Approved: March 26, 2008
Date

MINUTES OF THE HOUSE SOCIAL SERVICES BUDGET COMMITTEE

The meeting was called to order by Vice Chairman Peggy Mast at 3:30 p.m. on March 13, 2008, in Room 514-S of the Capitol.

All members were present with the exception of Representatives Crum and George who were excused.

Committee staff present:
Kimbra Caywood McCarthy, Kansas Legislative Research Department
Nobuko Folmsbee, Office of Revisor of Statutes
Judy Holliday, Committee Assistant

Conferees appearing before the committee:
Representative Marc Rhoades
Bill Cook, Board Chairman, Kansas Healthy Marriage Institute
Don Jordan, Secretary, Social and Rehabilitation Services
Mary Blubaugh, Executive Administrator, Board of Nursing
Richard Morrissey, Interim Director, Division of Health, Kansas Department of Health and Environment
Martin Kennedy, Commissioner Licensing Certification and Evaluation, Kansas Department on Aging
Mary Sloan, Director Government Affairs, Kansas Association Homes and Services for Aging
Jim Snyder, Silver Haired Legislators
Rick Cagan, Executive Director, National Alliance on Mental Illness
Michael Hammond, Executive Director, Association of Community Mental Health Centers of Kansas
Steve Denny, Sr. Outreach Services Coordinator, Four County Mental Health Centers, Independence
Nancy Trout, LSCSW, Aging Specialist, Agencies on Aging Association
Craig Kaberline, Executive Director, Kansas Area Agencies on Aging Association
Amy Campbell, Kansas Mental Health Coalition
Annette Graham, Director, Central Plains Area Agency on Aging
Kathy Greenlee, Secretary, Kansas Department on Aging

Written testimony submitted:
Gina McDonald, Vice President of Education and Advocacy, Kansas Children's Service League
Cindy Luxem, CEO and President, Kansas Health Care Association
Debra Harmon Zehr, President, Kansas Association of Homes and Services for the Aging
Terri Roberts, J.D., R.N., Kansas State Nurses Association

Others attending:
See attached list.

Hearing on HB 2920--Healthy marriages and strong families grant program based on the temporary assistance for needy family block grant

Representative Marc Rhoades, testified as a proponent of **HB 2920**. (Attachment 1) Representative Rhoades provided extensive information on the Temporary Aid to Needy Families (TANF) program established by Congress in 1996. The goals of the program was to provide assistance to needy families to enable children to be cared for in their homes or homes of relatives; end the dependency of needy parents on government programs by promoting job preparation; prevent and reduce out-of-wedlock births; and encourage marriage and two-parent families. He stated that directing just 1% of the TANF funds for the enhancement of healthy marriage and family formation in low-income adults would help accomplish these goals.

Bill Cook, Board Chairman, Kansas Healthy Marriage Institute, testified as a proponent of **HB 2920.** (Attachment 2) Mr. Cook stated that the Kansas Healthy Marriage Institute is dedicated to strengthening Kansas marriages and families, and is part of a state-wide effort to address a variety of social issues, including reducing poverty, reducing child abuse and neglect, preventing costly social service interventions, and increasing job stability. He supports the "1% Solution" (one-percent from the TANF Block Grant program)

to help build on positive work already happening in Kansas.

Don Jordan, Secretary, Social and Rehabilitation Services, testified as neutral on **HB 2920.** (Attachment 3) **HB 2920** requires the Kansas Department of Social and Rehabilitation Services to spend one percent from the TANF Block Grant to support healthy marriages and strengthen families through services that prevent the unnecessary separation of children from their families, and which promote permanent living arrangements for children. This would be accomplished through grants up to $50,000 to entities providing marriage services and services designed to strengthen families. The department is required to contract with a state university to design the program. The two current research projects in Kansas are directly funded by the federal Department of Health and Human Services/Administration on Children and Families and began in June 2007. The goal of this research project is to determine if the programs promoting marriage education and support actually strengthens families.

Written testimony only on **HB 2920** submitted by:
Gina McDonald, Vice President of Education and Advocacy, Kansas Children's Service League. (Attachment 4)

The hearing was closed on **HB 2920.**

Hearing on HB 2671--Board of nursing to oversee nurse and medication aides

Mary Blubaugh, Executive Administrator, Kansas Board of Nursing (KBN), testified as a proponent of **HB 2671.** (Attachment 5) Ms. Blubaugh told the Committee that the KBN voted to transfer responsibility for the training and certification of nurse aides, medication aides, and home health aides (CNA/CMA/HHA) from the Kansas Department of Health and Environment (KDHE) to the Board of Nursing. She testified that the boards of nursing have jurisdiction over licensure of nurses and the nursing care they provide, and it is the position of the National Council of State Boards of Nursing (NCSBN) that the state board of nursing should regulate the CNA/CMA/HHA program. KSBN is currently developing the implementation of new licensure software, with a requested transfer date of October 1, 2009. This date would provide both agencies to make a smooth transfer as well as allow KSBN to develop the needed licensure software.

Richard Morrissey, Interim Director, Division of Health, Kansas Department of Health and Environment (KDHE) testified as an opponent of **HB 2671.** (Attachment 6) Mr. Morrissey discussed the transfer responsibility for Training and Certification of Nurse Aide Registry, Medication Aides, Home Health Aides, administration of the Kansas Nurse Aide Registry, and criminal record checks for nurse aides to the Kansas State board of Nursing (KSBN). He testified that the certification program integrates state law with various federal requirements with other Health Occupations Credentialing and splitting these program responsibilities would be inefficient, and that the database currently maintained for active certification individuals would be duplicated by the transfer at considerable cost for both KDHE and KSBN. The current program has been effectively managed by KDHE since 1977 and meets every state and federal performance requirement, making it one of the best in the nation.

Martin Kennedy, Commissioner, Licensing Certification and Evaluation, Kansas Department On Aging (KDOA), testified as neutral on **HB 2671.** (Attachment 7) Mr. Kennedy expressed his concerns over several issues. His agency believes eliminating the provision from KSA 39-936(C)(1) for allowing Personal Nutrition Assistants (PNAs) was a drafting error and urged restoration of the provision to the bill. He suggested other language changes in the bill for clarification purposes. In addition, the PNA training requirement could be transferred to the Board of Nursing.

Mr. Kennedy explained the KDOA investigative process for allegations of resident abuse, neglect or exploitation by nurse aides. If an incident is confirmed it is entered into the registry, the individual is prohibited from working in Kansas adult care homes, and facilities are required to check this registry before hiring an aide.

MINUTES OF THE House Social Services Budget Committee at 3:30 p.m. on March 13, 2008, in Room 514-S of the Capitol.

Written testimony only on **HB 2671** was received from:
Cindy Luxem, CEO and President, Kansas Health Care Association (Attachment 8)
Debra Harmon Zehr, President, Kansas Association of Homes and Services for the Aging (Attachment 9)
Terri Roberts, J.D., R.N., Kansas State Nurses Association (Attachment 10)

The hearing on **HB 2671** was closed.

Hearing on HB 2752--Geriatric mental health act

Mary Sloan, Director Government Affairs, Kansas Association Homes and Services for Aging (KAHSA), testified as a proponent on **HB 2752.** (Attachment 11) Ms. Sloan spoke on the need to improve mental health access and services for elders. Challenges remain for older adults in need of mental health services, which include depression and other mental health issues; a high level of unmet needs including misdiagnosis, over-medication or inappropriate prescription; and barriers to accessing care which include transportation, availability and stigma. Attached to her testimony was a draft of substitute language for **HB 2752** which would enact a targeted program to increase access, raise awareness, and begin to provide outreach services delivered using existing Area Agency on Aging structures that would allow local control and flexibility.

Annette Graham, Director, Central Plains Area Agency on Aging, testified as a proponent on **HB 2752.** (Attachment 12) Ms. Graham told the Committee older adults experience issues that impact health, quality of life, and relationships, yet they receive the least amount of mental health services and are the most reluctant group to seek out services on their own behalf. Unmet needs are caused by lack of transportation, being homebound, limited availability of in-home mental health services, limited number of providers trained in aging issues, stigma among older adults, and increased costs for mental health services.

Ms. Graham testified that older adults are likely to receive mental health care from a general physician when they present with physical complaints, and those physicians often believe that depression is a normal part of aging. Unfortunately, this leads to lack of proper diagnosis, referral and treatment. **HB 2752** will provide for mental health services coordinated and implemented through the eleven Area Agencies on Aging, through collaboration with religious organizations; and health, mental health, and aging service providers delivered at the local level.

Rick Cagan, Executive Director, National Alliance on Mental Illness, testified as a proponent on **HB 2752.** (Attachment 13) Mr. Cagan spoke on the escalating suicide rates in older persons, and the fact that symptoms were rarely recognized and treated among the elderly. There is a misconception among health care professionals that depression is part of the aging process. A report found that 40 percent of suicidal older adults visited their primary care physician in the week prior to committing suicide. Mr. Cagan identified strategies in dealing with this crisis, including early recognition; diagnosis and treatment of depression and other mental health issues to prevent premature death and enhance independence and functioning for the elderly; and social supports from the family through education on mental health issues for the elderly.

Michael Hammond, Executive Director, Association of Community Mental Health Centers of Kansas; Steve Denny, Senior Outreach Services Coordinator, Four County Mental Health Centers, Independence; and Nancy Trout, LSCSW, Aging Specialist, Agencies on Aging Association, presented combined testimony as proponents on **HB 2752.** (Attachment 14)

Mike Hammond, Executive Director, Association of Community Mental Health Centers of Kansas, testified that Community Mental Health Centers are required to provide services to Kansans regardless of their illness or ability to pay, including assessment, diagnosis, treatment, case management, medication management crisis services, attendant care, respite care, and screening for inpatient hospitalization. He told the Committee that close collaboration of the Area Agencies on Aging (AAAs) and the Community Mental Health Centers could create a streamlined program of geriatric mental health services to seniors in all areas of the state.

Steve Denny, Senior Outreach Services Coordinator, Four County Mental Health Centers, Independence, spoke to the importance of direct service combined with public outreach and community networking. He told the Committee that there is evidence that depression can exacerbate the effects of cardiac disease, cancer,

strokes and diabetes. Older adults face declining physical health, personal losses, financial burdens and reduced independence, yet health care providers and family fail to refer senior for diagnosis and treatment of depression that may result from these challenges. Detecting and treating depression helps improve self-care, reduce isolation, and restore a sense of hope.

Nancy Trout, LSCSW, Aging Specialist, Agencies on Aging Association, testified that the majority of older adults seen at Prairie View suffer from clinical depression, anxiety or dementia, and that over 80 percent responded well or completely to treatment. She cited a recent study that identified the fact that depressive symptoms often predict nursing home placement in seniors, which is extremely expensive at the federal and state level and for the individual. From a monetary standpoint, it makes sense to prevent nursing home placement by serving and treating seniors in their homes and communities. These treatments have made life changing, and often life saving differences in the lives of many older adults.

Craig Kaberline, Executive Director, Kansas Area Agencies on Aging Association, testified as a proponent on **HB 2752**. (Attachment 15) Mr. Kaberline told the Committee that the Area Agencies on Aging are the "single points of entry" that coordinate the delivery of publicly funded community-based services to seniors in Kansas. The older citizens choose the services and arrangements best suited to them so they can remain in their home if they choose. He stated that the elderly population is increasing, and identifying mental health needs could possibly delay the need for nursing home care for some, save health care dollars, and improve the quality of life for the senior population of Kansas.

Amy Campbell, Kansas Mental Health Coalition, testified as a proponent on **HB 2752.** (Attachment 16) Ms. Campbell stated that the objectives of **HB 2752** build on the successes of the mental health programs offered to seniors in Kansas, while offering improvement of capacity and quality of the programs and expanding them to other communities. It would also provide the necessary funding for implementation including staffing at the Department on Aging and funding for the actual services.

Jim Snyder, Silver Haired Legislators, testified as a proponent on **HB 2752.** (Attachment 17) Mr. Snyder gave a detailed account of the number of community dwelling older individuals who experience mental health problems, including anxiety, depression, and cognitive problems (Alzheimer's disease and dementia). In nursing homes, the percentage of mental health issues increases, and the highest rate of suicide is in males age 85 and up–six times higher than the general population. The Silver Haired Legislature urges a program that will ensure that older adults reluctant to use mental health centers would have access to services in more comfortable and accessible surroundings such as their homes or in community facilities. Addressing the needs of Kansas' older adults will position our state for potential funding and programs provided at the national level.

