Approved: February 15, 2011
Date

MINUTES OF THE HOUSE AGING & LONG-TERM CARE COMMITTEE

The meeting was called to order by Chairman Bob Bethell at 9:00 am. on February 8, 2011, in Room 144-S of the Capitol.

All members were present except :
Representative Scott Schwab - absent

Committee staff present:
Katherine McBride, Office of Revisor of Statutes
Gordon Self, Office of Revisor of Statutes
Iraida Orr, Kansas Legislative Research Department
Craig Callahan, Kansas Legislative Research Department
Evelyn Walters, Committee Assistant

Conferees appearing before the Committee:

Jim Snyder, Kansas Silver Haired Legislature
Rick Cagan, Executive Director, NAMI/Kansas
Craig Kaberline, KS Area Agency on Aging Assn.
Mitzi McFatrich, KS Advocates for Better Care
Sky Westerlund, KS Chapter of National Assn of Social Workers
Amy Campbell, KS Mental Health Coalition
Debbie Holroyd, Alzheimer's Assn.
Steve Denny, Four Counties Mental Health Center
Don Strong, Mid KS Senior Outreach
Ernest Kutzley, AARP
Michelle Sweeney, Assn. Of Community Health Centers of KS, Inc.
Joe Ewert, KAHSA
Michelle Niedens, Alzheimer's Assn., Heart of America Chapter

Others attending:
See attached list.

Hearing on:
HB 2047 – Enacting the geriatric mental health act

Proponents:
Jim Snyder, speaker for Kansas Silver Haired Legislature, spoke in strong support of the program and it's need for the elderly constituents. (Attachment 1) Mr. Snyder also presented past testimony of Bryce Miller. (Attachment 2).
Rick Cagan, Executive Director of NAMI Kansas, spoke in support of the bill and need to provide greater focus in the provision of mental health services to the elderly. (Attachment 3).
Questions were asked by Representative Weber, Representative Moore, Representative Worley, and Chairman Bethell.
Craig Kaberline, Executive Director, KS Area Agency on Aging Assn., spoke in support of the need of this bill to address improve the quality of life for elderly in Kansas and to reduce health care and the costs of premature nursing home placement. (Attachment 4). A question was asked by Representative Weber.
Mitzi McFatrich, KS Advocates for Better Care, spoke in strong support of this bill. (Attachment 5).
Sky Westerlund, National Assn. of Social Workers, Ks Chapter, presented testimony in support of the bill (Attachment 6) and she requested support of an amendment to clarify who the providers of services are: which would be physicians, nurses and persons licensed by the behavioral-sciences regulatory board. A question was asked by Representative Moore. Chairman Bethell indicated to committee members that the amendment would be included in their bill book.
Amy Campbell, KS Mental Health Coalition, testified in support of the bill. (Attachment 7).
Debbie Holroyd, Outreach Coordinator, Alzheimer's Assn., spoke in support of the bill and agreed to provide data at the conclusion of the Dementia Bridge project to the committee. The written testimony was provided by Michelle Niedens, Alzheimer's Assn., Heart of America Chapter, (Attachment 8).

Written testimony in support of the bill was also provided by Steve Denny, Four Counties Mental Health Center, (Attachment 9). Don Strong, Mid KS Senior Outreach, (Attachment 10). Ernest Kutzley, AARP, (Attachment 11). Michelle Sweeney, Assn. Of Community Health Centers of KS, Inc. (Attachment 12). and Joe Ewert, Kansas Association of Homes and Services for the Aging. (Attachment 13).

No other conferees on **HB 2047.**

Chairman Bethell closed the hearing.

The next meeting is scheduled for February 10, 2011.

The meeting was adjourned at 9:40 am.

HOUSE AGING AND LONG TERM CARE COMMITTEE

DATE: 2/8/11

NAME	REPRESENTING
Travis Lowe	Little Govt Relations
Jim Snyder	SHC
Nathan Lindsey	Kearney + Associates
Debbie Hibnard	Alzheimers Association
Sky Westerlund	KNASW
Craig Koberline	KAA
Melissa Ward	Hein Law Firm
Ted Heuer	CS.
Mitzi McStrick	KABC

PLEASE USE BLACK INK

KANSAS SILVER HAIRED LEGISLATURE

503 Kansas Ave., Topeka, KS 66603 (785) 368-7326 silverhaired.legislature@aging.ks.gov

State-wide Geriatric Mental Health Program
House Aging & Long Term Care Committee
February 8, 2011

I am Jim Snyder, Speaker of the Kansas Silver Haired Legislature. I am here to present the urgent need for a Kansas Geriatric Mental Health program this year, in total or at least enough to get a practical program started. This is covered in House Bill 2047. We strongly favor this program.

Approximately 20% of community dwelling older individuals experience mental health problems. These include anxiety disorders, mood disorders such as depression, severe cognitive problems (Alzheimer's disease and other dementias). In addition, substance abuse—a significant issue—raises this percentage even higher.

In nursing facilities, the percentage of mental health issues increase from 60 to 80% of the population. Today, the highest rate of suicide is for males age 85 and up, and the 2nd highest rate is among adults age 75 to 84. The 85 & up group's suicides is six times higher than that for the general population.

Older adults do not receive adequate treatment. Many times, present case-workers can identify there is some sort of problem, but due to a number of built-in feelings—the stigma of mental problems....the shame of it all...loss of independence...being viewed as incompetent...and others—these older adults are reluctant to use present help such as mental health centers even if it were possible for them to get there physically. However, if treatment were available in more comfortable and accessible surroundings, chances improve that a more successful outcome would prevail.

The program as urged by the Silver Haired Legislature would insure treatment for this group of people. It would be implemented by the 11 Area Agencies on Aging (AAA's) across Kansas. The Kansas Department on Aging would administer and distribute the funds which the AAA's would use for <u>education, outreach, and direct services.</u>

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ATTACHMENT # 1

Education on mental health issues, signs, symptoms, treatment options would be provided to professional and direct care staff and service providers...including CNA's home health aides, community service providers, administrators, social workers, nurses, and physicians. This will include mental illness education—it's prevalence among older adults, differences between normal aging & mental illness, and diagnosis, treatment and good mental health maintenance.

Outreach would help target early identification, early intervention and prevention. This would be provided at locations used by older adults and their families such as doctors' offices, senior centers and religious organizations.

Direct Services would be provided by qualified mental health providers including the home, nursing home, community setting, community mental health center, or other mental health providers.

All parties concerned with this proposed program are confident it will provide an array of services that mental health and aging advocates have been working toward for many years. This program will take Kansas a long way in addressing needs of older adults and will position Kansas well for potential funding and programs currently provided at the national level. Programs including the Positive Aging Act, STOP Senior Suicide Ace, and other programs through the Administration on Aging.

Thank you.

& AGING COALITION

Kansas Mental Health Coalition

Topeka, Kansas

MARCH 13, 2008

Testimony presented to the Legislative Budget Committee
Re: HB ~~2236~~ 2752 Geriatric Mental Health Act

ON BEHALF OF THE KMHC

It is a pleasure to testify today regarding HB ~~2236~~ 27, a geriatric mental health act for Kansas. In case you are wondering older adults are those considered 60 years and older.

My name is Bryce Miller, Topeka, Kansas, a 76-year-old volunteer and mental health advocate. I was diagnosed with bipolar disorder in 1974 and have been in recovery mode for over 34 years.

In addition to being a state employee for 19 years as a management analyst and retiring in 1993, I have had numerous advocacy, volunteer roles in the mental health field.

