The Commission on
Women, Children, Seniors, Equity & Opportunity

CWCSEO

Connecticut General Assembly

REPORT TO THE CONNECTICUT GENERAL ASSEMBLY

OF THE

WORKING GROUP ON ALZHEIMER'S DISEASE AND DEMENTIA

PURSUANT TO

PUBLIC ACT 19-115: AN ACT CONCERNING ALZHEIMER'S DISEASE AND DEMENTIA TRAINING AND BEST PRACTICES

SUBMITTED: JANUARY 31, 2020

The Commission extends its special gratitude to Christy Kovel, Director of Public Policy at Alzheimer's Association Connecticut Chapter, for her guidance and leadership in the administration of this task force and preparation of this report.

Executive Summary and Prevalence

Alzheimer's disease is an irreversible, progressive brain disease that affects approximately 5.8 million Americans. Alzheimer's disease is a degenerative brain disease and the most common form of dementia. Dementia is not a specific disease. It's an overall term that describes a group of symptoms. It slowly destroys brain function, leading to cognitive decline (e.g., memory loss, language difficulty, poor executive function), behavioral and psychiatric disorders (e.g., depression, delusions, agitation), and declines in functional status (e.g., ability to engage in activities of daily living and self- care). It is one of the most feared diseases.

In Connecticut, it is estimated there are almost 80,000 individuals age 65 and older living with Alzheimer's disease or another dementia. Unless the disease can be effectively treated or prevented, the number will increase significantly in the next two decades. The greatest known risk factor for Alzheimer's is increasing age, but Alzheimer's is not a normal part of aging. While age increases risk, it is not a direct cause of Alzheimer's.

Most individuals with the disease are 65 and older. After age 65, the risk of Alzheimer's doubles every five years. After age 85, the risk reaches nearly one-third. Other risk factors include family history and genetics.

In more than 90 percent of people with Alzheimer's disease, symptoms do not appear until after age 60, and the incidence of the disease increases with age. The causes of Alzheimer's disease are not completely understood, but researchers believe they include a combination of genetic, environmental, and lifestyle factors. In rare cases, known as early or younger-onset, people develop symptoms in their 30s, 40s, or 50s. A significant number of people with Down syndrome develop dementia in their 50s.

Alzheimer's disease places enormous emotional, physical, and financial stress on individuals and their family members. Informal caregivers, such as family members and friends, provide the majority of care for people with Alzheimer's disease in the community. In Connecticut, family and friends provide an estimated $2.5 billion in unpaid care to individuals living with Alzheimer's and other dementias. The intensive support required for a person with Alzheimer's disease can negatively impact the caregiver's emotional and physical health. Informal caregivers often report symptoms of depression and anxiety and have poorer health outcomes than their peers who do not provide such care. Additionally, Connecticut's aging population and rebalancing initiatives toward home and community-based services will increase demand for paid direct care workers employed in community-based settings. Particularly, the demand for personal care attendants and home health aides is projected to increase substantially.

Dementia care costs are significant and are often a burden to families providing unpaid care. Caring for people with Alzheimer's disease also strains health and long-term care systems. For instance, individuals with the disease are hospitalized 2 to 3 times as often as people in the same age group who do not have the disease, and almost 70% of nursing home residents have a cognitive impairment. As the number grows, the disease will place a major strain on these care systems as well as on Medicare and Medicaid, major funders of this care.

A task force established in 2013 studied the care and services provided to persons diagnosed with Alzheimer's disease and dementia in the state. Based on the need to develop a state strategy to address and prepare for the escalating public health crisis, the findings and recommendations focused on strategies to increase public awareness, early detection and diagnosis of the disease, and addressing gaps in quality of care by building a capable workforce through dementia specific training. The recommendations also provided a guide to improve the quality of life for those affected by dementia and minimizing the associated public and private costs through better case management of the disease.

The 2013 State Task Force was cognizant of the establishment of the National Alzheimer's Project Act (NAPA) by President Obama in 2011 and the goals and objectives pursuant to this legislation as iterated in the first National Plan to Address Alzheimer's Disease released in 2012. The National Alzheimer's Project Act (NAPA) created an important opportunity to build upon and leverage HHS programs and other federal efforts to help change the trajectory of Alzheimer's disease and related dementias (AD/ADRD). The law calls for a National Plan for AD/ADRD with input from a public-private Advisory Council on Alzheimer's Research, Care and Services. The Advisory Council makes recommendations to HHS for priority actions to expand, coordinate, and condense programs in order to improve the health outcomes of people with AD/ADRD and reduce the financial burden of these conditions on those with the diseases, their families, and society. The National Plan to Address Alzheimer's Disease is updated yearly and progress reports can be found here.[1]

Nearly every state has published or is developing their own State Government Alzheimer's Disease Plan. The report generated from Special Act 13-11, An Act Establishing a Task Force to Study Alzheimer's Disease and Dementia, established a task force to study issues related Alzheimer's Disease and Dementia and the report has served as Connecticut's Alzheimer's Disease Plan.[2] Since the plan was initially released there has been progress made in legislation, new programs and advances in technology. It remains crucial to recognize the vital role varied professionals, local municipalities, and the private sector

[1] https://aspe.hhs.gov/report/national-plan-address-alzheimers-disease-2019-update
[2] https://act.alz.org/site/DocServer/AlzheimersTaskForceFINALREPORT.pdf?docID=28201

play in achieving the capacity to effectively respond and address the care and service needs of individuals and families affected by Alzheimer's and dementia.

Prevalence:

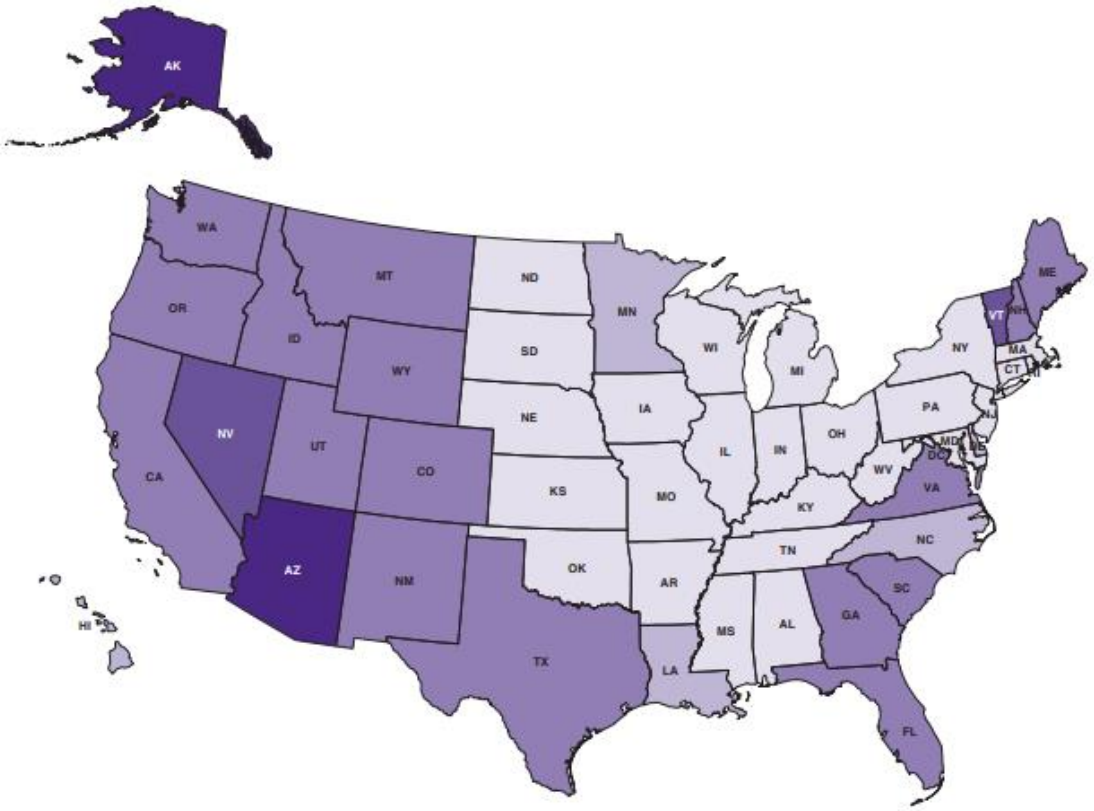
The number of Americans living with Alzheimer's is growing — and growing fast. An estimated 5.8 million Americans of all ages are living with Alzheimer's dementia in 2019. This number includes an estimated 5.6 million people age 65 and older and approximately 200,000 individuals under age 65 who have younger-onset Alzheimer's.

- One in 10 people age 65 and older (10 percent) has Alzheimer's dementia.
- Almost two-thirds of Americans with Alzheimer's are women.
- Older African-Americans are about twice as likely to have Alzheimer's or other dementias as older whites.
- Hispanics are about one and one-half times as likely to have Alzheimer's or other dementias as older whites.

As the number of older Americans grows rapidly, so too will the number of new and existing cases of Alzheimer's. By 2050, the number of people age 65 and older with Alzheimer's dementia may grow to a projected 13.8 million, barring the development of medical breakthroughs to prevent, slow or cure Alzheimer's disease. (Source: https://alz.org/alzheimers-dementia/facts-figures)

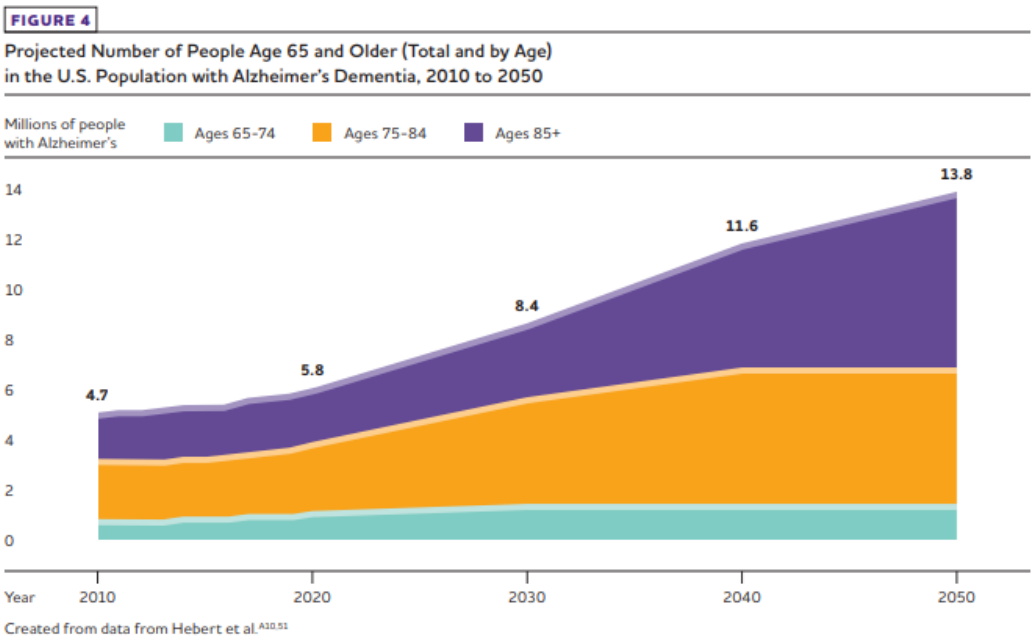
FIGURE 3

Projected Increases Between 2019 and 2025 in Alzheimer's Dementia Prevalence by State



Change from 2019 to 2025 for Washington, D.C.: 1.1%

Created from data provided to the Alzheimer's Association by Weuve et al.[A7:185]



Membership and Process Overview:

Per PA 19-115, the following individuals were appointed members to the Working Group:

Sec. 3. (Effective from passage) (a) The executive director of the Commission on Women, Children and Seniors shall convene a working group to review the recommendations of the task force established pursuant to section 1 of special act 13-11, determine gaps in implementation of the task force's recommendations and make recommendations concerning best practices for Alzheimer's disease and dementia care. (b) The working group shall be comprised of: (1) The executive director of the Commission on Women, Children and Seniors, or the executive director's designee, who shall be chairperson of the working group; (2) the executive director of the Connecticut chapter of the Alzheimer's Association, or the executive director's designee; (3) the Commissioner of Rehabilitation Services, or the commissioner's designee; (4) the executive director of the Connecticut chapter of the American Association of Retired Persons, or the executive director's designee; (5) the State Ombudsman, or the State Ombudsman's Substitute and (6) (A) a family representative of a person with Alzheimer's disease, (B) a family representative of a person with dementia, (C) a person diagnosed with Alzheimer's disease or dementia, and (D) a health care professional with expertise in the diagnosis and treatment of Alzheimer's disease and dementia, all appointed by the executive director of the Commission on Women, Children and Seniors. (c) The executive director of the Commission on Women, Children and Seniors shall make appointments and convene the working group not later than thirty days after the effective date of this section. Any vacancy shall be filled by said

executive director. (d) The administrative staff of the Commission on Women, Children and Seniors shall serve as the administrative staff of the working group.

Appointed Members:

- Steven Hernández, Executive Director, Commission on Women, Children and Seniors, Equity and Opportunity
- Christy Kovel, Director of Public Policy, Alzheimer's Association Connecticut Chapter
- Mairead Painter, State Long-Term Care Ombudsman
- Cynthia Resto, Department of Aging and Rehabilitation Services
- Vicki DePaolo- AARP Connecticut
- Dr. Kristina Dzanys UCONN Health
- Norm Schoeler, Caregiver
- Jim Taylor-Caregiver
- Geri Taylor-person diagnosed with Alzheimer's

Additional participation and input were provided by:

- LeadingAge CT-Mag Morelli, President
- LiveWell: Michael Smith, CEO, Stephani Shivers, COO-Community Services, Trish Bowen, COO-Residential Services and Anne Kenny, MD LiveWell Alliance/Resilient Living, PC
- Jewish Senior Services-Laura Snow Robinson, Program Director
- Alzheimer's Association volunteers, caregivers and persons living with the disease

The group met three times between September and December 2019.

September 18, 2019
October 31, 2019
December 3, 2019

Members focused on updating the Priority Recommendations in the 2013 report. Input was also obtained from additional stakeholders throughout the state.

Priority Recommendations: (updated)

1. **Promote public awareness and best practices in diagnosing Alzheimer's and dementia to connect those with Alzheimer's and their caregivers to available resources.**

    - Create a public/community awareness campaign through partnerships, including, but not limited to, the Alzheimer's Association, AARP, State Department on Aging, Area Agencies on Aging, faith-based and immigrant communities,

business/corporate associations, chambers of commerce, medical community and professional/trade associations to increase community and family awareness of resources, including the Alzheimer's Association Help Line and 211.

- Ensure coordinated messaging from all agencies addressing stigma with diagnosis, 10 Warning signs, resources and early stage programming. Branch out into networks for better reach), addressing stigma for those who are living with AD.

- Quality of care versus Quality of Life. Focus on engaging persons living with dementia and their care partners with supportive services.

- Disseminate informational packets to be distributed at doctors' offices, pharmacies, senior centers and other locations for individuals diagnosed with Alzheimer's disease and caregivers. Much of this information is available through the Alzheimer's Association.

    - Assess where and when this information goes out. Consider creating one standard packet to ensure consistency of provided information. Determine who else provides dementia care that should receive these packets.

2. **Promote Medicare Annual Wellness visits which include a cognitive impairment assessment for early detection and diagnosis, which is often not conducted in the visit.**

    - Currently this is only happening when requested. Encourage all seniors to request assessment in advance of their appointment.

    - Work with insurers and other organizations that may encounter persons living with dementia to support promotion about the importance of annual cognitive testing and the need for seniors to REQUEST the test prior to appointment.

3. **Develop a bank or other financial institution reporting project that includes reporting training programs.**

    - Cognitive impairment poses the most significant risk for exploitation. Bank or other financial institution personnel may be in a unique position to detect financial exploitation of older adults and individuals with dementia. Employees should be trained about potential red flags that indicate suspicious activity.