Kathy Greenlee, Secretary, Kansas Department on Aging, testified as neutral on **HB 2752.** (Attachment 18) Secretary Greenlee told the Committee that while **HB 2752** as amended would give the Department on Aging the authority to contract with any provider of care to older adults with mental disabilities, her preference is to distribute funds to the Area Agencies on Aging who would work directly with their local Community Mental Health Centers. Secretary Greenlee stated that while Area Agencies on Aging are the experts on aging, the Community Mental Health Centers are the experts on mental health.

Written testimony only on **HB 2752** received from:
Nancy Luber, LSCSW, on behalf of Kansas Mental Health Aging Specialists (Attachment 19)
Ernest Kutzley, Advocacy Director, AARP of Kansas (Attachment 20)
Brice Miller, on behalf of the Kansas Mental Health and Aging Coalition (Attachment 21)

The hearing was closed on **HB 2752.**

The meeting adjourned at 5:20 p.m. The next scheduled meeting is March 18, 2008.

HOUSE SOCIAL SERVICES COMMITTEE GUEST LIST

DATE: 3-13-08

NAME	REPRESENTING
Nancy Pierce	KHCA
Josh Kadel	KDHE
Marla Rhoden	KDHE
Dick Morrissey	KDHE
Phyllis Kelley	KACE
[illegible]	SRS
Karen Bakunas	SRS
Mike Hammond	ACLU-KS
Steve Deay	Four County MHC / Assig Subcommm
[illegible]	Prairie View Inc.
[illegible]	CPAAA
RICK CAGAN	NAMI Kansas
Beth Roberts	KHMI
Bill Cook	Kansas Healthy Marriage Inst.
Dena VanBruggen	KDOA
ADRIAN GUERRERO	KSBN
Mary Blubaugh	KSBN
[illegible]	KAHSA
[illegible]	KMHC
Terri Roberts	KSNA

PLEASE USE BLACK INK

Susan Arnold JAAA-Topeka (practicum student)

Benefits of Healthy Marriage and Family Formation Programs

Congress established the Temporary Aid to Needy Families (TANF) program in 1996 to:

- Provide assistance to needy families so children may be cared for in their own homes or in the homes of relatives;
- End the dependency of needy parents on government benefits by promoting job preparation, work and marriage;
- Prevent and reduce the incidence of out-of-wedlock pregnancies; and
- Encourage the formation and maintenance of two-parent families.

These goals directly or indirectly relate to benefits derived from healthy marriages and families.

"...from child welfare, to child-support enforcement, to anti-poverty assistance to runaway-youth initiatives—the need for each is either **created or exacerbated by the breakup of families and marriages**. It doesn't take a Ph.D. to understand that controlling the growth of these programs depends on preventing problems from happening in the first place...It's a commonsense **ounce of prevention** that will help temper the demand for a pound of costly social interventions later." *Wade F. Horn, Former Assistant Secretary for Children and Families, U.S. Department of Health & Human Services*

Broken homes come at a high price, both in financial and human capital...

- Nearly 40 percent (7,500) of Kansas marriages do not last until the 5th year.[16] [17]
- There were 9,145 marriage dissolutions in Kansas, 2006—38 percent were marriages lasting 4 years or fewer. Each divorce cost the State in excess of $30,000 in negative financial impact or approximately **$ 274 million*.**[8] [10]
- In 2006, there were 8,496 Kansas children affected by poverty, child abuse, and/or neglect as a result of marriage dissolutions. Federal and state spent $230 million for the remediation of Kansas poverty, child abuse and neglect. Nearly **$ 83 million*** (36 percent) was Kansas support for 5,781 children living in foster care.[8] [9]
- Less than half of all teens live with their married biological mother and father.[1] [11]
- In 2003, 1,017 juvenile offenders were placed in Kansas taxpayer supported residential facilities.
- American businesses lose $6 billion (Kansas, **$ 55 million***) annually due to decreased productivity stemming from marriage and relationship difficulties.[12] [14]

"Children who grow up in single-parent homes are less likely to marry, more likely to divorce, and more likely to have children outside of wedlock." Daniel T. Lichter et al., "Race and the Retreat from Marriage: A Shortage of Marriageable Men?" *American Sociological Review*

Teens from single-parent homes are twice as likely to drop out of high school, become teen parents, and one-and-one-half times more likely to stay at home has young adults. McLanahan and Sandefur, Growing Up

"...women raised in female-headed families are 53 percent likelier to have teenage marriages, 111 percent likelier to have teenage births, 164 percent likelier to have premarital births, 93 percent likelier to experience marital disruptions." *American Journal of Sociology*

House Social Services Budget Committee
March 13, 2008
Attachment 1 - 1

Fostering a cycle of poverty…

- Teen parents drop out of school at a higher rate than their peers, negatively impacting wages.[5]
- Over 75 percent of unmarried teen mothers are on welfare within 5 years of giving birth; 80 percent ultimately receive some form of public assistance.[5 6]
- In 2004, Kansas spent **$ 52 million*** on childbearing teens and **$ 35 million*** on children born to teen mothers—$12 million in Medicaid and SHCIP; and $23 million on child welfare. The loss in annual tax revenue due to decreased earnings of teen mothers is estimated at **$ 30 million***.[5]

At the same time…

- Marriage is associated with longer life expectancy, improved financial welfare, better physical and psychological health, reduced rates of alcohol and substance abuse, lower incidents of crime and domestic violence, lower rates of injury, illness and disability.[1]
- Marriage increases the likelihood of fathers having positive interaction with their children, in turn, reducing the incidence of juvenile offenses.[1 11]
- Happily married workers have better physical and psychological health, resulting in lowered liabilities and increased profitability.[15]
- Numerous studies demonstrate that couples participating in marriage education and enrichment programs have better communication skills, higher levels of marital satisfaction, better parenting skills and increased stability than couples who do not receive marriage support.[1 18 19 20 21]

"…couples are increasingly less prepared to be parents than prior generations. **Many of the couples saw their parents divorce and have themselves been reared in single-parent households.** Nothing on the horizon indicates that this trend is going to abate any time soon. More than half of all births in Oklahoma are funded with Medicaid, and nearly half of all births nationally are funded with Medicaid…Most young parents love their children greatly. But a healthy family relationship is not an experience most of them have ever had." *Howard Hendrick, Director, Oklahoma Department of Human Services*

Estimated annual cost to Kansas in assistance, diminished productivity and lost revenue: **$529 million***

Estimated physical, financial and emotional toll on adults and children: **Incalculable**

One percent = A pound of prevention

Healthy marriage and family formation programs include relationship education for youth, premarital preparation for engaged couples, marriage enrichment programs for married couples and related support. Numerical outcomes are a prerequisite for continued funding.

While many social service programs must focus on crisis intervention and management, **directing just 1 percent of TANF monies toward healthy marriage and family formation programs provides an outcome-based, cost-saving strategy aimed at prevention.**

The 1% Solution

Kansas Healthy Marriage Institute, on behalf of a coalition of social service agencies, requests **1%** of TANF funds for the enhancement of healthy marriage and family formation in low income adults. (The annual Kansas TANF Block Grant is $101,931,061.)

Proposal

- Develop healthy marriage service model for the State of Kansas
  - Oklahoma Public Strategies as consultants
- Statewide train the trainers program
  - Curriculum specific training for teen, pre-marriage, and married
- Relationship skill training for teens (ages 14-18)
  - Schools – FACT, PE, and health classes
  - Youth services programs targeting low income teens
  - Curriculum
  - Incentives
- Pre-marriage classes (for low income?)
  - Curriculum
  - Incentive – decreased cost for marriage license?
  - Mentor couple pre- and early marriage
- Married couples classes (for low income?)
  - Curriculum
  - Incentives – gas cards for transportation, gift card to offset childcare costs
  - Mentor couple
  - Follow up classes

Kansas Healthy Marriage Initiative Coalition

Renee Allerheiligen, St. Elizabeth Ann Seton Church Marriage Preparation Ministry, Wichita, KS
Kasey Baker, Manager of Marketing Dept., Bombardier Aerospace, Wichita, KS
John Bjerum, Communities in Schools of Harvey County, Newton, KS
Irene Caudillo, Catholic Community Services, Kansas City, KS
Greg Cole, SE Service, Wichita, KS
Andrea Conlee, Associates in Psychology and Family Services, Wichita, KS
Bill Cook, Spirit Aerosystems, Wichita, KS
Jacki Corrigan, Archdiocese of Kansas City Family Life Office, Kansas City, KS
Janice Dixon, LCMFT, Kansas Children's Service League, Wichita, KS
Michael Duxler, PhD, Kansas Marriage for Keeps and Newman University, Wichita, KS
Chris Ebberwein, PhD, Psychologist in Private Practice, Wichita, KS
Carla Eckels, KMUW Wichita Public Radio, Wichita, KS
Reuben Eckels, New Day Christian Church, Wichita, KS
Sabrina Esterline, KSN-TV, Wichita, KS
Rhonda Goodloe, Marriage for Keeps, Catholic Social Service, Garden City, KS
Robin Harris, Kansas State Department of Education, Topeka, KS
Karen Hauser, Catholic Charities of Salina, Inc., Salina, KS
Roger Harms, LMSW, Wichita Public Schools, Wichita, KS
Judy Hawk, The St. Francis Academy, Hutchinson, KS
Joyce Huff, Dibble Institute, Wichita, KS
Paula Jasso, Department of Social and Rehabilitation Services, Topeka, KS
Marsha Kaegi, TFI Family Services, Hutchinson, KS
Ray Kempel, First Southern Baptist Church, Hutchinson, KS
Kit Lambertz, StepStone, Wichita, KS
Judith Leonard, Wichita Catholic Diocese Family Life Office, Wichita, KS
Bob McElwee, Sacred Heart and St. Joseph Catholic Church, Frontenac, KS
John and Mary Mertes, Wichita Catholic Diocese Retrouvaille and Recovering Marriages, Wichita, KS
?Elaine Miller, Department of Social and Rehabilitation Services, Hutchinson, KS
Doug Morphin, Counseling & Mediation, Inc., Wichita, KS
Sandy Pickert, RN, FNP, CAE, Abstinence Education, Inc., Wichita, KS
Bethany Roberts, MSW, JD, Strong and Stable Families, University of Kansas, Lawrence, KS
Kelly Robbins, Western Kansas Child Advocacy Center, Scott City, KS
Aaron Scharenberg, Central Christian Church, Wichita, KS
Paula Scott, Department of Social and Rehabilitation Services, Wichita, KS
Charlotte Shoup Olsen, Kansas State University Research & Extension, Manhattan, KS
Walter Thiessen, Wichita Child Guidance Center, Wichita, KS
Karen Tones, Department of Sociology, Wichita State University, Wichita, KS
Denise Unruh, South Central Community Foundation, Pratt, KS
Cayla Wasson, Connecting Point, Wichita, KS
Joyce Webb, PhD, Psychologist, Catholic Charities, Wichita, KS
Christina Weber, Integrative Family and Therapy Service, Inc., Wichita, KS
Glenda Wilcox, Child Start, Wichita, KS
Fedra Zamphiropolos, Catholic Charities Marriage for Keeps Project, Manhattan, KS

References:

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[11]Family structure, father closeness, and delinquency: A report from National Fatherhood Initiative. Available at: www.fatherhood.org/research.htm. Accessed December 12, 2007.

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TANF Block Grant
FY 2009 Governor's Budget Recommendation

Item	FY 2007	FY 2008 GBR	FY 2009 GBR
Beginning Balance	7,515,516	12,393,297	12,875,093
Revenue			
TANF Block Grant	101,931,061	101,931,061	101,931,061
Transfer to CCDF	(25,454,946)	(22,830,161)	(23,003,301)
Transfer to SSBG	(7,191,254)	(7,191,254)	(7,191,254)
Transfer to Workforce Dev	(50,000)	(50,000)	(50,000)
Total	69,234,861	71,859,646	71,686,506
Total Available	76,750,377	84,252,943	84,561,599
Expenditures			
Central Office Adm	1,530,899	1,674,170	1,840,952
Information Technology	1,141,332	1,419,744	2,282,567
Regional Staff	9,283,378	10,456,434	10,495,022
TAF Cash Assistance	26,894,167	21,178,972	19,178,972
Child Care Assistance	2,212,904	11,236,518	11,258,003
TAF Employment Svcs	11,208,362	12,356,133	12,356,133
Domestic Violence Prevention	1,377,000	1,427,427	1,427,427
Substance Abuse	1,210,151	1,408,000	1,408,000
Foster Care Contracts	4,779,560	4,779,560	4,779,560
Permanent Guardianship	427,606	250,000	250,000
Family Preservation	4,291,721	5,190,892	5,190,892
Total	64,357,080	71,377,850	70,467,528
Ending Balance	12,393,297	12,875,093	14,094,071

Child Care and Development Fund

Item	FY 2007	FY 2008 GBR	FY 2009 GBR
Beginning Balance	(481,815)	-	-
Revenue			
CCDF Award	44,044,159	44,044,159	44,044,159
Transfer from TANF	25,454,946	22,830,161	23,003,301
Transfer to KDHE - Licensing	(2,137,856)	(2,237,228)	(2,237,228)
Total	67,361,249	64,637,092	64,810,232
Total Available	66,879,434	64,637,092	64,810,232
Expenditures			
Central Office Adm	919,685	1,010,787	1,011,055
Information Technology	581,868	518,442	778,071
Regional Staff	4,711,845	4,659,415	4,592,658
Child Care Quality	3,053,374	3,126,411	3,106,411
Early Head Start	7,889,393	7,889,618	7,889,618
Child Care Assistance	49,723,269	47,432,419	47,432,419
Total	66,879,434	64,637,092	64,810,232
Ending Balance	-	-	-
Total Surplus / (Deficit)	**12,393,297**	**12,875,093**	**14,094,071**

KANSAS HEALTHY MARRIAGE

1% SOLUTION

Good afternoon. I'm Bill Cook, Board Chairman of the Kansas Healthy Marriage Institute, or KHMI for short. KHMI is a state-wide non-profit initiative dedicated to strengthening Kansas marriages and families. I travel here today in support of the 1% Solution, which KHMI is sponsoring in coalition with a broad cross-section of Kansas organizations.

