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EDITOR'S MESSAGE

Kaaren Boothroyd, Editor

This issue of the *Journal of Aging Life Care*™ shares a wealth of research, data, and tools for Aging Life Care Professionals® and others working in the field of aging. We are thrilled to provide such a diversity of topics, rich with timely insights and resources. Here's what's inside these pages:

The first in a series of research on the profession of Aging Life Care leads us off in the article *Aging Life Care Association® Member Experiences, Values, and Priorities.* This national survey explores reasons for joining and remaining in ALCA, satisfaction with membership services, and member engagement.

Older Adults and Opioids: What They Know and Perceive describes the results of a study that explores older adults' knowledge, attitudes, and beliefs regarding opioids.

Our voices matter: Reflections of LGBT older adults in interprofessional simulations to prepare future older adult healthcare providers shares the results of an interprofessional study that emphasizes reflections of older LGBT healthcare participants about access to care and critical issues of social support.

A topic that is not often covered is discussed in *Coping with the Ambiguous Loss of Alzheimer's Disease: Strategies for Aging Life Care Managers® and Mental Health Professionals* and provides insights so relevant to the profession.

The review, *Ancillary Service Use in the Seniors Housing Industry: Implications for a Rapidly Aging, Post-COVID World,* outlines the housing and care needs of older adults, including the impact of COVID-19 on the industry, and the needs of the baby boomer population.

Approaches to Community Support for Older Adults and Alcoholism summarizes key areas of concern for older adults and alcoholism and discusses screening tools and suggestions for community practice specific to Aging Life Care Professionals.

We hope you'll share this valuable issue with colleagues, employees, and students. If you would like additional copies, please contact us at info@aginglifecare.org.

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Aging Life Care Association® Member Experiences, Values, and Priorities

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ABSTRACT

Aging Life Care Managers possess specialized knowledge in aging and disability, playing a crucial role in care coordination for families, caregivers, and older adults with ongoing health challenges. The Aging Life Care Association (ALCA) supports members through continuing education, professional development, and ethical practice standards. To understand the experiences and benefits of ALCA membership, a mixed-method study was conducted. Qualitative data from 35 member interviews explored reasons for joining and remaining in ALCA, satisfaction with membership services, and member engagement. These interviews informed a national survey capturing responses from 701 members. Findings reveal that Aging Life Care Managers join ALCA for community, professional credibility, and practice standards. Relationships with fellow members are key to member retention, and inclusion is another critical factor. Members also value clinical education and resources for business growth and sustainability. Initiatives aimed at marketing the services provided by an Aging Life Care Manager and creating a welcoming environment for new and early career members were endorsed by respondents. Fostering a more diverse and inclusive member base will ensure organizational growth and better meet the needs of the aging population.

Introduction

In 2022, as the Aging Life Care Association (ALCA) approached its 40th anniversary in 2025, its Board of Directors commissioned a comprehensive study to be conducted by a research team at the Center for Gerontology at Virginia Tech and the University of Washington in Seattle. The study aimed to understand the experiences of Aging Life Care Managers as ALCA members and to evaluate the benefits they provide to their clients.

This article explores how Aging Life Care Managers have experienced being members of ALCA. Systematically understanding their experiences elucidates the benefits of organizational membership and identifies areas for improvement. Given the rapidly aging population, a critical need exists for more Aging Life Care Professionals dedicated to serving older adults and their families. Below, the Virginia Tech and University of Washington research team ("the research team") highlights the benefits of ALCA membership and identifies areas for enhancing member engagement and satisfaction. From these insights, ALCA can showcase the advantages of membership and identify opportunities to expand its membership base, ultimately strengthening the ability of its members to meet the needs of an increasingly diverse population of older adults.

The research team conducted a descriptive study using a mixed-method approach. The approach involved interviews with a subset of ALCA members followed by the distribution of a national survey to all ALCA members. Insights gained from the interviews of ALCA members were instrumental in developing a comprehensive national survey. Below, we explain the study methods associated with the interviews and survey, present key findings, and discuss implications for ALCA members.

Methods

The ALCA Board of Directors had a long-standing goal to conduct research defining the value of Aging Life Care Managers. To fulfill this goal, the Board of Directors developed the project concept in collaboration with the research team. The research team developed the methodology and conducted the research study. Because the project involved gathering information from human subjects, the research team sought and subsequently received approval to conduct this study from Virginia Tech's Institutional Review Board (Protocol # 19-421). The combination of qualitative data from interviews and quantitative data from a national survey offered an in-depth understanding of ALCA members' experiences within the organization and with clients.

Member Interviews

Participant Recruitment

Participants were recruited by contacting ALCA's nine chapter presidents, who were also interviewed (each chapter of ALCA encompasses a

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region within the United States). Upon completing the presidents' interviews, each president was asked to suggest two ALCA members willing to participate in an interview, a seasoned member and a new member. Although this technique effectively recruited members, at the midpoint of recruitment, the sample of 20 participants failed to represent the diversity of all ALCA members. To ensure representation across membership (i.e., gender, race/ethnicity, engagement level of the member, location of practice, employees and business owners, professional background), the research team used purposive sampling to improve representativeness.

From March 2023 through October 2023, the research team enrolled a total of 35 participants across all regional chapters of ALCA. When saturation of responses was reached, the team concluded recruitment. Participants were largely Caucasian (n=26) and female (n=32); however, with the addition of purposive sampling, the sample included representation from individuals who identified as African American (5), Asian American (1), Latin American (2), and East Indian (1). Among the participants, 32 were female, and three were male. Participants were assured anonymity, and their names and locations were not connected to the results.

Interview Protocols

Based on input from ALCA leadership, the team developed a question protocol that focused on the following topics: 1) why respondents became members of ALCA, 2) why they remained ALCA members, 3) their satisfaction with ALCA membership services and benefits, and 4) their satisfaction with ALCA's member engagement. Participants were provided informed consent documents and were encouraged to be candid during the interview. Questions were sent in advance of the interviews, which were conducted via Zoom. Two members of the research team participated in each interview. Including two members helped ensure consistency of interview protocols, made the interviews more conversational, and helped the team clarify responses to the questions. To clarify responses, team members probed the ALCA member for greater detail. Interviews, which were recorded and transcribed using Rev.com, ranged between 30 and 45 minutes in length.

> A powerful reason that members are drawn to the organization and remain faithful to it is ALCA's Code of Ethics and Standards of Practice…
>
> *…our Code of Ethics, to me, is a huge reason why I am a member.*

Analysis

Individually, each member of the research team reviewed responses using an open coding procedure. Open coding is exploratory in nature and effectivity captures main ideas and patterns present in the data. Team members began coding by noting salient responses and unique circumstances presented in each of the interviews. Once the research team generated an initial list of constructs, they then identified preliminary categories of themes, such as positive aspects of membership and concerns about membership. Through an iterative process of constant comparison, the team refined its results, identifying additional subthemes that emerged upon systematic reading of the transcripts and that were included in the final coding scheme. Team members met periodically to discuss areas of congruence and contention.

The team used a combination of deductive qualitative analysis, which assumes that the theoretical dimensions of interest have been identified *a priori* (Gilgun, 2005), and an inductive grounded theory approach, which makes no such *a priori* assumptions (Strauss & Corbin, 1990). The purpose of the analyses was to provide a summary report of members' experiences. The analyses also informed the development of questions to be included in a national survey.

National Survey

Construction of the National Survey

Building upon themes identified in the interviews, the research team used a similar and iterative process to develop survey questions, which were honed for appropriateness and clarity of wording. As with the interview coding, the team met frequently to edit the wording of the survey questions.

The aim of the survey was to capture information from members – demographic and professional background, membership history, professional role, promotion of ALCA, experiences with ALCA members and clients, and ALCA services. Also, research team members considered completion time, ease of answering questions, and the value of answers. After developing a draft survey, the research team pilot-tested it with members of ALCA leadership prior to national distribution.

Recruitment of Survey Respondents

ALCA leadership sent the survey to all members via email on March 6, 2024. The survey remained open for 2.5 weeks, allowing members adequate time to complete the survey. To boost participation, ALCA leadership and chapter presidents sent reminder emails inviting members to participate. The survey was sent to 1,700 members. In total, 701 members responded to the survey, and 650 completed all questions. A response rate of 41% is within the expected range for survey responsiveness (Wu, Zhao, and Fils-Aime, 2022).

Analysis

After the survey closed, the data were exported to Excel for analysis. Data were reviewed for completeness;

respondents who opened the survey but did not answer any questions were deleted from calculations. Percentages for each response were calculated, and SPSS (Statistical Package for the Social Sciences) was used to analyze associations between responses.

Findings

Themes from Member Interviews

From the interviews, the research team identified six themes: 1) membership in a community of people with similar values and passion compels people to join ALCA, 2) members seek professional credibility and standards of practice, 3) collective expertise of members strengthens the value of membership, 4) relationships with ALCA members drive members' decision to renew their membership, 5) members value resources for growing and sustaining a business, and 6) members value an inclusive organization.

Theme 1: Membership in a Community of People with Similar Values and Passion

Theme One concerned the importance of ALCA serving as a hub for members with similar interests and values. For many, ALCA became an important organizational home. According to one member, camaraderie among members was appealing and a compelling factor in membership.

> *I attended a conference, and there was so much camaraderie and so many people sharing a lot of ideas. … these people are intelligent; they want to be the best at what they do, and I want to be part of that!*

Similarly, another member valued the sense of community that the organization provides. The member also valued being part of a whole and was drawn by the deep humanity of its members and the dedication to older adults that they observed among ALCA members.

> *I love being involved with the community, feeling part of the organization…you will find they are… some of the…most beautiful-hearted people… dedicated to the aging profession.*

Theme 2: A Source of Professional Credibility and Standards of Practice

A second theme was professional credibility and expertise afforded by being a member of ALCA. Prominent in the interviews was members' recognition of the importance of ALCA's Code of Ethics. The Code helped justify professional practice and activities on behalf of the people members served.

> *…our Code of Ethics, to me, is a huge reason why I am a member. That is how I **justify our pricing** and how I explain our services, that we abide by a **very strict Code of Ethics**…*

The Code of Ethics and Standards of Practice serve as important guides and criteria for how members comport themselves and run their practice. One member had this to say about the usefulness of the Standards of Practice over time:

> *It just was more apparent to me as time went [by that] there was the **Standards of Practice I could fall back on…***

Theme 3: Collective Expertise of ALCA Members

In addition to the camaraderie mentioned in an earlier theme, interviewees stressed that ALCA members were wellsprings of knowledge. Membership helped other members improve their own practice and increased their own understanding of business as well as of issues specific to older adults and their families.

> *I don't think people realize what it can do for you…the **knowledge base** that you acquire just from going to meetings and hearing different speakers…*

Members drew from the expertise of others to enhance their own business acumen. They found that their association with other ALCA members was invaluable.

> *I've met some really great **entrepreneurs**, and I've learned so much from other members…*

Not only was the support of fellow members helpful, but encouragement from others to pursue the work of being an Aging Life Care Manager proved invaluable as well. ALCA members assisted others through their general support and, in doing so, kept members up to date on important topics affecting their practice.

> *The **collegial support** and just keeping on top of issues as they evolve and arise is always so helpful.*

Theme 4: Retention Through Relationships with Other ALCA Members

Key to those who remained ALCA members over time were the relationships that members forged over many years. Relationships were built through years of trust and responsiveness to the needs of other members.

> *I could call so many people, and they get back to me in an hour or text them or people on the board… so there's a **trust and intimacy**…*

Having access to and the devotion of others was central to members' dedication to one another and to the organization. Relationships helped members surmount problems that arose and supported them with the knowledge that another member would prioritize and respond to their needs. Devotion was both inside the organization to individual members and outside to ALCA itself.

> *With **intense problems**…continuing to be a member has allowed me to have **access to others** who deal with the challenges of the role…*

Theme 5: Resources for Growing and Sustaining a Business

For many members, becoming an Aging Life Care Manager represents a career shift and requires building a business from the ground up. With this endeavor, members need resources about how to build a successful practice, including information on marketing to ensure visibility and tools for managing employees. With ALCA membership comes a plethora of resources geared toward starting, run-

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ning, and growing a business. Members value their access to these resources as they navigate the needs of clients and the needs of a business.

> *ALCA provides a lot of material, a lot of information, webinars, materials to purchase, and building the business. I mean, it's like you don't have to* ***start from scratch…***

Members recognize the need to sustain and grow their client base. However, identifying new clients, especially for early career Aging Life Care Managers, can be a challenge. The network of ALCA members across the country and opportunities to meet one another at conferences figures heavily into how Aging Life Care Managers gain new clients. One member spoke about the multiple avenues of referrals available through ALCA:

> *It's so great to get* ***referrals from ALCA****, whether it's people that have gone on the website…or people that have other care managers who've gone on the website and said…I met you at a conference, could I give a referral to you?*

Theme 6: Inclusivity of Members

A central theme that emerged was related to the inclusivity of members. The desire to belong extended across many categories, including longevity of ALCA membership and race and ethnicity. Although some members had joined recently, others had been members for over a decade. Each wanted to feel included in the organization. One member reflected upon their mentorship experience and how it contributed to a feeling of inclusion:

> *I got into their Aging Life Care management entrepreneurship class, and they assigned me a mentor, and my mentor was fabulous…I felt* ***welcomed and nurtured*** *by ALCA.*

Feeling included, particularly for newer members, was important; for some, it did not come instantaneously. One member talked about "being the new kid" in ALCA and how it took time to feel included. Another member said that when they joined, they felt there was a "cool kids club," and they were not a part of it.