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Advocacy positions I have had include:

1. Board member, National Alliance on Mental Illness (NAMI Kansas)
2. Board member and consumer representative, National Alliance on Mental Illness, Arlington, VA (NAMI)
3. Co-founder, Breakthrough House Inc., Topeka, KS
4. Governor's Mental Health Services Planning Council

In 2002, I traveled to Washington, D.C., to testify before the President's New Freedom Commission on Mental Health re: improvements needed in the older adults mental health system.

There is a quiet crisis in Kansas surrounding the older adults mental health system. However, in my

opinion a major crisis is about to erupt because of the arrival of the first wave of boomers.

Improved, more cost effective methods for improving the older adult mental health system in Kansas include:

A. Improved collaboration between stakeholders including private and public mental health professionals, community mental health centers, area adult associations, state agencies and non-profit mental health agencies. Timely and prompt treatment of depressed older adults.

B. Improved and timely mental health education for patients. It has been estimated that 80 percent of depressed older adults don't understand depression and the various treatments.

C. Provision of older adult peer support groups (facilitated by older adults). See attached DBSA Colorado Springs pamphlet. Note the "Later Life Support Group" meets every Wednesday at 12:30 p.m. in the Colorado Springs Senior Center.

2752
HB [redacted]eeds to proceed and the Kansas Department on Aging we believe is the proper state agency to administer the system by utilizing existing AAA organizations. Thank you for your consideration. [redacted] ?

NAMI Kansas
National Alliance on Mental Illness

Committee on Aging & Long Term Care

February 8, 2011

Presented by:
Rick Cagan
Executive Director

NAMI Kansas is a statewide grassroots membership organization dedicated to improving the lives of individuals with mental illness. Our members are individuals who are living with mental illnesses and the family members who provide care and support. NAMI Kansas provides peer support through a statewide network of local affiliates. We sponsor educational programs targeted at consumers of mental health services, their family members, and the general public. We advocate for individuals who are living with mental illness to ensure their access to treatment and supportive services.

We stand in support of House Bill 2074 and the need to provide greater focus in the provision of mental health services to the elderly.

More than a decade ago NAMI reported that suicide rates in older persons were on the rise; yet symptoms of depression were rarely recognized and treated among the elderly. As many as 90 percent of older persons who have depression did not get treatment for this disorder. We learned that depression is not the outcome of the natural processes of aging. Among Americans 65 and older, a reported five million suffered from serious and persistent symptoms of depression. Another one million suffered from major, or clinical, depression. Current estimates suggest that by 2030, 15 million older adults will suffer from a mental illness.

From 1980 to 1992, the suicide rate among persons 65 and older increased nine percent, and most striking was a 35 percent rise in rates of suicide for men and women age 80 to 84. The suicide rate among males 85 years and older was six times the rate of the general population. All but a handful of older people who committed suicide were suffering from depression, but a prominent researcher from the National Institute of Mental Health stated that "...misunderstandings about the nature of the aging process itself may cause the individual, the family, and even the health care professional to fail to recognize the symptoms of the disorder in older persons afflicted with multiple illnesses."

It has been well documented that older persons who were suicidal visited their primary care physician in the month before killing themselves, with nearly 40 percent making that visit in the week before committing suicide. It was concluded that doctors may not associate an older person's behavior with depression since the classic symptoms of sadness and withdrawal are frequently replaced with irritability or apathy.

Further data suggest the following relative to the need for focused mental health services for the elderly:

- Approximately 25 percent of the elderly experience significant clinical depression.
- Approximately 10 percent of the elderly suffer from dementia.
- Seniors are at the highest risk for suicide, out of all age groups in the American population.
- Primary care physicians identify mental illnesses only 50 percent of the time, although 25 percent of all patients seen in a primary care setting have a mental illness.

A 2001 report from the Administration on Aging on older adults and mental health identified an emerging "national crisis in geriatric mental health." A critical concern is the expected jump in the nation's elderly population as baby boomers begin to enter this age group. It was estimated that in less than thirty years, older adults will account for 20 percent of the population. The report noted that for the age group of 55 or older, 20 percent of Americans experienced a mental illness with some evidence showing that the occurrence of these illnesses may be under-reported. Also, suicide occurs at a higher rate in older adults than in any other age group.

The report also found that older Americans were denied access to needed treatment and services and cited several barriers to access such as a fragmented mental healthcare system, inadequate funding for treatment and services, services gaps, lack of professional training for the delivery of geriatric mental health treatment and services, and poor collaboration and coordination among providers. Stigma surrounding mental illnesses was also cited as a barrier to mental health care.

In order to meet the needs of older adults with mental illnesses, several strategies were identified in the report to ensure that appropriate and effective treatment and services will be available to the elderly. Most of these are germane to the issues anticipated in the presentation of HB 2047.

- Prevention and early intervention services
- Workforce issues: shortage of qualified providers and the need for educating providers regarding the specific needs of the elderly
- Coordinating and strengthening the financing of mental health services
- Increasing collaboration among providers and with consumer groups
- Ensuring access to affordable, comprehensive, quality mental health care
- Increasing public awareness and education
- Expanding research into aging and mental illness
- Encouraging consumer involvement
- Addressing the needs of multi-cultural populations

There has been an explosion of research into depression among the elderly which has yielded significant progress in understanding the nature, clinical course, and treatment of this serious disorder. Early recognition, diagnosis, and treatment can translate into the prevention of suffering or premature death and enhanced independence and functioning for the elderly. Social supports, especially from the family, are essential in treating an older person with depression.

A 2005 report from the Substance Abuse and Mental Health Services Administration (SAMHSA) focused on research findings on older adults and mental health with an emphasis on the stigma associated with mental illness among the elderly. One of the two strategies selected by the report as most promising to effect change was to empower and educate older adults with mental illnesses.

Another SAMHSA report from 2005 identified principal areas of focus to ensure meaningful mental health services for the elderly. These included screening and assessment by health care providers, home and community-based mental health outreach services and mental health treatment, and the integration of behavioral health care into medical settings.

It is in the context of these repeated findings over the last decade and more that we are now called on to provide some focus in the delivery of mental health services to the elderly in Kansas. NAMI Kansas urges the adoption of HB 2047 as a positive step in this direction.

Thank you for the opportunity to appear before the Committee today to address these critical issues.

KANSAS
AREA AGENCIES
ON AGING
ASSOCIATION

Meeting the Needs of Older Kansans

2910 SW TOPEKA BOULEVARD • TOPEKA, KS 66611 • 785-267-1336 • FAX - 785-267-1337

Testimony to the House Aging & Long-Term Care Committee Regarding HB 2047 - Geriatric Mental Health

February 8, 2011

The Kansas Area Agencies on Aging Association (K4A) represents the 11 Area Agencies on Aging (AAA) in Kansas, who collectively serve all 105 counties of Kansas. In Kansas, Area Agencies on Aging are the "single points of entry," that coordinate the delivery of publicly funded community-based services that seniors and their caregivers need. The Area Agency on Aging system is funded by federal, state and local resources, and administered locally. Service delivery decisions are made at the community level—often in the homes of the seniors who need those services. The Area Agencies on Aging carry out their federal mandate as "the Leader" on aging issues at the local level. The Kansas Area Agencies on Aging Association works to improve services and supports for all older Kansans and their caregivers.

Whether you are an older Kansan or a caregiver concerned about the well-being and independence of an older adult, Area Agencies on Aging are ready to help. Area Agencies on Aging in communities across the state, plan, coordinate and offer services that help older adults remain in their home - if that is their preference. Services such as home delivered meals and a range of in-home services make independent living a viable option. Area Agencies on Aging make a range of options available so that seniors choose the services and living arrangement that best suits them.

I appreciate the opportunity to appear before you today in support of HB 2047- geriatric mental health act. If Kansas wants to improve the quality of life for elderly Kansans and to reduce health care and the costs of premature nursing home placement, geriatric mental health is a great place to invest.