The Kansas Healthy Marriage Institute has a vision to strengthen marriage in our state by promoting lasting, positive relationships and active parenting. KHMI is a 501c3 not-for-profit corporation formed in May of 2006.

This state-wide effort was inspired by an initiative in Oklahoma that has led to efforts in many other states and at the national level. States' growing interest in promoting healthy marriages is driven by a desire to effectively address a variety of pressing social issues, including:

- Reducing Poverty
- Reducing Child Abuse and Neglect
- Preventing Costly Social Service Interventions
- Increasing Job Stability

The 1% Solution will build on some very positive work that is already happening in the state of Kansas. One of those is the "Marriage for Keeps" national research project. It's a federally-funded effort to provide marriage education to low income couples – supported by a scientific approach to measuring the effectiveness of the program. KHMI led the way in making Kansas one of eight national research sites, and is now training marriage workshop teachers and consulting on marriage education effectiveness. Marriage for Keeps is operating in Dodge City, Manhattan, Kansas City and Wichita.

Another great program that's happening in Kansas is called "Strong and Stable Families" at the University of Kansas. So far Strong and Stable Families has provided couples retreats for 105 couples who have adopted from the public child welfare system, and expects to serve 120 additional couples in the coming year. A preliminary report on the levels of marital satisfaction before and six months following training will be available Fall 2008.

Great as these programs are, they only begin to address the challenges of building a culture that supports healthy marriages. As you see in the white paper, the cost of unhealthy relationships is staggering. And yet there are proven, proactive resources available to build healthier marriages. I urge you to fully support this measure that will put our great state at the forefront of efforts to support healthier marriages and reduce the tremendous costs of picking up the pieces when people don't have the tools and training to make their relationships work.

House Social Services Budget Committee
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Kansas Department of

Social and Rehabilitation Services

Don Jordan, Secretary

Social Services Budget Committee

March 13, 2008

Healthy Marriages

Don Jordan, Secretary

For Additional Information Contact:
Dustin Hardison, Director of Public Policy
Docking State Office Building, 6th Floor North
(785) 296-3271

House Social Services Budget Committee
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Attachment 3-1

HB 2920 - Healthy Marriages

Social Services Budget Committee
March 13, 2008

Chairperson Bethell and members of the Committee, thank you for the opportunity to testify regarding the provisions of House Bill 2920. This bill requires the Kansas Department of Social and Rehabilitation Services to spend one percent ($1,019,311) from the Temporary Assistance to Needy Families (TANF) Block Grant to support healthy marriages and strengthen families through services that prevent the unnecessary separation of children from their families, and which promote permanent living arrangements for children.

This effort would be accomplished through grants up to $50,000 to entities providing marriage services and services designed to strengthen families. The department is required to contract with a state university to design the program.

Currently, there are two Healthy Marriage projects in Kansas, serving families in and around Garden City, Kansas City, Manhattan, and Wichita. Both projects are directly funded by the federal Department of Health and Human Services/Administration on Children and Families and began in June 2007. The total funding amount is approximately $5.8 million over a 5 year period for program services and a 3 year research component in Wichita. The goal of the research project is to determine if marriage education and support strengthens families.

Thank you for the opportunity to speak with you today. I stand ready for questions.

Kansas Children's Service League

Giving Kids Our Best. For Over 100 Years.

Toll-free
877-530-5275
www.kcsl.org

200 SW 30th, Suite 201
P.O. Box 5268
Topeka, KS 66605
Tel 785-274-3100
Fax 785-274-3822

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Kansas Children's Service League is the Kansas Chapter of Prevent Child Abuse America, a member of the Child Welfare League of America and the United Way. Accredited by the Council on Accreditation.

Testimony from Kansas Children's Service League
Regarding HB 2920
To the
House SRS Budget Committee
Representative Bob Bethel, Chair
March 13th, 2008

Thank you for the opportunity to testify today. My name is Gina McDonald and I am the Vice President of Education and Advocacy with Kansas Children's Service League (KCSL).

Kansas Children's Service League is a not for profit agency serving children and families across the state. In our 114 years, KCSL has provided a range of services driven by community need, spanning the areas of prevention, early intervention, treatment and placement. KCSL also has a long rich tradition of advocating for the needs of Kansas children and their families as reflected in our mission. Our collective efforts are aimed at keeping children safe, families strong and communities involved.

We at KCSL certainly agree with the concepts proposed in this bill. We certainly see the benefits of programs that "provide assistance to needy families to prevent unnecessary separation of children from their families, improve the quality of care and services to children and their families and ensure permanency for children by reuniting them with their parents."

We applaud these efforts and believe they are admirable. However we are concerned that unless there are programs already in place doing these things, a grant of 50,000.00 would not make a huge impact. That might pay for a part of one staff position, when you factor in health care and overhead.

Is this an attempt at privatizing parts of the responsibilities of TANF workers?

Once again, the goals are wonderful, but the commitment of resources are lacking.

Thank you for the opportunity to testify before you today.

KANSAS
STATE BOARD OF NURSING

Kathleen Sebelius, Governor
Mary Blubaugh MSN, RN
Executive Administrator
www.ksbn.org

Social Service Budget Committee
March 13, 2008

HB 2671

Mary Blubaugh MSN, RN
Executive Administrator

Good afternoon Chairman Bethell and members of the committee. My name is Mary Blubaugh and I am the Executive Administrator of the Kansas State Board of Nursing. I am here on behalf of the Board Members of the State Board of Nursing to provide support and information on the proposed statute changes to transfer responsibility for the training and certification of nurse aides, medication aides, and home health aides from the Kansas Department of Health and Environment to the Board of Nursing.

During a special board meeting on February 4, 2008 the board discussed and voted to support the bill to transfer CNA/CMA/HHA to the Board of Nursing. With that vote to support HB 2671 the board members voiced that the staff, equipment, and funding be transferred to KSBN and the implementation date be changed.

The definition of a nurse is a person who cares for the sick, a person who fosters, protects or promotes. National Council of State Boards of Nursing (NCSBN) define the practice of nursing as assisting clients or groups to attain or maintain optimal health, implementing a strategy of care to accomplish defined goals, and evaluating responses to nursing care and treatment. Nursing practice includes (1) basic health care that helps both clients and groups of people cope with difficulties in daily living associated with their actual or potential health or illness status, and (2) those nursing activities that require a substantial amount of scientific knowledge or technical skill. Nurses work with and through others, resulting in multiple interactions and relationships. The CNA/CMA/HHA is one of those professions that the nurse works with, supervises, and delegates tasks to. Boards of nursing have jurisdiction over licensure of nurses and the nursing care they provide. The board of nursing is the logical agency to regulate assistants to nurses. In 2003 NCSBN developed a Position Paper, model legislative and administrative rule language pertaining to regulation of CNA/CMA/HHA. It is the position of NCSBN that the state board of nursing should regulate CNA/CMA/HHA.

In 2004 there were 13 state boards of nursing who regulate CNA/CMA's. In 2007 the number had risen to 21. A review of the Member Board Profile from National Council of State Boards of Nursing Boards of Nursing also revealed that 26 Boards of nursing approved training programs for CNA/CMA. In the everyday operations of KSBN, staff

Landon State Office Building, 900 SW Jackson St., Ste 1051, Topeka, KS 66612-1230
Voice: (785) 296-4929 • Fax: (785) 296-3929

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receives e-mails, web submissions and phone calls with questions that pertain to CNA, CMA, or HHA.

KSBN is a fee funded agency, and it is important that the CNA/CMA/HHA program be self supporting. Fees paid by RN's, LPN's, ARNP's and LMHT's should not be used to fund the CNA/CMA/HHA programs. The fiscal note was conducted based on information received from KDHE on the expenditures and revenues, the programs will be self supporting with the federal match and the fee received for initial certifications.

KDHE and KSBN have met to discuss the logistics of the transfer. One area of discussion has been the software and transfer of data to the board of nursing. KSBN is currently in the beginning stage of development and implementation of new licensure software. Because of this, KSBN requests that the transfer date be October 1, 2009. This will provide time for both agencies to work together to make the transfer smooth and will allow KSBN to develop the needed licensure software.

In conclusion, KSBN does support the transfer of CNA/CMA/HHA from KDHE to KSBN. We ask for favorable action on this legislation. Thank you for your time and consideration and I will stand for questions.

KANSAS
DEPARTMENT OF HEALTH
AND ENVIRONMENT

Kathleen Sebelius, Governor
Roderick L. Bremby, Secretary

www.kdheks.gov

Testimony on
House Bill No. 2671
Presented to
House Social Service Budget Committee
By
Richard J. Morrissey
Kansas Department of Health and Environment
March 13, 2008

Chairperson Bethell and members of the committee, my name is Dick Morrissey and I serve as the interim Director of the Division of Health. Thank you for the opportunity to appear before you to discuss House Bill 2671, which would transfer responsibility for Training and Certification of Nurse Aides, Medication Aides, Home Health Aides, administration of the Kansas Nurse Aide Registry, and criminal record checks for nurse aides to the Kansas State Board of Nursing (KSBN).

Formal Nurse Aide Training and Certification was established in state law in 1977. The Kansas Department of Health and Environment has been the responsible agency since that date, with the responsibility being housed in the Health Occupations Credentialing Program. The Certification and Training Program for Nurse Aides is implemented to integrate state law with various federal requirements and to integrate with the requirements to become a medication aide or home health aide. To achieve optimal efficiency, the program is managed by staff and software that are shared with programs related to the other responsibilities within Health Occupations Credentialing, such as the licensure of Speech-Language Pathologists and Audiologists, Dietitians, and Adult Care Home Administrators. We believe that splitting these program responsibilities will not be as efficient as the current structure and may disrupt the statewide training program, which is functioning at a high level.

More than 100,000 individuals have completed Nurse Aide Training and been certified since 1977. A database for all of these individuals is maintained with approximately 50,000 individuals holding an active certification at any time as a Nurse Aide, Medication Aide or Home Health Aide. In Fiscal Year 2007, KDHE certified an additional 7,553 individuals. Information Technology experts advise that duplicating this database by another state agency may be problematic, and involve considerable cost for both KDHE and the board.

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KDHE also has maintained operation of the Kansas Nurse Aide Registry since 1991, pursuant to both federal and state law. This database is accessible to the Adult Care Home industry and to the public to provide information on whether the Nurse Aide has achieved the required level of training, whether they have a finding of abuse, neglect or exploitation, and whether or not a criminal record exists which would prohibit employment.

Cost must be considered. As noted above significant costs, some of which may be unknown until the conversion starts, will be incurred for necessary software changes. Application and renewal fees collected total about $250,000 annually and are currently deposited to the state general fund. If these fees are allocated to the board there would be a net loss in revenue to the state general fund.

Over the years KDHE has developed a strong network of training sites and instructors across the state, resulting in a Nurse Aide Training and Certification Program which is a model in the nation. The database system implemented on April 18, 2005, has allowed even more extensive automation of functions, related to not only the certification of Nurse Aides and the Nurse Aide Registry, but all programs administered by Health Occupations Credentialing. The program is currently developing an on-line application process for use by instructors and is in the testing process for online access to facilities for criminal record checks, which would provide a response to about 80% of checks within 36 hours.

The nurse aide training and certification program has been effectively managed by KDHE since 1977 and meets every state and federal performance requirement. It is recognized nationally as one of the best in the nation. The state of Missouri recently visited KDHE to audit the program and admired its automation, accuracy and efficiency.

