

Spring 5-1-2015

Connecticut's Elderly Population: An In-Depth Analysis of Current and Future Trends in Elder Care, with a Focus on Dementia and Cognitive Decline

Emily J. Snodgrass

University of Connecticut - Storrs, Emily.J.Snodgrass@gmail.com

Follow this and additional works at: http://digitalcommons.uconn.edu/srhonors_theses

 Part of the [Community Health and Preventive Medicine Commons](#), [Geriatric Nursing Commons](#), [Geriatrics Commons](#), [Health and Medical Administration Commons](#), [Health Services Research Commons](#), [Neurosciences Commons](#), [Other Public Health Commons](#), and the [Public Health Education and Promotion Commons](#)

Recommended Citation

Snodgrass, Emily J., "Connecticut's Elderly Population: An In-Depth Analysis of Current and Future Trends in Elder Care, with a Focus on Dementia and Cognitive Decline" (2015). *Honors Scholar Theses*. 454.
http://digitalcommons.uconn.edu/srhonors_theses/454

**Connecticut's Elderly Population: An In-Depth
Analysis of Current and Future Trends in Elder Care,
with a Focus on Dementia and Cognitive Decline**

**Emily Snodgrass
University of Connecticut
College of Agriculture, Health, and Natural Resources
Honors Advisor: Judy Brown, PhD
May 1, 2015**

Abstract:

The aging population in Connecticut currently represents ~15% of the state's population but is anticipated to rapidly increase over the next 20 years. My thesis is an examination of the types of interventions and programs currently available for elderly persons with memory impairment and cognitive decline, as well as the challenges associated with caring for a larger elderly population. Data collected from interviews with CT healthcare and research professionals representative of the diverse specialties of aging together with an analysis of current research literature are used to demonstrate the importance of continued research and expansion of appropriate and accessible services available to the elderly, their caregivers, and family.

Methods:

This project is composed of multiple parts. The first portion is composed mainly of research. Research on current legislation, practices, and options in the field of elder care was done through several avenues. I visited government agency websites, legislative agendas and reports in addition to reading scientific journal articles and research projects. This information was compiled and eventually organized in a short research paper.

In addition to the research paper portion of this project, I conducted interviews with professionals in the field of aging. Interviews were done both in person and through email exchange. I reached out to roughly 20 professionals in various fields of aging, explaining my work and asking if they would be interested in

participating in this thesis. Several declined do to lack of interest or time, or because their research focus was no longer in the field of aging. Those that did wish to participate were either interviewed in person or through a set of prepared questions sent by email. These interviews were then listed in full, by participant name. Afterwards, common themes, conflicting points, and shared predictions made by these individuals were analyzed in an analysis segment, along with with my own input regarding several issues.

Finally, a summary statement was made regarding this project. This conclusion describes the overreaching message of the research and interviews included in this project. Individuals that participated in the creation of this thesis were also acknowledged.

Introduction:

Americans are living longer than ever before. A report filed by the Centers for Disease Control (CDC) found that in 2012, the average American life expectancy was approximately 78.8 years (*Detailed Tables, 2013*). This is the longest life expectancy documented in the U.S. since records were started. The average American lifespan has increased by roughly 20 years since 1901, when women were expected to live approximately 57 years, and men 55 years (*United States Life Tables, 1921*). The older population in the U.S. is not only growing older, it is growing larger as well, and the CDC states that there were 43.1 million individuals aged 65 or older in the United States in 2012 (National Center for Health Statistics, 2013). The dramatic increase in lifespan in the United States has created an entirely new population,

with unique own health risks and critical problems. One such problem is that of memory loss. Memory loss occurs at many levels, ranging from normal, age-related memory loss, to dementia caused by conditions such as Alzheimer's disease, which are pathologic in nature (Plassman, 2007).

The effects of memory loss with increased age vary greatly. Minimal memory loss, associated with healthy aging, can have very little impact on an individual's day-to-day life, and may not be recognized as a health problem at all. Individuals with slightly more cognitive decline are often diagnosed with Mild Cognitive Impairment (MCI) or Cognitive impairment, no dementia (CIND) (Janice E Graham, 1997). These individuals often present with functional disability and a need for institutionalized care, but never received a formal diagnosis of dementia or Alzheimer's disease (Janice E Graham, 1997). Individuals with MCI and CIND are often more difficult to diagnose, because of a lack of formal definition of the "line" between mild cognitive impairment and dementia (Plassman, 2007). Individuals with more severe memory loss, caused by a condition like Alzheimer's disease, will decline much more rapidly and will likely be unable to live independently in advanced stages of the disease (Janice E. Graham, 1997). Because the affected population is only slated to grow over the next two decades, severe pathologic memory loss in the elderly population is an issue that needs to be tackled (*CT Commission on Aging*, 2011). This is especially true in areas with higher concentrations of older adults, like the state of Connecticut.

According to the Connecticut Commission on Aging, the state of Connecticut ranked 7th in the nation for highest median age in 2010 (*CT Commission on Aging*,

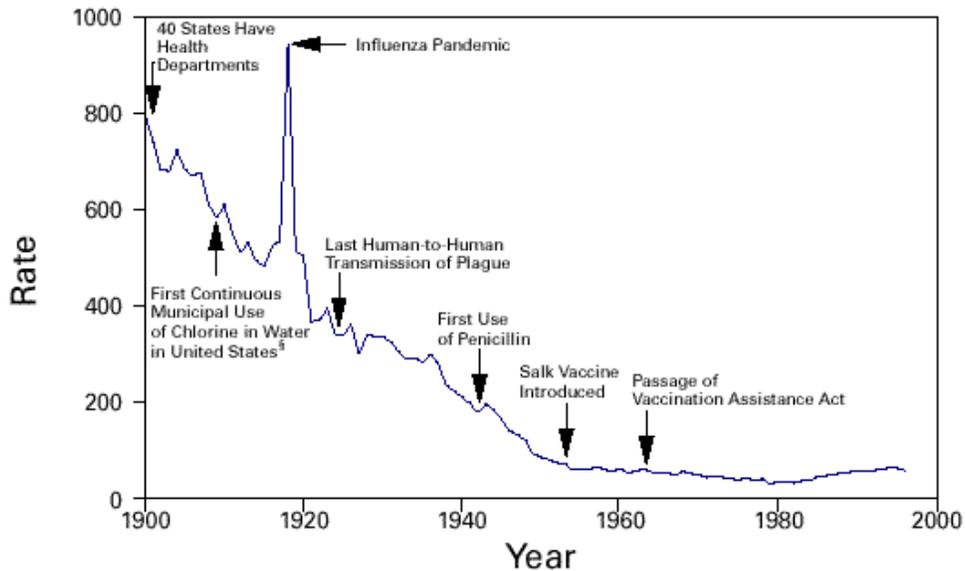
2011). From 2006 to 2009, Connecticut's population of adults aged 65 years and older grew by nearly 3.5%, while the number of individuals younger than 65 actually decreased (*CT Commission on Aging, 2011*). By 2040, Connecticut's population of individuals 65 years or older is anticipated to grow by 57%, while the population of people between the ages of 20 to 64 is only expected to experience a 2% growth in that same period (*Study of Funding and Support, 2015*). This large older population presents unique challenges for the state of Connecticut. One challenge is the increased likelihood of dementia within the population. One nationally representative study conducted in 2007 estimated that approximately 13.9% of individuals above the age of 71 in the United States will develop dementia (Plassman, 2007). Because Connecticut has a disproportionately large population of older adults, the care of elderly persons with memory loss will need to become an area of focus within the state. This growing older population will require different types of healthcare interventions, financial planning and assistance, and end of life care than previous generations. Healthy aging requires that morbidity and disease be compressed into a smaller timeframe near the end of life. To reach that goal will require the work of researchers, healthcare providers, as well as legislative bodies. Healthy aging cannot stem from one field, but rather requires the utilization of many resources. This process has been implemented in the United States before, and successfully eliminated several leading causes of death. Now, this broad-spectrum strategy needs to be applied to the area of memory and aging.

America: A Changing Health Landscape

In order to illustrate how a multi-pronged attack on a significant health concern can be extremely effective, historical comparisons can be made. While age-related conditions like memory loss are the focus of many researchers and healthcare providers today, the health issues of greatest concern in the U.S. have not always been associated with aging (*Achievements in Public Health*, 1999). There was a time in which the general population did not live long enough for age-related diseases to become a significant problem. This can be discovered through careful analysis of census data focused on cause of death. Cause of death data can be an indispensable tool in analyzing the health needs of a population. The leading causes of death at a given time, within a defined population, often point to pressing health issues that need to be addressed. Detailed records kept over extended periods of time also demonstrate how addressing the immediate needs of a population can spur major changes in overall health. For example, in 1900, pneumonia, tuberculosis, diphtheria and diarrhea and enteritis caused one third of all deaths, 40% of which were children under the age of 5 (*Achievements in Public Health*, 1999). These diseases had a devastating effect on the health of the overall population. The discovery of vaccinations and antibiotics were essential in learning how to effectively treat patients. Vaccinations virtually eliminated the occurrence of “diphtheria, tetanus, poliomyelitis, smallpox, measles, mumps, rubella, and *Haemophilus influenzae* type b meningitis” in the United States, while penicillin and other antibiotics provided a high rate of success treating previously incurable conditions like “streptococcal and staphylococcal infections, gonorrhea, and syphilis” (*Achievements in Public Health*, 1999). The incidence of these conditions

was decimated by new treatment options. Figure 1 below demonstrates how the introduction of multiple health interventions over the course of the 20th century contributed to a lower death rate due to infectious diseases (*Achievements in Public Health, 1999*).