As we age, many people believe that it is normal or expected that a person should become more depressed. But that's not the case. Depression is not a normal part of aging, and studies show that most seniors feel satisfied with their lives, despite increased physical ailments. However, when older adults do have depression, it may be overlooked because seniors may show different, less obvious symptoms, and may be less inclined to experience or acknowledge feelings of sadness or grief.

According to the National Institute of Mental Health, depression often co-occurs with other serious illnesses such as heart disease, stroke, diabetes, cancer, and Parkinson's disease. Because many older adults face these illnesses as well as various social and economic difficulties, health care professionals may mistakenly conclude that depression is a normal consequence of these problems—an attitude often shared by patients themselves. These factors together contribute to the under diagnosis and under treatment of depressive disorders in older people. Depression can and should be treated when it co-occurs with other illnesses, for untreated depression can delay recovery from or worsen the outcome of these other illnesses. The relationship between depression and other illness processes in older adults is a focus of ongoing research.

Across the nation, numerous studies have concluded that our senior population has the highest rate of

depression, anxiety and suicide. The studies also indicate that they often go untreated and undetected because of views towards aging and lack of recognition by medical professionals. We must look to design mental health programs for our current senior population that meets their mental health needs. If we want to address the mental health needs of seniors, the program needs to reach seniors where they are and that means providing the services in the home, apartment, assisted living or nursing home.

Older adults with symptoms of mental illness represent a rapidly emerging group in Kansas. However, few of these older Kansans, their families, or their caregivers are knowledgeable about mental health and how to access needed services and resources. In addition, health care systems have failed to adequately identify and address the complex and challenging needs of seniors who exhibit symptoms of mental illness and physical problems commonly related to aging.

The Association and its members believe this is an important area that the State of Kansas needs to address because of the ever increasing elderly population. By not adequately identifying and providing appropriate mental health care to older adults we are greatly increasing the possibility of premature institutionalization. We need to design a geriatric mental health program that will meet the needs of Kansas seniors regardless of where they reside. Whether the senior resides in their own home, apartment, assisted living or nursing facility, we must work on outreach, education and appropriate mental health services for this population.

If we can address mental health needs of this population, we can conceivably delay the need for nursing home care for some and save the state money on health care costs on the other end. Most importantly, we improve the quality of life for the senior population of Kansas.

Thank you for listening and I ask for your support of HB 2047.

National Strategy for Suicide Prevention

A Collaborative Effort of SAMHSA, CDC, NIH, HRSA, IHS

NATIONAL STRATEGY FOR SUICIDE PREVENTION

At a Glance - Suicide Among the Elderly

- The highest suicide rates of any age group occur among persons aged 65 years and older.
- There is an average of one suicide among the elderly every 90 minutes.
- In 1998, suicide ranked as the sixteenth leading cause of death among those aged 65 years and older and accounted for 5803 deaths among this age group in the U.S..
- Suicide disproportionately impacts the elderly. In 1998, this group represented 13% of the population, but suffered 19% of all suicide deaths.
- The rate among adults aged 65-69 was 13.1 per 100,000 (all rates are per 100,000 population), the rate among those aged 70-74 was 15.2, the rate for those aged 75-79 was 17.6, among persons aged 80-84 the rate was 22.9, and among persons aged 85+ the rate was 21.0.
- Firearms (71%), overdose [liquids, pills or gas] (11%) and suffocation (11%) were the three most common methods of suicide used by persons aged 65+ years. In 1998, firearms were the most common method of suicide by both males and females, accounting for 78% of male and 35% of female suicides in that age group.
- Risk factors for suicide among older persons differ from those among the young. In addition to a higher prevalence of depression, older persons are more socially isolated and more frequently use highly lethal methods. They also make fewer attempts per completed suicide, have a higher-male-to-female ratio than other groups, have often visited a health-care provider before their suicide, and have more physical illnesses.
- It is estimated that 20% of elderly (over 65 years) persons who commit suicide visited a physician within 24 hours of their act, 41% visited within a week of their suicide and 75% have been seen by a physician within one month of their suicide.
- In 1998, men accounted for 84% of suicides among persons aged 65 years and older.
- Suicide rates among the elderly are highest for those who are divorced or widowed. In 1998, among males aged 75 years and older the rate for divorced men was 3.4 times and widowed men was 2.6 times that for married men. In the same age group, the suicide rate for divorced women was 2.8 times and widowed women was 1.9 times the rate among married women.
- Several factors relative to those over 65 years will play a role in future suicide rates among the elderly, including growth in the absolute and proportionate size of that population; health status; availability of services, and attitudes about aging and suicide.

Kansas Advocates
for
Better Care

February 7, 2010

Rep.Bob Bethell
Chairman House Aging & Long-Term Care
Topeka Statehouse
Capitol Office Room: 55C-S

Dear Chariman Bethell, Vice Chairman Worley and Members of the Committee,

Thank you for hearing testimony this morning on HB 2047. Elders and persons with disabilities receiving long-term care in any setting will have experienced many major life transitions and losses. Their need for access to mental health care is critically important for their mental, emotional and physical functioning.

Kansas Advocates for Better Care strongly supports the provisions of this legislation. We are acutely aware of the lack of mental health assistance for persons living in nursing homes and assisted living and routinely assist families in trying to identify mental health support and resources for a loved one living in a long-term care setting. KABC supports the provisions of this geriatric mental health bill and applaud the access and intervention/treatment for persons using long-term care offered by competent mental health providers.

For many persons living in long-term care settings the ability to access services through the current mental health system is limited due to 1) their level of frailty, 2) their lack of transportation, 3) the lack of qualified personnel within a facility to address their mental health needs, and 4) the stigma associated for elders with requesting help and specifically mental health assistance. Many persons living in facilities have access to support and pastoral counseling, and from social service staff or their designee. Having been a pastor I am aware that my skills were not always up to the needs of my parishioners, and I did not hesitate to facilitate their work with a more skilled mental health professional. Persons in adult care homes are dealing with some of the most significant issues of life, loss of familiar home, loss of spouse, family friends and their social network, end of life contemplations, dependence on others to name a few. Most make the transition with help and support from some corner, many would welcome support to address such major life challenges.

I hope you will look favorably on this legislation and move it forward.

Kansas Advocates for Better Care is a non-profit organization that has been serving the needs of elders and persons with disabilities and advocating for improved long-term care in nursing homes and assisted living facilities for 35 years.

Thank you,

Mitzi E. McFatrich

Mitzi E. McFatrich
Executive Director
785-842-3088 or mitzim@kabc.org

HOUSE AGING & LTC
DATE: 2/8/11
ATTACHMENT # 5

913 Tennessee Suite 2 Lawrence,
phone: 785.842.3088 fax: 785.749.0029 toll-free: 800.525.178

TESTIMONY on HB 2047

February 8, 2011
House Aging and Long Term Care
Presented by Sky Westerlund, LMSW

Good morning Chairman Bethell and members of the Committee, I am Sky Westerlund, Executive Director of the Kansas Chapter, National Association of Social Workers. Thank you for the opportunity to visit with you this morning about HB 2047.

KNASW supports the need for mental health services for the aged populations. HB 2047 provides necessary services and treatment in the person's residence, wherever that may be. The flexibility of being able to visit clients in their own home increases the access to care.

KNASW identified some language that could be confusing regarding the providers of mental health treatment. The language "qualified mental health professionals" is vague. In order to avoid confusion and include all of the appropriately licensed persons who can provide mental health treatment we offer an amendment that includes three groups of people: physicians; nurses; and persons licensed through the Behavioral Sciences Regulatory Board.

This language clarifies who is qualified to provide the mental health treatment in an elder's home or other place of residence. KNASW asks for favorable passage of the amendment and the legislation.