- Potential red flags include: Recent changes to a person's will, misuse of Power of Attorneys, unusually high levels of activity or out-of-state charges. Banks should have immunity after reporting and addressing suspicious activity.[3]

4. **Increase support for informal caregivers who provide care for persons with dementia.**

   - Develop an affordable "train the trainer" dementia course based on the existing Alzheimer's Association caregiver support group leaders' training.

   - Develop a model similar to the American Red Cross' CPR training program, whereby trained educators could then offer accessible and affordable dementia education to caregivers or others in the community.

5. **Support and enhance rebalancing initiatives that focus on diversion of individuals with dementia who are at risk of nursing home placement to community-based settings.**

   - Increase funding to expand the CT Statewide Respite Care Program to reflect the growing demand. **(Fiscal impact)**

   - Expand and set aside slots for individuals with younger onset Alzheimer's disease in the Connecticut Home Care Program for the Disabled. **(Fiscal impact)**

   - Adult Day Care represents an option that prevents isolation and can delay or completely divert individuals from nursing facilities. Due to limited and diminishing reimbursements, several of Connecticut's Adult Day Centers are reducing services or closing. Ensure Adult Day Centers remain a viable community care option by increasing the current reimbursement level to meet operating costs based on level of care provided (e.g. medical model requires nurses, aides and medication/health monitoring). Daily rate should include transportation costs. Reimbursements should be adjusted annually to reflect Cost of Living Adjustments. **(Fiscal impact)**

6. **To minimize family disputes, ensure that the wishes of the individual are known and respected, and avoid costly court proceedings, encourage**

[3] Laura Snow Robinson from Jewish Senior Services has been a lead in the Bank Project training and financial exploitation work. Please see attached documents from Coalition for Elderjustice in CT. Additionally, the Commission on Women, Children Seniors Equity and Opportunity has a portal per https://wp.cga.ct.gov/cwcseo/seniors-home/seniors-financial-abuse/ as a training module for financial personnel.

financial planning (including assessment of assets) and advanced directives with the help of an attorney with specific knowledge in elder, probate or estate law.

- The Alzheimer's Association encourages legal and financial planning. Community education classes are offered as well as online learning opportunities.[4]

7. **Ensure coordination and connection to support services after diagnosis including: a checklist of next steps, identification of a care coordinator, and use of an integrated care model.**

    - Assess other models of integrated care and how they are being accessed.

    - Explore federal funding for research and demonstrations to achieve this goal. The 2010 Affordable Care Act is providing for time-limited innovation and demonstration projects that could result in new information about the cost-effectiveness of Alzheimer's and dementia treatments and care practices centered around care coordination and transitional care models.

    - Support CT's existing initiatives such as the State Innovation Model (SIM) and Medicare and Medicaid Enrollees Care Coordination Demonstration and encourage focused efforts on individuals with dementia.

8. **Study the financial impact of developing a Dementia Centers for Excellence (COE) or geriatric assessment units (GAU) at CT hospitals.[5]**

9. **The Departments of Social Services and Public Health should update the Interagency Referral Form (W10) to include a person-centered dementia care profile for pain management, wandering history, safety issues and behavioral triggers and reactions, or reflect other dementia care vulnerabilities and history. The form should be used across the continuum of care providers.**

    - The Department of Social Services developed the Interagency Referral Form (W10) to serve as physicians' orders for diagnoses, medications, treatments, recent immunizations, and allergies, as well as demographic information.

    - The one-page form or an electronic version of the form developed by the facility is

[4] https://training.alz.org/products/1017/legal-and-financial-planning-for-alzheimers-disease?_ga=2.113673923.592219189.1580400213-1409631794.1525896933

[5] Please see attached report from Dr. Kristina Dzanys.

used by hospitals, nursing facilities and home care agencies to communicate essential care information for patient well-being.

10. Increase and improve upon Alzheimer's and dementia training requirements for health care professionals and facilities serving individuals with Alzheimer's disease and dementia in Connecticut.

- Currently only "special care units" require dementia-specific training for staff. Connecticut's aging population and rebalancing initiatives towards home and community-based services will increase demand for direct care workers employed in community-based settings such as home health aides, homemakers and companions and personal care assistants. **(Since 2013, additional legislation has been passed. See Dementia Training CT Statutes Document for updated information).**

11. Increase connectivity and training opportunities for the home and community based direct care workforce by utilizing emerging high-tech training and education models.[6]

12. Integrate and continue basic level of dementia training and education for public safety responders, long-term care ombudsman, protective service employees, probate judges and court personnel. Expand annual missing persons police force training to include dementia education (see CGS § 7-294o).[7]

13. Expand upon current law to require mandatory dementia-specific training for hospital emergency room staff, including nurses, physicians and medical technicians. Build upon the existing collaboration between the Alzheimer's Association- CT Chapter and the CT Hospital Association.[8]

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[6] For Family Caregivers, an example of a new model of care called E-Livlihood may be found at https://www.elivelihood.com/elder-care/ (based in Colorado). Modules include:

- Opportunities for socialization
- Storage of documents
- Financial protections
- Health monitoring system
- Remote cognitive assessment
- Other technological advances

Please note the appended fact sheet on training of direct care workforce from the Alzheimer's Association.

[7] See appended Dementia Training CT Statutes Document for updated information.

[8] Note that pursuant to Conn. Gen. Stat. § 19a-490u (effective October 1, 2015), hospitals must train direct care staff on dementia.

"Sec. 19a-490u. Training in symptoms of dementia for hospital direct care staff.

14. **Encourage Alzheimer's and Dementia clinical trial participation. Today less than 1% of those living with the disease are participating in trials. We won't be able to find a cure unless this bottleneck is overcome. We have several outstanding research and trial sites in the state; also, patient care is improved when with clinical trial participation.**

15. **Improve dementia coordination efforts at the state level by establishing a permanent Alzheimer's and Dementia Working Group, led by a State Dementia Services Coordinator. Other states have implemented this model within state government to oversee the implementation and updating of the State Alzheimer's Disease Plan by evaluating existing programs and services. This is to streamline efforts and prevent duplication by identifying service gaps within state government.**

****Please find specific documents prepared by members as attachments to this report****

On or after October 1, 2015, each hospital, as defined in section 19a-490, shall be required to include training in the symptoms of dementia as part of regularly provided training to staff members who provide direct care to patients."

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Medicare Annual Wellness Visit

Under the Affordable Care Act, Medicare pays for an Annual Wellness Visit, which includes the creation of a personalized prevention plan and detection of possible cognitive impairment. This benefit began on January 1, 2011.

What is an Annual Wellness Visit?

While Medicare does not cover a routine physical exam, an Annual Wellness Visit (AWV) contains elements that are similar to a check-up or physical.

Who is eligible?

Any Medicare beneficiary who:

- Has been receiving Medicare Part B benefits for at least 12 months, and
- Has not had an initial preventive physical examination (the "Welcome to Medicare" exam) or an AWV within the past 12 months.

How often will Medicare pay for an Annual Wellness Visit?

Medicare will pay for an Annual Wellness Visit once every 12 months.

Are there any deductibles or co-payments for the visit?

No. The Medicare Part B deductible and coinsurance payments do not apply to the AWV.

Detection of cognitive impairment is included in the Annual Wellness Visit. What does that mean?

During the exam, the doctor will assess an individual's cognitive function by direct observation, with due consideration of information obtained by way of patient report, concerns raised by family members, friends, caretakers, or others.

What else is included in the Annual Wellness Visit?

Prior to or during your appointment, you will be asked by your doctor or health professional to complete some questions about your health. This is called a Health Risk Assessment (HRA). The answers may provide important information to discuss with your health professional during the Annual Wellness Visit. The doctor (or health professional) may check to make sure the heart, lungs, and other body systems are working properly. The doctor will probably ask questions about your daily routine, medical history, memory, as well as take certain routine measurements like height, weight, and blood pressure. Find a complete list of what is covered on the back of this sheet.

Who can perform an Annual Wellness Visit?

An Annual Wellness Visit may be performed by a doctor or other practitioner recognized by Medicare, such as a nurse practitioner, physician assistant, clinical nurse specialist, or other health professional (including a health educator, a registered dietitian or nutrition professional), or a team of such medical professionals who are working under the direct supervision of a physician.

What should you bring to the visit?

You should bring your completed Health Risk Assessment, and a complete list of your medications (including vitamins and over-the-counter drugs) or all your medication bottles for the doctor to review. You should also bring a list of your top two to three concerns or questions for the doctor. If you have concerns about your memory or a chronic health condition (such as diabetes, heart disease, or depression), you might consider bringing a family member or friend with you to the appointment.

With the talk of repealing the Affordable Care Act, will the Annual Wellness Visit be repealed?

It is highly unlikely. None of the proposals to repeal the Affordable Care Act (ACA) under consideration in Congress would change or repeal the Medicare provisions included in the ACA.

Included in the Annual Wellness Visit:

- Review and update medical and family history
- Review and update a list of current providers
- Measure height, weight, body mass index (BMI), blood pressure, and other routine measurements
- Assess for any possible cognitive impairment
- Review potential risk factors for depression, including current or past experiences with depression or other mood disorders (first Annual Wellness Visit only)
- Review functional ability and level of safety (first Annual Wellness Visit only)
- Establish or update a written screening schedule for the individual for the next 5-10 years, based on health status, screening history, and age
- Prepare a list of risk factors and conditions for which interventions are recommended or are underway for the individual, and a list of treatment options and their associated risks and benefits
- Provide health advice and a referral, as appropriate, to health education or preventive counseling services or programs, designed to reduce risk factors, such as for weight loss, smoking cessation, fall prevention, and nutrition.
- Review of the responses to the Health Risk Assessment

COALITION FOR ELDER JUSTICE IN CONNECTICUT

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REVIEW SHEET

Dementia and Financial Management Risk

What Financial Institutions Should Know

Alzheimer's disease (AD) and other forms of dementia cause progressive, largely irreversible, declines in cognition that lead to a complete loss of functional capacities. Such declines may pose enormous financial risks to older adults who are newly diagnosed or currently experiencing dementia. This review sheet will provide insight and a brief overview of the impact dementia has on older adults diagnosed with dementia and their ability to manage their finances.

DEMENTIA STATS

4 Important facts about dementia worldwide

1. Approximately 45 million people worldwide suffer from dementia
2. Worldwide, a new case of dementia is diagnosed every 4 seconds (7.7 million new cases each year)
3. Women over 65 are almost two times more likely to develop dementia than men over 65
4. By 2050, dementia is expected to affect 135 million people globally

In 2014, 13 % of Connecticut's senior population had some form of dementia. By 2050, this number is expected to rise by 25%

DEMENTIA FACTS

10 Early signs and symptoms of dementia

1. Memory loss that disrupts daily life
2. Challenges in planning or solving problems
3. Difficulty completing familiar tasks at home, at work or at leisure
4. Confusion with time or place
5. Trouble understanding visual images and spatial relationships
6. New problems with words in speaking or writing
7. Misplacing things and losing the ability to retrace steps
8. Decrease in poor judgement
9. Withdrawal from work or social activities
10. Changes in mood and personality

Alzheimer's disease is the most common form of dementia. It accounts for nearly 60-90% of all dementia cases

FINANCIAL MANAGEMENT

3 Key issues related to dementia and functional capacity in financial management

1. Studies have shown that older adults with mild to moderate cases of dementia have significantly impaired financial abilities, even though their basic calculation skills may still be intact.
2. When asked to self-assess their ability to pay bills, researchers found that older adults with dementia rate themselves significantly higher than there performance warrants.
3. Older adults with mild cognitive impairment and dementia are often NOT fully aware of their deteriorating financial skills.

A 2009 study revealed that close to 50% of older adults with dementia experience some kind of elder abuse.

Developed by CEJC Banking Action Team

For more information contact Center for Elder Abuse Prevention at Jewish Senior Services,
elderabuseprevention@jseniors.org or call (203) 396-1097

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Dementia-Capable Workforce

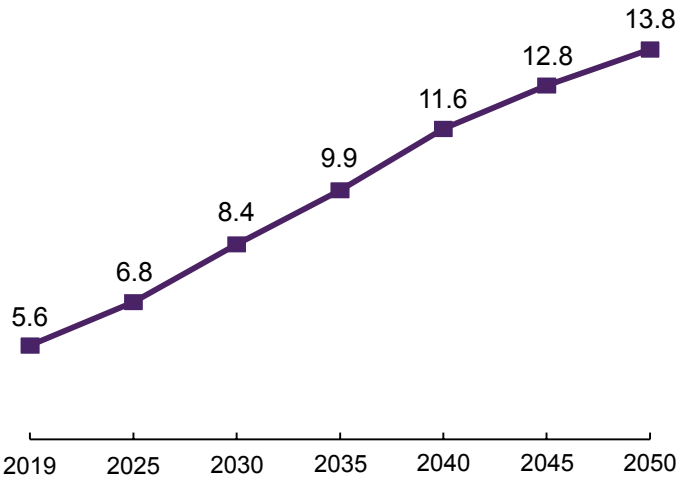
The older American population is rapidly increasing—and so will the number of people with Alzheimer's.

- By 2030, there will be a projected 74 million Americans aged 65 and older. They will make up more than 20 percent of the total U.S. population.
- In 2050, the oldest-old (those aged 85 and older) will comprise an estimated 22 percent of the 65+ population. Compared with 2012, this represents an additional 12 million oldest-old Americans.
- In 2019, an estimated 5.8 million Americans—5.6 million aged 65 and older—are living with Alzheimer's. That number is projected to reach 8.4 million in 2030 and nearly 14 million in 2050.

Despite the growing older population, few physicians specialize in geriatrics.

- Because of the extra years of training required and relatively low reimbursement rates, only a small percentage of health care professionals specialize in geriatrics. In fact, an additional year of geriatric training can actually reduce earnings power.
- In 2019, 49 percent of geriatric fellowship positions went unfilled.
- An overall lack of exposure to geriatrics during medical training means that most physicians will enter the workforce with little exposure to the needs of older adults.

Millions of Americans Age 65 and Older with Alzheimer's



The consequence is a physician workforce that is insufficient to meet the needs of today's older population. And that shortage will only get worse.

- The United States has approximately half the number of certified geriatricians it currently needs, and between now and 2030, the American Geriatrics Society estimates that nearly 25,000 more geriatricians will be needed.
- In 2017, 20 states were deemed "neurology deserts" due to a shortage of neurologists. Estimates indicate that the United States will need 19 percent more neurologists just by 2025 in order to meet increasing demand.

Non-physician health care providers also rarely have specialized expertise in treating older Americans.

- Fewer than one percent of registered nurses, physician assistants (PAs), and pharmacists specialize in geriatrics.
- Nine percent of nurse practitioners have special expertise in gerontological care, and only four percent of them have expertise in geriatric care with a primary care focus.
- Even though nearly three-quarters of social workers serve adults aged 55 and older, only four percent of them have formal geriatrics certifications.

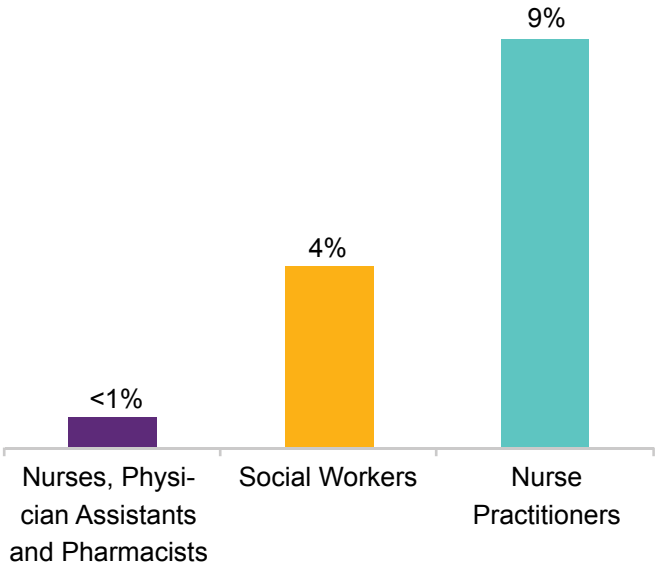
The workforce shortage also includes direct care workers—those who support individuals with daily activities and who are critical in maintaining the quality of life for people with dementia.