Concerns were also shared around competition for business between new and seasoned members. Some newer members desired collaboration and mentoring and at times felt that long-standing members of their local chapter failed to extend a warm welcome.

> *I can't be the only person that maybe has a little* ***tension*** *within their unit… some people feel there's* ***competition****. Um, and that's not me. I truly wholeheartedly believe in the benefit of the collaboration, but unfortunately that I don't feel that reciprocated in my local unit.… Because if you collaborate then maybe you're gonna take business from somebody else or something like that, being in the same field.*

For some members, racial and ethnic inclusion was a priority. Members wanted to see diversity among clients as well as among members. Interviews revealed that it is essential to address inclusion from many angles, including increased acknowledgment of historical challenges of people of color, allowing voices of members from different backgrounds to be heard and appreciated, and intentional efforts to promote inclusion among members. One member commended ALCA on its increased initiatives to be inclusive:

> *We know [people of color] are doing care management…so, definitely [ALCA should] try to do* ***more reaching out****. And we've seen over the years that [ALCA] is becoming more inclusive.*

Members also identified challenges regarding racial inclusion.

> *I spoke with another Aging Life Care Manager who's a woman of color, and she said her experience in the chapter can be rather* ***clique-ish****… And going to events, she felt like an outsider; she didn't feel welcomed.*

These challenges present opportunities for ALCA to create targeted initiatives to engage underrepresented communities of color, enhance member experiences, and foster a culture of inclusion and belonging.

Findings from the National Survey

The survey was nationally representative of ALCA members from 45 states. The South Central chapter had the largest percentage of members completing the survey. Members were largely white and female, congruent with member demographics from the interviews.

Demographic Findings

Among the 701 respondents who completed the survey, 95.8% were female, 3.3% were male, and 0.9% were non-binary or preferred not to answer. Respondents identified with the following race and ethnicities: Caucasian (90.8%), Hispanic, Latino, or Spanish

Table 1
Practice Type Among ALCA Members

PRACTICE TYPE	PERCENTAGE OF MEMBERS
Self-employed	56%
Employee of a for-profit company	31%
Employee of a non-for-profit or government agency	8%
Retired or other	5%
Total	**100%**

**Refer to Table 1a in the Appendix*

(2.6%), Black or African American (2.3%), Asian (1.6%), other (0.5%), and preferred not to answer (2.0%).

Practice and Profession

Members were asked about the nature of their practice and their preferred title with clients. Table 1 provides a breakdown of responses to practice type. Most were self-employed (56%), followed by employee of a for-profit company (31%).

Three-quarters of those surveyed utilize ALCA logos on business communication and marketing, demonstrating applicability across many practice types. To understand how titles are used, the survey included a question asking members to select one of 14 different titles. Each of the 14 titles was selected by at least one member. While there was diversity in the titles used, four were frequently used and represented 84% of respondents: (1) *Care Manager* (35%, n=243), *Geriatric Care Manager* (28%, n=195), *Aging Life Care Manager* (13%, n=93), and *Aging Life Care Professional* (8%, n=54).

For each title, we assessed how many were self-employed, employees of a larger organization, or other (refer to Table 1b in the Appendix). Among those who selected *Care Manager*, 47% were self-employed, 50% were employees, and 3% were other. Of those who use the title *Geriatric Care Manager*, 65% were self-employed, 30% were employees, and 5% were other. Fewer members use the title of Aging Life Care Manager; of those, 61% are self-employed. Very similar findings were found for those who use the title Aging Life Care Professional.

The overwhelming majority (92%) of respondents had careers prior to becoming an Aging Life Care Manager. Of members who transitioned from another career into an Aging Life Care management career, 54% joined ALCA within the first five years of becoming an Aging Life Care Manager, whereas less than a quarter joined at mid (6-15 years) (23%) or late-career (16 years or more) (23%) stages. Among respondents, 490 members (71%) hold at least one relevant certification, with the National Academy of Certified Care Managers (NACCM) as the most commonly held educational certification.

> *"I attended a conference, and there was so much camaraderie and so many people sharing a lot of ideas … these people are intelligent; they want to be the best at what they do, and I want to be part of that!"*

Membership

Respondents learned about the association through various channels, including word of mouth, online information, and educational programs. Notably, 71% of respondents identified colleagues (34%), an employer (28%), or word of mouth (9%) as their primary sources. By contrast, independent research, news media, and social media were less prominent, collectively accounting for fewer than 20% of responses. Additionally, less than 10% of respondents learned about ALCA through educational programs.

Respondents were asked to evaluate the importance of various aspects of membership for both joining and continuing their involvement with ALCA. Many respondents endorsed the following reasons for joining ALCA. Below we provide the percentage of respondents who rated the reasons deemed "very influential" for joining ALCA. Those respondents included:

- A professional organization relevant to the work of Aging Life Care management (62%)
- Belonging to an association grounded in a Code of Ethics and Standards of Practice (61%)
- Access to education relevant to the work of Aging Life Care management (58%)
- Increases professional credibility with clients (58%)

While not applicable to all respondents, 53% agreed that wanting to build and strengthen a business was a very influential reason for joining. Among respondents who identified with being an employee, 71% agreed that employer encouragement was very influential in their reason to join, and 67% agreed that having the employer pay for the membership was also very influential.

The reasons for joining ALCA closely mirrored those for remaining a member; however, additional factors emerged as "very influential." (The percentages exclude any members who listed the choice as non-applicable.)

- Being listed on the "Find an Aging Life Care Expert" search tool (55%)
- Level of camaraderie and support experienced among ALCA members (35%,)
- Access to ALCA members to brainstorm solutions about client and/or business challenges (34%)

While employers covering the cost to join ALCA was very influential, the cost to renew ALCA membership was less influential. Fewer than 20% of members noted cost of membership as "very influential" in the decision to renew. ACLA's strong Code of Ethics was influential in the decision to join and remained influential in the decision to renew (51% agreed it was very influential in the decision to renew).

Promotion of ALCA

Members play a significant role in promoting both the profession and ALCA. They serve as valuable sources of information for professionals who have not yet joined the association. We inquired about members' views on their role, and 92% agreed or strongly agreed that ALCA members are responsible for promoting the profession of Aging Life Care management. Only 3.5% disagreed. Seventy percent of members indicated they have promoted ALCA to a friend or colleague.

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Table 2
Perceived Importance of ALCA Initiatives

Initiatives	Percentage of responses marked as fairly & very important
Enhance marketing that explains the value of the services provided by an Aging Life Care Manager	73%
Creating a more welcoming environment, especially for new and early career members	63%
Using case studies to apply the Code of Ethics and Standards of Practice to the work of Aging Life Care management	60%
Increasing racial and ethnic inclusiveness among current and potential members	56%
Adding more opportunities to be individually mentored	47%

Experiences with ALCA Members and Clients

Although a sensitive issue, we asked members if they had experienced implicit bias or racism from other members, staff, or Board members. Most (88%) had never experienced implicit bias or racism from within ALCA; however, 12% had encountered implicit bias or racism from within the association. The same question was asked about client experiences. Seventy-eight percent of members indicated that they had never experienced implicit bias or racism from clients. Among those who had experienced implicit bias or racism from clients, 8% said it occurred rarely, and 14% said it occurred sometimes/often.

Further analysis revealed that there were too few responses of "often" and "always" experienced implicit bias or racism from members or clients to calculate whether those who identified as a minority race or ethnicity were significantly more affected than those of majority race or ethnicity. Consequently, it was not possible to derive reliable estimates on the association between race/ethnicity and experiences of bias. The chi-square confirmed that the results of the cross tabulation were non-significant (refer to Tables 2a and 2b in the Appendix).

ALCA Services

Services offered by ALCA add value to membership but with varying degrees of importance. When asked about the importance of clinical education, 63% regarded it as very important to their work as an Aging Life Care Manager. When asked about education pertaining to business development, 28% rated the service as very important.

ALCA initiatives were assessed because understanding the perceived importance of such initiatives could help the organization align its efforts with the needs of its members. Nearly three quarters (73%) of respondents endorsed an initiative to enhance marketing that explains the value of the services provided by an Aging Life Care Manager as fairly or very important. Table 2 shows additional ALCA initiatives and perceived importance among respondents.

To better understand the initiative to increase racial and ethnic inclusion, the research team assessed the association between those who endorsed the initiative as fairly or very important and those respondants' racial and ethnic identity. Findings show those who identify as White, Hispanic, Latino, or Spanish, Black or African American, and Asian have significantly higher responses of fairly or very important compared to slightly or not important at all (refer to Table 3a in the Appendix). However, we did not find the same trend among those who identify as other or preferred not to answer; note that only a total of 17 persons identified in these two categories.

Similarly, to better understand the initiative of mentoring, we assessed the association between those who endorsed the initiative as fairly or very important and the stage of their career (new, middle, and late career). Among those who were in their early career, 58% saw the initiative as fairly or very important, compared to 46% who were in mid-career and 42% who were in late career (refer to Table 4a in the Appendix). This finding was not unexpected, because early-career members are still establishing their professional knowledge and see the need for mentoring.

Limitations

Although the study included a substantial number of responses, they were predominantly from White women. The low number of responses from individuals of diverse racial and ethnic backgrounds prevented reliable estimates of associations between race, ethnicity, and other variables. While the study included a respectable response rate, the findings may be biased toward the responses from more engaged ALCA members.

Discussion and Conclusions

Many members emphasized that relationships are central to ALCA, for new members and for those who have remained in the organization for decades. Relationships are how new members are acquired and maintained. They are key to membership renewal and to membership development.

Membership development occurs through ALCA's members, who play a pivotal role in sustaining and growing the organization for the next generation of Aging Life Care Managers. Members should realize the importance of their reaching out to potential members and to is role and reach

out to potential members as well as those who are new to the organization. Some members felt that ALCA had an exclusive group that, perhaps unwittingly, excluded members. Fostering an inclusive and welcoming environment is critical for the future of the organization. Members should feel welcome and included. Special efforts should be made to increase the diversity of ALCA members, particularly in areas of the country that reflect diversity in race and ethnicity. Training programs may offer strategies so that all members are welcomed and included across the organization. Also, ALCA should consider initiatives that bring in members from underrepresented communities. Relatedly, ALCA needs to invest in initiatives to grow a new cadre of organizational leaders. Efforts such as these will enable the growth of the organization as a whole as well as its leadership.

A powerful reason that members are drawn to the organization and remain faithful to it is ALCA' s Code of Ethics and Standards of Practice, which members indicated are important features of the organization. More could be done to promote each. One way to do so would be to feature a case study during ALCA forums and use the Code of Ethics and Standards of Practice to guide case resolution.

Another highly ranked feature of the ALCA website is its search feature. It serves as an important networking tool and promotes members' businesses. ALCA should continue to ensure information is up to date and easily searchable.

In conclusion, ALCA offers its members unique services and support. It enables and strengthens its members to serve an older adult population, one with increasingly complex needs. ALCA has much to recommend it—mentorship of new members and a Code of Ethics and Standards of Practice that help guide the actions of all of its members. It has an important opportunity to expand its membership base by reaching out to a more diverse membership and nurturing them—a strategy that could attract new members and clients. ALCA might want to reach out to community colleges, historically black colleges and universities (HBCUs), and other four-year institutions to bring in new members who may be unaware of Aging Life Care management as a career. Other opportunities for garnering interest and diversifying potential new members includes offering scholarships and grants, and prominently featuring success stories and profiles of professionals of color within the Aging Life Care profession. Showcasing diverse role models can inspire students and young professionals to consider this rewarding career path.

Fostering relationships among ALCA members is at the heart of the organization. Opportunities exist though mentorship, growing members and future leaders, making members aware of organization resources, and training members to be knowledgeable about older adults and their care needs. With an aging population, the services provided by ALCA members will remain in high demand for many years to come. Growing membership and promoting the profession is crucial, as Aging Life Care management is still relatively new and largely unknown to the vast majority of the population. Increasing awareness and expanding the network of professionals is essential to meeting the future needs of this demographic.

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Appendix

Table 1a.

Cross Tabulation of Professional Title by Practice Type: Percentage of title use within whole sample

		PROFESSIONAL TITLE					
Practice Type		**ALC Professional**	**ALC Manager**	**Geriatric Care Manager**	**Care Manager**	**Other**	**Total**
Self-employed	Count	33	57	126	113	65	394
	% of Total	4.7%	8.1%	18.0%	16.1%	9.3%	56.2%
Employee	Count	17	30	58	122	43	270
	% of Total	2.4%	4.3%	8.3%	17.4%	6.1%	38.5%
Other	Count	4	6	11	8	8	37
	% of Total	0.6%	0.9%	1.6%	1.1%	1.1%	5.3%
Total	Count	54	93	195	243	116	701
	% of Total	7.7%	13.3%	27.8%	34.7%	16.5%	100.0%

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Table 1b. Cross Tabulation of Professional Titles with Practice Type: Percentage of title use within each practice type

Practice Type		PROFESSIONAL TITLE: ALC Professional	ALC Manager	Geriatric Care Manager	Care Manager	Other	Total
Self-employed	Count	33	57	126	113	65	394
	% within Title	61.1%	61.3%	64.6%	46.5%	56.0%	56.2%
Employee	Count	17	30	58	122	43	270
	% within Title	31.5%	32.3%	29.7%	50.2%	37.1%	38.5%
Other	Count	4	6	11	8	8	37
	% within Title	7.4%	6.5%	5.6%	3.3%	6.9%	5.3%
Total	Count	54	93	195	243	116	701
	% within Title	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Table 2a. Chi Square Test of Experienced Bias among Members and Race

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	14.608[a]	15	.480
Likelihood Ratio	13.513	15	.563
Linear-by-Linear Association	.001	1	.979
N of Valid Cases	650		

a. 16 cells (66.7%) have expected count less than 5. The minimum expected count is .07.

