

**MENTAL HEALTH CARE FOR OLDER ADULTS:
RAISING AWARENESS, ADDRESSING STIGMA,
AND PROVIDING SUPPORT**

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C O N T E N T S

	Page
Opening Statement of Senator Robert P. Casey, Jr., Chairman	1
Opening Statement of Senator Tim Scott, Ranking Member	2
PANEL OF WITNESSES	
Erin Emery-Tiburcio, Ph.D, ABPP, Co-Director, Rush Center for Excellence in Aging, Chicago, Illinois	5
Kenneth Rogers, M.D., MSPH, MMM, State Director, South Carolina Depart- ment of Mental Health, Columbia, South Carolina	7
Kimberly Williams, President and CEO, Vibrant Emotional Health, New York, New York	8
Jim Klasen, Certified Older Adult Peer Specialist (COAPS) Facilitator, Elkins Park, Pennsylvania	10
APPENDIX	
PREPARED WITNESS STATEMENTS	
Erin Emery-Tiburcio, Ph.D, ABPP, Co-Director, Rush Center for Excellence in Aging, Chicago, Illinois	31
Kenneth Rogers, M.D., MSPH, MMM, State Director, South Carolina Depart- ment of Mental Health, Columbia, South Carolina	46
Kimberly Williams, President and CEO, Vibrant Emotional Health, New York, New York	48
Jim Klasen, Certified Older Adult Peer Specialist (COAPS) Facilitator, Elkins Park, Pennsylvania	55
QUESTIONS FOR THE RECORD	
Erin Emery-Tiburcio, Ph.D, ABPP, Co-Director, Rush Center for Excellence in Aging, Chicago, Illinois	61
Kenneth Rogers, M.D., MSPH, MMM, State Director, South Carolina Depart- ment of Mental Health, Columbia, South Carolina	63
Kimberly Williams, President and CEO, Vibrant Emotional Health, New York, New York	65

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THURSDAY, MAY 19, 2022

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The Committee met, pursuant to notice, at 10 a.m., via Webex, Room 562, Dirksen Senate Office Building, Hon. Robert P. Casey, Jr., Chairman of the Committee, presiding.

Present: Senators Casey, Gillibrand, Blumenthal, Kelly, Warnock, Tim Scott, Collins, Braun, and Rick Scott.

OPENING STATEMENT OF SENATOR ROBERT P. CASEY, JR., CHAIRMAN

The CHAIRMAN. Good morning. The Special Committee on Aging will come to order. The hearing of this Committee will come to order.

Today, we are here to discuss a topic of growing and, I think, urgent national concern, which is the mental health crisis that is ravaging our Nation, including and especially our Nation's seniors. It is a topic that too often is discussed behind closed doors due to the unrelenting and unwarranted stigma attached to this issue.

It is estimated that one in four—one in four—older adults experiences a mental health condition, including depression, anxiety or substance use disorder. In 2020, Americans who were 85 years of age or older had the highest suicide rate of any group of Americans.

Many seniors are in pain and struggling to find help. In the year before the pandemic, more than 30,000, just by example in one State, 30,000 Pennsylvanians looked to the state mental health authority for support. I imagine that number would be even higher if more seniors knew this kind of care was available, and again, that was before the pandemic.

The pandemic has only worsened this crisis, as older adults have been forced to isolate in their homes, away from their family and friends. The resulting social isolation and loneliness has taken a terrible toll on older adults across the country. Research shows that social isolation has the same adverse impact on health as smoking 15 cigarettes a day, and it is correlated with an increased risk of depression.

Today we will hear from a panel of witnesses who will highlight the gaps in our mental health system, particularly for older adults,

and they will offer solutions. We will hear from Jim Klasen from Elkins Park, Montgomery County, Pennsylvania. Jim and his family know the harsh realities of stigma all too well. He knows the unfairness of being judged for needing help with a mental health condition. In his testimony, Jim says the support he has received enables him to now share his experience without shame. The reality is that too many older adults today face fragmented systems and roadblocks that prevent them from accessing the support that they need.

Both Congress, House and Senate, and the Biden Administration are focused on this issue, and that is good news but we have got to get a lot more done. President Biden recently announced his “unity agenda,” which calls for expansions in the mental health workforce, and also promotes mental health care itself in the community, so that is important, and it is a big step forward, but it is now time for Congress to act.

Ranking Member Tim Scott and I are introducing a bipartisan resolution, the very first of its kind, to raise awareness about the impact of mental health conditions and substance use disorder on older adults. Today, Ranking Member Scott and I will also be introducing the Advancing Integration in Medicare and Medicaid Act, which requires states to develop a plan to address the fragmentation in Medicare and Medicaid. These are the very programs which so many older adults rely upon for their mental health.

I am introducing, as well, a bill to give states funding to execute these plans so that individuals can have meaningful access to all of their health care needs. This includes primary care, mental health, long-term care, and more.

We have got work to do, but we are grateful that we have this opportunity to have this hearing today, and I will now turn to our Ranking Member, Ranking Member Scott.

OPENING STATEMENT OF SENATOR TIM SCOTT, RANKING MEMBER

Senator TIM SCOTT. Thank you, Chairman Casey, for holding another truly important hearing. To the guest panelists, thank you so much for participating in this process. Without question, your expertise will lend itself to us uncovering more solutions and providing more assistance to those who are certainly in need of that assistance.

I would also like to take the time to recognize the students behind the witnesses, the University of South Carolina’s pharmacy students, who are part of the Walker Scholars Program. They have decided to join us for the next three or four hours. I appreciate you all sticking around for the entire time. That was my joke and no one thought it was funny, but the good news is it was not that funny, but the truth is I am always happy to see folks in a room from my home State, and thank you so much for taking your time and investing a part of it in this important topic, and without any question, as the students are here with us, it really is important for us, Chairman Casey, to stress the importance of the Mental Health Awareness Act that we have both sponsored.

The truth is that too many of our seniors and, frankly, our general population, continue to feel this heavy weight on their shoul-

ders, and it is one that is palpable. I think it is true at all ages. There is no doubt that the suicide rate amongst our youngest Americans is way too high, and the same is true with our seniors.

I was talking to someone recently, just yesterday, and we were walking through one of my constituent calls, the rising crime and the officers that have been shot at a record level in the highest number of incidents focusing and targeting our officers in, frankly, the Nation's history.

We watched in Buffalo another racist attack. You go to the gas pump, and in South Carolina the gas prices doubled in less than 2 years. The fact of the matter is, if you are involved in an accident, which actually happened to the constituent's son yesterday, there are no rental cars. The parents who are looking for formula cannot find it.

There are reasons why Americans feel a level of burden and stress and challenges. It is the fact that economically, crime, safety, security, loneliness—I think it was Surgeon General Murthy who said that loneliness is like smoking 15 cigarettes a day—and just thinking about that is a lot for the average person coming out of a pandemic, and the lingering effect is undeniable.

That is why I am so thankful that Chairman Casey and I have worked diligently in a bipartisan fashion. There are many Americans who think nothing in Congress ever happens with the two sides coming together. Simply false. The truth is, all that we accomplish in the U.S. Senate requires a bipartisan coalition, and that is a blessing to the great United States of America.

One of those is the AIMM Act that Senator Casey has already described. Another one that I am working on is the ACADEMIC Act. It authorizes a comprehensive study of the long-term impact of COVID-19 and associated school closures, especially on children from low-income families. This bill is sponsored by Senator Rubio, Chairman Casey, and myself. Substance abuse, of course, and overdose deaths are skyrocketing as a result of the mental health crisis that we have seen.

For the first time, overdoses have exceeded 100,000 in America, around 107,000, more than car accidents for the first time. The lifetime odds of dying from opioid overdose are now higher than those car accidents.

To tackle opioid misuse and raise awareness, South Carolina launched a campaign called Just Plain Killers, particularly among the aging population who are prescribed opioids for chronic pain. In addition to the substance abuse, many seniors were plagued, as Senator Casey said, with loneliness, and I will do my best not to reiterate what he has said unless it is just necessary. Sometimes it is necessary to emphasize or re-emphasize the importance of the challenges that so many of our seniors face.

Also, in addition to that, I mentioned the deaths of our law enforcement officers, and the worst situation for those officers is to go to a domestic situation. It is one of the reasons why in Richland County, law enforcement officers received over 2,700 calls just in a year related to mental health crisis—not a crime, but a crisis, so we have legislation that focuses on the importance of co-responders so that you actually have officers and mental health experts going

to the scene so that we can address the issues in the home without making it necessarily a crime.

These are some of the topics that we will discuss and some of the important issues that we will have to face as a bipartisan coalition of people who believe in the future of America, and we are going to get it done.

Thank you all for being experts and providing your expertise with us today.

The CHAIRMAN. Thank you, Ranking Member Scott. I will next turn to witness introductions. I will do several and Ranking Member Scott I know will do one of our introductions.

Our first witness is Dr. Erin Emery-Tiburcio. Dr. Emery-Tiburcio is an Associate Professor of Geriatric and Rehabilitation Psychology and Co-Director of the Center for Excellence and Behavioral Health Disparities in Aging at Rush University Medical Center. She has a Ph.D in clinical psychology and completed her following in clinical geropsychology.

Thank you, Doctor, for being here with us today and sharing your expertise with the Committee, and we will turn next to Ranking Member Scott.

Senator TIM SCOTT. Thank you, Chairman Casey. It is my honor to introduce to all Dr. Ken Rogers. He helps South Carolinians navigate the mental health system as the Director of the South Carolina Department of Mental Health. The department operates 16 community-based outpatient mental health centers, clinics across all 46 counties, and 3 hospitals, including one for addiction treatment.

He has a long history of working to expand mental health services to underserved populations. He collaborates with traditional and nontraditional partners, including law enforcement. He is a native of the area called Dillon, South Carolina, and a graduate of the University of South Carolina School of Medicine. He completed his general psychiatry residency in child and adolescent psychiatry fellowship at the William S. Hall Psychiatric Institute at the University of South Carolina.

He earned a master of science and public health from the University of California Los Angeles. He is bicoastal. He holds a master's in medical management from the University of Southern California. Prior to coming back to South Carolina he was the Chief of Psychiatry at Parkland Health and Hospital Corporation in Dallas, Texas.

In his testimony, Dr. Rogers will talk about his department's work in providing mental health services and the pandemic's impact on mental health, especially for caregivers and our veterans.

We look forward to hearing your testimony and we thank you sincerely for being here.

The CHAIRMAN. Thank you, Ranking Member Scott. Our third witness is Kimberly Williams. Ms. Williams is the President and CEO of Vibrant Emotional Health. She has overseen the expansion of Vibrant's community-based programming to support older adult mental health. I want to thank Ms. Williams for being with us today and sharing your expertise with the Committee.

Finally our fourth witnesses is Jim Klasen from, as I mentioned earlier, Elkins Park, Pennsylvania, Montgomery County, right near

Philadelphia. Jim will share his recovery journey with the Committee. He is a Certified Peer Specialist Facilitator, Advanced Level WRAP Facilitator, and Certified Older Adult Certified Peer Specialist trainer. He brings over 40 years of experience in human services and in the workforce development field.

Jim, I am grateful you are here with us today, and I hope that picture you took with me earlier does not get you into any trouble back home, but thanks for being with us today.

We will turn to our first witness. Dr. Emery-Tiburcio, if you would present your testimony and then we will go to our next witnesses. Thanks very much.

**STATEMENT OF ERIN EMERY-TIBURCIO, PH.D,
ABPP, CO-DIRECTOR, RUSH CENTER FOR
EXCELLENCE IN AGING, CHICAGO, ILLINOIS**

Dr. EMERY-TIBURCIO. Thank you so much. Good morning, Chairman Casey, Ranking Member Scott, and distinguished members of this Committee. Thank you so much for the opportunity to speak with you today about mental health and substance use issues. My name is Erin Emery-Tiburcio and I co-direct the Rush Center for Excellence in Aging at Rush University Medical Center in Chicago.

The White House has recognized mental health and substance use as critical issues for all Americans, and I am grateful that this Committee recognizes that older adults' needs are an issue of equity. Not only is stigma about mental health and substance a barrier to effective screening and treatment and assessment but that stigma is compounded by systemic ageism that has resulted in severely lacking access to care for older adults.

Today I will point to three key issues for this Committee to consider in terms for the need for coordination for care for older adults who experience the most complex health issues, and access to care related to Medicare policies, and finally, the critical need for behavioral health workforce, trained to work with older adults.

I co-direct the SAMHSA-funded E-4 Center of Excellence for Behavioral Disparities in Aging, which has offered policy academies in three states—Illinois, Nebraska, and Pennsylvania—in our first year and a half. These three-part events bring together leaders of State entities from aging, mental health, substance use, transportation, housing, and others who rarely communicate with each other in their silos, and we bring them together for facilitated discussion to identify and fill gaps in meeting the needs of older adults with mental health and substance use issues.

We are honored currently to partner with the Pennsylvania Association of Area Agencies on Aging in our current policy academy. This committed and passionate group of policy academy members have highlighted these three issues, which we have seen in other states and across the country, in addition to the importance of telehealth and broadband access. Thank you, Senator Scott, for your fantastic work in this area.

Older adults with mental health and substance use issues are more likely to have chronic medical conditions, multiple medications, multiple health care providers, and multiple community-based organizations providing services, all of which put them at incredible risk for falling into the chasms of our fragmented health

care system, and because supportive housing in the community is rarely available or paid for, older adults with serious mental illness are more likely to be placed in an expensive nursing home that they do not want to be in and is ill-equipped to meet their needs.

Providing reimbursement for care coordination across health system and across community-based organizations for older adult is not only critical for equitable care but has been shown to reduce costs, particularly for individuals who are dually eligible for Medicare and Medicaid. These dual-eligible older adults and, quite frankly, every older adult with Medicare, struggles to find available mental health and substance use services.