Jayhawk Towers, 700 SW Jackson Street, Suite 801, Topeka, KS 66603-3
(785) 354-4804 • FAX: (785) 354-1456 • sky@knasw.com • www.knas

KANSAS MENTAL HEALTH COALITION

An Organization Dedicated to Improving the Lives of Kansans with Mental Illness

The Kansas Mental Health Coalition is comprised primarily of statewide organizations representing consumers of mental health services, families of consumers, community service providers and dedicated individuals as well as community mental health centers, hospitals, nurses, physicians, psychologists and social workers.
We all share a common goal: improving the lives of Kansans with mental illness.

Testimony presented to the
House Aging and Long Term Care Committee on House Bill 2047
February 9, 2011
By Amy A. Campbell

The Kansas Mental Health Coalition supports HB 2047 which would expand mental health services targeted to the needs of older Kansans. This measure has been nicknamed the "Bryce Miller Act" in honor of Bryce Miller – a long time state employee and tireless mental health advocate who mastered his own battle with mental illness and continued to be a productive contributing citizen of Topeka. His advocacy work was an example to all of us. Bryce cared deeply about improving the lives of people with mental illness and seniors, in particular. He researched solutions and pursued them with energy and passion. The Geriatric Mental Health Act was his number one priority when he passed away.

Older adults have unique mental health needs. Specialized services are more effective in reaching this growing population than standard centralized mental health services. It is important to reach out to older adults in the community and through primary health care providers and community based in-home visits in order to effectively evaluate an individual's needs and educate them about modern mental health care and its positive effects.

The objectives of HB 2047 build on the successes of the mental health programs currently offered in Kansas for seniors – while offering the opportunity to improve the capacity and quality of those programs and expand such services to other communities.

Research shows that older adults are less likely to access mental health treatment by independently reaching out to their local mental health providers. Offering access to treatment in a non-threatening manner which minimizes social stigma, in coordination with other community based health services, can reap more immediate and effective success. Mental health treatment works – it is just a question of making certain that the right type of services are available to our older adults and that they are encouraged to access the care they need. Empowering older adults with effective treatment for depression, anxiety, and all too often accompanying drug or alcohol abuse can postpone the need for more intensive inpatient or residential care.

This bill requires agency collaboration and provides services in a variety of home settings. These are important elements of providing effective treatment delivery to Kansans who are not likely to reach out to their local mental health center for care. The program is specifically designed to break through some of the common barriers that prevent important care from being delivered to seniors. The effective delivery of mental health treatment can also have powerful benefits for family members and caregivers.

The Kansas Mental Health Coalition supports HB 2047 and the work of the Kansas Mental Health and Aging Coalition in bringing this initiative to the forefront. Please support this legislation this session, along with the necessary funding for implementation.

KMHC, PO Box 4103, Topeka, KS 66604 PH: 785-

HOUSE AGING & LTC

DATE: 2/8/11

ATTACHMENT # 7

Aging and Long Term Care Committee
Testimony on Geriatric Mental Health
H.B. 2047
Michelle Niedens, L.S.C.S.W.
Alzheimer's Association, Heart of America Chapter
February 9, 2011

Chair Bethell and Members of the Committee:

The availability of competent geriatric mental health care is a special concern for those individuals and family members who face Alzheimer's disease. There are 53,000 Kansans who have Alzheimer's disease. 80% of them will face neuropsychiatric symptoms. That means in addition to increasing memory loss, mounting language deficits and increasing losses in function, they will face depression, anxiety, mood instability and destruction of behavior filter. These neuropsychiatric symptoms can manifest in resistance, psychosis and violence. They are the most frustrating, the most frightening, and the most stressful of the Alzheimer's experience. But that's not the end of the story. Additionally, they result in increased health care costs including increased use of emergency rooms, increased physician visits, and longer hospitalizations. 78% of the regions geriatric psychiatric hospitalizations are for the neuropsychiatric consequences of dementia. Total healthcare costs are more than three times higher for people with Alzheimer's and other dementias than for other people age 65 and older, according to the Alzheimer's Association's *2009 Alzheimer 's disease Facts and Figures*. Caregivers also suffer financial impact. 70% report that caregiving has interfered with their job. 53% report going in late, leaving early or taking time off during the day to provide care. 8% report they have lost job benefits because of the complications of the disease. 16% have had to take a leave of absence. The loss of productivity and job benefits impacts all of us.

For too many years we have separated out mental health issues from the behavioral and affective consequences of the dementias which only resulted in the retarded progression of understanding of neuropsychiatric issues and interventions as well as the absence of good tracking of co morbidity issues. Depression can be an early indicator of Alzheimer's disease. Additionally, there are numerous intersections between risk factors for Alzheimer's disease and severe and persistent mental health issues. There is a significant shortage of professionals who are dually competent in mental health and aging issues. We do not have the systems architecture to appropriately manage these complications, so individuals end up in higher cost treatment options and both prematurely institutionalized and disabled.

The Dementia Bridge project is an 18 month Administration on Aging funded pilot which began in October 2009 to explore the impact of establishing a dementia crisis coordinator in four Area Agencies on Aging: Northeast, Southeast, Wyandotte/Leavenworth and the Jayhawk Area Agency on Aging. The crisis coordinators react to cases that present with behavioral and affective complications of a dementia that severely impact quality of life and ability to provide care. As of December 31, 2010, the coordinators have had 85 bridge clients, completed an additional 123 consultations and have served 293 Kansans. Data to date has indicated that most people have talked with a health care/aging professional about the neuropsychiatric

issue prior to it escalating to a crisis and did not receive help. Shockingly, in response to the pre test question asking if they had been given additional services would have it made a difference, the majority indicated a negative response. Paradoxically, on post test, 93% responded that indeed the addition of the crisis coordinator did significantly help. Comparisons of pre and post neuropsychiatric inventory questionnaires substantiated improvements in most of the neuropsychiatric challenges. That tells us that caregivers are told so often that nothing can be done when dementia is on board, they believe it and suffer compounded trauma due to an uninformed and fractured system. Following the conclusion of the grant in March of this year, full analysis will occur utilizing other comparative data to assess cost efficacy and benefit. We are confident the trend seen in data thus far will remain consistent and meaningful as we integrate final analysis. While this project focuses solely on those with neuropsychiatric complications of a dementia, it is believed that the provision of a geriatric mental health specialist in the Area Agencies on Aging would serve to respond to all aging mental health issues. This would be an important step in reducing wasteful spending, system induced trauma and premature disability for this population. The bill could be interpreted in ways that could reduce current fiscal note, including part time positions, two Area Agencies on Aging sharing a full time position, strategized educational efforts to build competence in existing systems, and leveraging state funds for additional funding sources.

While it is understood that Kansas currently is struggling with state financing of services, ignoring the investment – both short and long term – of such services is fiscally irresponsible. If we care about subsequent generations, if we want a smart Kansas, we have to be able to keep hold of the larger vision while addressing immediate needs. There are increasing numbers of individuals with Alzheimer's disease. It is expected that the number will triple in the next 40 years. We can not responsibly wait to start thinking about innovative ways to address these overwhelming numbers at some later juncture. The Alzheimer's Association, Heart of America Chapter, asks that you pay attention to both the social and fiscal impact of the current failing system. We ask that you support HB 2047 and a move to more responsive, competent and effective service delivery.

Testimony for Aging and Long Term Care Subcommittee
February 1st, 2011
Steve Denny, LSCSW
Clinical Services Coordinator, Four County Mental Health Center
Governor's Mental Health Services Planning Council, Aging Subcommittee, Chair

Mr. Chair and members of the committee, thank you for allowing me to present today. I'm here to testify on behalf of Senior Outreach Services (SOS), a geriatric mental health program through Four County Mental Health Center in Independence. This program serves Montgomery, Wilson, Chautauqua, & Elk counties in the Southeast part of the state. I also serve as chair of the Aging Subcommittee to the Governor's Mental Health Planning Council. On behalf of both the Aging Subcommittee and Four County Mental Health Center, I would like to express full support for House Bill 2047.

