

Testimony of Erin Emery-Tiburcio, PhD, ABPP

Senate Aging Committee

Mental Health Care for Older Adults:

Raising Awareness, Addressing Stigma, and Providing Support

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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 community-based 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 "Community-based 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. Audio-

only 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 Age-Friendly 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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