FIGURE 1. Crude death rate* for infectious diseases — United States, 1900–1996[†]



*Per 100,000 population per year.

[†]Adapted from Armstrong GL, Conn LA, Pinner RW. Trends in infectious disease mortality in the United States during the 20th century. *JAMA* 1999;281:61–6.

[§]American Water Works Association. *Water chlorination principles and practices: AWWA manual M20*. Denver, Colorado: American Water Works Association, 1973.

Vaccination and antibiotic intervention contributed to the decline in deaths due to infection and disease (*Achievements in Public Health, 1999*). As these deaths declined in numbers, people began to live longer, and age-related causes of death increased in incidence. Records demonstrate that the leading causes of death in America have shifted from pneumonia and tuberculosis in 1900, to heart disease and cancer in 2013 (*Leading Causes of Death, 2015*). Intervention and research foci

have also shifted in order to determine how best to eradicate these new leading causes of death. The objective is to find new ways to prevent and eliminate the current leading causes of death, in the same way that vaccinations and antibiotics reduced the lethality of most infectious diseases. Aging, memory loss and dementia are one area that is being closely examined for potential in new interventions.

Alzheimer's Disease and other Dementias: Not an Individual Diagnosis

In 2012, Alzheimer's disease was the 6th leading cause of death in the United States (*Detailed Tables*, 2013). For persons aged 65 and older, it was the 5th leading cause of death (2011 Alzheimer's Disease Facts, 2011). Prior to the discovery of Alzheimer's disease, dementia in old age was seen as a normal sign of aging, and often resulted in people being admitted to psychiatric hospitals (*Hippius*, 2003). A German psychiatrist named Alois Alzheimer first documented the symptoms and brain characteristics of Alzheimer's disease in 1906 (*Hippius*, 2003). He described a 50-year-old woman that had been admitted to the Frankfurt Psychiatric Hospital in 1901 demonstrating "sleep disorders, disturbances of memory, aggressiveness, crying, and progressive confusion" (*Hippius*, 2003). Alzheimer continued to follow the woman's progressive symptoms until her eventual death, even after he left the hospital in 1902 (*Hippius*, 2003). It was the post-mortem study of this woman's brain matter that led to the discovery of Alzheimer's disease's characteristic plaques and tangles (*Hippius*, 2003).

Since the discovery of clinical Alzheimer's disease's effects on the human brain in 1906, diagnoses of Alzheimer's and other degenerative cognitive diseases have increased (*Hippius, 2003*). Today, Alzheimer's disease is responsible for roughly 69.9% of all dementias, and it's estimated that over 2 million Americans have Alzheimer's disease (*Plassman, 2007*). The conditions that affect cognitive function and lead to dementia, such as Alzheimer's disease, do not simply reduce the ability of individuals to remember events or people. Dementia is associated with difficulty solving problems, completing everyday tasks, confusion of time and space, poor judgment, depression, changes in mood and withdrawal from work or social life (*2014 Alzheimer's Disease Facts, 2014*). Because of these debilitating and progressive symptoms, individuals diagnosed with dementia tend to lose functionality and the ability to live independently. Those diagnosed with Alzheimer's disease, for example, eventually lose the ability to walk and even to swallow (*2014 Alzheimer's Disease Facts, 2014*). This loss of function often means that individuals with dementia require the assistance of others in order to perform in their day-to-day life.

The extreme debilitation of Alzheimer's disease and other forms of dementia mean that this is not a disease of individuals. Individuals diagnosed with dementia *will* need assistance. Often, family members take over the caregiving role. In 2011, the Alzheimer's Association estimated that "nearly 15 million Americans provide unpaid care to a person living with Alzheimer's disease or another dementia," and that 80% of at-home care is provided by family members of affected individuals (*2011 Alzheimer's Disease Facts, 2011*). In Connecticut in 2010, there were 169,828

Alzheimer's and dementia caregivers, who contributed nearly 193,399,655 hours of unpaid care (2011 Alzheimer's Disease Facts, 2011). The economic value of those hours was placed at \$2,307,257,883 (2011 Alzheimer's Disease Facts, 2011). Caregiving often results in stress, financial burden, and emotional hardship for caretakers that must continuously care for loved ones during a sharp decline in health (2011 Alzheimer's Disease Facts, 2011). The effects of dementia are not simply isolated to the individual diagnosed with the condition. Because dementia involves not only the diagnosed individual, but also requires individuals to fulfill caretaking roles, it impacts many more people than actually have the condition.

Connecticut is one of the oldest states in the nation, and is only anticipated to grow older (*CT Commission on Aging, 2011*). With an increase in elderly citizens will come an increase of those diagnosed with dementia (2011 Alzheimer's Disease Facts, 2011). An larger elderly population will require more care hours, and need may grow so large that family members cannot afford to provide the entirety of the care their loved ones need. Currently, Connecticut offers a respite program designed to offer temporary and short-term relief for caretakers (Caregiver Services, 2015). Services include but aren't limited to adult day care, home health aides, and short term assisted or nursing home living (Caregiver Services, 2015). As demand for these services increases, Connecticut will need to be able to fulfill those requests. Preparing for the increased need for care will require Connecticut to implement legislative initiatives to allocate care more effectively to a larger number of people, and to provide funding to existing resources for the elderly. This preparation will require a combined effort of both state and local officials in order to allocate care

appropriately (AGING SERVICES, 2013). As one Municipal Agent commented on the Connecticut State Plan on Aging in 2014, Connecticut's Department on Aging "must prepare one of the oldest states in the country for an explosion of older citizens" (*Connecticut State Plan on Aging*, 2014).

Connecticut Legislation and the Elderly: A Brief History

Connecticut's history of legislation focused on the elderly originated by federal mandate. The United States first nationally addressed the needs of older adults in 1935, with the passing of the Social Security Act (Administration on Aging, 2015). This was the largest legislative acknowledgement of the elderly until the federal government passed the Older Americans Act in 1965 (Administration on Aging, 2015). The act addressed concerns that there were not enough social support measures in place to ensure the healthy aging of older citizens (Administration on Aging, 2015). In 1973 the Older Americans Act was amended and required that states create Area Agencies on Aging, effectively dividing the state into smaller planning and service areas (Area Agencies on Aging, 2015). The purpose of Area Agencies on Aging was to compel states to distribute funding of the Older Americans Act on a more local level. The services provided by these Area Agencies include transportation assistance, home-delivered meals, and in some cases, funding for care programs for adults with dementia (Area Agencies on Aging, 2015).

Connecticut has five designated Area Agencies on Aging (Area Agencies on Aging, 2015). Each of these Area Agencies is apportioned by geographical location (Area Agencies on Aging, 2015). These private, not-for-profit organizations use federal,

state and local funds to keep seniors in their community informed and cared for (Caregiver Services, 2015).

While Area Agencies on Aging are able to allocate resources to various programs, they are not legislative bodies. More recently, Connecticut has created policy-making bodies to address the developing needs of the growing elderly population. In 2013, Connecticut created the State Department on Aging (AGING SERVICES, 2013). The department works in conjunction with the five Area Agencies on Aging in order to administer Older Americans Act programs as well as assessing the effectiveness of current service delivery methods (AGING SERVICES, 2013). While statewide agencies are more effective at creating viable legislative plans, community-based services are often more adept at delivering services to individuals. One of the major delivery pathways of care and services within the state is through the use of Municipal Agents in each town in Connecticut (Municipal Agents for the Elderly, 2009). Connecticut law requires that a Municipal Agent be assigned in “each of the 169 towns in Connecticut” (Municipal Agents for the Elderly, 2009). These agents often work within a senior center, and are tasked with distributing information to their local senior population (Municipal Agents for the Elderly, 2009). In addition, these Agents often organize events and services to their community, in order to promote activity and socialization (Municipal Agents for the Elderly, 2009).

Although these services can be very useful for active individuals, many older persons do not retain the ability to live completely independently. Elderly individuals that *do* require some assistance in order to avoid institutionalization can

take advantage of Connecticut's Medicaid waiver program (Fortinsky, 2014). Medicaid waiver programs are intended to keep people with disabilities, whose health insurance is often being paid for by Medicaid, out of nursing homes (Fortinsky, 2014). These programs are designed to save money, as private nursing homes can be extremely costly (Fortinsky, 2014). The Medicaid Waiver program, Connecticut Home Care Program for Elders (CHCPE), addresses the needs of individuals at risk of nursing home placement (DSS: CHCPE Alternate Care, 2015). The individuals that qualify for this program are over the age of 65, and require help with critical tasks such as feeding, bathing, and toileting (DSS: CHCPE Alternate Care, 2015). In order to utilize this program, individuals must complete a health screen and may need to contribute financially to the payment of their care, which is overseen by a care manager (DSS: CHCPE Alternate Care, 2015). In 2012, individuals diagnosed with Alzheimer's and other dementias composed approximately 24.2% of all enrollees in the CHCPE program (*Connecticut Home Care Program, 2012*).

Connecticut has a history of implementing Task Forces in order to formally research areas of current interest within the state. Aging has recently become a clear focus of the state government, and an increase in Task Forces dedicated to improving the quality of life for older Connecticut residents has been used to support that focus. In 2012, Special Act No. 12-6 created the Task Force on Aging in Place (Report of the Task Force to Study Aging in Place, 2014). The CDC defines "Aging in Place" as "the ability to live in one's own home and community safely, independently, and comfortably, regardless of age, income, or ability level" (Report of the Task Force to Study Aging in Place, 2014). The formal goal of this Task Force

was to study aspects of Connecticut infrastructure, transportation systems, tax code, nutritional support and insurance policies that would allow older members of the community to continue to live outside of private care facilities (Report of the Task Force to Study Aging in Place, 2014). Recommendations were made regarding the future of these programs, and the participants on the Task Force made predictions if changes would require legislation or financial contributions to occur (Report of the Task Force to Study Aging in Place, 2014).

