5-11-2013

Long-Term Care Need and Utilization among Baby Boomers and Older Adults with Mental Illnesses in Connecticut

Kathy G. Kellett

University of Connecticut - Storrs, kathy.kellett@uconn.edu

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

Recommended Citation

Kellett, Kathy G., "Long-Term Care Need and Utilization among Baby Boomers and Older Adults with Mental Illnesses in Connecticut" (2013). Doctoral Dissertations. 86.
http://digitalcommons.uconn.edu/dissertations/86
Long-term care (LTC) need and utilization already exist for the current cohort of older adults and are likely to become greater as boomers age and the number of people with mental illnesses increase. Underdeveloped community care and a lack of focus on appropriate alternatives to institutional care underscore the need that exists for adults with mental illnesses who experience substantial economic and social costs due to chronic conditions requiring LTC services and supports.

This study assesses LTC need and utilization among a subset of baby boomer and older adult respondents reporting mental illnesses in the 2007 Connecticut Long-Term Care Needs Assessment (Robison et al., 2007) and provides a more complete understanding of the LTC services and supports preferred by baby boomer and older adult respondents.

Differences in sample characteristics between boomers and older adults were noted in marital status, with significantly more boomers reporting being unmarried and having more education than older adults. In health and functioning, boomers and older adults were more similar than different, with more than three-quarters in both groups reporting functional impairment and more than half in both groups reporting comorbidity. About half in both groups reported unmet LTC needs. More boomers than older adults do not have a network of family and friends they can count on for social support or extra help. Similarly, most boomers and older adults report that they have just enough or not enough to make ends meet financially at the end of the month.
When exploring LTC need and utilization using logistic regression, outcomes show an association between screening positive for depression and functional impairment. Functional impairment was also a significant predictor of comorbidity. In contrast, unmet need was the stronger predictor when exploring perceived lack of social support and LTC outcomes.

Although this study did not find as many differences as expected between boomers and older adults with mental illnesses, it disseminates knowledge about variations in the LTC needs and preferences of these groups into a wider public consciousness and has the potential to influence LTC policies and programs in the future for adults with mental illnesses in Connecticut.
Long-Term Care Need and Utilization among Baby Boomers and Older Adults

with Mental Illnesses in Connecticut

Kathy G. Kellett

B.A., Saint Joseph College, 2000

A Dissertation
Submitted in Partial Fulfillment of the
Requirements for the Degree of
Doctor of Philosophy
at the
University of Connecticut
2013
Doctor of Philosophy Dissertation

Long-Term Care Need and Utilization among Baby Boomers and Older Adults
with Mental Illnesses in Connecticut

Presented by
Kathy G. Kellett, B.A., M.A.

Major Advisor
Thomas O. Blank, Ph.D.

Associate Advisor
Ronald Sabatelli, Ph.D.

Associate Advisor
Waldo Klein, Ph.D.

University of Connecticut
2013
DEDICATION

Many people throughout history have struggled with mental illnesses. Some of these include Abraham Lincoln, Isaac Newton, Charles Dickens, Ludwig van Beethoven, and Ernest Hemingway. These individuals and many of those with mental illnesses who are lesser known have enriched our lives in multiple ways. This study is dedicated to all people who have a serious mental illness and to the individuals who provide them with services and support so they can live more meaningful lives and have the potential to age positively and successfully.
ACKNOWLEDGEMENTS

Completing a dissertation requires support from many individuals. First, I want to thank Dr. Julie Robison, Associate Professor at the University of Connecticut Health Center, Center on Aging, David Guttchen, Director of the Connecticut Partnership for Long Term Care, and Julia Evans Starr, Executive Director of the Connecticut Commission on Aging, for allowing me to use data from the 2007 Connecticut Long-Term Care Needs Assessment (Robison et al., 2007).

Second, I want to thank the members of my advisory committee for their guidance and the broad range of expertise they shared. Dr. Thomas Blank has been my advisor throughout my doctoral journey. He was highly recommended by Dr. Mary Alice Wolf, Professor Emerita of Gerontology at Saint Joseph College where I earned a Masters Degree in Gerontology, and I have never once been disappointed in asking to have him as my advisor. Over the years, I have appreciated Dr. Blank’s availability and encouragement, his scholarship and expertise in teaching, and his role as a skillful researcher.

Dr. Ronald Sabatelli, Professor and Head of the Department of Human Development and Family Studies, mentored me during the classes I took with him. In particular, he emphasized the importance of theoretical frameworks and as a prolific author underscored the necessity of organizational skills in writing and importance of disseminating research results into a broader arena for everyone’s benefit. His wisdom in these areas has provided solid guidance that is invaluable.

My outside committee member, Dr. Waldo Klein, is a Professor of Research and Chair of the Focused Area of Study, Social Work Practice with Older Adults at the University of Connecticut, School of Social Work. His expertise in gerontology, research methods, and long-term care as well as his considerable investment in my learning was particularly helpful in broadening my thinking about aging issues and research methodology.
I value the knowledge, patience, and support of Alison Kleppinger, Clinical Data Manager at the University of Connecticut Health Center, Center on Aging, who readily shared her statistical expertise with me and enabled me to complete the analyses for this study.

Finally, I am grateful for family and friends who encouraged me throughout the journey. In particular, Frank Kellett, my husband who was always understanding of the multiple investments involved in pursuing my doctoral education and who selflessly provided the support necessary to help me achieve my goal. Our children, Tonya, Josh, and Chris, also sacrificed time with me on many occasions as they demonstrated their support and encouraged me to keep moving forward in my studies. Lastly, but certainly not least, an extended network of wonderful friends consistently provided strength and support enabling me to continue moving forward in my doctoral studies and to complete the requirements necessary for graduation.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>APPROVAL PAGE</th>
<th>i</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEDICATION</td>
<td>ii</td>
</tr>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>iii</td>
</tr>
<tr>
<td>TABLE OF CONTENTS</td>
<td>v</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>vii</td>
</tr>
</tbody>
</table>

## CHAPTER I. INTRODUCTION

- Statement of the Problem                        1
- Significance and Need for the Study              3
- Theoretical Framework: Political Economy        10
- Research Questions and Hypotheses               11

## CHAPTER II. BACKGROUND

- Long-Term Care                                  15
- Mental Illnesss                                 20
- Additional Factors Influencing the Probability of LTC  23
  - Utilization                                    23
- Population and Disability Trends and the Economic Burden of LTC  26

## CHAPTER III. METHODS AND PROCEDURES

- Research Design                                  28
- Overall Sample                                    29
- Sample for This Study                             33
- Instrument Development                            37
- Measures and Variables                            39
- Analyses                                          44

## CHAPTER IV. RESULTS

- Sample Characteristics                           49
  - Demographics                                    49
  - Health and Functioning                          50
  - LTC Plans, Service Use and Needs                54
  - Social and Financial Support                    61
- Additional LTC Services Requested                68
- Hypotheses Testing                                75

## CHAPTER V. DISCUSSION

- Outcomes of Research Questions                   90
- Outcomes of Hypotheses Testing                   95
- Potential Limitations of the Study              102
- Conclusions                                      104

## REFERENCES

- 106

## APPENDICES

- Appendix A: Legislation                          137
- Appendix B: Connecticut Resident General Survey  138
Appendix C: Connecticut Resident People with Disabilities Survey
LIST OF TABLES

Table 1. Potential LTC Users 16
Table 2. LTC Providers 17
Table 3. Six Connecticut Home and Community-Based Waiver Programs 30
Table 4. Survey Type/Color 34
Table 5. Numbers and Percentages of Completed Surveys by Type and Color 34
Table 6. Programs and Waivers Sampled 35
Table 7. Numbers and Percentages of Completed Surveys by Program or Waiver 36
Table 8. Survey Questionnaire Topics 38
Table 9. Activities of Daily Living and Instrumental Activities of Daily Living – Functional Needs 40
Table 10. Disability Categories 42
Table 11. Regression Models 46
Table 12. Demographics 50
Table 13. Health and Functioning 52
Table 14. Type of Disabilities 53
Table 15. Assistive Devices Used at Home or Work 54
Table 16. LTC Service Needs and Use 55
Table 17. Community LTC Needs and Use 56
Table 18. Additional LTC Service Needs and Use 57
Table 19. Not Using LTC Services 58
Table 20. Sources Used to Locate LTC Services 59
Table 21. Satisfaction with LTC Services Received 60
Table 22. Future Senior Center Use 60
Table 23. Management of Paid Services 61
Table 24. Social Support 62
Table 25. Living Arrangements 63
Table 26. Children 63
Table 27. Number of Days Leave Home for Any Reason 64
Table 28. Finances 66
Table 29. Additional Finances 67
Table 30. Insufficient Funds 68
Table 31. Additional LTC Services Requested 69
Table 32. Model 1: Predictors of Depression – Unmet Needs 76
Table 33. Model 2: Predictors of Depression – Functional Impairment 77
Table 34. Model 3: Predictors of Depression – Unmet Needs and Functional Impairment 78
Table 35. Model 4: Predictors of Depression – LTC Service Use 79
Table 36. Model 5: Predictors of Depression – Dissatisfaction with LTC Services 80
Table 37. Model 6: Predictors of Depression – LTC Service Use and Dissatisfaction with LTC Services 81
| Table 38. | Model 7: Predictors of Depression – Unmet Needs, Functional Impairment, LTC Service Use and Dissatisfaction with LTC Services | 82 |
| Table 39. | Model 8: Predictors of Comorbidity – Unmet Needs | 83 |
| Table 40. | Model 9: Predictors of Comorbidity – Functional Impairment | 84 |
| Table 41. | Model 10: Predictors of Comorbidity – Unmet Needs and Functional Impairment | 85 |
| Table 42. | Model 11: Predictors of Perceived Lack of Social Support – Unmet Needs | 86 |
| Table 43. | Model 12: Predictors of Perceived Lack of Social Support – Functional Impairment | 87 |
| Table 44. | Model 13: Predictors of Perceived Lack of Social Support – Unmet Needs and Functional Impairment | 88 |
CHAPTER 1
INTRODUCTION

The current system of long-term care (LTC) services in the United States is underdeveloped. This reality makes it difficult for boomers and older adults with disabilities to live independently and receive LTC in the community (Harrington, Ng, LaPlante, & Kaye, 2012; Hood, 2012; Kane 2012; Kane & Kane, 2012; Kane, Kane, & Ladd, 1998; Lynch, Estes, & Hernandez, 2008; O’Hara, 2007; Ng & Harrington, 2012; Ruiz, Urdapilleta, Clark-Shirley, Howard, & Poey, 2012). This descriptive/exploratory cross-sectional study assesses home and community-based LTC need and utilization among a subset of baby boomer and older adult respondents reporting mental illnesses in the 2007 Connecticut Long-Term Care Needs Assessment (Robison et al., 2007). It compares characteristics of the two cohorts to note differences and examines specific relationships and LTC outcomes to better understand the needs of those at risk for greater utilization of community-based and home-delivered LTC services.

Statement of the Problem

Demographic projections indicate the numbers and proportion of older adults in the United States is increasing significantly as baby boomers began turning 65 in 2011 (Federal Interagency Forum on Aging-Related Statistics, 2012). Due to the aging baby boomers, by 2030 there will be an estimated 61 million people aged 66 to 84 and another 9 million, born prior to 1946, will comprise the oldest individuals (Knickman & Snell, 2004). As the nation experiences this unprecedented population growth, demographic trends suggest that the number of older people with mental illnesses is also increasing (Chen, Cohen, & Kasen, 2007; Jeste et al., 1999; Jeste & Muñoz, 1999). It is estimated that by 2030 the number of Americans over age 65 with mental illnesses will double to approximately 15 million (The John A. Hartford Foundation, 2011).
Mental illness is an important health problem in the United States that carries a substantial economic burden of at least $300 billion annually (Centers for Disease Control and Prevention, 2011). Approximately 5.6 to 8 million older adults currently have one or more mental health/substance use conditions. These include depressive disorders and dementia-related behavioral and psychiatric symptoms, which present unique challenges for their care (Eden, Maslow, Le, & Blazer, 2012). Concerns about LTC need and utilization already exist for the current cohort of older adults and may become greater as boomers age. According to the Census Bureau (2003), boomers are the fastest growing segment of the population and, based on their lifetime prevalence rate, are predicted to demonstrate more mental illnesses in old age than any previously born cohort (Jeste et al., 1999; The John A. Hartford Foundation, 2011).

Population aging and the predicted increase in number of people with mental illnesses guarantee a growing need for LTC services (Estes & Wallace, 2008; Johnson, Toohey, & Wiener, 2007). Although it is well known in the literature that community care is important in the recovery of mental illnesses and that people with mental illnesses needing LTC report a preference for remaining in their homes, adequate, affordable community-based LTC services in the United States are underdeveloped and there is a lack of focus in developing appropriate alternatives to institutional care (Hood, 2012; Kane 2012; Kane & Kane, 2012; Kane, Kane, & Ladd, 1998; Lynch, Estes, & Hernandez, 2008; O’Hara, 2007; Ng & Harrington, 2012; Ruiz, Urdapilleta, Clark-Shirley, Howard, & Poey, 2012; U.S. Department of Health and Human Services, 2003).

In the current LTC system, more than 70 percent of government spending for LTC services is allocated to nursing homes and primarily funds institutional care rather home and community-based services (HCBS) (Knickman & Snell, 2004; Lynch et al., 2008). Medicare was designed to provide care for the aged and people with disabilities, but has focused on hospital and physician care and is limited in coverage for LTC services including the management of chronic diseases, such as mental illnesses (Lynch et al., 2008). As federal Medicare dollars are
constrained, more costs are shifted to individuals who are already burdened by Medicare’s high premiums (O’Brien, 2008).

Historically, at the national and state level, Medicaid has also made access to institutional care easier than to HCBS, and consequently the ratio between resources for HCBS and those made available to institutions is out of balance (Knickman & Snell, 2004; Lynch & Estes, 2001). Although Connecticut has made some progress in providing constituents with options for LTC services, the system remains unbalanced (Kassner et al., 2008). To provide a better ratio between home and community-based care and institutional care, it is necessary to provide a system of care that offers people options and control over the type of services they receive. This care is especially critical for adults with mental illnesses, who experience substantial economic and social costs due to chronic conditions that require LTC (Kellett, Robison, Gruman, & Shugrue, 2008).

**Significance and Need for the Study**

**Comparative Studies**

Recent studies comparing boomers and older adults focus on their perceptions and experiences of aging as well as their informational and service needs and the importance of identifying the likelihood of an individual’s need for future services and supports (Brossoie, Roberto, Willis-Walton, & Reynolds, 2010; Taylor, Morin, Parker, Cohn, & Wang, 2009). Without comparative studies such as these, it would be difficult to inform researchers, practitioners, educators, and policymakers about people’s need for and utilization of current and future LTC services and supports. Studies involving cohorts are important since it cannot be assumed that they are similar as they age. In fact, the literature indicates that while boomers and older adults share some similarities (i.e., common concerns about financial security, health, and the desire to age in place), there are very distinct differences among the two cohorts that arise from lifestyle and the inevitable aging process itself, and these have the potential to impact future
LTC need and utilization (Brossoie et al., 2010; Harwood et al., 1998; Ingster & Cartwright, 1995; Reid & Anderson, 1997).

**Differences Between Boomers and Older Adults**

Boomers differ from the generation of older adults in cohort size, are overall more educated, have more spending power, and demonstrate a greater independent spirit (Enterprise Forum Northwest, 2011). Over their lifetime, boomers have had better access to improved nutrition and medical technology and are therefore thought to be more likely than the older generation to have greater longevity. Due to the availability of vaccines and antibiotics, one would think that boomers would be less likely than older adults to suffer from infectious diseases and acute illness, but research demonstrates boomers are not as healthy as might be expected.

Unlike older adults, boomers have the highest prevalence of obesity (Centers for Disease Control and Prevention, 2009). Obesity significantly increases an individual’s chance of developing chronic diseases, such as cardiovascular disease and diabetes, and may lead to greater functional impairment (Soldo, 2006; U.S. Department of Health and Human Services, 2007). In a national study of Americans over 50, respondents reported poorer health, more chronic pain, and trouble doing routine physical tasks than their older peers had reported at the same age (U.S. Department of Health and Human Services, 2007). Other research shows that boomers with chronic conditions are at higher risk for comorbid conditions, such as depression and late onset addiction to alcohol, medications and illicit drugs (AARP, 2010; Gfroerer, Penne, Pemberton, & Folsom, 2003). Research shows that as the baby boomers age, the rates of illicit drug use will likely increase among them. A report by the Substance Abuse and Mental Health Services Administration (SAMHSA) reported that illicit drug use almost doubled among people age 50-59 between 2002 and 2007, increasing from about 5 percent in 2002 to 9 percent in 2007 (Han, Gfroerer, & Colliver, 2009). Illicit drug use contributes to a wide range of health and social problems and raises concerns about costs attributed to general medical comorbidity among older people with mental illness (Kilbourne et al., 2005).
The potential impact of the boomer cohort on an increase in comorbidity, or the combination of multiple chronic problems, is an especially challenging situation for health management and LTC, since the percentage of individuals without chronic problems decreases as people age and the percentages of multiple problems increase so that approximately half of people age 75 and older report two or more chronic conditions (U.S. Department of Health and Human Services, 2007). As boomers age, they will reach a time at which chronic problems, such as arthritis, may become more likely. While chronic conditions are the most common and costly of all health problems, they are also the most preventable through the modification of health-damaging behaviors (National Center for Chronic Disease Prevention and Health Promotion, 2009). Compared to the early 1900s, however, chronic rather than infectious diseases currently account for more deaths among community-dwelling adults in the United States (Strine et al., 2007).

One chronic condition that is more likely to have an impact on boomers than older adults as they age is substance abuse. Boomers are known to have a greater prevalence of substance abuse and dependence on illicit drugs than previous cohorts, and this cohort’s size alone is predicted to double the number of individuals needing care for substance use disorders (Substance Abuse and Mental Health Services Administration, 2012). Risk factors associated with substance abuse among boomers include a number of psychosocial variables such as stress, isolation, loneliness, the onset of illnesses, and depression (Patterson & Jeste, 1999).

Boomers are evidencing depressive disorders at significantly higher rates than older adults (Centers for Disease Control and Prevention, 2008; Centers for Disease Control and Prevention, 2010; The John A. Hartford Foundation, 2011; U.S. Department of Health and Human Services, 1999). These disorders are more common among individuals with chronic conditions (Barry, Murphy, & Gill, 2011; Lin, Zhang, Leung, & Clark, 2011). Among community-dwelling older adults, about eight to 20 percent experience symptoms of depression (Centers for Disease Control and Prevention, 2010). Depression is associated with distress and suffering
and can lead to impairments in physical, mental, and social functioning; it also negatively impacts the course and makes the treatment of other long-term diseases more challenging (Centers for Disease Control and Prevention, 2008; U.S. Department of Health and Human Services, 1999). Currently, an estimated six and a half million Americans aged 65 and older are affected by depression and with demographic trends this has the potential to become a major public health problem (National Alliance on Mental Illness, 2009). Depression is a major cause of morbidity in the United States and is associated with impaired quality of life (i.e., social functioning) and risk for greater disability (Strine et al., 2007). In 80 percent of cases, depression is a treatable condition (Centers for Disease Control and Prevention, 2008), but it typically is under-recognized and undertreated among older adults (U.S. Department of Health and Human Services, 1999). Since depression is a recurrent disorder, it is likely that many older adults in the future will have previously experienced depression, be at increased risk, and place greater pressures on LTC and other support services (AARP, 2010; Emptage, Sturm, & Robinson, 2005; Patterson & Jeste, 1999).

Mental illnesses and other chronic disabilities may put boomers at greater risk of limited social support than older adults (Strine, Chapman, Ballus, & Modak, 2008). Low social support is the lack of contact and interactions with other people and subjectively, is the feeling of loneliness or lack of companionship or communication with others (Weiss, 1982). In the literature, lack of social support has been shown to impact immune and cardiac functions as well as increase susceptibility to various infections (Berkman, 1995; Brummett et al., 2001; Moak & Agrawal, 2009; Speer & Schneider, 2003). In contrast, research shows that adequate levels of social and emotional support are associated with reduced risk of mental illnesses, physical illnesses, and mortality (Centers for Disease Control and Prevention, 2008). Social support serves an important function including information and instrumental support (Strine et al., 2008). Given some of the other factors associated with boomers, such as lower rates of marriage, higher levels of divorce, and fewer children, they may be less able to sustain
meaningful relationships with family and friends and as a result experience less social and emotional support as they age (Easterlin, MacDonald, & Macunovich, 1990; Fingerman, Pillemer, Silverstein, & Suitor, 2012; Lin & Brown, 2012; Pezzin & Schone, 1999; Ryan, Smith, Antonucci, & Jackson, 2012; Uhlenberg & Miner, 1996; Walker & Herbitter, 2005; Wegner, Davies, Shahtahmasebi, & Scott, 1996).

Life satisfaction is how one evaluates his/her life overall and is impacted by a number of factors including those related to health and social support (Strine et al., 2008). Given some of the differences between boomers and older adults, it is not surprising that research indicates that over the past two decades boomers have given their overall quality of life a lower rating than older adults (Cohn, 2008). Similarly, three decades of data from the General Social Survey show that boomers have on average experienced less happiness during their lives than older adults (Yang, 2008). An additional study of age-related patterns of psychological well-being also demonstrates that boomers are not as happy and are more stressed than older adults (Stone, Schwartz, Brodericka, & Deaton, 2010).

As the subgroup of boomers with mental illnesses age and become older adults, it should be noted that older adults are at increased risk for not receiving adequate and appropriate care and are more likely to experience significant disability and impairment, including compromised quality of life and the inability to function more independently in the community (Bartels, 2003). Because of the current lack of attention to the differences between the subgroups of boomers and older adults with mental illnesses and the unique characteristics of these groups, it is difficult to 1) identify primary consumers (i.e., boomers and older adults), 2) explore the differences that exist among them, and 3) consider the potential impact any differences between the groups could have on LTC need and utilization. For example, during midlife, boomers are more likely than their parents’ generation to be unmarried; these individuals tend to have fewer resources and are at greater risk for economic, health and social susceptibilities as demonstrated by current unmarried boomers (Lin & Brown, 2011). Due to
social vulnerabilities, it is also more likely that unmarried boomers would have fewer informal care providers available and would have greater informal caregiving needs than adults in the older cohort (Ryan et al., 2012).

**LTC Needs Assessment**

Research demonstrates that eighty-seven percent of older adults with disabilities want more choice and control over everyday decisions including the opportunity to receive LTC services in their homes (Kassner et al., 2008). More specifically, people with mental illnesses also demonstrate a preference to live in community-based settings (Bartels, Miles, Dums, & Levine, 2003). In order for positive transformational change to occur in Medicaid’s long-term services and supports, there must be a philosophy that embraces the rights of people with disabilities in all states. Currently only about six states spend more than half of their LTC funding on nursing facility alternatives (Commission on Enhancing Agency Outcomes, 2010).

In Fiscal Year (FY) 2009, Connecticut spent only 35 percent on Medicaid HCBS while 65 percent was spent on Medicaid Institutional Care expenditures (Commission on Enhancing Agency Outcomes, 2010). Although strategies exist to re-balance the LTC system in Connecticut, efforts to balance the state’s LTC system are progressing more slowly than in some of the leading states.

To help plot a course of action for LTC in Connecticut and to provide policymakers with an informational baseline, a needs assessment funded by the General Assembly, Public Act 06-188 (Appendix A), was initiated by the Long-Term Care Advisory and Long-Term Care Planning Committees. In the literature, needs assessments have been described as a systematic and ongoing process of providing helpful information about the needs of a target population to individuals and groups who will use it to make informed decisions about policy and programs (Reviere, Berkowitz, Carter, & Ferguson, 1996). It is an important participatory process that describes the actual and the ideal situations as well as potential solutions for the gap between the two (Kaufman, 1992; Reviere et al., 1996; Witkin & Altschuld, 1995). As a form of applied
social research, it extends beyond the collection of data and analysis to cover the utilization of results (Reviere & Carter, 1996).

The assessment authorized by the General Assembly was conducted by the UConn Health Center, Center on Aging and provided an opportunity to assess consumer preferences, the demographic shifts, the needs of providers, and the capacity and adequacy of the present LTC system in Connecticut. Literature disseminating the results of the assessment include the final report (Robison et al. 2007) and a focused report (Kellett et al., 2008) published specifically to explore the LTC needs of people with mental illnesses as identified in the 2007 Connecticut Long-Term Care Needs Assessment (Robison et al., 2007). An additional preliminary study (Kellett & Robison, 2008) using a subset of respondents explored variations in LTC between African Americans and Latinos with mental illnesses. Finally, a study using the 2007 Connecticut Long-Term Care Needs Assessment (Robison et al., 2007) data and focusing on a subset of people age 42 and older in three groups of community dwelling residents was recently published (Kellett, Shugrue, Gruman, & Robison, 2010).

Present Study

This present study provides an opportunity to further assess LTC need and utilization among a subset of baby boomer and older adult respondents reporting mental illnesses in the 2007 Connecticut Long-Term Care Needs Assessment (Robison et al., 2007). To date, there is a gap in the literature on the consumer beliefs, values, and LTC preferences of boomers and older adults with mental illnesses in Connecticut. None of the published reports, presentations, or journal articles using the 2007 Connecticut Long-Term Care Needs Assessment (Robison et al., 2007) data and referred to above provide outcomes of sub-analyses to explore or compare differences in the LTC needs or plans of baby boomers and older adults with mental illnesses. This study will provide a more complete understanding of LTC need and utilization among baby boomer and older adult respondents reporting mental illnesses in Connecticut and will contribute to the discourse on LTC reform and the importance of changing focus and funding
priorities to home and community-based supports. It will also help providers and policymakers improve access to LTC services for people suffering from mental illnesses in Connecticut.

This study will contribute to the broader literature by disseminating knowledge about variations in LTC of people self-reporting mental illnesses into a wider public consciousness and may help service providers and policymakers in other states think more strategically about how to address LTC need and utilization as an integral part of quality improvement efforts.

**Theoretical Framework: Political Economy**

Demographic changes occurring in the United States and the accompanying issues of individual and population dependency are deeply impacted by the political economy of the society. The development of the LTC system has not occurred within a vacuum, but the policies shaping these services have been influenced by economic, political, and socioeconomic factors (Collins, Estes, & Bradsher, 2001; Estes & Swan, 1993; Lynch & Estes, 2001). Longer life expectancy and the thinning of social supports are factors dominating health policy and impact dependency as the population ages.

In addition, growth in high-risk subgroups, such as those with mental illnesses, makes access to community-based resources more challenging. Chronic health problems, like mental illnesses, and associated comorbid conditions typically require a coordination of services across a broad range of individuals, such as family, informal caregivers, minimum wage health care workers, and social service workers. People needing LTC often encounter a fragmented system of health, social service, and entitlement programs and are unaware what services are available or how to navigate through the existing bureaucratic maze (Collins et al., 2001; Estes, & Swan, 1993).

The allocation of society’s scarce resources and the bureaucratic processes that are responsible for health care disparities further make adoption of a political economy framework useful because it recognizes the problem of resource allocation as a political matter requiring an evaluation of power relations. The political economy perspective used in this study provides a
lens for better understanding some of the inequalities that impact people as they age over the life course and is concerned with the social construction of certain forms of distribution and how they perpetuate inequality (Johnson, 1999). For example, despite the fact that consumers want access to a broad range of choices and funding for home and community-based LTC services and supports, an unequal share of government resources continues to be allocated for institutional services (Kassner, et al., 2008).

The political economy framework provides an approach to understanding social policy and aging and challenges some of the mainstream thinking in gerontology that reduces aging to an individual issue of dependency. It is sensitive to the connections between the macrolevel (societal), mesolevel (institutional level), and microlevel (individual level) dimensions of aging. In other words it includes an exploration of financial and industrial capital, the state’s role, LTC delivery systems, and consumer preferences. This multilevel theoretical model for social policy and aging recognizes that the struggles of consumers occur within the context of interlocking systems and other statuses (i.e., age, gender, race, and ethnicity) and involve differences in ideology that define issues of aging and determine how policies address these societal phenomena.

**Research Questions and Hypotheses**

In the first part of the study, research questions will be utilized as a means to describe the sample characteristics of boomers and older adults and to determine any specific differences existing between the two cohorts. In the second part of the study, the two groups will be combined to address the hypotheses and explore selected variables that have been associated with LTC need and utilization in the literature. Data aggregation is beneficial in examining various topics as well as indentifying areas of highest need so that resources can be targeted.
Research Questions

Similar to the Mental Health Focused Report (Kellett et al., 2008), the purpose of this study is to evaluate similarities and differences in LTC need and utilization among a specific subset of respondents identified in the 2007 Connecticut Long-Term Care Needs Assessment (Robison et al., 2007). In this case, the study compares the two cohorts – baby boomers and older adults – who self-reported a mental illness and focuses on the interrelationships between mental health and four areas: 1) Demographics, 2) Health and Functioning, 3) LTC Plans, Service Use and Needs, and 4) Social and Financial Support. The study will answer the following research questions:

1. How do the demographics of baby boomers and older adults with mental illnesses in Connecticut differ?
2. How do the health and functioning of baby boomers and older adults with mental illnesses in Connecticut differ?
3. What long-term care plans, service use and needs do baby boomers with mental illnesses in Connecticut have compared to older adults with mental illnesses in Connecticut? and
4. How do the social and financial support needs of baby boomers with mental illnesses in Connecticut differ from older adults with mental illnesses in Connecticut?