- High turnover, low pay, poor working conditions, and few opportunities for advancement make filling direct care positions difficult.
- By 2030, 3.4 million more direct care workers will be needed—a 48 percent increase from 2015.

What Can States Do?

- Incorporate dementia and geriatrics into workforce policies and commissions.
- Support financial incentives—such as loan forgiveness and grant programs—to encourage students and recent graduates to enter neurological and geriatric specialties.
- Develop career growth opportunities and educational assistance for direct care workers that would enhance the education pipeline, improve recruitment and retention, and maximize the existing workforce.

Percentage of Professionals Specializing in Geriatrics by Occupation



These shortages will have a profound impact on individuals with Alzheimer's and other dementias.

- A recent study showed that if a disease-modifying treatment were to become available in 2020, individuals with dementia would need to wait an average of 19 months in order to receive treatment.
- This study also concluded that between 2020 and 2040, approximately 2.1 million individuals with mild cognitive impairment will develop Alzheimer's while on waiting lists for treatment.
- The main cause of this tremendous backlog would be the limited number of specialists in the healthcare workforce.
- In addition, shortages in direct care workers will place an even bigger burden on family and friends who provide unpaid care—already an effort equivalent to nearly $234 billion per year.

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Dementia Training for Direct Care Workers

Those with Alzheimer's are high users of long-term care services.

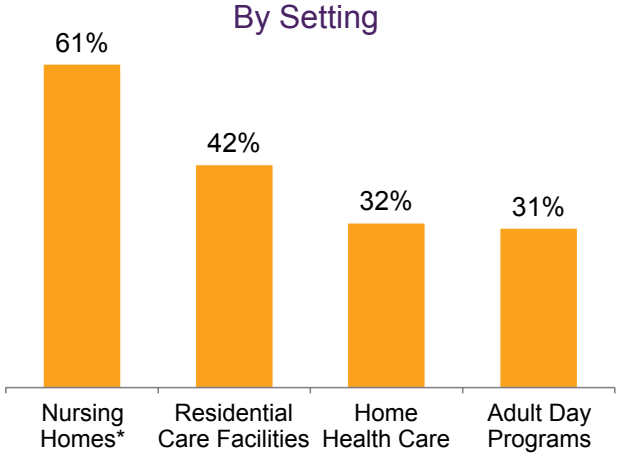
- At the age of 80, 75 percent of people with Alzheimer's are expected to be admitted to a nursing home, compared with just 4 percent of the general population.
- People living with Alzheimer's are nearly four times as likely to need skilled nursing facility care and over twice as likely to require home health care as individuals without the condition.
- More than 60 percent of seniors living in a nursing home have moderate or severe cognitive impairment. Among those in residential care settings, 42 percent have Alzheimer's or another dementia.

Individuals with Alzheimer's have needs that often make care delivery challenging and more demanding.

- More than 95 percent of individuals with dementia have at least one other chronic condition. Caring for someone with multiple chronic conditions—especially when that includes dementia—significantly complicates the care needed.
- As the disease progresses, individuals are unable to complete activities of daily living (such as eating, dressing, and bathing) without assistance.
- Over time, people with Alzheimer's will lose the ability to use words and may communicate their needs through behavior, which presents added challenges for care workers.

Percent of Individuals with Alzheimer's

By Setting



**Percentage with moderate or severe cognitive impairment*

What Can States Do?

- Require a minimum of six to eight hours of evidence-based dementia training for all those who serve individuals with dementia.
- Ensure continuing education to reinforce best practices in the care of those with dementia.
- Implement a culturally-competent curriculum that incorporates principles of person-centered care.
- Allow portability of completed dementia care training across employment settings.
- Ensure trainers meet minimum requirements to qualify as instructors of a dementia curriculum.
- Designate a state agency to monitor dementia training programs, evaluate their effectiveness, and ensure compliance with state dementia training requirements.

Care workers often do not have sufficient dementia-specific knowledge to effectively support those with Alzheimer's and other dementias.

- Certified nursing assistants and home health aides receive at least 75 hours of required training. But, Alzheimer's and dementia care is only one of 40 required topics that must be covered in this time frame.
- While reviews have shown that staff training programs to improve the quality of dementia care in nursing homes have positive benefits, staff are unlikely to receive adequate dementia training.
- Training that is provided often does not cover the skills and competencies that will equip workers to appropriately care for those with a significant cognitive impairment.
- Even in states with dementia-specific training requirements, many of those policies are out of date, cover only a subset of workers, lack competency standards, and have inadequate enforcement mechanisms.

Dementia training of those involved in the delivery of care can improve the quality of care and experiences for individuals with Alzheimer's and other dementias.

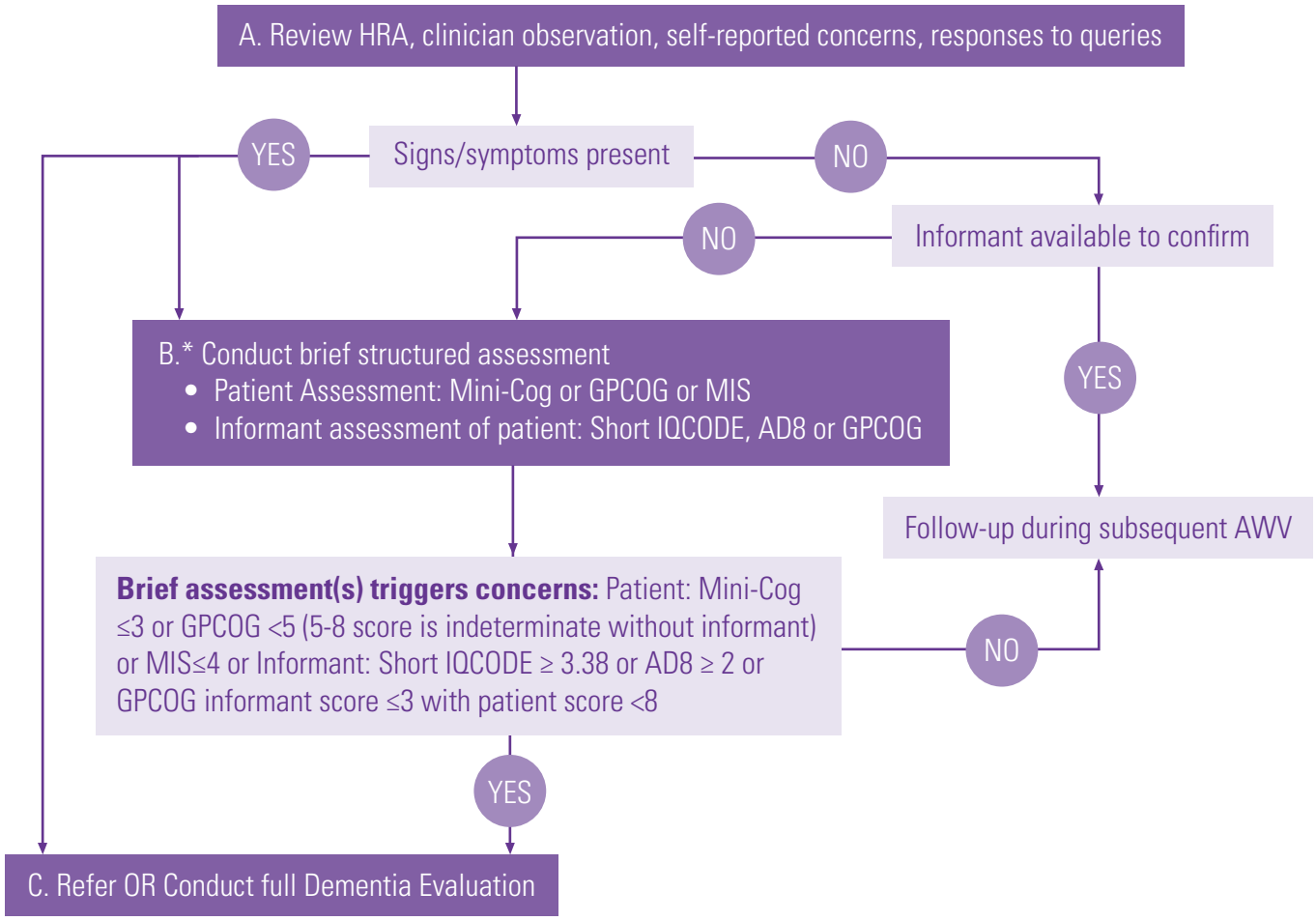
- A cornerstone of providing quality dementia care is to ensure that all professional care staff involved in the delivery of care to people with dementia receive dementia-specific training.
- Dementia training should ensure that care workers have the ability to:
    - Provide person-centered dementia care
    - Communicate with individuals with Alzheimer's
    - Address behavioral symptoms, including alternatives to physical and chemical restraints
    - Address specific aspects of safety, such as wandering.
- Periodic continuing education is also needed to ensure that care workers have the latest information on best practices in the care of those with dementia.

Direct Care Workers: Who Should Receive Training?

Direct Service Staff	An employee whose work involves extensive contact with participants or residents. These staff members may have different titles and may include registered nurses, licensed practical nurses, licensed vocational nurses, nurse practitioners, certified nurse aides, nursing assistants, physician assistants, home health or personal care aides, activities directors, feeding assistants, social workers, dietary staff, respite care providers, adult day care providers, and all occupational, physical, and speech therapy staff.
Administrative Staff	A senior manager of a facility or program, including administrators and managerial staff that supervise direct service staff.
Additional Staff	Those who have incidental contact with residents or program participants on a recurring basis. That includes people include housekeeping, front desk, maintenance, or other administrative staff, as well as other individuals who have such incidental contact.

ALZHEIMER'S ASSOCIATION®

Medicare Annual Wellness Visit Algorithm for Assessment of Cognition



* No one tool is recognized as the best brief assessment to determine if a full dementia evaluation is needed. Some providers repeat patient assessment with an alternate tool (e.g., SLUMS, or MoCA) to confirm initial findings before referral or initiation of full dementia evaluation.

AD8 = Eight-item Informant Interview to Differentiate Aging and Dementia; **AWV =** Annual Wellness Visit; **GPCOG =** General Practitioner Assessment of Cognition; **HRA =** Health Risk Assessment; **MIS =** Memory Impairment Screen; **MMSE =** Mini Mental Status Exam; **MoCA =** Montreal Cognitive Assessment; **SLUMS =** St. Louis University Mental Status Exam; **Short IQCODE =** Short Informant Questionnaire on Cognitive Decline in the Elderly

Cordell CB, Borson S, Boustani M, Chodosh J, Reuben D, Verghese J, et al. Alzheimer's Association recommendations for operationalizing the detection of cognitive impairment during the Medicare Annual Wellness Visit in a primary care setting. *Alzheimers Dement.* 2013;9(2):141-150. Available at http://download.journals.elsevierhealth.com/pdfs/journals/1552-5260/PIIS1552526012025010.pdf.

The Alzheimer's Association works on a global, national and local level to enhance care and support for all those affected by Alzheimer's disease and other dementias. Our services include:

- Professionally staffed 24/7 Helpline offering information, advice and referrals in more than 170 languages and dialects – **800.272.3900**
- Disease information and education programs – **alz.org**
- Health Care Professionals and Alzheimer's Center featuring patient, caregiver and health care provider resources – **alz.org/hcps**
- Alzheimer's and Dementia Caregiver Center featuring reliable information and helpful tools – **alz.org/care**
- Online connections and support through ALZConnected® – **alzconnected.org**
- Comprehensive database of local programs and services, housing and care services, and legal experts through our Community Resource Finder – **alz.org/crf**
- Customized action plans of resources and support based on patient needs through Alzheimer's Navigator® – **alz.org/alzheimersnavigator**
- Safety Center featuring information and tips for safety inside and outside of the home – **alz.org/safety**
- Dementia and Driving Resource Center – **alz.org/driving**
- Clinical study matching with TrialMatch® – **alz.org/trialmatch**
- Staff, programs and support groups in communities nationwide – **alz.org/findus**

Alzheimer's and Dementia Work Group Meeting
12/2/19
Kristina Zdanys, M.D.

Medicare Annual Wellness Visit (AWV) follow-up:

1) Medicare Advantage (MA) plans also offer AWV
    a. Data suggests that MA members have 42% higher rates of AWV than traditional Medicare (25.2%)
2) Private non-Medicare insurance for people over 65 have optional versions of AWV but may be called something different (e.g., "preventive visit")
3) Aetna, United Healthcare, and Anthem as examples do NOT delineate cognitive screens as part of AWV-equivalent visits

Other AWV data of interest:

1) Less than 20% of Medicare beneficiaries receive AWV based on data through 2015
2) More than 50% of primary care offices offer no AWVs to Medicare beneficiaries
3) Only about 23% of primary care offices are providing AWVs to at least a quarter of eligible Medicare enrollees
4) Medicare provides higher reimbursement for AWVs than traditional problem-based visits, so there is a financial incentive
5) AWVs are less frequently performed:
    a. Rural practices
    b. Practices with high percentages of patients enrolled in both Medicare / Medicaid
    c. Practices that care for high-risk patients
6) Among MA enrollees there appear to be disparities in

populations receiving AWV

a. Racial disparity: Whites have highest rate (26.3%), Hispanics lowest (18.3%)
b. Regional disparity: Northeast had LOWEST (19.5%) vs. South highest (27.1%)

References:

Carter EA. Annual Wellness Visits among Medicare Advantage enrollees: trends, differences by race and ethnicity, and association with preventive service use. AARP Public Policy Institute, May 2019.

Ganguli I, Souza J, McWilliams JM, & Mehrotra A. (2017). Trends in use of US Medicare Annual Wellness Visit, 2011-2014. JAMA; 317(21): 2233-2235.

Ganguli I, Souza J, McWilliams MM, & Mehrotra A. (2018). Practices caring for the underserved are less likely to adopt Medicare's Annual Wellness Visit. Health Affairs; 37(2): 283-291.

Centers of Excellence in Alzheimer's Disease (CEAD) follow-up:

-Overall New York State (NYS) Alzheimer's Disease Program / Caregiver Support Initiative is funded $27 million over 5 years.

-Funding was approved as part of NYS Budget in 2015 and Medicaid Redesign Initiative

-Program of caregiver support proposed to delay nursing home placement and reduce unnecessary hospital admissions

-$4.7 million funds Centers of Excellence

-Most funding comes from NYS Alzheimer's Disease Program but they also have a check-off that allows tax payers to designate a donation towards Alzheimer's services

-CEADs stem from the 1988 legislation that established Alzheimer's Disease Assistance Centers and Alzheimer's

Disease Community Assistance Program (AlzCAP) so they have statutory support for retaining funding for CEADs year to year
-No Federal funding
-CEADs independently also secure funding through various grants (Geriatric Workforce Education Program, ADRCs receive Federal funding to support research initiatives, Foundation grants, etc.)

Medicare Annual Wellness Visit

Kristina Zdanys, MD
Alzheimer's and Dementia Work Group, CWCSEO
October 31, 2019

Medicare Annual Wellness Visits (AWV)

- AWVs are OPTIONAL
- Fully covered annually by Medicare Part B
  - If additional tests / services ordered, may have cost
- Different from "Welcome to Medicare" visit at time of enrollment
- NOT a physical exam (Medicare does not cover physicals)
- Performed by MD, DO, PA, APRN, or other "medical professiona directly supervised by physician" (dietician, "health educator"…)
- Goal is to do health risk assessment and establish a personalized "Prevention Plan"

https://www.medicare.gov/coverage/

Components of AWV

- Health risk assessment.
- Review of medical and family history.
- List current providers and prescriptions.
- Height, weight, blood pressure, and other routine measurements.
- **Detection of any cognitive impairment.**
- Detection of depression (first visit only).
- Functional assessment (first visit only).
- List risk factors and treatment options.
- Screening schedule for preventive services.
- Personalized health advice / referrals.