Aging in place was not the only aspect of aging that received Task Force attention. Increased recognition of Alzheimer's disease and dementia has led to an increased legislative focus on assisting those diagnosed with the cognitive conditions in Connecticut. In 2013, Connecticut passed Special Act No. 13-11, An Act Establishing a Task Force on Alzheimer's Disease and Dementia (Report of the Task Force on Alzheimer's, 2014). This Task Force was formed as the state's response to the National Alzheimer's Project Act, passed unanimously by congress and signed into law by President Obama in 2011 (The National Alzheimer's Project Act, 2015). The Task Force analyzed current care options for those diagnosed with dementia, and established short- and long-term goals to prepare for the "escalating public health crisis" of Alzheimer's (Report of the Task Force on Alzheimer's, 2014). The Task Force ultimately focused on strategies to "increase public awareness," improve "early detection and diagnosis of the disease," and to "address gaps in quality of care- by building a capable workforce through dementia specific training" (Report of the Task Force on Alzheimer's, 2014).

The Task Forces on Aging in Place and on Alzheimer’s Disease made many recommendations in their final reports. However, these entities are limited in their ability to implement the changes that they deem necessary. For example, the Task Force on Alzheimer’s Disease and Dementia strongly recommended that the Connecticut Statewide Respite Care Program receive increased funding to mirror increased demand for the service (Report of the Task Force on Alzheimer’s Disease, 2014). Despite this strong recommendation, proposed budget cuts in the 2015 Governor’s plan actually reduced funding for this program by a fourth (Starr, 2015). In another example of the ineffectiveness of Task Force recommendations, recommendations made by the Task Force on Alzheimer’s Disease regarding the Connecticut Home Care Program were also unheeded in the proposed 2015 budget. In the final report by the Alzheimer’s Task Force, the members recommended “rebalancing initiatives that focus on diversion of individuals with dementia who are at risk of nursing home placement to community-based settings” (Report of the Task Force on Alzheimer’s Disease, 2014). In the 2015 proposed budget, intake into the program for adults “at risk” of nursing home entry was frozen, and individuals would not be permitted to enter the program that were not “at nursing home level care” (Starr, 2015). Julia Evans Starr, the Executive Director of Connecticut’s Legislative Commission on Aging testified to the Appropriations Committee that this cut would be in direct “opposition with the state’s commitment toward home and community based services” (Starr, 2015). The recommendations made by the Task Forces were not implemented into the 2015 proposed budget, and in fact were directly opposed by several of the proposed cuts. Unfortunately, this pattern of

diminished care options has not been isolated to the 2015 proposed budget cuts. Instead, care options and quality in Connecticut have remained at the same level, or have declined in the recent past.

Currently in Connecticut, and the Long Road Ahead

Connecticut has groups focused on elder care at the state and local level. From the State Department on Aging, to the Area Agencies on Aging to the more local Municipal Agents, funding and care is provided for in many ways. However, with current proposed state budget cuts, seniors will likely lose large portions of these benefits. According to the Western Connecticut Area Agency on Aging, in the Governor's 2015 Connecticut state budget proposal, recommendations were made to "raise the required co-pay for the Connecticut Home Care Program for Elders" (Western Connecticut Area Agency on Aging, 2015). The proposed copay increase from 7% to 15% may force seniors to drop out of the program, and instead seek long-term care in nursing homes (Western Connecticut Area Agency on Aging, 2015). Senator Beth Bye expressed concern regarding the cuts to the program, stating "it's a program that's keeping seniors in their community and reducing reliance on nursing homes" (Reiss, 2015). This proposed copay increase, in addition to the frozen enrollment for CHCPE, and the reduction of funding for the Connecticut Statewide Respite Care Program, may limit the quality and types of care that the elderly may be able to afford (Western Connecticut Area Agency on Aging, 2015).

This is not the first time in recent history that the elderly population in Connecticut has been on the receiving end of budget cuts. In 2011, Connecticut

altered its Medicaid coverage regulations, which resulted in over 220,000 individuals, many of them elderly, losing “coverage for over-the-counter medications and supplements (with exceptions for insulin and supplies, nutritional supplements for those with feeding tubes, and prenatal vitamins)” (An Update on State Budget Cuts, 2011). In 2012, Governor Dannel Malloy enacted budget cuts totaling over \$32,000,000 from the Connecticut Department of Social services, which includes the CT Home Care Program as well as Alzheimer Respite Care in the state (Malloy, 2012). Social welfare program budget cuts are not a novel concept in Connecticut budget reforms.

Despite these proposed cuts and limitations to current services for the elderly, there are still new interventions being tested in the state. Many interventions are occurring at a research or individual facility level, rather than through government pathways. Richard Fortinsky, Ph.D., a researcher and professor of medicine at the University of Connecticut, is the principal investigator in one of these projects. Dr. Fortinsky has a history of research in the field of elder care (UConn AgingNet, 2015). His research experience with successful interventions, like community-based classes, has led him to examine the possibility of implementing additional services into the pre-existing Connecticut Home Care Program (Fortinsky, 2014). This will be done through a randomized translational trial of the Care of Elderly Persons in their Home Environment (COPE) program (UConn AgingNet, 2015). Dr. Laura Gitlin of the Jefferson Center for Applied Research on Aging and Health, at Thomas Jefferson University, in Philadelphia, Pennsylvania originally developed and tested this program (Gitlin, 2010). Participants will receive

individualized care plans, including either traditional CHCPE services, or these traditional services plus in-home visits by nurse practitioners and an occupational therapist (Fortinsky, 2014). Dr. Fortinsky's research will focus on the effectiveness of these care options, as well as the cost-benefit analysis of the program within the publicly funded CHCPE (Translation of COPE, 2015).

In addition to the COPE trials, Fortinsky currently has funding to study the effectiveness of the Money Follows the Person program in Connecticut (UConn AgingNet, 2015). The 'Money Follows the Person' (MFP) program is initiatives to save taxpayers money, while allowing elderly persons the ability to remain at home rather than enter a nursing home environment (State of Connecticut, 2008). The program was opened to applicants in December of 2008, after Connecticut was granted federal approval to participate (State of Connecticut, 2008). The program is based on Medicaid reimbursement increases, paid to the state by the federal government during an elderly or disabled individual's first year back in their community (State of Connecticut, 2008). Dr. Fortinsky's current grant involves an analysis of the current program, and a rebalancing effort for the state's care policies for elderly and disabled individuals (UConn AgingNet, 2015).

Interventions are also occurring within care facilities. Current care options for the elderly often involve the utilization of in-home care, or placement into a care facility. There is a broad range of care options, and the choice is often based on the ability of an elderly individual to live independently. Dr. Patrick Coll, Professor of Medicine at the University of Connecticut, and Medical Director at several retirement and long-term-care facilities, has overseen care programs that are

designed to fit the capabilities of residents at several locations in Connecticut. At the Seabury Retirement Community in Bloomfield, Connecticut, specific care programs within the overall facility address the wide range of capabilities of residents. More functionally independent residents live without assistance, within a localized community with social, health, and wellness amenities nearby. Residents that need more assistance are later placed in programs for assisted living, dementia-specific assisted living, or in a skilled nursing facility. By having a “continuous care” model, Seabury allows seniors to enter increased levels of care as needed, and adjusts to any sort of decline in ability individuals experience over time.

Dr. Fortinsky and Dr. Coll are just two of many individuals in Connecticut focused on providing effective and high quality care to the elderly population. The individuals working closely with elderly individuals are often the first to observe the changes that Connecticut’s elderly population have gone through, and are expected to go through. These individuals have a wealth of knowledge in areas such as geriatric mental health, caregiver support, and even the education of future healthcare providers. These individuals are an essential resource when researching the current and future state of the elderly population in Connecticut.

Interviews:

The following interviews were completed both in person and through email collaboration. The views expressed by the individuals below are their own, and are not necessarily representative of the State of Connecticut's position on aging, or of their respective organizations' stance on healthy aging. Interviews may be formatted differently from the original responses for clarity.

Because each participating professional specializes in different aspects of aging, their interviews are listed separately, in alphabetic order. Participants' responses are then analyzed and summarized for common themes and conflicting ideas. The analysis includes observations and revelations that I had during the interview process, as well as throughout the subsequent analysis of information.

Patrick Coll, M.D.

Professor of Family Medicine and Medicine, Associate Director for Clinical Program, COA, UConn Health Center, Medical Director, Seabury Retirement Community, Bloomfield, CT, Assistant Medical Director, Riverside Healthcare Center, East Hartford, CT, Medical Director, Pilgrim Manor, Cromwell, CT, Medical Advisor, Middlewoods of Farmington

I noticed that many of the publication listed on your AgingNet profile focused on malpractice. What types of malpractice are most common when caring for the elderly population?

Most of the medical malpractice cases I have acted as an expert witness in have related to care provided in nursing homes. Many plaintiffs' attorneys across the country looked to nursing homes as a source of work. The issues that result in a malpractice case include pressure sores, falls resulting in a significant injury, and an inadequate response to a change in condition.

Are there any protective measures you believe should be enacted to prevent malpractice when caring for the elderly? Are there different issues that need to be addressed when looking at patients with dementia?

Having good communication with the patient and/or the patient's family can prevent many medical malpractice cases. Many unhappy patients and family members report that they pursued a medical malpractice case in large part because they felt the Dr. or the staff did not communicate with them and/or did not respond to their concerns.

What benefits do programs such as Money Follows the Person provide in Connecticut? Is there other legislation that focuses on improving long-term care practices in Connecticut?