Part of the reason for this is that Medicare reimbursement rates for older adult mental health and substance use is inadequate for engaging providers to enroll. Given that the highest rate of suicide, as you just highlight, Senator Casey, is among older adults, this lack of available mental health service is deadly.

Allowing for market rate reimbursement for mental health and substance use services is critical to assure that adequate provider enrollment, and further, consideration must be given to allow master's level clinicians eligibility to enroll in Medicare so that therapeutic relationships do not have to end just because someone turns 65.

An additional challenge is that a tiny fraction of the required behavioral health providers with specialized training in working with older adults are available, so in fact, some states do not even have a single board-certified geropsychologist or geriatric psychiatrist. I am the only one in the State of Illinois.

We are so grateful to Senator Casey for being a champion for funding the Geriatric Workforce Enhancement Programs, or GWEPs, as we call them, which are tasked with educating the health care workforce and the community about older adult health, along with transforming primary care to be age friendly. Proposed support for additional GWEPs with larger budgets, and critically, increased focus on older adult mental health and substance use would allow every region of the United States to have access to that high-quality training.

Finally, while children and families have been a consistent focus, which is important, Federal mandates for SAMHSA have not included older adults. With the unprecedented increase in older adult population in the U.S., legislation to mandate the permanent inclusion of older adults in SAMHSA priorities is desperately needed, along with expanding the HRSA-funded Graduate Psychology Education and Teaching Health Care Graduate Medical Education programs.

I am grateful to this Committee for considering including access to care related to Medicare policies, coordination of care for older adults with complex health issues, and the critical need for expanding the behavioral health workforce trained to work with older adults.

Thank you so much.

The CHAIRMAN. Doctor, thanks so much for your testimony. Before turning to Dr. Rogers I want to note the presence of Senator Collins, former Chair of this Committee.

Dr. Rogers?

**STATEMENT OF KENNETH ROGERS, M.D., MSPH, MMM,
STATE DIRECTOR, SOUTH CAROLINA DEPARTMENT
OF MENTAL HEALTH, COLUMBIA, SOUTH CAROLINA**

Dr. ROGERS. Thank you Chairman Casey and Ranking Member Scott for the opportunity to be here today.

The South Carolina Department of Mental Health is a comprehensive, statewide health system that is comprised of 16 mental health centers that cover the entire State and provide whole-person care, meaning that we are focused on both the physical and mental health care of our patients. We work in concert with federally qualified health centers, health systems, as well as non-traditional locations of service including schools, churches, and other community partners. Additionally, we operate two freestanding psychiatric hospitals, an inpatient substance treatment facility, and five veterans' nursing homes.

Like all states, South Carolina has seen an increase in the number of individuals seeking care throughout the pandemic. The two populations seeing the greatest increase are the youth and the elderly.

We have identified several reasons for this increased service need. First, social isolation has had an incredible impact on our elderly population. The activities that seniors in South Carolina often find helpful, such as attending religious services and going to day programs, among other community services, have been unavailable during the pandemic.

Second, is the sense of loss that has been experienced. Over a million Americans have died from COVID or its complications. Greater than 75 percent of COVID deaths was among individuals ages 65 and older. The majority of elderly individuals have experienced at least one personal loss over the past 2 years. Further complicating issues is that many programs serving the elderly either shut down or moved to a virtual platform during the pandemic.

The expansion of telehealth has been able to fill this void. SCDMH, the Department of Mental Health, cares for approximately 100,000 individuals yearly. Twenty percent of those individuals are older than age 55. In April 2020, the department moved all of our services virtually and telephonically. Within 2 months, we had at least one therapeutic contact with 99.9 percent of all the patients that we were seeing pre-pandemic.

Part of the reason is that we have been successfully shifting to telehealth over the course of 20 years, and is now the largest telehealth provider in the State of South Carolina. Additionally, because we are a unified service delivery system, we were able to track centrally all of our services that are being delivered throughout the system and move assets as needed.

Telehealth has certainly not been a panacea, as many of our patients live in areas with limited broadband coverage or do not have devices that afforded them adequately provide care, or cellular plans that afford them the opportunity to connect full time. Thankfully, we are now fully operational and able to provide telemedicine as well as in-person care. We have found that our elderly population as adjusted very well to these changes.

The challenges for providing care among aging populations are numerous. One of the biggest challenges has been an increase in

substance use during the pandemic. Since Federal funding for substance use and mental health treatment are split at the Federal level, developing programs that address these co-occurring issues is often difficult and challenging.

Second, many organizations do not provide both mental health and medical services in the same location. As a result, many older Americans have to visit multiple locations in order to obtain services. Each additional visit increases the likelihood that they will not obtain services or drop out of services.

There are several areas where South Carolina has done an exemplary job. We have developed excellent partnerships with law enforcement to make sure that officers are provided the skills needed to identify and services in a mental health crisis. We have also increased our crisis intervention teams, where individuals are able to provide mental health care to the extent possible.

South Carolina has been very committed to increasing services to our veteran population. The State has worked closely with the Department of Veterans Affairs to increase the number of veterans' nursing homes in South Carolina. The blending of State and Federal funding has allowed us to expand and make a difference.

I appreciate the opportunity to appear before the Committee today, and I am proud to lead the 4,300 individuals at the South Carolina Department of Mental Health who strive each day to provide both physical and mental health care to all South Carolinians. Thank you.

The CHAIRMAN. Dr. Rogers, thanks for your statement, and we will turn next to Ms. Williams, and I just want to note the presence, virtually, of Senator Rick Scott.

Ms. Williams?

**STATEMENT OF KIMBERLY WILLIAMS, PRESIDENT
AND CEO, VIBRANT EMOTIONAL HEALTH,
NEW YORK, NEW YORK**

Ms. WILLIAMS. Thank you, Chairman Casey, Ranking Member Scott, and members of the Special Committee on Aging for the opportunity to provide testimony on the important topic of mental health care for older adults.

My name is Kimberly Williams, and I am the President and CEO of Vibrant Emotional Health, a not-for-profit organization based in New York City that reaches over 3.5 million people every year. We work every single day to help save lives and help people get care anytime, anywhere, and in any way that works for them.

Vibrant leads a broad-based coalition in New York that develops and advocates for changes in policy and practice that are essential to meeting the mental health needs of older adults. Vibrant also serves as the administrator of the National Suicide Prevention Lifeline, which provides crisis support services for individuals, including older adults experiencing a mental health emergency.

The country faces what has been termed an "elder boom," or acknowledgment of the increased population growth of individual age 65 years and older. Older adults represent 54.1 million individuals, roughly 1 in 7 Americans. Twenty percent of older adults aged 55 and older have a diagnosable mental health or substance use disorder. Sadly, most older adults with cognitive and behavioral disorders do not get adequate care and treatment.

In addition, lower-income older adults who are both covered by Medicare and Medicaid are forced to navigate two complex insurance systems, each of which have different coverage and payment rules.

Today I want to share with you the story of an older individual served by Vibrant through our Older Adult Assertive Community Treatment team, a community-based model that addresses the needs of adults with serious mental illness.

A 62-year-old Caucasian woman located in the Bronx, New York, was admitted into the ACT program with serious mental illness and co-occurring chronic physical issues. She did not have stable housing and was using psychiatric hospitals as a housing solution due to stigma and verbal abuse she experienced within shelters.

The interdisciplinary team of providers delivered her weekly trauma-focused therapy and assistance with taking her psychiatric medications. Through these and other interventions she was able to gain insight into her mental health condition, address her physical health needs, and utilize coping strategies.

The ACT team advocated for her needs during appointments to ensure that she received appropriate treatment and resources. After a year in the program, her functioning improved enough to transition to a lower level of care. She voluntarily provides updates on her progress to the ACT team, and is incorporating many of the skills and strategies she learned within the program.

Her story is but one of many success stories which illustrate the power of providing comprehensive, integrated, recovery-oriented supports tailored to the unique needs of the older individual. By addressing challenges holistically we are able to improve mental health outcomes and keep older adults thriving in the community, reducing the use of costly or inappropriate settings.

As highlighted by this example, many older adults with mental health challenges also have chronic physical problems. Many older adults who seek treatment for late-onset mental health problems turn to their primary care physicians, making it critical to build linkages between mental health and physical health services, and to design integrated service structures.

Similarly, many of the needs of older adults with mental health problems are addressed through the aging service system. This system offers opportunities for prevention, identification, sites for community-based treatment, and more. Linkages and new integrated service models between mental health and aging services are key to better service provision.

A number of other recommendations can be implemented at the Federal, State, and local government levels to help improve older adult mental health care, including integrating mental health, substance use, physical health, and/or aging services, particularly for individuals who are eligible for both Medicare and Medicaid; improving access to mental health and substance use services including disseminating best practices; address the shortage of clinically and culturally competent workforce, in part by recruiting and training more providers, and also, in part, by including older adults themselves through paid and volunteer roles; and restricting how services are financed, particularly within Medicare and Medicaid so they are affordable, enhance integrated care and treatment, expand

the types of providers available, and support services in the home and community settings.

Vibrant stands ready to partner with members of this Committee, older adults with lived experience, and other stakeholders to implement these recommendations and improve mental health outcomes and quality of life for older Americans.

Thank you again for your time and consideration of this very important topic.

The CHAIRMAN. Ms. Williams, thanks very much for your testimony.

Senator Blumenthal has joined us, and we will turn to our last witness, Jim Klasen.

**STATEMENT OF JIM KLASEN, CERTIFIED OLDER
ADULT PEER SPECIALIST (COAPS) FACILITATOR,
ELKINS PARK, PENNSYLVANIA**

Mr. KLASEN. Good morning Chairman Casey, Ranking Member Scott, and members of the Senate Special Committee on Aging. Thank you for allowing me to testify here today on the issue of older adults and mental health.

My name is Jim Klasen. I am an older adult, 73 years old, who lives with mental and physical health challenges and a substance use disorder. Fortunately, today I am a person in recovery. Let me also say that I am grateful to the health care providers who cared for me when I needed it most. Professional intervention was necessary. However, it was not sufficient. What has sustained my recovery process over time has been what we call "peer support."

By peer support, I mean people who have been through it, helping others who are going through it. This can be done professionally, with certified peer specialists, or informally as well, but peer support is not where my story started. Even in my 20's I knew something was wrong. Mental health challenges ran in my family. I did seek help and got some, but still there seemed to be difficulties I could not quite name.

I moved to Philadelphia, Pennsylvania in 1986, for a great job opportunity, and that is when things really started to blossom, in ways both good and not so good. The new job was wonderful, but the profound depression that descended in about 6 months' time, not so much, and to complicate matters, I started self-medicating in a very harmful way.

I was a country kid who moved to the city determined to have the "great urban adventure," and what started as a party blossomed into full-blown addiction, and I am talking Philadelphia in the mid to late 1980's, so we are talking about street drugs, the epidemic that preceded the current opioid crisis, and crack cocaine has not gone away by any means. What followed for several very difficult years were the devastating effects of my substance use on my family, the toughest part of my story to tell and for me to deal with to this day.

Again I sought help, but help then focused on the drug use. We know now that an integrated approach to addressing mental health and substance use is more effective at getting at both the immediate troubling behavior and the underlying causes. My challenge was not that it was one problem or even two. I was navigating

through this debilitating depression—my diagnosis is bipolar disorder. At the time, just getting a grip on the substance use seemed to be the most immediate priority. Old-school recovery just meant stop using. That was not enough, though, because I was using for a reason, although the exact underlying problem was not crystal-clear, even to me, and a diagnosis does not fully explain why anyone uses drugs that dangerous and powerful.

Over time my recovery assumed a more comprehensive, integrated approach, and as I aged, so apparently did the field. After several hospitalizations, many “Rehab After Work” programs, medications, and several therapists, I was introduced to a self-help approach with an emphasis on wellness and less on illness.

This appealed to me. The first question was, “What are you like when you are well?” and I can assure you no one at that time was asking me what I was like when I was well. They wanted to know what was wrong with me and why I was acting the way that I was. I felt hope. I felt connection with someone who possibly understood.

Shortly thereafter I met two people at a wellness conference who introduced me to the concept of peer support, and that I could become a certified peer specialist and eventually a certified older adult peer specialist as well, so for 10 years now I have been a CPS, certified peer specialist, and a COAPS facilitator. Maybe the best thing is that I no longer have to manage these secret lives of addiction and mental illness. I can now share my experience without shame or stigma.

Now as an older adult myself, though, I can relate to the reluctance, embarrassment, and stigma that many do face in dealing with and disclosing such challenges. It is hard to talk about. The population of older adults is growing, and we come with mental health, physical health, and yes, even substance use issues. From my personal experience and the experience of thousands of my peers and from research we know that peer support is one solution and one that is beneficial and cost effective.

I am no expert on health policy, but I do share the concerns of other older adults for our future well-being. We have great programs and we know a lot more now than in the past, but we need more—more support and also more public awareness and education.

I want to thank you for your time. I hope that sharing my lived experience with my mental health challenges and substance use can contribute, can help the policy and program conversation, and, of course, I look forward to answering any questions. Thank you..

The CHAIRMAN. Thanks very much, Mr. Klasen, for sharing your personal experience. That is always of great benefit, not only to those who are part of this hearing but I think people well beyond this room, and we are grateful you are willing to do that, and I am so grateful for all of our witnesses.

Before I turn to our first set of questions, I also want to acknowledge Senator Warnock is here with us at the hearing virtually.

Jim, I will start with you, and what I just mentioned about you sharing your story. You talked about that terrible word “stigma,” which just has enveloped so many of these issues for so long, and it becomes, I guess, a barrier for folks to seek help or to be able to overcome the challenge that they have.

You had shared that that stigma led to self-medicating and you described for us what that meant in your life, and that eventually you found the support you needed and now you are able to help others, not only generally with these challenges but also help them with this issue of stigma.

I guess my first question is what can we do—we meaning the U.S. Senate, the U.S. House and Members of Congress—to address just that issue? There is lots to talk about, but that issue of stigma surrounding mental health to ensure that older adults feel both comfortable in seeking care but also supported when they try to avail themselves of that care.