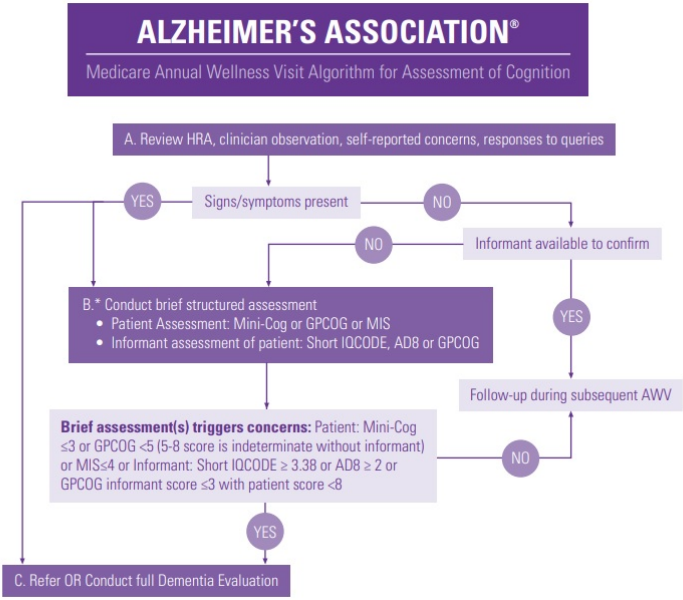
https://www.medicare.gov/coverage/y
https://www.cms.gov/Outreach-and-Education/Medicar
MLN/MLNProducts/Downloads/AWV_C

Cognitive Screening in AWV

- May not be conducted
- Does not need to be formalized assessment
- Medicare will cover assessment
- Physician's direct observation "counts"

Promotion of AWV

- Physicians / healthcare professionals
  - Educate regarding screening tools
  - Alzheimer's Association "Algorithm for Assessment of Cognition"
- Medicare beneficiaries
  - May not know:
    - Difference between AWV and physical
    - To schedule AWV
    - Potential benefits of AWV
    - To ask about formal cognitive screen

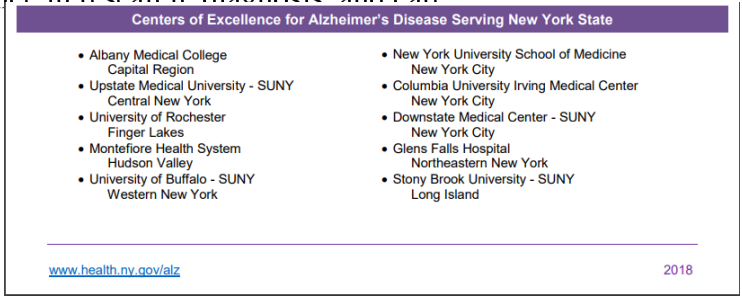

ALZHEIMER'S ASSOCIATION®
Medicare Annual Wellness Visit Algorithm for Assessment of Cognition
A. Review HRA, clinician observation, self-reported concerns, responses to queries
YES
Signs/symptoms present
NO
NO
Informant available to confirm
YES
B.* Conduct brief structured assessment
• Patient Assessment: Mini-Cog or GPCOG or MIS
• Informant assessment of patient: Short IQCODE, AD8 or GPCOG
Follow-up during subsequent AWV
Brief assessment(s) triggers concerns: Patient: Mini-Cog ≤3 or GPCOG <5 (5-8 score is indeterminate without informant) or MIS≤4 or Informant: Short IQCODE ≥ 3.38 or AD8 ≥ 2 or GPCOG informant score ≤3 with patient score <8
NO
YES
C. Refer OR Conduct full Dementia Evaluation

Enhancing Care Quality

Kristina Zdanys, MD
Alzheimer's and Dementia Work Group, CWCSEO
October 31, 2019

Dementia Centers of Excellence

- New York State Centers of Excellence in Alzheimer's Disease (CEAD):
  - Ten medical centers / teaching hospitals
  - Recognized by NYS and nationally
  - Receive funding through NYS Department of Health
  - Excellence in research, diagnosis, and care



New York CEAD Goals

- Early screening
- Early diagnosis
- Research causes and potential treatments
- Expand expertise of healthcare workforce
- Support for patients and caregivers

New York CEAD Services

- Interdisciplinary services for diagnosis
- Coordinated treatment and care management
- Linkage to community-based services for patients and caregivers
- Expert training of healthcare providers and students for detection, diagnosis, and management
- Support primary care providers in screening in community-based settings
- Information on / access to research and clinical trials
- Resources to increase public awareness

Funding

- Hospital center applies for grant through Department of Health
- Must demonstrate excellence in aforementioned goals / services
- Total funding $4.7 million
- $470,000 annually to each of 10 centers over 5 years

Geriatric Assessment Units (GAU)

- Assessment centers could be inpatient, outpatient, or home-based
- Interdisciplinary care teams
- Assess medical, cognitive, psychiatric, functional needs
- Coordinate with patient's primary care physician
- Facilitate referrals
- Non-interventional approaches may also be considered

https://www.schulich.uwo.ca/geriatrics/docs/Geriatric-As
Units-GAUs-Optimizing-Evidence-Based.pdf

GAU Goals

- Inpatient:
  - Restore functional status following acute illness
    - Late-acute, sub-acute, post-acute
  - Reduce long-term disability
  - Reduce long hospital stays
  - Reduce re-hospitalization
  - Improve rates of return home (vs. alternate levels of care)

https://www.schulich.uwo.ca/geriatrics/docs/Geriatric-As
Units-GAUs-Optimizing-Evidence-Based.pdf

GAU Goals

- Outpatient / home-based:
  - Expert sub-specialty, interdisciplinary assessment
  - Usually a consultative / diagnostic service
  - Address geriatric syndromes, functional decline
  - Does not replace primary care physician

GAU Evidence

- Less likely to be institutionalized, more likely to be alive and in o
  home one year later vs. usual care (Van Craen et al. 2010)
- Better cognitive outcomes if treated in GAU (Ellis et al. 2011)
- Overall cost ends up lower if consider hospital bills (St. John 2016)
- Reduced caregiver burden (Weuve et al. 2000)

Emergency Room Training

Current Statutes

- On or after October 1, 2015, each hospital, as defined in section 19
  490, shall be required to include training in the symptoms of deme
  as part of regularly provided training to staff members who provid
  direct care to patients.

- (Is that it?)

Preventing Elder Financial Exploitation
The Role of Financial Institutions in Connecticut
Evaluation-Staff Training

Instructions: Please take a few minutes to provide us with you feedback.

	Agree	Neutral	Disagree
The objectives of the training were clearly defined.	0	0	0
Participation and interaction were encouraged.	0	0	0
The topics covered were relevant to me.	0	0	0
The content was organized and easy to follow.	0	0	0
The training experience will be useful to my work.	0	0	0
The training objectives were met.	0	0	0
The time allotted for the training was sufficient.	0	0	0

1. What did you like most about this training?

2. Please list 3 aspects from this training you have learned or will take-away .

3. What aspects of the training could be improved? Are there

topics or issues that were not addressed?

4. How do you hope to change your practice as a result of this training?

5. Please share other comments or expand on previous responses here:

PREVENTING ELDER FINANCIAL EXPLOITATION:

The Role of Financial Institutions in Connecticut

Presented by: **Laura Snow**, MPH, Jewish Senior Services, Center for Elder Abuse Prevention

Date: June 15, 2016

COALITION FOR ELDER JUSTICE IN CONNECTICUT

PARTNERING TO PROTECT RIGHTS & PREVENT ABUSE

Partners

STATE DEPARTMENT ON AGING

BANKING COMMISSIONER CONNECTICUT

Connecticut Department of Social Services
Making a Difference

The Credit Union League of Connecticut

COALITION FOR ELDER JUSTICE IN CONNECTICUT
PARTNERING TO PROTECT RIGHTS & PREVENT ABUSE

CBA CONNECTICUT BANKERS ASSOCIATION

Jewish Senior Services®
excellence in our home and yours

Special thanks to the work and counsel of the Maine Senior$afe program and the Maine Council for Elder Abuse Prevention, Massachusetts Bank Reporting Project, Oregon Bankers Association and Oregon Department of Human Services.

About this Presentation

This presentation was created to provide information and guidelines for banking and other financial institutions in Connecticut.

If you would like to contact the committee, you can do so by emailing

Mimi Peck-Llewellyn J.D., at marie.peck.llewellyn@ct.gov
Attorney, Connecticut State Department on Aging
Elder Rights Advocate, CEJC

Disclaimer

- The information provided in these materials is general information, may contain errors, and is not intended to be relied upon as legal advice.

- While information pertains in part to legal issues, it is not a substitute for individualized advice from your own counsel.

- Anyone seeking specific legal advice or assistance should retain an attorney.

Workshop Agenda

PART 1 Introduction to the Problem

PART 2 Benefits of Identifying & Reporting Exploitation

PART 3 Financial Institutions Can Make a Difference

PART 4 Case Studies

Workshop Goals

- **Prevention**
- **Recognition**
- **Improved Response & Outcomes**

INTRODUCTION TO THE PROBLEM

Part 1

Why is Addressing this Issue Important?...

It Can Happen to Anyone

"To those seniors and especially elderly veterans like myself, I want to tell you this: You are not alone and you have nothing to be ashamed of. If elder abuse happened to me, it can happen to anyone." ~Mickey Rooney

Testimony to Senate Special Committee on Aging, March 2, 2011

Connecticut's Aging Population

- We're an old state
- 2030, 30% of population will be 60 years or older
- We have a high life expectancy

[1] National Adult Protective Services

Older Adults are Targets:

Income

- 34% of America's net worth
- Accumulated savings
- Steady monthly income
  - Social Security
  - Pension
  - Investments

[1]National Elder Abuse Incidence Study, 1998

Older Adults are Targets:

Vulnerabilities Related to Aging

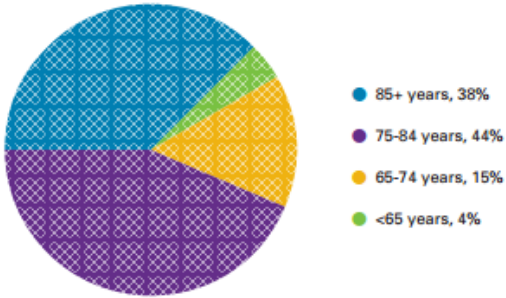
- Changes in managing finances
- Decline in financial literacy and knowledge
- Dementia (See Handout, Prevention)

[1]National Elder Abuse Incidence Study, 1998

Dementia In Connecticut

- 13% of senior population (2014)
- 25% increase by 2025
- Greatest risk stage:
- Mild Cognitive Impairment (MCI)

figure 1 Proportion of People With Alzheimer's Disease in the United States by Age



Percentages may not total 100 because of rounding.
Created from data from Hebert et al.[114], A3

Hebert et al. Neurology 2004; 62:1645 (6); available at alz.org/facts

Being An Older Adult = Being At Risk

- **$3 billion** is the financial cost of elder financial abuse
- **1 in 5** are victims of financial abuse
- **90%** of perpetrators are trusted others
  - **47%** are adult children

National Elder Abuse Incidence Study, 1998; True Link Report on Elder Financial Abuse 2015

Impact of Financial Abuse

More than just money, you lose:
health, emotional well-being and quality of life

↑ **Depression & anxiety**

↑ **Skipped medical care**

↓ **Health & nutritional intake**

- Medicaid support, state assistance
- One estimate1 million seniors skip meals as a result

BENEFITS OF IDENTIFYING & REPORTING EXPLOITATION

PART 2

Benefits of Identifying & Reporting

Community Benefits

- Improved safety
- Financial independence
- PREVENTION!

Business Benefits

- "-ions" – reputation, recognition, satisfaction
- ↓ Uninsured losses

Financial Institutions Can Play a Key Role

YOU may be the first to encounter financial abuse

- Frontline staff
- Utilize proactive measures
- Promote best practices
  - Reporting
- Reveal potential ***POLYVICTIMIZATION***

You Are Often First Voice of Reason

It's Also Important to Act because…

- May be a crime
- May be preventable

FINANCIAL INSTITUTIONS CAN MAKE A DIFFERENCE

PART 3

Outline

1. **Recognizing the signs of elder financial abuse**
   - Definitions of elder abuse
   - Red Flags of elder abuse
2. **Protecting your older customers**
   - Gathering information
   - Checking proper documentation
3. **Referring or reporting suspected financial abuse**
   - Following internal protocol
   - Reporting to your supervisor
   - Repeat reporting

1. Recognize the Signs

Learn to Identify Signs that Could Indicate Actual or Potential Fraud, Exploitation, or Abuse

This section will:

- Definitions of elder abuse and financial exploitation
- Review red flags of elder abuse and financial exploitation

DEFINITIONS

DEFINITIONS

Elderly

- Any resident of Connecticut aged 60 years or older.

Elder Abuse

- Any knowing, intentional, or negligent act by any other person, causing harm or serious risk of harm to a vulnerable elderly person

DEFINITIONS

Elder Financial Exploitation

- Act or process of taking advantage of an elderly person for monetary, personal or other benefit, gain or profit.
- If illegal, may be: larceny, theft, identity theft, false instrument, fraud, forgery, embezzlement

RED FLAGS
Elder Abuse

RED FLAGS

Suspicious **BEHAVIOR** that could indicate actual or potential abuse, fraud or exploitation.

