborative sessions:

- Overview of Substance Use Disorder (SUD)
- SUD Diagnosis (Dr. Rachel King)
- SUD Screening and Assessment (Dr. Saria El Haddad)
- SUD Treatment and Referral (Dr. Catharina Armstrong; Ms. Enid Watson)
- SUD Case Management
- SUD Innovative Models/Programs for Older Adults (Dr. Larry Schonfeld)

Projected increase in SUD rates for adults 50 years and older:

2.8 million (2006) to 5.7 million (2020)

Prescription Drug Abuse in Older Adults – health impacts:

- Opioids
 - Falls, delirium, fractures, pneumonia
- Tranquilizers
 - Falls and other motor coordination impairments, potentially intellectual and cognitive impairment
- Sedatives
 - Dizziness, loss of balance – higher risk for falls, disorientation; slowing of heart rate to dangerous levels if overdose occurs.

Risk of Harm from Polypharmacy in Older Adults:

- Those with ≥ 5 prescriptions
- Have chronic diseases of liver, kidney, or heart
- Taking certain drug classes (sedatives, opioids, tranquilizers, NSAIDS, anticoagulants etc)
- Those with *memory impairments* – difficulty taking medications as prescribed
- Those living alone
- Those with a substance abuse or psychiatric history



Source: Preventing Prescription Abuse in the Workplace

Recognizing SUD in Older Adults

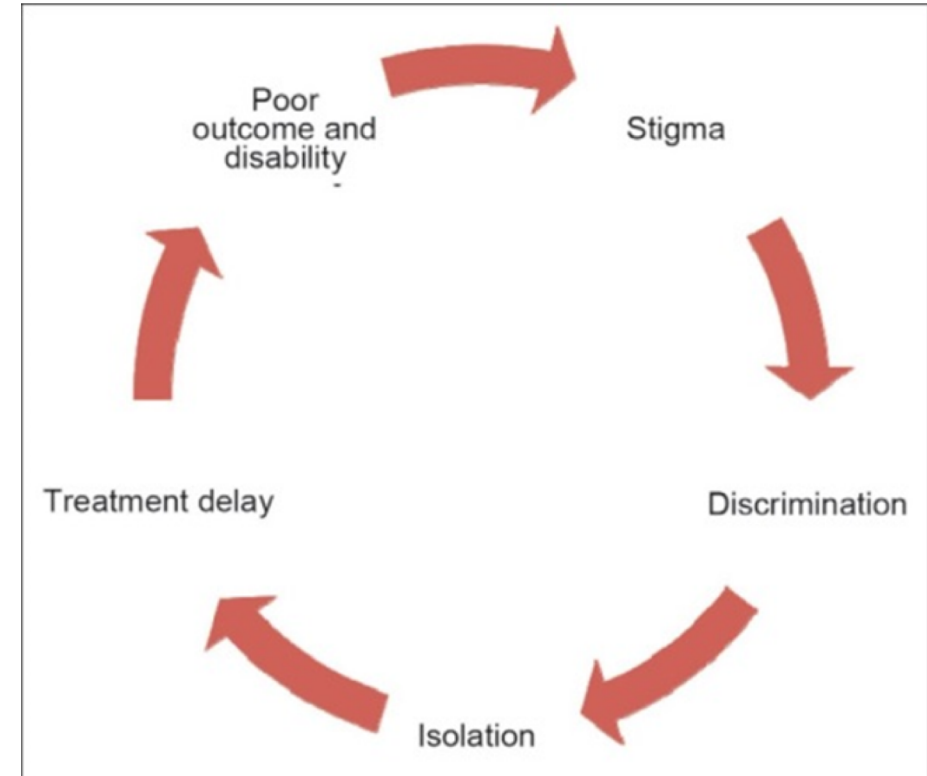
- Presentation of substance use may differ from young persons and include:
 - Falls
 - *Cognitive impairment*
 - Not taking medication as prescribed
 - Injuries
 - Family stress
 - Sleep disturbance