Hypotheses

Given that the research shows more support for internal factors (i.e., health and social support) predicting LTC need and utilization than external factors (i.e., transportation, insurance) (Borrayo, Salmon, Polivka, & Dunlop, 2002), additional analyses to explore LTC need and utilization will focus on internal factors and answer the hypotheses below. This is not to say that external factors, such as transportation or insurance, aren’t important or shouldn’t be explored, but that, in the literature, they are not as need-based as the internal factors in predicting LTC need and service utilization.
There are eight hypotheses. These will be tested with a combined sample across boomers and older adults. Given the prevalence of depression among boomers (AARP, 2010; Centers for Disease Control and Prevention, 2010; Patterson & Jeste, 1999; U.S. Department of Health and Human Services, 1999) and frail older adults (Fiske, Wetherell, & Gatz, 2009; U.S. Department of Health and Human Services, 1999), the first four hypotheses examine the association between depressive illness and unmet need for LTC services, functional impairment, LTC utilization, and satisfaction with LTC services.

1. A positive depression screen in boomer and older adults with mental illnesses is associated with unmet need for LTC services independent of demographic factors.
2. A positive depression screen in boomer and older adults with mental illnesses is associated with functional impairment independent of demographic factors.
3. A positive depression screen in boomers and older adults with mental illnesses is associated with LTC utilization independent of demographic factors.
4. A positive depression screen for boomers and older adults with mental illnesses is associated with dissatisfaction with LTC services independent of demographic factors.

Since there is a high prevalence rate of comorbidity among people with mental illnesses (Druss & Walker, 2011; Lin et al., 2011; Sokal et al., 2004; U.S. Department of Health and Human Services, 1999), the fifth and six hypotheses will examine the relationship between 1) comorbidity in boomers and older adults and unmet need for LTC services and 2) comorbidity in boomers and older adults and functional impairment.

5. Comorbidity in boomers and older adults with mental illnesses is associated with unmet need for LTC services independent of demographic factors.
6. Comorbidity in boomers and older adults with mental illnesses is associated with functional impairment independent of demographic factors.
The relationship between social support and health is well established in the literature (Holahan, Moos, & Bonin, 1997; Schwarzer, & Leppin, 1989) and, in the general population, reportedly acts as a buffer against stressful life events (DiMatteo, 2004). Given that boomers are projected to experience greater social isolation and less social support as a result of lower rates of marriage, higher rates of divorce, and fewer children (Easterlin, MacDonald, & Macunovich, 1990; Pezzin & Schone, 1999; Uhlenberg & Miner, 1996; Walker & Herbitter, 2005; Wegner, Davies, Shahtahmasebi, & Scott, 1996) and that people with mental illnesses often experience difficulty in developing and maintaining a social network (Davidson et al., 2004), the seventh and eighth hypotheses will examine 1) the association between perceived lack of social support and unmet need for LTC services and 2) the perceived lack of social support and functional impairment.

7. Perceived lack of social support among boomers and older adults with mental illnesses is associated with unmet need for LTC services independent of demographic factors.

8. Perceived lack of social support among boomers and older adults with mental illnesses is associated with functional impairment independent of demographic factors.

Understanding the relationships put forth in these hypotheses will 1) increase recognition of depressive illness, comorbidity, and lack of social support among people with mental illnesses, 2) potentially lessen the outcomes of depressive illness, comorbidity, and lack of social support, and 3) potentially diminish the burden people with mental illnesses place on LTC services. Overall, results would reveal the needs of a subgroup of people at greater risk for LTC services and provide additional knowledge to those who are in a position to plan for future LTC services to meet the needs of this group.
CHAPTER II

BACKGROUND

In this chapter, I will first describe what LTC is, who uses it and who the providers are. The multiple settings where LTC services are typically provided will also be described. A section describing mental illnesses and another on population and disability trends and the economic burden of LTC will follow.

Long-Term Care

LTC includes a continuum of broad-ranged maintenance and health services or devices provided on an inpatient, outpatient, or at-home basis to meet the medical, individual, or social needs of people with chronic or disabling conditions (Connecticut Commission on Aging, 2007; Evashwick, 2005). Approximately 12 million Americans receive some type of LTC; of these, an estimated 80 percent are over age 50 and about half are age 65 and older (AARP, 2006; Knapp, 2005). In Connecticut, approximately 10 percent of residents are affected by disabilities (Connecticut Long-Term Care Planning Committee, 2010; Kaiser Family Foundation, 2010). This is slightly lower than the national average of 11.9 percent (Shugrue, Migneault, & Robison, 2012). Overall, the prevalence of disability increases with age. In Connecticut, 5.2 percent of youth age 16-20, 8.4 percent of individuals age 21-64, and 33 percent of adults age 65 and older report a disability (Shugrue et al., 2012). The relative frequency of disability varies by age, with cognitive disability the most common among youth and ambulatory and independent living disabilities the more prevalent among older adults (Shugrue et al., 2012). Table 1 provides a description of potential LTC users, related age groups of potential LTC users, and prevalence of the disability in the population.
Table 1. Potential LTC Users

<table>
<thead>
<tr>
<th>Potential LTC Users</th>
<th>Age Groups</th>
<th>Prevalence of Disability in the Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persons with dementia (Alzheimer’s disease)</td>
<td>Incidence is greater in people 65 and older and increases with age, but can affect younger people</td>
<td>Four and a half million people nationwide have been diagnosed with Alzheimer’s disease (AD) (Alzheimer’s Association, 2006)</td>
</tr>
<tr>
<td>Persons with intellectual disability</td>
<td>Difficulties in adaptive behavior and manifestations are identified prior to age 18</td>
<td>Eight million (U.S. Department of Health and Human Services, 2004)</td>
</tr>
<tr>
<td>Persons with mental illness</td>
<td>Children, adolescents with significant emotional disturbances; Adults with diagnosable or severe and persistent mental disorders</td>
<td>One in five people has a diagnosable mental disorder during the course of a year (Satcher, 2000)</td>
</tr>
<tr>
<td>Persons with behavioral symptoms of underlying impairment</td>
<td>Challenging behaviors may occur in any age group and include physical and verbal agitation and aggression, behavioral excesses and deficits, self-destructive behavior and others (e.g., Alzheimer’s disease, dementia, obsessive-compulsive disorder)</td>
<td>Occur in nearly half of nursing home residents (Buhr &amp; White, 2006; Schreiner, 2001)</td>
</tr>
<tr>
<td>Persons with chronic conditions</td>
<td>Certain chronic health conditions causing functional impairments and leading to a need for long-term care can occur in any age group (e.g., diabetes, multiple sclerosis, muscular dystrophy)</td>
<td>Eighty percent of people age 65 and older currently have at least one chronic condition and half are living with at least two chronic conditions (Centers for Disease Control and Prevention, 2004)</td>
</tr>
<tr>
<td>Children with disabilities</td>
<td>Children birth to 18 who have a significant, chronic mental or physical condition</td>
<td>Approximately 18 million children are at increased risk for ongoing health care related to chronic physical, developmental, behavioral, or emotional conditions (Association of Maternal and Child Health Programs, 2003)</td>
</tr>
</tbody>
</table>

LTC may be provided by informal caregivers (e.g., family and friends) or by formal caregivers (e.g., specially trained paid professionals) (LaPlante, Kaye, Kang, & Harrington, 2008; Tsolova & Mortensen, 2006; U.S. Department of Health and Human Services, 2006b). Table 2 provides a general description of these LTC providers.
Table 2. LTC Providers

<table>
<thead>
<tr>
<th>LTC Providers</th>
<th>Description of Caregivers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informal caregivers</td>
<td>Informal caregivers are family and friends who provide care without pay, and are the primary source of long-term care (Doty, 2004; Feinberg &amp; Newman, 2004; Harding &amp; Higginson, 2003; Wolff &amp; Kasper, 2006). An estimated 44.4 million caregivers, or 21 percent of the U.S. population, provide unpaid care to family and friends age 18 and older (Pandya, 2005).</td>
</tr>
<tr>
<td>Formal Caregivers</td>
<td>Formal caregivers are paid, direct providers of long-term care services in a home, community-based or institutional setting and constitute a large and growing percentage of the workforce, both nationally and in Connecticut (U.S. Department of Health and Human Services, 2003).</td>
</tr>
</tbody>
</table>

LTC occurs in a range of settings depending on an individual’s needs, the availability of informal support, and reimbursement source (Kane et al., 1998). Below is a list of LTC locations and description of multiple settings where LTC may be provided.

**Home and Community-Based**

Home care includes a wide range of services to individuals and families in their homes aimed at increasing independence (National Center for Health Statistics, 2006; Weissert, Cready, & Pawelak, 2005) and is delivered through government regulated programs (Kane, 1995). Ten million Americans need some type of home and community-based services; of these, 58% are over 65 and 85% live outside of institutions (Kassner, Reinhard, Fox-Grage, Houser, & Accius 2008).

**Adult Day Services**

Adult day services have existed in the United States for about three decades and provide respite care for informal caregivers and a range of programs to meet the physical and socioemotional well-being of participants (Day, 2006; Jarrott, Zarit, Berg, & Johansson, 1998; Jennings-Sanders, 2004). Nationally, adult day services centers have grown in number from 18 in 1974 to 3,493 in 2002 (Pandya, 2004). Average enrollment
for each center is 42 people with approximately 25 people being served daily (Pandya, 2004).

**Assisted Living**

Assisted living has become more attractive to consumers and offers extended care options to older adults who may need assistance with Activities of Daily Living (ADLs) or who have other LTC needs (Kane & Wilson, 1993; Meyer, 1998). This LTC option has grown rapidly from the mid-1980s (National Center for Assisted Living, 2001) and increased to some 414,768 settings by 1998 (Wright, 2004).

**Residential Care Homes**

Residential Care Homes (RCHs), also known as Rest Homes or Homes for the Aged, are facilities for adults with disabilities who are unable to live independently (State of Connecticut, 2006). Residential care homes have increased since the 1980s, and each provides a home for between 2 to 10 people. Between 1995 and 2002, Medicaid waiver-funded residential care participants increased threefold to 120,000 (Kitchner, Hernandez, Terence, & Harrington, 2006). The number of licensed residential care facilities varies from state to state. California, for example, has 8,100 licensed facilities while Vermont has about 100 (California Registry, 2013; Vermont Registry, 2013).

**Continuing Care Retirement Communities**

Continuing care retirement communities, also known as life-care facilities or life-care communities, are a hybrid institution designed to meet evolving health and housing requirements (Center for Healthy Aging, 2006). Continuing care communities provide access to a range of living arrangements within the community, including independent living, assisted living, and skilled nursing facilities (Somers & Spears, 1992).

**Nursing Homes**

Nursing homes, or skilled nursing facilities (SNF), are the main providers of LTC for individuals who experience considerable functional or cognitive disabilities or need 24-
hour care (Pandya, 2001). More than 1.6 million Americans live in nursing homes (Walshe & Harrington, 2002). Since 1985, the number of nursing home residents in the United States has remained fairly constant (Houser, 2007). Estimates show that 46 percent of those 65 and older will spend some time in a nursing home (Spillman & Lubitz, 2002).

Intermediate Care Facilities for the Mentally Retarded (ICF/MR)
The ICF/MR program was established in 1971 when legislation was enacted for ICF/MR as an optional Medicaid program (U.S. Department of Health and Human Services, 2006a). Nationally, there are currently 7,400 ICF/MR serving approximately 129,000 people (U.S. Department of Health and Human Services, 2006a).

Psychiatric Hospitals
Psychiatric hospitals are institutions that provide psychiatric services for the diagnosis and treatment of people with mental illness. Some psychiatric hospitals are “forensic hospitals” that serve people in the penal system (U.S. Department of Health and Human Services, 2006c). There are approximately 300 psychiatric hospitals throughout the U.S.; some of these provide care for up to 400 patients (National Association of Psychiatric Health Systems, 2008).

Local Mental Health Authorities
The CT Department of Mental Health and Addiction Services (DHMAS) operates Local Mental Health Authorities (LMHAs) throughout each of the five regions of the state. These offer a wide range of crisis intervention services and therapeutic programs. Links to private and non-profit agencies are available through individual LMHAs. LMHAs in CT serve varying numbers of people depending on the geographical area and services offered (Connecticut Department of Mental Health and Addiction Services, 2008).
**Chronic Disease Hospitals**

Chronic disease hospitals provide care for people with chronic conditions that can’t be treated successfully on an outpatient basis. In CT, there are 6 chronic disease hospitals with inpatient treatment capacity ranging from 45 to 200 patients.

**Adult Foster Homes**

Adult foster homes, also called family care homes or domiciliary homes, are similar to small private homes in the community with the capacity to house one to five residents (Kane et al., 1998).

**Group Homes**

Group homes are small, residential, single-family homes within the community that accommodate one to six people with chronic conditions (i.e., developmentally disabled, intellectually disabled, disabled elderly, or mentally ill) (Spreat & Conroy, 2001).

**Respite Care Programs**

Respite care provides temporary relief to caregivers and includes home care, day care, and short-term institutional care (Kane et al., 1998). It more recently includes care for older adults. In CT, the Statewide Respite Care Program provides care for people with Alzheimer’s Disease and other related dementias and has eligibility requirements (Connecticut Department of Social Services, 2008).

**Mental Illnesses**

Mental illnesses refer to various mental disorders in which changes in a person’s thoughts, emotions, or behaviors contribute to suffering and are serious enough to require psychiatric intervention (American Psychiatric Association, 1994; Gazzaniga & Heatherton, 2006). Symptoms of a mental illness vary widely (American Psychiatric Association, 2000), are dependent on specific disorders, and have complex etiologies including interactions among genetic and environmental risk factors (Hyman, 2000; Kessler et al., 2005b; Mesidor et al., 2011).
Mental illnesses are pervasive and debilitating illnesses and account for four of the five top leading causes of disability (World Health Organization, 2007). In the United States, mental illness strikes approximately 58 million Americans in all age groups, genders, nationalities, and socioeconomic backgrounds (Keyes, 2005; National Institute of Mental Health, 2012). A recent report suggests that half of American adults will develop a mental illness during their lifetime (Centers for Disease Control and Prevention, 2011). In a given year, it is estimated that 26 percent, or one in every four, American adults suffer from some diagnosable form of a mental illness or clinically significant behavior that disrupts an individual’s thinking, feeling, mood, ability to relate to other people, and daily functioning (National Institute of Mental Health, 2012). Within this 26 percent, approximately six percent, or one in seventeen, of Americans with a diagnosable mental disorder experience serious mental illnesses (Kessler, Chiu, Demler, & Walters, 2005b; National Alliance on Mental Illness, 2007; Sundararaman, 2009; U.S. Department of Health and Human Services, 1999). These include disorders such as schizophrenia, bipolar disorder, major depressive disorder and other seriously disabling psychiatric conditions (Kessler et al., 2005b). Within the population of those who experience serious mental illness, approximately half have two or more mental disorders, with severity strongly associated to comorbidity (Kessler et al., 2005a; National Institute of Mental Health 2012; Sundararaman, 2009; U.S. Department of Health and Human Services, 1999).

Among individuals aged 55 years and older, almost 20 percent experience mental disorders or impairments that are not a part of normal aging, with the most common conditions including anxiety, severe cognitive impairment, and depression (Centers for Disease Control and Prevention, 2008; National Institute of Mental Health, 2011; Satcher, 2000; Speer & Schneider, 2003; Sundararaman, 2009; U.S. Department of Health and Human Services, 1999). Many older adults with mental illnesses tend to be less physically active and have more disability and impairments in activities of daily living than older people without mental health conditions (Center for Disease Control and Prevention, 2008; Speer & Schneider, 2003). They
also are often undertreated and suffer unnecessarily because of unmet LTC needs (The John A. Hartford Foundation, 2011).

Mental disorders are highly comorbid with other serious medical conditions, and these comorbid illnesses (Lin et al., 2011; Mesidor et al., 2011; Sokal et al. 2004) result in increased health care costs and diminished quality of life for individuals affected with mental illnesses (Federal Interagency Forum on Aging-Related Statistics, 2012; Hasche, Morrow-Howell, & Proctor, 2010; Kilbourne et al., 2005). Over half of all people with mental illnesses experience a psychiatric illness and serious health problems such as diabetes, hypertension, and obesity (Bartels & Desilets, 2012; Hutchinson, 2011). Major depression is highly correlated with diseases such as diabetes, coronary artery disease, chronic arthritis, and stroke (Egede, 2005; National Institute of Health, 2012), and individuals age 65 and older with clinically relevant depressive symptoms report higher rates of physical illness, increased functional disability, and greater health care resource utilization (Barry et al., 2011; Federal Interagency Forum on Aging-Related Statistics, 2012). High risk health behaviors, such as alcohol and other substance abuse, are also associated with mental illnesses (Leas & McCabe, 2007). In addition, people older than age 65 (12 percent of the U.S. population) are disproportionately at risk for intentional violent death (Centers for Disease Control and Prevention, 2007). Of those who die by suicide, more than 90 percent have a diagnosable mental disorder (Centers for Disease Control and Prevention, 2008; National Institute of Mental Health, 2012), and up to 75 percent who were older adults visited a doctor within a month before death (National Institute of Mental Health, 2007).

In Connecticut, approximately 600,000 adults exhibit symptoms of a mental illness, 135,000 report serious mental illnesses and another 66,000 have severe and persistent mental illnesses (Rell & Sullivan, 2004). A significant proportion of homeless and prison populations (n=396,500) have addictive disorders with or without additional mental illnesses (Rell & Sullivan,
2004). About the same percentage of adults nationally and in Connecticut report poor mental health (34% vs. 32%, respectively) (Kaiser Family Foundation, 2010).

While significant changes are occurring in the structure and financing of LTC and managed care, a widespread inattentiveness toward older adults with mental illnesses is present, and they are more likely to receive less satisfactory and suitable mental health care than younger adults with mental illnesses (Bartels, Levine, & Shea, 1999; Bartels et al., 2005). This group also tends to be underserved and experiences multiple disparities that have the potential to result in significant gaps between service need, infrastructure, and expenses (Gatz and Smyer, 2001; Harris, Edlund, & Larson, 2005; Mesidor et al., 2011). These disparities and potential for resulting gaps demonstrate some of the persistent inequalities and power differentials with which the political economy model is concerned.

Additional Factors Influencing the Probability of LTC Utilization

A number of factors have been known to influence the probability of depression and LTC utilization. Awareness of these is not only useful for exploring future demand but, also for providing clues that may delay or prevent LTC utilization.

**Depression**

Depression has long been known to negatively impact quality of life and indirectly is associated with other health problems including cardiovascular disease, with an estimated annual cost of more than $40 billion (Nease & Malouin, 2003; Pignone et al., 2002). Depression is both chronic and costly, but screening has been shown to improve outcomes especially when combined with system changes that support appropriate treatment and follow-up (Pignone et al., 2002).

**Disability**

Disability is associated with depressive symptoms as well as severity of depression (Barry, Allore, Bruce, & Gill, 2009; Chen et al., 2012) and in older adults, type of disability and
functional impairment are critical determinants of LTC use (Emptage et al., 2005; Johnson et al., 2007; U. S. Department of Health and Human Services, 2010).

**Comorbidity**

The presence of comorbidity increases with age because chronic conditions tend to rise with age. In the United States, 35 percent of people age 65 to 79 report having two or more diseases, and this rises to 70 percent for those age 80 and older (Fried, 2004). An analysis based on the 2006 Medicare Current Beneficiary Survey (The Scan Foundation, 2011) showed that 26 percent of adults age 65 and older with five or more chronic conditions also had functional impairments; this subset of people need LTC services and supports to assist them with daily living activities.

**Perceived Lack of Social Support**

Social support refers to the maintenance of social connections, involvement in social activities, and includes the perception of not only the structure of one’s social network but the concrete help and assistance received (Krueger et al., 2009). Perceived lack of social support recognizes the absence of social support and has been associated with late life depressive symptoms; it also has the potential to negatively impact well-being and other health outcomes (Blazer & Hybels, 2005). Less social support has also been a predictor of psychological comorbidity (Koch, 2008) and comorbid anxiety-depression (Colenda & Smith, 1993).

**Demographic Variables**

1. **Age**

Although depressive symptoms in older adults sometimes occur, depression is not a normal part of aging and the association between depressive symptoms and disability is unclear (Barry et al., 2009). The influence of age on LTC need and use is more evident with age being a strong predictor for LTC service utilization (Johnson et al., 2007; Kemper, Komisar, & Alecxih, 2005/2006; Stone, 2000; U.S. General Accounting, 2002; Weissert et al., 2005).
2. Gender

In the literature, female gender is a predictor of depression, with women reporting higher levels of depressive symptoms than men (Ostrove et al., 1999). LTC service use depends on multiple factors and includes gender as a predictor (Johnson et al., 2007). Women are at a higher risk than men for LTC use, primarily because they live longer (Agency for Healthcare Research and Quality, 2001; Barrett, 2007).

3. Marital Status

Unmarried status, including being widowed, separated, and divorced, has been associated with higher rates of depression (Burns, Sayers, & Moras, 1993; Nyer et al., 2010) and with greater risks for LTC services and supports from a paid provider (Agency for Healthcare Research and Quality, 2001; Johnson et al., 2007; Spillman & Pezzin, 2000).

4. Race/Ethnicity

There is a demonstrated association in the literature between race/ethnicity and depression in which there are higher rates among minority groups than Whites (Dunlop et al., 2003). Several national studies found that Blacks and Hispanics often exhibit higher levels of depressive symptoms than Whites and that minority groups are at greater risk of illness as a result of higher stress and have less access to material resources (Luo & Waite, 2005; Ostrove, Feldman, & Adler, 1999). Race/ethnicity is also associated with LTC use (Agency for Healthcare Research and Quality, 2001). In the past, LTC service use has been lower among Blacks, Hispanics, and Asians age 65 and older than among non-Hispanic Whites of the same age, but data show that LTC service use rates among Blacks have increased and are now higher than Whites (Pandya, 2005). In other minority groups, such as Asians and Hispanics, rates of LTC service use are lower than Whites or Blacks (Pandya, 2005).

5. Education

Lower levels of education are associated with poorer health outcomes, including depressive symptoms (Crimmins, Hayward, & Seeman, 2004; Seeman et al., 2008) and
There is also a strong association between lower levels of education and income (Ostrove et al., 1999) and lower levels of education and LTC use (Agency for Healthcare Research and Quality, 2001; Seeman et al., 2008).

6. Employment

Economic differences between the races are reflected in health differences (Williams, 2005). A recent Bureau of Labor Statistics report (U.S. Department of Labor, 2012) shows that although overall unemployment fell slightly in July 2012 to 8.1 percent from 8.3 percent in June 2012, Black and Hispanic unemployment did not follow the same course and remained critically elevated in July 2012 at 14.1 percent and 10.2 percent, respectively. Unemployment and lower income is associated with poorer health outcomes, including risk of depression and need for LTC services (Ostrove et al., 1999).

7. Household Income

In the literature, lower income is associated with both greater risk of depression (Areán, Gum, Tang, & Unützer, 2007) and the need for LTC services and supports (Alessixh & Kennell, 1994; Feder, Komisar, & Niefeld, 2000; Johnson et al., 2007).

Population and Disability Trends and the Economic Burden of LTC

National population and disability trends show that the number of adults age 65 and older increased from less than 5 percent in 1900 to more than 12 percent of the total population in 2000 (n=33 million) (Centers for Disease Control and Prevention, 2003) and will likely continue to grow to nearly 18 percent of the total population by 2025 (n=64 million) (U.S. Census Bureau, 2008). As the overall size of the population rapidly increases between 2000 and 2040, the number of adults with disabilities will also grow from approximately 10 million to 21 million. Because the population with disabilities will grow faster than the younger population, the economic burden of long-term care will inevitably increase (Johnson et al., 2007).
Based on the estimated increase in the incidence of mental health disorders among aging baby boomers, and the magnitude of this group, the number of elderly people with psychiatric illnesses is projected to increase by 275 percent or from approximately four million in 1970 to 15 million in 2030 (Jeste & Muñoz, 1999) and has the potential to significantly impact LTC costs (American Psychological Association Office on Aging, 2005). Results from studies using data from the National Comorbidity Survey Replication (NCS-R) confirm a growing understanding about the nature of mental illness across the lifespan and indicate that the pattern appears to be that the earlier in life a mental disorder begins, the slower a person is to seek treatment, and the more persistent the illness is (Kessler et al., 2003, Kessler et al. 2005a; Kessler et al., 2005b; Wang et al., 2005a; Wang et al., 2005b). Recognition of mental illnesses earlier in life has the potential to lessen the severity of the illness as people age and diminish the development of co-occurring mental illnesses. In addition, early treatment and better quality of care could also possibly reduce substantial limitations in the activities of daily living and work disability and reduce greater need for LTC for boomers and older adults as they age.

Other economic implications associated with the aging baby boomer cohort may pose significant challenges both on the national and state levels and should not be overlooked (Kingson, 2007). For example, health care financing, projected deficits in Social Security – the Old-Age, Survivor, and Disability Insurance program (OASDI) – and any existing economic uncertainty will likely simultaneously challenge the increased need and demand people with disabilities have for LTC (Kingson, 2007; Knickman & Snell, 2004).

On the state level, population trends in Connecticut are projected to increase only about 3 percent over the next 15 years, but it is important to note that the trend indicates the number of adults between 18 and 64 will decrease while the number of adults age 65 and older will increase by about 40 percent, as a result of the aging baby boomer cohort (U.S. Census Bureau, 2005). This growth in the older population and anticipated increases in disabilities, including mental illnesses, will no doubt also contribute to the economic burden of LTC.
CHAPTER III

METHODS AND PROCEDURES

Research Design

This study is cross-sectional by design and descriptive and exploratory in nature. Cross-sectional data are valuable for gaining a better understanding about how certain processes involved in LTC operate at one point in time and the range and limits of what is possible in the context of political economy. Descriptive research was chosen because the study from which the subset of data was taken was primarily designed to describe what exists in an area of interest and answers questions concerning the status of the subject of the study (Gay, 1976). General questions were used to gain information about the attitudes, perceptions and needs for services and as such can provide important information to concerned audiences about the expectations of respondents (Soriano, 1995). Associations based on past research are explored in the hypotheses to provide additional information on LTC need and utilization.

Variables that are particularly useful in answering the four research questions in this study are focused on the following topical areas: current and future plans (e.g., provision and payment of LTC services), health and functional status (i.e., overall mental health and physical functioning, use/need of assistive devices, disability status), LTC service use and unmet need for community-based LTC services (i.e., difficulties in obtaining services or information about LTC), availability of social support, financial resources (i.e., financial fitness), and demographics (i.e., age, gender, marital status, education). Independent variables used in the hypotheses to explore LTC need and utilization among boomers and older adults at greater risk include: screening positive for depression; the LTC outcomes of unmet need, utilization, and satisfaction with services.
**Overall Sample**

In this section, the focus is on how the survey process was conducted and what the overall sample was for the 2007 Connecticut Long-Term Care Needs Assessment (Robison et al., 2007). The subsample for this study is discussed in the next section.

Prior to conducting the study, the 2007 Connecticut Long-Term Care Needs Assessment (Robison et al., 2007) was approved by the University of Connecticut Health Center Institutional Review Board and the Department of Mental Health and Addiction Services (DMHAS) Institutional Review Board. Exempt status was requested and granted from both IRBs. Waiver of Informed Consent requirements and HIPPA Authorization requirements were requested from DMHAS and granted.

The main method of data collection for the 2007 Connecticut Long-Term Care Needs Assessment (Robison et al., 2007) was a self-administered, written survey mailed directly to a randomly selected sample of Connecticut residents. This was augmented by telephone interviews, survey packets distributed to numerous organizations, a web-based survey (as an optional survey format), and a widespread publicity campaign.

Older adults, middle-aged residents and people with disabilities of all ages were contacted for participation in the survey. In order to have enough power for an accurate analysis, a large sample was chosen for each group. Three different groups of Connecticut residents were identified for the randomized mailing survey: adults age 61 or older, baby boomers (age 42 to 60), and residents with disabilities of all ages. The overall sampling target of these three groups was 15,500:

- Older adults born in 1945 or earlier (n=5,250)
- Baby boomers born in 1946 – 1964 (n=5,250)
- People with disabilities of any age (n=5,000)

Voter registry and Department of Motor Vehicles (DMV) records were used to randomly choose the older adults and baby boomer groups. Over-sampling was employed to increase the
number of African American and Latino residents. People in these groups were identified through the use of zip codes, a cost-effective and strong measurement of social areas (Cobrda, 1995; Pittmann, Andrews, & Struening, 1986).