Mr. KLASSEN. Thank you. Thanks for the question, Senator Casey. I think there is a lot we all can do, but certainly, yes, in the Senate.

I think that there is an issue of, you know, just public awareness. Increasingly, we do see people coming out and talking about their mental health challenges and substance use challenges, whether celebrities or sports figures or, you know, at any level in our society, and I think every time that happens it opens a door for someone to say, “Maybe it is okay for me to talk about this.” Maybe it is okay for me to talk about this with my family, maybe in my community, my faith-based, wherever it is, and I think it is just an incremental process.

The CHAIRMAN. Is the mic not on?

Mr. KLASSEN. Oh, I am sorry. There it goes. It is on now.

The CHAIRMAN. Maybe you could just reiterate, briefly, what you just said.

Mr. KLASSEN. Yes. Yes, thank you for your question, Senator Casey, and what I was saying is I think there is a lot that we can all do, and certainly, sure, it starts at the top of our society and throughout.

For folks who are willing to come out and talk about mental health and substance use—and we see it increasingly. I think it is happening, but I also see in the media, right, in the mass media, mental health and substance abuse. There is just a lot of education that needs to happen.

The CHAIRMAN. No question about it, and I think that is true across the board. I wanted to—and I will keep it in my time because I know we want to get to other Senators—I wanted to ask a question of Dr. Emery-Tiburcio about these silos that we often identify with regard to mental health coverage for individuals when they have coverage both under Medicare and Medicaid. You described how navigating these two separate health care programs results in both confusion and unnecessary barriers to care.

I mentioned references to Pennsylvania. We have got about 400,000 folks in our State who are enrolled in both programs, 9 million seniors and people with disabilities, so it is a big number.

Can you speak to how greater alignment of both programs would help older adults access quality mental health services?

Dr. EMERY-TIBURCIO. Yes. Thank you, Senator, for an important question, so you are well aware of the navigation of Medicaid and Medicare and how complex they are on their own, and much more complex when an older adult has to navigate both for many conditions.

It is interesting, the legislation that you and Senator Scott have proposed to expand the PACE program may be a key to this work, so PACE programs provide highly integrated care, and as has been highlighted, the critical nature of integrated care for older adults, to manage the entire benefit of dual-eligible individuals, thus simplifying and significantly enhancing that care, but because PACE programs are often not real well-equipped to manage mental health and substance abuse, one potential to manage those silos would be to create a partnership with HRSA and SAMHSA-funded certified community behavioral health centers that may be ideal to assure that all of the home and community-based services provided by PACE and the specialty services provided by these CCBHCs may be able to effectively coordinate that care.

One critical element there, as well, is that additional training, perhaps by geriatric workforce enhancement programs, to both PACE programs and CCBHCs about older adult-specific needs may be critical, and certainly E-4 Center would be happy to collaborate in that effort.

The CHAIRMAN. Doctor, thanks very much. I will turn next to Ranking Member Scott.

Senator TIM SCOTT. Thank you, Chairman. I would like to continue on the discussion of the dual-eligibles. Dr. Rogers, can you explain the benefits of dual-eligible integration and how this will help states improve care once it is implemented?

Dr. ROGERS. Absolutely. If you look at South Carolina, for example, and you have got someone that has a mental health crisis and they end up in a hospital, that is often going to be paid for through Medicare, but let us say that person needs to go into the community and they need wraparound services, they need services if they are homeless, they need other services that may not be covered by Medicare. Many of those are going to be covered in Medicaid in South Carolina.

I think that figuring out how to blend Federal dollars and State dollars has been one of the ways that South Carolina has been able to manage our way through that, because many of the services that now are not blended, the State has actually stepped in to cover many of those services.

It usually is around areas such as social determinants, for example, coordination of care, for example, we talked earlier about the fact that many individuals need medical care as well as psychiatric care. Much of that psychiatric care is not necessarily provided in a doctor's office but may be provided in a community, it may be provided in a community residential treatment facility, so finding ways to actually figure out how to blend funding to be able to have that integrated care in a single setting is often very, very important.

Senator TIM SCOTT. Dr. Rogers, we are talking about, nationwide, a significant population. Nearly 12 million senior Americans are dual eligible, and so this approach that we are seeking to establish through the AIMM Act could have a tremendous impact on providing an enhanced level of care and assistance to those who may need it the most. Is that fairly accurate?

Dr. ROGERS. That is very accurate because the problem we are seeing in South Carolina with having an elderly population there is the same problem that we are seeing around the entire country.

Senator TIM SCOTT. Yes.

Dr. ROGERS. It is State to State. Oftentimes you see that disaggregation of care because of the way it is currently funded.

Senator TIM SCOTT. Thank you, sir. Another question for you, Dr. Rogers. I think through my opening comments about the important role that law enforcement plays in so many crises around the country, and specifically at home. The importance of finding a path to having co-responders, mental health experts also responding to the challenges that law enforcement officers are responding to seems to me to be a very important part of a new apparatus that could perhaps de-escalate.

That is one of the reasons why I have worked with Senator Cornyn and many others on the Law Enforcement De-Escalation Training Act to find a way to help those two worlds come together in order to serve the communities who desperately need perhaps more assistance.

Dr. Rogers, could you share the outcomes that have resulted from the partnership between the South Carolina Department of Mental Health and local law enforcement?

Dr. ROGERS. Absolutely. I think this is an area where we really have excelled as a State. Currently we are embedded with 17 of our local law enforcement agencies in South Carolina.

The things that we have seen is we have our crisis intervention teams, where we have officers that are actually going out with a trained clinician, usually a master's-level clinician that is actually out with them in the field. If it is related to mental health crisis they are able to dually engage. We also have individuals who are in call centers, and so we are able to really triage those calls on the front end.

For those areas that do not have an embedded clinician we have mobile crisis that is available in all 46 counties in South Carolina. Those mobile crisis teams can be called out by a family, by law enforcement, really by anyone. That allows us to respond, I think, to anything that is coming up in a fairly short period of time. If we go out, for example, and it is a difficult situation, law enforcement will often clear the scene, make sure it is a safe environment, and then mobile crisis will actually move in and continue to work with the family or individual, and it allows the officer to really move on to something else.

Then third, something that we have done is we have what is called first teams. We recognize that law enforcement often are encountering individuals in very difficult times. Often there is not a place to talk about it, so as a department, one of the things that we have done is to develop mental health services specifically for first responders.

Those individuals are actually able to come to a different location, able to engage with therapists that are specifically trained to work with law enforcement agents throughout the State. That has been a really incredible program that has benefited us a great deal.

Frequently, law enforcement is engaging with folks that are at their worst. They are in crisis at the time, and so trying to figure

out whatever we can do to be able to support law enforcement as well as the individuals who are in crisis has been something critical to us to do in terms of our law enforcement partnerships.

Senator TIM SCOTT. Thank you, Dr. Rogers. One of the things I would like to say—I know my time has run out, Mr. Chairman—is the importance of that scene that you have just described, the ability to clear a scene, to let the mental health experts address the challenge, so often the folks who are calling the law enforcement officers to the scene are the family members who love the individual who needs to figure out how to de-escalate the situation.

I think that is one of the reasons why it is so important that we do not just sugar-coat the issue by dig a little deeper in how we create an apparatus that actually works for the family who is trying to figure out how to de-escalate a situation, not to watch it explode in their very homes, so thank you very much for that answer. Chairman?

The CHAIRMAN. Thank you, Ranking Member Scott. I wanted to acknowledge, as well, Senator Braun, with us at the hearing, and our next Senator will be Senator Gillibrand who is joining us virtually.

Senator GILLIBRAND. Thank you, Mr. Chairman.

According to the National Center on Elder Abuse, approximately 1 in 10 older adults will become victims of elder abuse. Elder abuse has a physical, mental, and financial impact on older adults.

A 2019 Centers for Disease Control and Prevention report found that between 2002 and 2016, the non-fatal assault rate increased by 75.4 percent among men and 35.4 percent among women over the age of 60, and since 2020, crimes against older Asian American adults have become more prominent. This takes a toll on mental health. Racial discrimination and ageism can trigger chronic stress, anxiety, depression, and racial trauma.

There is so much that needs to be done here, but funding for elder abuse and justice programs authorized under Elder Abuse Prevention and Prosecution Act, the Elder Justice Act, and the Older Americans Act is a first step.

Dr. Emery-Tiburcio, how does racial discrimination and ageism affect someone's mental health, and what are steps that we can take to effectively detect, prevent, and treat elder abuse?

Dr. EMERY-TIBURCIO. Thank you so much for that question, Senator, so interestingly, ageism is what prevents many older adults from getting screened in the first place. We are not aware that older adults are using drugs. As Jim so eloquently pointed out, this is happening. In fact, I treated a 75-year-old gentleman who started using drugs at the age of 75 after retirement because he was bored, and the idea that our ageist ideas prevent us from thinking about older adults using substances, or our ageist beliefs that depression is a normal part of aging—it is not—are what prevents screening, assessment, and treatment from happening.

In fact, there are so many older adults, Senator Gillibrand, as you are pointing out around elder abuse, that are in their homes, and we do not see them, and we are not coordinating care into those homes, and so those folks end up being abused and not having their needs met, and so the degree to which ageism impacts our screening, assessment, and treatment is also affected by racism. In

fact, African America and other Black and Brown folks are not assessed, not treated, not offered treatment, even among Medicare beneficiaries, and so it is critical that we address these issues by universal screening for depression, anxiety, substance use, at a minimum, that we train community-based organizations to interact with older adults like Meals on Wheels and homemakers who are going into the homes and potentially seeing some of these issues, and making substance use services universally available.

We can also address ageism by increasing awareness of it, and to Senator Casey's point about increasing awareness of mental health and aging, increasing awareness of ageism even with our language, with frameworks like reframing aging from the Gerontological Society of America.

Thank you for identifying not only mental health and substance use stigma but also ageism in this space.

Senator GILLIBRAND. As you know, because of COVID we have seen so much more mental health needs grow exponentially. What are some of the barriers that our older adults are facing with regard to accessing mental health services? Are there ways we can improve utilization of existing services, and for older adults on Medicaid, how could enhancing Federal Medicaid funds to incentivize states to provide better community-based mental health services address the gaps in utilization?

Dr. EMERY-TIBURCIO. Access to services is an enormous issue, particularly for Medicare and Medicaid, in part because Medicare Advantage plans have been allowed to split physical health and behavioral health services, and as they do that then those folks who are seen in primary care not able to be treated by psychologists like me who are embedded in that primary care clinic.

As Dr. Rogers pointed out, as each successive referral that older adults get, they are less likely to connect to those services, and so if Medicare Advantage plans and Medicaid plans that are commercially available were encouraged or required to have more integrated care, that would increase access. That warm handoff inside the primary care clinic goes a long way to be able to assist that older adult to access services, and providing services in the communities where older adults are. We hear this is in our policy academies, we hear this in our community conversations, that folks trust people in their own community, whether we are talking rural Pennsylvania or we are talking urban Chicago, that people in their community are folks that they trust, and so creating those collaborations between faith-based organizations, between Area Agencies on Aging, and senior centers to be able to increase access from both a financial standpoint with increased access to those servicers as well as the collaborations.

Senator GILLIBRAND. Thank you. Ms. Williams and Mr. Klasen, just two followup questions if there is still time. Ms. Williams, given your experience with Vibrant Emotional Health, what are the benefits with peer support programs and community-based mental health services? How has this approach helped reduce stigma and support older adults receiving behavioral health care?

Mr. Klasen, thank you so much for sharing your experiences. It takes extraordinary courage and is incredibly important to bring awareness to this issue, and if there is time—the Chairman can

tell me because I cannot see the clock—what are the key ways to reduce stigma and what are some examples of coverage gaps that you have experienced?

Mr. KLASSEN. I am also hard of hearing. I am not sure I have the question, but what I would like to say, because this touches on, well, you know, what has been shared here with Dr. Rogers and Senator Scott, so I train folks with mental health challenges to help people, to become peer specialists, and thinking especially about the mobile crisis teams and working with law enforcement and all of that.

I had one guy named Will that we had trained as a peer specialist, and he got a job for a major provider, and struggled a bit with case notes and using the computer. He did not get fired. He got transferred. I started to get a new set of phone calls from a psychologist that was on this mobile crisis team that he was on, and the message there was, “We do not know how we did it without him.” Because of his lived experience and presence, he was able to de-escalate situations that professionals may have been challenged with.

Senator GILLIBRAND. Thank you. Ms. Williams, did you just want to answer the question that I asked you?

Ms. WILLIAMS. Thank you, Senator, for the question. Peer support has been incredibly powerful in terms of engaging older individuals, whom we, and other community organizations serve. Peers help by destigmatizing access, allowing individuals to share their own stories of hope and recovery, and building trusting relationships with other older individuals and engaging them effectively in care. I speak very highly of the use of integrating peer support with existing services.

Senator GILLIBRAND. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Gillibrand. We are joined by Senator Kelly, and now we will turn next to Senator Collins.

Senator COLLINS. Thank you, Mr. Chairman. I want to thank both you and the Ranking Member for shining a spotlight on this problem. I think that when most people have an image of someone who is addicted they think of a young male, and they do not think of an older person, and yet from a previous hearing that I held 4 years ago when I chaired this Committee, one of the witnesses told us that older adults make up 25 percent of the long-term opioid users and that Medicare beneficiaries are the fastest-growing population of diagnosed opioid use disorders, and the drug overdose crisis has only gotten worse since then. In my State, in 2020, more than 630 people lost their lives to overdoses. Equally startling, however, is the fact that there were nearly 9,000 non-fatal overdoses. We also know that people 85 and older have the highest suicide rate of any group.

We have a real problem, and I think hearings like this help shine a spotlight on the problem facing older Americans, and building off what Ms. Williams said and Mr. Klasen’s powerful testimony, I too want to endorse peer-to-peer counseling. I have visited the Bangor Area Recovery Network, which is a peer-to-peer program. It is very successful, but during COVID there have not been nearly as many face-to-face interactions, and I can see Mr. Klasen nodding as I am saying this. Did you say something you wanted to add?