Challenges in Recognizing SUD

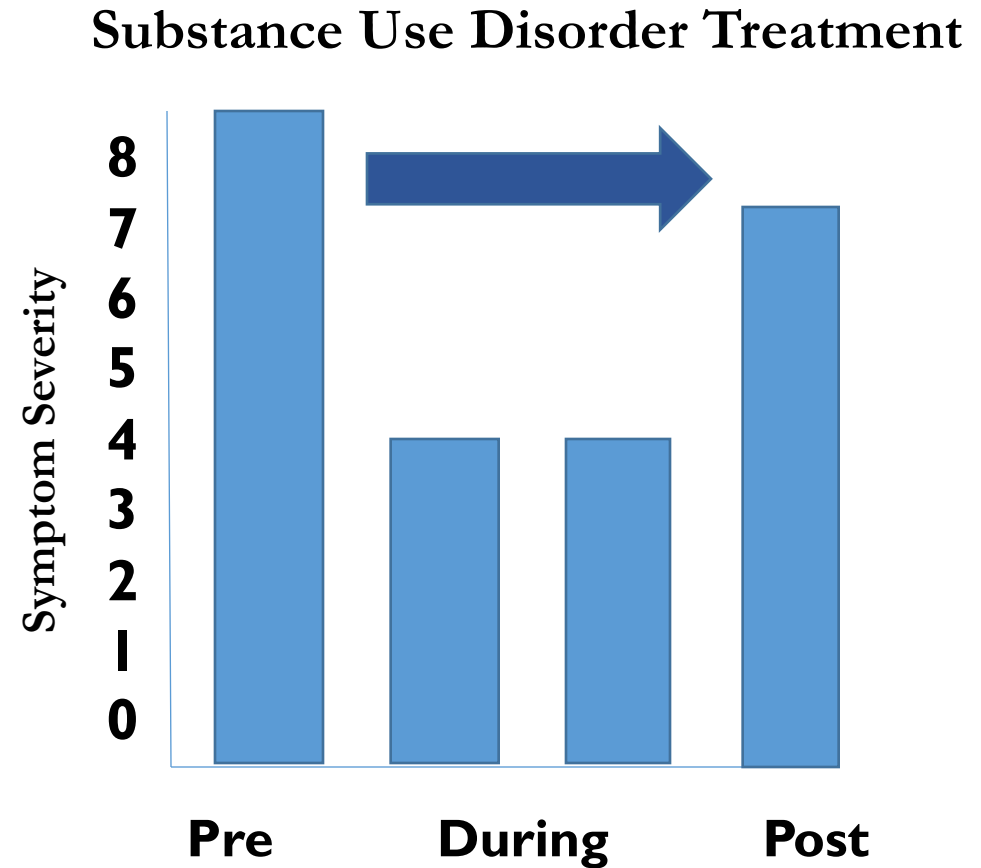
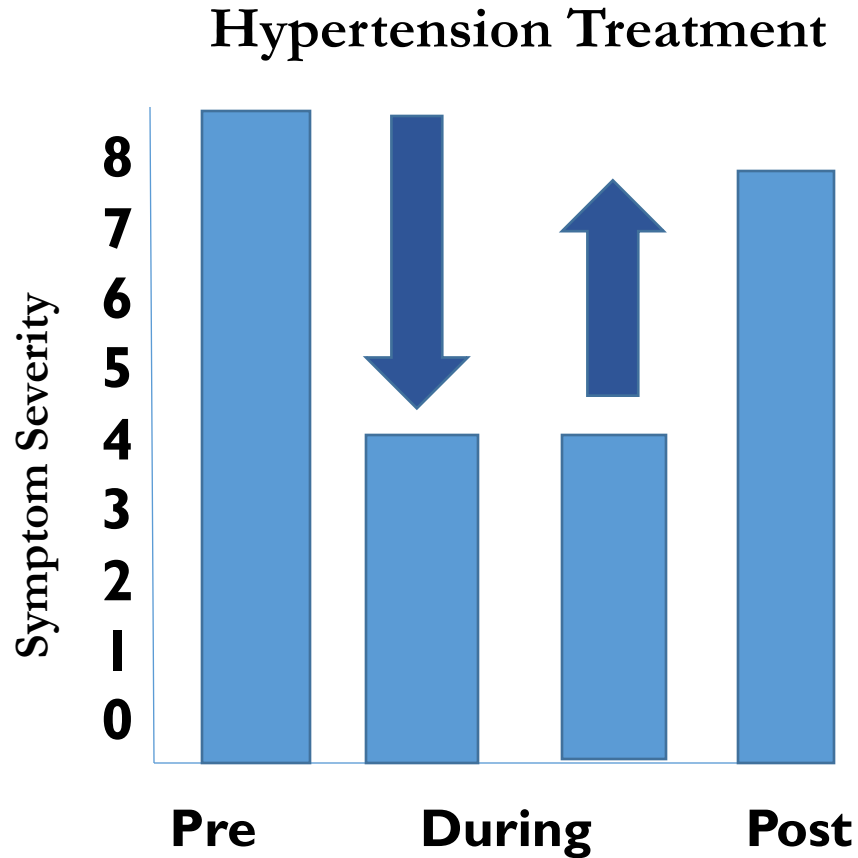
- Older adults are likely underdiagnosed with substance use disorder.
- Reasons:
 - *Co-morbidities may present similarly*
 - Screening tools not validated for older adults
 - Stigma
 - Provider bias