Residents with disabilities were identified from participation in one of several different state programs. Table 3 shows the six home and community-based Medicaid waivers available in Connecticut. In addition, individuals not actively receiving services were sampled from the DMR waiting list (DMR Wait), and surveys were mailed to randomly chosen participants in the state-funded Community Based Services (CBS), Medicaid for the Employed Disabled, and the Bureau of Rehabilitation Services (BRS) Benefits Counseling program; people in these two groups were combined into one “BRS” group. The Department of Health and Addiction Services (DMHAS) and Department of Social Services (DSS) providers were also contacted and asked to encourage clients whose contact information was unavailable to complete a survey.

Table 3. Six Connecticut Home and Community-Based Waiver Programs

<table>
<thead>
<tr>
<th>Waiver Program</th>
<th>Name for Purpose of the Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connecticut Home Care Program for Elders</td>
<td>Elder</td>
</tr>
<tr>
<td>Personal Care Assistance</td>
<td>PCA</td>
</tr>
<tr>
<td>Acquired Brain Injury</td>
<td>ABI</td>
</tr>
<tr>
<td>Katie Beckett</td>
<td>KatieB</td>
</tr>
<tr>
<td>Individual/Family Support and Comprehensive (these two programs were combined into one group)</td>
<td>DMR waiver group (actively receiving services)</td>
</tr>
</tbody>
</table>

(Robison et al., 2007)

The 15,500 residents allocated to the mail survey each received a personalized introductory letter, a survey booklet, and self-addressed, postage paid return envelope. The introductory letter included an explanation of the purpose for the survey, how the information would be utilized, a confidentiality clause, and a contact name and telephone number. A sentence in Spanish providing a number to call was included so people needing the survey in Spanish could request one. An incentive to complete the survey was given in the letter offering
participants an opportunity to win one of fifty $25.00 gift certificates. Four weeks after the first mailing, a second mailing was sent to those for whom a response card had not been received.

Survey booklets were printed in different colors so specific information received could be analyzed by group. A green general survey was sent to the 5,250 residents age 61 or older, a blue general survey was sent to 5,250 people age 42-60, and a yellow disability survey was sent to 5,000 people with disabilities. To distinguish between the different waiver programs, yellow disability surveys were tracked using an anonymous color-coding system on the front of the return envelope.

To reach Latino residents, the general survey and introductory letter were translated into Spanish. The internet survey was posted in both languages. Large print surveys in English and Spanish were available upon request for residents with vision impairment.

In addition to the surveys mailed to the 15,500 randomly chosen respondents, the general survey was made available to anyone in the public who wanted to complete it. These surveys were printed on a gray booklet and disability surveys were printed on an ivory booklet to distinguish them from the randomly mailed survey.

A total of 6,266 surveys were completed for the 2007 Connecticut Long-Term Care Needs Assessment: 5,059 by mail, 34 by phone, and 1,173 online (Robison et al., 2007). Of these, 4,698 were general surveys and 1,568 were disability surveys. Seventy of the general surveys were completed in Spanish. Of the 6,266 surveys that were completed, 4,039 were from the randomized mailing. Surveys completed by the general public resulted in 764 general surveys, 290 disability surveys, and 1,173 web-based surveys.

Response rates from the randomized mailing were greatest for older adults (34%; n=1,607). This was followed by people with disabilities (28%; n=1,278) and baby boomers (24%; n=1,154). The overall response rates for the three groups together were 29 percent. This takes into account those that were deceased, non-English/Spanish speaking people, wrong addresses, and other reasons for ineligibility. While response rates for Dillman’s (1991) Total
Design Method typically reach 50 to 70 percent for general public mail surveys, the overall response rate from the randomized mailing, which varied from 24 to 34 percent, is within the mail survey range of 10 to 60 percent mentioned by Chiu and Brennan (1990) and Harbaugh (2002).

Comparability and Generalizability

To determine the appropriateness of combining the random and nonrandom surveys in the initial sample, data from the green and blue randomized surveys were compared to the gray and web nonrandomized surveys across age, race/ethnicity, disability status, and geographical region. No differences were evident in age or disability status, and only minor differences were found with slightly more random respondents among the upper income category, more Latinos in the nonrandom group, and slightly more nonrandom respondents in the northern area of the state. Since the random and nonrandom samples were strongly comparable, they were combined for the analyses.

Mixed Methods Research

In the past, sampling procedures in the social and behavioral sciences have typically been divided into two broad categories (probability, purposive). While probability sampling utilizes some form of random selection and gives all the individuals in the population equal chances of being selected to be representative of the population, purposive sampling focuses on people a researcher thinks would be appropriate for the study and in so doing contributes more specific information from a smaller number of a more carefully chosen group (Jupp, 2006; Teddlie & Yu, 2007). There are, however, a large group of social and behavioral studies that use both quantitative and qualitative methods in different ways (Tashakkori & Creswell, 2007). While mixed methods approaches are still evolving, there remains no broadly accepted typology on mixed method sampling (Kemper, Stringfield, & Teddlie, 2003; Tashakkori & Creswell, 2007).

While most mixed method sampling is employed at different levels of a study and often used to separately answer quantitative hypotheses and qualitative questions (Tashakkori &
Teddlie, 2003), in some studies, mixed methods sampling strategies are used concurrently to
gather only quantitative data (Creswell, Plano, Gutmann, & Hanson, 2003; Maxwell, 1997). This
is what was done in the Connecticut Long-Term Care Needs Assessment (Robison et al.,
2007).

To increase participation from people with disabilities in the 2007 Connecticut Long
Term Needs Assessment (Robison et al., 2007), people from various Connecticut programs for
people with disabilities were sought as potential informational resources. Purposive methods
used in this study included convenience sampling, snowball or chain sampling, particularly in
the LMHAs, as well as opportunistic sampling.

In the 2007 Connecticut Long Term Needs Assessment (Robison et al., 2007), people
with disabilities were contacted through purposive random sampling, which involves taking a
random sample of a small number of units from a larger target population (Kemper et al., 2003).
Other people with disabilities were contacted through a stratified purposive sampling strategy, or
quota sampling, to achieve information from subgroups (Patton, 2002), and some people with
disabilities were reached through the general boomer and older adult randomized mail surveys
and internet.

**Sample for This Study**

The subsample for this study was drawn from respondents in the 2007 Connecticut
Long-Term Care Needs Assessment (Robison et al., 2007) who self-reported a mental illness.
In the survey, a “mental illness disability” is described as “mental illness or other psychiatric
disability such as schizophrenia or bipolar disorder” (Robison et al., 2007).

Exclusion data includes those who reported no disability (n=3,574), those with a
disability other than mental illness (n=1,780), those who didn’t report on disability (n=370) or
age (n=25), and those younger than boomers (n=143). After excluding these respondents, the
sample size is 374. Of these, 80 percent (n=299) are boomers and 20 percent (n=75) are older
adults.
Table 4 shows survey type and color, respondents receiving the various surveys, and whether data collection for particular surveys was considered random or nonrandom.

Table 4. Survey Type/Color

<table>
<thead>
<tr>
<th>Survey Type/Color</th>
<th>Respondents</th>
<th>Random (r) or nonrandom (nr)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Web</td>
<td>Internet respondents only</td>
<td>nr</td>
</tr>
<tr>
<td>Green</td>
<td>Boomers</td>
<td>r*</td>
</tr>
<tr>
<td>Blue</td>
<td>Older adults</td>
<td>r*</td>
</tr>
<tr>
<td>Buff</td>
<td>CT Partnership (boomer survey printed on buff paper; respondents called in due to interest in LTC information)</td>
<td>r</td>
</tr>
<tr>
<td>Gray</td>
<td>Call-ins (boomer, older adult, or people with disabilities printed on gray paper)</td>
<td>nr</td>
</tr>
<tr>
<td>Yellow</td>
<td>People with disabilities from waiver programs</td>
<td>r/nr</td>
</tr>
<tr>
<td>Ivory</td>
<td>Distributed at LMHAs</td>
<td>nr</td>
</tr>
</tbody>
</table>

*From voter/DMV records

Table 5 shows the numbers and percentage of respondents by type and color of survey completed. Compared to the nonrandom surveys, a greater percentage of completed surveys were from the randomized mailing (green, blue, buff, and yellow surveys) (58.8% vs. 41.2%, respectively).

Table 5. Numbers and Percentages of Completed Surveys by Type and Color

<table>
<thead>
<tr>
<th></th>
<th>web</th>
<th>green</th>
<th>blue</th>
<th>buff</th>
<th>gray</th>
<th>yellow</th>
<th>ivory</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boomers</td>
<td>13</td>
<td>0</td>
<td>22</td>
<td>4</td>
<td>18</td>
<td>145</td>
<td>97</td>
<td>299</td>
</tr>
<tr>
<td></td>
<td>4.3%</td>
<td>.0%</td>
<td>7.4%</td>
<td>1.3%</td>
<td>6.0%</td>
<td>48.5%</td>
<td>32.4%</td>
<td>100%</td>
</tr>
<tr>
<td>Older Adults</td>
<td>6</td>
<td>15</td>
<td>0</td>
<td>2</td>
<td>13</td>
<td>32</td>
<td>7</td>
<td>75</td>
</tr>
<tr>
<td></td>
<td>8.0%</td>
<td>20%</td>
<td>.0%</td>
<td>2.7%</td>
<td>17.3%</td>
<td>42.7%</td>
<td>9.3%</td>
<td>100%</td>
</tr>
<tr>
<td>Total</td>
<td>19</td>
<td>15</td>
<td>22</td>
<td>6</td>
<td>31</td>
<td>177</td>
<td>104</td>
<td>374</td>
</tr>
<tr>
<td></td>
<td>5.1%</td>
<td>4.0%</td>
<td>5.9%</td>
<td>1.6%</td>
<td>8.3%</td>
<td>47.3%</td>
<td>27.8%</td>
<td>100%</td>
</tr>
</tbody>
</table>

The various programs and waivers represented in the subsample are listed in Table 6. Participants from Katie Beckett are excluded because eligibility requirements for the waiver
include children through age 18. Due to the small number of participants in the ABI and PCA waivers, all individuals were mailed a survey and were therefore nonrandom.

Table 6. Programs and Waivers Sampled

<table>
<thead>
<tr>
<th>Program or waiver</th>
<th>Program or waiver description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABI</td>
<td>Acquired Brain Injury</td>
</tr>
<tr>
<td>BRS BPAO</td>
<td>Benefits, Planning, Assistance, and Outreach</td>
</tr>
<tr>
<td>BRS EMS</td>
<td>Emergency Medical Services</td>
</tr>
<tr>
<td>BRS SO5</td>
<td>Medicaid for the Working Disabled</td>
</tr>
<tr>
<td>BRS VR</td>
<td>Vocational Rehabilitation</td>
</tr>
<tr>
<td>CBS</td>
<td>Community-based services</td>
</tr>
<tr>
<td>DMHAS</td>
<td>Department of Health and Addiction Services</td>
</tr>
<tr>
<td>DMR</td>
<td>Department of Mental Retardation/Department of Developmental Services waivers combined and the waiting list</td>
</tr>
<tr>
<td>Elder</td>
<td>Connecticut Home Care Program for Elders</td>
</tr>
<tr>
<td>PCA</td>
<td>Personal care assistance waiver</td>
</tr>
</tbody>
</table>

Table 7 shows the numbers of respondents and percentages by various programs and waivers available for eligible Connecticut residents.
Table 7. Numbers and Percentages of Completed Surveys by Program or Waiver

<table>
<thead>
<tr>
<th>Program or waiver</th>
<th>Boomers n</th>
<th>Boomers %</th>
<th>Older Adults n</th>
<th>Older Adults %</th>
<th>Program or waiver total n</th>
<th>Program or waiver total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unknown</td>
<td>132</td>
<td>44.1</td>
<td>44</td>
<td>58.7</td>
<td>176</td>
<td>47.3</td>
</tr>
<tr>
<td>ABI</td>
<td>17</td>
<td>5.7</td>
<td>1</td>
<td>1.3</td>
<td>18</td>
<td>4.9</td>
</tr>
<tr>
<td>BRS BPAO</td>
<td>3</td>
<td>1.0</td>
<td>0</td>
<td>.0</td>
<td>3</td>
<td>.8</td>
</tr>
<tr>
<td>BRS EMS</td>
<td>1</td>
<td>.3</td>
<td>0</td>
<td>.0</td>
<td>1</td>
<td>.3</td>
</tr>
<tr>
<td>BRS SO5</td>
<td>30</td>
<td>10.0</td>
<td>0</td>
<td>.0</td>
<td>30</td>
<td>8.0</td>
</tr>
<tr>
<td>BRS VR</td>
<td>34</td>
<td>11.4</td>
<td>2</td>
<td>2.7</td>
<td>36</td>
<td>9.6</td>
</tr>
<tr>
<td>CBS</td>
<td>26</td>
<td>8.7</td>
<td>9</td>
<td>12.0</td>
<td>35</td>
<td>9.3</td>
</tr>
<tr>
<td>DMHAS</td>
<td>33</td>
<td>11.0</td>
<td>1</td>
<td>1.3</td>
<td>34</td>
<td>8.5</td>
</tr>
<tr>
<td>DMR</td>
<td>6</td>
<td>2.0</td>
<td>4</td>
<td>5.3</td>
<td>10</td>
<td>2.7</td>
</tr>
<tr>
<td>Elder</td>
<td>0</td>
<td>.0</td>
<td>12</td>
<td>16.0</td>
<td>12</td>
<td>3.3</td>
</tr>
<tr>
<td>PCA</td>
<td>17</td>
<td>5.8</td>
<td>2</td>
<td>2.7</td>
<td>19</td>
<td>5.3</td>
</tr>
<tr>
<td>Total</td>
<td>299</td>
<td>100</td>
<td>75</td>
<td>100</td>
<td>374</td>
<td>100</td>
</tr>
</tbody>
</table>

**Comparability and Generalizability**

In this study, the appropriateness of combining the random and nonrandom samples was determined by comparing the green and blue randomized surveys and yellow purposively randomized surveys in the initial study, with the exception of surveys received from respondents in the ABI, Katie Beckett, and PCA waivers, to the surveys in the nonrandom group across age, education, marital status, race, income, and self-reported health. Due to the small number of participants in the ABI, Katie Beckett, and PCA waivers, all consumers received a survey and as such were not randomized. Significant differences were found between the random and nonrandom groups in all the variables except race and income. The random and nonrandom groups are not strongly comparable, and as such generalizations cannot be made from the results of the sample back to the population.
Mixed Methods Research

While a sampling strategy should allow researchers to generalize the conclusions of their study to other groups, not all mixed methods are intended to be generalized (Teddlie & Yu, 2007). There are situations in which sampling choices are made on available resources, which may result in the “representativeness/saturation trade-off” (Teddlie & Yu, 2007, p. 87). While there is an obvious trade-off in using a sample that is not representative of a larger group, one of the advantages of mixed method sampling is that one is able to place greater emphasis on the selected sample allowing, as in this study, for a better understanding of a small group of Connecticut residents self-reporting mental illnesses.

Instrument Development

Development of the survey instrument was informed by a comprehensive review of the LTC and disability scientific and policy literature, a review of surveys used by other states, and input from the Connecticut Long-Term Care Advisory Council. Table 8 shows the major topics and brief explanation of quantitative and qualitative questions included in the twelve-page general resident survey booklet (Appendix B).
Respondents were asked if they filled out the survey themselves or if they required assistance to complete it. A final open-ended question provided an opportunity for respondents to add anything else they wanted.

In addition to the general survey, a second twelve-page survey was designed for people with disabilities (Appendix C). Additional questions further explored issues pertaining to this population, including assistive technology, transportation, and accessibility. Major topical areas
were identical to the general survey; however, in order to accommodate the additional questions in this survey, the section on caregiving was decreased to one question.

For most items, respondents were provided with numerous choices and asked to check either one or all that apply depending on the question. Other items included a Likert-type scale and respondents were asked to check one box for each statement indicating if each one was: Very likely, Somewhat likely, Not at all likely, or If you have already made this change (Robison et al., 2007). A number of other Likert-type scales were used including a choice of the responses: Excellent, Good, Fair, or Poor and Always, Sometimes, Rarely, or Never (Robison et al., 2007).

**Measures and Variables**

The hypothesis testing portion of this study investigates the relationship between screening positive for depression and the LTC outcomes of functional impairment, unmet need, utilization, and dissatisfaction. It explores the relationship between comorbidity and the LTC outcomes of functional impairment and unmet need. In addition, the study examines the association between perceived lack of social support and the LTC outcomes of functional impairment and unmet need. All measures were developed by the research team for the Connecticut Needs Assessment (Robison et al., 2007) or based on questions used in previous needs assessments and research. The following section describes the measures and variables used in the study to explore the aforementioned associations.

**Depression Screen**

Depression was assessed using the PRIME-MD (Primary Care Evaluation of Mental Disorders Procedure) two-item screen for depression (Spitzer et al., 1994). The two questions utilize a yes/no format and consist of the following two questions: “During the past month, have you been bothered by feeling down, depressed, or hopeless?” and “During the past month, have you been bothered by little interest or pleasure in doing things?” While answering “yes” to either or both of the two screening questions does not constitute a diagnosis of depression,
participants in the study were considered to have a depressive symptom if they responded “yes” to either one of the two questions. Initially validated by Whooley, Avins, Miranda, & Browner (1997), the PRIME-MD (Spitzer et al., 1994) has been validated by several other studies (Kroenke, Spitzer, & Williams, 2003; Lowe, Kroenke, & Grafe, 2005).

**LTC Need and Utilization**

Two scales were used to assess LTC need and utilization. The first scale assessed Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) functional needs (see Table 9). Lists for ADLs and IADLs were developed from the research of Katz et al. (1963) and Lawton and Brody (1969), respectively.

**Table 9. Activities of Daily Living and Instrumental Activities of Daily Living – Functional Needs**

<table>
<thead>
<tr>
<th>ADLs</th>
<th>Preparing meals</th>
<th>IADLs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taking a bath or shower</td>
<td>Shopping for groceries</td>
<td>Getting dressed</td>
</tr>
<tr>
<td>Getting in and out of a bed or chair</td>
<td>Doing routine household chores</td>
<td>Getting in and out of a bed or chair</td>
</tr>
<tr>
<td>Using the toilet</td>
<td>Managing money including keeping track of bills</td>
<td>Using the toilet</td>
</tr>
<tr>
<td>Eating</td>
<td>Doing laundry</td>
<td>Eating</td>
</tr>
<tr>
<td>Maintaining control of your bowel/bladder function</td>
<td>Taking medications</td>
<td>Maintaining control of your bowel/bladder function</td>
</tr>
<tr>
<td>Getting around inside the house</td>
<td>Getting to places out of walking distance</td>
<td>Getting around inside the house</td>
</tr>
<tr>
<td></td>
<td>Using the telephone</td>
<td></td>
</tr>
</tbody>
</table>

Each functional need was assessed on a Likert Scale with choices of: “No help,” “A little help,” “A lot of help,” and “Cannot do it at all.” For purposes of analysis, these choices were recoded to ranks of 0, 1, 2, and 3. Individual sum scores were created for ADLs and IADLs. The sum score for the seven ADLs ranged from a minimum of 0 to a maximum of 21, with a score of “0” indicating no help needed at all and a score of “21” indicating being totally dependent on
help for ADLs. The sum score for the eight IADLs ranged from a minimum of 0 to a maximum of 24, with a score of “0” indicating no help at all needed and a score of “24” indicating total dependence on help for IADLs.

The second scale that measured unmet need for community LTC services was assessed by a list of LTC services which can help people live in the community. These services included home health aides, homemaker services, visiting nurse, home-delivered meals, transportation service, friendly visitor services, care management, and adult day programs. Answer choices for these questions included: “Not using now and Do not need,” “Not using now but Do need,” “Using now and receiving Enough,” and “Using now but Need More.” Long-term care use was determined by combining the response categories from “Using now and receiving Enough” and “Using now but Need More.” The LTC use score ranged from a minimum of 0 to a maximum of 8 number of LTC services utilized. Unmet need for LTC need services was determined by combining the responses from “Not using now but Do need” and “Using now but Need More” categories. The unmet need score ranged from a minimum of 0 to a maximum of 8 number of LTC services needed. This measure came from the 1987 Connecticut Long-term Care Needs Assessment (Lusky & Rosen, 1987).

To learn more about LTC services needed, an open-ended question asked, “What additional services should Connecticut offer to older adults or people with disabilities?” Several lines were provided for respondents to write in their responses.

Disability and Comorbidity

Disability was defined as a physical or mental impairment that substantially limits one or more major life activities, such as walking, self-care, thinking, or working and utilized a yes/no response format. Table 10 shows the disability categories that were included.
Table 10. Disability Categories

| **Physical** disability or chronic illness disability that makes it difficult for you to walk, reach, lift, or carry |
| **Intellectual** or cognitive disability, such as mental retardation, Alzheimer’s disease, or other severe thinking impairment |
| **Mental illness** or psychiatric disability, such as schizophrenia or bipolar disorder |
| **Deafness** or other severe hearing impairment |
| **Blindness** or legal blindness |

Definitions of disability were taken from the Americans with Disabilities Act (1990). The presence of two or more diseases is the common standard for comorbidity (Fried et al., 2004). Since the sample for this study consists of people self-reporting a mental illness, a response of “yes” to any one or more of the disability categories, except mental illness or psychiatric illness, was recoded as positive for comorbidity.

**Perceived Lack of Social Support**

Perceived lack of social support was measured by two questions. The first question asked: “If you needed help, could you count on any family or friends to help you with daily tasks like grocery shopping, cooking, or giving you a ride?” The second question asked: “Can you count on anyone to provide you with the emotional support, such as someone to talk over problems with or help you make a difficult decision?” Both questions utilized a yes/no format. An answer of “No” to either of these screening questions indicates perceived lack of social support. These standard questions used in the Established Population for Epidemiologic Studies of the Elderly (Cornoni-Huntley et al., 1986) quantify social network support or lack thereof.

**Dissatisfaction with Services**

Dissatisfaction with LTC services was assessed by the question: “Overall, how well do the long-term care services you receive meet your needs?” Response categories included: “I do not use any services;” “Very well;” “Somewhat well;” “Not very well.” Participants who responded “Not very well” were invited to describe their experiences.
Demographic Variables

Demographic variables that may affect depression, LTC need and utilization, comorbidity, and perceived lack of social support are listed and discussed below.

1. Age

Survey respondents were either part of the baby boomer cohort, born between 1946 and 1964, or part of the older adult cohort, born in 1945 or earlier.

2. Gender

Gender was assessed with the two categories of “Male” and “Female.”

3. Marital Status

Marital status was measured with the following choice categories of: “Married,” “Widowed,” “Separated,” “Divorced,” “Never married,” and “Living together as though married.” The choice categories of “Married” and “Living together as though married” were reclassified into the category of “Married.” Similarly, the choice categories of “Widowed,” “Separated,” “Divorced,” and “Never married” were reclassified into the category of “Unmarried.”

4. Race/Ethnicity

Race/ethnicity was assessed with the following categories: “White or Caucasian,” “Black or African-American or Caribbean Black,” “Asian (including Asian Indian, Chinese, Filipino, Korean, or other Asian),” “American Indian or Alaska Native.” A separate question asked: “Are you of Spanish, Latino, or Hispanic origin?” Since the original, larger sample was predominantly White or Caucasian, race/ethnicity was recoded to “White or Caucasian,” “Black or African American,” “Hispanic,” and “Other.”

5. Education

Education was assessed with the choices: “8th grade or less,” “Some high school,” “High school diploma or GED,” “Technical school/community college,” “Some college,” “Two-year college degree,” “Four-year college degree,” and “Post graduate degree (masters/doctorate).” Educational categories of “8th grade or less,” “Some high school,” “High school diploma or
“GED” were recoded to “High school or less.” “Technical school/community college,” “Some college,” “Two-year college,” and “Four-year college” were recoded to “College.”

6. Employment

Employment was assessed by using the choice categories: “Work full time,” “Work part time,” “Retired,” “Homemaker,” “Volunteer,” “Attend school full or part time,” and “Unemployed.” The categories “Work full time” and “Work part time” were recoded as “Employed” and the categories “Retired,” “Homemaker,” “Volunteer,” and “Attend school full or part time” were recoded as “Unemployed.”

7. Household Income

Total monthly household income from all sources before taxes was classified into one of ten categories ranging from less than $1,000 each month to more than $9,000 each month. Respondents were instructed to include income such as wages, salaries, Social Security, retirement benefits, veteran’s benefits, public assistance, investment income, or any other income.

Analyses

Data were converted to the Statistical Package for Social Sciences (SPSS), version 19.0, from Microsoft Access tables to analyze and summarize all quantitative data. Data were analyzed question by question and descriptive statistics computed. Bivariate analyses were used to determine the relationship between two variables. A comparison of the response distributions both within and between the baby boomer and older adult groups in the sample was also performed.

To answer the general research questions, differences between older and boomer groups was analyzed using chi-square tests and, when appropriate, t-tests. As distribution-free statistics the chi square analyses do not require that the data fit the normal distribution, and they also require less restrictive assumptions about the data.
To address the hypotheses of this study, Pearson correlation coefficients were first performed to explore associations between depression, comorbidity, functional impairment, LTC needs, LTC service utilization, dissatisfaction with LTC, perceived lack of social support, and several demographic factors. Functional impairment was measured by counting each of 7 ADLs and 8 IADLs as “yes” if respondents reported needing any type of help. The ADL and IADL counts were highly correlated \( r = .58, p<.001 \), so each factor was summed together and added into the model as functional impairment. Demographic factors or covariates were age, gender, race, marital status, household income, employment, and education.

Correlations were also performed to test for multi-collinearity. All independent variables had a correlation of .4 or less. Tests with p-values less than 0.05 were considered statistically significant.

To address the 8 hypotheses, 13 different and unique logistic regression models were performed. The three main dichotomous outcome variables explored were 1) depression, 2) comorbidity, 3) perceived lack of social support. Three logistic regression models were performed for each main outcome with the exception of screening positive for depression in which seven different logistic models were performed. Within each logistic regression model, two blocks were performed to allow comparison of specific sets of variables adjusting for covariates and to observe the changes in explained variance for each different block and model. The first logistic regression model started with Block 1 and included only the covariates as predictors of the outcome (i.e., depression, comorbidity, perceived lack of social support) to reveal any differences in the characteristics of each outcome. Block 2 included unmet needs to measure its association with the outcome variable adjusted for all the covariates. A second logistic regression model included the covariates in Block 1 and then on Block 2 functional impairment was added as a predictor of the outcome variables adjusted for the covariates. The third logistic regression model included covariates in Block 1 and both unmet needs and functional impairment in Block 2 to reveal the association between both predictors with the
outcome, adjusted for covariates. The third logistic regression model was the final one for comorbidity and perceived lack of social support. For the depression outcome only, additional models were included. A fourth logistic regression model included covariates again in Block 1 and in Block 2, LTC service use. A fifth logistic regression model included covariates in Block 1 and in Block 2, dissatisfaction with LTC services. A sixth logistic regression model included covariates in Block 1 and in Block 2, both LTC service use and dissatisfaction with LTC services. A final logistic regression model included covariates in Block 1 and in Block 2 all four predictor variables (i.e., unmet need, functional impairment, LTC service use, and dissatisfaction with LTC services). These additional models were included to reveal the associations between the predictors with the outcomes, adjusted for covariates (Table 11).

Table 11. Regression Models

<table>
<thead>
<tr>
<th>Outcome Variable</th>
<th>Model</th>
<th>Block 1 Covariates</th>
<th>Block 2 Predictor Variables</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>1</td>
<td>Covariates*</td>
<td>Unmet needs</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Covariates*</td>
<td>Functional impairment</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Covariates*</td>
<td>Unmet needs &amp; functional impairment</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>Covariates*</td>
<td>LTC service use</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>Covariates*</td>
<td>Dissatisfaction with LTC services</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>Covariates*</td>
<td>LTC service use &amp; dissatisfaction with LTC services</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>Covariates*</td>
<td>Unmet needs, functional impairment, LTC service use, &amp; dissatisfaction with LTC services</td>
</tr>
<tr>
<td>Comorbidity</td>
<td>8</td>
<td>Covariates*</td>
<td>Unmet needs</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>Covariates*</td>
<td>Functional impairment</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>Covariates*</td>
<td>Unmet needs &amp; functional impairment</td>
</tr>
<tr>
<td>Perceived lack of social support</td>
<td>11</td>
<td>Covariates*</td>
<td>Unmet needs</td>
</tr>
<tr>
<td></td>
<td>12</td>
<td>Covariates*</td>
<td>Functional impairment</td>
</tr>
<tr>
<td></td>
<td>13</td>
<td>Covariates*</td>
<td>Unmet needs &amp; functional impairment</td>
</tr>
</tbody>
</table>

*Age, gender, race/ethnicity, marital status, household income, employment, education
Odds ratios and 95% confidence intervals indicated the effect of each predictor and whether it met statistical significance. Chi square tests and log likelihood indicate whether the set of factors in each model reliably predicts the outcome. Nagelkerke’s statistic (pseudo $R^2$) shows the total explained variance accounted for in the models. Hosmer and Lemeshow were run for a goodness of fit statistic.