Table 2b. Chi Square Test of Experienced Bias among Clients and Race

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	22.694[a]	20	.304
Likelihood Ratio	18.210	20	.574
Linear-by-Linear Association	1.537	1	.215
N of Valid Cases	650		

a. 22 cells (73.3%) have expected count less than 5. The minimum expected count is .01.

Table 3a. Cross Tabulation of Perceived Importance of Racial and Ethnic Inclusion and Race and Ethnic Identities

RACE		PERCEIVED IMPORTANCE OF INCLUSION: Not Important or Slightly	Important	Fairly or Very Important	Total
White	Count	119	143	327	589
	% within Race	20.2%	24.3%	55.5%	100.0%
Hispanic, Latino, or Spanish	Count	3	2	13	18
	% within Race	16.7%	11.1%	72.2%	100.0%
Black or AA	Count	1	1	13	15
	% within Race	6.7%	6.7%	86.7%	100.0%
Asian	Count	3	3	5	11
	% within Race	27.3%	27.3%	45.5%	100.0%
Prefer not Answer	Count	8	2	3	13
	% within Race	61.5%	15.4%	23.1%	100.0%
Other	Count	0	3	1	4
	% within Race	0.0%	75.0%	25.0%	100.0%
Total	**Count**	**134**	**154**	**362**	**650**
	% within Race	**20.6%**	**23.7%**	**55.7%**	**100.0%**

Table 3b. Chi-Square Tests of Perceived Importance of Racial and Ethnic Inclusion and Race and Ethnic Identities

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	28.065[a]	10	.002
Likelihood Ratio	25.583	10	.004
Linear-by-Linear Association	5.317	1	.021
N of Valid Cases	650		

a. 11 cells (61.1%) have expected count less than 5. The minimum expected count is .82.

Table 4a. Cross Tabulation of Perceived Importance of Mentoring and Career Stage

CAREER STAGE		PERCEIVED IMPORTANCE OF MENTORING			
		Not Important or Slightly	Important	Fairly or Very Important	Total
Early career	Count	28	34	85	147
	% within Career Stage	19.0%	23.1%	57.8%	100.0%
Mid-Career	Count	59	61	102	222
	% within Career Stage	26.6%	27.5%	45.9%	100.0%
Late Career	Count	73	89	119	281
	% within Career Stage	26.0%	31.7%	42.3%	100.0%
Total	**Count**	**160**	**184**	**306**	**650**
	% within Career Stage	**24.6%**	**28.3%**	**47.1%**	**100.0%**

Table 4b. Chi-Square Tests of Perceived Importance of Mentoring and Career Stage

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	9.982[a]	4	.041
Likelihood Ratio	9.980	4	.041
Linear-by-Linear Association	6.320	1	.012
N of Valid Cases	650		

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 36.18.

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Older Adults and Opioids: What They Know and Perceive

By Tamatha Arms, PhD, DNP, PMHNP-BC, NP-C; Stephanie Duea, PhD, RN; Noell Rowan, PhD, LCSW, LCAS, CCS; Matthew Peterson, PhD

ABSTRACT

Opioid overdose deaths in older adults (OAs) across the U. S. have increased 1886% between 1999 and 2019. An increase of 54% in those ages 55+ seeking opioid treatment was noted between 2013 and 2015. The purpose of this study was to describe OA's knowledge, attitudes, and beliefs regarding opioids. An electronic Qualtrics survey invitation was sent to all members of American Association of Retired Persons (AARP) across a southeastern state via postcard invitation. OA respondents (N=353) were primarily women (59%), white (92%), with a mean age of 68.1±6.4 years. Most respondents strongly agreed that people taking pain medications can become addicted (96%); prescription pain medications have similar effects as heroin (78%) and can cause problems with concentration and remembering (90%); 85% strongly disagreed that older adults rarely misuse or abuse their pain medications; and 34% strongly disagreed that they were not the type of person who would become addicted. Forty-six percent indicated they would be reluctant to get a prescription for an opioid medication due to worry of becoming addicted. Women and those with graduate education had better attitudes toward opioids, as they were less likely – compared to men and those with lower levels of education ($p<0.05$) – to feel that young and poor people are more likely to abuse or misuse opioids. Primary implications of this study affect clinical practice, patient education, and healthcare student education. Older adults' knowledge and perceptions of opioids needs to be highlighted in clinical practice and academia. Due to the addictive potential of opioids, OAs may be avoiding pharmaceutical treatment that may improve chronic disease and pain management, functionality, and quality of life.

Introduction

Older adults are the fastest growing population across the United States and are predicted to become 25% of the population by 2060 (Centers for Disease Control & Prevention [CDC], 2022). Older adults comprise approximately 25% of people who need long-term opioid treatment (Mojtabai, 2018). More than 27 million older adults have arthritis, and often this condition is treated with opioid medications because nonopioids either stop working or do not work well enough (Kaye, Baluch, & Scott, 2010). The number of outpatient opioid prescriptions increased almost ninefold between 1995 and 2010 (Resnick, 2022, p. 365), and according to a recent study, "the number of opioid overdose deaths in older Americans increased 1886% between 1999 and 2019" (Samuelson, 2022, para. 1). There has long been a myth that older adults are not part of the concern in the United States related to overdose and death from opioids. Since these statistics showing recent rapid increase of overdose death "goes against the grain" of society's perceptions of older adults, even many healthcare professionals are blind to this.

A significant gap in literature exists in older adults' knowledge and perception of opioids. Older adults have more chronic diseases than any other age demographic and chronic pain has been well associated with opioid treatment. Approximately 77% of older adults with heart disease, 40% of older adults seen in the outpatient setting, and almost 80% of persons with advanced cancer report chronic pain. Almost 10% of older adults use prescription opioids for chronic pain. Between 2013 and 2015, there was a 54% increase in persons ages 55 and older seeking opioid treatment, while the population growth was only 6%, and the number of older adults using heroin more than doubled (National Institutes on Drug Abuse [NIDA], 2020).

The purpose of this study was to determine the current knowledge, beliefs, and attitudes of older adults across a state in the southeast region of the U.S. regarding opioids.

Methods

This was a cross-sectional quantitative design. For this study, older adults were defined as 55 years old and older. This study was reviewed by a university's Institutional Review Board and was determined to be exempt from further review according to the regulatory category cited under 45 CFR 46.104(d).

Survey instrument

Prior research indicated lack of a validated tool for use with older adults (Glose, Arms, & Rowan, 2021). Therefore, questions were taken from various validated surveys, adapted, and reviewed by clinical experts and a gerontologist with expertise in survey development, formatting, and older adult literacy. The final survey consists of 52 items: 8 knowledge Likert-style questions, 12 belief Likert-style questions, 6 attitude Likert-style questions, and 7 categorical demographic questions. The entire 7-item PROMIS Prescription Pain Medication Misuse nv1.0 - short form V7a was used (Pilkonis et al., 2017), and the Brief Opioid Overdose Knowledge (BOOK) questionnaire was the final set of 12 True/False questions. Of these questions, six questions were adapted and revised from the Youth Opioid Study: Attitudes and Usage survey (Hazelden Betty Ford Foundation & The Christie Foundation, 2015), and four questions were adapted and revised from The Pain Opioid Analgesic Beliefs Scale (Lai et al., 2003). The BOOK questionnaire was developed in 2016 and as a 12-item True/False knowledge test to "quickly assess patient knowledge of opioids" (Dunn et al., 2016).

Recruitment

Older adults were recruited through a postcard sent out across the state in the southeastern region of the United States by the Association of American Retired Persons (AARP). The postcard had a Quick Response (QR) link to a secure Qualtrics survey and a phone number that potential participants could call to do the survey over the phone or to request a paper copy of the survey sent to them via postal service.

Statistical Analysis

Data were exported from Qualtrics to SAS version 9.4 (SAS Institute, Cary, NC) for cleaning and analysis. All survey instruments were scored according to published criteria. Data were checked for normality and summarized using appropriate univariate descriptive statistics, including mean ± SD, and counts and percentages. Data are available upon request.

Results

No participants called to complete the survey over the phone or to request a paper survey be sent to them. Three hundred fifty-five respondents completed most of the demographics survey questions (Table 1), although only N=253 provided their age (mean age = 68.1 ± 7.4 years; range 55-94 years). Most of the respondents were female (59.2%), white (91.8%), non-Hispanic (98%), and had at least an Associate's degree level of education (70.8%). Approximately one-quarter (28.5%) of the respondents reported a Master's or Doctorate degree, indicating a sample with a high level of education. Table 2 shows the number of participants who completed the different aspects of the survey. Three hundred forty-three participants completed the attitude section of the survey, but only 32 participants completed the BOOK section of questions.

> A key component to dealing with opioid misuse is to provide access to healthy social relationships to avoid isolation and mistrust of others.

Results indicate most respondents (96%) *strongly agreed* that people taking pain medications can become addicted; that prescription pain meds have similar effects as heroin (78%); and that prescription pain medications can cause problems with concentration and remembering (90%). Responding to questions about use and misuse, 85% *strongly disagreed* that older adults rarely misuse or abuse their pain medications, and 34% *strongly disagreed* that they were not the type of person who would become addicted. Forty-six percent indicated they would be reluctant to get a prescription for an opioid medication due to worry of becoming addicted. More than half (54%) felt that younger people are more likely to misuse or abuse prescription pain medication, but 85% felt that older adults do misuse or abuse their prescription pain medications. Sixty-six percent of the respondents felt they are *not the type of person who would become addicted to prescription pain medication*, while 12% felt they *could tell if a person was addicted by their physical appearance*, and 15% felt that people who are not college educated *are more likely to abuse/misuse prescription pain medication.*

The PROMIS prescribed pain medication questions showed that 94% of the respondents never abused prescription pain medication, leaving 6% who *sometimes or rarely do*. Twelve percent reported running out of their prescription pain medication early *sometimes or rarely*. Almost 3% reported *almost always/often/sometimes* running out of pain prescription early, with another 3% *rarely* running out of pain prescription early. Almost 2% used more of the prescribed pain medication than they were supposed to, with another 7% *rarely* using more prescribed pain medication than they were supposed to. Six percent reported *often/sometimes/rarely* running out of their prescribed pain medication too soon. Almost 13% *almost always/sometimes/rarely* take prescription pain medication against their healthcare provider's advice.

The knowledge questions revealed that more than 96% of respondents thought that *people taking pain medication can become addicted to them.* Sixteen percent thought it is safe to drive while taking pain prescriptions. Almost 19% *disagreed/strongly disagreed* that prescription pain medications are the same as illegal heroin. Eighty-five percent and 82% *agreed/strongly agreed* that prescription pain medications can cause constipation and increase risk of falls respectively. Seventy-eight percent reported they *agreed/strongly agreed* that pain prescription medications can cause problems with concentrating and remembering. Two-thirds (67%) of respondents *agreed/strongly agreed* that taking pain prescription medications can keep older adults independent, but 14% believed older adults *should not take prescription pain medicine.* Eighty nine percent (89%) *agreed/strongly agreed* that the effectiveness of prescription pain medication wears off and

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higher doses are eventually needed to get the same pain relief.

Most respondents (90%) knew that all overdoses are not fatal, and that cool, clammy skin (93%) and trouble breathing (93%) are both signs of opioid overdose. Ninety-two percent of respondents knew that restlessness, muscle and bone pain, and insomnia are symptoms of opioid withdrawal. Almost 100% (99%) of respondents knew that Narcan (naloxone) reverses the effects of an opioid overdose. Even though more than 80% knew that a sternal rub is used to evaluate consciousness, and that a person who is breathing should be placed in a recovery position, only 76% knew that they can begin delivering rescue breaths until emergency help arrives.

Seventy-six percent (76%) of respondents *did not* believe that people who take more of their prescription pain medication, or take it more often, or share their medication have good reasons for doing so, but only 11% believed they *are bad people.* Forty-six percent of respondents were *reluctant to get a pain medication prescription* due to concern of becoming addicted, and 36% believed that prescription pain medications *should only be used in the last stages of a severe illness, like cancer*. More than 40% believed they *would get* a prescription for pain medication if they asked for it, and 35% believed prescription pain medications *are safe to take with other prescription medications.* Only 17% of respondents would give a *friend or relative* an opioid who was in pain if they had a prescription for it, and 21% would take a pain medication offered to them from a *friend or relative if they were in pain.* Almost 5% had received prescription pain medicine from someone other than a health care provider in the last three months. Almost 14% *used more pain medication before the effects wore off,* and 9% u*sed more prescription pain medicine than they were supposed to* in the last three months. Twenty-nine percent of respondents reported feeling *a little bit/somewhat/quite a bit/ or very much* anxious when their pain medication prescription ran out. The majority (86%) of respondents believed that *having 1-2 alcoholic drinks daily while taking prescription pain medication would be harmful.*

Discussion

The purpose of this study was to determine the current knowledge, beliefs, and attitudes of older adults across a southeastern state. Survey results indicated that older adult participants had a mean t-score of 39.6 with an SD ± 4.4 on the prescription pain medication misuse survey. This indicates that the participants in this study "may be less likely to misuse their prescription pain medication" (Patient Reported Outcomes Measurement Information System [PROMIS], 2021, page 3). There was a difference between the number of participants who completed the questions at the beginning of the survey to those who completed the questions near the end of the survey. This may indicate either survey fatigue or that participants who did not know much about opioid overdose did not answer the questions.