Mr. KLASSEN. Yes, that is true, but I think it accelerated us into a world of telehealth.

Senator COLLINS. Yes.

Mr. KLASSEN. In some ways we were able to reach people that were not able to before. People in rural areas that did have the technology or maybe were reluctant to come to a physical place we were able to reach, so it kind of worked both ways.

Senator COLLINS. Thank you for bringing up telehealth because that leads me into my question, which I would like to hear from the rest of the panel on. We know that during COVID that a lot of face-to-face counseling sessions were canceled, and we know that isolation and loneliness can have serious, even deadly consequences for the health and well-being of our seniors. It is associated with a greater incidence of depression, substance abuse, diabetes, heart disease. In fact, studies have shown that the health risks of prolonged isolation are comparable to smoking an astonishing 15 cigarettes a day. Just think about that, so this is a call to action.

I would like to ask Dr. Emery-Tiburcio—all of us are having a little trouble on the last name, for which I hope you will excuse us—and Dr. Rogers and Ms. Williams about the role of telehealth. I have worked hard in the infrastructure to get funding with Jeanne Shaheen so we get it out to the rural areas, which exists in every State.

How can we ensure that telehealth plays a role in increasing access to proper screening and care for older adults, especially in rural areas, as we grapple with the ongoing shortages in the behavioral health workforce? If we could go straight across. Thank you.

Dr. EMERY-TIBURCIO. Thank you so much, Senator Collins. It is a critical question, I think, particularly for older adults. You know, we have a program that provides cellular-enabled tablets to older adults for accessing telehealth and for accessing social media, so that they can connect, and that program has been incredibly powerful in reducing loneliness.

Folks, though, who do not have that kind of a device or do not have access to broadband, as Dr. Rogers highlighted, those are individuals who require telephonic psychotherapy and interventions to be able to even access their primary care, and the annual wellness visit that Medicare provides is a wonderful way to be able to offer that screening telephonically, but continuing that Medicare coverage for telephone-only services is critical, so many of my patients who I continue to see only via telephone would not get services otherwise, and as we move forward, even hopefully out of this pandemic, that continued service will allow my patients who may have increasing medical issues as well that will not let them come at any given time, to continue to manage their mental health.

Senator COLLINS. I agree with you that we need to extend the reimbursement for telehealth and audio as well.

Dr. ROGERS, you represent a State that has a lot of rural areas, the way Maine does. What has been your experience with telehealth?

Dr. ROGERS. You know, Dr. Emery-Tiburcio said something earlier that I had not really thought about as much and that is the whole idea of ageism. One of the things that when we were first starting out with telehealth there were kind of these two ideas.

One is that older people do not use technology, and the second one is older people do not work because most of them are retired.

One of the things that we found as we started rolling out telemedicine is that both of those things are false, for the most part. We found that a lot of our elderly population continue to work, and one of the things that has been really beneficial about telemedicine is the fact that they do not have to actually miss work in order to have an appointment.

In South Carolina, many of our folks are working hourly jobs, so if you are taking an hour off, oftentimes you are having to take an entire day off, versus I have seen many people that are able to go out to their parking lot, sit in their car, have a 30-minute session with me, and then go back to work. That is a benefit for both the employer side but also the employee, who happens, in many cases, to be aged 65 or older.

Senator COLLINS. I am going to have to cut you off because I know I am over my time, much as I would like to continue this. Ms. Williams, could you provide me with an answer for the record, because I really am interested in what you have to say as well.

Ms. WILLIAMS. Yes. I would be glad to. Thank you for the question, Senator Collins. Quickly, I want to reinforce the extension for tele-mental health reimbursement and audio-only available services. We have been able to support some innovative programming within New York which are easily replicable. For example, providing treatment over the phone to support and engage older adults and make sure that they get access to the care that they need, and also working in partnership with the State of New York in the implementation of service demonstration grants which have included providing supports to older individuals in rural communities who are isolated, being able to provide them access with a laptop so that they can get the treatment that they need. Both of those examples serve as demonstration for the importance of making sure that we extend access to support utilization of telehealth services.

Senator COLLINS. Thank you, and thank you, Mr. Chairman. I also think that telehealth helps to reduce the unfortunate stigma that still exists, when people can get the counseling and help they need in the privacy of their own homes. Thank you.

The CHAIRMAN. Senator Collins, thanks very much, and I agree. Senator Kelly.

Senator KELLY. Thank you, Mr. Chairman. I was going to followup a little bit on Senator Collins' question. I think she covered the issue of opioid epidemic and substance use disorders and how it affects older adults, and like so many other states, I am sure like Maine, Arizona has been hit pretty hard by this, and it is not surprising that we often hear from the aging network, for lack of a better term here, that they often hear from seniors asking about what sort of substance use disorder treatment that their Medicare plan will cover, and often they do not like the answer.

If there is anything you left out about where these gaps in Medicare for older adults experiencing substance use disorder issues, if you just wanted to take a few more, like maybe a minute or so, to fill in the gaps there, and then I have got a question for Mr. Klasen.

Ms. WILLIAMS. Thank you, Senator Kelly, for the question. As was highlighted, given the growing population there is a growing need for these services, and Medicare, unfortunately, has limited coverage for substance use services. The services are not aligned with evidence-based practices and with the full treatment continuum. There are remedies for addressing those gaps, including ensuring that the full continuum of services are covered, ensuring that the full range of addiction specialists and treatment facilities are covered, and ensuring that parity is applied here so that older adults do not experience unnecessary discrimination and financial and treatment limitations, and so through addressing those gaps we can promote better access to care for older individuals and get more of them on the road to recovery.

Senator KELLY. Thank you. Mr. Klasen, as a peer specialist are your programs covered by Medicare?

Mr. KLASSEN. Some of them are, yes.

Senator KELLY. Some of them are, but some of them are not.

Mr. KLASSEN. That is correct.

Senator KELLY. My understanding is 60 percent of mental health professionals who work in rural areas, that their programs are not covered by Medicare. Does that sound about right to you?

Mr. KLASSEN. That sounds about right.

Senator KELLY. Imagine how disruptive this would be, you know, for somebody who ages into Medicare and then suddenly they find out that they cannot pay, their insurance, Medicare, will not pay for their provider and they have to pay out of pocket, and what this means to seniors in Arizona, and for them it feels rather arbitrary, and they often do not have supplemental coverage needed to make this care affordable.

That is why I am a co-sponsor of the Mental Health Access Improvement Act which would allow licensed professional counselors and licensed marriage and family therapists to provide services under Medicare. We have to expand the universe of providers to make care accessible and affordable. I mean, literally lives depend on this often.

Mr. Klasen, given your personal and professional experience, is there anything you would like to add to that, speaking to the need to bolster our workforce and ensure the continuum of care continues into Medicare?

Mr. KLASSEN. You know, thank you, Senator Kelly. Yes, it is complicated. A lot of this stuff goes into a lot of older adults are reluctant to ask for help to begin with. You know, we are all about rugged individualism, and I do not need public benefits, so part of it is relating with them on that issue, and then there is the frustration. If I am seeking help and getting kicked around to different places or the rules are different or it just seems to be taking too long, folks just, you know, abandon it.

I think with peer support, it is an interesting idea. I think of peer support more in direct service, but I think the idea that peers can talk to peers, older adults can talk to other older adults and relate to them, whether they are veterans or whether it is a substance abuse issue or whatever, and say, "You know, it is okay, and I have some information. I have some resources for you."

Senator KELLY. Well thank you, Mr. Klasen, and I yield back the remainder of my time.

The CHAIRMAN. Senator Kelly, thanks very much. We are at a point in the hearing where we will have some Senators coming to the hearing from other hearings they have had or returning to ask questions. In the interim I will start a second round. I cannot guarantee, because of the vote coming up, that every Senator will have a second round if they desire it, but I will start until we have a Senator returning.

I wanted to go back to Ms. Williams. You said, on page 3 of your testimony, you related a story of a 62-year-old woman living with serious mental illness and chronic health issues who also lacked stable housing, which I cannot even imagine what some people have to live through when they are experiencing all kinds of challenges at the same time.

You described how providing her tailored support unique to her mental and physical health as well as her own social circumstances. As a result she was able to get the care she needed in the community instead of a psychiatric hospital, and you go on to recommend better integration, as we heard before, of physical and mental health care with aging services.

I have got legislation I made reference to earlier, the Supporting States in Integration Medicare and Medicaid Act, which would provide \$300 million to states and CMS, Centers for Medicare and Medicaid Services, to develop and advance these integrated programs, and I guess a simple question about this kind of an approach. What is the value of that linkage, linking community-based services with medical care?

Ms. WILLIAMS. Thank you, Chair Casey, for this really important question. Older individuals who have chronic physical conditions and functional impairments are more likely to experience higher-cost services and more likely to experience poor outcomes. Better engagement with older adults will lead to better health outcomes, and improved engagement includes linking health services with social services, particularly around prevention and wellness. Medical providers can work collaboratively with Area Agencies on Aging to help to support older adults in managing their chronic conditions and also to help address unmet social needs. It is through this linkage between social and medical services that we can support the overall quality of life of older individuals, support better health and mental health outcomes, thus reducing the need for costlier services in nursing homes and other institutional settings.

The CHAIRMAN. Thanks very much. We will turn next to Senator Blumenthal.

Senator BLUMENTHAL. Thank you very much, Senator Casey, and thank you for holding this hearing. I am grateful to the witnesses for being here today on this tremendously important topic. As my colleagues may have remarked, and I apologize if I am repeating anything they have said or asked, I think this Nation is going through a mental health crisis. The trauma of COVID, the economic challenges faced by families, the deaths and illness that they have seen, at every age, most especially our children because they have been out of school, but really every age, and I fear our elderly

Americans, as much as children, even though they are perhaps less vocal, and they are more isolated.

I am particularly concerned—and I have just left a hearing of the Armed Services Committee; I am on that Committee and Veterans Affairs Committee—by the mental health of our veterans. We are only really beginning to understand how the impacts of trauma, seeing it, enduring it during military service, can be enduring and, in fact, can be increasing as age comes on. We now have a sizable veterans' community of advanced age. Due to the wonders of medical care they are living longer, but I wonder if the witnesses could comment on the needs and challenges faced by veterans as they age and what you have observed about the challenges they face and the programs that are available to them.

Dr. EMERY-TIBURCIO. Certainly, Senator, as you highlighted, we are only just beginning to understand trauma in later life, and there are many older adults who experience the effects of trauma for the first time after retirement. They have been working for years and engaged in childcare and engaged in family, and when they slow down enough sometimes those traumas resurface, and that may be particularly the case for veterans.

I happened to be working at the VA Boston Health System at the time of 9/11, and working in the nursing home, watching veterans watch the television and being incredibly distressed that (a) from their nursing home beds they were going to be called back into service, and (b) reliving those kinds of events over and over, and so as we watch things like the Ukraine war, the Russian attack on the Ukraine, so many veterans are experiencing those same traumas, and so increasing availability of services, certainly the VA has an incredibly powerful trauma center that has fantastic evidence-based programs, and there are some veterans who are not service-connected enough to be able to access those services effectively, and so assuring that those services are available in the community as well would be well regarded.

Senator BLUMENTHAL. Thank you. Any other comments?

Dr. ROGERS. Yes. I think in addition to the services that we know are needed by our vets, one of the things that we talked about earlier was the fact that we have a shortage of providers, so if you look at our older population and folks that are specifically trained to work in the geriatric area, we are seeing many of those folks retiring or not as many coming out of training, and so I think that part of what we are seeing is really a twofold issue. One is increase in need that we are seeing among the veteran population as it ages, but also the second piece is really not having enough trained people going into those areas to work with older adults.

Senator BLUMENTHAL. Thanks, Dr. Rogers.

Ms. WILLIAMS. Thank you, Senator Blumenthal, for the question. To add to Dr. Emery - Tiburcio's comment on ensuring that community-based providers are equipped to support older adults with mental health issues, for older adults who are veterans, it is imperative that those providers are adequately trained to identify and support the specific issues that affect this population.

Senator BLUMENTHAL. Thank you.

Mr. KLASSEN. Quickly—

Senator BLUMENTHAL. Sure.

Mr. KLASSEN I mean, no one can talk to a veteran like another veteran. I am not a veteran, but one of my co-facilitators, a Marine with significant military experience and is a peer specialist, I mean, just to me it was a very powerful combination.

Senator BLUMENTHAL. That is an excellent point. We have been trying to expand the peer-to-peer program, but as you point out, there is no one like one veteran talking to another veteran. Nothing like that kind of rapport and trust. Thank you.

Thanks, Mr. Chairman.

The CHAIRMAN. Thanks, Senator Blumenthal.

Ranking Member Scott.

Senator TIM SCOTT. To add on to Senator Blumenthal's rapport and trust, it is having had the same experience in so many ways. While different, the similarities of being in conflict, being in theater also adds to the ability to have someone who understands and appreciate the significant impact that life and/or serving your country has had. Having a father who served 27 years and a brother who served 32 years, and my other brother who served 26 years, I oftentimes hear the stories of how important it is to have someone who has been where you are, who has walked in your boots there with you, going through the journey.

Dr. Rogers, one of the things I note is in South Carolina we have Victory House in Walterboro, and other facilities for our veterans. The availability of space and capacity seems to be one of the challenges that we face nationwide. Would you talk, Dr. Rogers, for a minute about the importance of nursing homes and other veteran facilities in South Carolina ensuring this population are receiving adequate mental health services?

Dr. ROGERS. Absolutely. Thank you for that question, Senator Scott. One of the things that we have in South Carolina is we are actually in the process of building our fifth veterans' nursing home in the State.