Statistical significance has traditionally been reported by using one of a few pre-chosen probability values: 0.01, 0.05, and sometimes 0.001. These established threshold values provide a useful summary of the data and allow a researcher to call any result with a $p$-value of less than 0.01 or 0.05 significant. For this study, exact $p$-values are reported on appropriate analyses.

A qualitative analysis was conducted on an open-ended question asking what additional services Connecticut should offer older adults or people with disabilities. This analysis is useful in determining the scope of services respondents would like to be offered. ATLAS.ti 7, a computer software program used in the analysis, enables researchers to more easily code large amounts of text in creative yet systematic ways (Gibbs, 2007). It is based on a grounded theory method developed by Glaser and Strauss (1967) and uses standard qualitative analysis techniques (McCraken, 1988). Grounded theory has been well documented and used in research since the 1960s (Strauss & Corbin, 1990; Strauss & Corbin, 1994). The method includes analyzing data from each question line by line, organizing common themes and generating different categories with the intent of obtaining some quantifiable means. In the grounded theory method, additional categories are generated until no new themes are identified and similar statements are explored and compared to refine each category and ensure a greater understanding of each. In order to calculate which themes are mentioned more, or the proportion of response, the number of times any particular theme was mentioned will be divided by the total number of responses. By doing quantitative analysis on qualitative data, it will be
possible to determine which themes were mentioned more frequently and which may be more important than others based on frequency of reporting.
CHAPTER IV

RESULTS

Sample Characteristics

In this section, the background characteristics of the sample are described. In addition, comparisons between the boomer and older adult groups and the interrelationships between mental health and the following four areas are described: 1) Demographics, 2) Health and Functioning, 3) LTC Plans, Service Use and Needs, and 4) Social and Financial Support.

1. Demographics

Table 12 displays the demographics of the study sample grouped by boomers and older adults and provides answers to the first research question, “How do the demographics of baby boomers and older adults with mental illnesses in Connecticut differ?” Seventy-five percent of respondents in the sample are boomers with a mean age of 50.56. Twenty-five percent of respondents in the sample are older adults with a mean age 68.97. In both boomers and older adults, the majority are females (54.7% and 66.7%, respectively ($x^2 = 3.504, df=1, p=.040$), and significantly more are unmarried (84% and 72%, respectively; $x^2 = 5.737, df=1, p=.015$). A greater percentage of respondents in boomers and older adults are White or Caucasian respondents (77% and 70%, respectively). There were significant differences between the two groups in level of education ($x^2 = 8.490, df=2, p=.014$). Nearly half of boomers had high school or less (47.4%), but close to two-thirds of older adults had the same low levels of education (64.8%). Less than 10 percent of both boomers and older adults had any post graduate education (6.8% and 8.5%, respectively). More than half of boomers and older adults are unemployed (60% and 70%, respectively). Not surprisingly, the largest percentage of boomers and older adults reported a monthly household income of less than $1,000 (54.5% and 46.3%, respectively).
Table 12. Demographics

<table>
<thead>
<tr>
<th>Variable</th>
<th>Boomers</th>
<th></th>
<th></th>
<th>Older Adults</th>
<th></th>
<th></th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>mean</td>
<td>%</td>
<td>n</td>
<td>mean</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Years</td>
<td>299</td>
<td>50.56</td>
<td>75</td>
<td>75</td>
<td>68.97</td>
<td>25</td>
<td>.000</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>163</td>
<td>54.7</td>
<td>50</td>
<td>75</td>
<td>66.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>135</td>
<td>45.3</td>
<td>25</td>
<td>25</td>
<td>33.3</td>
<td></td>
<td>.040</td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>47</td>
<td>16</td>
<td>21</td>
<td>28</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unmarried</td>
<td>247</td>
<td>84</td>
<td>54</td>
<td>72</td>
<td></td>
<td></td>
<td>.015</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>227</td>
<td>77.2</td>
<td>53</td>
<td>70.7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>30</td>
<td>10.2</td>
<td>4</td>
<td>5.3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>32</td>
<td>10.5</td>
<td>16</td>
<td>21.3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>2.0</td>
<td>2</td>
<td>2.7</td>
<td></td>
<td></td>
<td>.059</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High school or less</td>
<td>139</td>
<td>47.4</td>
<td>46</td>
<td>64.8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some college</td>
<td>134</td>
<td>45.7</td>
<td>19</td>
<td>26.8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-graduate</td>
<td>20</td>
<td>6.8</td>
<td>6</td>
<td>8.5</td>
<td></td>
<td></td>
<td>.014</td>
</tr>
<tr>
<td>Employment Status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full or Part time</td>
<td>22</td>
<td>40</td>
<td>9</td>
<td>30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td>33</td>
<td>60</td>
<td>21</td>
<td>70</td>
<td></td>
<td></td>
<td>.250</td>
</tr>
<tr>
<td>Income</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;1,000</td>
<td>153</td>
<td>54.5</td>
<td>32</td>
<td>46.3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1,000-2,999</td>
<td>79</td>
<td>28.2</td>
<td>17</td>
<td>24.6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3,000-4,999</td>
<td>12</td>
<td>4.2</td>
<td>9</td>
<td>13.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5,000-8,999</td>
<td>19</td>
<td>6.8</td>
<td>8</td>
<td>11.6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9,000+</td>
<td>18</td>
<td>6.4</td>
<td>3</td>
<td>4.3</td>
<td></td>
<td></td>
<td>.120</td>
</tr>
</tbody>
</table>

2. Health and Functioning

Table 13 shows health and functioning. These outcomes answer the second research question, “How do the demographics of baby boomers and older adults with mental illnesses in Connecticut differ?” There was a significant difference ($x^2=4.551$, df=1, p=.022) in self-rated health between boomers and older adults, with a greater percentage of boomers reporting
excellent or good health (53.1% and 39.2%, respectively) but a greater percentage of older adults reporting only fair or poor health (46.9% and 60.8%, respectively). Not unexpectedly, the majority of respondents in both boomers and older adults screened positive for depression (74.1% and 80.8%, respectively). More than one-third of respondents in boomers and older adults reported having fallen in the past 12 months (42.1% and 45.8%, respectively). Wellness check-ups are an important part of preventive care. Over half of boomers and older adults indicated they have had a wellness check up in the past two years (57.5% and 58.7%, respectively). A summary score for ADLs shows a significant difference ($\chi^2=5.778$, df=1, $p=.014$) between boomers and older adults, with a greater percentage of boomers indicating they are not impaired (78.8% and 65.3%, respectively). In contrast, a summary score for IADLs shows a large percentage of both boomers and older adults were impaired in IADLs (77.2% and 82.2%, respectively).

The majority of boomer and older adults also reported comorbidity, or mental illnesses and at least one other disability (61.9% and 68.0%, respectively). Table 14 shows the numbers and percentages of boomers and older adults with other disabilities including: 1) a physical or chronic disability that makes it difficult to walk, reach, lift, or carry, 2) an intellectual or cognitive disability, such as mental retardation, Alzheimer’s disease, or other severe thinking impairment, 3) deafness or other severe hearing impairment, or 4) blindness or legal blindness. More than half of boomers and older adults with a mental illness also had a physical disability (50.5% and 54.8%, respectively). This was followed by slightly more than one-quarter of boomers and older adults who reported an intellectual disability (26.3% and 29.4%, respectively).
Table 13. Health and Functioning

<table>
<thead>
<tr>
<th>Health and Functioning</th>
<th>Boomers</th>
<th></th>
<th>Older Adults</th>
<th></th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td><strong>Self-Rated Health</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excellent/Good</td>
<td>156</td>
<td>53.1</td>
<td>29</td>
<td>39.2</td>
<td></td>
</tr>
<tr>
<td>Fair/Poor</td>
<td>138</td>
<td>46.9</td>
<td>45</td>
<td>60.8</td>
<td>.022</td>
</tr>
<tr>
<td><strong>Depression</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>215</td>
<td>74.1</td>
<td>59</td>
<td>80.8</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>75</td>
<td>25.9</td>
<td>14</td>
<td>19.2</td>
<td>.150</td>
</tr>
<tr>
<td><strong>Falls</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>122</td>
<td>42.1</td>
<td>33</td>
<td>45.8</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>168</td>
<td>57.9</td>
<td>39</td>
<td>54.2</td>
<td>.327</td>
</tr>
<tr>
<td><strong>Wellness Check Up</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>172</td>
<td>57.5</td>
<td>44</td>
<td>58.7</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>127</td>
<td>42.5</td>
<td>31</td>
<td>41.3</td>
<td>.482</td>
</tr>
<tr>
<td><strong>ADLs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impaired</td>
<td>62</td>
<td>21.2</td>
<td>25</td>
<td>34.7</td>
<td></td>
</tr>
<tr>
<td>Not Impaired</td>
<td>230</td>
<td>78.8</td>
<td>47</td>
<td>65.3</td>
<td>.014</td>
</tr>
<tr>
<td><strong>IADLs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Impaired</td>
<td>227</td>
<td>77.2</td>
<td>60</td>
<td>82.2</td>
<td></td>
</tr>
<tr>
<td>Not Impaired</td>
<td>67</td>
<td>22.8</td>
<td>13</td>
<td>17.8</td>
<td>.225</td>
</tr>
<tr>
<td><strong>Disability</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MI only</td>
<td>114</td>
<td>38.1</td>
<td>24</td>
<td>32.0</td>
<td></td>
</tr>
<tr>
<td>Comorbidity</td>
<td>185</td>
<td>61.9</td>
<td>51</td>
<td>68.0</td>
<td>.198</td>
</tr>
</tbody>
</table>
Table 14. Type of Disabilities

<table>
<thead>
<tr>
<th>Disability Type</th>
<th>Boomers</th>
<th></th>
<th>Older Adults</th>
<th></th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td>Physical disability</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>146</td>
<td>50.5</td>
<td>40</td>
<td>54.8</td>
<td>.301</td>
</tr>
<tr>
<td>No</td>
<td>143</td>
<td>49.5</td>
<td>33</td>
<td>45.2</td>
<td></td>
</tr>
<tr>
<td>Intellectual disability</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>75</td>
<td>26.3</td>
<td>20</td>
<td>29.4</td>
<td>.353</td>
</tr>
<tr>
<td>No</td>
<td>210</td>
<td>73.7</td>
<td>48</td>
<td>70.6</td>
<td></td>
</tr>
<tr>
<td>Deafness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>25</td>
<td>9.0</td>
<td>9</td>
<td>12.5</td>
<td>.245</td>
</tr>
<tr>
<td>No</td>
<td>253</td>
<td>91.0</td>
<td>63</td>
<td>87.5</td>
<td></td>
</tr>
<tr>
<td>Blindness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>21</td>
<td>7.4</td>
<td>5</td>
<td>7.1</td>
<td>.584</td>
</tr>
<tr>
<td>No</td>
<td>261</td>
<td>92.6</td>
<td>65</td>
<td>92.9</td>
<td></td>
</tr>
</tbody>
</table>

Respondents were asked if they had any problems with Medicare Part D, the prescription drug plan. The greatest percentage of boomers and older adults reported no problems (55.4% and 47.9%, respectively). Nearly one-third of boomers (30.9%) and 40.8 percent of older adults have never used the program. Boomers and older adults who use the program and have had problems with it (13.7% and 11.3%, respectively) were asked to describe the problems. Some of these responses reflecting the major concerns are included below.

Confusion around plans and companies soliciting plans

Don’t understand it!

The billing process

Failure to cover prescribed meds

Had to get prior authorization for med needed and finally had to change to meds less effective

Too expensive
Some people use assistive devices to help them at home or work. In this sample, there were no significant differences between boomers and older adults and the use or need of any of the assistive devices. In fact, the greatest percentage of respondents in both boomers and older adults reported that they don’t need help from the following assistive devices: building modifications (82.1% and 76.1%, respectively), mobility aids (83.0% and 78.9%, respectively), transportation aids (84.6% and 83.1%, respectively), or computer access aids (86.2% and 85.7%, respectively) (Table 15).

Table 15. Assistive Devices Used at Home or Work

<table>
<thead>
<tr>
<th>Assistive Devices</th>
<th><strong>Boomers</strong></th>
<th></th>
<th><strong>Older Adults</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>n</strong></td>
<td><strong>%</strong></td>
<td><strong>n</strong></td>
<td><strong>%</strong></td>
</tr>
<tr>
<td>Do not need</td>
<td>238</td>
<td>82.1</td>
<td>54</td>
<td>76.1</td>
</tr>
<tr>
<td>Currently use</td>
<td>30</td>
<td>10.3</td>
<td>10</td>
<td>14.1</td>
</tr>
<tr>
<td>Need but do not have</td>
<td>22</td>
<td>7.6</td>
<td>7</td>
<td>9.9</td>
</tr>
<tr>
<td>Do not need</td>
<td>240</td>
<td>83.0</td>
<td>56</td>
<td>78.9</td>
</tr>
<tr>
<td>Currently use</td>
<td>25</td>
<td>8.7</td>
<td>6</td>
<td>8.5</td>
</tr>
<tr>
<td>Need but do not have</td>
<td>24</td>
<td>8.3</td>
<td>9</td>
<td>12.7</td>
</tr>
<tr>
<td>Do not need</td>
<td>242</td>
<td>84.6</td>
<td>59</td>
<td>83.1</td>
</tr>
<tr>
<td>Currently use</td>
<td>16</td>
<td>5.6</td>
<td>5</td>
<td>7.0</td>
</tr>
<tr>
<td>Need but do not have</td>
<td>28</td>
<td>9.8</td>
<td>7</td>
<td>9.9</td>
</tr>
<tr>
<td>Do not need</td>
<td>249</td>
<td>86.2</td>
<td>60</td>
<td>85.7</td>
</tr>
<tr>
<td>Currently use</td>
<td>7</td>
<td>2.4</td>
<td>1</td>
<td>1.4</td>
</tr>
<tr>
<td>Need but do not have</td>
<td>33</td>
<td>11.4</td>
<td>9</td>
<td>12.9</td>
</tr>
</tbody>
</table>

3. LTC Plans, Service Use and Needs

Respondents were asked a question regarding current and future LTC plans and if they think they will ever need LTC (i.e., care at home, assisted living, or nursing home care). Outcomes in this section answer the third research question, “What long-term care plans, service use and needs do baby boomers with mental illnesses in Connecticut have compared to
older adults with mental illnesses in Connecticut?” There were no significant differences between the two groups. The majority of both boomer and older adults responded that they will need this kind of care (60% and 70.7%, respectively). Only a small percentage of boomers and older adults already have LTC care (7.6% and 10.7%, respectively). Nearly one-third of boomers (30.7%) and less than one-quarter (17.3%) of older adults don’t think they will need LTC.

Summary variables were created to determine LTC community service needs and use. Table 16 shows differences between boomer and older adult LTC service needs and use. Outcomes show that boomers reported a greater percentage of unmet need than older adults (55.5% and 45.9%, respectively). Compared to those not using services, significantly more \( (x^2=3.386, df=1, p=.043) \) boomers and older adults reported using services (57.2% and 68.9%, respectively).

<table>
<thead>
<tr>
<th>Service Needs and Use</th>
<th>Boomers</th>
<th>Older Adults</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Met needs</td>
<td>133</td>
<td>44.5</td>
<td>40</td>
</tr>
<tr>
<td>Unmet needs</td>
<td>166</td>
<td>55.5</td>
<td>34</td>
</tr>
<tr>
<td>Not using services</td>
<td>128</td>
<td>42.8</td>
<td>23</td>
</tr>
<tr>
<td>Using services</td>
<td>171</td>
<td>57.2</td>
<td>51</td>
</tr>
</tbody>
</table>

In Tables 17 and 18, when looking at the specific community LTC services people need and use for ongoing assistance due to age-related problems, serious injury, disabilities, or other issues, significant differences between boomers and older adults needs are noted in vocational rehabilitation service needs and job coach service needs. Significantly more boomers than older adults reported needing vocational rehabilitation services (27.8% and 8.3%, respectively; \( x^2=6.250, df=1, p=.007 \)) and job coach services (20.4% and .0%, respectively; \( x^2=9.126, df=1, p=.000 \)). Not surprisingly, significantly less boomers than older adults used home health aide services (13.7% and 33.3%, respectively; \( x^2=14.730, df=1, p=.000 \)), homemaker services
(21.4% and 42.9%, respectively; \(x^2=13.593, \text{df}=1, p=.000\)), care management services (31.3% and 45.6%, respectively; \(x^2=4.971, \text{df}=1, p=.020\)), and adult day program services (10.4% and 22.5%, respectively; \(x^2=7.446, \text{df}=1, p=.008\)).

Table 17. Community LTC Service Needs and Use

<table>
<thead>
<tr>
<th>LTC Service Use</th>
<th>Boomers</th>
<th>Older Adults</th>
<th>(p) value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n)</td>
<td>%</td>
<td>(n)</td>
</tr>
<tr>
<td><strong>Home health aide</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Need services</td>
<td>34</td>
<td>12.0</td>
<td>9</td>
</tr>
<tr>
<td>Don't need services</td>
<td>250</td>
<td>88.0</td>
<td>60</td>
</tr>
<tr>
<td>Using services</td>
<td>39</td>
<td>13.7</td>
<td>23</td>
</tr>
<tr>
<td>Not using services</td>
<td>245</td>
<td>86.3</td>
<td>46</td>
</tr>
<tr>
<td><strong>Homemaker</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Need services</td>
<td>64</td>
<td>22.8</td>
<td>13</td>
</tr>
<tr>
<td>Don't need services</td>
<td>217</td>
<td>77.2</td>
<td>57</td>
</tr>
<tr>
<td>Using services</td>
<td>60</td>
<td>21.4</td>
<td>30</td>
</tr>
<tr>
<td>Not using services</td>
<td>221</td>
<td>78.6</td>
<td>40</td>
</tr>
<tr>
<td><strong>Visiting nurse</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Need services</td>
<td>29</td>
<td>10.3</td>
<td>10</td>
</tr>
<tr>
<td>Don't need services</td>
<td>252</td>
<td>89.7</td>
<td>59</td>
</tr>
<tr>
<td>Using services</td>
<td>55</td>
<td>19.6</td>
<td>20</td>
</tr>
<tr>
<td>Not using services</td>
<td>226</td>
<td>80.4</td>
<td>49</td>
</tr>
<tr>
<td><strong>Home delivered meals</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Need services</td>
<td>50</td>
<td>17.7</td>
<td>10</td>
</tr>
<tr>
<td>Don't need services</td>
<td>232</td>
<td>82.3</td>
<td>59</td>
</tr>
<tr>
<td>Using services</td>
<td>24</td>
<td>8.5</td>
<td>11</td>
</tr>
<tr>
<td>Not using services</td>
<td>258</td>
<td>91.5</td>
<td>58</td>
</tr>
<tr>
<td><strong>Dial-a-ride service</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Need services</td>
<td>71</td>
<td>24.9</td>
<td>13</td>
</tr>
<tr>
<td>Don't need services</td>
<td>214</td>
<td>75.1</td>
<td>56</td>
</tr>
<tr>
<td>Using services</td>
<td>59</td>
<td>20.7</td>
<td>19</td>
</tr>
<tr>
<td>Not using services</td>
<td>226</td>
<td>79.3</td>
<td>50</td>
</tr>
<tr>
<td><strong>Friendly visitor</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Need services</td>
<td>55</td>
<td>19.6</td>
<td>9</td>
</tr>
<tr>
<td>Don't need services</td>
<td>226</td>
<td>80.4</td>
<td>58</td>
</tr>
<tr>
<td>Using services</td>
<td>16</td>
<td>5.7</td>
<td>5</td>
</tr>
<tr>
<td>Not using services</td>
<td>265</td>
<td>94.3</td>
<td>62</td>
</tr>
<tr>
<td><strong>Care management</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Need services</td>
<td>46</td>
<td>16.7</td>
<td>9</td>
</tr>
<tr>
<td>Don't need services</td>
<td>229</td>
<td>83.3</td>
<td>59</td>
</tr>
<tr>
<td>Using services</td>
<td>86</td>
<td>31.3</td>
<td>31</td>
</tr>
<tr>
<td>Not using services</td>
<td>189</td>
<td>68.7</td>
<td>37</td>
</tr>
</tbody>
</table>
When asked if they were able to get all the LTC services listed in Tables 17 and 18, a majority of boomers and older adults agreed they could get all the services listed that they need (57.6% and 61.5%, respectively). More than one-third in both groups reported they were unable to get the services they needed. There were no significant differences between boomers and older adults in reasons why they could not get services, but less than one-quarter of boomers and older adults reported they could not get services because they could not afford them (18%...
and 23%, respectively). Fifteen percent of boomers and 16 percent of older adults reported they didn’t know what services or help were available.

Respondents were asked to report if they do not use services and then if they use services, how they found out about the LTC services they use. Table 19 shows that significantly more boomers than older adults reported that they don’t use any services (40.1% and 24.3%, respectively; \( x^2 = 6.361, df = 1, p = .007 \)). Of the eleven different types of sources for learning about LTC care services shown in Table 20, the greatest percentage of boomers used a social worker or care manager (31.4%), doctor, nurse, or health provider (23.1%), or state agency (17.4%). In comparison, a greater percentage of older adults reported using a doctor, nurse, or other health provider (29.7%), social worker or other care manager (28.4%), or state agency (23.0%). There were significant differences between boomers and older adults in three LTC sources used: relatives, friends, and neighbors (\( x^2 = 3.806, df = 1, p = .043 \)); infoline (\( x^2 = 4.681, df = 1, p = .017 \)), and senior center (\( x^2 = 13.936, df = 1, p = .001 \)), with a greater percentage of older adults relying on relatives, friends, or neighbors and the senior center for information and a greater percentage of boomers seeking information from infoline, a phone-based service.

Table 19. Not Using LTC Services

<table>
<thead>
<tr>
<th>Not Using LTC Services</th>
<th>Boomers</th>
<th>Older Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>( n )</td>
<td>( % )</td>
</tr>
<tr>
<td>Do not use LTC services</td>
<td>120</td>
<td>40.1</td>
</tr>
</tbody>
</table>
Table 20. Sources Used to Locate LTC Services

<table>
<thead>
<tr>
<th>Sources Used to Locate LTC Services</th>
<th>Boomers</th>
<th>Older Adults</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Relatives, friends, or neighbors</td>
<td>38</td>
<td>12.7</td>
<td>16</td>
</tr>
<tr>
<td>Doctor, nurse, or other health provider</td>
<td>69</td>
<td>23.1</td>
<td>22</td>
</tr>
<tr>
<td>Social worker or care manager</td>
<td>94</td>
<td>31.4</td>
<td>21</td>
</tr>
<tr>
<td>State agency</td>
<td>52</td>
<td>17.4</td>
<td>17</td>
</tr>
<tr>
<td>Support organization (e.g., Easter Seals)</td>
<td>17</td>
<td>5.7</td>
<td>4</td>
</tr>
<tr>
<td>Telephone directory</td>
<td>10</td>
<td>3.3</td>
<td>4</td>
</tr>
<tr>
<td>Television, radio, or newspaper</td>
<td>9</td>
<td>3.0</td>
<td>6</td>
</tr>
<tr>
<td>Internet</td>
<td>9</td>
<td>3.0</td>
<td>1</td>
</tr>
<tr>
<td>Infoline</td>
<td>18</td>
<td>6.0</td>
<td>0</td>
</tr>
<tr>
<td>Senior center</td>
<td>7</td>
<td>2.3</td>
<td>9</td>
</tr>
<tr>
<td>School</td>
<td>5</td>
<td>1.7</td>
<td>1</td>
</tr>
</tbody>
</table>

Boomers and older adults were asked how often they have problems communicating with someone who provides them with LTC services because they speak a different language or are from a different cultural background. The largest percentage of both boomers and older adults reported never (52.3% and 47.7%, respectively) or rarely (23.8% and 22.7%, respectively), but the differences between groups were not significant.

Respondents were also asked how well the LTC services they receive meet their needs. Forty-nine percent (n=142) reported not receiving any services. Of the respondents who reported receiving services (n=187), the majority of boomers and older adults reported that overall the LTC services met their needs very well (51.7% and 55%, respectively). Another 42.2 percent of boomers and 40 percent of older adults reported that LTC services met their needs somewhat well, and less than ten percent of both reported their LTC services were not met very well. None of these differences between boomers and older adults were significant (Table 21).
Table 21. Satisfaction with LTC Services Received

<table>
<thead>
<tr>
<th>LTC Services Satisfaction</th>
<th>Boomers</th>
<th></th>
<th>Older Adults</th>
<th></th>
<th></th>
<th>p value</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td></td>
<td>n</td>
<td>%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very well</td>
<td>76</td>
<td>51.7</td>
<td>22</td>
<td>55.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somewhat well</td>
<td>62</td>
<td>42.2</td>
<td>16</td>
<td>40.0</td>
<td></td>
<td>.919</td>
<td></td>
</tr>
<tr>
<td>Not very well</td>
<td>9</td>
<td>6.1</td>
<td>2</td>
<td>5.0</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 22 shows that there were significant differences between boomers and older adults in future senior center use ($\chi^2=13.936$, df=1, p=.001). While a lower percentage of boomers reported it is not at all likely they would visit a senior center in the future, a greater percentage of older adults reported they would go to a senior center (29.6% and 43.7%, respectively). In contrast, a greater percentage of boomers than older adults report it is somewhat likely they would use a senior center in the future (43.2% and 29.6%, respectively). While a greater percentage of boomers than older adults report they very likely will use a senior center in the future (20.1% and 9.9%, respectively), not surprisingly, a greater percentage of older adults report they already go to a senior center.

Table 22. Future Senior Center Use

<table>
<thead>
<tr>
<th>Future Senior Center Use</th>
<th>Boomers</th>
<th></th>
<th>Older Adults</th>
<th></th>
<th></th>
<th>p value</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td></td>
<td>n</td>
<td>%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not at all likely</td>
<td>87</td>
<td>29.6</td>
<td>31</td>
<td>43.7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somewhat likely</td>
<td>127</td>
<td>43.2</td>
<td>21</td>
<td>29.6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very likely</td>
<td>59</td>
<td>20.1</td>
<td>7</td>
<td>9.9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I already go</td>
<td>21</td>
<td>7.1</td>
<td>12</td>
<td>16.9</td>
<td>.001</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In considering community LTC services, respondents were asked how they would prefer to arrange and manage paid services. The following three choices were presented.

1) You and an agency or provider talk about what services you want. The agency then decides on the services and schedule. The agency finds and arranges the services
for you. The agency processes the paychecks and handles any tax forms or financial paperwork.

2) Together with the agency or provider of your choice, you decide the services and schedule for the services you want. You and the agency work together to find and arrange these services. The agency processes the paychecks and handles any tax forms or financial paperwork.

3) You make the decisions about, find, and arrange your own services without the help of an agency or provider. You can get advice and training to learn how to hire and fire, train, pay, and manage your workers. You process the paychecks and handle any tax forms or financial paperwork.

Table 23 shows that over half of both boomers and older adults prefer the second approach involving collaboration between the consumer and an agency or provider in deciding the services and arranging for the scheduling of them (56.5% and 53.4%, respectively).

<table>
<thead>
<tr>
<th>Service Management Preference</th>
<th>Boomers</th>
<th></th>
<th>Older Adults</th>
<th></th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>The agency</td>
<td>53</td>
<td>21.5</td>
<td>20</td>
<td>34.5</td>
<td></td>
</tr>
<tr>
<td>You and the agency</td>
<td>139</td>
<td>56.5</td>
<td>31</td>
<td>53.4</td>
<td></td>
</tr>
<tr>
<td>You</td>
<td>54</td>
<td>22.0</td>
<td>7</td>
<td>12.1</td>
<td>.060</td>
</tr>
</tbody>
</table>

4. Social and Financial Support

Comparisons on measures of social and financial support answer the fourth research question, “How do the social and financial support needs of baby boomers with mental illnesses in Connecticut differ from older adults with mental illnesses in Connecticut?” Table 24 shows that the majority of boomers and older adults have a social network they can rely on to help with daily tasks such as grocery shopping, cooking, or providing a ride (52.2% and 64.9%, respectively; $x^2=3.800$, df=1, p=.034).
Respondents were also asked if they currently receive help from family and friends. There were significant differences between boomers and older adults, with a greater percentage of older adults receiving help (31.8% and 53.4%, respectively; $x^2=12.917$, df=1, $p=.002$).

More than three-quarters of both boomers and older adults report receiving the emotional support they need to talk about problems or to help them make a difficult decision.