If the committee acts to recommend the bill favorably for passage, we recommend that the committee amend the bill to:

1. change the effective date of the transfer to October 1, 2009;
2. make KDHE responsible for conducting all required background checks on unlicensed employees; and
3. increase the cap on the fees for background checks to $20.00.

We will be happy to work with the Revisor as necessary to develop the necessary amendments.

We believe the program is operating cost effectively and is providing high quality service to its customers as the present time. For the reasons stated above, we respectfully oppose HB 2671. I am happy to respond to any questions you may have.

KANSAS

DEPARTMENT ON AGING
KATHY GREENLEE, SECRETARY

KATHLEEN SEBELIUS, GOVERNOR

Testimony House Bill 2671
to
The House Social Service Budget Committee

by Martin Kennedy
Commissioner of Licensure, Certification and Evaluation

Kansas Department on Aging

March 13, 2008

Mr. Chairman and members of the committee, thank you for the opportunity to appear before you to discuss provisions of HB 2671 regarding the transfer of the Certified Nurse Assistant registry and education program to the Kansas Board of Nursing. As the regulator of adult care homes in the state, KDOA currently maintains a strong working relationship with the Health Occupations Credentialing program at KDHE. We have an interest in effective management of the program that assures qualified individuals are available to provide direct care for vulnerable Kansas seniors.

KDOA takes a neutral position on this bill. Should the bill move forward, there are a number of issues we believe need attention and consideration by your committee. These concerns are:

Paid Nutrition Assistants – The provision for allowing Personal Nutrition Assistants (PNA) has been eliminated from KSA 39-936(c)(1) altogether. We believe this is a drafting error and is not the intent of the bill to eliminate paid nutrition assistants. This deletion appears on page 5, line 6 though 8. The deleted language should be restored.

For consistency, the PNA training requirement could also be transferred to the Board of Nursing. CMS has specific training requirements for PNAs. PNAs are supervised by licensed nurses.

Placement of Findings of ANE on the Registry - Pursuant to both state and federal law (42 USC 1396r(g)(1)(C)and KSA 39-1401 et seq.), KDOA investigates allegations of resident abuse, neglect or exploitation by nurse aides against residents. If the Secretary of Aging confirms that an aide has committed such acts against a resident (after notice and opportunity for hearing) a notice of finding of the offence is placed on the registry and that individual is prohibited from working in Kansas adult care homes in the future. Facilities are required to check this registry before they hire an aide to make sure the applicant is eligible to work in Kansas facilities. The

NEW ENGLAND BUILDING, 503 S. KANSAS AVENUE, TOPEKA, KS 66603-3404
Voice 785-296-4986 Fax 785-296-0256
http://www.agingkansas.org

House Social Services Budget Committee
March 13, 2008
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law also provides that a record may be expunged if the finding involves a single incident of neglect and conditions are met.

To provide effective administration of these requirements, KDOA recommends adding a provision to the bill that requires the Board of Nursing to place on the registry findings of abuse, neglect or exploitation when they are confirmed by the Secretary of Aging. Likewise, if the Secretary finds that a finding of neglect should be removed from the Registry, then the Board would be required to remove the finding. Similar language may be needed to address this issue between KDHE and the Board of Nursing regarding allegations of abuse, neglect or exploitation against aides employed by Home Health Agencies.

Splits Background Checks Between 2 Agencies – Currently KDHE handles the criminal background checks for both certified staff and all other non-licensed staff. This bill now moves the background checks for nurse aides to the Board of Nursing and all other background checks remain with KDHE. This will require providers to run checks through either KDHE or Board of Nursing, depending which level of potential employee is at issue. We believe this additional step will create at least transitional problems for facilities that are used to dealing with a single agency for background checks.

Nurse Aide Training and Competency Evaluation (NATCEP) (42 USC 1396r(b)(4)(C)(ii)and 42 CFR 483.150) KDOA will work with the Board of Nursing regarding the federal requirements for nurse aide training programs. The federal rules have certain requirements that nurse aide training programs must have before training can be offered by a facility. The Board will also need to have regulatory expertise so it does not approve a training course for a facility that has lost its ability to conduct nurse aide training as a result of other enforcement activity (for example, civil monetary penalties in excess of $5,000 and patterns of harm level deficiencies in facility surveys). KDHE has a very effective tracking system for just this purpose. We hope these systems and resources are included in any transfer of functions.

Curriculum Revisions - Health Occupations Credentialing is currently in the process of revising three courses: The 90-Hour Certified Nurse Aide Course, the Operator course, and the Activity Director course. HOC is in the middle of field testing the state exam for CNAs. Transferring the nurse aide program now would jeopardize the completion of these curriculum revisions. We recommend a delayed transfer date to at least 2009 in order for this process to be completed before transfer.

Miscellaneous Corrections and Concerns –

Section (h), pg 3, lines 13 and 14. The reference to the Secretary of KDHE should be deleted. It should read, starting at line 13 "mentally retarded which has been granted an exception by the ~~secretary of health and environment upon a finding by the~~ licensing agency that an . . ."
Other clean-up amendments include:

- Pg 6, line 40, there's a typo, "subsection (f)" should be "subsection (d)"

- Pg 7, lines 10, 14, and 17 should have the words "or operator" added behind the word "administrator"

- Pg 8 lines 28 – 30 and pg 15 at lines 39 and 40- both contain the language "The provisions of this subsection shall not apply to a minor found to be in need of a guardian or conservator for reasons other than impairment." The purpose of this language is unclear.

Thank you for the opportunity to appear before you to discuss the Kansas Department on Aging concerns about HB 2671. I will be happy to answer questions you may have regarding our testimony.

KHCA
KANSAS HEALTH CARE ASSOCIATION

117 SW 6th Avenue, Suite 200
Topeka, Kansas 66603
(785) 267-6003 Phone
(785) 267-0833 Fax
www.khca.org Website
khca@khca.org E-mail

kcal ahca

March 13, 2008

Mr. Chairman and Committee Members-

The Kansas Health Care Association, and the Kansas Center for Assisted Living, representing nursing homes, assisted living, nursing facilities for mental health, homes plus, residential health care facilities and long term care units of hospitals appreciates the opportunity to present testimony concerning house bill 2671.

Our members do not support HB 2671.

The nurse aide registry has been located at KDHE since the beginning of the nurse aide training requirements in 1977. From our research, it is one of the most respected programs in the nation. KHCA/KCAL believes there should be a compelling reason for such a major transfer of this program to the Kansas Board of Nursing.

Over the years the Health Occupations Credentialing within the Kansas Department of Health and Environment has worked to improve the efficiency and convenience of the registry.

Since the system went live almost three years ago, enhancements to the database have been developed and implemented, such as on-line employment verification of nurse aides, medication aides, and home health aides, to fulfill federal requirements. The ability to verify employment on line is a real time saver for staff and fulfills the requirements sooner than the more cumbersome paper reporting.

All employees of nursing facilities must have a background check completed and this would still be done by KDHE thus creating an unnecessary burden on facilities. They will have to contact two different agencies, pay fees to two different agencies and adhere to two different reporting formats. It does not make sense to make a working system more cumbersome.

We understand HOC staff is currently testing on-line submission of criminal record check requests, and could have this up and running in the near future. Health Occupations Credentialing meets regularly with providers to ask for input on improving processes to keep Kansas seniors safe.

The Kansas Board of Nursing is a board geared from a policy and philosophical perspective to administrate licensing for professional nurses. We believe mixing these two professions could lead to unforeseen consequences.

In tight budget times this is not a good idea. The start-up dollars would be significant state general fund dollars and the moneys already spent improving the system at the Kansas Department of Health and Environment would be wasted.

We ask you to table this legislation.

Thank you.

Cindy Luxem
CEO, President
Kansas Health Care Association/Kansas Center for Assisted Living

House Social Services Budget Committee
March 13, 2008
Attachment 8

KAHSA
creating the future of aging services

To: Chairman Bob Bethell and Members
Social Service Budget Committee

From: Debra Harmon Zehr, President

Date: March 13, 2008

Testimony in Support of House Bill 2671

Thank you, Chairman Bethell and Members of the Committee, for this opportunity to offer written testimony on House Bill 2671.

The Kansas Association of Homes and Services for the Aging represents 160 not-for-profit aging service and long-term care providers who serve over 20,000 elders throughout the state. Together our members employ 6,200 Certified Nurse Aides.

KAHSA supports House Bill 2671, which would transfer responsibilities for the training and certification of nurse aides, medication aides and home health aides from the Kansas Department of Health and Environment to the Kansas State Board of Nursing. We support the balloon amendment to retain administration of the adult care home/home health criminal record check program at KDHE.

Thank you for this opportunity to provide our remarks on House Bill 2761.

785.233.7443
kahsainfo@kahsa.org

fax 785.233.9471
217 SE 8th Avenue
Topeka, KS 66603-3906
kahsa.org

House Social Services Budget Committee
March 13, 2008
Attachment 9

KSNA
KANSAS STATE NURSES ASSOCIATION

1109 SW Topeka Blvd
Topeka, Kansas 66612
785.233.8638. Fax 785.233.5222
www.nursingworld.org/snas/ks
ksna@ksna.net

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Susan Bumsted, M.N., R.N.
President

The Voice And Vision Of Nursing In Kansas

Terri Roberts, J.D., R.N.
Executive Director

TO: Bob Bethel, Chair of the SRS Social Services Budget Subcommittee
Members of the Committee

FROM: Terri Roberts J.D., R.N.
Kansas State Nurses Association

DATE: March 13, 2008

SUBJ: H.B. 2671 Transfer of CMA, CNA and HHA Registry

The Kansas State Nurses Association (KSNA) supports the proposed transfer of the CNA, CMA and HHA registry and education oversight from the Kansas Department of Health and Environment to the Kansas Board of Nursing *if adequate funding and personnel are authorized and provided for*. This proposal was considered in the 2004 Legislature in H.B. 2905 and KSNA supported the transfer at that time as well (testimony attached).

The Kansas Board of Nursing is a fee-funded agency, supported mainly from licensure renewal funds from the more than 40,000 licensees that renew every two years. KSNA believes that it would not be appropriate to place the burden of financing the registry on licensed nurses, and wants to insure that adequate funding and staff compliment are available for the work necessary to manage the registry. Additionally, the Board of Nursing has recently selected a new vendor for licensing software after a three year acquisition journey and the timing of the transfer would be best suited now rather than at a latter date, or the knowledge that it would occur so that accommodations for the entire system at the agency could be made as the new IT system (software and hardware) is implemented.

We would ask that the following be given serious consideration prior to the decision to support this proposal.

In order that the Board of Nursing is financially able and has sufficient personnel to maintain the level of services to current licensees, we recommend that the:

- staff compliment at KDHE to carry out this function be given to the Board of Nursing in additional FTE's for the agency when the transfer occurs,

- federal funding that accompanies the "registry" mandated by Congress also follows this function, or SGF necessary to fully fund the work,

- time-frame for the relocation and transition of activities be sufficient to ensure a smooth and order transition. KDHE has provided these services for over thirty years, and recognizing that time is not of the essence in executing this transfer, and we believe that a deliberate and thoughtful approach will provide both agencies some security that it will be accomplished without unnecessary disruption of the services transferred and, more importantly the services both agencies currently provide in addition to those being relocated.

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March 9, 2004

KSNA Testimony

H.B. 2905 – Transfer of CNA, CMA and HHA Registry, Education to Kansas Board of Nursing

TO: Sharon Swartz, Chairperson
Agriculture and Natural Resources Subcommittee
(Appropriations)

FROM: Janice Jones, MSN, RN
President
Kansas State Nurses Association

SUBJ: H.B. 2905 Transfer of CNA, CMA and HHA Registry,
Education to Kansas Board of Nursing

Good afternoon, my name is Janice Jones M.S.N., R.N. and I am the President of the Kansas State Nurses Association (KSNA). KSNA is the professional organization for Registered Nurses in the state and we are pleased to support the proposed transfer of the CNA, CMA and HHA registry and education oversight from the Kansas Department of Health and Environment to the Board of Nursing.

These three categories of unlicensed assistive personnel (UAP's) are already under the supervision of RN's and LPN's in carrying out their responsibilities and this agency to agency transfer is an appropriate approach to streamline their regulation and oversight. RN's must provide the education required of these three categories of care givers and must ensure that they are competent prior to completion of the required education. In the practice setting we work side-by-side to ensure residents of long-term care and individuals in their homes are receiving the essential services to continue in their every day lives.

While we have encouraged, supported and appreciate KDHE's initiation of curriculum updates to the CNA and CMA curriculum the past five years, this role will be easier for the Board of Nursing and their staff because of the content expertise they possess.