This testimony will focus on four primary areas that include the following:
(l) The mental health needs of older adults, and benefit of House Bill 2047 in meeting those needs.
(2) The importance of direct service combined with public outreach and community networking in geriatric mental health.
(3) A description of the Senior Outreach Services program as an example of the type of program that this bill could help fund in a rural area including key outcomes.

Needs of the Target Population

Research indicates a direct link between symptoms of depression and higher risk of nursing home admission (*Abstr AcademyHealth Meet.* 2003; 20: abstract no. 381). Untreated mental health conditions lead to increased healthcare costs. The Journal of the American Geriatric Society reports that Medicare patients who have depression combined with diabetes or congestive heart failure have significantly higher health care costs than those who have these chronic diseases in the absence of depression (2009). Unfortunately, mental health issues are often overlooked or not discussed in primary care settings and older patients are rarely referred to specialized mental health services (Journal of American Geriatrics Society, 2007).

The healthcare delivery system is not currently equipped to meet these challenges as the first set of baby boomers will turn 65 in 2011. According to the American Association for Geriatric Psychiatry (AAGP), the United States has only one psychiatrist for every 10,000 individuals over the age of seventy-five. Within a few years, the demand will be six times greater than it currently is Moreover, in April 2008, the AAGP testified that this shortage affected other disciplines as well. The numbers are alarming: only 3.6 percent of M.S.W. students specialize in aging, though the need will grow to sixty times that by 2020. Only 3 percent of psychologists define

their primary area of practice as geriatrics and only 28 percent of all psychologists report having any graduate training in geriatrics (Alzheimer's Association, 2008). . The University of Kansas estimates that the number of older adults accessing CMHC services could amount to 12,000 additional consumers in the next 20 years (Older Adult Access to Community Mental Health Services Final Report 2005-2008). Kansas desperately needs the help of HB 2047 to start developing a workforce to meet these needs.

Limited access to mental health services for Americans age 60 and older is identified by the Surgeon General's Report on Mental Health as increasing risk for suicide, psychiatric hospitalization, and premature placement in long-term care facilities (Department Health Human Services, 1999). People age 65 and older represent only 12 percent of the U.S. population, but they accounted for a disproportionate 16 percent of all suicide deaths in 2004 (CDC, 2005). The majority of older adults, who commit suicide, have diagnosable depression (Conwell, 1996). The American Association for Geriatric Psychiatry testified that "there is accumulating evidence that depression can exacerbate the effects of cardiac disease, cancer, strokes, and diabetes (2005)."

The Surgeon General's Report (1999) estimates that at least 19.8% of older Americans (over age 55) experience mental illness. If one considers the challenges faced with aging, it becomes clear that this is not a coincidence. Declining physical health, personal losses, reduced independence, and financial burdens are just of the few issues faced by many older adults. Many people see seniors as just "slowing down" when in fact they may be exhibiting symptoms of undiagnosed and untreated depression. Misconceptions by providers, family, and seniors themselves result in failure to refer seniors for diagnosis and treatment that in turn can lead to serious consequences for seniors which can include the following:

- Increased risk of suicide
- Increased risk for both psychiatric and medical hospitalization
- Premature placement in nursing homes
- Exacerbation of physical problems
- Alcohol and/or drug abuse or dependence

The emotional and financial costs of each consequence are apparent. Both the statistics and personal observations show that many older adults are in need of mental heath or substance abuse treatment. Unfortunately only a few actually receive services. Almost two-thirds of older adults with a mental disorder do not receive needed services (Rabins, 1996). However, if diagnosed and treated 60 to 80% of older adults will benefit from treatment (Schneider, 1996). The rate of older adults accessing services on their own is particularly low due to a variety of factors including stigma and access issues.

The majority of SOS clients that we have served in our catchment area present with similar needs. Major Depression and Anxiety Disorders are the most common conditions treated in SOS. These illnesses commonly lead to isolation, withdrawal, decreased self-

care, low motivation, appetite changes, intense worry, hopelessness, feelings of worthlessness, and thought/plans of suicide in severe cases. Many clients struggle with multiple personal and physical losses. Chronic pain and physical illness often cause psychiatric symptoms to intensify. Often prescription medication or alcohol is used to cope with both physical and emotional pain. Seniors also deal with financial struggles, family conflict, and are vulnerable to physical and financial exploitation.

The SOS targets adults age 60 and older, who live independently or in assisted living. One of the primary goals of the program is to achieve prolonged independence in the community. Detecting and treating depression helps improve self-care, reduce isolation, and restore a sense of hope. By emphasizing and supporting independent living when it is safe and reasonable, SOS strives to counter premature nursing home placement Not clear why you have a citation since you are describing SOS services not presenting statistical data.The direct services provided by SOS targets these symptoms and other issues through treatment collaboration with community partners.

Direct Service

Stigma towards mental health services is a significant access barrier to treating mental illness in older adults. Many older clients are fearful of their family or friends discovering that they have mental health problems. Fear of losing independence, fear of being committed to the hospital, and negative media depictions are factors often cited by seniors in Southeast Kansas that contribute to stigma. One specific SOS client told staff that he parked two blocks away and walked so that his neighbors wouldn't see his vehicle parked at the Center. This type of stigma is a reflection of why seniors with mental health issues seek treatment at such a low rate.

One way that the SOS program addresses stigma is to offer in-home services. This allows seniors to share their problems in the comfort and security of their home environment. In-home services also help to address physical health and transportation barriers that often effect seniors in rural areas. As the following services are being described, it is important to understand that non-traditional methods such as in-home therapy are crucial to addressing stigma and outreaching seniors with mental health needs.

The SOS program provides three primary outpatient services to participants in the program: Individual Outreach; Individual Therapy; and Case Management. A brief description of each is provided below.

Individual Outreach: This is normally the first service provided when a referral is received on a new client. There is currently no reimbursement for this service, but it is crucial to reaching clients in rural areas. Research has supported the effectiveness of outreach services in identifying isolated older adults with mental illness (Citters, Bartel, 2004). During an individual outreach, SOS staff explains the program and most importantly seek to connect and develop trust.

Individual Outpatient Therapy: This service is provided by a mental health professional. SOS clients have the option to receive services in-home throughout treatment. This service is reimbursed through Medicare, Medicaid, and private insurance, which is our program's primary source of income. Unfortunately, Medicare Part B? only reimburses at 50% after co-pay as indicated earlier. ? missed where you discussed earlier This is a deterrent for sustainability since over half of our clients carry Medicare Part B as their primary insurance. Don't understand this – is it Medicare Part B that reimburses 50%? This reimbursement issue further justifies the support that this bill would provide.

Case Management: This service is provided by bachelor's level staff. Case Management is quite similar to traditional mental health case management. Case Management goals are often targeted towards increasing socialization, managing medications/medical appointments, and improving communication between different providers. SOS Case Management is only reimbursable for Medicaid clients, who meet the risk or functional criteria for psychiatric rehabilitation services. A very small percentage of SOS clients meet this criterion.