<table>
<thead>
<tr>
<th>Social Support</th>
<th>Boomers</th>
<th></th>
<th>Older Adults</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Extra help from family and friends</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>139</td>
<td>47.8</td>
<td>26</td>
<td>35.1</td>
</tr>
<tr>
<td>Yes</td>
<td>152</td>
<td>52.2</td>
<td>48</td>
<td>64.9</td>
</tr>
<tr>
<td>Currently receive help from family and friends</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>151</td>
<td>51.7</td>
<td>29</td>
<td>39.7</td>
</tr>
<tr>
<td>Yes</td>
<td>93</td>
<td>31.8</td>
<td>39</td>
<td>53.4</td>
</tr>
<tr>
<td>Do not need this help</td>
<td>48</td>
<td>16.4</td>
<td>5</td>
<td>6.8</td>
</tr>
<tr>
<td>Emotional support</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>71</td>
<td>24.7</td>
<td>14</td>
<td>19.4</td>
</tr>
<tr>
<td>Yes</td>
<td>217</td>
<td>75.3</td>
<td>58</td>
<td>80.6</td>
</tr>
</tbody>
</table>

Table 25 shows that the majority of boomers and older adults reported living alone (48.8% and 54.7%, respectively). Significant differences were noted between boomers and older adults, with more older adults reporting living with a spouse or partner (14.4% and 26.7%, respectively; $x^2=6.461$, df=1, $p=.011$), more boomers living with their children who are under age 18 (5.4% and .0%, respectively; $x^2=4.193$, df=1, $p=.026$), and more boomers who report living with a parent (9% and .0%, respectively; $x^2=7.300$, df=1, $p=.002$).
Table 25. Living Arrangements

<table>
<thead>
<tr>
<th>Living Arrangements</th>
<th>Boomers</th>
<th></th>
<th>Older Adults</th>
<th></th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td>Live alone</td>
<td>146</td>
<td>48.8</td>
<td>41</td>
<td>54.7</td>
<td>.219</td>
</tr>
<tr>
<td>With spouse/partner</td>
<td>43</td>
<td>14.4</td>
<td>20</td>
<td>26.7</td>
<td>.011</td>
</tr>
<tr>
<td>With my children under age 18</td>
<td>16</td>
<td>5.4</td>
<td>0</td>
<td>.0</td>
<td>.026</td>
</tr>
<tr>
<td>With my children over age 18</td>
<td>16</td>
<td>5.4</td>
<td>5</td>
<td>6.7</td>
<td>.416</td>
</tr>
<tr>
<td>With a parent</td>
<td>27</td>
<td>9.0</td>
<td>0</td>
<td>.0</td>
<td>.002</td>
</tr>
<tr>
<td>With another relative</td>
<td>10</td>
<td>3.3</td>
<td>2</td>
<td>2.7</td>
<td>.555</td>
</tr>
<tr>
<td>With a friend or roommate</td>
<td>29</td>
<td>9.7</td>
<td>5</td>
<td>6.7</td>
<td>.286</td>
</tr>
</tbody>
</table>

In this subset, significantly more boomers than older adults had at least one child age 17 or younger (15.8% and 2.8%, respectively; \( \chi^2=3.893, \text{df}=1, \ p=.045 \)), and a greater percentage of older adults reported having at least one child age 18 or older (45.6% and 75.0%, respectively; \( \chi^2=7.773, \text{df}=1, \ p=.005 \)). More than three-quarters of boomers (82.9%) and nearly two-thirds of older adults (63.3%) with living children have children who live nearby and within 45 minutes (Table 26).

Table 26. Children

<table>
<thead>
<tr>
<th>Children who are living</th>
<th>Boomers</th>
<th></th>
<th>Older Adults</th>
<th></th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td>Children who are living</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No, do not have any living children</td>
<td>22</td>
<td>38.6</td>
<td>8</td>
<td>22.2</td>
<td>.077</td>
</tr>
<tr>
<td>Yes, at least one child age 17 or younger</td>
<td>9</td>
<td>15.8</td>
<td>1</td>
<td>2.8</td>
<td>.045</td>
</tr>
<tr>
<td>Yes, at least one child age 18 or older</td>
<td>26</td>
<td>45.6</td>
<td>27</td>
<td>75.0</td>
<td>.005</td>
</tr>
<tr>
<td>Children live within 45 minutes of you</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>29</td>
<td>82.9</td>
<td>19</td>
<td>63.3</td>
<td>.066</td>
</tr>
</tbody>
</table>
Boomers and older adults were asked how many days per week, on average, they leave their home for any reason. Table 27 shows that one-third of boomers and almost the same of older adults report leaving their house for any reason every day (33.1% and 32.4%, respectively). The majority of both boomers and older adults report that they go out enough (61.2% and 73.6%, respectively).

Table 27. Number of Days Leave Home for Any Reason

<table>
<thead>
<tr>
<th>Number of Days Leave Home</th>
<th>Boomers</th>
<th>Older Adults</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Leave home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Only for medical</td>
<td>34</td>
<td>11.7</td>
<td>10</td>
</tr>
<tr>
<td>appointments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than one day per</td>
<td>20</td>
<td>6.9</td>
<td>5</td>
</tr>
<tr>
<td>week</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-3 days per week</td>
<td>62</td>
<td>21.4</td>
<td>16</td>
</tr>
<tr>
<td>4-6 days per week</td>
<td>78</td>
<td>26.9</td>
<td>19</td>
</tr>
<tr>
<td>Every day</td>
<td>96</td>
<td>33.1</td>
<td>24</td>
</tr>
<tr>
<td>Number of days leave</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>home is the right</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>amount</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, I go out enough</td>
<td>175</td>
<td>61.2</td>
<td>53</td>
</tr>
<tr>
<td>No, I want to go out</td>
<td>95</td>
<td>33.2</td>
<td>18</td>
</tr>
<tr>
<td>more</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No, I want to go out</td>
<td>16</td>
<td>5.6</td>
<td>1</td>
</tr>
<tr>
<td>less</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Tables 28 and 29 show results for financial aspects of respondents’ lives. There were no significance differences in total monthly household income between boomers and older adults. The greatest percentage of boomers and older adults reported a total monthly household income of less than $1,000 (54.5% and 46.3%, respectively) or between $1,000-2,999 (28.2% and 24.6%, respectively). While the greatest percentage of boomers and older adults reported the income to support one person (76.6% and 70%, respectively), a greater percentage of older
adults (28.6%) than boomers (12.9%) reported that the income supports two people. Results for income supports were significant ($X^2=14.271, df=4, p=.006$).

There were significant differences between boomers and older adults in the total value of assets ($X^2=21.316, df=1, p=.003$). Although most boomers and older adults had less than $5,000 in total assets (75.2% and 64.6%, respectively), older adults had more than boomers in the $150,000 - $249,999 range (12.3% and 1.8%, respectively). There were also significant differences in home or condominium ownership, with more older adults reporting ownership than boomers (34.2% and 18.2%, respectively; $X^2=8.911, df=1, p=.003$).

Table 29 shows that one-third of both boomers and older adults reported they could count on someone for financial help (33.8% and 32.4%, respectively). At the end of the month, the greatest percentage of boomers (44.3%) reported that they don’t have enough to make ends meet, while the greatest percentage of older adults (37.8%) reported they just have enough to make ends meet at the end of the month.
Table 28. Finances

<table>
<thead>
<tr>
<th>Finances</th>
<th>Boomers</th>
<th></th>
<th>Boomers</th>
<th></th>
<th></th>
<th>Older Adults</th>
<th></th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total monthly household income</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;1,000</td>
<td>153</td>
<td>54.5</td>
<td>32</td>
<td>46.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1,000-2,999</td>
<td>79</td>
<td>28.2</td>
<td>17</td>
<td>24.6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3,000-4,999</td>
<td>12</td>
<td>4.2</td>
<td>9</td>
<td>13.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5,000-8,999</td>
<td>19</td>
<td>6.8</td>
<td>8</td>
<td>11.6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9,000+</td>
<td>18</td>
<td>6.4</td>
<td>3</td>
<td>4.3</td>
<td>.120</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Income supports:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 person</td>
<td>213</td>
<td>76.6</td>
<td>49</td>
<td>70.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 people</td>
<td>36</td>
<td>12.9</td>
<td>20</td>
<td>28.6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 people</td>
<td>14</td>
<td>5.0</td>
<td>1</td>
<td>1.4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 people</td>
<td>14</td>
<td>5.0</td>
<td>0</td>
<td>.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 people</td>
<td>1</td>
<td>.4</td>
<td>0</td>
<td>.0</td>
<td>.006</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total assets</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; $5,000</td>
<td>206</td>
<td>75.2</td>
<td>42</td>
<td>64.6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$5,000 - $14,999</td>
<td>28</td>
<td>10.2</td>
<td>3</td>
<td>4.6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$15,000 - $29,999</td>
<td>11</td>
<td>4.0</td>
<td>3</td>
<td>4.6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$30,000 - $74,999</td>
<td>6</td>
<td>2.2</td>
<td>1</td>
<td>1.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$75,000 - $149,999</td>
<td>3</td>
<td>1.1</td>
<td>2</td>
<td>3.1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$150,000 - $249,999</td>
<td>5</td>
<td>1.8</td>
<td>8</td>
<td>12.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$250,000 - $349,999</td>
<td>8</td>
<td>2.9</td>
<td>2</td>
<td>3.1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$350,000 or more</td>
<td>7</td>
<td>2.6</td>
<td>4</td>
<td>6.2</td>
<td>.003</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Own home</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>238</td>
<td>81.8</td>
<td>48</td>
<td>65.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>53</td>
<td>18.2</td>
<td>25</td>
<td>34.2</td>
<td>.003</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Respondents were asked what things they did not have enough money for in the past 12 months. Table 30 shows that a greater percentage of boomers than older adults lacked sufficient funds to pay for certain items. Significantly more boomers than older adults were unable to pay for: rent (23.7% and 10.7%, respectively; $x^2=6.156$, df=1, p=.008), utility bills (36.5% and 12.0%, respectively; $x^2=16.604$, df=1, p=.000), owning or repairing a car (36.5% and 13.3%, respectively; $x^2=14.776$, df=1, p=.000), needed food (36.1% and 17.3%, respectively; $x^2=9.670$, df=1, p=.001), prescription medication (25.1% and 10.7%, respectively; $x^2=7.217$, df=1, p=.004), and dental care (31.4% and 17.3%, respectively; $x^2=5.840$, df=1, p=.010). In addition, boomers were significantly less likely to be able to pay more than the minimum balance due on a credit card (25.1% and 10.7%, respectively; $x^2=7.217$, df=1, p=.004). Nearly one-third of older adult respondents (32%) reported always having enough money, while less than twenty-five percent of boomers (22.4%) reported always having enough money.
Table 30. Insufficient Funds

<table>
<thead>
<tr>
<th>Expenses</th>
<th>Boomers</th>
<th></th>
<th>Older Adults</th>
<th></th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td>Pay rent</td>
<td>71</td>
<td>23.7</td>
<td>8</td>
<td>10.7</td>
<td>.008</td>
</tr>
<tr>
<td>Pay utility bills</td>
<td>109</td>
<td>36.5</td>
<td>9</td>
<td>12.0</td>
<td>.000</td>
</tr>
<tr>
<td>Own/repair car</td>
<td>109</td>
<td>36.5</td>
<td>10</td>
<td>13.3</td>
<td>.000</td>
</tr>
<tr>
<td>Buy needed food</td>
<td>108</td>
<td>36.1</td>
<td>13</td>
<td>17.3</td>
<td>.001</td>
</tr>
<tr>
<td>Fill prescription for medicine</td>
<td>75</td>
<td>25.1</td>
<td>8</td>
<td>10.7</td>
<td>.004</td>
</tr>
<tr>
<td>Obtain dental care</td>
<td>94</td>
<td>31.4</td>
<td>13</td>
<td>17.3</td>
<td>.010</td>
</tr>
<tr>
<td>Obtain eyeglasses or hearing aides</td>
<td>72</td>
<td>24.1</td>
<td>11</td>
<td>14.7</td>
<td>.051</td>
</tr>
<tr>
<td>Obtain other medical care</td>
<td>61</td>
<td>20.4</td>
<td>9</td>
<td>12.0</td>
<td>.062</td>
</tr>
<tr>
<td>Pay for home modifications</td>
<td>38</td>
<td>12.7</td>
<td>9</td>
<td>12.0</td>
<td>.523</td>
</tr>
<tr>
<td>Pay for assistive devices</td>
<td>31</td>
<td>10.4</td>
<td>6</td>
<td>8.0</td>
<td>.357</td>
</tr>
<tr>
<td>Pay more than minimum balance due on a credit card</td>
<td>75</td>
<td>25.1</td>
<td>8</td>
<td>10.7</td>
<td>.004</td>
</tr>
<tr>
<td>Pay into retirement account</td>
<td>69</td>
<td>23.1</td>
<td>12</td>
<td>16.0</td>
<td>.119</td>
</tr>
<tr>
<td>Pay for care of a parent or child with disabilities</td>
<td>15</td>
<td>5.0</td>
<td>2</td>
<td>2.7</td>
<td>.302</td>
</tr>
<tr>
<td>Always had enough money</td>
<td>67</td>
<td>22.4</td>
<td>24</td>
<td>32.0</td>
<td>.059</td>
</tr>
</tbody>
</table>

Additional LTC Services Requested for Older Adults or People with Disabilities

A qualitative component was included in the assessment to find out more about LTC service needs and to probe deeper in terms of what kinds of additional services might be needed by respondents. Boomer and older adult respondents who completed either a general or a disability survey were asked an open-ended question about what services the state should provide older adults or people with disabilities. The question asked, “What additional services should Connecticut offer to older adults or people with disabilities?” Data for this question consist of verbatim quotations with enough context to be interpretable. After comparing and
contrasting 144 boomer and 36 older adult responses to this question, they were grouped under the following six distinct themes:

- Healthcare Services
- Programs and Services
- Transportation
- Financial Assistance
- Housing
- Other comments

Results for boomers and older adults are similar and demonstrate that healthcare services and programs and services were the two most important services wanted for older adults or people with disabilities. These were followed by transportation, financial assistance, and housing. Separate response rates for each theme are compared by group and displayed in Table 31. Subsequently, each theme is discussed in detail with supporting quotes provided.

<table>
<thead>
<tr>
<th>LTC Services</th>
<th>Boomers</th>
<th></th>
<th>Older Adults</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of Responses</td>
<td>%</td>
<td>Number of Responses</td>
<td>%</td>
</tr>
<tr>
<td>Healthcare Services</td>
<td>36</td>
<td>25</td>
<td>12</td>
<td>33</td>
</tr>
<tr>
<td>Programs and Services</td>
<td>36</td>
<td>25</td>
<td>12</td>
<td>33</td>
</tr>
<tr>
<td>Transportation</td>
<td>27</td>
<td>19</td>
<td>6</td>
<td>17</td>
</tr>
<tr>
<td>Financial Assistance</td>
<td>20</td>
<td>14</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Housing</td>
<td>18</td>
<td>13</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Other Comments</td>
<td>7</td>
<td>4</td>
<td>2</td>
<td>5</td>
</tr>
</tbody>
</table>

Healthcare Services

One-quarter of boomer and one-third of older adult responses to the question about what services Connecticut should provide to older adults or people with disabilities demonstrate that healthcare services are very important and should be better provided so that older adults and people with disabilities can treat and manage their illnesses. For some boomer
respondents, providing improved healthcare includes offering more affordable comprehensive health insurance or universal healthcare to people with lower incomes and those that have conditions that might disqualify them. Respondents also indicated a need for healthcare information to assist them with insurance issues. Older adult responses were similar to boomers but included coverage for home services and low cost gap insurance.

- **Affordable long-term care insurance for people with some conditions like breast cancer, depression, etc., that might disqualify them** – Boomer
- **Better access to care by eliminating the spendown for Medicaid and requiring doctors to accept Medicare and Medicaid** – Boomer
- **Help with Medicare and other insurance issues** – Boomer
- **Make my long term care provider pay for at home services** – Older Adult
- **Some form of low-cost health insurance or supplemental coverage to Medicare** – Older Adult

Some respondents indicated a need for better pharmacy plans that take into account prescription discounts and assistance paying for high priced prescriptions.

- **Better pharmacy plans** – Boomer
- **Help with prescription plans and paying for medications** – Boomer
- **Lower costs for pharmaceutical plans** – Boomer

Some respondents requested healthcare services that include dental insurance and affordable dental services, audiology and vision care.

- **More dental services and dentists who take Medicaid in the NW corner of the state** – Boomer
- **Dental care and assistance with related bills as well as better services for health impairment and help with costs for hearing aids** – Boomer

In addition, respondents suggested that there is a need for behavioral health services including increased mental health counseling services and supports and alternative healthcare options, such as naturopathic medicine.

- **If I’m depressed how can I get up to call for help? It’s easier to stay in bed or on the couch** – Boomer
More telephone support (crises lines) for those who are depressed. There are too few services for the depressed at every age group – Boomer

Psychiatric care and evaluation – Older Adult

Homeopathy – alternative medicine, naturopathic medicine – Older Adult

A few respondents indicated there should be specialized nursing homes for geriatric mental patients where comprehensive care can be provided.

Nonviolent or rarely violent, long-term geriatric mental patients like me shouldn’t stagnate in places like Whiting. There ought to be psychiatric nursing homes for 55 and older which provide our services, less restricted, free or for what we can afford – Boomer

Programs and Services

Twenty-five percent of boomer and one-third of older adult responses focused on the need for better and more affordable provider programs and services. This includes home and community-based services to older adults and people with disabilities that offer alternatives to nursing home care (i.e., personal care assistance, homemaker services, group homes). Some respondents suggested that more dependable personnel are needed in home health services.

Expansion of personal care assistant waivers for more people with higher incomes – Boomer

More personal assistance services with longer hours – Boomer

More homemaker services allowed for people from the state – Boomer

Dependable home health aides; they don’t show up when supposed to, can get away with it because people are elderly, don’t do the work they’re supposed to – Older Adult

Dependable, good help with someone to substitute when the regular people can’t make it – Older Adult

Respondents suggest that more residential group homes in the community are necessary as alternatives to nursing homes and to provide a more home-like environment for older adults or people with disabilities who need daily support.

More group homes – Boomer
Some respondents would like a wider range of programs and services designed specifically for boomers or younger people with disabilities, while older adults emphasized a need for programs that include socialization.

* More agencies to better assist the elderly including free programs – Boomer
* More innovation in services and service provision, especially for the baby boomer cohort – Boomer
* Older adults seem to have a lot of resources. Younger people with disabilities are usually forgotten and have fewer services available than older adults – Boomer
* Option of homemaker services for younger people with disabilities who don’t need “hands on” assistance – Boomer
* More social events with opportunities for crafts – Older Adult
* PM activities in senior center. Provide additional lectures, low cost trips – Older Adult
* Companionship for socialization – Older Adult

Respondents suggest the need for a better way to share information about disability and related services and how to access them. This includes the importance of cultural competence and the need for communicating with people in their own language, which was only mentioned by older adult respondents.

* Provide one-on-one information sharing on disability – Boomer
* An older person and/or people with disabilities Hot Line to seek out advice and direction – Boomer
* There should be a centralized system to let people know which services are available – Boomer
* In order for a person to benefit completely from services, he/she needs to be able to understand the language, so assigning a helper that communicates in their language is necessary – Older Adult
* More personnel to aid with services who are bilingual – Older Adult

Some respondents suggested that affordable food and nutrition services should be provided to those community dwelling older adults and people with disabilities who are no longer able to prepare their own food.
Provide affordable meals on wheels – Boomer

Transportation

Nineteen percent of boomer and 17 percent of older adult responses to the question about what services Connecticut should provide to older adults or people with disabilities suggest that more affordable accessible transportation services should be provided. This includes services with expanded hours that include evening hours and weekends and more comprehensive service routes that include all areas of the state. Some respondents report that such services are necessary for medical appointments, shopping, and other activities for people who do not drive and cannot use public transportation.

Transportation that is affordable and easily accessible – Boomer

More transportation – evenings and weekends – Boomer

More buses – Boomer

Transportation to dialysis, chemo, and radiation treatments free of charge or for a small charge – Boomer

Dial-a ride/paratransit regions should overlap (i.e., Someone from Hartford should be able to go to Waterbury or New Haven) – Boomer

Dial-A-Ride should be free as we are on a fixed income – Older Adult

Financial Assistance

Fourteen percent of boomer and slightly less than 10 percent of older adult responses suggest that older adults and people with disabilities need financial assistance. This includes money management services, discounts, tax reductions, and tax incentives.

Budgeting classes – I have more than 10 thousand dollars in credit card debt – Boomer

Legal help with past debt money management – Boomer

Property tax relief – Boomer

Having someone tell me about any discounts the town might offer seniors such as tax breaks on their housing – Older Adult
Financial help with repairs, maintenance, and household services in the form of sliding scale rates on their housing – Older Adult

Respondents indicate that financial assistance is needed to help older adults and people with disabilities pay for basic life expenses, such as the rising cost of food and utilities.

I don’t have enough money for food – Boomer

More money for food stamps even if you’re working part time to make ends meet – Boomer

Heating and electric bills assistance – always get the run around from team and have not been able to have electric heat, can’t buy food – Boomer

Housing

Thirteen percent of boomer and only three percent of older adult responses indicate the importance of affordable housing in local communities. This includes alternative living options for older adults and people with disabilities (i.e., group homes) and concerns regarding financial aid for house or subsidized housing.

Affordable housing in local communities – Boomer

Most important for elderly mentally retarded (Downs Syndrome) after death of parents is to be placed in a group home with limited number of clients and feel comfortable as living previously with family and parents – Boomer

More subsidized housing – Boomer

Housing to better meet the needs of the individuals – Older Adult

Other suggestions for housing include handicap accessible housing for people with disabilities.

More wheelchair accessible housing – Boomer

Other Comments

A small number of boomer (2%) and older adult (5%) responses focused on the need for job programs, training, and access to available jobs in the state of Connecticut for people with disabilities.

Job training for independence – Boomer

Job programs, job training – Boomer
More jobs – Boomer

Opportunity for job employment – Older Adult

Hypotheses Testing

To further explore LTC need and utilization, 8 hypotheses were tested. This section reports the results of that testing. The hypotheses were tested by using logistic regression, an approach that has a wide range of application in research to mainly formulate models sorting the factors that might determine whether or not an outcome happens. In other words, its purpose is to enable prediction of future outcomes. It also allows researchers to find the best fitting model to describe the relationship between the dependent variable and a set of independent or predictor variables (Munroe, 2005; Schemper, 2003).

The first set of analyses addressed the first four hypotheses that examine the association between screening positive for depression and functional impairment, unmet need for LTC services, LTC utilization, and dissatisfaction with LTC services. Table 32 shows Model 1 that includes Block 1 with covariates and Block 2 with unmet needs added. When adding unmet need to the model, there is an explained variance of 6 percent. Explained variance “measures the relative gains in predictive accuracy when prediction based on covariates replaces unconditional prediction” (Schemper, 2003, p. 2299) and quantifies the degree to which covariates determine a specific outcome. At greater than p=.05, the model fits the data (p=.378), however it should be noted that in all regression models a better fit yields a larger p value. In this model, people with unmet needs are 123 percent or more than twice as likely to screen positive for depression than those without unmet needs (OR=2.23, p=.003).
Table 32. Model 1: Predictors of Depression – Unmet Needs

<table>
<thead>
<tr>
<th>Predictors</th>
<th>Block 1</th>
<th>Block 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sig.</td>
<td>Odds Ratio</td>
</tr>
<tr>
<td>Older adults</td>
<td>.600</td>
<td>1.21</td>
</tr>
<tr>
<td>Male</td>
<td>.684</td>
<td>0.89</td>
</tr>
<tr>
<td>White</td>
<td>.274</td>
<td>1.42</td>
</tr>
<tr>
<td>Married</td>
<td>.433</td>
<td>1.35</td>
</tr>
<tr>
<td>Income &lt;$2,000</td>
<td>.920</td>
<td>1.03</td>
</tr>
<tr>
<td>Employed</td>
<td>.144</td>
<td>0.65</td>
</tr>
<tr>
<td>&lt; High School</td>
<td>.782</td>
<td>0.91</td>
</tr>
<tr>
<td><strong>Unmet needs</strong></td>
<td><strong>.003</strong></td>
<td><strong>2.23</strong></td>
</tr>
</tbody>
</table>

**Model summary**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Chi square (df, sig.)</td>
<td>14.216 (8, .076)</td>
</tr>
<tr>
<td>Log likelihood</td>
<td>344.319</td>
</tr>
<tr>
<td>Nagelkerke</td>
<td>0.06</td>
</tr>
<tr>
<td>Hosmer &amp; Lemeshow Test</td>
<td>.378</td>
</tr>
</tbody>
</table>

*Note: Sig.=significance; CI=confidence interval.*

Model 2 (Table 33) includes Block 1 with covariates and Block 2 with functional impairment added. When adding only functional impairment to the model, there is an explained variance of 6 percent. At greater than p=.05, the model fits the data (p=.902). People with one functional impairment are 10 percent more likely to screen positive for depression than those without any functional impairments (OR=1.09, p=.014). The percentage of probability rises to 20 percent for people reporting two functional impairments, 30 percent for those reporting three functional impairments and so on.
Table 33. Model 2: Predictors of Depression – Functional Impairment

<table>
<thead>
<tr>
<th>Predictors</th>
<th>Block 1</th>
<th>Block 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sig.</td>
<td>Odds Ratio</td>
</tr>
<tr>
<td>Older adults</td>
<td>.657</td>
<td>1.17</td>
</tr>
<tr>
<td>Male</td>
<td>.621</td>
<td>0.87</td>
</tr>
<tr>
<td>White</td>
<td>.287</td>
<td>1.41</td>
</tr>
<tr>
<td>Married</td>
<td>.298</td>
<td>1.51</td>
</tr>
<tr>
<td>Income &lt;$2,000</td>
<td>.971</td>
<td>1.01</td>
</tr>
<tr>
<td>Employed</td>
<td>.137</td>
<td>0.64</td>
</tr>
<tr>
<td>&lt; High School</td>
<td>.744</td>
<td>0.89</td>
</tr>
<tr>
<td><strong>Functional impairment</strong></td>
<td>.014</td>
<td>1.09</td>
</tr>
</tbody>
</table>

Model summary

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Chi square (df, sig.)</td>
<td>12.750</td>
<td>8, .121</td>
</tr>
<tr>
<td>Log likelihood</td>
<td>341.880</td>
<td></td>
</tr>
<tr>
<td>Nagelkerke</td>
<td>0.06</td>
<td></td>
</tr>
<tr>
<td>Hosmer &amp; Lemeshow Test</td>
<td>.902</td>
<td></td>
</tr>
</tbody>
</table>

*Note:* Sig.=significance; CI=confidence interval.

Model 3 (Table 34) includes Block 1 with covariates and Block 2 with unmet needs and functional impairment added together. When adding both these predictors to the model, there is an explained variance of 8 percent. At greater than p=.05, the model fits the data (p=.756).

People with unmet needs are still twice as likely to screen positive for depression even with functional impairment in the model (OR=2.05, p=.009).
Table 34. Model 3: Predictors of Depression – Unmet Needs and Functional Impairment

<table>
<thead>
<tr>
<th>Predictors</th>
<th>Block 1</th>
<th>Block 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sig.</td>
<td>Odds Ratio</td>
</tr>
<tr>
<td>Older adults</td>
<td>.683</td>
<td>1.16</td>
</tr>
<tr>
<td>Male</td>
<td>.628</td>
<td>0.87</td>
</tr>
<tr>
<td>White</td>
<td>.291</td>
<td>1.40</td>
</tr>
<tr>
<td>Married</td>
<td>.312</td>
<td>1.50</td>
</tr>
<tr>
<td>Income &lt;$2,000</td>
<td>.962</td>
<td>1.01</td>
</tr>
<tr>
<td>Employed</td>
<td>.140</td>
<td>0.64</td>
</tr>
<tr>
<td>&lt; High School</td>
<td>.751</td>
<td>0.90</td>
</tr>
<tr>
<td>Unmet needs</td>
<td>.009</td>
<td>2.05</td>
</tr>
</tbody>
</table>

Model summary

Chi square (df, sig.) 19.216 (9, .023)
Log likelihood 334.819
Nagelkerke 0.08
Hosmer & Lemeshow Test .756

Note: Sig. = significance; CI = confidence interval.