The eight *knowledge* of opioid questions for older adult participants in this study revealed that 89% answered the questions correctly. This is compared to the results of Glose et al (2021), in which only 75% of the participants answered six of the eight knowledge questions correctly. This may be due to the increased societal attention that opioids and opioid use overdoses have been receiving recently. The BOOK questionnaire, which asks True/False questions about opioid knowledge, revealed that more than 90% of the respondents answered 8 of the 12 questions correctly and more than 75% answered 11 of the 12 questions correctly. This shows that this sample was highly educated, with most participants having an Associate's degree or higher and were very knowledgeable about opioids.

Most participants felt that income and educational levels did not correlate with the likelihood of misusing or abusing opioids. However, a study by Zanjani, Brooks, Waters, Parsons, and Slattum (2020) indicated low-income older adults were more likely to receive a prescription for opioids. Most participants felt that older adults can misuse and abuse opioids, but more than half of the participants felt that *young people are more likely to misuse or abuse their prescription pain medications.* Thus, older adults know that addiction transcends age but believe that younger persons are more likely to be addicted. Eighty-eight percent of participants felt that they *could tell if a person was addicted to their prescription pain medication by their physical appearance,* indicating a lack of knowledge and/or understanding of how addiction works. This sample was biased in that 66% felt they *are not the type of person who would become addicted to prescription pain medicine*, indicating a separation of oneself from those who become addicted.

Even though more than 27 million Americans take a prescription pain medication to treat arthritis, 72% of the respondents in this study did not believe/agree that pain prescription medicines are a good treatment for pain from arthritis. This study revealed similar results to the earlier study by Glose and colleagues (2021), which showed that 32% of participants believed opioids are a good treatment for arthritis, while this study showed that 28% of participants believed opioids to be a good treatment for arthritis. This study also had similar results in the percentage (46%) of participants feeling *reluctant to take an opioid due to fear of addiction*, compared to the earlier study that showed 64%.

Implications

Prevention should be the focus of opioid misuse and abuse in older adults (Resnick, 2022). However, this study highlighted older adults' perceptions of opioids and the potential for addiction, which may lead to avoidance of a pharmaceutical treatment that improves chronic disease and pain management, functionality, and quality of life. As such, we address some of the implications for clinical practice, patient education, and healthcare student education below.

Providers caring for older adults are on the front line of assessing, diagnosing, intervening, treating, and evaluating older adults' perceptions of opioids. Understanding the older adult's perception of prescription pain medication prior to prescribing may alert the prescriber to any common misconceptions so these

can be addressed early on. Regular screening for early detection of opioid use disorder and adverse impacts on the older adult's health and safety should be incorporated into every clinic visit and conducted by case workers or caregivers when they are present in the home. The PROMIS prescription pain medication misuse v1.0– short form 7a can be completed by a patient, a proxy, or a provider in a very short time. In this study, most of the older adults knew that naloxone (Narcan) is used to reverse an opioid overdose, so the prescriber should give the patient a naloxone rescue kit prescription along with any prescribed pain medication prescription (Resnick, 2022). The authors did not ask if the older adult respondents knew how to use a naloxone rescue kit, but this should be part of the education provided to the patient.

A patient's cultural values, language, education, literacy level, and health practices should be assessed prior to any opioid education activity. Equally important is assessing for understanding after the education activity, and to assess not only the patient's understanding, but that of family members or caregivers as well. Ensuring family members and caregivers of older adults can recognize signs of opioid overdose, and know how to respond, can be lifesaving.

Aging Life Care Managers (ALCMs), social workers, and caregivers need to be aware of signs and symptoms of opioid misuse and overdose and be trained in the use of naloxone rescue kits as well as providing emergency resources in case of a true emergency. In addition, ALCMs need to be a part of an interdisciplinary team providing care for older adults to foster communication with caregivers and other professionals. A key component to dealing with opioid misuse is to provide access to healthy social relationships to avoid isolation and mistrust of others. ALCMs can provide a bridge to healthy social support that is often lacking for older adults, particularly in dealing with chronic pain and chronic illnesses. There is much work to be done to enhance social support opportunities for older adults and to be aware of the needs of older adults dealing with pain daily.

Integrating evidence of older adult opioid knowledge and perceptions into course content for health professions students would enhance cultural awareness as the students transition into practice and work with older adults. Interprofessional students at Virginia Commonwealth University's school of medicine, nursing, pharmacy, psychology, social work, and allied health professions participated in a community based interprofessional care coordination wellness initiative. The students received training curriculum on opioid harm reduction, motivational interviewing and Screening, Brief Intervention, and Referral to Treatment (SBIRT) for older adults then implemented the project in low-income residential housing units. This training initiative significantly increased student knowledge in understanding overdose risk and their belief that they could counsel older adults about opioids. This study indicated the feasibility of incorporating and implementing an interprofessional curriculum on opioids and older adults (Zanjani et al., 2020).

Limitations

There are limitations to this study that need to be considered. This study covered only one state in the southeastern region of the United States. Even though the research team attempted to recruit Spanish-speaking older adults, this was not successful. Most, if not all, participants were members of AARP. All participants were able to take the survey online, indicating a higher level of digital literacy and possibly a higher level of income than the average older adult nationally. This study focused on opioids only and cannot be used to infer information about older adults and other substances. Finally, the response rate for some questions was low (~10% of total sample), potentially leading to bias in the available data and cautious generalizability.

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Our Voices Matter: Reflections of LGBT older adults in interprofessional simulations to prepare future older adult healthcare providers

By Noell L. Rowan, PhD, LCSW, LCAS, CCS; Stephanie R. Duea, PhD, RN; and Tamatha Arms, PhD, DNP, PMHNP-BC, NP-C

ABSTRACT

The majority of healthcare recipients in the United States continue to be older adults.

Aging Life Care Managers are in critical roles to make positive changes to enhance culturally sensitive and overall care for LGBT older adults. It is imperative that Aging Life Care Managers serving as advocates be given tools to be successful particularly for vulnerable populations such as LGBT older adults. The purpose of this paper is to describe an interprofessional study involving increased health knowledge of social work and nursing students in providing care for LGBT older adults. The use of clinical simulation to improve practice skills in interprofessional teams is highlighted. Emphasis is on reflections of older LGBT healthcare participants about access to care and critical issues of social support in order to provide specific action steps and practice approaches that will enhance culturally sensitive health care.

Introduction and Background

Aging Life Care Managers serving as advocates and caregivers for older adults are frequently involved with the complexities of health care and require acute awareness of the needs of vulnerable older adult populations. Members of the LGBT older adult communities have been noted in the scholarly literature as underserved sexual and gender minorities with significant health disparities and healthcare needs. Some healthcare concerns include being less likely to disclose sexual orientation or gender identity, or to seek health care due to fear of discrimination and service costs (Fredriksen-Goldsen & Kim, 2017; Fredriksen-Goldsen, Hoy-Ellis, Goldsen, Emlet, & Hooyman, 2014; Rowan, 2012; Rowan & Giunta, 2014; Zelle & Arms, 2015). Even though much work has begun to educate health care service providers with curriculum development, dissemination of educational seminars, and wellness of LGBT older adults deemed a priority by U.S. Department of Health and Human Services (2012), more work is needed to enhance cultural sensitivity to the health care needs of LGBT older adults (Meyer & Johnston, 2014; Moone, Cagle, Croghan, & Smith, 2014; National Resource Center (NRC)

on LGBT Aging, 2020).

Smith, Rowan, Arms, Hohn, and Galbraith (2021) noted that, within nursing and social work schools, there is a lack of interprofessional clinical preparation on health care specific to LGBT older adults and developed a curriculum for both nursing and social work students to boost healthcare knowledge and provide interactive simulation experiences. This curriculum intervention was developed as a result of Rowan and Beyer's (2017) healthcare survey of LGBT older adults in coastal North Carolina that deemed development of culturally sensitive health care a priority. The aim of the interprofessional educational intervention was to improve the health-related knowledge and cultural sensitivity/awareness specific to LGBT older adults of nursing and social work healthcare providers. Smith and colleagues (2021) describe the mixed-method intervention using didactic lecture with pre- and post-test measures along with lab-based clinical simulations showing statistically significant results, positive change in attitudes, and enhanced healthcare knowledge among nursing and social work students. This intervention curriculum project provided support for interdisciplinary education and research that impacts the preparation of the next generation of culturally sensitive healthcare providers for LGBT older adults (Smith et al., 2021).

The purpose of this paper is to provide description of (a) the development of the clinical simulation elements of the project (Smith et al., 2021), (b) engagement with actual members of the LGBT older adult communities who participated actively in the clinical simulations, and (c) the reflections of LGBT older adult participants about access to health care and critical issues of social support. As a conceptual framework, this research utilized the lens of a Health Equity Promotion Model (Fredriksen-Goldsen et al., 2014) as a transition from a narrow focus on health disparities to the enhanced wellness potential of LGBT people across the life span. As older adults continue to be the largest segment of the U.S. population in need of health care, it is vital that health professionals be trained to provide culturally sensitive care and the highest level of health care available with knowledge and sensitivity of LGBT older adults.

Reflection of LGBT older adult — *I really want to get across that older people are sexually active. … we actually do have sex and it's a missed opportunity to really find out what's going on with the person, if you assume that we're not sexually active. …*

Methods

Materials and methods for the larger mixed-methods study were described in detail in the Smith et al. (2021) article. What follows below is a description of our approach with members of the LGBT older adult community to develop the qualitative segment of the mixed-methods study.

Development of the Project

The project required considerable engagement with interdisciplinary faculty, the community, and students in both nursing and social work programs. As facilitated by the culture of the College of Health and Human Services within the authors' university, nursing and social work faculty joined together to create this interprofessional project. Faculty worked together, wrote, and were subsequently awarded a community engagement grant funded internally through the university. The purpose of these community engagement grants is to support scholarly projects that represent collaborative partnerships among community partners, student, and faculty teams. Projects funded by this internal mechanism are expected to advance the development of community partner capacity, engage students in service learning and/or research, and facilitate the evolution of faculty scholarly identity related to community-identified needs (Rowan, Smith, & Arms, 2017).

Engagement with Actual Members of the LGBT Older Adult Communities

Social work faculty engaged with the local affiliate of the community organization Services and Advocacy with LGBT Elders (SAGE) and were quickly met with enthusiasm to participate in this project. Members of the local LGBT older adult communities were eager to be invited to our university campus and engage with nursing and social work students to teach about cultural sensitivity/awareness to improve health care provisions.

Development of Simulation Scenarios

Several meetings were held with the social work faculty member and members of the local LGBT older adult communities to create healthcare scenarios and prepare for acting them out live in a simulation environment while being captured on film with social work and nursing students. Older adult LGBT community members were invited to write their own scenario, which was often an actual healthcare event that happened to them in the past. This met the International Nursing Association for Clinical Simulation and Learning (INASCL) standard for simulation design, which states that content experts should be consulted when designing the simulated experience (INASCL, 2021). All students were prebriefed and given didactic content to read prior to the simulated experience.

One undergraduate nursing and one graduate social work student volunteered (as healthcare teams) to participate in each simulated experience while the simulations were live streamed into a large classroom of their peers. Students in the class-

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room were strategically seated in an interprofessional way to view the simulations. The simulation teams and faculty from the schools of social work and nursing worked together to facilitate the process. The standards of operations and professional integrity were adhered to prior and during the simulation.

Debriefing Process

This project and simulated experience were developed from the simulation-enhanced interprofessional education standard. Faculty used the Promoting Excellence and Reflective Learning in Simulation (PEARLS) tool for the debriefing process with all social work and nursing students, faculty members, and the older adult members of the SAGE community (Bajaj et al., 2018). Students were also able to ask the older adults questions about LGBT older adult populations. Expert members of the community were very open and welcomed questions from the students. Debriefing the different scenarios allowed students to also ask questions of faculty. Differences and overlaps in roles between social workers and nurses were pointed out and discussed as well.

Qualitative Questions

As stated previously, this was a mixed-methods study conducted within the Health Equity Promotion Model framework (Fredericksen-Goldsen, et al., 2014) with nursing and social work students. The quantitative analysis can be found elsewhere (Smith et al., 2021).

In addition to the collection of quantitative data, several open-ended questions were posed to the students. Participants were asked to answer one open-ended qualitative question on the pretest *(How does one's gender identity and sexual orientation impact health?)* and two open-ended questions on the posttest *(How does one's gender identity and sexual orientation impact health? and What did you learn today that you will incorporate into your practice? Please be specific when describing how you will incorporate the lessons learned into your practice.)* (Smith et al., 2021).

Responses to the open-ended questions and the reflections of LGBT older adults were reviewed and analyzed by all three researchers independently and then collectively using content analysis. The content analysis was conducted using inductive logic after the researchers discussed their own potential biases to ensure credibility (Lincoln & Guba, 1985).

Reflections of LGBT Older Adults

Four primary themes about how gender identity and sexual orientation influence health were derived from analysis of student qualitative data: (a) bias of health care providers, (b) access to quality care, (c) specific healthcare needs, and (d) health risks of LGBT older adults (Smith et al., 2021). The following reflections of LGBT older adults reinforced the student- related themes and provide messages that each of the LGBT older adults wanted to make clear in order to assist future healthcare providers.