South Carolina is organized a little differently than many other states in that our veterans' nursing homes actually fall under the Department of Mental Health, and part of that is because the first nursing home that was opened in South Carolina to serve veterans in 1971, was opened by the department because we were trying to move people from the State hospital that were veterans, and many of those folks had significant mental health issues but many really did not, and so over time we have developed some degree of expertise, and part of that expertise is really figuring out how do we have the resources to really work with our older veteran population, so we have a number of veterans who actually work in our system. We also have a number of geriatric psychiatrists, psychologists, that are actually with us specifically with the veteran population, so for example, the deputy director at our department oversees our nursing homes is a geriatric psychiatrist who his very engaged and involved in making sure that the mental health service needs are met for that population.

That focus on the veteran population as well as the aging population has been something that the department has been very focused on.

Senator TIM SCOTT. Thank you, sir. Switching to another topic, Dr. Emery-Tiburcio—close enough?

Dr. EMERY-TIBURCIO. Close enough.

Senator TIM SCOTT. How do you actually pronounce it?

Dr. EMERY-TIBURCIO. Emery-Tiburcio.

Senator TIM SCOTT. Tiburcio.

Dr. EMERY-TIBURCIO. Yes.

Senator TIM SCOTT. Thank you, Doctor. The issue of overdoses plaguing our Nation in a way that we have not seen ever—107,000 deaths, as we talked about earlier, and the challenge of fentanyl coming across. I cannot tell you the number of parents that I have talked to who have lost their child because of the first try with something that was laced with fentanyl, and the number of our seniors who are having a similar experience as well.

Can you talk for a minute about the importance of this missed challenge that we are facing?

Dr. EMERY-TIBURCIO. Absolutely. Thank you for raising that important topic. You know, it is interesting. There was a study that just came out that looked at the last 10 years of data, and demonstrated a 1,886 percent increase in opioid overdose deaths, and another report just came out showing that adults aged 65 to 74 face the largest increase in the drug death rate of any age group, so this is an older adult issue.

Interestingly, as we look at older adults, in particular, and why this is an issue, ageism is a piece, as I have said previously, this idea that we do not look at older adults and think drug use, so we do not screen, so we do not assess, so we do not treat, and the idea that part of that data, the authors of that JAMA study, pointed to racism as being a key factor, that older Black men died at a rate 10 times that of other groups, and older Black men, as Senator Blumenthal was just bringing up trauma, older Black men are much more likely to be victims of trauma, including a lifelong experience of racial trauma, lack of access to health care, and do not trust health providers, for good reasons. Black and Brown folks in hospitals do not get treated for their pain as much as white folks, and so with that, folks are more likely to self-medication, as Jim has highlighted, and so, again, we need to be screening. We need to be assessing. We need to be providing these services, and I would be remiss if I did not also point out that in addition to opioids, alcohol is actually the most abused substance by older adults in the U.S., and we do not provide nearly enough attention to that as well, and particularly during the pandemic the issue has exploded.

Senator TIM SCOTT. Thank you, ma'am. Mr. Chairman?

The CHAIRMAN. Thank you, Ranking Member Scott. I want to thank all of our witnesses. We are going to have to adjourn, but we could go on for a good while with all of the expertise that you bring to bear and your own either personal experiences or professional expertise, and in many cases both. We are grateful for the work you have done to bring that level of insight and expertise to the hearing today.

I want to start by, as well, thanking Ranking Member Scott for hosting this hearing with me today and to elevate the need to improve mental health care for older adults. As we heard today, seniors face many challenges in just navigating the mental health system, including limited awareness about where to look for help and

the stigma surrounding mental illness and treatment, stigma as it relates to both illness and treatment. These challenges lead these individuals, these Americans, to feel unsupported and very much alone and nowhere to turn.

There are people like Jim who shared his story with the Committee today, and tells us why we need to have a more integrated approach to mental health and substance use disorder for older adults, and that is one of the reasons that Ranking Member Scott and I have introduced the Advancing Integration in Medicare and Medicaid Act—I will use the acronym, the AIMM Act—which requires states to develop a plan to address fragmentation in both Medicare and Medicaid. These programs which so many older adults rely upon for their mental health, both programs become so essential for people's lives, and we have got to make sure they are better integrated.

I look forward to continuing to elevate solutions to our Nation's mental health crisis, including solutions to help our seniors.

Now I will turn to Ranking Member Scott for his concluding statement.

Senator TIM SCOTT. Thank you, Chairman, for holding another really important hearing. To all of our witnesses today, thank you for sharing your expertise, and frankly, your passion, as well as your experience on such an important topic, especially during the week where we celebration Older Americans' Mental Health Awareness Day.

Whether it is the AIMM Act that I have introduced with the assistance of Chairman Casey, or the ACADEMIC Act, or the Law Enforcement De-Escalation Training Act, the one thing that I am confident of is that we are taking this issue more seriously today than we have in the past, and that is really good news for the future.

Far too little has been done, and we need to push forward in making sure that we pass meaningful legislation that provides more resources to our senior population. America is only growing older, which means that the problem will only get worse unless we bring more solutions to the table, now.

Thank you all for being here.

The CHAIRMAN. Ranking Member Scott, thank you, and again I want to thank all of our witnesses for their testimony, the answers to the questions they provided, and of course their own expertise that they will continue to bring to bear on these issues.

For the record, if any Senators have additional questions for witnesses or statements to be added to the record the hearing record will be kept open for 7 days until next Thursday, May 26th.

Thanks everyone, for participating, and this concludes today's hearing.

[Whereupon, at 11:27 a.m., the Committee was adjourned.]

APPENDIX

Prepared Witness Statements

Testimony of Erin Emery-Tiburcio, PhD, ABPP

Senate Aging Committee

Mental Health Care for Older Adults:

Raising Awareness, Addressing Stigma, and Providing Support

May 19, 2022

Good morning, Chairman Casey, Ranking Member Scott, and distinguished members of this committee. Thank you so much for the opportunity to speak with you today about the mental health and substance use needs of older adults. My name is Erin Emery-Tiburcio, and I am an Associate Professor in the departments of Psychiatry & Behavioral Sciences and Geriatric Medicine at Rush University Medical Center, where I co-direct our Rush Center for Excellence in Aging, our HRSA-funded Geriatric Workforce Enhancement Program called CATCH-ON, and our SAMHSA-funded E4 Center of Excellence for Behavioral Health Disparities in Aging with my colleague and co-director, Robyn Golden – a significant contributor to these remarks.

The White House has recognized mental health and substance use as a critical issue for all Americans. I am grateful that this committee recognizes older adult mental health and substance use needs as an issue of equity. Not only is stigma about mental health and substance use a barrier to effective screening, assessment, and treatment for these disorders, but that stigma is compounded by systemic ageism at policy, provider, community, and individual levels that has resulted in severely limited access to effective care for older adults. Today, I will point to

three key issues for this Committee to consider in creating policy to address equity for older adults: access to care related to Medicare policies, the need for coordination of care for older adults who experience the most complex health issues, and the critical need for expanding the behavioral health workforce trained to work with older adults.

Access to care

Allowing for market rate reimbursement for mental health and substance use services is critical to assure adequate provider enrollment. Medicare provides much needed coverage for older adults and those with disabilities. Unfortunately, reimbursement rates for both mental and physical health services are inadequate for engaging providers to enroll.¹ In fact, psychiatrists are the most frequent providers to opt out,² leaving older adults with little or no service. While the Senate Finance Committee report states that, in this situation, “patients are more likely go out of network for behavioral health services,” the reality is that if their insurance does not cover services or providers who take their insurance are not available, they will not get services.³⁻⁵ This is particularly true for individuals who are eligible for both Medicare and Medicaid (“dual eligibles”), many of whom have serious mental illness, often with comorbid substance misuse, because they are required to navigate two separate and confusing systems, and rarely have the resources to consider out-of-network options. Given that the highest rate of suicide in the US is among older adults,⁶ most of whom have seen a primary care provider in the previous month,⁷ the lack of available mental health providers is deadly.

Medicare Advantage plans must be required to allow for coordinated care by not separating contracts for health systems that also have behavioral health services. Optimal care for all adults coordinates mental and physical health care.⁸ This is particularly the case for older adults with

disorders ranging from depression⁹ to serious mental illness^{8, 10, 11} to substance misuse.¹²

Unfortunately, Medicare Advantage plans have been allowed to split contracts for physical and behavioral services so that older adults cannot receive services in one coordinated setting. When I worked as a psychologist in primary care, we saw repeatedly that my primary care physician colleagues treated patients whose insurance did not cover mental health services at Rush, so they had to be referred out for mental health treatment. The mental health and substance use provider lists were very small, and reflected no training in working with older adults. Consistent with the literature on integrated care vs. community referrals,^{13,14} few of these older adults received needed mental health services.

Most providers neglect to screen older adults for substance use disorders due to the ageist beliefs that older adults don't use drugs, and that they stop drinking alcohol while taking high risk medications, despite SAMHSA recommendations for universal screening.¹⁵ This is particularly problematic since the start of the pandemic, as alcohol consumption among older adults has increased dramatically.¹⁶ In the limited cases that are detected (many apparent before the adult turned 65), the continuum of care offered to older adults is flawed, in that it offers inpatient and standard outpatient services, but not the critical stabilizing intensive outpatient programs that so many older adults need to be healthy, nor services provided in communitybased settings. This disparity is due, in part, to the fact that the Mental Health Parity and Addiction Equity Act does not apply to state Medicaid or Medicare fee-for-service – while parity theoretically exists for younger adults, it does not exist at all for older adults. We strongly echo the Senate Finance Committee report statement that, “insurance companies must be held accountable for putting mental health care on par with physical care. Medicare, Medicaid, and CHIP must also deliver on the promise of parity. There can be no cutting corners in mental

health and SUD coverage.” Additionally, the vast majority of substance use clinicians are at the master’s level and cannot bill Medicare. So long-term relationships that stabilize adults in the community for some must end when that individual turns 65. They lose access to their therapist because of their age, creating a vast unmet need for treatment that exists solely by reason of a patient’s age. Given the lack of available Medicare providers and for continuity of care, consideration must be given to providing master’s level clinicians eligibility to enroll as Medicare providers. Similarly, the [Access to Mental Health Act \(S. 870\)](#) advocates for allowing social workers to provide psychotherapy services in skilled nursing facilities – filling another crucial gap in care.

Coordination of Care

The Senate Finance Committee report on [Mental Health Care in the United States: The Case for Federal Action](#) aptly identifies key issues in behavioral health for Americans that apply to older adults, including awareness of the need for coordination of benefits for individuals who are eligible for both Medicare and Medicaid (“dual eligibles”), ongoing coverage for telehealth, and the need for increased access to broadband (intense gratitude to Senator Scott for his key legislation in these areas!). What the report left out was the critical need for coordination across health care entities and community-based organizations – especially for older adults who will otherwise fall through the cracks of a splintered system.

More than half (56%) of adults with complex physical health needs report anxiety, depression, substance misuse, or emotional or psychological problems resulting from their illness.¹⁷ Among people with serious illness, those reporting mental health issues were more likely to feel socially isolated, experience financial vulnerabilities, and experience problems with

their medical care. Experiencing loneliness or isolation – certainly exacerbated by COVID-19 – has been associated with a 29% increased risk of heart disease and 32% increased risk of stroke.¹⁸ Further, older adults with bipolar disorder have an average of three to four medical conditions,¹⁹ and individuals with schizophrenia are significantly more likely than others to die prematurely of cardiovascular and respiratory disease.²⁰ Managing one illness at any age is challenging, but older adults with both medical and mental health or substance use issues, multiple medications, multiple health care providers, and often multiple systems providing services require assistance in coordinating care. In fact, a survey of recipients of long-term services and supports found that 81% reported unmet needs, including help with self-care or other daily activities (21.1%); services that meet needs and goals (30.0%); assistive technology (54.3%); home modifications (52.2%); and transportation (26.7%).²¹ Note that many of these services are not reimbursed by Medicaid or Medicare, yet these are exactly the services that allow older adults to remain in their homes with dignity, better quality of life and lower health care utilization. In fact, strong social support services, such as transportation and help for family caregivers can lead to lower health care use and costs.²²

The “aging network” of community-based organizations, including Area Agencies on Aging (AAAs), local senior centers, and other community-based organizations, offer an array of services, including care management, home-based support services, home-delivered meals, socialization initiatives, and evidence-based health promotion workshops, along with education about a wide range of programs, services, and housing options. These services are funded through the Older Americans Act, though agencies struggle to provide services at the level needed by older adults with mental health and substance use issues, as most are not able to access payments via CMS. Further, communication between health systems and the aging

network is rare, thus transitions of care from the hospital or clinic to the community is where older adults fall through the cracks – or rather, chasms. It is in these chasms where chronic medical and behavioral health issues are exacerbated by lack of care.²³

Innovative, effective programs exist that coordinate services across health and social care and must be implemented broadly to meet the needs of older adults. For example, the Bridge Model of transitional care, initially developed in 2007 by my colleagues at Rush and disseminated to nearly 200 hospitals since, leverages master's prepared social workers to provide a comprehensive intervention to support patients and those that care for them after a hospitalization or rehabilitation stay.²⁴ The biopsychosocial assessment completed by the transitional care social worker identifies individuals' immediate priorities, concerns with the care plan such as working with home health, and questions about ongoing care needs such as medication changes. The social worker intentionally collaborates with healthcare providers across the continuum but also with local social service providers – often engaging programs offered through the local AAA to support people in their recovery. By having one foot in healthcare and one foot in the community, this social worker is able to balance various care plans and whole-person needs to engage relevant providers and address fragmentation across systems in a way that managed care organization care coordinators do not. The Bridge Model has demonstrated decreased re-hospitalizations and emergency department visits, higher likelihood of attending follow-up primary care visits, and reduced patient and caregiver stress.²⁵ The Bridge Model was included as part of the Center for Medicare and Medicaid Innovation's "Communitybased Care Transitions Program," from 2012-2016 which ended, despite seeing meaningful impact among individuals served.