Elder Abuse

- ***Concerning tone or content*** of language directed towards older adult
- ***Noticeable neglect*** or decline in appearance,
- ***Increased confusion***, word-finding problems, memory issues
- ***Expresses stress*** regarding personal life and relationships

RED FLAGS
Elder Financial Exploitation
BEHAVIOR

RED FLAGS

Elder Financial Exploitation: BEHAVIOR

- ***Unusual degree*** of fear, anxiety, submissiveness or deference of elderly customer
- ***Lacks knowledge*** about personal financial status
- ***Excessive interest*** in elderly's finances or accounts is expressed by trusted other
- ***Unexplained or unusual excitement over a financial windfall*** or prize check

RED FLAGS

Elder Financial Exploitation: BEHAVIOR

- ***Noticeable neglect*** or decline in appearance, grooming, or hygiene.
- ***New inability to afford cost of daily*** living is expressed
- ***Sudden appearance of previously uninvolved relatives*** claiming their rights
- ***New associations*** with “friends” or strangers

RED FLAGS
Suspicious Account Activity

RED FLAGS

Suspicious Account Activity

➢ ***Noticeable change in banking or financial management habits***

- Frequent & large withdrawals
- Sudden Non-Sufficient Fund (NSF) activity
- Inconsistent debit transactions

➢ ***Uncharacteristic nonpayment*** for services

➢ ***Disregard to penalties*** when closing of CDs or accounts

RED FLAGS

Suspicious Account Activity

- ***Sudden changes*** in who is conducting financial transactions on behalf of client
- ***Abrupt changes to financial documents*** such as power of attorney, joint accounts, account beneficiaries
- ***Making requests beyond legal authority*** outlined in provided documents
- ***Monies not being used in the interest or intent*** of the customer

RED FLAGS

Suspicious Account Activity

- ***Change of address*** on accounts to new recipient's address
- ***Previously inactive account or new joint account*** are suddenly active
- ***Suspicious signatures***
- ***Unexplained disappearance of funds*** or valuable possessions

FinCEN Top Reported SARs Activity

1. Coercion
2. Abuse of POA
3. Unusual wire activity

2. PROTECTING YOUR OLDER CUSTOMERS

THESE ARE SUGGESTED STEPS TO ASSIST EMPLOYEES OF FINANCIAL INSTITUTIONS IN DETERMINING IF QUESTIONABLE TRANSACTIONS SHOULD OR SHOULD NOT BE PROCESSED

This section will:

- Prevention Steps
- Gathering information
- Checking proper documentation

PREVENTION STEPS

PREVENTION STEPS

Opening A Joint Account

- ***Understand reason*** *for adding joint owners to account.*
- ***Listen or look for signs of dementia***
- ***Ask if anyone has Power of Attorney or is Conservator***
- ***Speak with client alone****: tell other person it's standard safety practice to speak alone with client before opening joint account.*

PREVENTION STEPS

News About Joint Accounts

JOINT ACCOUNT ACTIVITY MAY BE CRIMINAL

New Criminal Case Law: State vs. Lavigne:

- CT Supreme Court
- Ruled banking law defines who has **access** to joint account, but *does not determine* ***ownership*** of funds in a joint account.
- Up to jury to decide based on evidence

GATHERING INFORMATION

Interviewing Older Clients

Stress may create communication problems

Things to consider

- Ensure they have all assistive devices.
  - Ex. Glasses, hearing aids, dentures
- Minimize background noise
- Look for signs of dementia (Dementia Handout):
  - Poor financial competency
  - Word finding, language problems
  - Memory & recall
  - Poor awareness (insight)
  - Impulse & impaired judgment

Interviewing Older Clients

Stress may create communication problems

THINGS TO CONSIDER

- Show records or evidence of concerns. Note their response.
- As much as possible encourage involving a third party:
  - Family member or friend
  - Their attorney
  - Dept. of Social Services Protective Services
  - Town Social Worker

GATHERING INFORMATION

Large Transactions

OR

Frequent Withdrawals

- ***Learn the reasons*** for the change in account activity
- ***Gather explanations*** from your customer NOT from the person who might be accompanying them
- ***If your customer is prevented from answering*** or the person accompanying them answers, this may be a sign of financial exploitation

CHECKING DOCUMENTATION

CHECKING DOCUMENTATION

Authority to Act for an Elderly Person

- ***Exaggerating or Misunderstanding authority for an elderly person*** is common for people who commit financial exploitation
- ***Check all proper authorization & documentation***
  - Signature cards
  - Power of Attorney
  - Conservatorship/Guardianship*

3. Reporting or Referring Elder Financial Abuse

Learn to refer to your internal protocol for reporting elder financial abuse and consider alternatives to reporting if an internal protocol is not in place.

This section will:

- Advocate you follow internal protocols on how to report
- Instruct you on informing client of need to involve supervisor
- Instruct you on how and why to repeat reporting

FOLLOWING INTERNAL PROTOCOL

FOLLOWING PROTOCOL

Personnel Should Note

- ***Internal Protocol*** is one provided by you place of employment
  - Tell your supervisor
  - If no protocol, still report to supervisor
- ***Time*** the sooner a report is made, the faster the exploitation can be stopped
- ***"Proof"*** tangible proof is not necessary, suspicion is adequate
  - ***Determination of financial abuse & exploitation is made by***

REPORTING TO YOUR SUPERVISOR

TELL YOUR CLIENT

Personnel Should Note

- ***If there is a suspicion or concern*** consider explaining to client that a supervisor must review the request

- ***What your supervisor can do***
  - SEPARATE
  - EXPLAIN
  - DELAY OR STOP TRANSACTION
  - NOTIFY

REPEAT REPORTING

REPEAT REPORTING

Personnel Should Note

- ***Remain vigilant***
- ***Respond and report*** when new details and incidents occur

REPEAT REPORTING

Personnel Should Note

- ***Financial exploitation and abuse*** increases the risk of victimization
- ***Victimization can continue*** after your initial report
- ***No sufficient proof*** is available to pursue an investigation from first report
- ***A person may refuse help the first time,*** but not subsequently

CASE STUDIES

PART 4

Case Studies

These case studies are based on actual events. While names and locations are fictional, scenarios like these are very real

This section will:

- Encourage you to recognize the Red Flags of elder financial abuse and exploitations
- Encourage you to determine what steps should be taken

Mrs. Jarvis: Background

Mrs. Jarvis is a 76 year old widow and a loyal customer of Husky Credit Union (HCU) for over 2 decades. She is well known by the branch employees and they can always expect to see her on Monday afternoons when she comes in to make deposits and withdraw her weekly spending money. Today she came into the branch a second time this week. Mrs. Jarvis approached Jeremy, a teller at HCU, and asked to have $4,000 transferred from her savings account to her checking account.

Mrs. Jarvis: Questions

- **Do you have any concerns about the situation?**
- **What do you think you would do next?**

Mrs. Jarvis: Gathering Information

Upon her request, Jeremy becomes concerned. He has known Mrs. Jarvis since he started working at HCU and has worked with her on several transactions. However, this is an unusual request. Jeremy knows that Mrs. Jarvis currently manages her own finances and seems fully mentally aware. She is very physically active, as she mentions how often she walks, everyday, and is able to visit the bank weekly, and independently, to deposit and draw out cash to pay her bills. All of the accounts are in her name, since her husband passed away 2 years ago.

Mrs. Jarvis: Gathering Information

Jeremy politely asks Mrs. Jarvis why she is making such a large transfer. A tad frustrated, Mrs. Jarvis explains that she has been promised $500,000 in winnings from a lottery drawing in the United Kingdom. She explains to Jeremy that they have been sending her notifications and reminders that if she does not send in an administration fee of $5,000, by a specified date, the winnings will become null. Mrs. Jarvis shows Jeremy the letter, which looks very official, and goes on to admit that she has been sending amounts ranging between $50-$100. She is worried about missing the deadline to receive the winnings, and would like to meet the deadline by sending in one final payment.

Mrs. Jarvis: Questions

- **What are the red flags here?**
- **How would you respond to Mrs. Jarvis explanation?**
- **What would you consider reviewing upon hearing Mrs. Jarvis' explanation?**

Mrs. Jarvis: Gathering Information

Jeremy respectfully voices his concerns to Mrs. Jarvis that this may be a scam and that she is not likely to receive any money. She does not believe Jeremy though, and is confused why it would not be true. She tells Jeremy that she wants the money to leave for her children and grand children when she passes away. Jeremy asks her what her family thinks about this situation and she mentions that her son has also said this is a scam. She says that because of this she no longer discusses her financial affairs with him. Jeremy remains concerned. Since all of her accounts are in her name, it is difficult to speak with any of her family about the situation without committing a breach of confidentiality.

Mrs. Jarvis: Questions

- **Is there anymore information Jeremy can gather and how?**
- **Are there other steps he might consider at this point?**

Mrs. Jarvis: Gathering Information

Jeremy takes a moment to review Mrs. Jarvis' account history. He notices that whereas in the past she tended to withdraw small and like-amounts of cash on a regular, weekly, basis, the amounts she is withdrawing have become larger and more frequent.

Mrs. Jarvis: Questions

- **How should Jeremy handle this information and what should his next steps be?**

Mrs. Jarvis: Next Steps

Very concerned, Jeremy informs Mrs. Jarvis that he must speak with his supervisor to review her request. He asks Mrs. Jarvis to please wait a moment while he speaks with his supervisor.

Jeremy approaches his supervisor and explains the situation. Equally concerned, Jeremy's supervisor asked to speak with Mrs. Jarvis in his office.

Mrs. Jarvis: Summary & Added Notes

- Always review the knowledge you have about your customers.
  - Habits and behaviors: financial, social and personal (if known).
  - Access what information you have on hand. For example, account activity history.
- Educate yourself about elder financial abuse and exploitation
  - Scams: Foreign lotteries are illegal
  - AARP Fraud Watch – tracks client reported scams
  - Any internet news search “elderly financial abuse or scam”
- If you are having concerns, consult with your supervisor.

Mrs. Jarvis: Common Scam Tactics

- **Gain trust and confidence** through charisma by using a business name similar to a well-established organization or by communicating concern for the elders well-being.
- **Indicate that the elder is lucky** or has been chosen
- **Ask them to make an immediate decision** with a limited offer
- **Secrecy:** Ask the victim not to discuss the details as it is a "special" offer
- **Closing the deal quickly** with little risk of exposure to the

PREVENTING ELDER FINANCIAL EXPLOITATION:

Reporting and Referring for Supervisors

Presented by: Laura Snow & Erin Burk, Center for Elder Abuse Prevention, Jewish Senior Services

Date: September 14, 2016

COALITION FOR ELDER JUSTICE IN CONNECTICUT

Partners

Special thanks to the work and counsel of the Maine Senior$afe program and the Maine Council for Elder Abuse Prevention, Massachusetts Bank Reporting Project, Oregon Bankers Association and Oregon Department of Human Services.

About this Presentation

This presentation was created to provide information and guidelines for banking and other financial institutions in Connecticut.

If you would like to contact the committee, you can do so by emailing

Mimi Peck-Llewellyn J.D., at marie.peck.llewellyn@ct.gov
Attorney, Connecticut State Department on Aging
Elder Rights Advocate, CEJC

Review the presentation here: https://ctcwcs.com/financial-abuse-exploitation-portal/

Disclaimer

- The information provided in these materials is general information, may contain errors, and is not intended to be relied upon as legal advice.

- While information pertains in part to legal issues, it is not a substitute for individualized advice from your own counsel.

- Anyone seeking specific legal advice or assistance should retain an attorney.

Workshop Goals

- **Confidentiality**
- **Obligations and Options**
- **Model Response**
  - Identification of abuse
  - Responding to requests from Protective Services for the Elderly
- **Prevention Efforts**

CONFIDENTIALITY: LAWS, EXCEPTIONS, IMPACT

Specific to older adult exploitation

Confidentiality Laws

CONNECTICUT

- **CT General Statute**
  - 664 C.G.S. § 36(a)-42

Financial institutions may not disclose financial records to any person except the customer or the customer's authorized agent.

FEDERAL

- **Gramm Leach Bliley Act**
  - 15 U.S.C. § 6802

Financial institutions may not disclose **nonpublic personal information** to non-affiliated third parties without providing notice to the customer and an opportunity to opt-out

Exceptions to Federal Confidentiality Law

Cases of elder abuse may be reported to local, state, federal authorities/agencies under the following exceptions (*See Guidance*):

- To protect or prevent fraud, unauthorized transactions, claims or other liability
- To law enforcement regarding public safety
- With consent of consumer
- Subpoenas
- States with mandated requirements to report

Reporting to Dept. Social Services/PSE in CT

Connecticut

- Financial Institutions are ***not mandated*** to report to PSE
  - ***Mandated*** training
- Financial Institutions may ***voluntarily*** report:
  - Nonpublic information under federal exception guidelines
  - Public information
  - Publicly viewed safety concerns, and/or concerns of behavior or well-being in branch
  - Immunity from liability for good faith reporting

(319dd C.G.S. § 17(b)-451)

Publicly Viewed Safety Concerns

Examples:

- Signs of incapacity
- Personal care or well-being concerns (not financial)
- Undue influence-coercion
- Inability to talk to senior

QUESTIONS?

ABOUT CONFIDENTIALITY & DISCLOSURE?

REPORTING ROUTES & REFERRAL OPTIONS

Reporting Routes

- Calling 9-1-1- Emergencies & Crimes
- Federal Mandatory Reporting –SAR
- State Reporting & Referral

Calling 911

Always call 911 if you believe that a customer is in **immediate danger**!

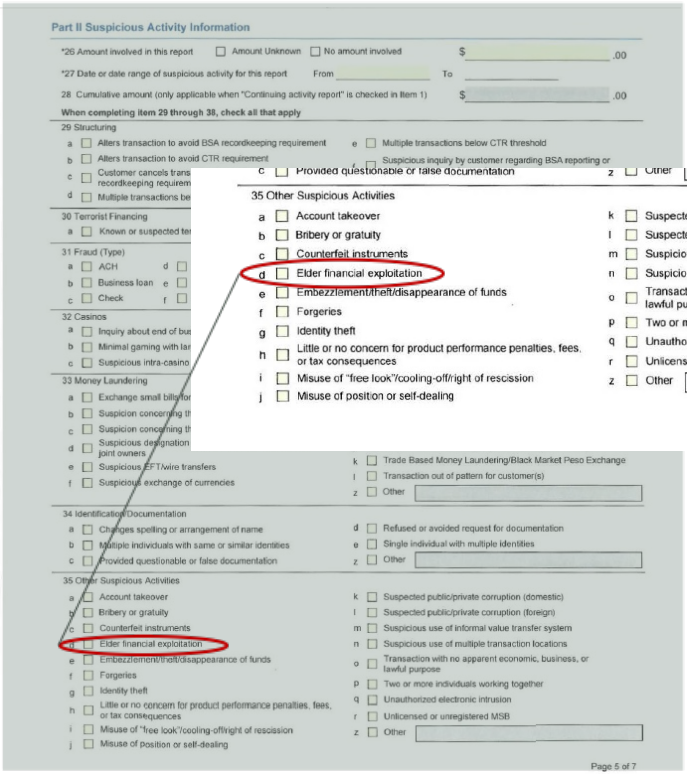
- Law Enforcement
  - Non-emergency issues excepted under GLBA
  - **Ex**. Check fraud or forgery, cashing coins more than face value, senior or person accompanying is intoxicated

Federal Mandatory Reporting Requirements

FinCEN: Suspicious Activity Report (SAR)

- A SAR is appropriate where the financial institution knows, suspects, or has reasons to suspect that a transaction had no business or apparent lawful purpose or is not the sort in which the particular customer would normally be expected to engage, and the financial institution knows of no reasonable explanation for the transaction after examining the available facts.

- The Financial Crimes Enforcement Network (FinCEN) requests that financial institutions include the term "**elder financial exploitation**" when filing a SAR in instances of financial exploitation of the elderly. See FIN-2011-A003.



Part II Suspicious Activity Information

*26 Amount involved in this report ☐ Amount Unknown ☐ No amount involved $ _____ .00

*27 Date or date range of suspicious activity for this report From _____ To _____

28 Cumulative amount (only applicable when "Continuing activity report" is checked in Item 1) $ _____ .00

When completing item 29 through 38, check all that apply

29 Structuring

a ☐ Alters transaction to avoid BSA recordkeeping requirement
b ☐ Alters transaction to avoid CTR requirement
c ☐ Customer cancels transaction to avoid BSA recordkeeping requirement
d ☐ Multiple transactions below CTR threshold
e ☐ Multiple transactions below CTR threshold
f ☐ Suspicious inquiry by customer regarding BSA reporting or recordkeeping requirement
z ☐ Other

30 Terrorist Financing

a ☐ Known or suspected terrorist/terrorist organization

31 Fraud (Type)

a ☐ ACH
b ☐ Business loan
c ☐ Check
d ☐
e ☐
f ☐

32 Casinos

a ☐ Inquiry about end of bus
b ☐ Minimal gaming with lar
c ☐ Suspicious intra-casino

33 Money Laundering

a ☐ Exchange small bills for
b ☐ Suspicion concerning th
c ☐ Suspicion concerning th
d ☐ Suspicious designation
e ☐ Suspicious EFT/wire transfers
f ☐ Suspicious exchange of currencies
k ☐ Trade Based Money Laundering/Black Market Peso Exchange
l ☐ Transaction out of pattern for customer(s)
z ☐ Other

34 Identification/Documentation

a ☐ Changes spelling or arrangement of name
b ☐ Multiple individuals with same or similar identities
c ☐ Provided questionable or false documentation
d ☐ Refused or avoided request for documentation
e ☐ Single individual with multiple identities
z ☐ Other

35 Other Suspicious Activities

a ☐ Account takeover
b ☐ Bribery or gratuity
c ☐ Counterfeit instruments
d ☐ Elder financial exploitation
e ☐ Embezzlement/theft/disappearance of funds
f ☐ Forgeries
g ☐ Identity theft
h ☐ Little or no concern for product performance penalties, fees, or tax consequences
i ☐ Misuse of "free look"/cooling-off/right of rescission
j ☐ Misuse of position or self-dealing
k ☐ Suspected public/private corruption (domestic)
l ☐ Suspected public/private corruption (foreign)
m ☐ Suspicious use of informal value transfer system
n ☐ Suspicious use of multiple transaction locations
o ☐ Transaction with no apparent economic, business, or lawful purpose
p ☐ Two or more individuals working together
q ☐ Unauthorized electronic intrusion
r ☐ Unlicensed or unregistered MSB
z ☐ Other

Page 5 of 7

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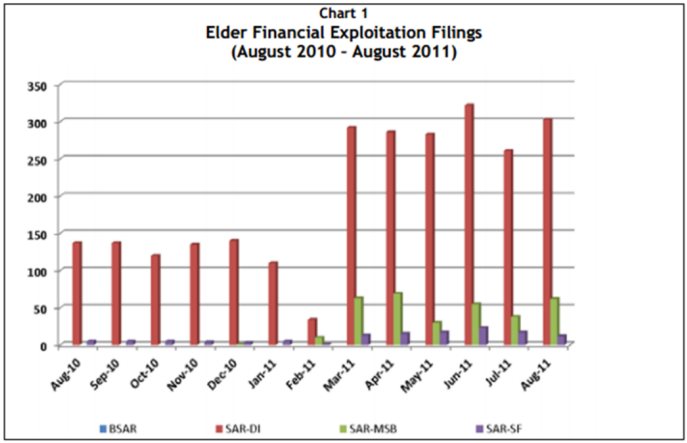
Page 5 of 7

Impact of Change in SAR Guidelines

2011 – Advisory to include “elder financial exploitation” in SAR

382% increase in reports



Mandatory Reporting Requirements

FinCEN: Suspicious Activity Report (SAR)

- ***NOT*** **a substitute for local reporting**
  - Although it may eventually lead to involvement of local authorities
  - Financial institutions are encouraged report to state and local agencies where appropriate

State Reporting & Referrals

When a client voluntarily is open to help:

- Document client consent to share information with third party.