Our only hesitation in supporting this proposal is the funding and personnel issues that arise when one agency inherits the responsibilities of another. KSNA cannot support that these new functions be funded through RN and LPN licensure fees generated at the Board of Nursing. The State General Fund (SGF) revenue and federal monies used now by KDHE to support this work should follow the services to the Board of Nursing.

In order that the Board of Nursing is financially able and has sufficient personnel to maintain the level of services to current licensees (customers if you will), we recommend that the:

- staff compliment at KDHE to carry out this function be given to the Board of Nursing in additional FTE's for the agency when the transfer occurs,

- federal funding that accompanies the "registry" mandated by Congress also follows this function, and that the Board of Nursing be timely and appropriately apprized of the ramifications of "cost-based accounting" required to receive such federal money. This may impact the best date of transfer for purposes of tracking costs and reporting such expenditures.

- time-frame for this relocation of activities be sufficient to ensure a smooth and orderly transition. KDHE has provided these services for over thirty years, and recognizing that time is not of the essence in executing this transfer, and we believe that a deliberate and thoughtful approach will provide both agencies some security that it will be accomplished without unnecessary disruption of the services transferred and, more importantly the services both agencies currently provide in addition to those being relocated.

KSNA has also received information that a *substantive amendment* may be proposed to add another category of care-givers, to this transfer bill. KSNA supports maintaining this bill as a transfer bill only for these already recognized unlicensed care-givers. We are reluctant to support a substantive amendment that has not had the benefit of full debate and dialogue, particularly since it implements brand new Federal rules permitting states to implement *Nutritional or Feeding Assistants* in long-term care facilities.

Thank You.

10-2

KAHSA

creating the future of aging services

To: The Honorable Bob Bethell and Members of the House Social Services Budget Committee
From: Mary Sloan, Director of Government Affairs
Date: Friday, March 13, 2008
Re: House Bill 2752

Good morning, my name is Mary Sloan, Director of Government Affairs for the Kansas Association of Homes and Services for the Aging (KAHSA.)

I am pleased to have the opportunity to speak to you today on the issue of the mental health service needs of older adults and House Bill 2752 which is intended to address those needs.

KAHSA is a member of the Kansas Mental Health and Aging Coalition and is in favor of legislation to improve mental health access and services for elders.

KAHSA represents about 160 non-profit long-term care providers in Kansas – many of whom have residents who are in need of mental health services.

You each may have heard at other times about the major challenges facing older adults in need of mental health services. As you probably know, these challenges include:

- The fact that older adults are at a significant risk of negative outcomes related to depression and other mental health challenges.
- There is a high level of unmet need among older adults.
- There are significant barriers to accessing care – including transportation, availability and stigma.

Undesirable outcomes for elders experiencing depression and other mental illnesses occur because older adults frequently do not receive adequate treatment, or due to complicating factors of age and other illnesses, may receive a misdiagnosis, may receive an inappropriate prescription, or may be over-medicated.

Additionally, older adults with serious mental illnesses are three times more likely to enter a nursing home than seniors without serious mental illness. And mental health providers estimate that 60 to 80% of older adults residing in nursing facilities experience some type of mental disorder.

785.233.7443
kahsainfo@kahsa.org

fax 785.233.9471
217 SE 8th Avenue
Topeka, KS 66603-3906
kahsa.org

House Social Services Budget Committee
March 13, 2008
Attachment 11-1

Therefore, to try to address possible solutions, KAHSA has worked with the Association of Area Agencies on Aging, the Association of Community Mental Health Centers, the Silver-Haired Legislature, the Mental Health and Aging Coalition and others to draft and support legislation to enact a targeted program to increase access, raise awareness and begin to provide outreach services.

Together we have created a draft of substitute language for HB 2752 – and it is attached here. While the original language outlines many good ideas – this alternate language more specifically seeks to create and enact a program overseen by KDOA that would provide the three key components outlined by the original – education, outreach and services. Further, it specifically outlines that those services would be delivered under the auspices of KDOA to those in need -- wherever they reside. It would be statewide program using existing AAA structures that would allow local control and flexibility.

In closing, I would like to thank you for this opportunity to address the members of this Committee about the important issue of mental health challenges and services for the aging in Kansas -- and to provide testimony urging the adoption of the substitute language, and finally to ask for your support in addressing this critical and unmet need. I will be happy to address any question you may have now or research any issue further and report back to you.

Central Plains Area Agency on Aging

cpaaa

510 North Main ✯ Suite 502 ✯ Wichita, Kansas 67203-3752

ANNETTE GRAHAM
Executive Director

Administration — (316) 660-7298
Information & Assistance
(316) 660-5120 ✯ (800) 367-7298
FAX — (316) 383-7757

House Social Services Budget Committee
Testimony on H.B. 2752
Mental Health for Seniors

Good afternoon and thank you Chairman Bethel and Committee members for allowing me this time to address your committee today. My name is Annette Graham; I am the Executive Director of the Central Plains Area Agency on Aging. Our agency coordinates the services for a tri -county region that includes Butler, Harvey and Sedgwick Counties. I am pleased to speak to you on the issue of mental health and older adults; this is an issue that I have been involved with for over twenty years. I am here to testify in support of HB 2752.

My comments will focus on the urgent need for mental health services for older Kansans. I am here to voice support for this bill, to discuss the need for these services and discuss specifics of the service delivery model that would be implemented through this bill.

HB 2752 would address the urgent need that Aging service providers see on a daily basis in our communities. Older adults experience significant mental health issues that negatively impact their health, their quality of life, and their relationships. There is a high level of unmet need among older adults, there are significant barriers to accessing services, the number of older adults experiencing mental health issues is increasing and there is an urgent need for Kansas to address this issue.

Approximately 20% of community dwelling older individuals experience mental health problems which include anxiety disorders, mood disorders such as depression, severe cognitive problems such as Alzheimer's disease and other dementias. The number of older adults experiencing substance abuse is also a significant issue which raises this percentage even higher than the 20% figure. For the older population residing in nursing facilities the percentage that experience mental health issues ranges from 60 to 80% of the population . These conditions can be debilitating and they can be terminal. The highest rate of suicide is for males age 85 and over, the second highest rate is among adults age 75 to 84. The suicide rate for males age 85 and older is six times higher than that for the general population.

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The data highlights that older adults do not receive adequate treatment: they face issues of under diagnosis, misdiagnoses, inappropriate medications, inadequate referral and follow up. Less than 3% of older adults receive treatment by a mental health specialist. They are the age group who receive the least amount of mental health services and they are the most reluctant group to seek out services on their own behalf. Even when services are sought out there are many barriers that interfere with access: lack of transportation, individuals that are homebound, limited availability of in home mental health services, cultural barriers, limited number of providers trained in aging issues, the magnified issue of stigma among older adults, the compounding impact of ageism and the increased costs for mental health services. Under Medicare the copay cost for mental health services is 50% whereas for medical care the copay is 20%.

The level of unmet need is immense and there is a need for specialized services for this growing population. Meeting the needs of this population is becoming increasingly critical as the population grows and as the boomers starts entering this phase of life in just three short years. In Kansas, the percentage of adults age 60 and over is higher than the national average of 12%, Kansas is at 16.9%. In the rural areas that percentage is much higher. Too often the mental health needs of older adults are not identified, under diagnosed, misdiagnosed or inadequately treated. Older adults are more likely to receive mental health from a general physician and often they present with physical complaints, rarely do they present with a mental health complaint. The diagnosis process is complex due to the presenting problem often being not the mental health issue but rather a physical complaint, the multitude of co-occurring medical conditions, multiple medications and the interactions of these prescription medications. Often the mental health issues are not identified. Unfortunately, many people, including some professionals believe that depression is a normal part of aging. This belief contributes to lack of appropriate diagnosis, referral and treatment. Older adults are less likely to be referred for psychotherapy and treatment by mental health professionals, and more likely to be prescribed medication. Seniors utilize mental health services less than any other age group and it is estimated that as many as 63% of adults age 65 and older do not receive appropriate treatment.

The fastest growing segment of the population is the age 65 and over. Between 2000 and 2030 America's older population will double, growing to 70 million. The number of older adults with mental health disorders will also grow. Unless action is taken to address the needs of the growing population, the system of care will be overwhelmed and the medical utilization rates and costs will sky rocket. Government is already spending funds for the provision of services for this population. The medical care cost for the older adults with mental health issues is 50% higher than for those without mental

health disorders. These older adults are three times more likely to enter a nursing home than a senior without a mental disorder. It is estimated that 60 to 80 % of older adults residing in a nursing home experience some type of mental disorder. We are already paying the price for the mental health problems in older adults; we are paying for it through increased medical costs, excess disability, and premature institutionalization.

There are numerous barriers to accessing care. They include stigma which for older adults is even greater than for the general population, ageism which undervalues older adults and their well being and worth, inaccessessible care, limited services, limited numbers of trained specialized mental health providers, lack of awareness about mental health issues of older adults by providers of services and lack of transportation. Older adults themselves are often fearful of seeking treatment, they worry about losing benefits if they identify themselves as needing mental health treatement and they worry about losing their independence, being labeled or viewed as "incompetent" and being put into a nursing home.

HB 2752 would provide for mental health services for older adults to be coordinated and implemented through the 11 Area Agencies on Aging (AAA's) across Kansas. The request is for $1,808,000. This money would be allocated to the 11 Area Agencies on Aging utilizing the same formula that is currently used to allocate the state funds for the Senior Care Act program. Kansas Department would administer and distribute the funds and $48,000 of the funds would cover their administrative costs. The funds that would be allocated to the AAA's would be utilized at the local level, with 50% of the funds for direct mental health services, 25% for education and 25% for outreach.

It is critically important that each of these categories be included as all three are necessary to adequately meet the mental health needs of older adults. Education on mental health issues, signs, symptoms, treatment options and how to work with older adults with mental health issues will be provided for a variety of professionals, direct care staff, and service providers. This can include CNA's, home health aides, community service providers, administrators, social workers, nurses, and physicians. This will include education about mental illness, it's prevalence among older adults, the difference between normal aging and mental illness, how these problems can be diagnosed, treated, and how to maintain good mental health in aging, the available resources, and community services referral options.

Outreach is a key component which will target early identification, early intervention and prevention. Mental health outreach will be provided at locations frequented by older adults and their families such as doctors' offices, senior centers and religious organizations to increase information

sharing and early identification of high risk individuals and families. Information will be provided on preventative measures and positive mental health promotion. This will be done through collaboration with religious organizations, health, mental health and aging service providers .The AAA's will collaborate at the local level with providers to contract for delivery of each of these components.

Direct services will provide for access to an affordable and comprehensive range of quality mental health services. This would be provided by qualified mental health providers in a range of locations which include: the individuals own home, a nursing home, an assisted living, a community setting, a community mental health center, or other mental health providers.

Community providers including community based organizations, Community Mental Health Centers, and other mental health providers would be requested to submit proposals to outline how they could provide services in the local area. This process mirrors how the SCA program is administered and managed at the AAA level. The program costs, service units and outcomes would be developed based on the proposals. This model ensures that the services are tailored to the needs and resources at the local level and maximizes the resources and strengths of each AAA planning and service area. This is a collaborative model that will be developed to meet the needs of the communities and population across Kansas. The services will be provided regardless of place of residence, in the individuals own home, in the housing complex, in the nursing facility, in the assisted living... This model will provide for prevention, early intervention, education and treatment. This will provide a service for older adults in Kansas that builds on the recommendations from the National Association of Mental Health and Planning & Advisory Councils report from 2007 and the recommendations that came out of the Older Adults and Mental Health: Issues and opportunities recommendations from the Department of Health and Humans Services Administration on Aging in 2001.

HB2752 will provide for an array of services that mental health and aging advocates have been working towards for many years. We believe that this bill will take Kansas a long way in addressing the needs of older adults, their families, and our communities. We believe this bill will position Kansas well for potential funding and programs currently proposed at the national level which includes the Positive Aging Act, STOP Senior Suicide Act, and some additional programs through the Administration on Aging.

In closing I would like to than you for this opportunity to address this important issue. I would be happy to address any questions you might have.

NAMI Kansas
Kansas' Voice on Mental Illness

www.namikansas.org
112 SW 6th Avenue, Suite 505, PO Box 675, Topeka, Kansas 66601
(785) 233-0755

House Social Services Budget Committee
Geriatric Mental Health Act
March 13, 2008

Presented by:
Rick Cagan, Executive Director

Mr. Chairman and members of the Committee, my name is Rick Cagan. I am the Executive Director of NAMI Kansas, the National Alliance on Mental Illness.

NAMI represents consumers of mental health services and their family members. We are a grassroots organization providing peer support, education and advocacy dedicated to improving the lives of individuals with mental illness, including children and adults, and their families. NAMI Kansas has a statewide membership and has been providing advocacy, peer support, and education in Kansas for 27 years.