Stigma Can...

- Isolate individuals and families
- Encourage people to deny a fatal illness and ignore its symptoms
- Keep desperately ill people from seeking help
- Increase risk of overdose or relapse
- Persuade society to choose far more expensive and ineffective alternatives to treatment: \$80,000 vs \$6500



Chronic Disease Management



**Why is Treatment for Substance Use Disorders Evaluated Differently?
Both Require Ongoing Care.**

Barriers to identification

- Physician factors:
 - stereotypes about addiction
 - stereotypes about older adults
 - lack of knowledge about treatment
- Patient factors:
 - denial
 - shame and guilt
- Diagnostic factors:
 - *co-morbid conditions*- may obscure or be used to explain symptoms of substance abuse
 - age related changes: falls, anemia, neuropathy, *altered cognition*
 - fewer overt warning signs
 - DSM criteria less applicable

DSM-5 Criteria for SUD	Consideration for Older Adult
A substance is often taken in larger amounts or over a longer period than was intended.	Cognitive impairment can prevent adequate self-monitoring. Substances themselves may more greatly impair cognition among older adults than younger adults.
There is a persistent desire or unsuccessful efforts to cut down or control substance use.	It is the same as the general adult population.
A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.	Consequences from substance use can occur from using relatively small amounts.
There is craving or a strong desire to use the substance.	It is the same as the general adult population. Older adults with entrenched habits may not recognize cravings in the same way as the general adult population.
There is recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or at home.	Role obligations may not exist for older adults in the same way as for younger adults because of life-stage transitions, such as retirement. The role obligations more common in late life are caregiving for an ill spouse or family member, such as a grandchild.
There is continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.	Older adults may not realize the problems they experience are from substance use.
Important social, occupational, or recreational activities are given up or reduced because of substance use.	Older adults may engage in fewer activities regardless of substance use, making it difficult to detect.
There is recurrent substance use in situations in which it is physically hazardous.	Older adults may not identify or understand that their use is hazardous, especially when using substances in smaller amounts.
Substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.	Older adults may not realize the problems they experience are from substance use.
Tolerance is developed, as defined by either of the following: <ul style="list-style-type: none"> 1 A need for markedly increased amounts of the substance to achieve intoxication or the desired effect 2 A markedly diminished effect with continued use of the same amount of the substance 	Because of the increased sensitivity to substances as they age, older adults will seem to have lowered rather than increase in tolerance.
Withdrawal, as manifested by either of the following: <ul style="list-style-type: none"> 1 The characteristic withdrawal syndrome for the substance 2 The substance or a close relative is taken to relieve or avoid withdrawal symptoms 	Withdrawal symptoms can manifest in ways that are more "subtle and protracted." ¹⁴⁹ Late-onset substance users may not develop physiologic dependence; <i>or</i> nonproblematic users of medications, such as benzodiazepines, may develop physiologic dependence.