Based on experience as a clinician in this program, I've found that a large portion of seniors do recover from mental illness. Many clients report improvement after only one outreach visit and never require admission to our program. I have observed multiple clients who have been discharged in full-remission of symptoms; however, success varies with each client. Factors such as severity of physical health problems, social supports, family history, and willingness to make changes play a role in achieving success. The following case example demonstrates both the severity of the issue and the success that can be achieved with effective treatment:

Last summer, the crisis department at Four County Mental Health Center received a call from a family member of an older man, who was concerned for his well-being reporting that he was depressed and having thoughts of suicide. Two crisis workers went to his home to check on him. Upon arrival, this gentleman revealed that things were going "terrible" and indicated that he was planning on ending his life today. He showed the two crisis workers a pistol that he intended to use. Both crisis workers tried to intervene, but he insisted that he was going to end his life and asked them both to leave. The older gentleman got in his car with two firearms with the intention of driving out to a country road and shooting himself. They observed the man leave his home and drive to the country road he referenced. They saw him pull over in his vehicle. At just that moment law enforcement arrived on the scene.

This story could have ended very tragically, but fortunately, it didn't. Fred now looks back on that day with both regret and joy. "It's been a complete turnaround"
At that time, Fred believed that suicide was the only way to escape his feelings of depression, loneliness, and multiple stressors he was dealing with at the time. "I held it in until I was too late." At that time, he was isolated, grieving over the recent loss of his wife, and believed that there was no one that could help him. After this event, things

began to change for Fred. He was hospitalized and treated in a geriatric psychiatric facility. He was discharged and began to receive outpatient treatment through Four County Mental Health Center. He was provided medication services, crisis supports, and began to participate in therapy and case management through Four County's geriatric specialty program known as "Senior Outreach Services." In fact, some two of his follow-up providers were the same workers who responded on that dark day. It is also important to recognize that Fred approached his services with an attitude of acceptance, appreciation, and desire to improve himself.

Today, his life looks much different. He participates in volunteer activities and visits friends and family on a regular basis. He has close relationships with his family and is willing to use them as supports. Fred goes to visit people in need at the nursing home and repairs broken furniture for friends in the community. He also has agreed to help other clients with mental health issues by encouraging them and teaching them woodworking skills. He has developed a trusting relationship with his case manager and members of the crisis department. "I never met anyone out there (Four County) that I didn't like or that wasn't nice to me." He now appreciates his life and is a contributing member of his community.

There are two important points we should take from Fred's story. First of all, many older adults struggle with depression, anxiety, and other mental health problems just like Fred. Many times, like Fred, these individuals have never received treatment for mental health issues. Many older adults do not understand the benefits of getting treatment and are not comfortable discussing these kinds of problems with their primary care providers due to stigma and limited education on the topic. This is why specialized geriatric mental health services are needed in communities throughout the State. Fred recommends that older adults struggling with depression or other mental health should seek help earlier rather than later. "They should talk to somebody and get things off their chest."

Second, Fred's recovery was not a straight climb to the top. He had periods after he was discharged where he became depressed and thought of suicide. However, this time he had adequate supports from his providers and community members to help him get through the tougher times. Mental illness can often have peaks and valleys. It is crucial that older adults have adequate services to assure they are safe and well. Fortunately, Fred received those services at just the right time. These services are not available in many communities throughout Kansas. This is why advocacy and support of geriatric mental health legislation as well the existing mental health service delivery system is so important. Without intervention, it is likely that Mr. Jones wouldn't be here to tell his story. Fortunately, he got the help he needed and his family, community, and Fred are all better off as a result.

I will close this section with an example of a senior, who didn't get help in Montgomery County. A family friend and neighbor of over 30 years had been living by himself for almost 10 years since the death of his wife. He became ill and required hospitalization

twice. Upon discharge from his second hospitalization, he began to receive home care services. One evening he called his home care nurse asking her to use the back door instead of the front. The next morning, she found him lying dead in front of his back door due to a fatal self-administered gun shot wound to the head. His depression was not reported, but is now evident in looking back. His providers, as well as family, were not able to recognize the depression, which is why the next section of this testimony is so crucial.

Public Outreach and Education

Mental illness is often unrecognized and not reported by seniors. Suicide, unfortunately, is one of the consequences of this fact. Research indicates that up to 47% of adults aged 65 and older, who committed suicide, saw their primary doctor within one week of killing themselves, while 70% saw their doctor within one month (NIH, 2001). SOS provides in-service presentations to educate providers on depression and suicide in older adults on an ongoing basis The SOS model has found partnership and collaboration with other providers invaluable in reaching seniors especially in rural areas.

The SOS approach also involves many other partners in the community.We seek to network and educate every referral source possible. These sources include the AAAs, assisted living, physicians, home health agencies, hospitals, and health departments. The SOS program has provided over 40 public presentations to the general public since the project start date. Examples include AARP, senior housing, hospitals, assisted living facilities, and community organizations such as Rotary Club. These presentations serve to educate the public on symptoms of mental illness in seniors and have generated numerous referrals and further opportunities for public education. Through these efforts, public awareness is increased and stigma is reduced.

One of our strongest partners has been the Southeast Kansas Area Agency on Aging. The AAA case managers have provided over 30 referrals to our program since the start of our project. We have collaborated on numerous difficult cases and serve together on several community projects targeting the aging. The AAA has also contracted with Four County Mental Health Center to provide caregiver therapy to caregivers. Our partnership has set an example of how mental health and aging services can work together. Similar types of partnerships will be essential in implementing this bill.

Key Outcomes

Access

The SOS program successfully completed a 3 year grant project in May of 2010.has outreached or would you want to say served over 300 seniors since 2007. Since the inception of the project, Four County Mental Health Center has seen a 50% increase in adults served, who are 60 and older in comparison to the two years prior to the project. Direct services and public education to help seniors access services at a higher rate,

which was the primary purpose of the project.

Treatment

The program has also demonstrated effectiveness in the treatment model for the patient's directly served through SOS services. The following key outcomes were achieved with statistically significant data.

- Reduction of Psychiatric Symptoms at admission, discharge and 3 month intervals
- Improvement in quality of life on SF-36 Health outcomes survey
- Increased participant satisfaction in social activities, relationships, & overall life satisfaction
- ***89% of program participants continued to live independently in the community***
- ***93% of program participants did not require inpatient psychiatric hospitalization during treatment***

Awareness

The community outreach effort has also yielded positive results in reducing stigma and increasing awareness of mental health needs in older adults. The surveys have consistently shown an excellent response from nearly 300 respondents, who have indicated that the public education has been effective in reducing stigma and increasing public awareness of mental health needs in older adults. The education efforts have diversified our referral sources and established the SOS program as a valid treatment option for older adults in Montgomery and Wilson counties.

Conclusion

The SOS program exemplifies the programs, services, and workforce needs in Kansas to improve mental health services for older adults. Four County Mental Health Center has collaborated with numerous agencies successfully and demonstrated increasing community investment in our services. Quality direct service, combined with public education, has helped SOS establish itself as a reputable program in Southeast Kansas. This has resulted in reduced stigma, increased public awareness of mental health needs in seniors, reduction in nursing home placement, and **most importantly,** higher quality of life for the people we serve.

The need for funding to sustain our program remains a major concern. Outreach and public education were funded solely through federal grant dollars, which ended in May of 2010. The current budget cutbacks will limit our ability as an agency to sustain these services if support does not become available through HB 2047. As stated earlier, these services are important in improving access to older adults with mental health needs in rural areas. The majority of rural areas in Kansas do not have specialized aging and mental health services and will not have the capacity to provide these services without supportive legislation.I would like to thank you for your time and consideration on these crucial issues.

Testimony for Aging and Long Term Care Subcommittee
January 31, 2011
Don Strong, LCPC
Director of Mid Kansas Senior Outreach
Mid Kansas Senior Outreach, Mental Health Association South Central Kansas
Governor's Mental Health Services Planning Council, Aging Subcommittee

Mr. Chair and members of the committee, thank you for allowing me to present today. I'm testifying on behalf of Mid-Kansas Senior Outreach(MKSO), a geriatric mental health program funded by a Targeted Expansion Grant through the **S**ubstance **A**buse and **M**ental Health **A**dministration. I am the director of Aging Services for the Mental Health Association and also director of MKSO and the director of the TRIAD Council of South Central Kansas.