Model 4 (Table 35) includes Block 1 with covariates and Block 2 with LTC service use. When adding this predictor to the model, there is an explained variance of 2 percent. At greater than p=.05, the model fits the data (p=.574). The variable added to this model did not significantly contribute to it. There is no significant association between LTC service use and screening positive for depression in this sample.
Table 35. Model 4: Predictors of Depression – LTC Service Use

<table>
<thead>
<tr>
<th>Predictors</th>
<th>Block 1</th>
<th></th>
<th></th>
<th>Block 2</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sig.</td>
<td>Odds Ratio</td>
<td>95% CI</td>
<td>Sig.</td>
<td>Odds Ratio</td>
<td>95% CI</td>
</tr>
<tr>
<td>Older adults</td>
<td>.600</td>
<td>1.20</td>
<td>0.59-2.44</td>
<td>.620</td>
<td>1.19</td>
<td>0.58-2.43</td>
</tr>
<tr>
<td>Male</td>
<td>.684</td>
<td>0.89</td>
<td>0.53-1.50</td>
<td>.712</td>
<td>0.96</td>
<td>0.53-1.52</td>
</tr>
<tr>
<td>White</td>
<td>.274</td>
<td>1.42</td>
<td>0.75-2.67</td>
<td>.277</td>
<td>1.42</td>
<td>0.75-2.67</td>
</tr>
<tr>
<td>Married</td>
<td>.433</td>
<td>1.35</td>
<td>0.63-2.92</td>
<td>.417</td>
<td>1.37</td>
<td>0.63-2.96</td>
</tr>
<tr>
<td>Income &lt;$2,000</td>
<td>.920</td>
<td>1.03</td>
<td>0.53-2.01</td>
<td>.919</td>
<td>1.03</td>
<td>0.53-2.02</td>
</tr>
<tr>
<td>Employed</td>
<td>.144</td>
<td>0.65</td>
<td>0.36-1.15</td>
<td>.189</td>
<td>0.67</td>
<td>0.36-1.21</td>
</tr>
<tr>
<td>&lt; High School</td>
<td>.782</td>
<td>0.91</td>
<td>0.48-1.73</td>
<td>.741</td>
<td>0.89</td>
<td>0.46-1.71</td>
</tr>
<tr>
<td>LTC Service Use</td>
<td></td>
<td></td>
<td></td>
<td>.726</td>
<td>1.10</td>
<td>0.63-1.92</td>
</tr>
</tbody>
</table>

Model summary

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Chi square (df, sig.)</td>
<td>5.297 (8, .725)</td>
</tr>
<tr>
<td>Log likelihood</td>
<td>353.237</td>
</tr>
<tr>
<td>Nagelkerke</td>
<td>0.02</td>
</tr>
<tr>
<td>Hosmer &amp; Lemeshow Test</td>
<td>.574</td>
</tr>
</tbody>
</table>

*Note: Sig.=significance; CI=confidence interval.*

Model 5 (Table 36) includes Block 1 with covariates and Block 2 with only dissatisfaction with LTC services. When adding this predictor to the model, there is an explained variance of 12 percent. At greater than p=.05, the model fits the data (p=.212). The variable added to this model did not make a significant contribution to it. There is no significant association between dissatisfaction with LTC and screening positive for depression in this sample.
Table 36. Model 5: Predictors of Depression – Dissatisfaction with LTC Services

<table>
<thead>
<tr>
<th>Predictors</th>
<th></th>
<th>Block 1</th>
<th></th>
<th>Block 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Sig.</td>
<td>Odds Ratio</td>
<td>95% CI</td>
</tr>
<tr>
<td>Older adults</td>
<td></td>
<td>.147</td>
<td>0.50</td>
<td>0.20-1.27</td>
</tr>
<tr>
<td>Male</td>
<td></td>
<td>.198</td>
<td>0.61</td>
<td>0.28-1.29</td>
</tr>
<tr>
<td>White</td>
<td></td>
<td>.787</td>
<td>0.88</td>
<td>0.37-2.10</td>
</tr>
<tr>
<td>Married</td>
<td></td>
<td>.216</td>
<td>2.32</td>
<td>0.61-8.86</td>
</tr>
<tr>
<td>Income &lt;$2,000</td>
<td></td>
<td>.341</td>
<td>0.59</td>
<td>0.20-1.71</td>
</tr>
<tr>
<td>Employed</td>
<td></td>
<td>.028</td>
<td>0.33</td>
<td>0.12-0.88</td>
</tr>
<tr>
<td>&lt;$ High School</td>
<td></td>
<td>.452</td>
<td>0.79</td>
<td>0.32-1.66</td>
</tr>
<tr>
<td>Dissatisfaction with LTC Services</td>
<td></td>
<td>.072</td>
<td>1.98</td>
<td>0.91-4.18</td>
</tr>
</tbody>
</table>

Model summary

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Chi square (df, sig.)</td>
<td></td>
<td>14.050 (8, .080)</td>
</tr>
<tr>
<td>Log likelihood</td>
<td></td>
<td>172.213</td>
</tr>
<tr>
<td>Nagelkerke</td>
<td></td>
<td>0.12</td>
</tr>
<tr>
<td>Hosmer &amp; Lemeshow Test</td>
<td></td>
<td>.212</td>
</tr>
</tbody>
</table>

Note: Sig.=significance; CI=confidence interval.

Model 6 (Table 37) includes Block 1 with covariates and Block 2 with LTC service use and dissatisfaction with LTC services. When adding both these predictors to the model, there is an explained variance of 12 percent. At less than p=.05, the model is not a good model fit (p=.002), and the two variables entered together did not make a significant contribution to the model. There is no significant association between LTC use and dissatisfaction with LTC and screening positive for depression in this sample.
Table 37. Model 6: Predictors of Depression – LTC Services and Dissatisfaction with LTC Services

<table>
<thead>
<tr>
<th>Predictors</th>
<th>Block 1</th>
<th></th>
<th>Block 2</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sig.</td>
<td>Odds Ratio</td>
<td>95% CI</td>
<td>Sig.</td>
</tr>
<tr>
<td>Older adults</td>
<td>.147</td>
<td>0.50</td>
<td>0.20-1.27</td>
<td>.140</td>
</tr>
<tr>
<td>Male</td>
<td>.198</td>
<td>0.61</td>
<td>0.28-1.29</td>
<td>.195</td>
</tr>
<tr>
<td>White</td>
<td>.787</td>
<td>0.88</td>
<td>0.37-2.10</td>
<td>.906</td>
</tr>
<tr>
<td>Married</td>
<td>.216</td>
<td>2.32</td>
<td>0.61-8.86</td>
<td>.187</td>
</tr>
<tr>
<td>Income &lt;$2,000</td>
<td>.341</td>
<td>0.59</td>
<td>0.20-1.71</td>
<td>.336</td>
</tr>
<tr>
<td>Employed</td>
<td>.028</td>
<td>0.33</td>
<td>0.12-0.88</td>
<td>.020</td>
</tr>
<tr>
<td>&lt; High School</td>
<td>.452</td>
<td>0.79</td>
<td>0.32-1.66</td>
<td>.625</td>
</tr>
<tr>
<td><strong>LTC Service Use</strong></td>
<td><strong>.428</strong></td>
<td><strong>0.63</strong></td>
<td><strong>0.27-1.94</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Dissatisfaction with LTC Services</strong></td>
<td><strong>.084</strong></td>
<td><strong>1.93</strong></td>
<td><strong>0.91-4.10</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Model summary**

| Chi square (df, sig.)         | 14.706 (9, .099) |
| Log likelihood                | 171.557         |
| Nagelkerke                    | 0.12            |
| Hosmer & Lemeshow Test        | .002            |

*Note:* Sig.=significance; CI=confidence interval.

Model 7 (Table 38) includes Block 1 with covariates and Block 2 with all the predictors for depression included in the model. When adding these four predictors to the model, there is an explained variance of 19 percent. At greater than p=.05, the model is a good model fit (p=.303), and the four variables entered together make a significant contribution to the model. In the full model for depression, people with functional impairment are 13 percent more likely to screen positive for depression even with unmet needs, LTC service use, and dissatisfaction with LTC services.
Table 38. Model 7: Predictors of Depression – Full Model

<table>
<thead>
<tr>
<th>Predictors</th>
<th>Block 1</th>
<th>Block 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sig.</td>
<td>Odds Ratio</td>
</tr>
<tr>
<td>Older adults</td>
<td>.138</td>
<td>.49</td>
</tr>
<tr>
<td>Male</td>
<td>.206</td>
<td>.61</td>
</tr>
<tr>
<td>White</td>
<td>.724</td>
<td>.85</td>
</tr>
<tr>
<td>Married</td>
<td>.201</td>
<td>2.39</td>
</tr>
<tr>
<td>Income &lt;$2,000</td>
<td>.361</td>
<td>.60</td>
</tr>
<tr>
<td>Employed</td>
<td>.033</td>
<td>.34</td>
</tr>
<tr>
<td>&lt; High School</td>
<td>.469</td>
<td>.73</td>
</tr>
<tr>
<td>Unmet needs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Functional impairment</td>
<td>.025</td>
<td>1.13</td>
</tr>
<tr>
<td>LTC Service Use</td>
<td>.323</td>
<td>0.56</td>
</tr>
<tr>
<td>Dissatisfaction with LTC Services</td>
<td>.437</td>
<td>1.40</td>
</tr>
</tbody>
</table>

Model summary

- Chi square (df, sig.): 22.458 (11, .021)
- Log likelihood: 161.809
- Nagelkerke: 0.19
- Hosmer & Lemeshow Test: .303

Note: Sig.=significance; CI=confidence interval.

In the first set of analyses, the full model does not support the first hypothesis that a positive screen in boomer and older adults with mental illnesses is associated with unmet need. Only the reduced model (Table 34) indicates that screening positive for depression and unmet need are associated. When the predictors, LTC service use and dissatisfaction for LTC services are added, the sample shrinks since only about half of the sample reports using LTC services. This, no doubt, contributes to the outcomes in the full model. The full model supports the second hypothesis that screening positive for depression is associated with functional impairment. The full model shows that neither LTC utilization nor dissatisfaction with services is associated with screening positive for depression and therefore does not support the third and fourth hypotheses (Table 38).
The second set of analyses examined the association between comorbidity and functional impairment and unmet needs. Model 8 (Table 39) includes Block 1 with covariates and Block 2 with unmet needs added. When adding unmet need to the model, there is an explained variance of 8 percent. At greater than p=.05, the model fits the data (p=.783). People with unmet needs are 93 percent more likely to report comorbidity than those without unmet needs (OR=1.93, p=.006).

Table 39. Model 8: Predictors of Comorbidity – Unmet Needs

<table>
<thead>
<tr>
<th>Predictors</th>
<th>Block 1</th>
<th></th>
<th>Block 2</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sig.</td>
<td>Odds Ratio</td>
<td>95% CI</td>
<td>Sig.</td>
</tr>
<tr>
<td>Older adults</td>
<td>.605</td>
<td>0.85</td>
<td>0.45-1.57</td>
<td>.755</td>
</tr>
<tr>
<td>Male</td>
<td>.909</td>
<td>0.97</td>
<td>0.60-1.55</td>
<td>1.000</td>
</tr>
<tr>
<td>White</td>
<td>.567</td>
<td>0.83</td>
<td>0.45-1.54</td>
<td>.540</td>
</tr>
<tr>
<td>Married</td>
<td>.888</td>
<td>1.04</td>
<td>0.54-2.02</td>
<td>.649</td>
</tr>
<tr>
<td>Income &lt;$2,000</td>
<td>.306</td>
<td>1.35</td>
<td>0.75-2.44</td>
<td>.305</td>
</tr>
<tr>
<td>Employed</td>
<td>.174</td>
<td>0.69</td>
<td>0.40-1.17</td>
<td>.234</td>
</tr>
<tr>
<td>&lt; High School</td>
<td>.029</td>
<td>2.00</td>
<td>1.07-3.73</td>
<td>.041</td>
</tr>
<tr>
<td><strong>Unmet needs</strong></td>
<td><strong>.006</strong></td>
<td><strong>1.93</strong></td>
<td><strong>1.20-3.10</strong></td>
<td></td>
</tr>
</tbody>
</table>

Model summary

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Chi square (df, sig.)</td>
<td>19.342 (8, .013)</td>
</tr>
<tr>
<td>Log likelihood</td>
<td>406.032</td>
</tr>
<tr>
<td>Nagelkerke</td>
<td>0.08</td>
</tr>
<tr>
<td>Hosmer &amp; Lemeshow Test</td>
<td>.783</td>
</tr>
</tbody>
</table>

Note: Sig.=significance; CI=confidence interval.

Model 9 (Table 40) includes Block 1 with covariates and Block 2 with functional impairment added. When adding functional impairment to the model, there is an explained variance of 18 percent. At greater than p=.05, the model fits the data (p=.968). This model shows that it is 22 percent more probable that people reporting functional impairment will also have comorbidity (OR=1.22, p=.000).
Table 40. Model 9: Predictors of Comorbidity – Functional Impairment

<table>
<thead>
<tr>
<th>Predictors</th>
<th>Block 1</th>
<th>Block 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sig.</td>
<td>Odds Ratio</td>
</tr>
<tr>
<td>Older adults</td>
<td>.464</td>
<td>.79</td>
</tr>
<tr>
<td>Male</td>
<td>.966</td>
<td>.99</td>
</tr>
<tr>
<td>White</td>
<td>.533</td>
<td>.82</td>
</tr>
<tr>
<td>Married</td>
<td>.849</td>
<td>1.06</td>
</tr>
<tr>
<td>Income &lt;$2,000</td>
<td>.469</td>
<td>1.24</td>
</tr>
<tr>
<td>Employed</td>
<td>.112</td>
<td>.64</td>
</tr>
<tr>
<td>&lt; High School</td>
<td>.023</td>
<td>2.09</td>
</tr>
<tr>
<td><strong>Functional impairment</strong></td>
<td>.000</td>
<td><strong>1.22</strong></td>
</tr>
</tbody>
</table>

**Model summary**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Chi square (df, sig.)</td>
<td>44.818 (8, .000)</td>
<td>Log likelihood</td>
</tr>
<tr>
<td></td>
<td></td>
<td>372.851</td>
</tr>
<tr>
<td>Nagelkerke</td>
<td>0.18</td>
<td></td>
</tr>
<tr>
<td>Hosmer &amp; Lemeshow Test</td>
<td>.968</td>
<td></td>
</tr>
</tbody>
</table>

*Note: Sig.=significance; CI=confidence interval.*

Model 10 (Table 41) includes Block 1 with covariates and Block 2 with unmet needs and functional impairment added. When including these two predictors in the model together, there is an explained variance of 19 percent. At greater than p=.05, the model fits the data (p=.996). The model shows that people with functional impairment are 20 percent more likely to report comorbidity even when unmet need is included in the model (OR=1.20, p=.000).
### Table 41. Model 10: Predictors of Comorbidity – Full Model

<table>
<thead>
<tr>
<th>Predictors</th>
<th>Block 1</th>
<th></th>
<th></th>
<th>Block 2</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sig.</td>
<td>Odds Ratio</td>
<td>95% CI</td>
<td>Sig.</td>
<td>Odds Ratio</td>
<td>95% CI</td>
</tr>
<tr>
<td>Older adults</td>
<td>.406</td>
<td>0.76</td>
<td>0.41-1.43</td>
<td>.332</td>
<td>0.71</td>
<td>0.356-1.40</td>
</tr>
<tr>
<td>Male</td>
<td>.989</td>
<td>0.99</td>
<td>0.61-1.60</td>
<td>.612</td>
<td>1.13</td>
<td>0.68-1.88</td>
</tr>
<tr>
<td>White</td>
<td>.519</td>
<td>0.82</td>
<td>0.43-1.51</td>
<td>.492</td>
<td>0.79</td>
<td>0.40-1.53</td>
</tr>
<tr>
<td>Married</td>
<td>.908</td>
<td>1.04</td>
<td>0.53-2.02</td>
<td>.746</td>
<td>1.12</td>
<td>0.54-2.31</td>
</tr>
<tr>
<td>Income &lt;$2,000</td>
<td>.453</td>
<td>1.25</td>
<td>0.69-2.28</td>
<td>.805</td>
<td>1.08</td>
<td>0.57-2.05</td>
</tr>
<tr>
<td>Employed</td>
<td>.117</td>
<td>0.65</td>
<td>0.38-1.13</td>
<td>.709</td>
<td>0.89</td>
<td>0.50-1.59</td>
</tr>
<tr>
<td>&lt; High School</td>
<td>.021</td>
<td>2.11</td>
<td>1.11-4.00</td>
<td>.207</td>
<td>1.55</td>
<td>0.78-3.08</td>
</tr>
<tr>
<td>Unmet needs</td>
<td></td>
<td></td>
<td></td>
<td>.070</td>
<td>1.59</td>
<td>0.96-2.65</td>
</tr>
<tr>
<td>Functional impairment</td>
<td>.000</td>
<td>1.20</td>
<td>1.11-1.30</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Model summary**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Chi square (df, sig.)</td>
<td>47.745</td>
<td>.000</td>
</tr>
<tr>
<td>Log likelihood</td>
<td>368.973</td>
<td></td>
</tr>
<tr>
<td>Nagelkerke</td>
<td>0.19</td>
<td></td>
</tr>
<tr>
<td>Hosmer &amp; Lemeshow Test</td>
<td>.996</td>
<td></td>
</tr>
</tbody>
</table>

*Note: Sig.=significance; CI=confidence interval.*

The fifth hypothesis that comorbidity in boomers and older adults with mental illnesses is associated with unmet need for LTC services independent of demographic factors is not supported by the full model (Table 41). The sixth hypothesis, however, that comorbidity in boomers and older adults with mental illnesses is associated with functional impairment independent of demographic factors is supported in the full model.

The third set of analyses addressed perceived lack of social support and explored the association between that outcome, unmet need and functional impairment. Model 11 (Table 42) includes Block 1 with covariates and Block 2 with unmet needs. When including this predictor in the model, there is an explained variance of 13 percent. At greater than p=.05, the model fits the data (p=.903). The model shows that people with unmet needs are 112 percent more likely, or twice as likely, to report perceived lack of social support (OR=2.12, p=.002).
Table 42. Model 11: Predictors of Perceived Lack of Social Support – Unmet Needs

<table>
<thead>
<tr>
<th>Predictors</th>
<th>Block 1</th>
<th>Block 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sig.</td>
<td>Odds</td>
</tr>
<tr>
<td>Older adults</td>
<td>.030</td>
<td>0.49</td>
</tr>
<tr>
<td>Male</td>
<td>.282</td>
<td>0.71</td>
</tr>
<tr>
<td>White</td>
<td>.008</td>
<td>0.43</td>
</tr>
<tr>
<td>Married</td>
<td>.003</td>
<td>0.35</td>
</tr>
<tr>
<td>Income &lt;$2,000</td>
<td>.423</td>
<td>0.78</td>
</tr>
<tr>
<td>Employed</td>
<td>.894</td>
<td>0.85</td>
</tr>
<tr>
<td>&lt; High School</td>
<td>.003</td>
<td>1.04</td>
</tr>
<tr>
<td><strong>Unmet needs</strong></td>
<td><strong>.002</strong></td>
<td><strong>2.12</strong></td>
</tr>
</tbody>
</table>

Model summary

Chi square (df, sig.) 34.041 (8, .002)
Log likelihood 399.865
Nagelkerke 0.13
Hosmer & Lemeshow Test .903

*Note: Sig.=significance; CI=confidence interval.*

Table 43 (Model 12) includes Block 1 with covariates and Block 2 with functional impairment. When including this predictor in the model, there is an explained variance of 12 percent. At greater than p=.05, the model fits the data (p=.483). The model shows that people with functional impairment are 6 percent more likely to perceive lack of social support (OR=1.06, p=.033).
Table 43. Model 12: Predictors of Perceived Lack of Social Support – Functional Impairment

<table>
<thead>
<tr>
<th>Predictors</th>
<th>Block 1</th>
<th></th>
<th>Block 2</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sig.</td>
<td>Odds</td>
<td>95% CI</td>
<td>Sig.</td>
</tr>
<tr>
<td>Older adults</td>
<td>.046</td>
<td>0.52</td>
<td>0.27-0.98</td>
<td>.035</td>
</tr>
<tr>
<td>Male</td>
<td>.328</td>
<td>0.78</td>
<td>0.48-1.27</td>
<td>.446</td>
</tr>
<tr>
<td>White</td>
<td>.004</td>
<td>0.39</td>
<td>0.21-0.74</td>
<td>.004</td>
</tr>
<tr>
<td>Married</td>
<td>.002</td>
<td>0.33</td>
<td>0.16-0.67</td>
<td>.002</td>
</tr>
<tr>
<td>Income &lt;$2,000</td>
<td>.575</td>
<td>0.83</td>
<td>0.45-1.55</td>
<td>.448</td>
</tr>
<tr>
<td>Employed</td>
<td>.634</td>
<td>0.87</td>
<td>0.50-1.51</td>
<td>.944</td>
</tr>
<tr>
<td>&lt; High School</td>
<td>.921</td>
<td>0.97</td>
<td>0.52-1.77</td>
<td>.641</td>
</tr>
<tr>
<td>Functional impairment</td>
<td>.033</td>
<td>1.06</td>
<td>1.00-1.13</td>
<td></td>
</tr>
</tbody>
</table>

Model summary

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Chi square (df, sig.)</td>
<td>30.768 (8, .000)</td>
</tr>
<tr>
<td>Log likelihood</td>
<td>397.568</td>
</tr>
<tr>
<td>Nagelkerke</td>
<td>0.12</td>
</tr>
<tr>
<td>Hosmer &amp; Lemeshow Test</td>
<td>.483</td>
</tr>
</tbody>
</table>

Note: Sig.=significance; CI=confidence interval.

The final Model shown in Table 44 (Model 13) includes Block 1 with covariates and Block 2 with unmet needs and functional impairment. When including both these predictors in the model, there is an explained variance of 15 percent. At greater than p=.05, the model fits the data (p=.989). The model shows that people with unmet needs are 96 percent more likely to perceive lack of social support even with functional impairment in the model (OR=1.96, p=.007).
The seventh hypothesis that perceived lack of social support among boomers and older adults with mental illnesses is associated with unmet needs is supported in the full model (Table 44). The final hypothesis, that perceived lack of social support is associated with functional impairment independent of demographic factors is not supported.

Additional Results

Additional results from the first set of analyses exploring associations with depression show that in the full model (Table 38) being unemployed is significant (p=.031). In comparing the LTC service use subset to the whole sample, it appears that employment may become significant because being unemployed and a boomer are correlated with the outcome. This outcome and the others mentioned below are discussed more completely in the discussion section.
Similarly, in the second set of analyses when examining associations related to comorbidity, Table 39 shows that in addition to unmet needs, lower levels of education in the reduced model is significant (p=.041). Again, correlations between education and other predictors appear to be influencing the outcomes.

In the third set of analyses, in the reduced and full models (Tables 42-44), race/ethnicity and marital status are significant predictors of perceived lack of social support. Specifically, being in a minority group and unmarried predict perceived lack of social support.
CHAPTER V
DISCUSSION

This study sought to further assess LTC need and utilization among a subset of baby boomer and older adult respondents reporting mental illnesses in the 2007 Connecticut Long-Term Care Needs Assessment (Robison et al., 2007). Given the gap in literature on the beliefs, values, and LTC preferences of boomers and older adults with mental illnesses in Connecticut, this study provides a comparison of differences in the LTC needs or plans of baby boomers and older adults with mental illnesses. The study also uses regression analysis to determine the relationship between a single dependent (criterion) variable and one or more independent (predictor) variables to better understand LTC need and utilization among boomers and older adults with mental illnesses in Connecticut.

Outcomes of Research Questions

Demographics

As noted in Chapter I, the literature suggests there are numerous differences between boomers and older adults that arise from lifestyle and the inevitable process of aging (Brossoie et al., 2010; Harwood et al., 1998; Ingster & Cartwright, 1995; Reid & Anderson, 1997). These cohort differences have the potential to impact LTC need and utilization and are important to consider. While cohort differences show that boomers are more likely to have higher levels of education (American Hospital Association, 2007; Ryan et al., 2012), they also indicate that the younger cohort has greater health problems than older adults (Centers for Disease Control and Prevention, 2009). This includes a higher rate of depressive disorders and related issues such as increased risk of social isolation and lower life satisfaction (AARP, 2010; Stone et al., 2010; Strine et al., 2008; Walker & Herbitter, 2005).

Similar to outcomes reported in the literature, boomers in this subsample are more likely than older adults to have higher levels of education (Ryan et al. 2012), but overall there were few differences between the two groups in demographics with the exception of gender and
marital status. There were significantly more female boomer and older adult respondents than male (p=.040). A significantly greater percentage of boomers reported being unmarried (p=.015). This difference is not surprising when looking at other studies. Using data from the 1980, 1990, and 2000 Census and the 2009 American Community Survey, researchers Lin and Brown (2012) found that the number of unmarried boomers has grown by more than 50 percent since 1980 and that one in three boomers are unmarried. Unmarrieds are more likely to experience poorer economic, health, and social outcomes; in fact the prevalence of disability among unmarrieds than marrieds is twice as high (Lin & Brown, 2012). The increase in unmarrieds among boomers leaves them more vulnerable to the challenges of aging than their counterparts and to those in the older cohort (Lin & Brown, 2012). Research focused on people with mental illnesses shows individuals reporting mental illnesses are significantly more likely to be unmarried than those with other disabilities or those without any disabilities (Kellett et al., 2010). The status of being unmarried may potentially pose problems in terms of network strength and support for LTC if and when needed. As a result, it is important that health care and social service providers as well as policy makers recognize the risk profiles of unmarried boomers, particularly those with mental illnesses, to ensure they receive the services necessary and have equal opportunity to age well.

Health and functioning

In health and functioning, a significantly greater percentage of boomers self-reported “Excellent /Good” health while a greater percentage of older adults self-reported “Fair/Poor” health (p=.022). A greater percentage of boomers than older adults reported no impairment in ADLs (p=.014), but on all other health and functioning variables boomers and older adults had similar outcomes.

LTC plans, service need and utilization

In terms of LTC plans, service needs and use although a greater percentage of boomers reported unmet needs, differences in unmet need between the two groups were not at a
significant level. Where there were some significant differences, it was not unexpected. For example, significantly more boomers than older adults reported needing vocational rehabilitation and job coach services and significantly less boomers than older adults reported using certain LTC home and community-based services, such as home health aide and homemaker services.

It was also not surprising that there were significant differences between groups in the sources used to locate the LTC sources that are used. It appears that older adults may have a stronger social network than boomers since older adults are significantly more likely to rely on relatives, friends, or neighbors. Research shows older adults are significantly less concerned than boomers about losing touch with family and friends, having someone close to talk to, or feeling that no one cares for them (Moschis & Mathur, 2007). On the other hand, boomers in this subsample appear more likely than older adults to seek information from Infoline. Given that the demand for LTC services is likely to increase among the boomer cohort as they age, this information may be useful in developing strategies to reach targeted groups with mental illnesses when trying to disseminate information about LTC services and supports. Targeted groups within the population of those with mental illnesses would most likely include those who are the most vulnerable, such as women who are widowed or divorced, minorities, individuals who live alone, and those who are economically disadvantaged (Lynch & Estes, 2001). Since there were significant differences between boomers and older adults in future senior center use, with a greater percentage of boomers indicating it’s somewhat likely they might consider using a senior center in the future, towns might be well-advised to further develop senior center programs, funding permitted, to continue meeting the needs of older adults who already report using senior centers and to engage boomers in the future.

Similarities between the two groups show that while a greater percentage of respondents in this sample report being able to get the LTC services they need, more than one-third in both groups were unable to get the services they needed. Slightly less than one-quarter in both groups could not get services because they couldn’t afford them and slightly less than
one-quarter in each group reported they were unaware of what services existed. This demonstrates that finances and lack of knowledge about services are barriers to receiving LTC help. Recognizing the importance of these barriers and striving to address them is necessary in working towards reducing social inequalities. There is a critical need to educate people with mental illnesses and their families about LTC, what it is, how it could be useful, how much it costs, and the choices that are available. Having a clear single point of entry for people with disabilities to learn about LTC services would undoubtedly be advantageous and make it easier for people to access the services they need.

Since slightly more than half of both boomers and older adults in this subsample report the preference for a collaborated approach to the management of paid LTC services, and with an anticipated surge in the growth of Connecticut residents expected to need such services (Connecticut Commission on Aging, 2011), it seems clear that independence, choice, and control are important to boomers and older adults with mental illnesses and that efforts to rebalance the demand for institutional and community-based services should be met by increasing the supply of LTC community-based services. This will include efforts to address existing barriers to LTC services, such as continued shortages in the workforce and affordable housing. Because chronic healthcare problems involve a broad range of multiple parties from the patient to the physician to access to financial resources for reimbursement of services, expansion of LTC services in preferred community-based settings that are responsive to the interests of users and their families would provide a hopeful reality to a system that in the past has been more institutionally dominated.

Social and financial support

Outcomes of this study indicate that although half of boomer respondents in the subsample rely on help from family and friends, nearly half do not receive that support. While it is encouraging that older adults in the subsample report a greater dependency on and responsiveness from their social network, there is concern that fewer boomers experience this
same support. In addition, data demonstrate that significantly fewer boomers than older adults live with a spouse or partner. While this reflects outcomes in the literature as discussed in Chapter 2 and is related to boomers and the potential risks for more limited social support (Easterlin et al., 1999; Uhlenberg & Minor, 1996; Walker & Herbitter, 2005), it raises concerns about what level of informal LTC support will be available for this group of people with disabilities. The literature also establishes a strong theoretical basis and empirical evidence that supports the idea that social relationships or the lack thereof not only impact care but health itself (Centers for Disease Control and Prevention, 2008; Speer & Schneider, 2003). Isolation is known to be a major risk factor for mortality, and researchers continue to explore the relationship between the social and economic situations of adults and health in an effort find ways to help aging people maintain physical well-being and independence (Berkman, 1995; Brummet et al. 2001; Centers for Disease Control and Prevention, 2008). This is all the more important for people with mental illnesses who struggle with ongoing healthcare needs and related issues.