We stand in support of House Bill 2752 and the need to provide greater focus in the provision of mental health services to the elderly.

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

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

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

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

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

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

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

In order to meet the needs of older adults with mental illnesses, several strategies were identified in the report to ensure that appropriate and effective treatment and services will be available to the elderly. Most of these are germane to the issues anticipated in the presentation of HB 2752.

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

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

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

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

It is my understanding that the reauthorization of the Older Americans Act approved by Congress in September included the provisions of the Positive Aging Act. First introduced in 2004, the Positive Aging Act called for improved mental health care for the elderly and recognized that our health care system was not positioned to appropriately identify and treat the occurrence of mental illnesses among the elderly. These Older Americans Act provisions authorize competitive grants to states for the development and operation of systems for the delivery of mental health screening and treatment services for older adults as well as competitive grants to states for programs to increase public awareness regarding the benefits of mental health prevention and treatment in older adults, for the reduction of the stigma associated with mental disorders in older adults, and reduction of age-related prejudice and discrimination regarding mental disorders in older adults.

It is in the context of these repeated findings over the last decade and more that we are now called on to provide some focus in the delivery of mental health services to the elderly in Kansas. NAMI Kansas urges the adoption of HB 2752 as a positive step in this direction.

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

Association of Community Mental Health Centers of Kansas, Inc
720 SW Jackson, Suite 203, Topeka, Kansas 66603
Telephone: 785-234-4773 / Fax: 785-234-3189
Web Site: **www.acmhck.org**

House Social Services Budget Committee

Testimony on
Mental Health Services for Seniors
H.B. 2752

March 13, 2008

Presented by:

Mike Hammond, Executive Director, ACMHCK, Inc.
Steve Denny, Senior Outreach Services Coordinator, Four County Mental Health Center, Independence, Kansas
Nancy Trout, L.S.C.S.W., Aging Specialist, Prairie View, Inc., Newton, Kansas
Chair, Kansas Mental Health and Aging Coalition

Mister Chairman and members of the Committee, my name is Mike Hammond, I am the Executive Director of the Association of Community Mental Health Centers of Kansas, Inc. Joining me today in our testimony are Steve Denny, Senior Outreach Services Coordinator, Four County Mental Health Center in Independence, and Nancy Trout, Aging Specialist, Prairie View, Inc., Newton, Kansas and Chair of the Kansas Mental Health and Aging Coalition. We appreciate the opportunity for a focused discussion on mental health services for seniors in Kansas. I am going to share some background information briefly, and then will turn it over to Steve and Nancy for information more specific to their respective Community Mental Health Center (CMHC).

The Association represents 27 licensed CMHCs which provide services to meet the particular needs of their local communities. The public mental health system is a partnership between State and local government. With a collective staff of over 4,000 professionals, the CMHCs provide services to Kansans of all ages with a diverse range of presenting problems. The CMHCs provide assessment, diagnosis, treatment, case management, medication management, crisis services, attendance care and respite care as well as many other services to individuals and families dealing with mental illness. In addition, the CMHCs provide screening for individuals who may need inpatient hospitalization. We serve more than 123,000 Kansans each year, and as part of licensing regulations, are required to provide services to all Kansans who present for treatment, regardless of their illness or ability to pay. In 2006, the CMHCs served 10,224 seniors age 55 and older.

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

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

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

According to the National Rural Health Association, people from rural or frontier areas have a high percentage of seniors with Medicare coverage, are less likely to enroll in Medicaid, and have less knowledge about that and other social services. Right now, Medicare does not provide

coverage for many providers of mental health care and treatment. In addition, it only reimburses for 50% of the cost to provide treatment to seniors with mental illness, and that only for a very few licensed practitioners. The passage of federal legislation that expands Medicare coverage to include all mental health clinicians who are licensed for independent practice by their state licensing boards will help to close the gap for rural Kansas seniors and those with mental illness, and allow them access to treatment by a mental health professional in their own community.

One other policy that impacts access to mental health treatment and care for seniors as well as other Kansans is the inequity between physical health and mental health benefits in group health insurance policies. In Kansas, insurance companies who offer health insurance offer policies that limit the number of outpatient visits, inpatient stays, higher co-pays and office visit obligation fees, and also caps the lifetime benefit for policy holders. All of these are hindrances to Kansans who need access to mental health treatment and care.

The Association supports the Department on Aging in their efforts to bring mental health care and treatment to seniors in Kansas. With me today are two experts in this topic from two CMHCs in Kansas. They are Steve Denny, Senior Outreach Services Coordinator, Four County Mental Health Center in Independence, and Nancy Trout, Aging Specialist, Prairie View, Inc., Newton, Kansas and Chair of the Kansas Mental Health and Aging Coalition. They will share with you a brief outline of the needs of seniors in their communities, ways in which their organizations reach out and provide services to seniors, and how they have been able to improve the lives of older Kansans in their communities.

Four County Mental Health Center (Steve Denny)

Mister Chairman and members of the Committee, thank you for allowing me to present today. I'm here to testify on behalf of Senior Outreach Services (SOS), a geriatric mental health program through Four County Mental Health Center in Independence. Our current senior program serves Montgomery and Wilson Counties. I was also recently appointed Chair of the Aging Subcommittee to Governor's Mental Health Planning Council. In speaking on behalf of both of these positions, I would like to express full support for House Bill 2752.

This testimony will provide one example of how this bill will benefit older adults throughout our State. It will describe the importance of direct service combined with public outreach and community networking. This testimony will outline the needs of the target population and then describe the services that SOS has implemented to address these needs.

Needs of the Target Population

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

Psychiatry testified that "there is accumulating evidence that depression can exacerbate the effects of cardiac disease, cancer, strokes, and diabetes (2005)."

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

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

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

The majority of SOS clients present with similar needs. Major Depression and Anxiety Disorders are the most common conditions treated in SOS. These illnesses commonly lead to isolation, withdrawal, decreased self-care, low motivation, appetite changes, intense worry, hopelessness, feelings of worthlessness, and thought/plans of suicide in severe cases. Many clients struggle with multiple personal and physical losses. Chronic pain and physical illness often cause psychiatric symptoms to intensify. Often prescription medication or alcohol is used to cope with both physical and emotional pain. Seniors also deal with financial struggles, family conflict, and are vulnerable to physical and financial exploitation.

The SOS targets adults age 60 and older, who live independently or in assisted living. One of the primary goals of the program is to achieve prolonged independence in the community. Detecting and treating depression helps improve self-care, reduce isolation, and restore a sense of hope. By emphasizing and supporting independent living while it is safe and reasonable, SOS strives to counter premature nursing home placement (Department of Human Services, 1999). The direct services provided by SOS targets these symptoms and other issues through direct service and collaboration with community partners.

Direct Service

Stigma towards mental health services is a significant access barrier to treating mental illness in older adults. Many older clients are fearful of their family or friends discovering that they have mental health problems. Fear of losing independence, fear of being committed to the hospital, and negative media depictions are factors often cited by seniors in Southeast Kansas that contribute to stigma. One specific SOS client told staff that he parked two blocks away and walked so that his neighbors wouldn't see his vehicle parked at the Center. This type of stigma is a reflection of why seniors with mental health issues seek treatment at such a low rate (Rabins, 1996).

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

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

Individual Outreach: This is normally the first service provided when a referral is received on a new client. There is currently no reimbursement for this service, but it is crucial to reaching clients in rural areas. During an individual outreach, SOS staff explain the program and most importantly seek to connect and develop trust. Between May and November of 2007, SOS provided outreach services to 70 new referrals, 30 of these clients chose to open services in our program.

Individual Outpatient Therapy: This service is provided by a mental health professional. As stated earlier, SOS clients have the option to receive it in-home throughout treatment. This service is reimbursed through Medicare, Medicaid, and private insurance, which is our program's primary source of income. Unfortunately, Medicare only reimburses at 50% after co-pay as indicated earlier. This is a deterrent for sustainability since over half of our clients carry Medicare Part B as their primary insurance. This reimbursement issues further justifies the support that this bill would provide.

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

These services are currently provided by four staff serving Montgomery and Wilson Counties. All four positions are funded primarily by a three year grant through a "Rural Healthcare

Services Outreach Grant." This grant is funded by the Office of Rural Healthcare Policy, a division of The Health Resources and Services Administration or "HRSA." Additional sources of income are discussed in the service descriptions. The program is comprised of two licensed masters' level social workers and two bachelor's level case managers.

The SOS program is currently working with Pittsburg State University to track outcomes and monitor the effectiveness of these services. Unfortunately, data is not yet available as we have not even completed the first year of our project. However, based on experience as a clinician in this program, I've found that a large portion of seniors recover from mental illness. Many clients report improvement after only one outreach visit and never require admission to our program. I have observed multiple clients who have been discharged in full-remission of symptoms; however, success varies with each client. Factors such as severity of physical health, social supports, family history, and willingness to make changes play a role in achieving success. The following three case examples demonstrate this variation of success. They also exemplify common issues that contribute to mental illness in seniors. The names have been changed to protect client confidentiality

Irene *is a 92 year old white female residing in an assisted living facility. She was referred for symptoms of intense anxiety and depression including suicidal thoughts. Irene was struggling with the move from her home of over 60 years to a one bedroom apartment. She was quite isolative and had stopped many of the activities she once enjoyed. She responded very quickly to therapy and reported significant relief after one session. Irene returned to knitting and crocheting and began to interact more with the other residents. One of her friends secretly entered her cross-stitching project in the state fair. On our next to last session, she very proudly showed me a grand champion ribbon that she'd won for this project. She was discharged after six months of treatment. She is still doing well today, nearly two years later.*

John *is a 76-year old white male. He is a war veteran and suffers symptoms of Post Traumatic Stress Syndrome after observing awful events in a Prisoner of War camp. In addition, John has financial stressors, family problems, and is dealing with multiple health problems. He has several medical appointments per week and multiple service providers. John's case manager attends all of his medical appointments and communicates regularly with John's Primary Care Physician. He has been in service nearly two years and continues today. There have been multiple hospitalizations, both medical and psychiatric, along with brief stays in the nursing home; however, John remains in the community today. It can be said with relative certainty that this would not have happened without SOS staff helping him manage his physical and psychiatric needs in the community.*

Bob *is a 66-year old Vietnam Veteran. He was referred by a psychiatric hospital after he became severely depressed. He reported intent, plan, and had access to guns to end his own life. His depression was fueled by severe breathing problems due to Chronic Obstructive Pulmonary Disease (COPD) along with loneliness and loss of his spouse. Throughout the first year of treatment, he reported ongoing thoughts and plans of suicide. In time, he began to improve slowly. A few months ago, when asked about suicidal thoughts, he replied in this fashion, "I've been thinking... My COPD is progressing about like it is supposed to. I know that I don't have much time left and I certainly don't want to do anything to shorten it." He remains in treatment*

today as he still continues to cope with depression and health issues. John was able to accept his physical health issues and still find meaning and reason to live.

Each of these cases is examples of how geriatric mental health services have helped seniors in Southeast Kansas. I will close this section with an example of a senior, who didn't get help. A family friend and neighbor of over 30 years had been living by himself for almost 10 years since the death of his wife. He became ill this summer and required hospitalization twice. Upon discharge from his second hospitalization, he began to receive home care services. One evening he called his home care nurse asking her to use the back door instead of the front. The next morning, she found him lying dead in front of his back door due to a fatal self-administered gun shot wound to the head. His depression was not reported, but is now evident in looking back. His providers, as well as family, were not able to recognize the depression, which is why the final section of this testimony is so crucial.

Public Outreach and Education

Mental illness is often unrecognized and not reported by seniors. Suicide, unfortunately, is one of the consequences of this fact. Research indicates that up to 47% of adults aged 65 and older, who committed suicide, saw their primary doctor within one week of killing themselves, while 70% saw their doctor within one month (NIH, 2001). Both providers and the general community assume it to be a normal part of aging. This is one of the reasons why public education is so important. Since May of 2007, SOS has provided five in-service presentations to educate providers on depression and suicide in older adults. Several more are scheduled in the upcoming year.

The SOS program initiates outreach and education in a variety ways. We seek to network and educate every referral source possible. These sources include the AAAs, assisted living, physicians, home health agencies, hospitals, and health departments. The SOS could not survive without referrals and strong relationships with these agencies. In 2007, "The Senior Outreach Services Consortium" was formed to oversee the Rural Healthcare Outreach grant project. This consortium consists of representatives from hospitals, assisted living, health departments, and AAA in both Wilson and Montgomery County. This group has committed to addressing the mental health needs of senior in our community and provides further opportunity for public education through networking.