> Adding culturally sensitive knowledge and interprofessional simulation experiences within social work and nursing curricula increases cultural awareness/ sensitivity and knowledge in future healthcare professionals.

Treat Transgender Clients with Genuine Kindness (quotes from older members of the transgender community):

"As seniors in the medical/health care environment, our greatest risks are generally from individuals who are not open and not willing and not acting with kindness. The greatest common denominator is when people demonstrate passive aggressive behavior. Please do the very best you can in loving kindness…to do the next right thing."

Recognition of Significant Relationships and Marriage Equality (quotes from older lesbian participants):

"…we've been struggling with the idea of recognition of our relationship on that level for 29 years. And now that we are legal and allowed and have the benefits and the ability to be able to call each other wife, spouse, and married partner…it's just really hard to walk into a place that doesn't have any idea what to do with it. Healthcare centers are a clear place where that takes place. Where you walk in and people make assumptions about you and who you are to each other and just hopefully you won't make those assumptions in the future."

Awareness of Undetectable Viral Load – Untransmissible Disease (quotes from older gay male participants with HIV):

"If a [person with HIV] is virally suppressed such that their viral load is undetectable for six months or longer, they do not have to disclose their[HIV] status to sex partners…Prep meds can be prescribed to HIV negative patients…Should you be exposed to HIV, you are not likely to contract HIV [with administration of Prep meds]….With Prep meds, an undetectable viral load equals untransmissible disease."

"It is really important that caregivers are learning that."

Access to Health Care and the Environment (quote from older lesbian participant):

"We take a lot of cues from what we see in a healthcare environment. So when we walk in, …there's literature in the lobby for LGBT patients. There's information available about

not just heterosexual sexual behavior, but LGBTQIA sexual behavior, and that, is so important. So, I would say that when you get into your practice environments, pay attention to what you see. Um, quite honestly when I walk into a doctor's waiting room, or especially an exam room and I see a Bible on the counter, I have nothing against the Bible, but that's a red flag to me. 'Cause that's not necessarily going to be a welcoming environment, and I need to be careful."

Inquiring About Sexual Activity in Older Lesbian Clients (quote from older lesbian participant):

"I really want to get across that older people are sexually active. … we actually do have sex and it's a missed opportunity to really find out what's going on with the person, if you assume that we're not sexually active. And so, I'm hopeful that you will keep that in mind and figure out how to ask the same kinds of questions."

Somewhere to Go and Ask Questions in a Welcoming Community (quotes from older lesbian participants):

"I came out when I was 40, and had I had someplace that I could have gone to have asked questions, um, I would not have been destroying everybody's life up to the time I was 40, so to speak. 'Cause I got married, didn't know I shouldn't have. Twice, actually. And once I decided to come out, I knew that I had to help other people, other youth, adults come out as who they really were, uh and who they really are. I'm just thankful, you know, that I, that I could do that and that I found a welcoming community. And my message to anybody would be, just treat everybody with respect and dignity. It doesn't matter who you are, just respect and dignity is just the very base of how we should treat people."

Implications and Conclusions

As older adults continue to be the largest population needing health care, it is imperative that health professionals learn how to provide culturally sensitive health care and demonstrate cultural sensitivity in their practice and interpersonal interactions with clients. The messages provided by the members of LGBT older adult communities clearly state the importance of creating a welcoming healthcare environment (culturally sensitive care and respectful demeanor and including LGBT marketing materials/images in waiting areas), asking questions to get to know who the clients are and their significant support systems, treating clients with respect and dignity, and strengthening awareness of health knowledge specific to the health needs of LGBT older adults. These learning experiences should include training on implicit bias *(Know thyself!)*, how words matter *(Neutral Terms; Stigma)*, microaggressions in health care settings *(Is this place safe?),* and cultural humility *(Let's seek first to understand).*

Intentional integration of LGBT content into academic teaching and learning environments is necessary. Didactic information on LGBT older adults typically has a minimal presence, if any, in the classroom setting in social work and nursing schools. As such, there needs to be a concerted effort to integrate LGBT content across the lifespan into the curriculum. Additionally, there needs to be support for LGBT and LGBT older adults related research.

Adding culturally sensitive knowledge and interprofessional simulation experiences within social work and nursing curricula increases cultural awareness/sensitivity and knowledge in future healthcare professionals. In order to move beyond awareness, there is an opportunity to develop learning experiences based on principles of competency-based education and assessment to deepen these learning experiences.

Older adults continue to be the largest population needing health care. Professionals need to be trained to give culturally sensitive health care and demonstrate this competency in their practice and personal interactions with LGBT older adult clients/patients. This culturally sensitive curriculum (didactic and simulation) increases awareness and knowledge in future healthcare professionals. As one nursing student, who is also a member of the transgender community, noted: "*We are the change and we need to treat people [clients/patients] as humans and that will bring the change."*

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Coping with the Ambiguous Loss of Alzheimer's Disease: Strategies for Aging Life Care™ and Mental Health Professionals

By Daniel J. Koltz, PhD and Rebecca L. Koltz, PhD, LCPC, NCC

ABSTRACT

Alzheimer's Disease (AD) poses a growing societal concern in the 21st century, impacting millions of families worldwide. Informal caregivers, often family members, play a crucial role in supporting individuals with AD. This paper explores the multifaceted challenges informal caregivers face, addressing positive and negative factors influencing their experiences. Positive factors include meaningful interactions and support, while negative factors encompass role disruptions, guilt, and the ambiguity surrounding future planning. The prevalence of informal caregiving is significant, with millions of individuals providing care for family members with AD. As caregiving needs intensify, the emotional toll on caregivers becomes pronounced, necessitating comprehensive support systems.

The emotional journey of caregivers involves navigating through ambiguous loss, characterized by the ongoing decline in cognitive abilities. This adds complexity to the grieving process, as caregivers mourn not only the eventual loss through death but also the evolving facets of their loved one's identity. The authors emphasize the need for tailored interventions that acknowledge and address caregivers' unique challenges, and consider cultural, familial, and societal factors.

Introduction

Due to its increasing prevalence, Alzheimer's Disease (AD) is one of the pressing societal concerns in the 21st century (Collins & Kishita, 2019). For family members who are caregivers, several factors influence positive or negative experiences (Garity, 2006). Positive factors include interaction with loved ones, nursing staff, and formal support sources. Negative factors include role disruptions, guilt, and ambiguity regarding future planning. According to John Hopkins Medicine (2021), informal caregivers are often family members who do not receive payment for services. AARP has estimated 65.7 million people act as informal caregivers for special needs children or adults who cannot live alone. In 2023, more than 16 million informal caregivers provided care for a family member with AD (Centers for Disease Control, 2023), with 86% of those caregivers related to the care receiver. Since the early 1990s, family caregivers have been noted as a group in need of support (Brown & Kleist, 1999). Collins and Kishita (2019) found that the rate of depression was high among caregivers of people with dementia, and women were at a greater risk. They noted that interventions were needed to reduce "burden and depressive symptoms" (p. 2355).

The multifaceted nature of caregiving for individuals with Alzheimer's Disease necessitates a deeper exploration of the challenges faced by informal caregivers. Beyond the tangible aspects of care provision, caregivers often grapple with emotional and psychological burdens. The emotional toll is exacerbated by the profound impact of witnessing a loved one's cognitive decline. Studies have shown that caregivers frequently experience feelings of grief as they navigate through the gradual loss of the person they once knew (Boss, 2002). This phenomenon, known as ambiguous loss, adds a layer of complexity to the caregiving experience. The struggle to reconcile the individual's physical presence with their diminishing cognitive capacities contributes to the emotional strain on caregivers. Addressing the nuances of ambiguous loss is crucial for developing effective support mechanisms for caregivers (Boss, 2006).

Moreover, the evolving caregiving landscape is intertwined with societal shifts and demographic changes. As the global population ages, the demand for caregivers escalates, and the role of informal caregivers becomes even more pivotal. It is essential to delve into the socio-cultural factors that shape the experiences of informal caregivers. Cultural nuances, family dynamics, and societal expectations play a significant role in

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determining the support networks available to caregivers. Understanding the context is imperative for tailoring interventions and strategies that resonate with caregivers across various cultural and familial backgrounds. An inclusive approach to caregiving research will contribute to the development of comprehensive strategies that acknowledge and address the unique challenges caregivers face in different societal contexts. The authors will address the role of the informal caregiver, explain the ambiguous loss often experienced in caregiving, and provide strategies for Aging Life Care Managers and mental health professionals who work with caregivers.

Informal Caregiving

According to the Family Caregiver Alliance (2016), an informal caregiver does not receive compensation, is often a family member, and assists with tasks of daily living. As AD advances, caregiving needs become greater, taking a significant toll on caregivers (Gossner, Anlhla, and McPhee, 2021). As noted in the literature, caregivers experience elevated levels of grief given that loss is associated not only with eventual death, but also with personality changes and declining recognition and memory (Stone & Jones, 2009).

The economic implications of informal caregiving add another layer of complexity to the already challenging landscape. The Family Caregiver Alliance (2016) highlights the uncompensated nature of informal caregiving, emphasizing that those providing care for individuals with AD often do so without financial remuneration. This lack of financial support burdens caregivers, impacting their financial stability and potentially limiting their ability to access resources that could enhance the quality of care provided. As caregiving needs intensify with the progression of AD, the strain on caregivers becomes even more pronounced, underscoring the urgency for support systems, including counseling, that address the emotional dimensions of caregiving (Gossner et al., 2021).

The emotional journey of caregivers is a nuanced narrative that extends beyond grief alone. Stone and Jones (2009) delve into the intricate dynamics of caregiver grief, emphasizing that the mourning process is not confined to the eventual loss through death, but encompasses the ongoing losses associated with the disease's progression. Alterations in personality as well as declining recognition capacity and memory of the individual with AD adds layers of complexity to the grieving process. Caregivers find themselves continually adapting to the evolving nature of the disease, not only mourning what has been lost, but also grappling with the ever-changing facets of their loved one's identity. Acknowledging and understanding the multifaceted dimensions of caregiver grief is essential for developing targeted interventions that provide meaningful support throughout the ambiguous loss trajectory of AD caregiving.

Ambiguous Loss

Betz and Thorngren (2006) note that families experiencing loss on a "daily or ongoing basis are not recognized or legitimized by society" (p. 359). Boss (1999) notes two types of ambiguous loss: 1. physically absent and psychologically present, and 2. physically present and psychologically absent. An AD diagnosis presents as the second type of ambiguous loss, namely an individual who is physically present and psychologically absent. For families with ambiguous loss, the mourning process is less clear (Betz & Thorngren, 2006). Family members may find themselves in new and unfamiliar roles – a wife who operates more as a nurse, or a daughter or son who operates as a caregiver. This type of role change can bring a range of feelings, from profound sadness to anger. Caregivers grieve the loss of the person and shared roles, a partner, and a future together (Alzheimer Society, 2019). This type of loss is different because there is no closure, and grief cannot be fully resolved.

Ambiguous loss adds complexity to grief as the time and space to grieve are not the same as with a physical death.

Ambiguous loss adds complexity to grief as the time and space to grieve are not the same as with a physical death (Alzheimer Society, 2019). Some caregivers are unable to resolve the loss because AD occurs in stages. AD is a progressive form of dementia (Healey & Renes, 2014), with needs that are ever revolving. In the beginning stages, there is a decline in executive function. This results in an impaired ability to infer social cues, narratives, and stimuli correctly. There are memory issues that worsen over time. The progression of the disease impacts individuals in "unique and contextualized" ways (Healey & Renes, 2014, p. 142). Duggleby, Williams, Wright, and Bollinger (2009) note that caregivers who could accept the illness, find positive aspects in the experience, and see future possibilities were able to cope more effectively with the AD diagnosis.

Styles of grieving. Styles of grieving play a crucial role in understanding how individuals navigate the complex terrain of ambiguous loss. Doka and Martin (2010) offer valuable insights by characterizing grief as a continuum with two distinctive styles: intuitive and instrumental. Intuitive grievers engage with their emotions, experiencing grief through the movement of feelings and coping by taking the necessary time to process. On the other hand, instrumental grievers approach grief intellectually and physically, immersing themselves in tasks as a way of responding to their emotions. While some individuals may have a greater reliance on one style, it is common for caregivers to use a combination of both intuitive and instrumental grieving styles. Recognizing these diverse approaches is essential to understanding how caregivers respond to the challenges associated with AD caregiving (Yalom, 2010).

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Gamino et al. (2020) conducted a comprehensive study to explore the reliability and validity of Doka and Martin's styles of grief. Their findings provided robust evidence supporting the reliability of the instrumental and intuitive subscales, indicating consistency in the measurement of these distinct grieving styles. The study also demonstrated mild to moderate support for the construct validity of these styles. Furthermore, Gamino et al. (2020) highlight that the research endorses the coexistence of intuitive and instrumental grief patterns in individuals, emphasizing the complexity and diversity of grief responses. This recognition of a blend of styles underscores the need for a flexible and personalized approach to addressing caregivers' unique emotional needs and reinforces the importance of tailoring interventions to accommodate the varied ways individuals navigate the grieving process.

Strategies for Aging Life Care Managers® and Mental Health Counseling

For Aging Life Care Managers and mental health professionals working with families coping with the ambiguous loss of caregiving, there are strategies to help. What follows are seven strategies to use when working with caregivers: name ambiguous loss; name and normalize feelings; develop coping skills; engage social support; provide education; teach communication skills; and provide hope (See figure 1). Before working with families, care managers and counselors must engage in self-awareness. People who work with families impacted by AD must explore their own relationship to aging, death, and dying (Granello & Fleming, 2008). Unless one has personally experienced the loss associated with AD, it may be difficult to comprehend the ambiguous loss associated with an AD diagnosis.