Although there were no significant differences between boomers and older adults in total monthly household income, there were significant differences in the number of people the income supports and in total assets. Significantly more older adults reported owning a home, but overall there were more similarities than differences in finances between the two groups. For example, a greater percentage in both groups reported not being able to count on anyone for financial help and had not enough or just enough to make ends meet at the end of the month. In addition, a greater percentage of boomers than older adults reported insufficient funds for housing, utility bills, personal transportation, medical needs, and for retirement. If people with mental illnesses in general report insufficient funds for many of the necessities of life, such as shelter, there should be concerns about how they will be able to finance their LTC needs, especially in light of the fact that healthcare expenditures continue to rise. Out-of-pocket healthcare costs are of particular concern and represent a significant burden on the elderly
because they are typically inversely related to their ability to pay for them. In the literature, little attention has been paid to health equity and social justice in healthcare as they relate to older people with disabilities (Estes & Wallace, 2008). Awareness of social categories of inequality helps raise political awareness and promote policy change as well as encourage important community level changes that may lead to the reduction of future disparities and unmet LTC needs among boomer and older adults with mental illnesses in Connecticut. Striving to reduce the socioeconomic-health gradient and economic burden associated with an aging population through research and the dissemination of results has the potential to help promote justice for future cohorts of older people.

When asked an open ended question about what additional LTC services they would request for older adults or people with disabilities, both boomers and older adults responded similarly. The two groups shared concerns about provisions for affordable, accessible healthcare, for better more affordable programs and services, more affordable and accessible transportation, financial assistance including tax reductions and incentives, and affordable housing in the community. Thinking about LTC within the context of political economy challenges us to listen to the voice of consumers and their LTC need and utilization experiences. In the words of Lerner, “It means developing intellectual courage” (Lerner, 1986, p. 228) – the kind of courage that seeks to gain a better understanding of the needs of consumers with mental illnesses in an effort to rebalance the LTC system through social policy changes so that the social threads binding individuals across cohorts, gender, race, ethnicity, and social class will be more equivalent across the life course.

Outcomes of Hypotheses Testing

LTC need and utilization

No studies in the literature have focused on the association between LTC outcomes (i.e., need and utilization) and screening positive for depression, comorbidity, and perceived lack of social support among boomers and older adults with mental illnesses generally or in
Connecticut. Much of the existing literature exploring depressive illnesses and health care utilization focuses on inpatient and outpatient medical services involving elderly populations and does not include boomers receiving LTC services in the community (Koenig, Shelp, Goli, Cohen, & Blazer, 1989; Luber, Meyers, Williams-Russo, 2001; Waxman, Carner, & Blum, 1983). Other studies on comorbidity and health care utilization (Glynn et al., 2011; Mackenzie, Reynolds, Cairney, Streiner, & Sareen, 2012) and lack of social support and health care utilization (Kent & Yellowlees, 1995; Padgett & Brodsky, 1992; Phillips & Murrell, 1994; Reinhardt, Boerner, & Benn, 2003) also focus on different age groups of people than this study and on services that are not community-based.

The outcomes of this study are important because they demonstrate a number of associations related to LTC need and utilization. Results of this study show there is an association between screening positive for depression and the potential for increased LTC needs, particularly among boomers and older adults with mental illnesses reporting unmet need and functional impairment. Results also demonstrate an association between comorbidity in boomers and older adults with mental illnesses and unmet need and functional impairment. In addition, the study shows an association between perceived lack of social support and unmet need for LTC services particularly among non-white, unmarried respondents.

**Depression**

**Unmet Need**

The first hypothesis that a positive depression screen in boomer and older adults with mental illnesses is associated with unmet need for LTC services independent of demographic factors was not supported in the full model in this study. It should be noted that the sample in the full model was reduced due to the inclusion of the predictors LTC service use and dissatisfaction with LTC services. The large number of missing cases (n=220) makes those included in the full model (n=154) a subsample of respondents using LTC services.
The first hypothesis was, however, supported by the reduced model when including the predictors unmet need and functional impairment (Table 34). In this model, the sample had far fewer missing cases and represented more of the respondents. The observation in the reduced model is important because both predictors contribute significantly to the model and at p=.756 the model is a good fit. The association between screening positive for depression and unmet need could be possible for many reasons. Individuals with mental illnesses often use services and support over an extended period of time, and if those needs go unmet, the risk for becoming depressed could increase. In this study, respondents with unmet needs were twice as likely to screen positive for being depressed. Though this observation is from the reduced model, it indicates the importance of screening for depression, referring people to appropriate services in a timely manner and optimizing symptom management to improve quality of life. Efforts to identify unmet need and minimize it through future assessments and changes in the availability of services and supports may help people with mental illnesses live more independently within their communities as many have expressed they would like to do.

**Functional Impairment**

The second hypothesis that a positive screen for depression is associated with functional impairment independent of demographic variables was supported by the full model in this study. Respondents with greater functional impairment were more likely to screen positive for depression. Likely reasons for this outcome include the characteristics of depression and the potential that exists for depression to result in disability through decreases in physical, cognitive and emotional functioning. Conversely, higher levels of functional impairment and disease have also been known to contribute to depression. Since there is sometimes a decline in functional reserve in people as they age, it is important to treat any reversible causes of disability. While this may not improve physical functioning, it has been known to improve role and emotional functioning and in so doing may decrease the need for certain LTC supports (Emptage et al., 2005; Johnson et al., 2007; U. S. Department of Health and Human Services, 2010).
Although aspects of depression, such as interest and motivation, impact quality of life and functional ability, the relationship between depression and functional impairment provides a backdrop for developing interventions targeting certain functional deficits in respondents who also screen positive for depression or vice versa. The high prevalence of depression among boomers and older adults with mental illnesses and its ability to often be successfully treated, suggests that universal screening may be warranted. There is also a need for interventions that include triaging, psychoeducation for clients and their families, and partnerships with various professionals who are willing to adapt and tailor responses to a system of care that supports people with mental illnesses who experience depression and who want to receive care in the community.

**LTC Service Use and Dissatisfaction with LTC**

A positive screen for depression in boomers and older adults with mental illnesses independent of demographic factors was not associated with LTC utilization or dissatisfaction with services and therefore neither the third nor fourth hypothesis was supported in the study. This finding was somewhat surprising in light of the results that unmet need was a significant predictor in the reduced model (Table 34). It is possible that results may be influenced by the smaller sample size when examining all four variables (Table 38). Although the last two predictors in this model did not significantly contribute to it, future research should explore the relationships between screening positive for depression, unmet need, LTC service use, and dissatisfaction with LTC services in a larger sample of people with mental illnesses to determine the predictive influence of these variables on depression.

**Comorbidity**

**Unmet Need**

The fifth hypothesis that comorbidity in boomers and older adults is associated with unmet need independent of demographic variables is not supported by the study in the full model. Given that the association between unmet need and comorbidity was significant
(p=.006) in the reduced model, future research should explore the association between comorbidity, unmet need and functional impairment in a larger sample to better determine the predictive impact of unmet need on the outcome of comorbidity.

*Functional Impairment*

The sixth hypothesis that functional impairment is associated with comorbidity independent of demographic factors is supported by the study. Comorbidity, or multiple chronic health problems, increase as people age and can lead to impairments in physical, mental, and social functioning. It is not surprising therefore that there is an association between functional impairment and comorbidity. In 2000, an estimated 125 million people had one or more chronic illnesses, and fifty million had a functional limitation; by 2020 it is projected that 157 million Americans will have one or more chronic conditions accounting for 80 percent of the health care spending (Wu & Green, 2000). Among the Medicare population, 83 percent of individuals have at least one chronic condition and 25 percent have at least five co-morbidities (Anderson, 2005). Comorbidity is not only associated with high health care utilization and expenditures and has been shown to be associated with risk of disability (Fried & Guralnik, 1997; Stuck et al., 1999), but it is not uncommon for people with comorbidity and disability to be the heaviest users of LTC.

It’s important to note that although comorbidity and disability are costly, they are the most preventable through screening, diagnosis, disability prevention and modification of health-damaging behaviors (Fried & Guralnik, 1997). A basic principle emerging from the scientific literature suggests the need to treat comorbid conditions concurrently (Quello, Brady, & Sonne, 2005; U. S. Department of Health and Human Services, 2010), but this can be a difficult proposition to implement for a number of reasons. A better approach to potentially diminish comorbidity might be found through screening, diagnosis, intervention, and treatment. Given that frailty is associated with comorbidity and functional impairment, especially in older adults, it may also have the potential for prevention when screening and interventions are implemented.
Although health status evolves as people age, there are opportunities to better coordinate care for people with mental illnesses and in so doing lessen the disparities among this population and also decrease the burden placed on the LTC system by people with comorbidity and functional impairments. Future research should explore standardized approaches to screening for comorbidity and functional impairment in an ongoing effort to develop interventions that would prevent onset and adverse outcomes for these conditions.

**Perceived Lack of Social Support**

**Unmet Need**

The seventh hypothesis that a perceived lack of social support is associated with unmet need for LTC services independent of demographic factors was supported in the study. Sample characteristics in this study demonstrate that slightly more boomers than older adults report unmet needs and about one-third reported being unable to get the services they need with the greatest percentage reporting cost of services as a reason for not being able to get the needed services. Future research should investigate the unmet needs of people with mental illnesses as well as their levels and sources of social support and consider ways to reduce any risk they might experience related to a lack of social support.

**Functional Impairment**

The eighth and final hypothesis that a perceived lack of social support among boomers and older adults with mental illnesses is associated with functional impairment independent of demographic factors was not supported in this study. Functional impairment is a chronic stressor that affects a person’s ability to interact with the environment in which he or she lives and is known to increase the risk for depression. The literature demonstrates a positive association between physical functional impairment and emotional distress. In the stress-buffering model (Kwok, Yeung, & Chung, 2011), stress interacts with social support in such a way that the effects of stress are lessened under conditions of stronger social support. It was
thought therefore that there would be an association between people with mental illnesses who perceive a lack of social support and functional impairment, but this was not the case.

**Additional Outcomes**

Other outcomes from the hypotheses testing are interesting and equally important. In the first set of analyses, exploring associations with depression, the full model (Table 38) shows that being unemployed is significant (p=.031). In the literature, unemployment is associated with poorer health outcomes, including risk of depression and need for LTC services (Ostrove et al., 1999). Being unemployed and having a lower socioeconomic status contributes to poorer health outcomes and disparities (Agency for Health Research and Quality, 2011). This particular outcome presents an opportunity for providers and policymakers to consider ways to increase consumer input regarding employment and to strengthen employment opportunities for disadvantaged populations through appropriate state programs, such as the Bureau of Rehabilitation Vocational Rehabilitation program.

Similarly, in the second set of analyses when examining associations related to comorbidity, Table 39 shows that in addition to unmet needs, lower levels of education in the reduced model is significant (p=.041). While correlations between education and other predictors may be influencing the outcomes, it should be noted that in the literature there is an established association between lower levels of education and risk of comorbidity (Ostrove et al., 1999). Since individuals with limited educational experiences are at greater risk for poorer health outcomes (Smedley, Stith, & Nelson 2003), providers and policymakers should consider how best to identify educational disparities and create an improved process to ensure better education for those in minority groups who suffer from mental illnesses and are at greatest risk for overall poorer outcomes.

In the third set of analyses, in the first reduced model including only unmet need (Tables 42), being a minority and unmarried are significant predictors of perceived lack of social support. In the second reduced model including only functional impairment (Table 43), being a boomer, a
minority, and unmarried significantly predict perceived lack of social support. In the full model (Table 44), being a minority and unmarried with unmet needs predicts perceived lack of social support. Research demonstrates that people in minority groups have less access to supportive resources (Luo & Waite, 2005; Ostrove et al., 1999), and that unmarried individuals experience less support from a paid provider (Agency for Healthcare Research and Quality, 2001; Johnson et al., 2007; Spillman & Pezzin, 2000).

It is well known that our healthcare system unevenly distributes services across populations and that these disparities are due to differences in access to care, provider biases, and limited provider-consumer communications and/or paucity in health literacy (Agency for Healthcare Research & Quality, 2011). It is important therefore that further research aim to include disadvantaged groups with mental illnesses in order to more clearly identify areas of perceived lack of social support. It will also be important to promote and strengthen existing networks of support that have the potential to alleviate the burden placed on the LTC system, as those without informal supports become more dependent on the formal LTC system.

**Potential Limitations of the Study**

Potential limitations for this study are defined as issues inherent in the type of research being conducted. While the cross-sectional design provides a useful snapshot of the outcome of interest for subgroups within a population, no definitive causal conclusions can be inferred from data gathered through this approach (Bland, 2001). This study also assessed people with LTC only living in Connecticut and did not include information related to individuals living in other states.

Further, secondary data were used. A major disadvantage of using this type of data is that it may not answer specific research questions or contain the information that the researcher would like to have. A related issue is that the variables used may have been defined or categorized differently than the researcher might have chosen. For example, in this study, the crucial identifier of a person with mental disability was self-reported “yes” or “no” on a single
question. Such self-report relied on interpretation of identifications made by others, and, in turn, that may have varied between boomers and older adults. While needs assessments rely on participants’ self-assessments and perceptions of needs, these might be subject to bias and in so doing impose an additional limitation on the outcomes. Although self-report is often viewed as a suitable methodology for studying human characteristics (Howard, 1994), there is concern in the literature about the construct validity of self-report measures (Harrison, McLaughlin, & Coalter, 1996), particularly that other influences besides content may cloud what exactly is being measured (Paulhaus, 1991). Additionally, an overarching issue is the credibility of self-assessments or reports and that these may be subject to different sources of inaccuracy.

As a result of drawing people from particular service programs, such as the waiver programs, sample biases (i.e., subject selection) may also be present in the data being used. Selection biases occur when the groups compared are different; these differences may influence the outcome and introduce a substantial source of skew (Hartman, Forsen, Wallace, & Neely, 2002). For example, in this study, individuals from six home and community-based Medicaid waivers were sampled from as were individuals not actively receiving services from the DMR waiting list. By definition, the inclusion of subjects from nonequivalent groups introduces selection bias.

Another limitation involving the sample is the size disparity between the boomer and older adults groups (80% and 20%, respectively). The sample for this study was drawn from the people with disabilities group in the overall sample (Robison, et al., 2007). After all exclusion criteria were met for this study, the number of boomers was far greater than that of older adults (299 and 75, respectively). This is not surprising since the sample from which the subsample was taken for this study had a greater response rate for boomers than older adults for the people with disabilities survey. Additionally, cultural considerations that distinguish boomers from older adults, such as literacy rates and values regarding the privacy of personal information, may influence older adult rates of survey participation (Quinn, 2010). While the size
disparity between the two groups should be taken into account for internal comparisons, it does not negate the value of the data or outcomes of the analyses.

The use of zip codes is a valuable strategy used in marketing research and service utilization studies, but oversampling at the zip code level is a limitation because it fails to identify people in nonminority zip codes that have high levels of minorities living in them. Likewise using voter registry and DMV records to randomly select boomers and older adults is a bias because it eliminates people with disabilities who may not have registered to vote or who may not have driver’s license.

While some of the limitations in this study prevent generalizing from the sample of interest to the population, there are still outcomes of interest that are useful to service providers and policymakers as they consider how best to meet the LTC needs of boomers and older adults with mental illnesses in Connecticut. For example, understanding the association between functional impairment, unmet need and screening positive for depression may have implications for LTC in helping identify people at risk for LTC services. Similarly, an awareness of the association between functional impairment, unmet need and comorbidity may lead to urgently needed research on strategies to diminish the impact of comorbidity and in so doing reduce the burden it places on the LTC system. While some have associated lack of social support with increases in health care utilization (Padgett & Brodsky, 1992), better understanding of the association between functional impairment, unmet need and perceived lack of social support may be useful to service providers in helping people identify and/or develop the affective and instrumental support of family and friends that is known to have a positive influence on helping people adapt to chronic illness (Reinhardt et al., 2003) and could reduce dependency on the LTC system of supports.

Conclusions

This study sought to provide a more complete understanding of LTC need and utilization among baby boomer and older adult respondents reporting mental illnesses in Connecticut.
within a larger political and economic framework. It is based on the assumptions that LTC services do not develop in an isolated manner, but within a broader structural reality and are influenced by economic, political, and sociocultural factors. This study contributes to the ongoing discourse on LTC reform and the importance of changing focus and funding priorities to home and community-based supports. Further, the outcomes of this study have implications for boomers and older adults with mental illnesses in Connecticut. For example, people with mental illnesses who also report greater functional impairment and unmet need may be more likely to screen positive for depression. Screening positive for depression, while not conclusive, is an indicator to help identify individuals at risk of LTC utilization. Identifying those at risk whether it be for depressive illnesses, comorbidity, or perceived lack of social support could diminish a greater need for LTC and alleviate the burden on Connecticut’s LTC resources, but it also has the potential to enable the targeted population of those with mental illnesses to live a better quality of life.

This study also contributes to the broader literature by disseminating knowledge about variations in LTC of people self-reporting mental illnesses into a wider public awareness and may help service providers and policymakers in other states think more strategically about how to address LTC need and utilization as an integral part of quality improvement efforts.
REFERENCES


APPENDICES

Appendix A: Legislation

Appendix B: Connecticut General Resident Survey

Appendix C: Connecticut Resident People with Disabilities Survey
Be it enacted by the Senate and House of Representatives in General Assembly convened:

Sec. 38. Section 1 of special act 02-7 is amended to read as follows (Effective July 1, 2006):

[The Office of Policy and Management shall conduct] The General Assembly, after consultation with the Commission on Aging, the Long-Term Care Advisory Council and the Long-Term Care Planning Committee, shall contract for a comprehensive needs assessment of the unmet long-term care needs in the state and project future demand for such services. Such assessment shall include, [a review of the Department of Mental Retardation's waiting list] but not be limited to, a review and evaluation of: (1) The number of persons presently at risk for having unmet long-term care needs, (2) the number of persons potentially at risk for having long-term care needs over the course of the next thirty years, (3) both costs and public and private resources available to meet long-term care needs, including the adequacy of current resources, projected costs and the projected resources needed to address long-term care needs over the next thirty years, (4) the existing array of services available to persons with long-term care needs, (5) existing and potential future models of public and private service delivery systems for persons with long-term care needs, (6) state government's programmatic structure in meeting the needs of persons requiring long-term care, (7) strategies that may assist families in making provisions for their own long-term care needs at reasonable costs, and (8) the service needs of the state's elderly population with long-term care needs with emphasis on healthcare, housing, transportation, nutrition, employment, prevention and recreation services. Such assessment shall also include recommendations on qualitative and quantitative changes that should be made to existing programs or service delivery systems, including recommendations on new programs or service delivery systems to better serve persons with long-term care needs.
Appendix B

Connecticut Resident General Survey
Shaping Our Future: A Survey of Connecticut’s Citizens

The State of Connecticut will make decisions about future programs and policies based on the responses to this survey! Please share your experiences and future plans.

ALL RESPONSES ARE CONFIDENTIAL AND ANONYMOUS.

Please check only one box per question, unless instructed to do otherwise.

Current and Future Plans

1. I am currently living in: (Check only one.)
   - My own house
   - My own apartment
   - Condominium/Townhouse
   - Senior housing complex
   - Assisted living facility
   - Retirement community (age 55+ only)
   - With my child in his/her home
   - With my parent/s in their home
   - Other _________________

2. If you were to remain in your present residence, what services do you think you might use as you grow older? Check all that you think might be helpful for you.
   - Home maintenance or handyman services
   - Homemaker services for shopping, cleaning, laundry, paying bills, etc.
   - Home health care for bathing or other personal care
   - Transportation
   - Meals delivered
   - Lawn care, snow shoveling, or taking garbage to the curb
   - Other ______________________

3. Do you think you will ever need long-term care, including care at home, assisted living, or nursing home care?
   - No
   - Yes
   - I already receive long-term care

4. If you needed long-term care in the future, who do you think will provide this care? Or, if you already receive long-term care, who provides this care? Check all that apply.
   - Spouse/partner
   - Adult child
   - Friend or neighbor
   - Home care agency
   - Assisted living staff
   - Nursing home staff
   - Other ______________________
   - I don't know
5. Do you currently have long-term care insurance for nursing home or home health care? This does **not** include life insurance, medical or other health insurance, Medicare, Medicaid or Title 19.
   - No
   - Yes
   - Not sure

6. As you grow older, how likely are you to move to, or live in, each of the following arrangements? Please check one box for each statement indicating if each one is very likely, somewhat likely, not at all likely, or if you have already made this change.

<table>
<thead>
<tr>
<th>Arrangement</th>
<th>Very likely</th>
<th>Somewhat likely</th>
<th>Not at all likely</th>
<th>Already made this change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remain in your own home without modifications</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Remain in your own home with some modifications to adjust for physical problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Remain in your own home with home health care or homemaker services provided at home</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sell your house and move to an apartment or condominium</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Live in senior housing – apartments for seniors and people with disabilities with no special services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Live in a retirement community that provides some meals, housekeeping, transportation, and social activities for age 55+ only</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Live in an assisted living facility that provides meals, housekeeping, transportation, and limited nursing care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Live in a nursing home</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Live in a continuing care retirement community that provides independent living units, assisted living, and nursing home care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Live with my adult child in his/her home</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
7. How do you plan to pay (or how do you currently pay) for any long-term care services? This can include care at home, assisted living, or nursing home care. Check all that apply.
- □ No plans or do not know
- □ Long-term care insurance
- □ My family will pay for it
- □ Private health insurance
- □ Savings or investments
- □ Medicare
- □ Sell my home
- □ Medicaid or Medicaid waiver
- □ Reverse mortgage
- □ Other __________________

8. If you or a family member needed long-term care for a 5 year period, how much could you afford to pay each year for this care?
- □ I could not afford to pay anything
- □ $25,000 - $49,999 each year
- □ Less than $10,000 each year
- □ $50,000 - $99,999 each year
- □ $10,000 - $24,999 each year
- □ $100,000 or more each year

9. If you were living by yourself and had to enter a nursing home, what do you think should happen with your home and other property once you could no longer pay for your care?
- □ I should sell all my property before getting government assistance
- □ I should be able to keep some of my property for my relatives, even if this means more tax money goes to pay for my care
- □ I’m not sure

Health

10. Overall, how would you rate your health during the past month?
- □ Excellent
- □ Fair
- □ Good
- □ Poor

11. During the past month, have you often been bothered by feeling down, depressed, or hopeless?
- □ No
- □ Yes

12. During the past month, have you often been bothered by little interest or pleasure in doing things?
- □ No
- □ Yes

13. Overall, how would you rate the quality of care given to you from all your doctors, nurses, and other health providers in the last 12 months?
- □ Excellent
- □ I did not see a doctor or other health provider in the last 12 months
- □ Good
- □ Fair
- □ Poor

14. Have you gained or lost at least 10 pounds without trying in the last 12 months?
- □ Yes, I gained at least 10 pounds
- □ No, my weight stayed the same
- □ Yes, I lost at least 10 pounds
- □ No, I lost or gained weight on purpose
15. A fall is when your body goes to the ground without being pushed. Did you fall in the last 12 months?
   ☐ No  ☐ Yes

16. Have you had any of the following health exams? Check all that you have had…

   In the past year:  In past two years:
   ☐ Blood pressure check  ☐ Bone density test
   ☐ Cholesterol screening  ☐ Mammogram
   ☐ Dental cleaning  ☐ Prostate exam
   ☐ Flu vaccine  ☐ Sigmoidoscopy or colonoscopy
   ☐ Pneumonia vaccine  ☐ Wellness check up

17. Have you had any problems with Medicare Part D – Medicare’s new prescription drug plan?
   ☐ I have never used it
   ☐ No
   ☐ Yes → If Yes, Please describe the difficulties you have experienced:

   ____________________________________________________________
18. Do you need help from another person for any of the following activities because of a disability or health problem? Check **one** box to show how much help you need with each activity: no help, a little help, a lot of help, or you cannot do the activity at all.

<table>
<thead>
<tr>
<th>Activity</th>
<th>No help</th>
<th>A little help</th>
<th>A lot of help</th>
<th>Cannot do it at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparing meals</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shopping for groceries</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doing routine household chores</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Managing money, including keeping track of bills</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doing laundry</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taking medications correctly</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Getting to places out of walking distance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Using the telephone</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taking a bath or shower</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Getting dressed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Getting in and out of a bed or chair</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Using the toilet</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintaining control of your bowel/bladder function</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Getting around inside the house</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

______________________________
19. Some people use assistive devices to help them at home or at work. Please mark one box for each statement to indicate if you do not need it, currently use it, or do need it but do not have the assistive device.

<table>
<thead>
<tr>
<th>Assistive Device</th>
<th>I do not need it</th>
<th>I currently use it</th>
<th>I do need it, but do not have it</th>
</tr>
</thead>
<tbody>
<tr>
<td>Building modifications (entrance ramps, expanded doorways, accessible space, etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Mobility aids (electric wheelchair, stair lift, etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Transportation aids (lift van, adaptive driving controls, etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Computer access aids (touch screens, keyless entry, voice to text software, etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Other</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

20. A disability is defined as a physical or mental impairment that substantially limits one or more major life activities, such as walking, self-care, thinking, or working. Please check No or Yes for each one to indicate if you have any of the following disabilities.

<table>
<thead>
<tr>
<th>Disability</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical disability or chronic illness disability that makes it difficult for you to walk, reach, lift, or carry</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Intellectual or cognitive disability, such as mental retardation, Alzheimer’s disease, or other severe thinking impairment</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Mental illness or psychiatric disability, such as schizophrenia or bipolar disorder</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Deafness or other severe hearing impairment</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Blindness or legal blindness</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

21. If you have a disability, what is your primary disability? _______________________

22. If you have a disability, how old were you when your disability started? _____ years
Employment and Transportation

23. Are you currently employed, volunteering, or going to school? Check all that apply.
- Work full time
- Homemaker
- Attend school full or part time
- Work part time
- Volunteer
- Unemployed
- Retired

24. If you are not currently working for pay, do you want to have a job?
- I am working for pay
- No
- Yes → If Yes, Are you actively job hunting at this time?  □ No  □ Yes

25. At what age do you plan to retire or work fewer than 20 hours a week?
- ______ age when I plan to retire or fewer than 20 hours/week
- I am already retired, working fewer than 20 hours/week, or not working

26. If you are not in school at this time, do you want to get more schooling or education?
- No
- Yes → If Yes, What education are you interested in? ____________________

27. What kinds of difficulties do you have in getting the transportation that you need? Check all that apply.
- I have no difficulties – the transportation I use is fine
- I have no car available to me or I do not drive
- A person is not always available to assist or to drive me
- It costs too much
- Public buses are not available or not dependable
- Dial-a-ride or other van service is not always available, not dependable, or too slow
- The van or bus will not take me to all the places I need to go
- Other ____________________

28. Do problems with transportation make it difficult for you to do any of the following? Check all that apply.
- Go to medical appointments
- Socialize or visit friends and family
- Shop or do errands
- Take part in community activities
- Go to work or get a job
- Other ____________________
**Community Long Term Care Services**

29. Long-term care services can be used when people need ongoing assistance because of age-related problems, serious injury, disabilities, or other difficulties. The following is a list of paid long-term care services which can help people live in the community. Please tell us if you **use or need** any of these services for yourself. Check one box for each service.

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Not using now and Do not need</th>
<th>Not using now but Do need</th>
<th>Using now and receiving Enough</th>
<th>Using now but Need more</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home health aide from an agency or personal care assistant (for bathing, dressing, daily living needs, etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Homemaker services from an agency (for laundry, shopping, cleaning, etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Visiting nurse (to change bandages, give injections, etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Home delivered meals (Meals-On-Wheels, etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Dial-a-ride or van service (transportation for shopping, medical appointments, etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Friendly visitor services (social visits from volunteers)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Care management (assessment, coordination, and monitoring of services by a social worker, nurse, etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Adult day program (activities and health services provided at care centers)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Handyman services (home maintenance, minor repairs)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Lawn or snow services (lawn care, snow removal)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
30. Are you able to get all the above long-term care services that you need?
   □ I do not need any services
   □ Yes
   □ No → If No, Why can’t you get the services you need?
     Check all that apply.
     □ Cannot afford services
     □ Services are not available in my area
     □ Cannot find someone to hire
     □ Services are unreliable or give poor care
     □ Services are not accessible for people with disabilities
     □ Services are not available in my language
     □ Do not know what services or help are available
     □ Other ___________________

31. How did you find out about the long-term care services you use?
   Check all that apply.
   □ I do not use any services
   □ Telephone directory
   □ Relatives, friends, or neighbors
   □ Television, radio, or newspaper
   □ Doctor, nurse, or other health provider
   □ Internet or on-line
   □ Social worker or care manager
   □ Infoline (211)
   □ State agency
   □ Senior center
   □ Support organization (e.g., Easter Seals, Alzheimer’s Association, etc.)
   □ School
   □ Other ___________________

32. How often do you have problems communicating with someone who provides long-term care services to you because they speak a different language or are from a different cultural background?
   □ Always
   □ Rarely
   □ I do not use any services
   □ Sometimes
   □ Never

33. Overall, how well do the long-term care services you receive meet your needs?
   □ I do not use any services
   □ Very well
   □ Somewhat well
   □ Not very well → Please describe your experiences:
     ________________________________________________

34. How likely is it that you will go to a senior center in the future?
   □ Not at all likely
   □ Somewhat likely
   □ Very likely
   □ I already go
35. There are different ways for people to arrange and manage their paid services. Managing your paid services can include finding someone, training them, deciding on a work schedule, and paying them. If you had a choice, how would you like to manage your paid services, including any you use now or might use in the future? Please check the one approach you would like best.