The SOS program has provided over 30 public presentations to the general public since 2005. Examples include AARP, senior housing, hospitals, assisted living facilities, and community organizations such as Rotary Club. These presentations serve to educate the public on symptoms of mental illness in seniors and have generated numerous referrals and further opportunities for public education. Through these efforts, public awareness is increased and stigma is reduced.

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

health and aging services can work together. Similar types of partnerships will be essential in implementing this bill.

The SOS program is an example of the types of successful projects HB 2752 could create. The SOS program has outreached to 170 seniors since 2005. We have collaborated with numerous agencies successfully and are increasing community investment in our services. The SOS program has educated various healthcare providers, as well as the general public. Quality direct service, combined with public education, has helped SOS establish itself as a reputable program in Southeast Kansas. This has resulted in reduced stigma, increased public awareness of mental health needs in seniors, reduction in nursing home placement, and **most importantly,** higher quality of life for the people we serve.

Prairie View, Inc. (Nancy Trout)

Mister Chairman and members of the Committee, thank you for your time and interest in the mental health of Kansas seniors. I am Nancy Trout, clinical social worker and Aging Specialist at Prairie View, Inc.'s East Wichita outpatient office. For over 23 years, I have worked with older adults and their families providing direct services in mental health venues and community outreach and education to the general public and to professionals who serve elders. I come to you today at the request of Mary Carman, Ph.D., who is Vice President of Older Adult Services at Prairie View, Inc., a regional behavioral health organization with a hospital in Newton and six outpatient offices in five counties. Prairie View also has an inpatient psychiatric hospital which served close to 60 older adults (65 and over) this past year. In addition, we have a geriatric Intensive Outpatient Program that serves older adults 2-3 days a week for three hours a day.

In the calendar year 2007, 1,732 clients age 65 years old and older were served by Prairie View, Inc., in six locations. Approximately 35 % of these were seen in nursing homes. In addition, over 200 were served in Caregiver Support Groups and supportive counseling through grants from two Area Agencies on Aging. However, this is estimated to be a small percent of the older adults needing mental health services.

Prairie View has had a division of older adult services since 1979 and we have intentionally built this program for the past 29 years. We currently have 17 staff that specialize in treating older adults. Some of these staff see older adults full time while others see adults and older adults. These include LSCSWs, Ph.D.s, ARNPs, and MDs. However, many more are needed given the growth in this population.

We also have a post doctoral program in geriatrics for psychologists and a psychology internship program.

The majority of older adults seen at Prairie View suffer from clinical depression, anxiety, or dementia. Depression is regarded as a chronic illness and is no less in need of treatment than heart disease. Research has shown that over 80% of older depressed people respond well or completely to treatment. Generally a combination of therapy/counseling and medications work best. Anxiety is also very treatable.

Dementia, with its' many causes (e.g. Alzheimer's, multi-infarcts, Lewy Body Disease) effects not only the person who has the dementia but also the caregivers. New medications are available that slow the process of Alzheimer's disease and help the individual maintain function longer. Other treatments are available to help other causes of dementia. Counseling and education for both the person with dementia (in the early stages) and the caregiver is critical.

Approximately 65% of older Americans who live at home and need assistance are cared for solely by family and friends. Family caregivers perform the first line of care for frail older adults by providing needed services at home, usually for several years before seeking institutional care. The value of the services family caregivers provide for "free" is estimated to be $196 billion per year. But there is a price for this. The rate of depression and physical illnesses among caregivers is much higher than that of the general population.

A recent study revealed that older adults caring for a spouse who experience caregiver strain had a mortality risk 63% higher than control subjects. Caregivers, who have had caregiver training and/or belong to a caregiver support group, show a 50% reduction in needing nursing home care placement for their loved one.

Others this afternoon have provided more information on the statistics and the need for services. Stigma, funding, and attracting trained professionals are serious problems that must be addressed. In 2002, Prairie View provided 84 hours of caregiver training through a grant funded by the Central Plains Area Agency on Aging. More resources such as these are needed. We also provide Caregiver support groups in five counties in collaboration with South Central AAA and Central Plains AAA, but more are needed. House Bill 2752, if passed and implemented, would allow many seniors to receive the care and treatment they deserve for depression and other mental illnesses.

In **Attachment A**, there are a number of statistics that outline the impact that lack of treatment and services for seniors' mental health may have on seniors, their families, and our communities.

A recent study by the Centers for Medicare and Medicaid (CMS) (see **Attachment B**) identified the fact that depressive symptoms many times predict nursing home placement for seniors. Nursing home placement is extraordinarily expensive, at the federal and state, and for the individual and their family. It makes budgetary sense, then, to prevent nursing home placement by serving and treating seniors in their homes and communities.

Mr. Denny has presented several case examples of older adults with mental health problems. I have hundreds of similar cases where treatment has made a life changing, often life saving difference. I would like to offer two more.

Ethel *is a 78 year old woman with severe debilitating arthritis. Her fingers on each hand curl in so that even holding a glass is done with her knuckles. She has a bone growing out of the bottom of her left foot. She moved from a different community to a local long term care facility two years ago. Her sister was planning on moving in with her in an assisted care apartment but died 2 weeks before moving in. Ethel's physical health deteriorated, she became more despondent, and began to make comments about ending her life. She received individual therapy and one of*

our ARNPs started her on an antidepressant medication. She showed immediate but gradual improvement and continues to do well as of today.

Mel *is an 88 year old World War II veteran. He spent 40 days in the snow and freezing weather overseas without any shelter. He was shelled and shot at and experienced horror that to this day affect him. He has had stomach problems since the war and problems sleeping. In spite of being successful in his career, he and his wife divorced and his two children, who live in different cities,have contact with him but are not caregivers. We were able to provide a volunteer as an informal caregiver who could take Mel out to eat several times a week, help him with his eye drops when he has infections, and check on him daily.*

Mel has severe Parkinson's, eats no fruit or vegetables, and mostly exists on drinking a quart of milk each day. He spends much of his time at home sitting. His house is so cluttered that it is hard to walk from one room to another. Much of his time is in front of the TV. He is awake from 3:00 am on and his depression has worsened. He is now wearing the same clothes for a week or two. His family does not go with him to doctor appointments and he will not ask them to go. He fell recently, injured his shoulder and could not get up. We have now talked him into a life line and will be contacting his daughter. This is a fiercely independent man who still drives and wants to stay at home. There are services available to him. However, outreach and identification are desperately needed and it is imperative that his depression is treated.

I would strongly support House Bill No. 2752 as a way to address some of the mental health needs of this deserving population. These are our parents, our aunts and uncles, and ultimately, ourselves.

Thank you very much for the opportunity to present just a small view of how seniors might benefit from the passage of this bill, and the collaboration between AAAs and CMHCs. We are happy to stand for questions.

ATTACHMENT A

New National Age Population Estimates

- ✓ Elderly population is projected to grow rapidly between 2010 and 2030, as the 76 million "baby boomers" reach 65 yrs of age.
- ✓ By 2030, older adults will account for 20% of the nation's people, up from 13% today. Simply by virtue of the growth of the older population, the need for geriatric mental health services will increase.
- ✓ The most common disorders, in order of prevalence, are: anxiety disorders, severe cognitive impairment (including Alzheimer's disease), and mood disorders (such as depression).
- ✓ Between 8-20% of older adults in the community, and up to 37% of those who receive primary care, experience symptoms of depression.
- ✓ Older Americans under-utilize mental health services. Barriers include: stigma surrounding mental illness, denial of problems, access barriers, fragmented and inadequate funding for mental health services, lack of collaboration and coordination among primary care and aging services providers, gaps in services, and lack of enough professional staff trained in the provision of geriatric mental health services.
- ✓ It is estimated that only 50% of older adults who acknowledge mental health problems receive treatment from any health care provider, and only a fraction of those receive specialty mental health services.
- ✓ Access to community based mental health services is problematic for older people because of several factors, including: the growing reliance on managed care, the targeting of MHS to specialized groups that exclude the elderly, and the emphasis public providers place on serving the severely chronically mentally ill. In addition, Community Mental Health Centers often lack staff trained in addressing non-mental health medical needs, which are especially important for older adults.
- ✓ Various studies indicate a high prevalence of mental illness in nursing homes. Dementia and depression appear to be the most common mental disorders in this setting. However, most residents with mental disorders do not receive adequate treatment. Approximately 66% of those in nursing homes suffer from mental disorders, including Alzheimer's and related dementias.
- ✓ Although adults 60 years of age and older constitute 13% of the United States population, they account for only 7% of all inpatient psychiatric services, 6% of community mental health services, and 9% of private psychiatric care.
- ✓ Less than 3% of all Medicare reimbursement is for the psychiatric treatment of older patients.
- ✓ It is estimated that between 18-25% of older adults are in need of mental health care for depression, anxiety, psychosomatic disorders, adjustment to aging, and schizophrenia.
- ✓ The Surgeon General's Report indicates that 15% of older men and 12% of older women treated in primary care clinics regularly drink excessively.
- ✓ Older adults have the highest suicide rate of any age group, and persons over the age of 85 have a rate double that of any other group.

ATTACHMENT B

Journal of the AMERICAN GERIATRICS SOCIETY

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Abstract

Depressive Symptoms in Older People Predict Nursing Home Admission

Yael Harris, PhD, MHS and James K. Cooper, MD†*

From the *Office of Clinical Standards and Quality, Centers for Medicare and Medicaid Services, Baltimore, Maryland; and † Department of Medicine, School of Medicine, George Washington University, Washington, DC.

Address correspondence to Yael Harris, PhD, MHS, Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Mailstop S3-02-01, Baltimore, MD 21244. E-mail: yharris@cms.hhs.gov

Abstract

OBJECTIVES: To evaluate the power of several self-reported depressive symptoms to predict nursing home admission (NHA).

DESIGN: A Cox proportional hazards model was used to estimate the risk of NHA.

SETTING: Data were from the Health Outcomes Survey (a national random sample of 137,000 Medicare + Choice enrollees aged 65 and older), the Nursing Home Minimum Data Set, and the Medicare Enrollment Database.

PARTICIPANTS: Medicare beneficiaries aged 65 and older enrolled in a Medicare Managed Care Plan who were self-respondents to the questionnaire and were not institutionalized at the time of the survey.

MEASUREMENTS: Variables were self-reported functional status, chronic health conditions, demographics, and several mood-related questions.

RESULTS: After controlling for age, race, sex, marital status, home ownership, functional status, and comorbid conditions, individuals who identified themselves as feeling sad or depressed much of the time over the previous year were at significantly higher risk of NHA.

CONCLUSION: A single question about depressive symptoms can be used to identify individuals at higher risk of NHA. There may be benefit from better screening and treatment of depression in community-based older people. Depression and social support may be linked. This study was targeted and did not attempt to explain everything that affects NHA. Investigation of the relationship between social support, depression, and NHA should be considered in future research.

KANSAS
AREA AGENCIES
ON AGING
ASSOCIATION

Meeting the Needs of Older Kansans

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

Testimony to the House Social Services Budget Committee Regarding HB 2752 - Geriatric Mental Health

March 13, 2008

Chairman Bethell and members of the Social Service Budget Committee Budget, I am Craig Kaberline, Executive Director of the Kansas Area Agencies on Aging Association (K4A). I represent the 11 Area Agencies on Aging in Kansas who plan and coordinate community-based services for seniors in all 105 counties in Kansas.

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

The Area Agencies on Aging in Kansas are part of a national network of 655 organizations established under the Older Americans Act (OAA) in 1973 to respond to the needs of seniors and caregivers in every local community. The services available through the Area Agencies on Aging fall into five broad categories: Information and Access services, Community Services, In-Home services, Housing and Elder Rights. Within each category a range of programs is available.

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

Area Agencies on Aging offer programs that make a difference in the lives of all older adults from the frail older person who can remain at home if they receive the right services to those who are healthy and can benefit from social activities and volunteer opportunities provided by community-based programs.

I appreciate the opportunity to appear before you today to speak about HB 2752 and geriatric mental health needs in Kansas. If Kansas wants to improve the quality of life for elderly Kansans and to reduce health care and the costs of premature nursing home placement, geriatric mental health is a great place to invest.

House Social Services Budget Committee
March 13, 2008
Attachment 15-1

As we age, many people believe that it is normal or expected that a person should become more depressed. But that's not the case.

Depression is not a normal part of aging, and studies show that most seniors feel satisfied with their lives, despite increased physical ailments. However, when older adults do have depression, it may be overlooked because seniors may show different, less obvious symptoms, and may be less inclined to experience or acknowledge feelings of sadness or grief.

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

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

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

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

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

Thank you for listening and I ask for your support of HB 2752 as amended.