Universal Screening



Screen ALL patients, not just those whom you think may have a problem.

- Using alcohol and other drug can affect one's health and safety, as well as how one makes decisions. Therefore, we ask all patients questions about their use of these substances. By alcohol, we mean beer, wine, wine coolers, or liquor.
- By drugs we mean medications such as prescription pain pills, prescription sleeping pills, or other prescription medication, marijuana, or illegal drugs
- All of your answers are strictly confidential, unless you or someone else is in immediate danger.

Is it OK to ask you these questions?

Florida BRITE Project

- Screening and intervention program, **Florida Brief Intervention and Treatment for Elders (BRITE)** project, a 3-year, state-funded pilot program of screening and brief intervention for older adult substance misusers (alcohol, medications, illicit substance misuse problems) and psychiatric issues (depression and suicide risk).
- Findings: most prevalent substance use problem was with misuse of prescribed medications then alcohol, over the counter medications and illicit substances. Recipients of the brief intervention had improvement in medication misuse, alcohol and depression measures.



Source: Schonfeld et al AJPB 2011

Lessons Learned from BRITE

- Many older adults do not meet criteria or characteristics used to identify SUDs in younger people
- Age-related physical, metabolic changes increase risk for problems in the 60+ age group.
- SBIRT can be conducted by trained professionals anywhere, not just in primary care settings
- Aging services appeared to find a higher concentration of people exhibiting risky use of alcohol, drugs.
- Older adults' misuse of medications is very different from younger adults' abuse of medications
- Reliance on age-specific screening instruments and age-appropriate interventions makes SBIRT an effective approach for older adults

Case Management Approach Advantages

- Comprehensive approach which can speak to complex multi-morbidities in older adults
- Ability to connect older (possibly isolated) adults to community resources
- SUD interventions are rooted in an overarching approach emphasizing total health which can lessen addiction stigma and possible avoidance of treatment or relapse



Keurbis et al. Clinics in Geriatric Medicine, 2014-08-01, Volume 30, Issue 3, Pages 629-654

- Program evaluations of case management models provide support that it is an important tool in working with older adults.

Geriatrics Addiction Program (GAP)

<https://www.nyconnects.ny.gov/services/geriatric-addictions-program-at-lifespan-sofa45363>



CCBHC SUD Case Management (Iowa): adults with serious mental illness

- a team-based process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services to meet an individual's needs including, but not limited to, physical and behavioral health, social services, housing, employment and education to promote quality, cost-effective outcomes. Case management teams have documented experience/training in the field of substance use disorder treatment.
- Face-to-Face contact (every 90 days)
- Monthly contact (in person, phone or video)
- Annual standardized assessment
- Annual person-centered plan – update as needed
- Quarterly updates from service providers
- Monitor/coordinate services and appointments
- Referrals as necessary



<https://dhs.iowa.gov/sites/default/files/MHDS-CCBHC-Care-Coordination-Chart.pdf?011420191649>



Diabetes Continuum of Care: Using Behavioral Health and Substance Use Disorder Integration to Address Older Adults with Cognitive Impairments and Diabetes

What are your questions and comments?



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DIABETES IN SPECIAL & VULNERABLE POPULATIONS: A NATIONAL LEARNING SERIES

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WEBINAR #1
Thursday, March 14

Diabetes Continuum of Care: Using Referrals, Outreach, and Care Coordination to Address Oral Health and Diabetes



WEBINAR #2
Tuesday, April 9

Diabetes Continuum of Care: Using Behavioral Health and Substance Use Disorder Integration to Address Older Adults with Cognitive Impairments and Diabetes



WEBINAR #3
Thursday, April 18

Diabetes Continuum of Care: Using Health Promotion/Behavior Change to Address Childhood and Adult Obesity and Diabetes



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Diana Lieu
Senior Manager



Irene Hilton, DDS, MPH
Dental Consultant



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Senior Program Manager



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THANK YOU!

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Feel free to contact our NCA collaborating partners and speakers from today's webinar:

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