Navigating the landscape of grief involves recognizing its diverse manifestations, with individuals often adopting various grieving styles. Countertransference issues of professionals, when working with loss, emerge as a critical consideration, particularly given the varied ways people express and cope with grief. An Aging Life Care Manager or mental health professional may have an emotional reaction, bias, or perception that influences how they react toward the individuals they are working with based on similar experiences (Simply Psychology, 2023). As highlighted by Doka and Martin (2010), some individuals lean toward an instrumental grieving style, characterized by an intellectual and physical engagement with grief, often involving tasks and actions. This action-oriented approach may be misunderstood as a lack of emotional depth by counselors, emphasizing the importance of awareness and sensitivity in the therapeutic process (Yalom, 2010).

In the context of these strategies, understanding the caregiver's grieving style takes center stage. The effectiveness of specific interventions hinges on aligning them with the caregiver's predominant grieving style. Assessing whether the caregiver leans toward an intuitive or instrumental focus is crucial, as strategies tailored to one style may be less effective for the other (Doka & Martin, 2010). This nuanced approach becomes especially pertinent when considering the multifaceted nature of grief responses among caregivers (Gamino et al., 2020). Maintaining an open ear to diverse expressions of grief is essential, and Aging Life Care Managers or counselors must guard against judging how individuals choose to navigate and express their grief. Recognizing that not every caregiver needs verbal processing to cope with loss underscores the importance of flexibility and individualized support in the caregiving journey.

Name ambiguous loss. When assisting families, we should start by identifying and naming ambiguous loss (Betz & Thorngren, 2006) associated with AD. Families often do not know how to describe what they are feeling or experiencing when coping with the devastating effect of AD. Naming what they are experiencing as ambiguous loss gives caregivers a word with which to understand and verbally share their experience. Additionally, it helps caregivers understand how they are grieving, whether they are more intuitive or instrumental, and the potential strengths and areas of concern with either process.

Along with ambiguous loss comes the loss of dreams and hopes associated with retirement. Betz and Thorngren (2006) note that losing identity while caregiving is not uncommon. For family caregivers of those with AD, their expected future has now significantly changed. Retirement has changed to focus on caregiving rather than all the hopes and dreams it started with. Additionally, once death occurs, retirement plans have further changed as caregivers are alone. In some ways, caregiving

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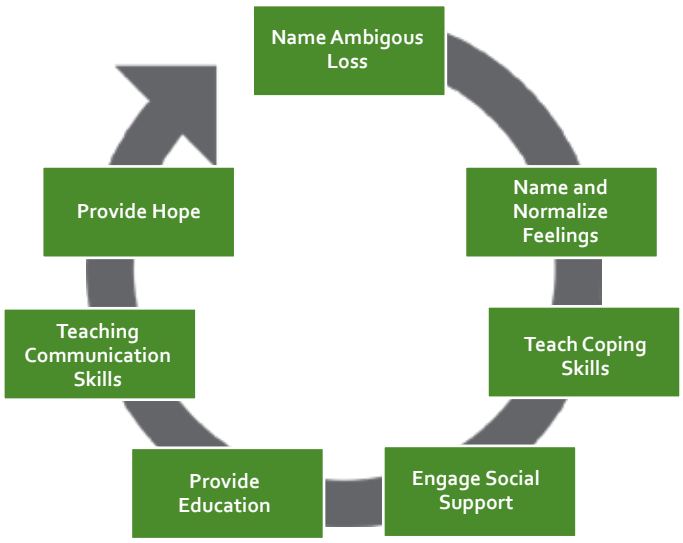
Figure 1 Seven Strategies for Mental Health Counselors



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provides purpose; for some, after death, that sense of purpose is lost.

Name and normalize feelings. Second, we can help caregivers name and validate their feelings (Alzheimer's Society, 2019; Granello & Fleming, 2008). We must be aware of the internal conflicts that caregivers experience (Brown & Kleist, 1999). It is common in this situation to feel shame or fear of judgment for their feelings. Aging Life Care Managers and mental health professionals can help families understand that the feelings of grief and loss they are experiencing are normal and expected to validate the family's feelings and provide a safe space for them to express their emotions. Using creative activities may be one way for counselors to encourage the expression of grief when words are too difficult. Creative expression allows one to slow down and explore feelings from a more external vantage point.

Develop coping skills. Coping strategies should address stress. Granello and Fleming (2008) note that stress can result in depression and anxiety for AD caregivers. Furthermore, the quality of life for individuals with AD is greatly influenced by the well-being of their caregivers. We can work with families to develop coping skills, such as relaxation techniques or mindfulness practices, to help them manage their emotions and stress levels. Mindfulness is filled with paradox, and it is important to help caregivers learn to think paradoxically by living with and tolerating ambiguity. For example, a caregiver may believe that they either need to take care of themselves or the person with AD. Paradoxical thinking suggests they can do both (Alzheimer Society, 2019).

Engage social support. Engaging social support becomes paramount in alleviating the isolation that often accompanies the caregiving role, particularly in the later stages of AD. Caregivers face unique challenges, including the inability to take breaks as the demands of caregiving intensify. In the advanced stages of AD, the progressive cognitive decline of the loved one contributes to a sense of psychological absence, further exacerbating the isolation experienced by caregivers. The emotional toll of witnessing this decline and the relentless nature of caregiving responsibilities create a potent catalyst for loneliness.

As caregivers navigate this challenging landscape, it is crucial to recognize how the dynamics of engaging with social support may evolve over time. In the face of increased caregiving demands, finding time for social connections can become even more challenging. However, seeking support remains essential for maintaining the caregiver's mental and emotional well-being. To facilitate this, caregivers are encouraged to explore community or extension health and wellness programs available through local universities. These programs can provide a valuable network of resources, including support groups and educational opportunities tailored to the specific needs of caregivers. Additionally, there are local chapters of Alzheimer's Disease organizations that work with families who have loved ones with neurocognitive diagnoses. Connecting caregivers with these resources offers a lifeline of support. It creates a space for caregivers to share experiences, gain insights, and find solace in the company of others facing similar challenges. This proactive engagement with social support is a crucial aspect of ensuring that caregivers are not alone in their journey and have access to the resources they need to navigate the complexities of AD caregiving.

Provide education about AD. Fourth, caregivers may need education about an AD diagnosis. Many families do not fully understand the stages of AD or the associated behaviors. Many also do not understand that this is not a diagnosis that improves; it progressively declines. Granello and Flemming (2008) note that education can reduce the stress associated with caregiving because caregivers more fully understand what to expect. Education should include the three primary stages of Alzheimer's Disease (early, mid, late) and associated behaviors. Education can be very helpful for caregivers who lean more toward an instrumental style of grief. Healey and Renes (2014) note that psychoeducation was instrumental in improving care both for the person with AD and the caregivers. Providing families with information and resources about AD, including its progression and potential treatments, will help families feel more prepared for the changes that will occur. At the same time, it is important to be aware that providing education too early in the relationship process may lead to other issues, such as grief and negative emotions, which may impact the family's ability to take in and process this information.

> Families often do not know how to describe what they are feeling or experiencing when coping with the devastating effect of ambiguous loss.

Families may also need assistance evaluating changes in their home environment. An acronym to help frame that discussion is SOCK.

S: Safety is paramount and becomes critical as the person with the AD diagnosis declines.

O: Organization may need to change as the individual gets more confused. For example, they may need more visual cues for how to do things or where things are.

C: Communicate in multiple forms.

K: Keep routines the same. This is important for someone with an AD diagnosis.

Teach communication strategies. Granello and Flemming (2008) note that caregivers must be aware of their nonverbal communication as much as their verbal communication. The Alzheimer's Association provides a helpful handout titled Compassionate Communication (2022). With a decreasing ability to verbally communicate, some people with AD have increased awareness of nonverbal communication. We can encourage open communication

between family members, which helps them to process their feelings and share their experiences. Guiding how to communicate effectively with loved ones and navigate difficult conversations is very important as well.

Provide and help maintain hope. Duggleby et al. (2009) note the importance of hope for caregivers of individuals with AD. We can be holders of hope, not by offering hope that the diagnosis will improve, but by reframing hope and what that means with an AD diagnosis. While a person with AD is not going to get better, hope emerges with acceptance of the disease, and there are ways to cope with the diagnosis as a caregiver. Duggleby et al. (2009) report that setting short-term goals contributes to greater hope. We can encourage families to focus on the present rather than dwelling on what has been lost. This can involve finding ways to enjoy their time with their loved ones and making the most of their shared moments.

Overall, Aging Life Care Managers and mental health professionals can help families cope with the ambiguous loss associated with AD by naming ambiguous loss; naming and normalizing feelings; developing coping skills; engaging social supports; providing education; teaching communication skills; and providing hope. We are poised to help families navigate this difficult and complex situation. Support is also critical post-caregiving. Caregiving is a physically, emotionally, and mentally exhausting experience; it is important to consider what support is needed after a loved one with AD dies.

Post Caregiving Support

Post-caregiving support refers to the assistance and resources provided to caregivers after they have completed their caregiving role. Figure 2 shows additional strategies for post-caregiving support.

1. Continued management and counseling - Caregivers can benefit from further counseling or therapy to help them cope with the emotional toll of caregiving. They can explore their feelings, process their experiences, and develop coping strategies for the future.

2. Support groups - Support groups provide a safe space in which to connect with others who have shared similar experiences. This helps caregivers feel less isolated and gives them a sense of community.

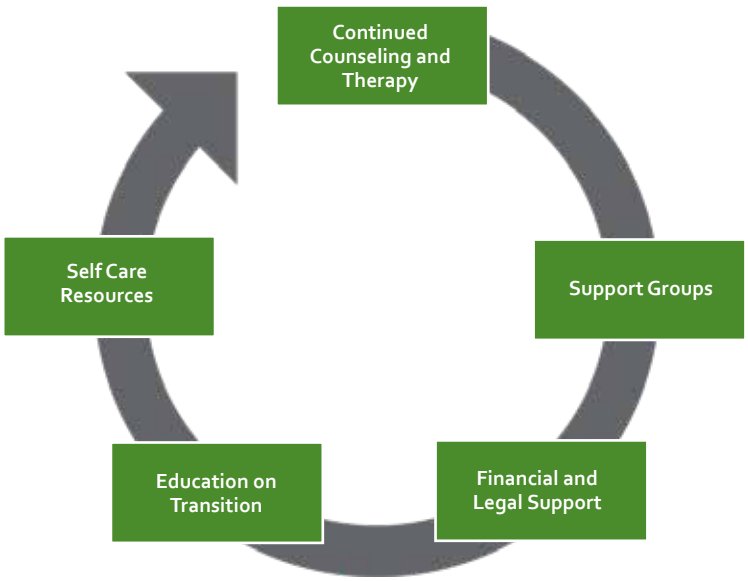
3. Financial and legal support - Caregivers may need assistance with financial or legal matters, such as managing finances or planning. Support can be provided through financial planning services, legal advice, or access to government assistance programs.

4. Education on transitions - Caregivers may benefit from education on the transition experience to help them prepare for their post-caregiving roles or improve their skills in areas such as communication, problem-solving, and stress management. Normalizing the experience of transition can be helpful in much the same way that normalizing ambiguous loss is.

5. Self-care resources - Caregivers may need resources and support to help them take care of their own physical and emotional well-being, such as exercise programs, relaxation techniques, or access to healthcare services.

Overall, post-caregiving support is crucial for caregivers to help them cope with the emotional toll of caregiving, take care of their own needs, and prepare for the future. By providing a range of support options, Aging Life Care Managers and mental health professionals can help caregivers feel empowered to navigate the challenges of post-caregiving life.

Figure 2 Strategies Post Caregiving



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Biographies

Daniel J. Koltz, PhD

Daniel J. Koltz, PhD received his doctorate in Leadership and Gerontology from Concordia University – Chicago and his Master's in Community Health from Montana State University. His current duties are between teaching in the gerontology undergraduate certificate program and Montana State University - Extension as a Gerontology Specialist. His research is focused on providing respite to caregivers and providing resources to Kinship caregiver programming with grant-funded projects of 1.25 million dollars focused on caregivers. He is also working to bring research-based healthy aging programming to all 56 counties in Montana to improve longevity and quality of life across the lifespan.

Rebecca L. Koltz, PhD

Rebecca L. Koltz, PhD, has been a licensed professional counselor for nearly 20 years, working with families, children, and adults. Her research interests center on understanding the challenges and strengths associated with rural counseling and exploring wellness and prevention across the lifespan with a specific focus on aging and caregiving. She uses creative and experiential approaches to teaching and counseling. She is the Principal Investigator on a 4-million-dollar grant focused on placing counseling students in rural communities to maintain the health and well-being of Montana rural communities.

Ancillary Service Use in the Seniors Housing Industry: Implications for a Rapidly Aging, Post-COVID World

By John Cantiello, PhD and Andrew Carle, MHS

ABSTRACT

This review outlines the housing and care needs of older adults. The findings presented in this paper are based on the analysis of survey results from a 2018 study on 50 American Seniors Housing Association (ASHA) member and non-member seniors housing provider organizations, the subsequent impact of COVID-19 on the seniors housing industry, and the continued aging and related service needs of the baby boomer population. The data analyzed in this review show that assisted living and independent living operators recognize the expanding care needs of their residents and are positioned to address them at some level. Implications for care coordinators, such as Aging Life Care Managers and other healthcare professionals, are also explored. Overall, the paper highlights the industry's potential to provide integrated care models that support the health and well-being of older adults.