National Strategy for Suicide Prevention

NATIONAL STRATEGY FOR SUICIDE PREVENTION

At a Glance - Suicide Among the Elderly

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

KANSAS MENTAL HEALTH COALITION

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

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

Testimony presented to the
House Social Services Budget Committee On House Bill 2752
By Amy A. Campbell - March 13, 2008

The Kansas Mental Health Coalition supports HB 2752 which would expand mental health services targeted to the needs of older Kansans.

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

The objectives of HB 2752 build on the successes of the mental health programs currently offered in Kansas for seniors – while offering the opportunity to improve the capacity and quality of those programs and expand such services to other communities.

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

Evidence based best practices are broadly researched and published for the treatment of older adults with mental illness. This bill specifically requires the implementation of such practices and includes family support, peer support and integration with other community based health care services. The effective delivery of mental health treatment can also have powerful benefits for family members and caregivers.

The Kansas Mental Health Coalition supports HB 2752 and the work of the Kansas Mental Health and Aging Coalition in bringing this initiative to the forefront. Please support this legislation this session, along with the necessary funding for implementation including the staffing at the Department on Aging and funding for the actual services.

Please feel free to contact me or our Chair Roy W. Menninger MD for more information:
KMHC, PO Box 4103, Topeka, KS 66604 PH: 785-969-1617

House Social Services Budget Committee
March 13, 2008
Attachment 16

Kansas Silver Haired Legislature

KANSAS SILVER HAIRED LEGISLATURE

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

State-wide Geriatric Mental Health Program
House Appropriations Social Services Committee
March 13, 2008

I am Jim Snyder, Speaker of the Kansas Silver Haired Legislature. I am here to present the urgent need for a Kansas Geriatric Mental Health program this year, in total or at least enough to get a practical program started. This is covered in House Bill 2752. We strongly favor this program.

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

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

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

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

House Social Services Budget Committee
March 13, 2008
Attachment 17-1

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

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

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

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

I have included a copy of the Silver Haired Resolution and I assure you this program meets the need of our concerns.

Thank you.

SILVER HAIRED LEGISLATURE RESOLUTION 2406

A RESOLUTION providing direction for SHL Representatives to support proposed mental health legislation by the Kansas Mental Health Coalition and others.

WHEREAS, The Kansas Silver Haired Legislature and the people of Kansas consider mental health to be essential to the well-being of our older citizens and the quality of life in Kansas; and

WHEREAS, Kansas Silver Haired Bill 2401 will address this situation, but may not be the verbage required; and

WHEREAS, the Kansas Silver Haired Legislature wishes to maintain a total position on this issue: Now, therefore,

Be it resolved by the Silver Haired legislature of the State of Kansas: **That the position of the Silver Haired Legislature is for a positive geriatric mental health state-wide program and that representatives of this body are allowed latitude in presenting the position of the Silver Haired Legislature insofar as it is germane to this and to SHL 2401.**

KANSAS
DEPARTMENT ON AGING

Kathleen Sebelius, Governor
Kathy Greenlee, Secretary
www.agingkansas.org

Testimony on
HB 2752/Geriatric Mental Health Act

Social Services Budget Sub-Committee

By Secretary Kathy Greenlee
Kansas Department on Aging

March 13, 2008

Chairman Bethell and Members of the Committee:

Since becoming Secretary, I have consistently heard from seniors and their advocates that geriatric mental health services in this state are inadequate. I have had the opportunity during the past year to testify two times regarding HB 2236, a bill that also addresses geriatric mental health. During an interim legislative budget committee hearing last December, SRS Secretary Don Jordan and I both appeared to demonstrate our support for addressing this critical issue.

HB 2236 provided for a demonstration grant program. My preference is that we collectively look for sustainable funding rather than demonstration grants. HB 2752, as introduced, would give the Department on Aging the authority to contract with "any provider of care to older adults with mental disabilities." My preference is to distribute funds to the Area Agencies on Aging (AAAs) and require collaboration in the field. My expectation would be that AAAs work directly with their local Community Mental Health Centers. While AAAs are the experts on aging, CMHCs are the experts on mental health. I support the suggested amendments to this bill.

I applaud your effort to press forward on addressing this issue. Geriatric mental health services such as those proposed by this bill are not currently funded in the KDOA budget. However, I am willing to stay engaged in this conversation as we search for ways to provide funds to address the mental health needs of Kansas seniors.

New England Building, 503 S. Kansas Avenue, Topeka, KS 66603-3404
Voice: (785) 296-4986 • Toll-Free: (800) 432-3535 • Fax: (785) 296-0256
TTY (Hearing Impaired): (785) 291-3167 • E-Mail: wwwmail@aging.state.ks.us

Kansas Mental Health Aging Specialists
Social Services Budget Committee
Chairman Representative Bob Bethell
March 13, 2008

House Bill 2752

Chairman and members of the Committee, thank you for the opportunity to submit written testimony on HB 2752. We represent a group of Aging Specialists from Community Mental Health Centers who work with older adults in our communities (both rural and urban). At each of our Community Mental Health Centers, we provide therapy services and community education about mental illness to older persons, their families and to professionals working with them. Among our agencies funding sources are diverse and include federal, state, local, endowment, contracts with Area Agencies on Aging, and grant monies.

We support House Bill 2752, with the revisions and welcome the opportunity to work collaboratively with the Kansas Department on Aging and the Area Agencies on Aging. Funding from this bill will fill a need for services, which current funding sources (Medicaid, Medicare, and private insurance) do not meet. We believe providing funding through the Kansas Department on Aging to be distributed and managed by the local Area Agencies on Aging, will effectively address the unique unmet education, outreach, assessment and service delivery needs of older Kansans.

There are barriers to older adults receiving mental health services. We as Aging Specialists at Community Mental Health Centers suggest that with the funding from House Bill 2752 these needs can be addressed as follows:

- Increased identification of those older persons at risk of suicide (older adults have a suicide rate of 14 per 100,000, compared to 11 per 100,000 in the overall U.S. population and are less likely to seek help).

- Increased education of professionals, including aging, mental and physical health care professionals, to better identify and refer older persons to mental health services (75 percent of older adults who commit suicide have visited their primary care physician within a month of their suicide: 20 percent the same day and 40 percent within one week).

- Increased in-home caregiver counseling (one collaborative effort between a Community Mental Health Center and an Area Agency on Aging in 2007 more than doubled the number of caregivers they expected to service in the first year).

- Increased in-home assessment and treatment for homebound older adults (84 percent of older adults have at least one chronic health problem, 62 percent have two or more chronic health problems, which limits access to mental health treatment outside the home).

- Increased access to mental health treatment in nursing facilities (reports suggest that one in four nursing home residents suffer from depression).

- Increased access of handicapped accessible transportation to mental health treatment (21 percent of older adults do not drive; many have health problems, which limit their ability to access public transportation).

- Increased education of older adults, their families and professionals, to recognize the inter-relatedness of mental and physical health among older persons (25 percent of older adults with chronic illnesses have depression).

To illustrate what this statistical information can mean to older Kansans, the following is an example of an older woman who recently received treatment at a Community Mental Health Center in Kansas (some of the details have been altered to protect her privacy).

Just two years ago, Helen retired and made plans to move to another state to be near a lifelong friend, where they planned to enjoy retirement together. She sold her home, packed up her belongings and she along with her dog made the big move.

Only a few months later, Helen's friend was diagnosed with cancer. The cancer did not respond to treatment and soon Helen became her friend's end of life caregiver. Not long after Helen began caring for her friend, she was also diagnosed with cancer. Helen's cancer responded well to chemotherapy and she continued to care for her dying friend. After a year long battle with cancer, Helen's friend passed away, and not long after, Helen's dog also died. Helen was all alone in an unfamiliar state. She couldn't afford to continue living in the home of her friend, so with the encouragement of her daughter she moved to Kansas to be near her daughter's family.

Nearly as soon as Helen arrived, her daughter knew something was terribly wrong with her mother. Helen was severely depressed. She cried all day, had suicidal thoughts and had even searched out ideas on how she might take her own life. At Helen's daughter's insistence, Helen came to the Community Mental Health Center, where she received medication from a psychiatrist to help with her depression and began seeing an Aging Specialist (clinical social worker with a specialty in aging), who worked with her on coping with her grief and loss, adjusting to the changes in her life, and to begin building a new life for herself.

With medication, the support of her family, and the Community Mental Health Center, Helen's mood improved. She no longer felt hopeless and suicidal. Though she still grieved the loss of her sister, she was able to find enjoyment in life again. She began

attending church activities, enjoyed time with her daughter and grandchildren, and recently got a new dog.

Funding this bill with the revisions will provide early interventions in mental health assessment, education, outreach and services to many older Kansans. Likewise, with early treatment, older persons are likely to have less severe symptoms and fewer medical and psychiatric hospitalizations. Additionally, older adults who receive these mental health services will remain living in the community and avoid premature nursing home placement.

Thank you for considering this testimony.

Nancy Luber, LSCSW
Clinical Social Worker/Aging Specialist
Johnson County Mental Health Center
1125 W Spruce
Olathe, KS 66061
E-mail: nancy.luber@jocogov.org
Phone: 913-782-2100

Ruth Shadel, LSCSW
Clinical Social Worker/Aging Specialist
Bert Nash Community Mental Health Center
200 Main Street, Suite A
Lawrence, KS 66044
E-mail: rshadel@bertnash.org
Phone: 785-830-1718

Steve Denny, LSCSW
Clinical Social Worker/Aging Specialist
Four County Mental Health Center
1601 West 4th
Coffeyville, KS 67337
E-mail: sdenny@fourcounty.com
Phone: 620-251-8180; 620-464-3199
Independence office: 620-331-1748

Nancy Trout, LSCSW
Clinical Social Worker/Aging Specialist
Prairie View, Inc.
East Wichita Outpatient Office
9333 E. 21st St. North
Wichita, KS 67206
E-mail: kctrout@yahoo.com
Phone: 316-643-4726

AARP Kansas
555 S. Kansas Avenue
Suite 201
Topeka, KS 66603

T 1-866-448-3619
F 785-232-8259
TTY 1-877-434-7598
www.aarp.org/ks

March 13, 2008

The Honorable Bob Bethel, Chairman
House Social Services Committee

Reference - HB 2752

Good afternoon Chairman Bethel and Members of the House Social Services Budget Committee. My name is Ernest Kutzley and I am the Advocacy Director for AARP Kansas. AARP represents the views of our over 371,000 members in the state of Kansas. Thank you for allowing us to present our comments in support of enhanced mental health services for seniors in Kansas.

AARP believes the need for mental health services for older Americans is not being adequately met. According to estimates, a minimum of about 40 percent of older people in the community have unmet mental health needs.

Normal aging is not characterized by mental or cognitive disorders, and there are effective interventions for most mental disorders experienced by older people (e.g., depression, anxiety and disorders associated with the inability to adjust to life changes or that may be secondary consequences of physical ailments or medical interventions).

Older adults with mental disorders include people whose conditions develop in old age as well as those whose disorders begin at a younger age and continue as chronic or recurrent illnesses. Depression in the aging and the aged is a major public health problem. Alcoholism and other substance abuse disorders also are found among older adults. Too often, these disorders go undiagnosed or are misdiagnosed.

Treatment for mental disorders among older people is generally provided by primary care physicians or physicians who lack training in psychiatric care. This problem is exacerbated by the shortage of mental health professionals trained in geriatrics and by the scarcity of nursing facility staff with education and training in the care of people with mental disorders. Other professionals who can provide mental health services to older people, including gerontological social workers and geriatric nurse practitioners, are also in short supply.

Therefore AARP believes that states should:

- Ensure coordination of mental health services with all appropriate health, long-term services and supports (LTSS) and aging network services—at the local level, area agencies on aging should have cooperative working

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agreements with community mental health centers to meet the mental health needs of older people in the community;

- Ensure that people with mental illness or retardation who are not admitted to a nursing home as the result of a Preadmission Screening and Annual Resident Review have home- and community-based services and receive appropriate treatment in the most appropriate setting.
- Establish mechanisms to ensure that LTSS agencies and mental health authorities address the mental health needs of older people who require LTSS as well as the LTSS needs of people with mental illness.
- Encourage innovative service-delivery models for mental health services, such as bringing mental health services into homes, senior centers, and residential care facilities (including board and care homes).

Therefore, AARP Kansas supports legislation such as HB 2752 that will include:

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

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

Thank you.
Ernest Kutzley

& AGING COALITION

Kansas Mental Health Coalition

Topeka, Kansas

MARCH 13, 2008

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

ON BEHALF OF THE KMH&AC

It is a pleasure to testify today regarding HB ~~2236~~ 2752, a geriatric mental health act for Kansas. In case you are wondering older adults are those considered 60 years and older.

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

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

Advocacy positions I have had include:

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

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

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

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

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

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

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

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

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