This testimony will focus on two primary areas that include the following:

1) The importance of the direct service combined with public outreach and community networking in geriatric mental health.
2) Services provided by the MKSO program and the workforce needs related to those services.

It is estimated that the numbers of seniors living in Kansas will double by the year 2025 with the "baby boomer" residents of Kansas swelling the numbers and providing new challenges for the state of Kansas to meet the needs of our rapidly aging state.

Needs of the Target Population:

Research indicates that there is a direct link between older person's mental health and their physical health resulting in increased healthcare costs. Unfortunately, mental health issues are often overlooked or not discussed in primary care settings and older patients are rarely referred to specialized mental health services. Untreated mental illness has a devastating impact on the older adult and is associated with impaired independent and community based functioning, impaired cognition, poor medical and health outcomes, high medical co-morbidity, increased disability and mortality and compromised quality of life. Mental illness among older adults has been correlated with increased use of health care, increased placement in nursing homes, increased burden on medical care providers, and higher annual health care costs (Bartels, et al 2002). And yet, even with this knowledge systems of care have been slow to respond and address the special health care needs of the older adult. Services are fragmented, and require the senior to seek them out; and then do not adequately address mental health needs.

In a position statement of the Kansas Mental Health Coalition (2008) provided to the Kansas legislature it was reported that mental illness is often unrecognized and not reported by seniors. Many people see seniors as just "slowing down" when in fact they may be exhibiting symptoms of undiagnosed and untreated depression or anxiety. Misconceptions by providers, family, and seniors themselves result in

failure to refer seniors for diagnosis and treatment. Because of stigma attached to mental health conditions and services, as well as a pre-disposition to self-reliance and a fear of losing independent living home or family placement, many Kansas seniors are unlikely or are unable to seek mental health services, except through education and outreach, such as provided by the Gatekeeper Case Finding and Response System of MKSO.

Direct Service:

The purpose of the MKSO program is to identify and refer at risk seniors who are experiencing mental health problems that threaten their ability to live independently and to ensure that comprehensive services are delivered to assist in maintaining their independence. MKSO "Gatekeeper project is unique in that its basic premise is to seek out at risk seniors in need as opposed to waiting for a vulnerable senior to access services. This is accomplished by;

- Developing a competent community-wide network of community gatekeepers who are to identify and refer at risk seniors to MKSO.
- Establish a 24 hour call-in center to receive Gatekeeper referrals ensuring follow through services be provided
- Developing a collaborative, integrated community infrastructure to provide services to at risk seniors
- Resulting in improving the mental health and overall wellness of identified at-risk seniors.

The MKSO program offers in-home services allowing those seniors who are unable or unwilling to access mental health services the opportunity to receive services at their homes. MKSO provides three primary outpatient services to participants in the program: Gatekeeper outreach education, Care coordination, and Individual Therapy. These services are currently provided by a staff of five serving Sedgwick county and funded by the TCE SAMHSA grant including (2) LSCSW social workers, (1) case manager, (1) nurse care coordinator (1) intake worker/

The following outcomes have been achieved in the two years of service provided by the program:

- 560 at-risk seniors have been identified and referred to MKSO from Sedgwick County.
- 505 at-risk seniors have received wrap-around care services.
- 290 at-risk seniors have received in-home mental health therapy
- 455 at-risk seniors have been able to retain their independent living.
- Avg. cost of $901 per client served.
- 77% reduction in depression for clients needing mental health services.\

Conclusion:

The MKSO program exemplifies the programs, services, and workforce needed in Kansas to improve mental health services for older adults. MKSO has collaborated with numerous agencies successfully and demonstrated increased community investment in our services. Quality direct service, combined with quality outreach education has helped MKSO establish itself as a viable program to provide services to the at-risk seniors of Sedgwick County.

The need for funding to sustain our program remains a major concern. Outreach education is currently funded solely through federal grant dollars, which will end in Sept. of 2010. The current budget cutbacks will limit our ability as agency to sustain these services if support does not come available.

In the midst of the current budget crisis, this is a key opportunity to begin working toward the development of a comprehensive mental health program that provides the funding needed to serve the older adults living in Kansas.

Thank You!

Don E. Strong, LCP
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January 30, 2011

The Honorable Bob Bethel, Chairman
Aging and Long-Term Care Committee

Reference - HB 2047

Good morning Chairman Bethel and Members of the House Aging and Long-Term Care Committee. My name is Ernest Kutzley and I am the Advocacy Director for AARP Kansas. AARP represents the views of our over 341,000 members in the state of Kansas. Thank you for allowing us to present our comments in support of enhanced mental health services for seniors in Kansas.

At least one in five older Americans suffers from a mental disorder. Among Medicare beneficiaries age 65 and older, the most common mental disorders, in order of prevalence, are anxiety, dementia or other cognitive impairments, and depression. By 2030 the number of older people with such disorders is expected to double, to 15 million, equaling or exceeding the number of younger people with such conditions. Moreover a substantial and growing percentage of older adults are misusing alcohol, prescription drugs, or other substances. Demand for mental health and substance abuse services is also expected to grow as the baby-boom cohort, which has tended to use such services more frequently and feel less stigmatized by seeking care, continues to age. Nevertheless there is a substantial unmet need for mental health and substance abuse services for older adults.

Older adults requiring mental health services are more likely than younger adults to receive inappropriate or inadequate treatment, due in large part to insufficient training in geriatrics among clinicians in routine settings. Most Medicare-covered mental health services are provided by primary care physicians, not specialists. General mental health clinicians may lack training in basic assessment and treatment of mental disorders connected to aging. Personal reticence by older adults to acknowledge mental health problems, as well as the perceived social stigma against those who do, further compound appropriate recognition of and treatment options for mental disorders.

In addition, there may be limited adoption of proven practices as part of usual care or little evidence of treatments' effectiveness. For example there is scant research on the effectiveness of treatments for anxiety, especially for older populations.

Also, cognitive disorders are frequently undiagnosed or are misdiagnosed in older patients. Although geriatric mental health assessment tools exist, they are often not integrated into routine practice. Further, some physicians and other providers may be less likely to diagnose alcohol and substance abuse disorders among older adults. Many older people are also reluctant to seek counseling to help them cope with the challenges of later life, such as bereavement, disability, loneliness, and isolation.

HOUSE AGING & LTC

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ATTACHMENT # 11

The significance of these challenges is grimly evident in the fact that the 2005 death rate by suicide was highest for people age 80 years and older, and was over 50 percent higher than the rate for teens age 15 to 19. Further, the suicide rate for white men age 80 and older in 2005 was more than three times the rate for males age 15 to 19.

While Medicare's coverage of mental health and substance abuse services has gradually improved over the years by adding a partial hospitalization benefit and eliminating the payment limit on Part B mental health services, coverage continues to reflect restrictions that do not apply to other health service.

AARP believes that states should:

- Ensure coordination of mental health services with all appropriate health, long-term services and supports (LTSS) and aging network services—at the local level, area agencies on aging should have cooperative working agreements with community mental health centers to meet the mental health needs of older people in the community;
- Ensure that people with mental illness or retardation who are not admitted to a nursing home as the result of a Preadmission Screening and Annual Resident Review have home- and community-based services and receive appropriate treatment in the most appropriate setting.
- Establish mechanisms to ensure that LTSS agencies and mental health authorities address the mental health needs of older people who require LTSS as well as the LTSS needs of people with mental illness.
- Encourage innovative service-delivery models for mental health services, such as bringing mental health services into homes, senior centers, and residential care facilities (including board and care homes).