In Connecticut if you need long-term care services and you are poor the main option is admission to a skilled nursing facility, which will be covered by the Medicaid program. Money follows the person is an innovative effort to try and facilitate these patients staying at home by providing additional services for them in their home.

The prevalence of dementia in Connecticut is likely to increase with the growing elderly population. In your opinion, will the current laws in place be able to accommodate the needs of this particular population?

Laws governing conservatorship and the appointment of a legal Guardian have been improved over the last several years. In my opinion Connecticut should revisit the law as it pertains to the renewal of a motor vehicles license for older residents. The law regarding involuntary confinement should also specifically address the involuntary confinement of residents in dementia specific skilled nursing facilities and dementia specific assisted living facilities.

What is the number one change to Connecticut's elder care policy that you would like to see implemented?

Medicaid funding for assisted living.

How do you think future and current healthcare providers can become better at providing care for elderly patients, and those with dementia? Are there any themes that do not get enough attention when teaching future physicians?

The undergraduate medical school curriculum is extremely full. Even though most future physicians will spend a significant part of their professional careers managing the care of older patients, there is a paucity of geriatrics education for medical students. Every medical student in the United States should be taught geriatrics related care.

Laura Donorfio, Ph.D., M.A.

Associate Professor, Department of Human Development and Family Studies, University of Connecticut

It can be easy to forget that caregivers experience stress similar to that of the persons that they care for. What makes research about caregiver wellbeing so important?

I think it is so important because of the sheer numbers of people who will be caregiving for a relative in the foreseen future. With the aging explosion (starting to happen and anticipated) and the estimated numbers who will end up with the condition of dementia alone, we are going to need our informal caregivers more than ever. Informal caregivers save the government, and hence our tax dollars, billions of dollars. We need to keep caregivers as healthy as possible and to offer them respite in any way we can. Other countries pay their informal caregivers, we here in the U.S. do not. I think they are a group overlooked and taken advantage of.

Has the caregiving role changed over the time that you've been researching it? What are the biggest struggles caregivers today face, which may not have been faced 10 years ago?

Yes I do think it has changed, but maybe not in the illnesses their care-receivers have. I think the role has intrinsically changed. Caregivers have more pressures than they ever had in history. Caregivers (primarily women) have more on their plate than ever before, including being in the work force themselves. I think

“time” is the biggest struggle—having enough and trying to fit everything in. Also, “stress” seems to be at an all-time high for those in the U.S. Lastly, the launching of children, and then children moving back because of the compromised economy accentuate the stressors the sandwich generation is experiencing.

How will Connecticut’s growing elderly population change the role of caregiving? Do you believe people will rely more on care services?

I am not sure the growth of the older population will change the role of the caregiver as much as the caregiver (boomer) will change the face of caregiving, what they need as far as help, services, etc. They will change the logistics of caregiving; make it work better for them. Absolutely people will rely more on care services. I also think the segregation of the older population (various housing options) and getting away from intergenerational households has created a more independent older population that may not want the help of informal caregivers and instead want more formal caregiving. People don’t want to burden their kids.

Are there any current care interventions for older adults that you believe aren’t used to their potential? Are there any programs you want more people to know about?

I think providing more care and services at home, such as that which is being tested with Money Follows the Person are needed. It is shown that home care is less expensive than formal care but more education is needed to remove stigma. I want more people to know about home care options. I also want more people to know

more and understand hospice care. Many feel it is for cancer patients during the last two weeks of their life.

What is the number one change to Connecticut's elder care policy that you would like to see implemented?

Home care- both in home services and being allowed to remain at home.

I noticed you looked at the effects of different interventions on caregivers, support, educational literature, and creative movement. What made these three interventions stand out to you as potentially helpful programs?

All of them provide a sounding board and outlet for caregivers. Caregivers feel alone and isolated and need connections with others going through the same hardships. They need to know they are not alone and what services and options are out there and acceptable. We still have a social stigma on what we should be doing for our older relatives (parents) versus others.

How do you think future and current healthcare providers can become better at providing care for elderly patients, and those with dementia? Are there any themes that do not get enough attention when teaching future physicians?

Services need to be more tailored to the individual, their family and their needs. We are not in a cookie cutter society and need to recognize this. Dementia itself has a stigma attached to it. People would rather die than think of getting

dementia, let alone full-blown Alzheimer's. I think education needs to happen to remove the stigma associate with Alzheimer's.

Michael M. Ego, Ph.D.

Professor, Department of Human Development and Family Studies, University of Connecticut

According to the US Census Bureau website, in 2013 approximately 13.6% of Connecticut residents were born outside of the US. How is this population slated to change in the next 10 to 20 years?

In the United States, between the years 1980-2000, the number of foreign-born immigrants rose from 5.3 M to 17.3 M. Currently, twelve percent (12%) of the population over 65 is foreign-born. These numbers are counted legal residents. In Connecticut, the projection for growth in the next 10 to 20 years of foreign-born persons will rise with the same proportions as previously. There is one variable that may affect this statistic and that is what U.S. Congress and the President may do with regard to legislation regarding illegal immigration. If illegal immigrants are given amnesty or other conditional status to stay in the United States, then the projected numbers will double in Connecticut.

How can healthcare providers more effectively reach out to minority populations?

Healthcare providers must take advantage of the "informal support networks" that are an integral part of the minority community. These informal units include places of worship, markets and stores, beauty salons and barber shops, alternative medical practice locations, and other places where the minority community congregate. Healthcare providers will not identify minority populations

at community centers, local medical clinics, and other formal networks in the neighborhoods where minority communities reside.

How does the existing minority population of Connecticut, in addition to an influx of immigrants, change the face of aging in Connecticut? What types of new interventions and services do you believe there will be a need for?

There are two key words in addressing this issue: *Acculturation* (adopting the culture of the new land) and *Assimilation* (commitment to acculturation and an acceptance by the major community). Acculturation happens in multiple stages for new immigrants, depending upon what family members (children, grandchildren) are willing to engage in acculturating with new society. If the acculturation is slow, then the elder will not embrace the new land.

Thus, new interventions and services that may be developed has to start with determining the level of acculturation and assimilation of immigrants. Of course, for some, language will be a barrier in participating in formal network programs. This is where the identification of informal networks is so important in doing outreach to the older minority populations.

I noticed that last year you designed and reviewed the first Asian Pacific American Community Needs Assessment completed in Connecticut. Why has that group historically been left out of needs assessments in the state? How do the needs of the aging APA population differ from those of the majority population?

The major reason is due to a concept call the "Model Minority Myth." This myth has existed since the 1960s, when Americans perceived the Asian Pacific American population as high achievers and successful citizens, and that they had resources to take care of their families. Thus, most formal support networks ignored the APA communities for that reason. The truth is that while the historically placed ethnic groups that include Japanese-Americans, Chinese-Americans, Korean-Americans, South Asian Americans and Filipino-Americans have been able to assimilate into the American mainstream, there are ethnic groups primarily from Southeast Asia (Vietnamese, Cambodian, and Laotian) who are not advantaged and need health, social and community services to live their lives comfortably.

The Model Minority Myth is a stereotype that Americans have of all APA groups in the United States, and until that perception is changed, there will continue to be inequality of services and programs for the APA community.

Have you found that minority elder care follows a different pattern than that of the majority groups in a population? How do cultural values change the way in which elder care is approached by individuals and families?

First, it depends upon the generation and wave concepts. Generation refers to the number of cohort groups have been in the United States. In some minority groups, there are up to six generations of Americans who have acculturated and assimilated to American living in differing patterns. The longer a group has been in

the United States, there will be less association with their native land in terms of language, culture and customs.

The concept of filial piety (taking care of elders) among the minority population is actually no different than from majority populations. There may be variability among different groups, but most families do care about elders. In fact, only 5% of the total U.S. population of people aged 65 is in nursing homes. Care of elders occurs in family settings for the most part, but there is now the creation of the "sandwich generation" of middle aged person who accept of the responsibility of elder care, as well as assuming the child care in their families. This phenomenon will be tested in the future, and new policies by employers to address this issue must be a high priority in the near and immediate future.

Dementia and cognitive impairment are a growing problem within rapidly aging states like Connecticut. Have you encountered noticeable cultural differences in approaching conditions like dementia between populations? Does the role of the caretaker vary culturally?

My observation and my reading of the research show that dementia and cognitive impairment are slowly gaining attention by our society and families. The reality of "no cure" for dementia at the present time creates a minimum level of understanding by caregivers. At the same time, the projections are that by the year 2050, if no cure is found, that 1 out of 5 persons over age 65 would suffer from some form of dementia or cognitive impairment.

The cultural differences again are tied to knowledge and information based generational cohort effect - how long a minority group has been in the United States. For the recent immigrants, there is a "shame" factor to having a family member that has dementia and cognitive impairment in their country of origin (particularly in the Asian and Pacific American countries) and thus their attitudes may take a similar stance in the United States. However, for those populations that have been in the United States for multiple generations, they will behave and react similarly to how most Americans feel about dementia and cognitive impairment, which is care of maintenance with no hope of a cure or recovery.

Several of your earlier research publications focused on how to keep gerontology and aging relevant, and making sure these subjects received attention in educating future healthcare providers. What is the best way in which to maintain focus on this growing population?

The major learning point for all healthcare providers is that new technology and medical advancement will enable baby boomers and all subsequent generations of Americans to live a completely different life than the post-WWII population of elders. The perception by most of the American society is that the lives of their grandparents in their later years will be similar to baby boomers and subsequent generations, when the truth is that concepts like retirement, employment, leisure, and right-to-die will be totally different than previous generations. These are the key messages that need to be shared with the general society at large.

What do you think the state of Connecticut is doing well in regards to caring for its growing elderly population? What problems still need to be addressed?