At the policy level, the “self-direction” movement,²⁶ an alternative to traditionally delivered and managed services, is included in several states’ Medicaid plans or waivers.²⁷ In the traditional system, when people with disabilities and older adults needed help with activities of daily living and navigating their communities, they typically have little choice about who helps, when that support was delivered, or what the worker would or would not do. The self-direction movement offers Medicaid beneficiaries the option to select their own workers and create an individualized budget to help them live more independently. Making self-direction a standard option for Medicaid and infusing it across “dual eligible” plans are two ways the program could be impactful for more people, and offer significant savings over standard plans.²⁶

For several years, many states incorporated self-direction principles as part of their implementation of the “Money Follows the Person” demonstration program. From 2007 to 2019, the program provided states with enhanced federal matching funds for services and supports needed to help older adults and people with disabilities transition from institutional care to community-based care. Forty-four states participated, impacting approximately 100,000 older adults and people with disabilities. “Money Follows the Person” helped many states establish programs to support transition from institutions to the community by enabling them to develop service and provider infrastructure. Many participating states also developed housing-related services and hired housing specialists to help beneficiaries locate affordable accessible housing, a common barrier to aging in the community and avoiding institutional care. These services are critical for older adults with serious mental illness and/or substance use disorders, particularly those with limited resources that make them “dual eligibles.”

As we have seen during the recent COVID-19 pandemic, expanded access to services furnished via telehealth helped bridge traditional gaps in access to mental health services.

Audioonly telehealth, in particular, served as a vital tool to extend services to individuals who either lacked the technological familiarity with telehealth platforms or who lived in areas lacking access to broadband internet services. As the mental health impact of the pandemic will be with us long after the end of the actual pandemic, I ask the Committee to support a longer-term extension of the current telehealth coverage flexibilities, as well as equal coverage and reimbursement for mental health services furnished via telehealth.³⁴ Again, we are grateful to Senator Scott for key legislation in this area.

Each of these program innovations have made significant progress in bridging the chasms inherent in the American health care system and community services. Policies that support such care coordination, housing assistance, and transitions of care must be implemented.

Behavioral Health Workforce

As the United States Senate and House of Representatives work to pass a bipartisan mental health reform package before the conclusion of 117th Congress, we look to your leadership to ensure that improvements and increased funding levels for training programs are inclusive of all populations across the lifespan, particularly for older adults where the need is urgent.

While the behavioral health workforce is vastly understaffed for all ages, by 2030, it is estimated that we will only have 27% of needed psychiatrists, 9% of needed social workers, and 5% of needed psychologists with specialized training in working with older adults.^{28,29} The need may be even greater as trends are showing more than 10% decline in psychiatrists from 2003 – 2013.³⁰ As of 2018, the national average was 2.6 geriatric psychiatrists for every 100,000 adults over age 65,³¹ and there are currently only 65 board certified geropsychologists in the entire

US.³² We will never have enough geriatric specialists, so it is critical to assure that all health care providers and the community-based organizations who provide support services have basic competency in meeting the needs of older adults.

Funding mechanisms exist to support the training of health care providers and community-based organizations in working with older adults, though a greater focus on mental health is needed. We are very grateful to Senator Casey for being a champion for the funding of the Geriatric Workforce Enhancement Programs (GWEPs) and Geriatric Career Achievement Awards (GACAs). GWEPs are responsible for providing education to health care providers, students, community-based organizations, older adults and caregivers about older adult health and health care, along with transforming primary care to meet the needs of older adults. All GWEPs currently address some mental health issues via implementation of the [4Ms of an AgeFriendly Health System](#) (What Matters, Medication, Mentation/Mind, and Mobility), an evidence-based framework for older adult health from the Institute for Healthcare Improvement that is currently practiced in more than 2700 health systems. As such, GWEPs are primed for expanding that focus in future funding cycles to include a greater focus on mental health and substance use. The GWEP based at Rush University Medical Center that I co-direct, called CATCH-ON, is focused directly on mental health issues, currently finalizing an online certificate program for mental health clinicians to attain foundational competency in older adult mental health that will launch in late spring, 2022. We are also offering an in-person fellowship to a small cohort of mental health clinicians to build both knowledge and skill in this area. If all GWEPs were to increase focus on the mental health and substance use needs of older adults, every region of the US would have access to high quality training. Further, GWEPs are required to build partnerships with community-based organizations, including Area Agencies on Aging

(AAAs), which are ideal for expanding such training to the aging network and direct care workforce, as well as potentially other community organizations, first responders, and others who meet the needs of older adults. Proposed support for additional GWEPs with larger budgets would allow for these critical needs of older adults to be more effectively met. While most states represented in this committee have GWEPs, this additional funding may allow for every one of your states to benefit from this essential workforce development program.

In September of 2020, SAMHSA funded Centers of Excellence for Behavioral Health Disparities in Aging, African Americans, and LGBTQ individuals. Rush University Medical Center was awarded funding for [the Engage, Educate, and Empower for Equity: E4 Center of Excellence for Behavioral Health Disparities in Aging](#). With this funding, we have engaged more than 10,000 professionals in just 20 months between live and recorded educational events. We have created educational materials, including a [toolkit to aid health care and community based organizations build partnerships](#) to improve the care of older adults who may otherwise fall through the cracks of our splintered healthcare system. We have also engaged three states (Illinois, Nebraska, and Pennsylvania) in policy academies that bring together state entities who rarely communicate with each other, including mental health, substance use, aging, transportation, housing, Medicaid, and local chapters of the National Alliance on Mental Illness, to identify gaps in meeting the needs of older adults and generating a plan to begin to fill the gaps.

We have been honored to host our current policy academy in Pennsylvania, in partnership with the Pennsylvania Association of Area Agencies on Aging (P4A). This incredibly committed and passionate group of state leaders has highlighted needs for local implementation of mental health services where older adults are, including in senior centers and

Area Agencies on Aging. They have also highlighted the challenges of being unable to provide continuous services to adults with substance use disorders as they turn 65, as most substance use disorder counselors are not eligible to bill Medicare. As described above, a lack of mental health and substance use clinicians enrolled as Medicare providers is a significant barrier to service provision in Pennsylvania. We have heard similar concerns in other states, along with barriers to effective care and housing for older adults with serious mental illness, who are often placed in nursing homes they don't want to be in, and who are ill-equipped to meet the needs of these individuals.

SAMHSA has funded similar centers in the past, but more consistent funding would ensure educational efforts maintain momentum over time. As the older adult population is growing in the US with improvements in medical, public health, and social efforts, legislation to mandate the inclusion of older adults in SAMHSA priorities is desperately needed. While the visit rate for older adults in primary care is more than double that of children age 1-17,³³ multiple pieces of legislation seeking to boost funding for targeted populations often exclude older adults. Leaving older adults out of such legislation leaves primary care providers – and every health services professional – ill-equipped to provide effective services across the lifespan, exacerbating the problem of inequitable care for older adults.

An additional barrier to effective training of health care providers in meeting the needs of older adults is a pipeline problem. Given limited exposure of students to older adults early in their educational careers, along with few training opportunities due to Medicare restrictions on billing for trainees, there are few mental health providers entering geriatrics as a specialty. While consideration must be given to allowing “incident to” billing for mental health trainees under the direct supervision of qualified licensed mental health clinicians, increased funding for training

and incentives for entering geriatrics is also critical. Examples include expanding the HRSA-funded Graduate Psychology Education (GPE) and Teaching Health Center Graduate Medical Education (THCGME) programs directed toward training in geriatrics, along with increasing focus on loan repayment programs for working with underserved older adults.

I am grateful for this Committee's attention to the three key issues to address equity for older adults: access to care related to Medicare policies, the need for coordination of care across the continuum of health care and community-based organizations for older adults who experience the most complex health issues, and the critical need for expanding the behavioral health workforce trained to work with older adults. I am also grateful to the Rush Center for Excellence in Aging team and our organizational partners that contributed to this work.

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Testimony of Kenneth Rogers, MD
Mental Health Care for Older Adults:
Raising Awareness, Addressing Stigma, and Providing Support

May 19, 2022

Thank you Chairman Casey and Senator Scott for the opportunity to be here today.

The South Carolina Department of Mental Health (SCDMH) is a comprehensive, statewide health system that is comprised of 16 mental health centers that provide whole person care, meaning that we are focused on both the physical and mental health of our patients. We work in concert with federally qualified health centers, health systems, as well as non-traditional locations of service including schools, churches and other community partners. Additionally, we operate two free standing psychiatric hospitals, an inpatient substance-use treatment facility, and five veterans' nursing homes. Like all states, South Carolina has seen an increase in the number of individuals seeking care throughout the pandemic. The two populations seeing the greatest increase are the youth and the elderly.

We have identified several reasons for this increased service need. First, social isolation has had an incredible impact on our elderly population. The activities that seniors often find helpful, including attending religious services and going to day programs, among others, were largely unavailable during the pandemic. Secondly is the sense of loss that has been experienced. Over a million Americans have died from COVID or its complications. Greater than 75% of COVID deaths was among individuals 65 and older. The majority of elderly individuals have experienced at least one personal loss over the past two years. Further complicating issues is that many programs serving the elderly either shut down or moved to a virtual platform during the pandemic.

The expansion of telehealth has been able to fill this void. SCDMH cares for approximately 100,000 individuals each year. Twenty percent of those individuals are over 55. In April, 2020, the department moved all of our services virtually and telephonically. Within 2 months, we had at least one therapeutic contact with 99.9% of the patients that we were seeing pre-pandemic. Part of the reason that we were successful in making this shift is because we have had more than 20 years of experience in running a statewide telehealth system that is one of the largest in South Carolina. Additionally, because we are a unified system, we were able to track our service delivery centrally and were able to pool resources across the system. Telehealth was certainly not a panacea, as many of our patients lived in areas with limited broadband coverage or did not have adequate devices or cellular plans that afforded them the amount of data needed to connect to services. Thankfully, we are now fully operational and able to provide both telemedicine as

well as in-person care. We have found that our elderly population was able to adjust to these changes.

The challenges of providing care for the aging population are numerous. One of the biggest challenges has been an increase in substance use during the pandemic. Since federal funding for substance use and mental health treatment are split at the federal level, developing programs that address these dual diagnosis issues are challenging. Secondly, many organizations do not provide both mental health and medical services in the same location. As a result, many older Americans have to visit multiple locations to obtain services. Each additional visit increases the likelihood that they will not obtain services.

There are several areas where South Carolina has done an exemplary job:

1. We have developed excellent partnerships with law enforcement to make sure that officers are provided the skills needed to identify and manage mental health crises. We have also increased the presence of mental health professionals in dispatch centers and crisis intervention teams that respond to events where mental health is a possible contributor.
2. South Carolina has been very committed to increasing services for our veteran population. The state has worked closely with the Department of Veterans Affairs to increase the number of veterans' nursing homes in South Carolina. This blending of state and federal funds has made a remarkable difference in our ability to expand services.

I appreciate the opportunity to appear before the committee today. I am proud to lead the 4,300 individuals at SCDMH who strive each day to improve the physical and mental health of all South Carolinians. I am happy to answer any questions you may have.

US Senate Special Committee on Aging

“Mental Health Care for Older Adults: Raising Awareness, Addressing Stigma, and Providing Support”

May 19, 2022

Testimony of Kimberly Williams, President and CEO, Vibrant Emotional Health

Thank you, Chairman Casey, Ranking Member Scott, and members of the Special Committee on Aging, for the opportunity to provide testimony on this important topic of mental health care for older adults. My name is Kimberly Williams and I am the President and Chief Executive Officer of Vibrant Emotional Health (Vibrant). For 50 years, Vibrant has been at the forefront of promoting mental and emotional well-being and providing support for individuals, families, and communities through our innovative programs, advocacy, and education.

Vibrant is unwavering in our belief that everyone can achieve emotional wellness with the right care and support. This belief is at the center of our work and our aim to erase stigma around mental health. We work every single day to help save lives and help people get care anytime, anywhere and in any way that works for them. Vibrant is proud to be the founder and administrator of the Geriatric Mental Health Alliance of New York, which has the goal of developing and advocating for changes in mental health policy and practice that are essential to meet the mental health needs of older adults.

Mental Health Challenges Facing Older Adults

As the older adult population in the country continues to grow, so does the need for robust programs designed to meet and address their unique challenges. In 2019, approximately 16% of the population living in the United States, or 54.1 million individuals, were aged 65 and older.¹ The older adult population between 2009 and 2019 increased 36%, by approximately 14.4 million individuals, while the under 65 population increased by just 3% during the same time period. According to estimates from the Centers for Disease Control and Prevention (CDC), approximately 20% of adults age 55 and older have a diagnosable mental health and/or substance use disorder, including dementia.² Even more have emotional challenges that have a significant impact on quality of life. The range of mental health conditions includes anxiety and depression, which often co-occur with dementia; psychotic conditions, such as schizophrenia, bipolar disorder and severe depression; and substance use disorder.

While there has been much focus on older adult physical health and how social determinants of health can impact quality of life outcomes, there is less awareness of older adult mental health needs and how social, economic, and environmental factors impact overall mental well-being. For older adults, financial

¹ US Department of Health and Human Services, Administration on Aging. *2020 Profile of Older Americans*.

Published May 2021 <https://acl.gov/aging-and-disability-in-america/data-and-research/profile-older-americans>

² Centers for Disease Control and Prevention and National Association of Chronic Disease Directors. *The State of Mental Health and Aging in America Issue Brief 1: What Do the Data Tell Us?* Atlanta, GA: National Association of Chronic Disease Directors; 2008

stability, food security and nutrition, accessible housing, and social supports are interconnected when viewed through the lens of effect on mental well-being. Low-income older adults are more likely to be

lonely, which has been linked to depression, cognitive decline, and Alzheimer's disease, as well as a host of physical conditions.³ Raising awareness of seniors' mental health challenges and how they interact with other challenges is key to improving and maintaining the mental health of older adults.