☐ You and an agency or provider talk about what services you want. The agency then decides on the services and schedule. The agency finds and arranges the services for you. The agency processes the paychecks and handles any tax forms or financial paperwork.

☐ Together with the agency or provider of your choice, you decide the services and schedule for the services you want. You and the agency work together to find and arrange these services. The agency processes the paychecks and handles any tax forms or financial paperwork.

☐ You make the decisions about, find, and arrange your own services without the help of an agency or provider. You can get advice and training to learn how to hire and fire, train, pay, and manage your workers. You process the paychecks and handle any tax forms or financial paperwork.

36. What additional services should Connecticut offer to older adults or people with disabilities?
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

Social Support

37. If you needed some extra help, could you count on any family or friends to help you with daily tasks like grocery shopping, cooking, or giving you a ride?
☐ No  ☐ Yes

38. Do you currently receive this type of extra help from family or friends at least once a week?
☐ No  ☐ Yes  ☐ I do not need this help

39. Can you count on anyone to provide you with emotional support, such as someone to talk over problems with or help you make a difficult decision?
☐ No  ☐ Yes
40. Who do you currently live with? Check all that apply.
   □ No one - I live alone        □ With a parent
   □ With a spouse or partner    □ With another relative
   □ With my child/ren under age 18 □ With a friend or roommate
   □ With my child/ren age 18 or over

41. Do you have any children who are living? Check all that apply.
   □ No, I do not have any living children
   □ Yes, at least one child age 17 or younger
   □ Yes, at least one child age 18 or older

42. Do any of these children live within 45 minutes of you (this includes those who live with you)?
   □ No          □ Yes          □ I do not have any living children

43. How many days per week, on average, do you leave home for any reason?
   □ Only for medical appointments   □ 4-6 days per week
   □ Less than one day per week     □ Every day
   □ 1-3 days per week

44. Is the number of days you leave home each week the right amount for you?
   □ Yes, I go out enough
   □ No, I want to go out more
   □ No, I want to go out less

**General Information**

45. What is the zip code or name of the town you live in? ________________

46. What is your age? _____

47. What is your gender? □ Male    □ Female

48. What is your marital status?
   □ Married        □ Separated      □ Never married
   □ Widowed        □ Divorced       □ Living together as though married

49. What language do you mainly speak at home?
   □ English        □ Polish        □ Other ________________
   □ Spanish        □ Russian

50. Which category best describes your race? Check only one.
   □ White or Caucasian
   □ Black, African-American, or Caribbean Black
   □ Asian, including Asian Indian, Chinese, Filipino, Korean, or other Asian
   □ American Indian or Alaska Native
   □ Other ____________________

51. Are you of Spanish, Latino, or Hispanic origin?
   □ No          □ Yes
52. What is the highest grade or year you finished in school?
☐ 8th grade or less
☐ Some college
☐ Some high school
☐ Two-year college degree
☐ High school diploma or GED
☐ Four-year college degree
☐ Technical school/community college
☐ Post graduate degree (masters/doctorate)

Financial

53. What category best describes your total monthly household income from all sources before taxes? Include income such as wages, salaries, Social Security, retirement benefits, veteran’s benefits, public assistance, investment income, or any other income.
☐ Less than $500 each month
☐ $4,000 - $4,999
☐ $500 - $999
☐ $5,000 - $6,999
☐ $1,000 - $1,999
☐ $7,000 - $8,999
☐ $2,000 - $2,999
☐ $9,000 - $12,499
☐ $3,000 - $3,999
☐ $12,500 or more each month

54. How many people are supported by this income (including you)? ______

55. What category best describes the total value of your assets? Do not include your home or your car. Assets include bank accounts, stocks, bonds, investment or business property, and the cash value of any life insurance.
☐ Less than $5,000
☐ $75,000 - $149,999
☐ $5,000 - $14,999
☐ $150,000 - $249,000
☐ $15,000 - $29,999
☐ $250,000 - $349,999
☐ $30,000 - $74,999
☐ $350,000 or more

56. Do you own your own home or condominium/townhouse?
☐ No
☐ Yes

57. If you needed some extra help financially, could you count on anyone to help you, that is, by paying any bills, housing costs, medical costs, or providing you with food or clothes?
☐ No
☐ Yes

58. In general, how do your finances usually work out at the end of the month? Do you find that you usually end up with… (Check only one.)
☐ Some money left over
☐ Just enough to make ends meet
☐ Not enough money to make ends meet
59. Were there any times in the past 12 months when you did not have enough money to:
(Check all that apply.)

- Pay rent, mortgage, or real estate taxes
- Pay utility bills (heat, electricity, phone)
- Own or repair a car
- Buy needed food
- Fill a prescription for medicine
- Obtain dental care
- Obtain eyeglasses or hearing aids
- Obtain other medical care
- Pay for home modifications to adjust for physical needs
- Pay for the assistive devices or technology that I need
- Pay more than the minimum balance due on a credit card
- Pay into a retirement account
- Pay for the care of a parent or child with disabilities
- I have always had enough money

Caregiving

60. Do you provide unpaid care and assistance for a relative or friend who lives in Connecticut because of old age, disabilities, or other problems?
- No → If No, Skip to question 72, page 12
- Yes → If Yes, Continue to question 61

61. How many relatives or friends do you provide this care for? Do not include children without disabilities.

_______ number of relative/s or friend/s you provide care for

62. Think of the person you provide the greatest amount of care for. Do not include children without disabilities. How is this person related to you? Check only one.

- Spouse or partner
- Child with disabilities under age 18
- Child with disabilities age 18 or older
- Parent
- Other relative – specify relationship: _______________
- Friend

63. How old is this person?

- Less than 18
- 18 - 59
- 60 - 64
- 65 - 84
- 85 - 99
- 100 or older

64. How close to you does this person live?

- Lives with me
- Lives in my town or a nearby community
- Lives more than 45 minutes away

65. Does this person have any memory problems?

- None
- Moderate
- Mild
- Severe
66. In the past year, how often have you missed work or used sick or vacation time to care for this person?

- [ ] I do not work
- [ ] None
- [ ] 1 - 5 days
- [ ] 6 - 10 days
- [ ] 11 days or more

67. The following is a list of paid long-term care services which can help people live in the community. Please tell us if the person you provide care for uses or needs any of these services. Check one box for each service.

<table>
<thead>
<tr>
<th>Service</th>
<th>Not using now and Does not need</th>
<th>Not using now but Does need</th>
<th>Using now and receiving Enough</th>
<th>Using now but Needs more</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home health aide from an agency or personal care assistant (for bathing, dressing, daily living needs, etc.)</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Homemaker services from an agency (for laundry, shopping, cleaning, etc.)</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Visiting nurse (to change bandages, give injections, etc.)</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Home delivered meals (Meals-On-Wheels)</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Dial-a-ride or van service (transportation for shopping, medical appointments, etc.)</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Care management (assessment, coordination, and monitoring of services by a social worker, nurse, etc.)</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Adult day program (activities and health services provided at care centers)</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Other</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>
68. Is this person able to get all the services that he/she needs?

☐ He/she does not need services
☐ Yes
☐ No → **If No**, Why can’t this person get the services that he/she needs? Check all that apply.
☐ Cannot afford services
☐ Services are not available in his/her area
☐ Cannot find someone to hire
☐ Services are unreliable or give poor care
☐ Services are not accessible for people with disabilities
☐ Services are not available in his/her language
☐ Do not know what services or help are available
☐ Other ________________

69. How often does this person have problems communicating with someone who provides care to him/her because they speak different languages or are from a different cultural background?

☐ Always  ☐ Rarely  ☐ I am the only caregiver
☐ Sometimes  ☐ Never

70. Please describe any other problems this person has experienced with his/her paid services.

__________________________________________

71. How did you find out about the services this person uses? Check all that apply.

☐ He/she does not use any services  ☐ Telephone directory
☐ Relatives, friends, or neighbors  ☐ Television, radio, or newspaper
☐ Doctor, nurse, or other health provider  ☐ Internet or on-line
☐ Social worker or care manager  ☐ Infoline (211)
☐ State agency  ☐ School
☐ Support organization (e.g., Easter Seals, Alzheimer’s Association, etc.)  ☐ Other ________________

72. Did anyone help you fill out this survey? Check all that apply.

☐ No, I filled it out myself  ☐ My adult child  ☐ My paid assistant or helper
☐ My spouse/partner  ☐ My parent  ☐ Other ________________
Thank you for taking the time to participate in this survey. Please mail your completed survey in the envelope provided, or mail to:

Martha Porter, University of Connecticut Health Center
263 Farmington Avenue, Building 7, Farmington, CT 06030-6147
Appendix C

Connecticut Resident People with Disabilities Survey
Shaping Our Future: A Survey of Connecticut’s Citizens

The State of Connecticut will make decisions about future programs and policies based on the responses to this survey! Please share your experiences and future plans.

ALL RESPONSES ARE CONFIDENTIAL AND ANONYMOUS.

Please check only one box per question, unless instructed to do otherwise.

Current and Future Plans

1. I am currently living in: (Check only one.)
   - □ My own house/condominium/townhouse
   - □ My own apartment
   - □ Supervised living apartment or program
   - □ Group home or community living arrangement
   - □ Transitional group home or halfway house
   - □ Community training home
   - □ Retirement community (age 55+ only)
   - □ With my parent/s in their home
   - □ With my child in his/her home
   - □ Housing complex for seniors or people with disabilities
   - □ Assisted living facility
   - □ Retirement community (age 55+)
   - □ Other ____________________

2. Who do you currently live with? Check all that apply.
   - □ No one – I live alone
   - □ With a spouse or partner
   - □ With a parent
   - □ With another relative
   - □ With a friend or roommate
   - □ With a live-in paid assistant
   - □ With my child/ren under age 18
   - □ With my child/ren age 18 or over
   - □ Other ____________________
3. If you were to remain in your present residence, what services do you think you might use as you grow older? Check all that you think might be helpful for you.
   - Home maintenance or handyman services
   - Homemaker services for shopping, cleaning, laundry, paying bills, etc.
   - Home health care for bathing or other personal care
   - Personal care assistance for daily living needs, paid for privately or with a waiver
   - Nursing care to give injections or provide other specialized medical treatments
   - Paid staff for monitoring or supervision only
   - Paid staff for recreation and social activities
   - Transportation
   - Meals delivered or made for you
   - Lawn care, snow shoveling, or taking garbage to the curb
   - Other ________________________

4. As you grow older, how likely are you to move to, or live in, each of the following arrangements? Please check one box for each statement indicating if each one is very likely, somewhat likely, not at all likely, or if you have already made this change.

<table>
<thead>
<tr>
<th></th>
<th>Very likely</th>
<th>Somewhat likely</th>
<th>Not at all likely</th>
<th>Already made this change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remain in your own home without modifications</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Remain in your own home with some modifications to adjust for physical problems</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Remain in your own home with home health care or homemaker services provided at home</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Sell your house and move to an apartment or condominium</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Live in senior housing – apartments for seniors and people with disabilities with no special services</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Live in housing for seniors or people with disabilities – apartments for seniors and people with disabilities with no special services</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Live in an assisted living facility that provides meals, housekeeping, transportation, and limited nursing care</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Live in a nursing home</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Live with my parent/s in their home</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Live with another relative in his/her home</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Other ________________________</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
5. Do you think you will ever need long-term care, including care at home, assisted living, or nursing home care?
   □ No
   □ Yes
   □ I already receive long-term care

6. If you needed long-term care in the future, who do you think will provide this care? Or, if you already receive long-term care, who provides this care? Check all that apply.
   □ Spouse/partner
   □ Adult child
   □ Parent
   □ Friend or neighbor
   □ Paid personal assistant
   □ Home care agency
   □ Group home staff
   □ Assisted living staff
   □ Nursing home staff
   □ Other service provider
   □ Other __________________
   □ I don't know

7. Do you currently have long-term care insurance for nursing home or home health care? This does not include life insurance, medical or other health insurance, Medicare, Medicaid or Title 19.
   □ No
   □ Yes
   □ Not sure

8. How do you plan to pay (or how do you currently pay) for any long-term care services? This can include care at home, assisted living, or nursing home care. Check all that apply.
   □ No plans or do not know
   □ Long-term care insurance
   □ My family will pay for it
   □ Private health insurance
   □ Savings or investments
   □ Medicare
   □ Sell my home
   □ Medicaid or Medicaid waiver
   □ Reverse mortgage
   □ Other __________________

9. If you or a family member needed long-term care for a 5 year period, how much could you afford to pay each year for this care?
   □ I could not afford to pay anything
   □ $25,000 - $49,999 each year
   □ Less than $10,000 each year
   □ $50,000 - $99,999 each year
   □ $10,000 - $24,999 each year
   □ $100,000 or more each year

10. If you were living by yourself and had to enter a nursing home, what do you think should happen with your home and other property once you could no longer pay for your care?
    □ I should sell all my property before getting government assistance
    □ I should be able to keep some of my property for my relatives, even if this means more tax money goes to pay for my care
    □ I'm not sure
Health

11. Overall, how would you rate your health during the past month?
   □ Excellent       □ Fair
   □ Good           □ Poor

12. During the past month, have you often been bothered by feeling down, depressed, or hopeless?
   □ No              □ Yes

13. During the past month, have you often been bothered by little interest or pleasure in doing things?
   □ No              □ Yes

14. During the past 12 months, how many times were you admitted as a patient in a hospital and stayed at least overnight?
   □ No visits       □ 3 – 5 times
   □ 1 or 2 times    □ 6 or more times

15. During the past 12 months, how many times did you use an emergency room at a hospital?
   □ No visits       □ 3 – 5 times
   □ 1 or 2 times    □ 6 or more times

16. During the past 12 months, how many times did you use any type of mental health, behavioral health, or substance abuse counseling or services?
   □ No visits       □ 3 – 5 times
   □ 1 or 2 times    □ 6 or more times

17. Overall, how would you rate the quality of care given to you from all your doctors, nurses, and other health providers in the last 12 months?
   □ Excellent       □ I did not see a doctor or other health provider in the last 12 months
   □ Good
   □ Fair
   □ Poor

18. Have you gained or lost at least 10 pounds without trying in the last 12 months?
   □ Yes, I gained at least 10 pounds □ No, my weight stayed the same
   □ Yes, I lost at least 10 pounds    □ No, I lost or gained weight on purpose

19. A fall is when your body goes to the ground without being pushed. Did you fall in the last 12 months?
   □ No              □ Yes

20. Do you smoke?
   □ No              □ Yes
21. Have you had any of the following health exams? Check all that you have had…

In the past year:

☐ Blood pressure check
☐ Cholesterol screening
☐ Dental cleaning
☐ Flu vaccine
☐ Pneumonia vaccine

In past two years:

☐ Bone density test
☐ Mammogram
☐ Prostate exam
☐ Sigmoidoscopy or colonoscopy
☐ Wellness check up

22. Have you had any problems with Medicare Part D – Medicare’s new prescription drug plan?

☐ I have never used it
☐ No
☐ Yes → If Yes, Please describe the difficulties you have experienced:

______________________________________________________________________________
23. Do you need help from another person for any of the following activities because of a disability or health problem? Check one box to show how much help you need with each activity: no help, a little help, a lot of help, or you cannot do the activity at all.

<table>
<thead>
<tr>
<th>Activity</th>
<th>No help</th>
<th>A little help</th>
<th>A lot of help</th>
<th>Cannot do it at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparing meals</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shopping for groceries</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doing routine household chores</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Managing money, including keeping track of bills</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doing laundry</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taking medications correctly</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Getting to places out of walking distance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Using the telephone</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taking a bath or shower</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Getting dressed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Getting in and out of a bed or chair</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Using the toilet</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintaining control of your bowel/bladder function</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Getting around inside the house</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

__________________________
24. A disability is defined as a physical or mental impairment that substantially limits one or more major life activities, such as walking, self-care, thinking, or working. Please check No or Yes for each one to indicate if you have any of the following disabilities.

<table>
<thead>
<tr>
<th>Disability Type</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical disability or chronic illness disability that makes it difficult for you to walk, reach, lift, or carry</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Intellectual or cognitive disability, such as mental retardation, Alzheimer’s disease, or other severe thinking impairment</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Mental illness or psychiatric disability, such as schizophrenia or bipolar disorder</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Deafness or other severe hearing impairment</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Blindness or legal blindness</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

25. If you have a disability, how old were you when your disability started? _____ years

26. What is your primary disability? _______________________

27. Some people use assistive devices to help them at home or at work. Please mark one box for each statement to indicate if you do not need it, currently use it, or do need it but do not have the assistive device.

<table>
<thead>
<tr>
<th>Device Type</th>
<th>I do not need it</th>
<th>I currently use it</th>
<th>I do need it, but do not have it</th>
</tr>
</thead>
<tbody>
<tr>
<td>Building modifications (entrance ramps, expanded doorways, accessible space, etc.)</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Mobility aids (electric wheelchair, stair lift, etc.)</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Transportation aids (lift van, adaptive driving controls, etc.)</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Computer access aids (touch screens, keyless entry, voice to text software, etc.)</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Communication aids (communication boards, voice activated telephone, etc.)</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Devices for people who are deaf (TDD, TTY, phone relay services, etc.)</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Other</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>
28. How physically accessible for you is your home, your workplace, or other places you want to go? Check one box for each to indicate how accessible each one is for you overall.

a. Your home or residence:
   - [ ] Totally
   - [ ] Somewhat
   - [ ] Not at all → Please explain: ______________________

b. Your place of work:
   - [ ] Totally
   - [ ] Somewhat
   - [ ] Not at all → Please explain: ______________________
   - [ ] I do not work

c. Where you want to shop or do errands:
   - [ ] Totally
   - [ ] Somewhat
   - [ ] Not at all → Please explain: ______________________

d. Any recreation or leisure activities you want to do in the community
   - [ ] Totally
   - [ ] Somewhat
   - [ ] Not at all → Please explain: ______________________
**Community Long Term Care Services**

29. Long-term care services can be used when people need ongoing assistance because of age-related problems, serious injury, disabilities, or other difficulties. The following is a list of paid long-term care services which can help people live in the community. Please tell us if you use or need any of these services for yourself. Check one box for each service.

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Not using now and Do not need</th>
<th>Not using now but Do need</th>
<th>Using now and receiving Enough</th>
<th>Using now but Need more</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home health aide from an agency or personal care assistant (for bathing, dressing, daily living needs, etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Homemaker services from an agency (for laundry, shopping, cleaning, etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Visiting nurse (to change bandages, give injections, etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Home delivered meals (Meals-On-Wheels, etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Dial-a-ride or van service (transportation for shopping, medical appointments, etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Friendly visitor services (social visits from volunteers)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Care management (assessment, coordination, and monitoring of services by a social worker, nurse, etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Adult day program (activities and health services provided at care centers)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Handyman services (home maintenance, minor repairs)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Lawn or snow services (lawn care, snow removal)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
30. Are you able to get all the above long-term care services that you need?
   □ I do not need any service
   □ Yes
   □ No → If No, Why can’t you get the services you need?
     Check all that apply.
     □ Cannot afford services
     □ Services are not available in my area
     □ Cannot find someone to hire
     □ Services are unreliable or give poor care
     □ Services are not accessible for people with disabilities
     □ Services are not available in my language
     □ Do not know what services or help are available
     □ Other ___________________

31. How did you find out about the long-term care services you use?
   Check all that apply.
   □ I do not use any services
   □ Telephone directory
   □ Relatives, friends, or neighbors
   □ Television, radio, or newspaper
   □ Doctor, nurse, or other health provider
   □ Internet or on-line
   □ Social worker or care manager
   □ Infoline (211)
   □ State agency
   □ Senior center
   □ Support organization (e.g., Easter Seals, Alzheimer’s Association, etc.)
   □ School
   □ Other ___________________

32. How often do you have problems communicating with someone who provides long-
    term care services to you because they speak a different language or are from a
different cultural background?
   □ Always
   □ Rarely
   □ I do not use any services
   □ Sometimes
   □ Never

33. Overall, how well do the long-term care services you receive meet your needs?
   □ I do not use any services
   □ Very well
   □ Somewhat well
   □ Not very well → Please describe your experiences:
      ___________________________________________________________

34. How likely is it that you will go to a senior center in the future?
   □ Not at all likely
   □ Somewhat likely
   □ Very likely
   □ I already go
35. There are different ways for people to arrange and manage their paid services. Managing your paid services can include finding someone, training them, deciding on a work schedule, and paying them. If you had a choice, how would you like to manage your paid services, including any you use now or might use in the future? Please check the one approach you would like best.

☐ You and an agency or provider talk about what services you want. The agency then decides on the services and schedule. The agency finds and arranges the services for you. The agency processes the paychecks and handles any tax forms or financial paperwork.

☐ Together with the agency or provider of your choice, you decide the services and schedule for the services you want. You and the agency work together to find and arrange these services. The agency processes the paychecks and handles any tax forms or financial paperwork.

☐ You make the decisions about, find, and arrange your own services without the help of an agency or provider. You can get advice and training to learn how to hire and fire, train, pay, and manage your workers. You process the paychecks and handle any tax forms or financial paperwork.

36. What additional services should Connecticut offer to older adults or people with disabilities?

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

Social Support

37. If you needed some extra help, could you count on any family or friends to help you with daily tasks like grocery shopping, cooking, or giving you a ride?

☐ No ☐ Yes

38. Do you currently receive this type of extra help from family or friends at least once a week?

☐ No ☐ Yes ☐ I do not need this help

39. Can you count on anyone to provide you with emotional support, such as someone to talk over problems with or help you make a difficult decision?

☐ No ☐ Yes
40. How often do you participate in any community activities or groups, such as a community center, social group, advocacy group, religious group, support group, sports group, or any other community group?
   □ Never or almost never  □ Once or twice a month
   □ Once or twice a year  □ Once a week or more
   □ Every few months

41. How many days per week, on average, do you leave home for any reason?
   □ Only for medical appointments  □ 4-6 days per week
   □ Less than one day per week  □ Every day
   □ 1-3 days per week

42. Is the number of days you leave home each week the right amount for you?
   □ Yes, I go out enough
   □ No, I want to go out more
   □ No, I want to go out less

43. What keeps you from going out more often? Check all that apply.
   □ Nothing, I go out as much as I want
   □ Health concerns
   □ Financial concerns
   □ Emotional concerns
   □ No person to assist me
   □ Accessibility issues
   □ Other ______________________

44. Do you provide any unpaid care and assistance for a relative or friend who lives in Connecticut because of old age, disabilities, or other problems?
   □ No  □ Yes

**Employment and Transportation**

45. Are you currently employed, volunteering, or going to school? Check all that apply.
   □ Work full time  □ Homemaker  □ Attend school full or part time
   □ Work part time  □ Volunteer  □ Unemployed
   □ Retired

46. If you are not currently working for pay, do you want to have a job?
   □ I am working for pay
   □ No
   □ Yes → If Yes, Are you actively job hunting at this time? □ No □ Yes

47. At what age do you plan to retire or work fewer than 20 hours a week?
   ____ age when I plan to retire or fewer than 20 hours/week
   □ I am already retired, working fewer than 20 hours/week, or not working

48. If you are not in school at this time, do you want to get more schooling or education?
   □ No
   □ Yes → If Yes, What education are you interested in? ______________________
49. How do you usually get to places out of walking distance? Check all that apply.
   □ Drive myself
   □ Get a ride from someone else (family member, friend, paid assistant)
   □ Public transportation, such as the bus or train
   □ Group home or day program van
   □ Dial-a-ride or other van service for people with disabilities
   □ Scooter or electric wheelchair
   □ Other __________________

50. What kinds of difficulties do you have in getting the transportation that you need? Check all that apply.
   □ I have no difficulties – the transportation I use is fine
   □ I have no car available to me or I do not drive
   □ A person is not always available to assist or to drive me
   □ It costs too much
   □ Public buses are not available or not dependable
   □ Dial-a-ride or other van service is not always available, not dependable, or too slow
   □ The van or bus will not take me to all the places I need to go
   □ Other __________________

51. Do problems with transportation make it difficult for you to do any of the following? Check all that apply.
   □ Go to medical appointments  □ Socialize or visit friends and family
   □ Shop or do errands  □ Take part in community activities
   □ Go to work or get a job  □ Other __________________

General Information

52. What is the zip code or name of the town you live in? ______________

53. What is your age? _____

54. What is your gender?  □ Male  □ Female

55. What is your marital status?
   □ Married  □ Separated  □ Never married
   □ Widowed  □ Divorced  □ Living together as though married

56. What language do you mainly speak at home?
   □ English  □ Polish  □ Other __________________
   □ Spanish  □ Russian

57. Which category best describes your race? Check only one.
   □ White or Caucasian
   □ Black, African-American, or Caribbean Black
   □ Asian, including Asian Indian, Chinese, Filipino, Korean, or other Asian
   □ American Indian or Alaska Native
   □ Other __________________________

168
Are you of Spanish, Latino, or Hispanic origin?
☐ No  ☐ Yes

What is the highest grade or year you finished in school?
☐ 8th grade or less  ☐ Some college
☐ Some high school  ☐ Two-year college degree
☐ High school diploma or GED  ☐ Four-year college degree
☐ Technical school/community college  ☐ Post graduate degree (masters/doctorate)

Financial

What category best describes your total monthly household income from all sources before taxes? Include income such as wages, salaries, Social Security, retirement benefits, veteran’s benefits, public assistance, investment income, or any other income.
☐ Less than $500 each month  ☐ $4,000 - $4,999
☐ $500 - $999  ☐ $5,000 - $6,999
☐ $1,000 - $1,999  ☐ $7,000 - $8,999
☐ $2,000 - $2,999  ☐ $9,000 - $12,499
☐ $3,000 - $3,999  ☐ $12,500 or more each month

How many people are supported by this income (including you)? ______

What category best describes the total value of your assets? Do not include your home or your car. Assets include bank accounts, stocks, bonds, investment or business property, and the cash value of any life insurance.
☐ Less than $5,000  ☐ $75,000 - $149,999
☐ $5,000 - $14,999  ☐ $150,000 - $249,000
☐ $15,000 - $29,999  ☐ $250,000 - $349,999
☐ $30,000 - $74,999  ☐ $350,000 or more

Do you own your own home or condominium/townhouse?
☐ No  ☐ Yes

If you needed some extra help financially, could you count on anyone to help you, that is, by paying any bills, housing costs, medical costs, or providing you with food or clothes?
☐ No  ☐ Yes

In general, how do your finances usually work out at the end of the month? Do you find that you usually end up with… (Check only one.)
☐ Some money left over
☐ Just enough to make ends meet
☐ Not enough money to make ends meet
66. Were there any times in the past 12 months when you did not have enough money to:
   (Check all that apply.)
   □ Pay rent, mortgage, or real estate taxes
   □ Pay utility bills (heat, electricity, phone)
   □ Own or repair a car
   □ Buy needed food
   □ Fill a prescription for medicine
   □ Obtain dental care
   □ Obtain eyeglasses or hearing aids
   □ Obtain other medical care
   □ Pay for home modifications to adjust for physical needs
   □ Pay for the assistive devices or technology that I need
   □ Pay more than the minimum balance due on a credit card
   □ Pay into a retirement account
   □ Pay for the care of a parent or child with disabilities
   □ I have always had enough money

67. Did anyone help you fill out this survey? Check all that apply.
   □ No, I filled it out myself  □ My adult child  □ My paid assistant or helper
   □ My spouse/partner  □ My parent  □ Other ______________________

68. Is there anything else you would like to add?

....................................................................................................................
....................................................................................................................
....................................................................................................................
....................................................................................................................
....................................................................................................................
....................................................................................................................
....................................................................................................................
....................................................................................................................
....................................................................................................................

Thank you for taking the time to participate in this survey.
Please mail your completed survey in the envelope provided, or
mail to:
Martha Porter, University of Connecticut Health Center
263 Farmington Avenue, Building 7, Farmington, CT 06030-6147