There are too many people still living at or near poverty level, and it is estimated that almost 40% of older persons rely solely on Social Security Benefits and Medicaid for their livelihood. Most of these individuals are 85 years old and older, and have not received the attention of most communities and government agencies.

What is the number one change to Connecticut's elder care policy that you would like to see implemented?

The White House Conference on Aging will be held again in 2015. At previous conferences, new policies have been proposed to improve the lives of older persons. The issue of elder justice is on the agenda for the 2015 conference, which deals with abuse and neglect of older persons, financially, physically and mentally, and CT needs to align with federal initiatives to support older persons in CT who face these conditions.

Are there any Connecticut programs and care options that you believe are under-utilized?

There is discussion in the State Legislature to abolish the State Commission on Aging, which I believe would be a huge mistake. However, in the current budget challenges that Connecticut, priorities must be set for budget allocations, and unfortunately, the topics and issues that affect older persons in CT may not be

addressed, if the Commission is abolished. The State needs to maximize the expertise and knowledge of Commission members to respond to the needs of all older persons living in Connecticut.

Joan Monin, Ph.D.

Assistant Professor of Epidemiology (Chronic Diseases), Yale School of Public Health

It can be easy to forget that caregivers experience stress similar to that of the persons that they care for. What makes research about caregiver wellbeing so important?

Research on caregiving for older adults is so important because as our population becomes older more caregivers will be needed. Although caregiving can be rewarding and give people a sense of purpose and meaning in their lives, it can also be quite stressful. Especially when care recipients are suffering on a daily basis, this can take an emotional and physical toll on family caregivers. For example, when care recipients have dementia, caregivers have a particularly high risk of physical and psychological strain.

How will Connecticut's growing elderly population change the role of caregiving? Do you believe people will rely more on care services?

More and more family caregivers will be needed as the population ages. This will also mean more reliance on formal health care services, such as nursing homes and home health services.

I noticed one of your publications focused on the cardiovascular reactivity of spouses to their loved ones suffering. Having a loved one diagnosed with a disease like Alzheimer's is understandably devastating mentally and

emotionally, but can that diagnosis also affect the caregiver's physical well being?

In my publication about spouse's cardiovascular reactivity to their partner's suffering, these were couples in which one partner had osteoarthritis or lower back pain. No one had Alzheimer's disease in this sample. This study showed that when older adult spouses are exposed to their partner's pain or they think about their partner's suffering, their blood pressure and heart rate increase. Chronic elevated cardiovascular reactivity has been linked with cardiovascular disease.

Much of your recent research seems to involve the spousal relationship in situations where one spouse is ill. Why is this relationship such a valuable research focus?

I find the spousal caregiving context to be interesting because spouses are often very emotionally close to one another. Also, they are likely to live together. This high emotional closeness and physical proximity can increase the risk of caregiver burden. Spousal caregivers are also likely to be sole caregivers, meaning they are at risk for becoming isolated.

Another interesting aspect of spousal relationships is that when people first get married and are relatively younger and healthier they often take care of one another. However, as people become older, one or both partners may become sick or disabled, requiring one of them to become a primary caregiver or for both to collaborate to support one another. I am interested in studying what makes couples transition successfully to a caregiving role.

Are there any resources that you wish were available to assist individuals that are forced to transition from spouse or partner into the caregiving role? What interventions or programs would be most helpful for these individuals?

Respite and support services are extremely important for the mental and physical health of family caregivers. It is crucial for caregivers to have time to take care of themselves and to interact with their social network. Physical activity programs and interventions that keep caregivers connected to friends and family are important for maintaining and improving caregivers' health. It is also helpful if caregivers and care recipients can be involved in interventions together to improve their communication and have fun together.

Have you seen depression impact individual's ability to live independently? In a sort of "chicken or the egg" question, does depression typically manifest as a *result* of a loss of ability, or can the loss of independence occur as a result of depression?

It goes both ways. If people become functionally disabled and feel less independent, this often leads to depression. However, when people become depressed, they often stop taking care of themselves physically, and this can lead to disability. It is really important for people to take care of both their physical and psychological needs.

Do caregivers typically recognize their own depressive symptoms? How common is depression in the caregiver role?

Depression in caregivers is quite common, mostly when caregivers are feeling emotionally and physically strained in their role. My research also shows that caregivers are more likely to be depressed when they perceive that their care recipient is suffering and they are unable to relieve that suffering. We mostly rely on caregivers' depressive symptoms in research, so the rates of depression in caregivers may be underestimated.

What research foci do you believe will become more important as the elderly population continues to grow?

It will be important to understand how people can take care of their older family members without becoming overburdened. I think this will involve understanding the emotion regulation strategies people can use to maintain feelings of compassion and not become too overburdened. It also means understanding what resources are needed from the community and the government to help people take care of their loved ones and help them age in place. Another enormously important research foci is finding a cure for Alzheimer's disease and other forms of dementia, which place a very large burden on older adults and their loved ones.

What is the number one change to Connecticut's elder care policy that you would like to see implemented?

We need to help support family caregivers and formal caregivers (e.g. in nursing homes, home health aides). For example, rather than placing older adults in nursing homes, it would be beneficial to provide payment to family caregivers to

offset the cost of not working. More importantly, we need to raise the wages of people who work at nursing homes and who help older adults in their homes. These individuals are grossly underpaid, and there is high turnover and burnout in these jobs. This often means that older adults are receiving very low quality care. We need to take care of our caregivers so they can give care to others.

Margaret Rathier, M.D.

Associate Professor of Medicine, Center of Aging, University of Connecticut School of Medicine

I read one of your articles from 2005 focused on delirium in the elderly. I know this was published close to ten years ago, but some of the statistics were surprising. Delirium often went undiagnosed or unrecognized, and was closely associated with higher mortality rates in hospital-admitted elderly patients. Why do you think a condition that affects such a large portion of admitted elderly patients is so hard to diagnose?

It is not hard to diagnose. The change in mental status that accompanies illness is often not acknowledged as a separate disease process unless the patient is extremely agitated.

Do preconceived ideas of the mental state of elderly persons play a role in missing the symptoms of delirium? For example, could some symptoms be written off as simply “age-related?”

That is possible. The two most common risk factors for delirium are advanced age and dementia, which is more common with advanced age. We rely heavily on the family to tell us how a patient’s mental status with delirium is different from their baseline. We teach the medical students and resident physicians that is very important to obtain a functional history for each patient admitted; how they walk, dress, bath, take their meds.

I noticed you worked on a Geriatric Review Syllabus for the American Geriatrics Society. What do you think is the most important thing for up and coming healthcare workers to understand about working with the elderly population? Would you make any changes to current medical school curriculum?

A significant percent of healthcare workers will be treating older patients. The first thing is to acknowledge their own biases about aging. Older patients can recover from illness and at times improve. Taking care of frailer older patients often requires a multidisciplinary team; from nonprofessional caregivers, nurses, dentists, therapist, pharmacists, physicians. One role for Geriatric/gerontologic education is interdisciplinary – how to work together to take care of older patients.

Medical school curriculum should include exposure to older patients throughout the curriculum with exposure to all sites of care; hospital, office, home, skilled nursing facilities so the physicians have an exposure to these areas of practice.

As the elderly population in Connecticut continues to grow, are there any medical professions that you believe are experiencing a shortage of people? What medical specialists are needed to serve this growing population?

I think there will be a shortage of primary care physicians comfortable taking care of older patients with significant chronic diseases. I am more concerned about a shortage of trained lower paid nursing professionals who are needed to care for older adults; given the high cost of living in Connecticut.

Connecticut state care programs seem to focus on community-based care.

What makes this model of care so appealing? What benefits does it provide to individuals utilizing these services?

The benefit of the model is that the patient remains in charge of him/her self. In an institutional environment (skilled nursing facility) unless you are wealthy, you often have a roommate, need to eat what is served, eat and shower when you are told. Community based care for elders is cheaper than institutional care.

In 2012, Alzheimer's disease was the 6th leading cause of death in the United States. As Connecticut's elderly population grows, the incidence of Alzheimer's is also likely to increase. What do you think is the biggest issue facing older Connecticut residents diagnosed with Alzheimer's disease or other forms of dementia?

Having enough formal and informal services to help care for patients with dementia. Patients and their families having enough money to pay for services or respite care for themselves if they are the primary caregivers. Being able find a homemaker or home health aides who can work with patients with behavioral problems associated with dementia

Are there any current interventions for adults with dementia that you believe aren't used to their potential? Are there any programs you want more people to know about?

The Alzheimer's Association sponsors caregiver support groups, caregiver support and respite grants. The use of adult day programs to give family caregivers relief from the stress of caring for someone 24/7.

Are there any legislative changes or government programs that you would like to see develop in response to the growing elderly population of Connecticut?

The State of Connecticut Department of Social Services sponsors a program called the Connecticut Home Care Program for Elders that provides a case management system and money for services for poor elderly to help them live at home rather than have to move into a skilled nursing facility.

The Program of All Inclusive Care for the Elderly (PACE) model of care is not available in Connecticut but it is one where care for poor elderly is coordinated a day center; with the goal being to maintain function and prevent nursing home placement.

Julie Robison, Ph.D.

Associate Professor of Medicine, University of Connecticut School of Medicine

I noticed that you've done some research regarding the effectiveness of Connecticut's Money Follows the Person Program. That program seems to focus on transitioning people out of nursing homes. Why is this goal so important?

Money Follows the Person is a rebalancing demonstration – its primary goal is to shift the balance of long term supports and services (LTSS) from being provided in institutions to community-based care. Historically, there has been a bias toward requiring people who need LTSS to be institutionalized. In recent decades, it has become clear that people prefer to receive LTSS in the community and that, on average, these services cost less in the community. Both federal and state policies have therefore focused on the goal of rebalancing these services. One rebalancing strategy is to help people living in institutions who want to be in the community to make that transition.