- Each situation is unique, but it is crucial that the responsible manager/supervisor consider all options and if at all possible make **at least** one referral.

Reporting to Protective Services

- DSS: Protective Services for the Elderly
- Refer to ***PSE Form W-675*** *(See W-675)*
- You may report name of individual, perpetrator, and concern about account activity.
- ***Do not share without legal advice***: dollar amounts, type of accounts, specifics of transactions unless fall under federal exceptions
- PSE will be required to seek further consent or involve court if consent cannot be granted before obtaining more information.

REFERRAL OPTIONS

Impact of Involving PSE Social Workers

- **Evaluate**
  - Situation
  - Capacity
  - Well-being
- **Devise plan of care aimed at**
  - Enhancing an elder's safety
  - Preserving their right to self-determination
- **Services Provided**
  - Crisis intervention
  - Arrange for and coordinate:
    - Adult day program
    - Companion/Homemaker
    - Home health care
    - Counseling
    - Home delivered meals
    - Long-term care
    - Emergency housing

Impact of Disclosure: Involving PSE

- **In extreme cases**
  - Can seek court authorization to provide services to a person who appears to “lack the capacity” to give consent to reasonable and necessary services
  - Apply to the Probate court for the appointment of a Conservator

Response Timeframe

- **Response to initial PSE reports**: must triage based on risk
- Immediate – same day
- 2-3 days
- 3-5 days

- **Probate court request for Temporary conservatorship**: Same week to freeze accounts until competency hearing may be held

- **Probate court request for Full conservatorship orders**: Can take up to 6 months for probate court to appoint

Other Referral Options

- **CT Dept. of Banking** – Consumer Affairs Team for further guidance and resources, can assist in determination of whether to investigate or refer to another agency. 1-800-831-7225.

- **Legal Services for the Elderly** – Help them make the first call. Provides free legal services to all seniors; POA help. 1-800-453-3320.

- **Consumer Law Project for Elders** – consumer debt and identity theft. 1-800-296-1467

- **Access Agency/Agency on Aging** – benefits, care, and

Repeat Reporting

- Reminder to repeat reporting
  - Slow process, which may necessitate repeat reporting to allow building of evidence and action to be taken/accepted
  - Many individuals and organizations may be involved
  - Lack of follow-up, both internally and externally
  - Confidentiality may limit how much information can be shared with the reporting institution or reporting individual

Best Practices Summary

- Summary of best practices:
  - Train
  - Create protocol
  - Seek anonymous guidance if unsure
  - Report
  - Refer – help customer make referral as much as possible
  - Repeat report

- Keep scam or exploitation examples on hand

QUESTIONS?

INTERNAL PROTOCOL

Developing Internal Protocol

Each financial institute should develop a written protocol for internal reporting of suspected exploitation of a vulnerable adult.

- Eliminates confusion and delay in response
- Delegates reporting responsibility
- Improves reporting efficiency

Model Internal Protocol

- When a teller has a concern
  - Who should they tell?
  - When should a supervisor or other senior officer be told?
- Who will determine if and/or make a report to local, state or federal agencies?
- What information or documentation should be gathered?
- What information should be provided to state agencies or local law enforcement?
- Who will respond to requests from Protective Services for

Model Internal Protocol

Action Steps
That Might Be Included In An Internal Protocol

FRONT LINE STAFF OPTIONS

- Front line staff **immediately report** to supervisor.

- And/or:

  - Interview, inquire, gather information

  - Counsel client on implications and alternatives

  - Share an “awareness” document

Model Internal Protocol

Action Steps
That Might Be Included In An Internal Protocol

MANAGER OPTIONS

A model internal policy may advocate managers:

- SEPARATE
  - Even if teller has already spoken to the customer alone, consider talking with them additionally.
- EXPLAIN
  - Advise customer on risks, options, and concerns
  - Seek consent from customer
- DELAY OR STOP TRANSACTION
- NOTIFY
  - Suspicious Activity Report
  - Other internal levels of management
  - Law enforcement
  - Other outside parties

Interviewing Older Clients

Stress may create communication problems

Things to consider

- Ensure they have all assistive devices.
  - Ex. Glasses, hearing aids, dentures
- Minimize background noise
- Look for signs of dementia (*See Dementia*):
  - Poor financial competency
  - Word finding, language problems
  - Memory & recall
  - Poor awareness (insight)
  - Impulse & impaired judgment

Interviewing Older Clients

Stress may create communication problems

THINGS TO CONSIDER

- Show records or evidence of concerns. Note their response.
- As much as possible encourage involving a third party:
  - Family member or friend
  - Their attorney
  - Dept. of Social Services Protective Services
  - Town Social Worker

QUESTIONS OR THOUGHTS?

ABOUT PROTOCOL CONSIDERATIONS

PREVENTION EFFORTS

Prevention Efforts

You may be able to prevent financial exploitation before it happens.

THINGS TO CONSIDER

- Establishing close working relationships with local reporting and aging service agencies
  - Local law enforcement, PSE
- Community education on “Age Friendly” banking
  - Customers, Aging Services agencies
- Binder of sample fraud, scam, financial exploitation cases
- Regular staff education on current elder exploitation and age-related topics
  - Role-play, practicing interviewing techniques to avoid coming off as confrontational or offensive

Prevention Efforts

You may be able to prevent financial exploitation before it happens.

THINGS TO CONSIDER

- Alternatives to Joint Accounts
- "View Only" online accounts
  - Third Party Online Monitoring or "Read Only"
- High Visibility Debit Cards
  - Colors, larger font, card design (arrows/indentations)
- Family Debit Cards
  - Spending limits, designated places for use, restrictions to full account
- Improve process for POA
  - Helping financial caregivers (preventing exploitation)
- Waiver/Consent to Share Information
  - "Emergency Contact" form in case of incapacity or

COALITION FOR ELDER JUSTICE IN CONNECTICUT

PARTNERING TO PROTECT RIGHTS & PREVENT ABUSE

: REVIEW SHEET

Preventing Elder Financial Exploitation

The Role of Financial Institutions in Connecticut

Elder financial exploitation and fraud is the illegal taking, misuse, or concealment of funds, property, or assets of an older adult. This is a growing concern. Financial institutions can play a key role in the identification, detection, and prevention of this form of elder abuse and are encouraged to recognize the signs of elder financial abuse and fraud, taking the proper steps to protect their older customers, and making the proper report or referral in the event elder financial abuse or exploitation is occurring.

RED FLAGS

QUICK FACT: In 2010, the estimated cost of elder financial abuse was $2.9 billion.

10 Commonly Arising Signs & Risk Factors of Elder Financial Abuse & Exploitation

- Noticeable signs of neglect or decline is appearance
- Increased confusion, word-finding, or memory issues
- Unusual degree of fear, anxiety, or submissiveness
- Noticeable changes in financial management habits
- Abrupt changes to financial documents and accounts
- Unexplained disappearance of funds
- Unusual and uncharacteristic account activity
- Sudden "non-sufficient" fund activity
- New associations or "friendships"
- Sudden changes in the management of older customer's finances

ACTION STEPS

QUICK FACT: The non-financial impact of financial abuse is devastating. Seniors skip meals, and suffer from adverse physical and mental outcomes.

5 Important Questions to Answer When Developing Internal Protocol

1. When personnel have a concern:
   - Who should they tell?
   - When should a supervisor be told?
2. Who will determine if and/or when a report is made to local, state, or federal agencies?
3. What information or documentation should be gathered?
4. What information should be provided to local or state agencies, or law enforcement?
5. Who will respond to requests from Protective Services for the Elderly (PSE)?

4 Steps Managers Can Take When They Suspect Elder Financial Abuse

1. **SEPARATE**: Consider speaking with your older customer one-on-one to get a better idea of the situation at hand
2. **EXPLAIN**: Advise your older customer and explain risks, options, and concerns to prevent abuse or when it occurs
3. **DELAY OR STOP TRANSACTIONS:** To stop any further exploitation of your older customer's accounts and funds
4. **NOTIFY**: Either by filings an appropriate SAR, or contacting internal levels of management. You may also consider contacting local law enforcement or other appropriate state and federal agencies.

Developed by CEJC Banking Action Team

For more information contact Erin Burk at the Center for Elder Abuse Prevention at Jewish Senior Services, eburk@jseniors.org or call (203) 396 1097

COALITION FOR ELDER JUSTICE IN CONNECTICUT

PARTNERING TO PROTECT RIGHTS & PREVENT ABUSE

: REVIEW SHEET

Preventing Elder Financial Exploitation

The Role of Financial Institutions in Connecticut

REPORTING

Exceptions to Federal Confidentiality Laws

- To protect or prevent fraud, unauthorized transactions, claims or other liability
- To law enforcement regarding public safety
- With consent of consumer
- Subpoenas
- States with mandated requirements to report

The toll-free In-State referral line for Protective Services for the Elderly (PSE) is **1-888-385-4225**

In Connecticut:

- Financial institutions may **VOLUNTARILY** report:
  - Publicly viewed safety concerns and/or concerns of behavior or well-being in branch
  - if **CONSENT** is obtained from your older customer; CT gives immunity from liability for good faith reporting
  - Non-public information under federal exception guidelines (see above)
  - Public information

SCAMS & TACTICS

SCAMMER TACTICS:

- Secrecy
- Authority
- Urgency
- Legitimacy
- Reciprocity

9 Scams to Watch Out For ...

1. **Obituary Scam**– Using obituaries to target recent widows, scammers attempt to collect false debts of the deceased.
2. **Magazine Subscriptions**– Company sends free magazines and convinces a senior he owes money for the subscription.
3. **Sweepstakes**- 'Contest' claims a senior won a prize and needs to send in money to collect winnings.
4. **Charitable Donations**- Unscrupulous charities take advantage of generosity and memory loss to request donations repeatedly.
5. **Investment Scams**– Salesperson convinces a senior that an unusual asset , like a horse farm, is worth significant investment.
6. **Grandparent Scam**– Scammer calls late at night pretending to be a grandchild in need o f emergency funds by wire.
7. **Helpful Nephew Scam**– Trusted relative visits a senior frequently and asks to borrow money, knowing the request will be forgotten.
8. **Sweetheart Scam**– Scammer befriends a lonely older adult to get access to money or be written into the will.
9. **TV Shopping Trickery**– As-Seen-On-T.V. products hide extra fees and charges in the fine print

Christy Kovel, Director of Public Policy
Alzheimer's Association Connecticut Chapter

Dear Christy:

I understand that you are assisting with the State Legislature's Alzheimer's and Dementia Working Group and so I am reaching out to you as a means of submitting comments to the group. Thank you in advance for accepting our comments.

LeadingAge Connecticut commends the Alzheimer's and Dementia Working Group as they strive to update the recommendations contained in the *2013 Report of the Task Force on Alzheimer's Disease and Dementia,* also referred to as Connecticut's Alzheimer's Disease and Dementia Plan. LeadingAge Connecticut had several members who served on the original task force and we are very interested in the current review of its report.

The original report was very comprehensive and we know that priorities will be placed on recommendations that are to be updated or added. To assist in this effort, LeadingAge Connecticut would like to share our perspective on what we believe should be included in the updated recommendations. We hope that the working group will find this input to be helpful in their review of the entire report.

LeadingAge Connecticut's recommendations regarding the update to the 2013 Report of the Task Force on Alzheimer's Disease and Dementia

As an association representing not-for-profit providers of aging services across the full continuum of services, supports, health care and housing, LeadingAge Connecticut recommends that the State Plan for Alzheimer's Disease and Dementia include the following priorities:

1. Place an emphasis on proper diagnosis and assessment with a goal of establishing truly person-centered treatment plans that recognize and value the role of self-determination.
2. Ensure statewide availability of high-quality community-based resources to obtain proper diagnosis, assessment and treatment.
3. Monitor the success of PA 19-115 which places the topics of cognitive impairment and geriatric depression into the physician statutory CEU program, while also encouraging medical and nursing professionals to voluntarily seek advanced training in these areas.
4. Recognize that people living with dementia must be provided meaningful and purposeful community engagement.
5. Support initiatives to raise community awareness, support, and advocacy with the goal of reducing stigma and increasing understanding and acceptance.

Thank you for your attention to our comments and we offer our assistance to you and the working group as you move forward with your review of the report.

Sincerely,

Mag

Mag Morelli, President

(203) 678-4477
110 Barnes Road, Wallingford, CT 06492

Comments and recommendations for the Committee provided by LiveWell: Stephani Shivers, COO – Community Services; Michael Smith, CEO; Trish Bowen, COO-Residential Services

Priority Recommendations-Connecticut Alzheimer's Plan

Promote public awareness and best practices in diagnosing Alzheimer's and dementia to connect those with Alzheimer's and their caregivers to available resources.

Create a public/community awareness campaign through partnerships, including, but not limited to, the Alzheimer's Association, AARP, State Department on Aging, Area Agencies on Aging, faith-based and immigrant communities, business/corporate associations, chambers of commerce, medical community and professional/trade associations to increase community and family awareness of resources, including the Alzheimer's Association Help Line and 211.

We would recommend that any public/community awareness campaign should include people living with dementia at the forefront and promote positive options for living well with dementia.

In 2017, LiveWell became the state licensee for the Dementia Friends USA program. Dementia Friends is a grass-roots public awareness campaign that focuses on 5 key messages about dementia that are delivered through volunteer led, 1 hour information sessions. LiveWell has intentionally collaborated with CT's Area Agencies on Aging, AARP and the Alzheimer's Association to coordinate the delivery of the program (through volunteer Champions in each C4A region) and to share specific CT based service resources with attendees. As of December 2019, CT has 3273 Dementia Friends and 115 volunteer Champions. To learn more: www.dementiafriendsct.org

We have also found performances of "To Whom I May Concernâ" to be incredibly impactful. To Whom I May Concernâ (TWIMC) was created in CT by Maureen Matthews (www.towhomimayconcern.org) is an interactive readers theater style performance of a script that is crafted and performed by people living with dementia. LiveWell has supported the creation of 3 TWIMC scripts and sponsored multiple performances as part of their dementia friendly efforts.