Introduction

The Federal Interagency Forum on Aging-Related Statistics (2020) projects that the number of Americans aged 65 years or older is expected to grow from 56 million in 2020 to approximately 73 million in 2030, representing one in five residents. By 2034, the US Census Bureau further estimates that there will be more Americans over the age of 65 (77 million) than under the age of 18 (76.7 million) for the first time in the nation's history (U.S. Census Bureau, 2018). Because health problems, cognitive decline, and mobility limitations accompany the aging process (Pearson et al., 2019), the ability of seniors housing providers to document as well as improve health outcomes and seamlessly communicate information between consumers and health provider networks is becoming an increasingly strategic imperative. In the United States, seniors housing provides residential care to approximately two million older adults, almost evenly divided between independent and assisted living communities (Freedman & Spillman, 2014; Stevenson & Grabowski, 2010), with the industry projected to nearly double in size (to 3.8 million residents) by 2040 (Burnham Mace & Standish, 2019).

This paper outlines the housing and care needs of the aging baby boomer population and examines recently published literature to determine the extent to which assisted living and independent living operators are offering their residents coordinated access to ancillary health services. The findings presented in this paper are based on the analysis of a study conducted in 2018 by Cantiello and Carle. The study examined 50 American Seniors Housing Association (ASHA) member and non-member seniors housing provider organizations. The study findings are discussed and blended with current literature to highlight the extent to which assisted living and independent living community operators are forming relationships with providers that perform ancillary services. Commentary is made on how well the seniors housing industry is equipped to offer coordinated ancillary services. Particular attention is paid to the rationale for utilizing ancillary services in the industry and lessons learned from COVID-19.

The COVID-19 pandemic highlighted the importance of integrated care models that support the health and wellbeing of older adults, as they can offer a range of services and supports that can help to address a wide range of patient needs. Seniors housing communities are uniquely positioned to provide coordinated care to this population. It is important for Aging Life Care Mangers, advocates, and families to be familiar with housing options available to older adults that support their health and well-being. As such, implications for Aging Life Care Managers and other healthcare professionals are explored.

Background

Distinguishing Factors Between Assisted Living and Independent Living

Assisted living communities, also known as assisted living facilities, are residential communities that provide assistance with activities of daily living (ADLs) to individuals who require help with tasks such as bathing, dressing,

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and medication management. These communities typically offer a range of services and amenities, such as housekeeping, meal preparation, transportation, and social activities, to help residents maintain their independence and quality of life (National Center for Assisted Living, 2021). The market for assisted living has grown steadily over time and has become a key component of the U.S. long-term care system (Mollica et al., 2009). Assisted living represents a key middle ground option for adults who may require some help with ADLs, such as bathing or dressing, but do not require the level of skilled nursing care that is provided in a nursing home. Assisted living communities vary greatly with respect to size, ownership, services, and regulatory policies. Studies have shown that increases in the number of assisted living facilities are associated with decreases in the number of private-pay residents for nursing homes (Grabowski, Stevenson & Cornell, 2012), as they offer more appropriate and less expensive care for those who otherwise do not require skilled nursing services.

Independent living communities are living communities for healthy older adults who are active and able to live on their own. These communities offer residents an independent lifestyle and provide opportunities for them to connect socially with other people in the same age group (Witt & Hoyt, 2020). Residents of these communities usually do not require assistance with ADLs, but they can benefit from the services provided by their community for assistance with instrumental activities of daily living (IADLs) such as cooking, transportation, home maintenance, and housekeeping. While independent living communities do not directly provide health services, residents may access and purchase third-party home health and related ancillary services that are deliverable within the community.

The Impact of COVID-19 on the Seniors Housing Industry

The COVID-19 pandemic impacted most industries in the United States. However, the seniors housing industry was at the forefront of the pandemic. The seniors housing industry serves older people, who are at a higher risk for health complications if they contract COVID-19 (Kapadia, 2020). Consequently, this population represents one with an elevated vulnerability.

During the pandemic, many assisted living and independent living facilities implemented extensive safety protocols, including isolation policies, to prevent and slow the spread of COVID-19 (Kapadia, 2020). The Centers for Disease Control and Prevention (CDC) released isolation recommendations for assisted living communities to follow during the pandemic that were similar to recommendations for nursing homes (Centers for Disease Control and Prevention [CDC], 2020). Some of these isolation recommendations were quite strict, including months-long restrictions on visitors and other non-essential personnel to the community, elimination of group dining and activities, and in-room quarantine for up to 14 days for residents who were contact-traced to potential COVID-19 exposure. This social isolation likely increased loneliness and decreased the quality of life among seniors housing residents. Assisted living facilities, in particular, were significantly affected by COVID-19 in terms of the high number of positive cases and the implementation of numerous restrictions to curb the spread of the disease among their residents (Resnick, Galik, Holmes, & McPherson, 2021).

While occupancy rates within both assisted living and independent living facilities declined overall during the pandemic, they do appear to have made a strong comeback. In October 2023, the National Investment Center for Seniors Housing & Care (NIC) released data on seniors housing occupancy rates for the third quarter of 2023. The overall occupancy rate increased to 84.4%, which reflects an increase of 6.6 percentage points from a COVID-19 pandemic low of 77.8%. Assisted living occupancy rates were reported to be at 82.6%, up 8.7 percentage points from its pandemic low of 73.9% in 2021, but still below the pre-pandemic level of 89.6%. Independent living occupancy rates increased to 86.1%, up 4.5 percentage points from its pandemic low of 81.6% in 2021, but still below the pre-pandemic level of 89.6% (National Investment Center for Seniors Housing & Care [NIC], 2023).

In addition to long-term projections for growth, a factor contributing to the recent recovery in the seniors housing industry can be attributed to the effects of social isolation experienced during the COVID pandemic by those living alone, which more than doubled from a pre-pandemic level of 27% in 2018 to 56% in June 2020 (National Poll on Healthy Aging, 2020). The availability of vaccines in late 2020 and early 2021 made seniors housing communities and their congregate social settings more appealing for many seniors.

However, several long-term challenges will likely continue to affect seniors housing operators. The industry will need to address issues related to staffing and funding to ensure sustainability. Although staffing was a challenge before the pandemic, COVID-19 exacerbated the situation. Facilities are now facing even greater difficulties in attracting and retaining staff, especially since these are often low-paying jobs that are physically demanding (Bowers, 2023; Chatterjee, 2022). Efforts to increase staffing levels will be critical moving forward. In addition to staffing and workforce issues, the senior living industry is also contending with the financial aftermath of the pandemic, along with the difficulties posed by challenging economic conditions in general (Bowers, 2023). During the pandemic, assisted living facilities incurred losses of approximately $30 billion (Argentum, 2021a). These losses can be attributed to increased expenses, low occupancy rates, and staff shortages.

Ancillary Services in the Seniors Housing Industry

The use of ancillary services in the seniors housing industry is widespread, and these services are becoming increasingly popular (Senior Housing News, 2017a). Ancillary services include any services besides those typically offered in assisted or independent living facilities. While no formal definition exists, in general, ancillary services refer to additional business lines or service offerings that supplement the ongoing housing and care needs of seniors housing residents.

Often, ancillary services are billed separately and can be requested and utilized in an a la carte fashion. Some providers opt to bring the services in-house, while others provide them through third parties. There are realized benefits to both ancillary service models. The most popular ancillary care services are home health care, rehabilitation services, and hospice care (Adler, 2018).

In addition to improving the overall health and wellness of residents, a goal of providing ancillary services is to increase overall length of residency. It has been reported that the average length of stay in a retirement community is 22 months, down from 36 months in previous years (Liepelt, 2017). Ancillary services allow senior living facilities to retain residents longer, reducing turnover as well as the cost of vacant units and the marketing expenses required to fill them. In addition, as the entry age into a facility continues to increase across all levels of seniors housing, the ability to meet the needs of higher-acuity residents relies increasingly on ancillary and extended care services.

While ancillary services have the potential for added net revenue, there are many organizations in the seniors housing industry that have not explored adding ancillary services to their service line. As a majority private pay industry, many organizations are uncomfortable dealing with third-party providers and payers, with the growth of managed care further complicating the payments system by adding multiple payers and reimbursement mechanisms to the mix. Nonetheless, ancillary services provide a competitive edge to facilities in an increasingly competitive seniors housing environment. The opportunity to provide more complete care and strengthen the bottom line has not been lost on leaders in the seniors housing field. Rod Burket, Gardant Management CEO and National Center for Assisted Living board member, explained:

"If we don't do it directly ourselves, we want to have coordination and collaboration with all caregivers. We know that the more acuity, the more therapies we can offer in the building, the better it is for the resident and family, the longer they can stay. Or, their exodus to a hospital or nursing home gets shorter." (Senior Housing News, 2017b, para. 41)

> ...there is an opportunity for the industry to consider development of uniform quality measures that will allow comparison of access to ancillary services and health outcomes measures across all providers...

Although the majority of the services offered are home health, hospice, and rehabilitation, many senior living facilities are increasingly offering more ancillary services. Some of the more creative offerings include salons and spas, dentistry, acupuncture, gym and recreation centers, swimming pools, housekeeping, and transportation (Senior Housing News, 2019). The length of stay with facilities that offer a variety of ancillary services is about 12% longer than facilities without ancillary services (Adler, 2018). In 2018, Brookdale Senior Living saw a profit of $8.3 million based on the use of ancillary services (Adler, 2018).

A challenge many seniors housing facilities face is finding fully staffed ancillary services. Currently, there is already a labor shortage, specifically within healthcare services. It is predicted that by the year 2025, there will be a shortage of at least 500,000 home health aides, 100,000 nurse aides, and 29,000 nurse practitioners (Meola, 2019). To combat this labor shortage, many companies are using third-party services. In addition to staffing issues, Medicare may pay for some services, but new regulations and the amount of "red tape" around reimbursement and licensing has caused many facilities and companies to contract third-party services rather than start offering their own ancillary services. Medicare is additionally becoming stricter on services that are reimbursable. This is the case for almost every service, including rehabilitation services, home healthcare, cosmetic services, and dentistry (Adler, 2018). There is risk, however, to contracting with third-party services. Facilities and companies do not always have input into the service providers that the third-party companies hire or how the service providers are trained. Yet, the facilities assume accountability for these third-party companies; often, when these third- party companies are not performing well or providing a high quality of care, the contracting facility and residents are the ones that suffer. Some senior care facilities are training aides to provide a wide variety of services within facilities.

Methodology

Data reported in this review come from a 2018 survey of independent and assisted living facilities conducted by Cantiello and Carle (2018). In order to assess seniors housing industry readiness and/or preparation in meeting the coordinated health and technological needs of residents within independent and assisted living settings, Cantiello and Carle (2018) conducted a survey to determine the extent to which providers within independent and assisted living facilities were offering coordinated access to ancillary health services for independent or assisted living residents, tracking health and wellness outcomes, and using electronic health records (EHRs). Solicitations for online survey participation were distributed to approximately 200 American Seniors Housing Association (ASHA) member and non-member seniors housing provider organizations, resulting in 50 completed surveys.

Respondents included 16 of the

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ASHA 2017 Top-50 largest providers, along with mid- to small-size organizations, representing a total of approximately 1,500 senior housing communities, with 138,000 units nationwide. Of the total housing units, approximately 49,000 (36%) represented independent living, and approximately 87,000 (63%) represented assisted living (including memory care units). Among all respondents, 35 (70%) represented providers with 1-25 senior housing communities, 7 (14%) providers with 26-50 communities, and 8 (16%) providers with 51 or more communities. Quantitative analysis was applied to the data collected in order to gain an understanding of seniors housing providers' readiness and/or preparation to meet the health and wellness needs of residents within independent and assisted living settings.

Results

Analysis of the survey results revealed that, of the total housing units, approximately 49,000 (36%) represented independent living and approximately 87,000 (63%) represented assisted living (including memory care units). In terms of service mix, 37 respondents (74%) provided independent living services, while 49 (98%) provided assisted living services. In terms of services provided, 36 (72%) reported providing both assisted living and independent services, 13 (26%) provided only assisted living, and 1 (2%) reported providing only independent living services. Among all 50 respondents, a majority (39, or 78%) indicated offering residents access to at least one ancillary health service, via some form of formal (ownership or written) relationship.

In the 2018 study, among the 37 respondents providing *independent living* services, 32 (86%) reported offering residents formal access to at least one ancillary health service. Among respondents offering formal access, the ancillary health services most commonly available were *rehab* (27, or 84%), *private duty home health* (26, or 81%), and *primary physician care* (23, or 72%). The least reported ancillary service offered was *adult day care* (8, or 25%) (Figure 1). The research concluded that, while access across any ancillary service was lower on average than in assisted living (see Figure 1), the fact that every ancillary service is being formally offered at some level among independent living respondents suggests an awareness of the value of these services to residents, and the facilities' ability to enhance access to these services moving forward.

In the same survey, among the 49 respondents providing *assisted living*, 42 (88%) reported offering residents formal access to at least one ancillary health service. Among respondents providing access, the ancillary health services most commonly available were *rehab* (37, or 88%), *pharmacy* (37, or 88%), and *primary physician care* (31, or 74%). The least available ancillary service was *adult day care,* (15, or 36%) (Figure 2). While more than half of all assisted living respondents are offered formal access to 8 of the 12 ancillary services identified, there is opportunity for expansion to such access across all services.