Mental health conditions among older adults tend to be widely under-recognized and often are untreated or undertreated among older adults. Providers, caregivers, and older adults themselves tend to view symptoms of mental health conditions as a part of the life changes that may occur as we age. Stigma, ageism and lack of awareness about mental illness and the effectiveness of treatment can result in reluctance to seek or accept behavioral health services. Other barriers older adults face in accessing appropriate treatment include: Too few clinically, culturally, competent mental health professionals and paraprofessionals specializing in geriatric mental health, including peer specialists; shortage of mental health professionals who accept Medicare and limited coverage of mental health providers under Medicare; shortages of home and community-based services, despite recent tele-mental health reimbursement policy changes; over-reliance on primary health care providers without adequate expertise; and over-reliance on institutional care, largely due to inadequate support for family caregivers and a shortage of supportive housing as an alternative to institutional care. In addition, for many older adults who are low income and receive both Medicare and Medicaid, it is a challenge to understand which services may be covered and which providers are eligible by the programs to provide the services. In many cases these individuals are forced to navigate two complex insurance systems – Medicare and Medicaid- that have differing coverage and payment rules.

Untreated mental disorders and developmental challenges result in substantial human suffering. They are major contributors to premature disability and death. Untreated mental health disorders also contribute to social isolation and high rates of suicide amongst older adults, particularly men over the age of 85.⁴ Untreated or undertreated mental health conditions also drive overall healthcare system costs higher by contributing to avoidable placement in institutions and long-term care facilities instead of allowing people to age in place with the proper support. America's older adults deserve better.

Addressing Access to Care

While the challenges in reducing stigma and improving care for older adults are formidable, there are many reasons to be hopeful that progress can continue to be made in addressing older adult mental health concerns. Community based programs like Vibrant's older adult Assertive Community Treatment (ACT) team, offer an interdisciplinary, evidenced-based practice that provides treatment, rehabilitation, and support services, using a person-centered, recovery-based approach, to individuals who have been

³ Mental Health Technology Transfer Center Network Region Three. Emerging Factors: Impact on an Aging Population. Published July 2019 <https://mhttcnetwork.org/sites/default/files/2019-07/Emerging%20FactorsFact%20Sheet%20%282%29.pdf>

⁴ Substance Abuse and Mental Health Services Administration. (2022, April 28). People at Greater Risk of Suicide. <https://www.samhsa.gov/suicide/at-risk>

diagnosed with serious mental illness. Vibrant's ACT team is perhaps the only such team in the country that is specifically tailored toward serving the older adult population.

By helping to address difficulties an individual may be facing holistically, we are able to improve mental health outcomes and keep older individuals with serious mental illness thriving in the community.

Program successes include a 62-year-old Caucasian woman located in Bronx, NY who was admitted into the ACT program with a serious mental illness and co-occurring chronic physical health issues. She did not have stable housing and was using psychiatric hospitals as a housing solution due to stigma and verbal abuse she experienced within shelters. The interdisciplinary team of counselors, social workers, nurses and other support specialists provided her with weekly trauma focused therapy and assistance with taking her psychiatric medications. Through these and other interventions, she was able to gain insight into her mental health condition, address her physical health conditions, and utilize coping strategies. The ACT team advocated for the client's needs during all appointments to ensure that she received appropriate treatment and resources. After a year in the ACT program, the client improved enough to transition to a lower level of care. She voluntarily provides updates on her progress to the ACT team and appears to be progressing well and incorporating many of the skills and strategies learned within the program.

Addressing substance use disorders is also crucial for older adult mental health care. The ACT team was able to support a 52-year-old African American man who came to the program with a substance use disorder in addition to other mental health concerns. The client was hospitalized on a monthly basis since admittance to the program due to non-compliance with the prescribed psychotropic medication regimen. As a result of the interventions and activities provided by the ACT team, his substance use became more sporadic over time. The ACT team diligently worked with the client on utilizing harm reduction strategies in an attempt to help him reduce his use of substances and escorted him to physical health appointments to address co-existing conditions. Eventually, the client was able to maintain abstinence from all illicit substances and able to maintain compliance with his medication regimen. The client voluntarily calls the ACT team on a monthly basis to provide an update on his sobriety. The client continues to utilize exercise as a positive coping strategy and has begun to engage with programs aimed at re-entering the workforce.

These successes illustrate the power of providing comprehensive, integrated, recovery-oriented supports that are tailored to the unique needs of the individual. Most older adults with mental health problems also have chronic physical problems. Many older adults who seek treatment for late onset mental health problems turn to their primary care physicians rather than to mental health professionals. For these reasons it is critical to build linkages between mental health and health services, indeed to design new structures of service which are inherently integrated. Similarly, many of the needs of older adults with mental health problems are addressed through the "aging" service system. This system offers potential for prevention, opportunities for identification, sites for community-based treatment, and more. Linkages and new, integrated service models between mental health and aging services are, we believe, a key to better service provision.

Dissemination of best practices for addressing older adult mental health is important in order to reach more older adults who may be facing behavioral health challenges. Vibrant, through our role convening

the Geriatric Mental Health Alliance of New York, was the lead catalyst for legislation in New York State that helped to lay the groundwork for planning and innovative programming for this population. The Geriatric Mental Health Act of New York established an interagency planning council at the state level and an older adult mental health service demonstration grants program to fund innovative services. The grant program, which is a \$2M annual state investment, has been funded for over a decade with four rounds of grantmaking and has focused on a variety of innovative programming, including the integration of physical and mental health care, the community gatekeeper model, and partnership programming between mental health, substance use and aging services. The programming has resulted in improved mental health outcomes for thousands of older adult New Yorkers and many of the programs have been sustained beyond the grant period. This state level model of planning and demonstration programming is a model that can easily be replicated in other states and supported by the federal government.

Recommendations for Raising Awareness, Reducing Stigma, and Providing Support

With the number of older adults expected to reach 80.8 million, or 21.6% of the United States' population by 2040, the work of the Special Committee on Aging to raise awareness of older adult mental health challenges is critically important.⁵ Vibrant recommends the following in order to raise awareness, reduce stigma and provide support for older adult mental health.

- *PROMOTE MENTAL HEALTH:* Federal, state, and local governments should create and pursue opportunities to promote mental health and to prevent the development or exacerbation of mental and substance use disorders in the aging population. It is particularly important to build this goal into the health care delivery system and into the efforts to modernize the aging services system and to develop "age-friendly" communities. This includes creating and expanding opportunities for older adults to have meaningful engagement in their communities as formal and informal providers of services and supports to other older adults.
- *SUPPORT AGING IN THE COMMUNITY:* Governments should create policies that support and enable older adults with mental disorders to live where they choose—usually in the community. It is particularly important to provide housing alternatives to institutions for older adults with co-occurring serious physical and mental disorders, including supportive housing and in-home care. Medicare and Medicaid incentives and reimbursements should support aging in place as much as possible.
- *SUPPORT FAMILY CAREGIVERS:* Provide support for family caregivers, including, but not limited to, those who care for aging spouses or parents with mental disorders, older adults who care for grown children with mental disabilities, and grandparents raising grandchildren. This should include, but not be limited to, tax benefits, income replacement due to lost wages and/or benefits associated with family caregiving, as well as services such as counseling, psycho-education, support groups, and respite.

⁵ See 1

Ensure that older adults are able to have a role in designating their “family caregivers” by supporting those who are “chosen family,” in addition to those that may be biologically or legally related to the care recipient.

- *IMPROVE ACCESS TO MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES:* To improve access to these services, it will be necessary: to increase the amount of service available in both the public and private sectors; make services more affordable, mobile, and available in home and community settings such as senior centers, senior housing,

naturally occurring retirement communities (NORCs), and houses of worship; increase access to broadband as well as to technologies that enable older adults to receive telehealth services inclusive of tele-mental health services; and incentivize states to develop interstate licensure compacts for a wide variety of mental health providers in order for older adults to have increased choice of provider and additional provider capacity to serve the growing population.

- *IMPROVE QUALITY:* The quality of mental health and substance abuse services for older adults needs vast improvement across care settings and in both the public and the private sectors. This must include improved identification and treatment of mental health and substance use challenges by health and aging services providers as well as mental health and substance abuse providers. Mental health conditions are not a part of the normal aging process. These conditions can and should be properly treated and managed to allow older adults increased quality of life and improved health outcomes.
- *INTEGRATE MENTAL HEALTH, PHYSICAL HEALTH, AND AGING SERVICES:* Integrating screening for and treatment of mental and substance use disorders into primary and specialty health care is vital as these disorders are likely to also have chronic physical health conditions and older adults may be reluctant to go to specialty behavioral health settings. It is particularly important to improve identification and treatment of mental, substance use, and behavioral disorders in long-term care settings, i.e., in home health care, adult medical day care, assisted living, and nursing homes. Aging services settings such as senior centers, senior housing, NORCs, meals-on-wheels and similar services should routinely engage in screening for and treatment of mental and substance use disorders in partnership with mental health, substance abuse, or health care organizations. Reducing Medicare and Medicaid coverage and cost-sharing disparities and streamlining program information would allow older adults to feel empowered to make informed choices about their care.
- *PROMOTE CULTURAL COMPETENCE:* Racial and ethnic minority populations within the older adult population increased from 7.8 million in 2009, approximately 20% of older Americans, to 12.9 million in 2019, approximately 24% of older Americans, and are projected to increase to 27.7 million in 2040, representing an estimated 34% of older

adults.⁶ Services need to be responsive to cultural differences and sensitivities. It is particularly important for services to be provided in the older adult's preferred language and method of communication.

- *PROVIDE PUBLIC EDUCATION:* Additional extensive educational efforts are needed to combat stigma, which causes reluctance to acknowledge or get help with mental or substance use disorders. Education is also needed about mental illness, the effectiveness of treatment, and where treatment is available. Expanded information and referral services specifically related to older adults would be of great value. Combating

ageism is key in addition to stigma, which results in the expectation that depression and other mental disorders are unavoidable among older adults. Ignorance about mental illness and its treatment can lead to under or no treatment for older adults, increasing suffering and contributing to suicidal ideation.

- *ADDRESS DETERMINANTS OF HEALTH:* A "whole person" approach to health care must also consider the social determinants of health, which have been shown to be real factors in an individual's well-being. Older adults with mental or substance use disorders often face social and economic problems such as social isolation, inadequate income, and poor housing. It is important to help them address these kinds of problems as well as to provide treatment for their mental and physical disorders. Federal, state, and local governments can and should pursue policies that address the determinants of health and encourage positive outcomes.
- *WORKFORCE DEVELOPMENT:* The current shortage of clinically and culturally competent providers will almost certainly get worse as the elder boom continues to take place. There are two distinct issues to address: size and quality. In order to have the needed workforce, new incentives to recruit and retain workers is paramount. There should also be more initiatives to develop both paid and volunteer helping roles for older adults themselves. Enhancing professional and paraprofessional education and training are also critical to building the workforce of the future. Additionally, direct support of mental health and substance abuse providers to work with older adults through programs such as loan forgiveness and other relevant incentives can help build a robust workforce
- *DESIGN NEW FINANCE MODELS:* Additional coordination between Medicare and Medicaid would increase efficiencies and reduce costs while meeting the needs of older adults. Currently there is not enough funding for geriatric mental health services in both the public and the private sectors. While Vibrant and other organizations have been able to advocate for innovative funding models in order to ensure resources are being used most effectively, more funding and resources are needed. In addition, financing

⁶ See 1

models and reimbursement incentives need to be restructured so as to support services provided in home and community settings; support integrated service delivery; encourage the use of state-of-the-art practices and service innovation; expand beyond the medical model; broaden Medicare coverage to include essential services such as case management; expand the providers eligible for Medicare reimbursement; and to facilitate pooling funding across service systems.

- *PROMOTE PUBLIC AND PRIVATE SECTOR READINESS:* Governmental entities need to prepare for the mental health and substance abuse challenges of the growing older adult population. Planning and the clarification of responsibility for developing needed services should happen immediately, and include opportunities for stakeholders to provide meaningful input. Employers can also promote readiness by making programs that promote mental well-being among older workers and supportive policies for workers that are caregivers available.

Vibrant remains ready to partner with Members of the Committee, older adults with lived experience and other stakeholders to implement these recommendations and improve mental health outcomes. Thank you again for your time and consideration of this very important topic.

**Statement of Jim Klasen
Certified Older Adult Peer Specialist (COAPS) Facilitator
Hearing before the U.S. Senate Special Committee on Aging
May 19, 2022**

**“Mental Health Care for Older Adults: Raising Awareness, Addressing Stigma,
and Providing Support”**

Good morning Chairman Casey, Ranking Member Scott and Members of the Senate Special Committee on Aging. Thank you for allowing me to testify here today on the issue of older adults and mental health. It is an honor to be here. My name is Jim Klasen. I am an older adult, 73 years old, who lives with mental and physical health challenges and a substance use disorder. I am a person in recovery or, as I prefer to say, a person in wellness. I am indeed grateful to the professional health care providers who have treated me. However, medical treatment, as necessary as it was, was not sufficient. What has sustained my recovery process has been “peer support.”

By peer support, I mean the trust and care best achieved with a person who has experienced the same or similar challenges and often past trauma. In a room with others “in recovery,” the immediate connection is healing. Peer support is people who have been through it helping others who are going through it.

But peer support is not where my story started. In fact, it came relatively late in the game. For many years, starting in my 20s, I sensed something was wrong. Mental health challenges like

depression ran in my family with a great aunt and then my younger sister. I sought help and got some, but still, there seemed to be difficulties I couldn't quite name.

When I moved to Philadelphia, Pennsylvania in 1986, things started to blossom, both with a wonderful job opportunity and with a profound, debilitating depression. To complicate matters, I was self-medicating with drugs and alcohol in a very harmful way. So much so, that really, to the observer, the presenting issue was substance use.

I was a country kid who moved to the city determined to have the "great urban adventure." What started as partying with a new colleague blossomed in my case into full-blown addiction. And, remember, this is Philadelphia in the mid to late 80s, so we are talking about street drugs and the epidemic preceding the current opioid crisis (and crack cocaine has not gone away by any means). What followed for several very difficult years were the devastating effects of my substance use disorder on my family. I also underwent intensive treatment, several hospitalizations, therapy, and more.