Was there a major change that sparked this initiative, or was it simply driven by the growing elderly population in the state?

MFP was first authorized under the federal 2005 Deficit Reduction Act; 30 states' MFP programs were funded at that time. MFP was expanded to all states (a few chose not to do it) under the Affordable Care Act in 2010. The program was developed to address the institutional bias I described above. A series of smaller

grants, called Systems Change grants, preceded the DRA; CT had a nursing home transition grant under that earlier initiative that was small but very successful. Applying for an MFP grant was a natural progression for CT and there was a strong group of advocates in the state who supported it because of the nursing home transition program's earlier success.

A side note –about 40% of the MFP transitions are older adults (65+). The rest are younger people with all types of disabilities – mental health, physical health, brain injuries, and developmental disabilities. The growing elderly population is a motivator, and so is the large number of people of all ages with disabilities who live in institutions because they can't get the services and support they need in the community.

I noticed that on the MFP Dashboard, from the 6-month evaluation to the 24-month evaluation there was a slight dip in people that felt their families and friends helped them around the house. Do you believe that this will become a bigger issue, as Connecticut's elderly population is slated to grow so drastically in the next 20 years?

Research literature shows that about 80% of LTSS is provided by family and other informal (unpaid) caregivers. That has been very consistent and will likely continue into the future. However, the availability of caregivers for the number of older adults will decrease - just in numerical terms. I think this trend will be mitigated somewhat by more caregiving from other older adults (siblings, spouses,

friends) to make up the gap in numbers of adult children, but it will certainly be an issue.

The change in the MFP data from 6-24 months may be reflecting a reduced need for assistance, as people adjust to living in the community on their own.

I met with Dr. Fortinsky earlier this year to discuss the implementation of COPE into Connecticut's long-term care program for older adults. What makes dementia a condition that is best treated at home? How does a program like COPE contribute to a better care experience overall?

People with dementia, like everyone else, generally prefer to remain at home in their familiar environment and receive care there. Transitions to a new environment are more difficult for someone with cognitive deficits because it is harder for them to understand where they are and why. In familiar settings, people with dementia can function at a higher level for longer, as long as they have the supports they need. Programs like COPE help caregivers of people with dementia develop optimal ways to provide support and maintain their own health and well being.

Connecticut state care programs seem to focus on community-based care. What makes this model of care so appealing? What benefits does it provide to individuals utilizing these services?

This is a national trend, not just CT. It is a win-win situation, where people can get care in the settings they prefer for lower cost, on average. People can

maintain their usual daily routines and social and community connections when they stay at home or in the community they have lived in.

What do you think the state of Connecticut is doing well in regards to caring for its growing elderly population? What problems still need to be addressed?

CT is streamlining services for older adults who are eligible for Medicaid in particular, developing a standard assessment process and providing LTSS in the CT Home Care Program in the community to any older adult who needs them, with no waiting list. MFP is helping people of all ages, including older adults, leave nursing homes and setting up the infrastructure needed to deliver community-based care effectively.

Problems that still need to be addressed (not a comprehensive list!):

- Support for family/informal caregivers
- Shortages of geriatricians
- Identifying and prioritizing older adults' goals of care and goals for high quality of life, rather than treating each medical condition in a vacuum.
- Transportation alternatives to cars that are affordable and flexible
- Information hubs for learning about ways to stay engaged in local communities
- Mental health and substance abuse treatments geared toward older adults
- Payment systems and savings/insurance programs for LTSS for middle income people

- Care coordination among primary care, medical specialties, behavioral health, and LTSS providers
- Workforce shortages in direct care workers

What is the number one change to Connecticut's elder care policy that you would like to see implemented?

A mandatory insurance program that covers a proportion of LTSS costs, through employer and employee contributions for all ages. This would have to be at a national level.

What do you believe the biggest challenge in caring for Connecticut's growing elderly population will be? Do you have any advice for up-and-coming healthcare providers?

The biggest challenge is the sheer volume of older adults – more than 20% of CT residents will be over 65 by 2020 – and the workforce shortages at all levels that we're already facing.

My advice for future healthcare providers is to get training in geriatrics or gerontology, whichever is appropriate for your field because the majority of your clients/patients/customers will be older. Understand the variety within the older adult population – a healthy 65 year old is very different from a frail 95 year old.

- Explore technology solutions to challenges of aging

- Don't compartmentalize – what is good for older adults is usually good for everyone

Gail Sullivan, M.D., M.P.H.

Professor of Medicine, University of Connecticut School of Medicine,
Associate Director for Education and Program Director, Geriatric Medicine Fellowship, Center on
Aging, UConn Health Center

It's my understanding that your work focuses on helping professionals develop techniques and patterns that would help them more effectively treat older adults. What have you recognized as the area in which healthcare providers need the most improvement?

Actually my work is in area of education research – what interventions are most successful in changing behaviors/performance of various trainees, particularly medical students and resident physicians – including in internal medicine, family medicine, and ob-gyn. Also, I have looked at outcomes from programs designed to change practicing physicians knowledge/behaviors.

I believe that different healthcare providers will need to make changes in different areas. Firstly, physicians – both trainees and practicing physicians – need to improve their basic approaches to older patient in these areas:

- Making changes to medical history and physical exam procedures. A greater focus on function, vision, hearing, likely life expectancy and competing mortality risks is necessary. In addition, specific assessments for geriatric conditions such as falls, fractures, recurrent hospitalizations, confusion, and urinary incontinence should occur more often.

- Much more careful use of medications. Physicians need to pay attention to dose, frequency, specific choice of medicine within class, side effects masquerading as new problems, and medication interactions.
- Focus on threats to independence that are immediate or are most likely to occur within 2 years, rather than threats that are distant and perhaps beyond patient's life expectancy
- A much, *much* more careful use of diagnostic tests. This means much less use of expensive tests that will result in false positives, more workups, and eventual avoidable morbidity.
- A lack of counseling on exercise, all types, as a 'fountain of youth' (if there is one) for elders. This can be misleading.
- Much, *much* less use of ER and hospitalization of elders.
- A greater focus on quality of life.
- And less 'medicalization' of expended changes due to aging. This comes with an improved understanding of customary aging.

If I had to pick 1 or 2 of these, (the low hanging fruit), I would pick better medication use and reduced reliance on ER/hospitalization (For example, sending every patient with a fall to the ER).

If you could make one change to current medical school curriculums, what would it be? Are there classes that you believe should be mandatory for future care providers?

Right now, I would implement mandatory experiences in geriatrics in year 1, 2, and 3 of medical school.

What would be better some day would be to have many more teachers skilled in geriatrics throughout medical school. This would include surgeons with excellent geriatric skills, psychiatrists, nurses, pharmacists, etc. Everyone and anyone providing basic or clinical teaching to medical students, with older adults, needs to be expert in geriatric medicine.

Finally, we would need a system of care (in which medical students learn) that provides high quality of care to older adults. Right now medical students at UConn and most schools train in settings that provide seriously poor quality of care to older adults – so how will medical student be able to learn and practice high quality of care after graduation?

As the elderly population in Connecticut grows, do you believe that there will be a need for certain types of healthcare providers? What types of jobs do you believe will become more numerous?

I think there is a difference between what we need (which follows from the demographics of the CT state population) and what we are likely to have. What we will have will depend almost entirely about finances. The fields – whether nursing, pharmacy, or medicine – that have higher reimbursement in relation to hassle factors will increase in jobs. Those that have higher hassle factors not balanced by higher reimbursement will simply disappear. Jobs follow the money. If there's no payment source for job, no one will train and fill the job.

What we need is a skilled health care force, from home health aides all the way to most skilled sub-sub specialists, that provide high quality, cost-conscious care of older adults. I would call that “high value” of care. Right now we have incredibly expensive, poor quality of care in general, with a few programs as exceptions. This is “low value” care. Unless the healthcare worker in question will be caring only for children and adolescents, who will represent a smaller piece of the health care pie, they will need to be highly skilled in care of older adults.

In your opinion, what will be the biggest challenge new healthcare providers will face as they look to care for the growing elderly population in Connecticut?

No reimbursement and a health care system that is set up to provide poor care, no matter how conscientious you are.

Analysis:

The professionals included in this project have extremely varied careers, research interests, and opinions regarding elder care in Connecticut. I found that despite this variation, several themes remained constant throughout the professionals' responses. For example, the shift towards caring for the elderly in their home environment was promoted by most of the interviewed professionals. Programs such as COPE and Money Follows the Person were cited as positive examples of programs that will reduce stress for patients, as well as save money for taxpayers. Nevertheless, interviewees acknowledged that this shift from institutionalized care to a home-based model creates unique challenges for the elderly population and their loved ones.

One of the major challenges of the shift towards home-based care is determining exactly *who* will provide this care for the elderly. Historically, family has taken on this role. In the future, this may not be the case. Dr. Laura Donorfio explained how the change in the typical caretaker role has shifted, even as recently as in the last 10 years. As she explained, women have historically taken on the caregiver role. Today, there are more women than ever before in the workforce, and they may be unable to take on the responsibility of the caregiver role in addition to their careers. In order to fill the caregiver role, Dr. Donorfio predicts that care services will be utilized more frequently in the future. It is important to note that utilization of care services does not necessarily negate the idea that homecare will be the preferred system of care. It is easy to assume that because caregiver services will be utilized, elders will be sent to nursing homes when family cannot provide the

care they require. Instead, the idea that care *within* the home can be completed by *outside* services is one that is becoming more and more popular. A more independent elderly population may take advantage of formal caregiving services within their home in order to maintain the lifestyle they are accustomed to. This means that family members will not necessarily need to provide all aspects of care for their elderly relatives.