FIGURE 1: ANCILLARY SERVICE ACCESS - IL

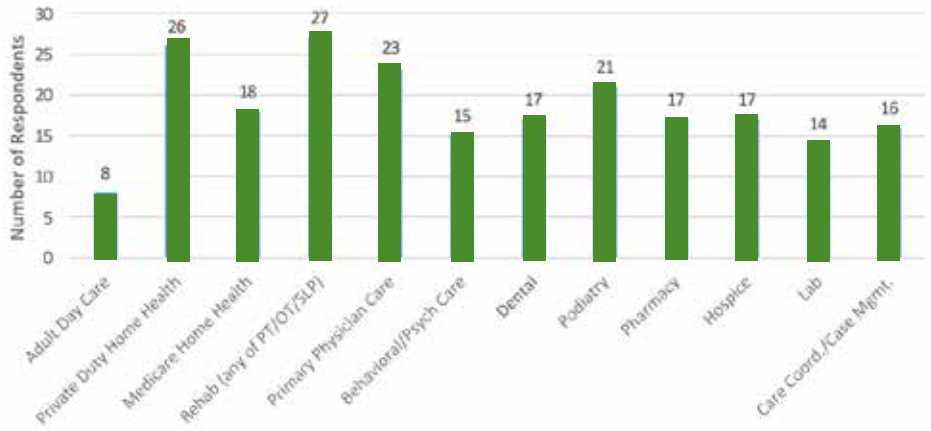
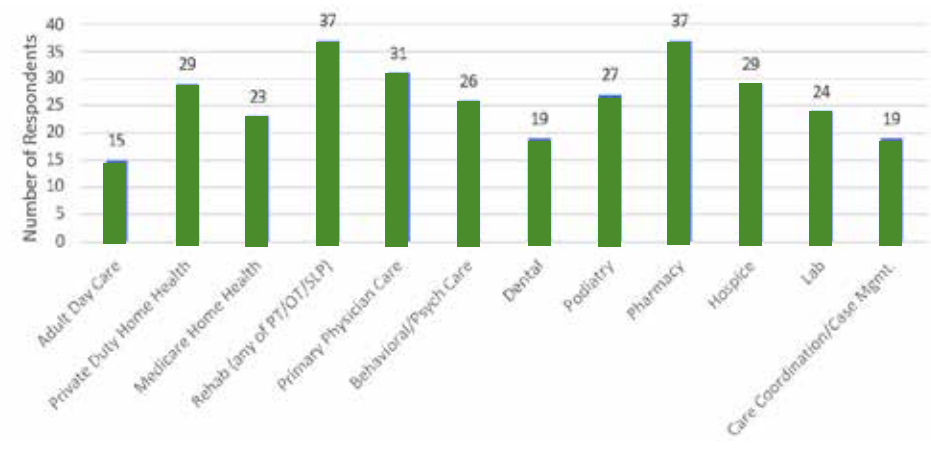


FIGURE 2: ANCILLARY SERVICE ACCESS - AL



The use of ancillary services in the seniors housing industry is widespread, and these services are becoming increasingly popular.

DIscussion

The survey responses discussed in this paper provide a snapshot of the extent to which independent and assisted living seniors housing operators address the ancillary health care needs of their residents. The survey identified the nature of formal relationships with health care providers and service providers.

Based on survey responses, large numbers of seniors housing providers already provide or are positioning themselves to provide their residents with access to ancillary health care and supportive services for documented health outcomes. The most offered ancillary services reported in both independent and assisted settings include rehab, private duty home health care, and primary care physicians. Most of these services are offered in the community itself and through some form of formal relationship between the community and the service provider.

With one of the nation's largest population segments aging and moving into retirement, the seniors housing industry is both poised for growth and facing many challenges. Some of those challenges include remaining competitive, providing appropriate and quality care for seniors, and meeting the unique challenges that the baby boomer generation faces. Ancillary care services address many of these industry challenges but come with their own set of challenges pertaining to cost and staffing.

As one response, the influence of technology allows care facilities to provide ancillary services and quality of care outcomes more efficiently with fewer staff. Implementing technology within seniors housing facilities and teaching seniors to access these technologies can lead to a better bottom line and increased provision of ancillary services. Furthermore, especially in the wake of COVID-19, the increased use of technology in the form of internet access for residents and telehealth capability improvements has the potential to improve both access and quality of life for residents.

In terms of COVID-19, the public health emergency, the greater understanding of the negative effects of isolation, and advances in telehealth, infection control, vaccines, and other mitigation strategies offer significant implications for the seniors housing industry. Many of the temporary measures and waivers that were put in place during the pandemic will expire, while others will improve quality of care and ability to respond to future viruses. For example, the Centers for Medicare & Medicaid Services (CMS) may begin enforcing pre-pandemic regulations related to staffing, infection control, and resident assessments, among others. In addition, the end of the public health emergency could result in changes to reimbursement rates, coverage requirements, and other policies that impact the seniors housing industry (Argentum, 2021b).

> The seniors housing industry holds the potential to assume a leadership role within a bundled pre- and post-acute care continuum.

Conclusions

In general, the survey responses analyzed in this review showed that assisted living and independent living operators recognize the expanding needs of their residents and are positioning themselves to address them. In this regard, there is an opportunity for the industry to consider development of uniform quality measures that will allow comparison of access to ancillary services and health outcomes measures across all providers, to which third-party payer organizations are accustomed, and which private pay consumers are soon likely to expect. Such development may allow seniors housing to document its unique competitive advantages toward becoming a significant player within both a pre- and post-acute care continuum.

The rapidly rising cost of healthcare in the United States is likely to play a critical role in the development of *bundled* third-party healthcare payers – whether in the form of accountable care organizations (ACOs), managed Medicare/Medicaid, or new models of single payer managed care organizations (MCOs) yet to be developed. In 2016, Medicare and Medicaid accounted for a total of $1.24 trillion, or 38% of total national health expenditures (NHE) (Cantiello & Carle, 2018). Of these NHEs, hospitalizations accounted for 32.8% percent as the largest single expense, with the largest preventable component being 30-day readmission rates of more than 17% (Centers for Medicare & Medicaid Services [CMS], 2016a). While readmissions have been the initial focus of CMS efforts to reduce costs, the long-term strategy for any government payer will likely require a greater focus on pre-acute care that can reduce or avoid initial hospitalizations, and other costs associated with chronic health conditions. Short of these approaches, both Medicare/Medicaid and their subset of hospitalization expenditures are expected to nearly double, to $2.36 trillion and $857 billion, on a total NHE of $5.7 trillion by 2026 (CMS, 2016b)

The baby boomer generation accounts for 74.1 million people, or 25% of the U.S. population (Exner, 2017). Educated consumers will seek seniors housing and care options that can return the most value on their retirement resources, with a focus on minimizing healthcare costs. In fact, a study by the American Seniors Housing Association (ASHA, 2018) found that seniors housing communities that provide access to integrated care services are more likely to be viewed as an attractive option by potential residents and their families (ASHA, 2018). At the same time, third-party payers will be seeking sources for referrals or incentivized partners that can document the ability to reduce not only readmissions, but initial hospitalizations and other chronic care costs as well.

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In an increasingly integrated healthcare setting, the significance of care coordination positions, such as Aging Life Care Managers, is set to become more pronounced, with the potential for formally staffed roles within senior housing environments. To this end, Aging Life Care Managers could work collaboratively with patients, families, and the healthcare team to address the social determinants of health, access to care issues, the coordination of services, and compliance with treatment recommendations. These are all tasks that Aging Life Care Managers regularly perform to improve health outcomes (Mayfield and Lambert, 2019).

The COVID-19 pandemic has accentuated the need for care coordination roles, especially in managing health disparities and care coordination for older adults. In a retrospective study that examined Medicare claims at a large health system during the pandemic, Smith et al. (2022) found that older patients who had four or more indicators for risk from delayed or missed care had higher mortality and steep declines in inpatient and outpatient utilization. This finding highlights the importance of care coordination among the older adult population. Lessons learned from the pandemic are likely to underscore the importance of the role of Aging Life Care Managers in helping to prevent delayed or missed care. Their contributions could be increasingly valuable in promoting better health outcomes and quality of life for patients and their families in a post-COVID world.

The seniors housing industry holds the potential to assume a leadership role within a *bundled* pre- and post-acute care continuum. This is particularly true in the wake of the COVID- 19 pandemic, which highlighted the importance of integrated care models that support the health and well-being of older adults. Seniors housing communities are uniquely positioned to provide this type of care if they can offer the range of services, care coordination, and supports to address a wide range of resident, family, and potential third-party payer needs.

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Approaches to Community Support for Older Adults and Alcoholism

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ABSTRACT

Alcohol misuse among older adults continues to be a rising public health concern in the United States and can be a challenge to address in community settings. Aging Life Care Managers have the capacity to make a difference with their work in communities dealing with older adults and problematic alcohol use. This article summarizes key areas of concern with older adults and alcoholism and discusses some screening tools and suggestions for community practice specific to Aging Life Care Managers.

Problems with misuse of alcohol among older adults remains one of the increasing public health concerns in our country (Blow, 2000; Koob, 2022; Yarnell, Li, MacGrory, Trevisan, & Kirwin, 2020). Aging Life Care Managers are trained to be aware of common aging health concerns such as sleep disturbances, increased risk of injury, inflammation, and risk of chronic health conditions; yet it is equally important to be mindful that alcohol misuse can accelerate age-related changes. As front-line professionals in health care encounters with older adults, Aging Life Care Managers can make a huge impact by having keen awareness of the unique challenges that come with alcohol-related concerns in older adults. This article serves as a professional update to encourage Aging Life Care Managers in their daily work and to provide information pertinent to community support for alcoholism and older adults.

First of all, older drinkers are prone to alcohol-induced issues with memory, coordination, balance, reaction time, and the ability to drive a car (White, Orosz, Powell, & Koob, 2023). Taking more medications can also be associated with aging, and medications taken alongside drinking alcohol can pose negative effects to older adults and their ability to live independently. Koob (2022) reports that older adults have a greater likelihood of higher blood alcohol concentrations compared to younger adults when drinking a similar amount of alcohol because of differences in physiology and the increased challenge of metabolizing alcohol. What this means is that older adults can develop alcohol-related issues such as falls, injuries, or liver damage simply by drinking a similar amount of alcohol as younger adults. Some reasons why older adults cannot successfully drink large amounts of alcohol are that older people have less lean body mass and less total body water than younger adults, and the central nervous system is more sensitive to the effects of alcohol (NIH, 2020).

Older women may be even more vulnerable to health concerns related to drinking alcohol than older males due to gender differences in physiology and the ability to process alcohol in the body (Koob, 2022; Mauro, Askari, & Han, 2021; NIH, 2020). As older women age, issues with metabolism, hormonal and menopausal issues, mobility problems, and other illnesses place them at risk for health concerns and specialized treatment needs (Mauro, Askari, & Han, 2021; Rowan, 2012). On top of these special issues of women's health, it is important to recognize that members of minority groups such as sexual minority (e.g., lesbian, gay, bisexual) and gender minority (e.g., transgender) also have heightened needs for specialized screening, assessment, and treatment when it comes to drinking alcohol. Unique social stressors, often referred to as minority stress, can play an important role in alcohol use disorders (AUD) and enhance the need for timely screening, assessment, and treatment. Minority stress can be described as the stress that comes with being a member of a minority in society and having to deal with prejudice, discrimination, and stigma with expectations of rejection and concealing of one's identity in order to function (Meyer, 2007). Research findings demonstrate the importance of paying attention specifically to sexual minority women and the connection to hazardous drinking (Lewis et al., 2021; Rowan & Butler, 2014). For example, Rowan and Butler (2014) found that it is especially helpful to connect clients with therapists or health care providers who preferably are members of lesbian communities or who can connect older lesbians with alcoholism to community support with specific outreach to sexual minority groups, such as

Alcoholics Anonymous. Community self-help support groups can help to reduce stigma, shame, and isolation, particularly if there are welcoming introductions made and assistance in locating specialized groups.

Many older adults who misuse alcohol can benefit from screening of alcohol use and some brief education to reduce ongoing health risks. If older adults show symptoms of sleep problems, memory loss, depressed mood, anxiety, aches/pains, poor diet, or loss of sexual interest, these can be indicative of alcohol misuse (NIH, 2020 2020). Healthcare professionals can provide screens such as The Alcohol Use Disorders Identification Test (AUDIT: Babor, de la Fuente, Saunders, & Grant, 1992), the Short Michigan Alcoholism Screening Test-Geriatric Version (SMAST-G: Blow, et al., 1992), or CAGE (Ewing, 1984). Screening for issues with alcohol combined with a brief intervention from health care providers can prevent costly interventions after prolonged alcohol misuse. Perhaps Aging Life Care Managers can work alongside a primary health provider and consult with licensed addiction specialists to provide screening and brief intervention in medical or community settings.

In conclusion, some of the main takeaways for Aging Life Care Managers concerning older adults and alcoholism are:

1. Keep in mind the potential added health risks for older adults and drinking alcohol. The recommended guidelines are that older women consume one drink or less a day, and two drinks or less a day for men (Office of Disease Prevention & Health Promotion, 2021).

2. Rethinking Drinking, from the National Institute on Alcohol Abuse and Alcoholism, is an online resource that provides useful information on reassessing drinking. It is important to talk with older adults about drinking alcohol and ask questions using screening tools in order to catch drinking problems as early as possible.

3. Asking older adults and their caregivers about drinking alcohol can assist in bringing down medical costs and make a tremendous impact on the overall health of older adults.

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