We now know a more integrated approach to addressing mental health needs and substance use needs is effective at getting to both the immediate troubling behavior and the underlying causes. My challenge was that it wasn't one problem or even two. I was navigating through debilitating depression (and a diagnosis with bipolar disorder). At the time, just getting a grip on the substance use seemed to be most immediate priority for my doctors. Old school recovery meant just stop using. That wasn't enough though because I was using for a reason, although the exact underlying problem was not crystal clear and even a diagnosis does not fully explain

why anyone uses drugs that dangerous and powerful. We now look to more trauma informed practices for early indicators like neglect and abuse for some of those predictors. I am very fortunate that over time my treatment team took a more comprehensive approach to mental, behavioral, and substance use. But the story didn't stop there.

After several hospitalizations, many "Rehab after Work" programs, medications, and several therapists, I was introduced to a self-help wellness tool, the Wellness Recovery Action Plan (WRAP), that seemed to make sense for me. For me, the key to WRAP was a question asked early on in the process: "Describe what you are like when you are well." I can assure you that no one was asking me what I was like when I was well. Family, friends, counselors wanted to know what was wrong with me and why I was behaving the way I was. I was as stumped as they were, discouraged and angry. The focus on wellness was refreshing and helped to introduce an element of hope.

That was in 2011, 25 years after the start of my symptoms, and coincidentally, the summer of the WRAP Around the World Conference in Philadelphia. WRAP Around the World is a conference that empowers individuals through self-directed care to create and implement a Wellness Recovery Action Plan. At the conference, I met two people who worked at a local mental health organization and encouraged me to become a peer specialist. This led me to join the Certified Older Adults Peer Specialist (COAPS) programs here in Pennsylvania.

And for ten years now, I have been a facilitator of these and other related trainings. I estimate that I have trained more than 800 other individuals with similar mental health and substance use challenges who want to help others. What has been so liberating and healing for me is to no longer try to manage secret lives of addiction and mental illness. I now share my experience without shame or stigma.

As an older adult myself (and a late bloomer, so to speak!) I can relate to the reluctance, embarrassment and stigma many face in dealing with and disclosing mental health and substance use challenges. We all know the population of older adults is growing. Those of us who are older come with mental health, physical health, and yes, even substance use issues. From my personal experience, the experience of thousands of my peers, and from research, we know that peer support can be beneficial and cost-effective.

I am no expert on health policy and health insurance, but I do share the concerns of other older adults for our future well-being. We need well-coordinated, comprehensive services that includes peer support. I also know that this is not just an issue for older folks alone but is a societal issue with many implications. I hope that sharing my lived experience with mental health and substance use challenges helps the policy and program conversation. And, of course, I hope to answer your questions. Thank you.

Questions for the Record

U.S. Senate Special Committee on Aging
**“Mental Health Care for Older Adults: Raising Awareness, Addressing Stigma, and
 Providing Support”**
 May 19, 2022
 Questions for the Record
Dr. Erin Emery-Tiburcio

Senator Mike Braun

Question:

Lack of care coordination and broader structural issues existing across the different health care programs and agencies at the federal, state and local levels can lead to fragmented care for individuals, misaligned incentives for payers and providers, and administrative burdens delaying access to care services. As a result, many health care beneficiaries are left with a complex and disconnected system to navigate. In your testimony, you discussed some of these barriers to access and the need for more cross-sector collaboration in coordinating care at the different levels of government. How can we incentivize better care coordination between federal and state health care entities and community-based organizations to improve care experiences for older Americans, including those struggling with mental health or substance use issues?

Response:

Thank you, Senator Braun for this important question. One way to incentivize better care coordination would be to require that block grants provided to states as well as Medicare Advantage plans include care coordinators whose role is to facilitate communication across transitions of care and follow high risk older adults in the community. That is, as older adults are discharged from one setting of care (e.g., hospital, skilled nursing facility) to another (e.g., skilled nursing facility, home), the care coordinator assures that care plans and medications are clear to care providers, the family, and the older adult; assures that payment for all services is clear, especially for “dual eligibles;” and tracks the older adult through to their long term destination, including connections to primary care and community based organizations for homebased services. High risk older adults, including those with mental illness and substance abuse should then be followed with ongoing care coordination to emergency room, hospital, and nursing home admissions. These care coordinators would ideally be based in local communities or otherwise have the ability to connect meaningfully with community-level providers and organizations. The [E4 Center](#) has produced a [toolkit](#) to assist health care entities and community-based organizations create these effective partnerships. The Illinois [Choices for Care](#) model provides a service like this specifically at hospital discharge for individuals who are nursing home eligible. While this model is effective for starting to link people to community-based care, these funds are not available to fund any support post-discharge, when research suggests the majority of support needs emerge. Some Medicare Advantage plans currently provide care coordination, but not at this depth and breadth; it is likely that this service would be a cost savings as more older adults would be able to remain in their homes with coordinated care at home.

Note that CMS's proposal to ask hospitals to submit data on screening patients for social drivers of health as part of its quality reporting program is a step in the right direction, but they are not collecting data about care coordination interventions to address needs nor providing guidance to hospitals that the expectation is to respond to needs rather than just identify them. CMS could make clear the hope that hospitals do this, and CMMI could align with this opportunity and fund a renewed community-based care transitions demonstration program to test out hospitals partnering with community-based organizations to address needs.

Question:

Where can current resources be administered more efficiently to improve state-level operations and community-based services so we can achieve greater value from our investments in each?

Response:

Thank you, Senator Braun for another great question. My written remarks highlight the importance of the "self-direction" movement, in which Medicaid (and perhaps Medicare, in the future) beneficiaries are offered the option of managing their own health care budget to live more independently. These programs have demonstrated improved health, independence, and wellbeing for beneficiaries, and cost savings for insurers. As managed care plans are increasingly providing the benefits for older adults, requiring self-direction as an option may provide a more efficient use of resources. For many with serious mental illness and substance use, this may include paying for housing, as that is the most significant barrier to healthy living for so many. For community-based services, a significant challenge among aging network community-based organizations is funding uncertainty, which can catalyze workforce turnover, lack of investment and long-term program planning. Turnover is expensive and disrupts quality programming. State agencies, such as state units on aging, could address this by providing community-based organizations with longer funding agreements and clarity on what will be viewed as successful implementation that would lead to renewed contracts. There are also increasing efforts of community-based services to organize themselves into networks with lead entities to provide shared infrastructure such as referral software and to facilitate contracting with healthcare entities. While these hub models do take some investment, they facilitate connection and cross sector collaboration in a broader and more efficient way than two-agency partnerships. This may produce overall cost savings to both state and federal governments.

U.S. Senate Special Committee on Aging
“Mental Health Care for Older Adults: Raising Awareness, Addressing Stigma, and
Providing Support”
May 19, 2022
Questions for the Record
Dr. Kenneth M. Rogers

Senator Mike Braun

Question:

Addressing the opioid epidemic in America requires a multidimensional approach, notably, proper prescriber and patient education around the addictive nature of opioids. I am proud to have two pieces of legislation with Senator Markey—the LABEL Opioids Act and the Safer Prescribing of Controlled Substances Act—which aim to provide increased awareness around the dangers of opioids to prescribers and patients alike. In your experience overseeing addiction services at South Carolina’s Department of Mental Health, I am sure you have witnessed firsthand the destructive nature of the opioid crisis. Can you speak to the importance of provider and patient education in health care services today over the dangers of opioid consumption and use?

Response:

Communication between patient and provider is critically important as many of the opiates that are abused frequently come from prescribers. Many patients are unaware of the relative risk of using opiates either long-term or short-term. Having conversations about this level of risk and how to minimize them is a conversation that needs to occur before prescribing these medications. It is also important to limit the number of doses of medication that is provided to many patients based on the expected severity of the pain as well as the length of the pain. Patient should also be instructed on ways to return medications to pharmacies or other disposal locations to prevent diversion or unexpected overdose by family members or friends.

Question:

You described one of the biggest challenges of providing care for the aging population has been an increase in substance use during the pandemic. What is being done to address this increase in substance use and how would more accurate labeling and safer prescribing standards help in the effort to protect seniors and other Americans from developing an opioid or substance use disorder going forward?

Response:

One of the greatest benefits that I’ve seen over the past several years are the prescription drug monitoring programs that are mandated in each state. The level of awareness that prescribers have about the number of potentially addictive medications that are available to the patient is critical and safely prescribing these medications and preventing overuse and/or misuse. Additionally, making sure to obtain an adequate substance use history is critical in all populations, but especially in older Americans who are frequently assumed not to have substance use issues. Having the conversation about use is critical.

Question:

Historically, telehealth has benefitted both seniors and disabled persons, as well as those living in rural places like Indiana, which often experience barriers in access to care services. In Indiana, our local aging services and community-based organizations have seen great success experimenting with telehealth and innovation in virtual care and outreach services to alleviate isolation issues and maintain social connections with older adults and those living in rural communities. What have you observed about the effectiveness of telehealth in lessening mental health and substance use issues for older adults and how can we improve current efforts?

Response:

Telehealth has been an extremely beneficial way to reach many individuals who previously have not had access to mental health or substance use services. This has especially benefited individuals living in rural counties in America where access may be difficult. Telehealth has also substantially helped older Americans who freely have difficulty accessing services because of transportation issues. The ability to expand the services, however, has been limited in many locations by the availability of both devices to link to the Internet as well as the availability of broadband access.

U.S. Senate Special Committee on Aging
**“Mental Health Care for Older Adults: Raising Awareness, Addressing Stigma, and
 Providing Support”**
 May 19, 2022
 Questions for the Record
Ms. Kimberly Williams

Senator Jacky Rosen

ADDRESSING GAPS IN MENTAL HEALTH CARE SERVICES IN RURAL

AREAS: Nevada consistently ranks at or near the worst in the country in terms of access to mental health care services, and the disparities are particularly acute in the northern and more rural areas of our state, which tend to contain a higher percentage of older adults. Last December, one of the only psychiatric hospitals in northern Nevada closed its doors after more than 40 years of service, leaving Nevadans with even less care despite the ever-increasing demand for mental and behavioral health care services. In the interim, however, I’m pleased that Nevada will be receiving more than \$43 million in funding from the American Rescue Plan – which I voted for – to support behavioral health needs, including crisis services, suicide prevention resources, direct treatment, and workforce development funding. This funding, paired with the forthcoming nationwide launch of the 9-8-8 suicide prevention lifeline, will prove critical in helping our state – and particularly northern Nevada and our rural areas – fill some of the gaps in access to care and help save lives while Congress continues to work on additional support systems.

Question:

As President and CEO of Vibrant Emotional Health, which administers the National Suicide Prevention Lifeline, what type of targeted outreach campaigns are you working on to ensure all Americans – and particularly our seniors – know about the nationwide transition to 9-8-8 starting July 16th to ensure they are aware of this critical resource?

Response:

Thank you Senator Rosen for this important question. Vibrant Emotional Health was pleased that Congress unanimously passed the National Suicide Hotline Designation Act in 2020, which directed 9-8-8 to be the universal dialing code to reach the National Suicide Prevention Lifeline. The Lifeline is the nation’s mental health and suicide prevention network that responds 24/7 to calls, chats and texts from any individual, including older adults, that needs support for mental health, suicidal, or other emotional distress. 9-8-8 represents an easy-to-remember number for individuals in distress, particularly older adults, to access the life-saving interventions provided by the trained crisis counselors. In addition to enhancing awareness of the existing Lifeline service, the nationwide transition to 9-8-8 in July 2022 also represents an opportunity to educate mental health providers, advocates, other stakeholders, and the public about the Lifeline. Vibrant, through our 988 State Planning Grants which were issued in 2021, has provided support and technical assistance to states and territories as they transition to 9-8-8. This includes support for the consistency of messaging about the Lifeline service and resources available in their communities. Vibrant continues to participate in multiple sector-wide webinars focused on

messaging and promoting 988, with the aim to empower mental health and community serving organizations, many of whom serve older adults, to communicate to their networks and clients about 988. Vibrant is also working closely with SAMHSA and other federal partners to ensure awareness of this critical resource and the transition to the 9-8-8 dialing code.

Question:

Can you tell me more about how the National Suicide Prevention Lifeline is filling in some of the gaps in access to care for those in rural communities where there may not be a full-time provider of mental health care services? Additionally, how does the Lifeline serve as a critical starting point for referral to community-based mental health resources for those in crisis where there are local resources within reach?

Response:

Thank you Senator Rosen for highlighting the role Lifeline crisis centers play in connecting individuals to care. The Lifeline and the trained crisis counselors at the local crisis centers in the Lifeline network offer life-saving emotional support and referral resources for individuals experiencing a mental health, suicidal, or other emotional distress. Research indicates that individuals in rural communities are at higher risk of suicide, so the safety net that the Lifeline provides is a critical service to help keep individuals safe. The trained crisis counselors are able to build trust with the individual in crisis in order to provide effective interventions and referrals to the appropriate community resources. For the majority of individuals contacting the Lifeline, speaking with a trained crisis counselor will be all that is needed to work collaboratively through their distress. This is particularly important for rural communities or communities where there are shortages of mental health professionals, as the Lifeline is filling in the gaps that may exist in crisis care. For individuals who do need in-person interventions or a higher level of care, the Lifeline represents a large front door to broader crisis care continuum of services. Through the Vibrant 988 State Planning Grants issued in 2021, Vibrant provided technical assistance and encouraged states to convene diverse stakeholders, including individuals from rural and other communities, to ensure there is sufficient capacity at crisis centers to provide statewide coverage of contacts to the Lifeline, and to build out or connect appropriate higher-level services such as mobile crisis teams and respite/stabilization units across the state to serve all communities. Ongoing funding support from Congress as well as states will be needed to ensure all communities have a robust crisis continuum.