Caregiver compensation was another topic brought up by several interviewees. This was a topic that I had not considered previously, and it was interesting that this became a major theme in several interviews. Dr. Donorfio and Dr. Joan Monin both brought up the topic of paying informal caregivers. Connecticut doesn't currently offer compensation for caregivers that miss work. Implementation of a payment program for informal caregivers could allow more family members the ability to care for their family members at home. It is not just informal caregivers that interviewees feel need to be better compensated. Dr. Monin described the high turnaround rate of formal caregivers, whom she believes are not paid at a rate that befits their stressful job. One of the consequences of a low pay grade for caregiving professionals is the possibility of reduced quality of care. Individuals that provide caregiving services may need to take many clients, stretching their abilities thin in order to make a living wage. This means that each individual they care for receives less attention, and could lead to dangerous situations for frailer adults.

Unfortunately, with the current budget cut outlook, government implementation of a compensation program is extremely unlikely. While most interviewees stressed

the importance of investing in elder care programs and implementation of programs to support caregivers, these programs are instead being cut or severely reduced.

Another consistent theme within these interviews was that of improved care for the elderly by healthcare providers, specifically through communication and education channels. As an undergraduate student that is interested in pursuing a career in healthcare, I was especially interested in this topic. Dr. Julie Robison highlighted the importance of improving geriatric care services, noting that in 2020, 20% of Connecticut's population is expected to be age 65 or older. Dr. Robison went on to explain that understanding the variety of aged individuals was especially important. There is no "catch-all" treatment plan for the elderly, because health statuses of individuals vary so much. This will require appropriate communication by elderly individuals about what health goals they have, and by care providers about what type of lifestyle they can realistically maintain. Because the life expectancy of Americans has grown to an average of 78.8 years, healthcare professionals will need to become adept at treating older patients than their predecessors (*Detailed Tables*, 2013). Dr. Donorfio stressed that services will need to become more tailored to the individual, which can only occur if effective communication occurs between elderly patients and their care providers. This is especially true in the shifting care landscape, where individuals will likely need to choose between home-based care and care in an established facility or community. Dr. Coll, who studied medical malpractice claims by elderly individuals, also discussed the idea of effective communication. Dr. Coll explained that many of the malpractice claims that he encountered during his time in research were caused by

a lack of communication. Often, families felt that the only way they could incite the changes they wanted made to loved one's care was to resort to legal action. I found this interesting, because it seems like more costly for care providers to have to deal with litigation than to provide an appropriate level of care to begin with.

Education is another key aspect of the future of geriatric care in Connecticut. Many interviewees felt that current geriatric education requirements of healthcare providers were insufficient. When discussing how up and coming healthcare providers should prepare to treat a more elderly population, Dr. Margaret Rathier maintained that the first thing new healthcare providers will need to acknowledge is their own bias about aging. I found this statement to be especially important. In my own research experience working with elderly participants, I found my expectations of this population were very often wrong. It is easy to assume that elderly individuals will be quiet and conservative, and that their advanced age means that they may not process information as rapidly as younger people. I found this is simply not true. My experiences forced me to realize my incorrect preconceived notions of what normal aging involved, and how healthy aging affects cognitive abilities. It was the involvement that I had with the elderly population that made me realize that I had an incorrect understanding of aging. Elderly patients may face different issues than other populations, but this does not mean their treatment by physicians and other healthcare professionals should drastically change. Dr. Robison explained this theme by simply saying healthcare providers should not compartmentalize, and that "what is good for older adults is usually good for everyone." Dr. Rathier seemed to feel this way as well. She discussed the fact that

increased exposure for new physicians in all areas of elder care would lead to professionals that were more comfortable with the elderly population.

Another important theme discussed by Dr. Rathier is the idea that elder care will require an interdisciplinary approach to care. While primary care physicians will play an essential role in elder care, Rathier explained that professionals in the areas of nursing, dentistry, therapy, pharmacy, and nonprofessional caregiving could all benefit from being more comfortable with elderly patients. This is especially important in the area of cognitive decline. Often, interventions are more effective the earlier a cognitive issue is detected. The more types of healthcare providers that are familiar with the signs of cognitive issues, the more likely it is that they will be able to identify individuals that may be experiencing a decline in mental capacity and refer them to the appropriate professional.

As discussed in the research portion of this project, diagnoses of Alzheimer's disease and other forms of cognitive impairment will likely increase with the growing senior population in Connecticut. This larger population of individuals with memory loss or chronic cognitive decline will necessitate statewide policy changes and unique support in order to remain as healthy as possible, for as long as possible. Dr. Coll asserted that improvements have been made to policies that affect individuals with dementia, especially in the areas of conservatorship and legal guardian status, but budget cuts have hindered other attempts to assist these individuals. The Task Force on Alzheimer's report published in 2014 set goals of increased awareness and early diagnosis of the disease, and also addressed the need for a workforce comfortable with treating Alzheimer's patients (2014 Alzheimer's

Disease Facts, 2014). The Task Force strongly supported the expansion of homecare programs for adults with dementia, though many of those recommendations were negated by budget cut proposals in 2015 (2014 Alzheimer's Disease Facts, 2014). Dr. Ego discussed the current State Legislature debate regarding the abolishment of the State Commission on Aging, which could further damage the future of effective policy in the area of aging. Instead of limiting the types of programs that are available to individuals with dementia and their loved ones, these programs should instead be expanded to meet the increased need of a larger elderly population.

In addition to the interdisciplinary approach, a more detailed approach to geriatric care is essential to providing the best care possible. Dr. Fortinsky emphasized this point. He explained that patients are often reluctant to bring up memory issues with their physicians, largely because of the stigma associated with memory loss. Physicians, in turn, do not always enquire about memory or cognitive function. Fortinsky described the reluctance of doctors to enquire about memory as being a side effect of a lack of continued education about geriatric care. Because doctors know that there is no cure for memory loss or cognitive decline, they may be reluctant to make a diagnosis. However, there are interventions and care plans that can assist individuals with memory loss and cognitive decline. While there is still no cure for conditions like Alzheimer's disease, with a proper diagnosis and assistance, individuals can continue to remain independent for longer.

Dr. Gail Sullivan was one of the most experienced professionals I interviewed in regards to the education of healthcare providers. Like Dr. Fortinsky, she emphasized the importance of taking a proper medical history and asking the right

questions of elderly patients. Dr. Sullivan asserted that the overall focus of healthcare professionals should be on quality of life when treating elderly patients. Overmedication, use of too many expensive diagnostic tests, and high rates of hospitalization threaten the health of elderly individuals, who may not need such drastic interventions to maintain an independent lifestyle. In addition, Dr. Sullivan echoed the sentiments of many of the other interviewees that the current status of care in Connecticut needs to improve. By providing poor examples of good geriatric care to current medical students, the cycle of poor care is unlikely to break.

In addition to the themes discussed above, there were several topics brought up by participants in their responses that I had not considered while framing interview questions. For example, when asked what change to Connecticut's elder care policy he would most like to see implemented, Dr. Ego stated that he would like to see Connecticut take a more definitive stance on elder abuse policy. While I had not studied elder abuse statistics in Connecticut, the large elderly population would suggest that elder abuse might be a significant risk in the state. Logically, a larger senior population would place a larger number of individuals at risk of abuse. This may be especially true for individuals suffering from cognitive decline or memory loss, who are more vulnerable and may not be able to report such abuses.

Another example of a topic I had not previously researched was that of racial disparities in available support services. Dr. Ego discussed the idea of the "Model Minority Myth," wherein the Asian Pacific American population was perceived as being largely self-sufficient, with no real need of supportive services. Dr. Ego explained that while some ethnicities were able to assimilate into American culture,

other ethnic groups have not been as successful at assimilation, and require additional aid services to remain healthy. While I knew that Dr. Ego had helped design and review the first Asian Pacific American Needs Assessment in Connecticut, I had not previously understood why such a project was completed. Racial disparity in available care and additional services was something I had not researched thoroughly prior to this project, but needs to be considered when discussing healthy aging in Connecticut. More research needs to be done in the areas of elder abuse and racial disparity in Connecticut. More effective policies regarding elder abuse and equality of care in the state should be created sooner rather than later, as a larger elderly population puts a larger number of individuals at risk of experiencing these issues.

Each of these interviews provided insight into the status of elder care in Connecticut. The information provided by professionals currently in the field of aging is invaluable when discussing the future of elder care, and especially when determining what aspects of healthy aging will require significant focus in the coming years. The professionals interviewed for this project are passionate about providing quality care to the elderly. Their experiences in the field of aging, whether in medical practice or academic research, should be the base of future government policy development regarding the elderly. By comprehending the importance of an environment in which older adults achieve their lifestyle goals while maintaining an independent lifestyle for as long as possible, Connecticut can more effectively meet the challenges of a rapidly aging population.

Conclusion:

Connecticut is one of the oldest states in the nation, and the elderly population of the state is only slated to grow in the future. In order to properly care for the growing senior population, aging services across the state need to be prepared to offer services that provide support and information to a large number of individuals. This includes services specifically for individuals diagnosed with dementia and cognitive impairment, who will require care after they are no longer able to maintain an independent lifestyle.

The professionals interviewed in this project work with seniors in many capacities. Through research and medical work, they have seen firsthand which areas of Connecticut aging policy are lacking. The future health of the growing elderly population in Connecticut will be largely determined by the work that these professionals and their peers are doing now. Their insight and knowledge will be an essential resource for future policymakers and healthcare professionals who will be addressing the needs of the growing elderly population in the state of Connecticut. Without changes to care options and state policy, older adults may not be able to access the types of care that will keep them independent, and more importantly, healthy. These changes start with disseminating information to the current elderly population, and conducting research to determine new and better ways to assist the senior population of Connecticut.