Disseminate informational packets to be distributed at doctors' offices, pharmacies, senior centers and other locations for individuals diagnosed with Alzheimer's disease and caregivers. Much of this information is available through the Alzheimer's Association.

Information is also available through the National Institutes on Aging
https://order.nia.nih.gov/view-all-alzhemer-pubs

Promote Medicare Annual Wellness visits which include a cognitive impairment assessment for early detection and diagnosis, but is often not conducted in the visit. (Dr. Dzanys)

Cognitive impairment poses the most significant risk for exploitation. Develop a bank reporting project that includes bank reporting training programs. Bank personnel may be in a unique position to detect financial exploitation of older adults and individuals with dementia. Employees should be trained about potential red flags that indicate suspicious activity. Potential red flags include: Recent changes to a person's will, misuse of Power of Attorneys, unusually high levels of activity or out-of-state charges. Banks should have immunity after reporting and addressing (Christy)

suspicious activity. (Steve, Christy,Cindy,Mairead)

Since 2016, LiveWell has been the state lead for the Dementia Friendly America movement, and has been fostering dementia friendly practices. Members of the DFA network in other states have done 'sector-based training' with banks and DFA resources for this sector are available on their website:
https://static1.squarespace.com/static/559c4229e4b0482682e8df9b/t/59aea905ff7c507dd94e6a1d/1504618757922/DFA-SectorGuide-Financial+8.9.17.pdf

Through our Dementia Friendly Southington initiative (https://dementiafriendsct.org/southington/) we have developed and delivered dementia friendly training for Liberty banks in Southington, and their President is very interested having more training. He has shared that while they have training in fraud protection, it does not contain specific training on serving those with dementia. LiveWell holds interest in further expanding dementia-specific training for banks and recommends a work-group collaboration to explore the current training fraud protection training for banks (Elder Justice Action, EPS, AARP), national best-practices for dementia friendly banks and financial institutions, and the perceived needs of Connecticut's banking professionals. Comprehensive, dementia-inclusive, Connecticut specific training can then be adapted/created. A common response path can also be determined not just for individuals with suspicious banking activity, but also for individuals who are identified as possibly experiencing undetected dementia symptoms without suspicious banking activity.

Increase support for informal caregivers who provide care for persons with dementia.

Develop an affordable "train the trainer" dementia course based on the existing Alzheimer's Association caregiver support group leaders' training. Develop a model similar to the American Red Cross' CPR training program, whereby trained educators could then offer accessible and affordable dementia education to caregivers or others in the community.

LiveWell has an established history of providing caregiver education to professionals, family, formal and informal caregivers. We have an 8 hour training that has been delivered through the 1199 Union to CNAs in CT, we have delivered the 6 week SAVVY Caregiver program, and as a part of our current ACL-ADPI grant, we are offering a 6-week series (12 hours total) targeted for families who have a member recently diagnosed with dementia. Over our 25+ year history as a dementia service provider, we have provided education and consulting services for organizations

across the country seeking to improve their dementia services. We would be happy to work on the development of a 'train the trainer' course that specifically focuses on understanding dementia AND the specific resources available in Connecticut. We could certainly build upon the Dementia Friends program to offer a higher level of education.

Perhaps modify ""train the trainer" dementia course based on the existing Alzheimer's Association caregiver support group leaders' training" to read training that is based on progressive evidence informed or evidence based training (which may or may not be branded by the Alzheimer's Association).

Support and enhance rebalancing initiatives that focus on diversion of individuals with dementia who are at risk of nursing home placement to community-based settings.

- Increase funding to expand the CT Statewide Respite Care Program to reflect the growing demand. (Fiscal impact)
- Expand and set aside slots for individuals with younger onset Alzheimer's disease in the Connecticut Home Care Program for the Disabled. (Fiscal impact)
- Adult Day Care represents an option that prevents isolation and can delay or completely divert individuals from nursing facilities. Due to limited and diminishing reimbursements, several of Connecticut's Adult Day Centers are reducing services or closing. Ensure Adult Day Centers remain a viable community care option by increasing the current reimbursement level to meet operating costs based on level of care provided (e.g. medical model requires nurses, aides and medication/health monitoring). Daily rate should include transportation costs. Reimbursements should be adjusted annually to reflect Cost of Living Adjustments. (Fiscal impact) (Christy, Mairead)

Day care reimbursements continue to challenging and transportation costs are a significant burden to providers.

To minimize family disputes, ensure that the wishes of the individual are known and respected, and avoid costly court proceedings, encourage financial planning (including assessment of assets) and advanced directives with the help of an attorney with specific knowledge in elder, probate or estate law. (Mairead, Elderjustice Coalition)

As a part of their Administration on Community Living Alzheimer's Disease Program Initiative (ACL-ADPI) project, LiveWell is implementing a program that includes education sessions and a 1:1 service which includes time spent on comprehensive planning (e.g. planning for current and future care needs, legal, financial and comprehensive advance directives). Deeper dive education sessions have been held on End of Life Decision Making, Living Wills, and Legal Planning.

See additional documents provided by Anne Kenny, MD on Palliative/Hospice Care, Advance Directives, Surrogate Decision Making, need to monitor emerging trends in other terminal conditions (Aid in Dying, Voluntary Stopping of Eating or Drinking).

As mentioned in the last meeting, the above recommendation should be teased out to read something like:

> To minimize family disputes, ensure that the wishes of the individual are known and respected, and avoid costly court proceedings: ensure understanding on terminal nature of disease, end of life wishes, and surrogate decision making with help of medical/counseling professional with specific knowledge of dementia; establish comprehensive advance directives with the help of a medical/counseling professional or attorney with specific knowledge in elder law; encourage financial planning (including assessment of assets and costs associated with quality care) with an attorney with specifying knowledge in elder, probate or estate law.

Ensure coordination and connection to support services after diagnosis including: a checklist of next steps, identification of a care coordinator, and use of an integrated care model.

There are a number of emerging post-diagnostic support programs – both national and international. We would recommend that any integrated care models should be based on evidence-based/informed best practices, and provided by experienced personnel.

As a part of their Administration on Community Living Alzheimer's Disease Program Initiative (ACL-ADPI) project, LiveWell is piloting a program that includes a 6 week education series and a 1:1 service specifically designed to help families navigate their next steps after receiving a dementia diagnosis. LiveWell Navigators work in partnership with clients to identify areas of strengths, needs, hopes, and goals. Navigation is built upon foundational understanding of 'Me and My Story' and sessions focus five areas that have been identified as necessary and key components for living well with dementia. (Emotional Support, Dementia & Adaptive Strategies, Social & Meaningful Engagement, Planning, and Health & Wellness). Navigation meetings are personalized for each situation and can include anywhere from 3-10 visits over the course of 3-12 months. Over the course of the meetings, the navigator and clients work collaboratively to identify and address goals for each pillar to guide meaningful living, health, well-being and quality of life. When all five focus areas have been addressed, clients move into a self-management period and are educated on when/how to activate new supports/services or re-engage with a navigator to determine best next steps. The goal of the program is to equip families to address the changes people with dementia may encounter throughout the progressive stages of their dementia experience.

Explore federal funding for research and demonstrations to achieve this goal. The 2010 Affordable Care Act is providing for time-limited innovation and demonstration projects that could result in new information about the cost-effectiveness of Alzheimer's and dementia treatments and care practices centered around care coordination and transitional care models. Support CT's existing initiatives such as the State Innovation Model (SIM) and

Medicare and Medicaid Enrollees Care Coordination Demonstration and encourage focused efforts on individuals with dementia. (Margy at DORS)

In 2018 LiveWell received a 3 year ACL-ADPI cooperative agreement to pilot and demonstrate several new supports and services specifically targeted toward those living alone with dementia, those with intellectual disabilities and dementia, and caregiver consultations for behavioral expressions. As a part of this project LiveWell is piloting their Navigating Dementia Program (including education sessions and individual/family dementia navigation services), several evidence-based/informed Occupational Therapy interventions including Skills2Care, Skill2Care-ID, and Care of Persons in their Environment (COPE-CT), and Home Based Memory Rehabilitation. They are also hosting training and education opportunities on Dementia & Intellectual Disabilities, Dementia Specifid Occupational Therapy Interventions, and Dementia Friendly Training for First Responders, and other Community Contacts. The ACL-ADPI projects are highly regarded demonstration projects and provide the opportunity to launch new evidence-based/informed services to families impacted by dementia who are living in the community.

Enhance Care Quality

Study the financial impact of developing a Dementia Centers for Excellence (COE) or geriatric assessment units (GAU) at CT hospitals. (Dr. Dzanys)

The Department of Social Services developed the Interagency Referral Form (W10) to serve as physicians' orders for diagnoses, medications, treatments, recent immunizations, and allergies, as well as demographic information. The one-page form or an electronic version of the form developed by the facility is used by hospitals, nursing facilities and home care agencies to communicate essential care information for patient well-being. The Departments of Social Services and Public Health shall update the Interagency Referral Form (W10) to include a person-centered dementia care profile for pain management, wandering history, safety issues and behavioral triggers and reactions, or reflect other dementia care vulnerabilities and history. The form shall be used across the continuum of care providers. (May require legislation) (Mairead, Vicki Veltri, Mag Morelli)

There are few Alzheimer's and dementia training requirements for health care professionals and facilities serving individuals with Alzheimer's disease and dementia in Connecticut. Currently only "special care units" require dementia-specific training for staff. Connecticut's aging population and rebalancing initiatives towards home and community based services will increase demand for direct care workers employed in community-based settings such as home health aides, homemakers and companions and personal care assistants. See page 29 for detailed recommendations for dementia- specific training requirements across the continuum of care. (Requires legislation) (All)

There is a growing body of work on best care practices nationally and internationally (including training for physicans). We would recommend that all training should be based on evidence-based/informed best practices, and provided by experienced trainers.

To lay a foundation for training, we'd recommend the comprehensive work on Standards of Care

(downloadable from this page) by Alzheimer Scotland and their Promoting Excellence Framework which details the knowledge and skills required for dementia care workers (at 4 levels of expertise). Having an evidence based/informed framework to guide decisions on training requirements would provide a solid foundation for Connecticut legislators and providers. The Promoting Excellence Framework is a great example of a 'tiered' approach that was called for in this recommendation from the 2013 report (pg. 29).

- Currently, regulations for dementia training exist in Alzheimer's special care units or programs. There is a need to educate large numbers of people in fields and in roles that connect with individuals with dementia. Create a system of "tiered" education to meet the workforce needs. These levels of education should correlate to the level and degree of connection that the caregiver has to the person with dementia.

As far as physician education goes, we would recommend evidence based/informed training on best practices for delivering a diagnosis. Resources for this include results from the ABIDE study and the AD Appointment website ADappt: https://www.adappt.health/en/informatie

There are also a number of studies showing the educational impact of partnering medical school students with people with dementia (eg. The PAIRS Program, Buddy Program, the DUO Program). We would recommend these types of partnerships be a hallmark of CT medical and nursing school programs.

As a part of our Administration on Community Living Alzheimer's Disease Program Initiative (ACL-ADPI) project, LiveWell has begun providing professional education to CT Occupational Therapists on evidence based/informed OT interventions for persons with dementia and their caregivers. In Nov. 2019 we partnered with the Connecticut Occupational Therapy Association to host a Dementia Summit and we are fostering an ongoing "Community of Practice" on Dementia which will meet quarterly to support OT's professional development in best practices. We have also hosted certification training on specific evidence based/informed interventions (Skills2Care, COPE, Skills2Care-ID) for CT OTs.

Increase connectivity and training opportunities for the home and community based direct care workforce by utilizing emerging high tech training and education models. (all)

Integrate and continue basic level of dementia training and education for public safety responders, long-term care ombudsman, protective service employees, probate judges and court personnel. Expand annual missing persons police force training to include dementia education (CGS § 7-294o). (May require legislation) (all)

As a part of their Administration on Community Living Alzheimer's Disease Program Initiative (ACL-ADPI) project, LiveWell is partnering with the Connecticut Area Agencies on Aging to develop and deliver sector-based 'dementia friendly' training for public safety responders, meals on wheels workers, and community housing providers. Levering national best practices from the Dementia Friendly America network, a curriculum is currently being piloted in the North Central region and will be scaled to the other 4 regions over the course of the next 18 months. The Southington Fire and Police are the early adopters and are requiring all responders to complete this training. With current grant funding, LiveWell plans to host 16 trainings in hopes to train a minimum of 400 individuals.

Require mandatory dementia-specific training for hospital emergency room staff, including

nurses, physicians and medical technicians. (May require legislation) Build upon the existing collaboration between the Alzheimer's Association- CT Chapter and the CT Hospital Association. (Dr. Dzanys, all)

There is a growing body of work on this nationally and internationally. We would recommend that training should be based on evidence-based/informed best practices, and provided by experienced trainers.

Additional recommendations not addressed in this document

Explore and implement technology solutions that can be used to support the highest level of function and independent living for a variety of conditions (including dementia). Leverage learning by DDS (who have used technology supports extensively) and ensure people with dementia and families have access to technology solutions through insurances and Medicaid Waiver program.

Create a Specialized Task Group including persons with ID, family caregivers, dementia & ID professionals, ethicists and policymakers to explore the unique care, rights, and surrogate decision-making needs for emerging population of those with ID & Dementia. Charge the group to:

- Identify best practice resources for the care and support of individuals living with an intellectual disability AND dementia including diagnosis, non- pharmacological interventions, medication management, surrogate decision making, palliative care and advance directives
- Review existing policies and systems and evaluate alignment with needs of those with ID & Dementia.
- Mandate education for direct care workers and families on new ways to support those living with ID & Dementia

Explore and support the development of innovative, affordable residential solutions for people living with dementia.

Note: One thing we did note in the recommendations is that the Alzheimer's Association is frequently cited as the only resource for materials. While we greatly appreciate the Association, its efforts and resources, we believe it is important to include additional references for best practice resources. The following links are to national resources for evidence based/informed best practices:

National Institute on Aging

https://www.nia.nih.gov/health/alzheimers

National Research Summit on Care, Services, and Supports for Persons with Dementia and Their Caregivers

https://www.nia.nih.gov/2020-dementia-care-summit

National Alzheimer's Disease Resource Center – all best practice resources from ACL – storehouse of webinars and reports

https://nadrc.acl.gov

Discussion and Recommendations for Dementia Working Group on Palliative and Hospice Care for Persons Living with Dementia

Anne Kenny, MD
LiveWell Alliance/Resilient Living, PC

Goals: The right care at the right time

Dementia is a progressive and terminal illness, characterized by impaired memory, thinking, reasoning, communication and, ultimately, physical function including walking and swallowing. Abilities, including planning and self-care, deteriorate as the disease progresses. Because of this, care partners are often left with the emotionally challenging task of decisions about future care and life-sustaining treatments. For a likely host of reasons, people living with dementia receive sub-optimal care during the late stage of the disease, including overly aggressive treatment, low palliative care referrals, and poor pain/symptom management.

- Only 3-39% of PLWD complete advance care planning.
- The rate of hospice referral for PLWD is only about 11%.
- Physicians' training focuses on cure, rather than care.
- Dementia is both chronic and terminal - a combination not well addressed in the healthcare environment.
- Prognostication for PLWD is difficult, making the referral to and scrutiny while enrolled complex.
- Research in palliative and hospice in PLWD is limited.