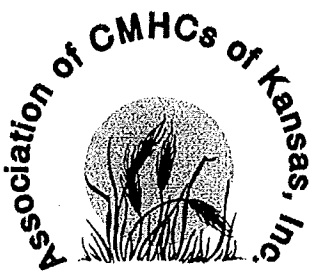
Therefore, AARP Kansas supports legislation such as HB 2047 that will include:

- Creation of a statewide program within KDOA to provide grants for mental health services.
- Education, outreach and services;
- Coordination through the state's area agencies on aging;
- Services to seniors wherever they reside (home, apartment, assisted living or nursing home).

We respectfully request your support for enhanced mental health services for Kansas Seniors. We appreciate the opportunity to provide this testimony.

Thank you.

Ernest Kutzley



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Aging and Long Term Care Committee

Testimony on
Mental Health Services for Seniors
H.B. 2047

February 1, 2011

Michelle Sweeney, Advocacy and Member Services Coordinator
Association of Community Mental Health Centers of Kansas, Inc.

Mr. Chairman and members of the Committee, my name is Michelle Sweeney, I am the Advocacy and Member Services Coordinator with the Association of Community Mental Health Centers of Kansas, Inc.

The Association represents 27 licensed CMHCs which provide services to meet the particular needs of their local communities. The public mental health system is a partnership between State and local government. With a collective staff of over 4,000 professionals, the CMHCs provide services to Kansans of all ages with a diverse range of presenting problems. The CMHCs provide assessment, diagnosis, treatment, case management, medication management, crisis services, attendance care and respite care as well as many other services to individuals and families dealing with mental illness. In addition, the CMHCs provide screening for individuals who may need inpatient hospitalization. We serve more than 118,000 Kansans each year, and as part of licensing regulations, are required to provide services to all Kansans who present for treatment, regardless of their illness or ability to pay. In FY 2010, the CMHCs served 13,372 seniors age 55 and older.

As you are aware, many seniors in our communities have or will develop some mental illness during their golden years. As seniors face losses of health, family, friends, neighbors and even isolation as they age in place, they may develop depression or other mental health issues. Seniors deserve to maintain their mental health, and deserve to receive treatment so they can live well and age successfully.

We believe that Area Agencies on Aging (AAAs) and CMHCs can and should work in close collaboration to identify seniors who may need mental health services and then provide treatment to those individuals. This collaboration could vastly improve the quality of life for many seniors in Kansas. The creation of a program of geriatric mental health services to seniors is wholeheartedly supported by the Association. We stand ready and willing to collaborate with the Department on Aging to promote system changes to the Kansas long term care infrastructure, including streamlined access to services.

Two critical factors in accessing mental health care are provider availability and acceptability by consumers. Kansas has only five urban counties, with the rest of the state made up of frontier, rural, dense rural counties and semi-urban counties. A person living in a rural area may be Medicare eligible or have other insurance or coverage for mental illness, but if the nearest provider is hours away, their access to care becomes limited. The result is that those in rural Kansas may experience a delay in care, inconsistent care, or no care.

According to the National Rural Health Association, people from rural or frontier areas have a high percentage of seniors with Medicare coverage, are less likely to enroll in Medicaid, and have less knowledge about that and other social services. Right now, Medicare does not provide coverage for many providers of mental health care and treatment---only for a very few licensed practitioners. In addition, it only reimburses for 50 to 80 percent of the cost to provide treatment to seniors with mental illness, The passage of federal legislation that expands Medicare coverage to include all mental health clinicians who are licensed for independent practice by their state licensing boards will help to close the gap for rural Kansas seniors and those with mental illness, and allow them access to treatment by a mental health professional in their own community.

Needs of the Target Population

Limited access to mental health services for Americans age 60 and older is identified by the Surgeon General's Report on Mental Health as an increasing risk for suicide, psychiatric hospitalization, and premature placement in long-term care facilities (Department Health Human Services, 1999). Males, 85 and older, have the highest rates of suicides of any other group at 21 per 100,000 (Center for Disease Control, 1999). The majority of older adults, who commit suicide, have diagnosable depression (Conwell, 1996). The American Association for Geriatric Psychiatry testified that "there is accumulating evidence that depression can exacerbate the effects of cardiac disease, cancer, strokes, and diabetes (2005)."

Surgeon General's Report (1999) estimates that at least 19.8 percent of older Americans (over age 55, experience mental illness. If one considers the challenges faced with aging, it becomes clear that this is not a coincidence. Declining physical health, personal losses, reduced independence, and financial burdens are just of the few issues faced by many older adults. Many people see seniors as just "slowing down" when in fact they may be exhibiting symptoms of undiagnosed and untreated depression. Misconceptions by providers, family, and seniors themselves result in failure to refer seniors for diagnosis and treatment that in turn can lead to serious consequences for seniors which can include the following:

- Increased risk of suicide
- Increased risk for both psychiatric and medical hospitalization
- Premature placement in nursing homes
- Exacerbation of physical problems
- Alcohol and/or drug abuse or dependence

The emotional and financial costs of each consequence are apparent. Both the statistics and personal observations show that many older adults are in need of mental heath or substance abuse treatment. Unfortunately only a few actually receive services. Almost two-thirds of older adults with a mental disorder do not receive needed services (Rabins, 1996). However, if diagnosed and treated 60 to 80 percent of older adults will benefit from treatment (Schneider, 1996). In rural communities, the rate of older adults accessing services on their own is particularly low due to a variety of factors including stigma and access issues.

For older Kansans, adequate services are critical to ensure safety and well-being. Though needed, such specialized geriatric mental health services are not available in many communities throughout Kansas. Kansas has some of the "grayest" counties in the country, with large number of seniors per capita.

Seniors many times will share things that are bothering them with their primary care doctors, who may or may not know how to screen for depression or other disorders. Thus, a senior suffering from depression, anxiety or other illness may not be identified. With the medications and therapies that are available today, there is no reason for one of our Kansas seniors to suffer without treatment or medication.

Community based treatment and care are a wise investment, costing only an average of $300 to $660 a month for a Medicaid consumer with chronic conditions. Nursing home placement—which may occur without community based services—costs nearly $4,000 a month in Kansas. The cost savings is one reason to expand community based services, but the other is to ensure the dignity and quality of life for our elders.

The Association supports the passage of HB 2047, and we offer our collaboration in any way possible with the Department on Aging to accomplish to goals of this bill. Thank you very much for the opportunity to present just a small view of how seniors might benefit from the passage of this bill, and the collaboration between AAAs and CMHCs.

KAHSA
creating the future of aging services

To: Chairman Bob Bethell, and Members,
House Aging and Long Term Care Committee
From: Debra Zehr, President
Date: Tuesday, February 1, 2011

TESTIMONY IN SUPPORT OF HOUSE BILL 2047

Thank you, Chairman Bethell and Members of the Committee. I am Debra Zehr, President of the Kansas Association of Homes and Services for the Aging (KAHSA). We represent 160 not-for-profit nursing homes, retirement communities, hospital long-term care units, assisted living facilities, low income housing and community-based service programs that serve more than 20,000 older Kansans every day.

KAHSA stands in support of House Bill 2047, which calls for the Kansas Department on Aging to administer a statewide program, in collaboration with the Area Agencies on Aging and mental health centers, to provide mental health education, outreach and services to older Kansans regardless of their place of residence.

Older Kansans experience high rates of depression, anxiety and other mental health challenges, putting them at increased risk for physical health problems, premature institutionalization and suicide. Yet they are disproportionately underserved due to transportation problems, lack of availability of specialized services and stigma.

We appreciate the Committee's attention to the important issue of mental health service access for older Kansans. I am happy to answer questions.

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