Sources:

1. 2011 Alzheimer's Disease Facts & Figures: Includes a Special Report on Facts & Figures. *Alzheimer's & Dementia*, Volume 7, Issue 2.: The Journal of the Alzheimer's Association. March 2011.
2. 2014 Alzheimer's Disease Facts and Figures. Rep. N.p.: Alzheimer's Association, 2014. Print.
http://www.alz.org/downloads/Facts_Figures_2014.pdf
3. *Achievements in Public Health, 1900-1999: Control of Infectious Diseases*. Publication no. 48(29);621-629. N.p.: Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, 1999. Print.
<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm4829a1.htm>
4. "Administration on Aging (AoA)." Older Americans Act & the Aging Network. U.S. Department of Health and Human Services, n.d. Web. 04 Mar. 2015.
5. "AGING SERVICES: About the State Department on Aging." AGING SERVICES: About the State Department on Aging. CT Department of Aging Services, 23 Oct. 2013. Web. 10 Mar. 2015.
<<http://www.ct.gov/agingservices/cwp/view.asp?a=2510&q=313020>>.
6. "Area Agencies on Aging & Services." Area Agencies on Aging & Services. Missouri Department of Health & Senior Services, n.d. Web. 04 Mar. 2015.
7. "Caregiver Services." Western Connecticut Area Agency on Aging: An Aging and Disability Resource Center. WCAAA, n.d. Web. 10 Mar. 2015.
<<http://wcaaa.org/our-programs/ourprograms.asp>>.
8. *Connecticut Home Care Program for Elders Annual Report To the Legislature*. Rep. N.p.: Connecticut Department of Social Services, 2012. Web. 12 Mar. 2015.
<<http://www.ct.gov/dss/lib/dss/pdfs/reports/annualreport2012opt.pdf>>.
9. *Connecticut State Plan on Aging*. Rep. N.p.: State Department on Aging, October 1, 2014 – September 30, 2017. CT Aging Services. Web. 11 Mar.

2015. <http://www.ct.gov/agingservices/lib/agingservices/pdf/2015_-_2017_approved_ct_state_plan_on_aging.pdf>.
10. *CT Commission on Aging Fact Sheet*. N.p.: CT Commission on Aging, 2011. <http://www.cga.ct.gov/coa/pdfs/Fact%20Sheets/Aging%20Issues%20Fact%20Sheet%205-16-11.pdf>
 11. de Jager CA. 2010. *Memory in the Elderly*. In: JH Stone, M Blouin, editors. *International Encyclopedia of Rehabilitation*. Available online: <http://cirrie.buffalo.edu/encyclopedia/en/article/148/>
 12. *Detailed Tables for the National Vital Statistics Report (NVSR) "Deaths: Final Data for 2013."*. Rep. 2nd ed. Vol. 64. N.p.: n.p., 2013. Print. National Vital Statistics Report.
 13. "DSS: CHCPE Alternate Care Unit." DSS: CHCPE Alternate Care Unit. State of Connecticut: Department of Social Services, 13 Mar. 2015. Web. 29 Mar. 2015. <<http://www.ct.gov/dss/cwp/view.asp?a=2353&q=305170>>.
 14. Fortinsky, Richard. "Interview with Dr. Fortinsky." Personal interview. 21 Nov. 2014.
 15. Gitlin LN, Winter L, Dennis MP, Hodgson N, Hauck WW. *A Biobehavioral Home-Based Intervention and the Well-being of Patients With Dementia and Their Caregivers: The COPE Randomized Trial*. *JAMA*.2010;304(9):983-991. doi:10.1001/jama.2010.1253.
 16. Hippus H, Neundorfer G. *The discovery of Alzheimer's disease*. *Dialogues Clin Neurosci*. 2003;5:101-108.
 17. Janice E Graham, Kenneth Rockwood, B Lynn Beattie, Robin Eastwood, Serge Gauthier, Holly Tuokko, Ian McDowell, *Prevalence and severity of cognitive impairment with and without dementia in an elderly population*, *The Lancet*, Volume 349, Issue 9068, 21 June 1997, Pages 1793-1796, ISSN 0140-6736, [http://dx.doi.org/10.1016/S0140-6736\(97\)01007-6](http://dx.doi.org/10.1016/S0140-6736(97)01007-6). (<http://www.sciencedirect.com/science/article/pii/S0140673697010076>)

18. Khaw, K T. "Epidemiological Aspects of Ageing." *Philosophical Transactions of the Royal Society B: Biological Sciences* 352.1363 (1997): 1829–1835. Print.
19. *Leading Causes of Death, 1900-1998*. Rep. N.p.: n.p., n.d. *Leading Causes of Death*. United States Center for Disease Control and Prevention. Web. 15 Feb. 2015.
20. Malloy, Dannel P. Governor's Allotment Reductions. Budget Evaluation and Rescission List. N.p.: n.p., 2012. BUDGET OFFICE ANNOUNCES \$170 MILLION IN RESCISSIONS TO HELP BRING STATE BUDGET INTO BALANCE. State of Connecticut, 28 Nov. 2012. Web. 28 Mar. 2015.
<http://www.ct.gov/opm/lib/opm/budget/2012_2013_biennial_budget/DeficitMitigationPlan/RescissionTransmittalMemo_11282012.pdf>.
21. Municipal Agents for the Elderly. Publication. CT Aging Services, Sept. 2009. Web. 11 Mar. 2015.
<<http://www.ct.gov/agingservices/lib/agingservices/manual/agingnetworkandcommunityorganizations/municipalagentsfortheelderlyfinal.pdf>>.
22. "The National Alzheimer's Project Act (NAPA)." National Alzheimers Plan. Alzheimer's Association, n.d. Web. 9 Mar. 2015.
<<http://napa.alz.org/national-alzheimers-project-act-background>>.
23. National Center for Health Statistics. *Health, United States, 2013: With Special Feature on Prescription Drugs*. Hyattsville, MD. 2014.
24. Plassman, B.L. et al. "Prevalence of Dementia in the United States: The Aging, Demographics, and Memory Study." *Neuroepidemiology* 29.1-2 (2007): 125–132. *PMC*. Web. 2 Mar. 2015.
25. Reiss, Max. "Budget Cuts Could Drive Elderly Residents Into Nursing Homes." NBC Connecticut. N.p., 18 Mar. 2015. Web. 19 Mar. 2015.
<<http://www.nbcconnecticut.com/news/local/Budget-Cuts-Could-Drive-Elderly-Residents-Into-Nursing-Homes-296804131.html>>.

26. Report of the Task Force on Alzheimer's Disease and Dementia . Rep. N.p.: n.p., 2014. Connecticut General Assembly. Web. 5 Mar. 2015.
<<http://www.ct.gov/agingservices/lib/agingservices/pdf/alzheimerstaskforcefinafinalreport.pdf>>.
27. Report of the Task Force to Study Aging in Place. Rep. N.p.: n.p., 2013. Report of the Task Force to Study Aging in Place. Connecticut General Assembly, Jan. 2013. Web. 13 Mar. 2015.
<<http://www.cga.ct.gov/coa/pdfs/AginginPlaceTF/Aging%20In%20Place%20Task%20Force%20FINAL%20report.pdf>>.
28. Starr, Julia E. Testimony of Julia Evans Starr Executive Director, Connecticut's Legislative Commission on Aging. Appropriations Testimony HB-06824 DSS. Connecticut General Assembly Appropriations Committee, 27 Feb. 2015. Web. 10 Mar. 2015.
<<http://www.cga.ct.gov/coa/pdfs/Testimony/2015%20Testimony/Appropriations%20DSS%20DORS%20SDA%20budget2-27-15final.pdf>>.
29. State of Connecticut. Department of Social Services. *Governor Rell Announces New Initiative to Help Nursing Home Residents Come Home*. Department of Social Services. State of Connecticut, 4 Dec. 2008. Web. 27 Mar. 2015.
<<http://www.ct.gov/dss/lib/dss/pdfs/mfp/govannouncesmfp.pdf>>.
30. *Study of Funding and Support for Home and Community-Based Care for Older Adults and Persons with Alzheimer's Disease*. Publication. N.p.: Connecticut's Legislative Commission on Aging, 2015.
Print.<http://www.cga.ct.gov/coa/pdfs/publications/2015/homecarestudy2014Final.pdf>
31. "Translation of COPE for Publicly-Funded Home Care Clients and Their Families (COPECT)." ClinicalTrials.gov. U.S. National Institutes of Health, 10 Feb. 2015. Web. 15 Feb. 2015.
<<https://clinicaltrials.gov/ct2/show/record/NCT02365051>>.
32. "UConn AgingNet." Richard Fortinsky, Ph.D., at the UConn Center on Aging. UConn Center on Aging, n.d. Web. 7 Mar. 2015.
<<http://www.agingnet.uhc.edu/bios/fortinsky.html>>.

33. *United States Life Tables (1890, 1901, 1910, and 1901-1910)*. Publication. N.p.: Department of Commerce, Bureau of the Census, 1921.
Print.<http://www.cdc.gov/nchs/data/lifetables/life1890-1910.pdf>

34. "An Update on State Budget Cuts." An Update on State Budget Cuts —. Center on Budget and Policy Priorities, 9 Feb. 2011. Web. 29 Mar. 2015.
<<http://www.cbpp.org/cms/?fa=view&id=1214>>.

35. "Western Connecticut Area Agency on Aging." Western Connecticut Area Agency on Aging. WCAAA, n.d. Web. 20 Mar. 2015. <<http://wcaaa.org/>>.