A recent qualitative study that included the opinions PLWD and their carers regarding care in the late stage of dementia found 5 themes

- Avoiding dehumanizing treatment and care
    - Remain socially connected
    - Delaying institutionalization
    - Rejecting burdens of futile treatment
    - ACP may lock into a pathway
- Confronting emotionally difficult conversations
    - Difficult to address death
    - Unprepared to face cognitive decline
- Navigating existential tensions
    - Accepting inevitable incapacity and death
    - Fear of causing the death
    - Alleviating decisional responsibility
- Defining personal autonomy
    - Struggling with unknown preferences
    - Depending on carer advocacy (and for carers – if to breach ACP)
- Lack of confidence in the healthcare setting
    - Distrust clinician knowledge of dementia
    - Difficulty in receiving palliative or hospice support

Finally, after listening to the discussion of the working group and that the discussion of advanced directive documentation and issues will be largely in the realm of the legal system, I believe there are trends and concerns that need a wider discussion.

- Many people are not engaged in ACP and we need a full contingency of spiritual leaders, healthcare leaders, dementia specialists and legal experts contemplating and discussing how to increase these numbers.
- We are facing a time when ACP is also being pushed and tested. Aid in Dying and Voluntary Stop Eating and Drinking (VSED) is becoming legal in more and more states. Those living with dementia are asking for Aid in

Dying that serves their particular circumstance. U Washington has proposed an advance directive that clarifies what type of treatment (antibiotics, hospitalization, etc) for each stage of dementia (https://static1.squarespace.com/static/5a0128cf8fd4d22ca11a405d/t/5cd9efd571c10b87cbaf4676/1557786582104/dementia-directive.pdf) . Going even further, Judith Schwarz, RN, PhD from End of Life Choices New York has proposed an advance directive that limits hand feeding when one is no longer able to feed themselves. (https://www.nytimes.com/2018/04/30/well/live/an-advance-directive-for-patients-with-dementia.html).

Continued discussion of the trends that are coming in dementia care need further discussion a group of stakeholders in the state to prepare for the changes, with the goal to minimize patient and family distress, avoid costly and traumatizing miscommunications and court cases.

Recommendations

Overarching Theme: Enhancing ability of PLWD/carers to access information/support/techniques to aid in conversations and decisions at the late stage of dementia so that care can be modified to fit personal/family goals. Enhance the discussion on advance directives in those that avoid/ignore them and prepare for the trends in limits that others are asking for in their advance directive.

Potential enhancements

PLWD/Carer

- Navigation assistance enhanced in common doorways they enter such as Area Agency on Aging or Alzheimer Association
- Using ACP that addresses flexibility to carer (e.g. Prepareforyourcare.org) and that addresses issues other than medical to get at goals (e.g. Five Wishes)

- Enhanced understanding of the AlzAssoc helpline to avoid unneeded emergency department visits or hospitalization

Primary Physician

- Detailing on resources to provide to patients regarding navigation/ACP
- Detailing on hospice criterion for dementia

Homehealth Agencies/Hospice

- Modified reimbursement away from medical model to chronic illness/palliative care model
- Ability to use Telehealth (with reimbursement) to allow for care at the time of need to avoid unneeded emergency department visits or hospitalization
- Seminars to assist in understanding documentation for hospice for PLWD to alleviate fears of entering

State and all Stakeholders

- Expand discussions and recommendation on ACP from just the legal stakeholders to all involved
- Continue discussion of changes proposed and likely coming in more robust advance directive with attention to their potential controversial aspects

CONNECTICUT

Statutes

Conn. P.A. 14-194 (effective October 1, 2014)

Summary: This new statute that requires that home health agencies, residential care homes, assisted living services agencies, and licensed hospice care organizations provide training and education on Alzheimer's disease and dementia symptoms and care to all staff providing direct care upon employment and annually thereafter.

Connecticut General Statutes Annotated
Undesignated Section
P.A. 14-194 An Act Concerning the Alzheimer's Disease and Dementia Task Force's Recommendations on Training

§ 2. Training on Alzheimer's disease and dementia symptoms for licensed hospice care organization staff [Tentative name line supplied by publisher]

Each home health agency, residential care home and assisted living services agency, as those terms are defined in section 19a-490, and each licensed hospice care organization operating pursuant to section 19a-122b shall provide training and education on Alzheimer's disease and dementia symptoms and care to all staff providing direct care upon employment and annually thereafter. The Commissioner of Public Health shall adopt regulations, in accordance with the provisions of chapter 54,1 to implement the provisions of this section.

§ 11. Training on Alzheimer's disease and dementia symptoms for Department of Social Service's protective services employees [Tentative name line supplied by publisher]

The Commissioner of Social Services shall ensure that all employees assigned to the Department of Social Service's protective services for the elderly program who directly interact with elderly persons receive annual training in Alzheimer's disease and dementia symptoms and care.

Conn. Gen. Stat. § 17a-227 (effective October 1, 2014)

Summary: This statute was amended recently to require all residential facilities serving persons with Down syndrome 50 years of age or older shall have at least one staff member trained in Alzheimer's disease and dementia symptoms and care.

Connecticut General Statutes Annotated
Title 17A. Social and Human Services and Resources
Chapter 319B Department of Developmental Services

§ 17a-227. Licensing and regulation of residential facilities for persons with intellectual

disability, Prader-Willi syndrome or autism spectrum disorder

(b) The commissioner shall adopt regulations, in accordance with the provisions of chapter 54,[1] to insure the comfort, safety, adequate medical care and treatment of such persons at the residential facilities described in subsection (a) of this section. Such regulations shall include requirements that: (1) All residential facility staff be certified in cardiopulmonary resuscitation in a manner and time frame prescribed by the commissioner; (2) records of staffing schedules and actual staff hours worked, by residential facility, be available for inspection by the department upon advance notice; (3) each residential facility develop and implement emergency plans and staff training to address emergencies that may pose a threat to the health and safety of the residents of the facility; (4) department staff verify during quality service reviews and licensing inspections, that (A) staff is adequately trained to respond in an emergency, and (B) a summary of information on each resident is available to emergency medical personnel for use in an emergency; (5) all residential facilities serving persons with Down syndrome fifty years of age or older have at least one staff member trained in Alzheimer's disease and dementia symptoms and care; and (6) not less than one-half of the quality service reviews, licensing inspections or facility visits conducted by the department after initial licensure are unannounced.

Conn. Gen. Stat. § 17b-349e (2013)

Summary: This statute provides for respite care services for caretakers of Alzheimer's patients, and mandates that qualified providers must have specialized training in Alzheimer's disease.

Connecticut General Statutes Annotated
Title 17B. Social Services
Chapter 319Y Long-Term Care

§ 17b-349e. Respite care services for caretakers of Alzheimer's patients. Definitions. Requirements.

(a) As used in this section:

(1) "Respite care services" means support services which provide short-term relief from the demands of ongoing care for an individual with Alzheimer's disease.

(2) "Caretaker" means a person who has the responsibility for the care of an individual with Alzheimer's disease or has assumed the responsibility for such individual voluntarily, by contract or by order of a court of competent jurisdiction.

(3) "Copayment" means a payment made by or on behalf of an individual with Alzheimer's disease for respite care services.

(4) "Individual with Alzheimer's disease" means an individual with Alzheimer's disease or related disorders.

(b) The Commissioner on Aging shall operate a program, within available appropriations, to provide respite care services for caretakers of individuals with Alzheimer's disease, provided such individuals with Alzheimer's disease meet the requirements set forth in subsection (c) of this section. Such respite care services may include, but need not be limited to (1) homemaker services; (2) adult day care; (3) temporary care in a licensed medical facility; (4) home-health care; (5) companion services; or (6) personal care assistant services. Such respite care services

may be administered directly by the Department on Aging, or through contracts for services with providers of such services, or by means of direct subsidy to caretakers of individuals with Alzheimer's disease to purchase such services.

(c) (1) No individual with Alzheimer's disease may participate in the program if such individual (A) has an annual income of more than forty-one thousand dollars or liquid assets of more than one hundred nine thousand dollars, or (B) is receiving services under the Connecticut home-care program for the elderly. On July 1, 2009, and annually thereafter, the commissioner shall increase such income and asset eligibility criteria over that of the previous fiscal year to reflect the annual cost of living adjustment in Social Security income, if any.

(2) No individual with Alzheimer's disease who participates in the program may receive more than three thousand five hundred dollars for services under the program in any fiscal year or receive more than thirty days of out-of-home respite care services other than adult day care services under the program in any fiscal year, except that the commissioner shall adopt regulations pursuant to subsection (d) of this section to provide up to seven thousand five hundred dollars for services to a participant in the program who demonstrates a need for additional services.

(3) The commissioner may require an individual with Alzheimer's disease who participates in the program to pay a copayment for respite care services under the program, except the commissioner may waive such copayment upon demonstration of financial hardship by such individual.

(d) The commissioner shall adopt regulations in accordance with the provisions of chapter 541 to implement the provisions of this section. Such regulations shall include, but need not be limited to (1) standards for eligibility for respite care services; (2) the basis for priority in receiving services; (3) qualifications and requirements of providers, which shall include specialized training in Alzheimer's disease, dementia and related disorders; (4) a requirement that providers accredited by the Joint Commission on the Accreditation of Healthcare Organizations, when available, receive preference in contracting for services; (5) provider reimbursement levels; (6) limits on services and cost of services; and (7) a fee schedule for copayments.

(e) The Commissioner on Aging may allocate any funds appropriated in excess of five hundred thousand dollars for the program among the five area agencies on aging according to need, as determined by said commissioner.

Conn. Gen. Stat. § 17b-403 (effective October 1, 2014)

Summary: The Long-Term Care Ombudsman statute was amended effective October 1, 2014 to require the Ombudsman to provide training to representatives in Alzheimer's disease and dementia symptoms and care.

Connecticut General Statutes Annotated
Title 17B. Social Services
Chapter 319AA Office of Long-Term Care Ombudsman

§ 17b-403. Duties of State Ombudsman

(b) The State Ombudsman shall serve on a full-time basis, and shall personally or through

representatives of the office:

(6) Provide administrative and technical assistance to representatives and training in areas including, but not limited to, Alzheimer's disease and dementia symptoms and care;

Conn. Gen. Stat. § 19a-195a (effective October 1, 2014)

Summary: This statute was amended recently to require that emergency medical technicians must complete a 30 hours refresher training that includes training in Alzheimer's disease and dementia symptoms and care.

Connecticut General Statutes Annotated
Title 19A. Public Health and Well-Being
Chapter 368D Emergency Medical Services

§ 19a-195a. Regulations re: recertification and state-wide standardization of certification

(a) The Commissioner of Public Health shall adopt regulations in accordance with the provisions of chapter 541 to provide that emergency medical technicians shall be recertified every three years. For the purpose of maintaining an acceptable level of proficiency, each emergency medical technician who is recertified for a three-year period shall complete thirty hours of refresher training approved by the commissioner, or meet such other requirements as may be prescribed by the commissioner. The refresher training or other requirements shall include, but not be limited to, training in Alzheimer's disease and dementia symptoms and care.

(b) The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, to (1) provide for state-wide standardization of certification for each class of emergency medical services personnel, including, but not limited to, (A) emergency medical technicians, (B) emergency medical services instructors, and (C) emergency medical responders, (2) allow course work for such certification to be taken state-wide, and (3) allow persons so certified to perform within their scope of certification state-wide.

Conn. Gen. Stat. § 19a-490u (effective October 1, 2015)

Summary: Hospitals must train direct care staff on dementia.

Connecticut General Statutes Annotated
Title 19A. Public Health and Well-Being
Chapter 490u Training in symptoms of dementia for hospital direct care staff.

Sec. 19a-490u. Training in symptoms of dementia for hospital direct care staff.

On or after October 1, 2015, each hospital, as defined in section 19a-490, shall be required to include training in the symptoms of dementia as part of regularly provided training to staff members who provide direct care to patients.

Summary: These sections of the statute - 512, 513, 515 and 519 - governing the licensure of nursing home administrators were amended by Public Act No. 14-194, effective November 1, 2014, and require certain Alzheimer and dementia specific training as a condition of licensure and renewal of licensure for nursing home administrators.

Connecticut General Statutes Annotated
Title 19A. Public Health and Well-Being
Chapter 368v Health Care Institutions

§ 19a-512. Licensure by examination. Minimum requirements

(b) Minimum education and training requirements for applicants for licensure are as follows:

(1) Each person other than an applicant for renewal, applying prior to February 1, 1985, shall have completed: (A) A program so designed as to content and so administered as to present sufficient knowledge of the needs to be properly served by nursing homes, laws and regulations governing the operation of nursing homes and the protection of the interest of patients therein and the elements of good nursing home administration, or presented evidence satisfactory to the Department of Public Health of sufficient education and training in the foregoing fields; and (B) a one-year residency period under the joint supervision of a duly licensed nursing home administrator in an authorized nursing home and an accredited institution of higher education, approved by said department, which period may correspond to one academic year in such accredited institution. The supervising administrator shall submit such reports as may be required by the department on the performance and progress of such administrator-in-training, on forms provided by the department. This subdivision shall not apply to any person who has successfully completed a program of study for a master's degree in nursing home administration or in a related health care field and who has been awarded such degree from an accredited institution of higher learning.

(2) Each such person applying on or after February 1, 1985, in addition to the requirements of subdivision (1) of this subsection, shall either (A) have a baccalaureate degree in any area and have completed a course in long-term care administration approved by the department, or (B) have a master's degree in long-term care administration or in a related health care field approved by the commissioner.

(3) Each such person applying on or after November 1, 2014, in addition to the requirements of subdivisions (1) and (2) of this subsection, shall have completed training in Alzheimer's disease and dementia symptoms and care.

§ 19a-513. Licensure by endorsement

In order to be eligible for licensure by endorsement pursuant to sections 19a-511 to 19a-520, inclusive, a person shall submit an application for endorsement licensure on a form provided by the department, together with a fee of two hundred dollars, and meet the following requirements: (1) Hold a current license in good standing as a nursing home administrator in another state that was issued on the basis of holding, at a minimum, a baccalaureate degree and having passed the examination required for licensure in such state; (2) have practiced as a licensed nursing home administrator for not less than twelve months within the twenty-four-month period preceding the date of the application; and (3) have received training or education in long-term care, including,

but not limited to, Alzheimer's disease and dementia symptoms and care or have certified, in writing, agreement to receive such training or education not later than one hundred twenty days after license issuance. No license shall be issued under this section to any applicant against whom disciplinary action is pending or who is the subject of an unresolved complaint.

§ 19a-515. License renewal. Continuing education requirement

(b) Each licensee shall complete a minimum of forty hours of continuing education every two years, including, but not limited to, training in Alzheimer's disease and dementia symptoms and care. Such two-year period shall commence on the first date of renewal of the licensee's license after January 1, 2004. The continuing education shall be in areas related to the licensee's practice. Qualifying continuing education activities are courses offered or approved by the Connecticut Association of Healthcare Facilities, LeadingAge Connecticut, Inc., the Connecticut Assisted Living Association, the Connecticut Alliance for Subacute Care, Inc., the Connecticut Chapter of the American College of Health Care Administrators, the Association For Long Term Care Financial Managers, the Alzheimer's Association or any accredited college or university, or programs presented or approved by the National Continuing Education Review Service of the National Association of Boards of Examiners of Long Term Care Administrators, or by federal or state departments or agencies.

§ 19a-519. Regulations. Programs of instruction and training

(a) The Commissioner of Public Health shall adopt regulations, in accordance with the provisions of chapter 54,1 with respect to standards for: (1) Approval of institutions of higher education, (2) course or degree requirements, or both, for licensing and renewal of licenses, which requirements shall include, but not be limited to, nursing home administration, management behavior, financial management, business administration, psychosocial behavior, gerontology, Alzheimer's disease and dementia, (3) the residency training program, and (4) reinstatement of individuals who fail to renew their licenses upon expiration, as provided in section 19a-515, to carry out the provisions of sections 19a-511 to 19a-520, inclusive.

(b) The Commissioner of Public Health may make provision for one or more programs of instruction and training sufficient to meet the requirements of sections 19a-511 to 19a-520, inclusive, considering the accessibility of such programs to residents of this state, if he finds there are not a sufficient number of approved courses conducted in this state.

Conn. Gen. Stat. § 19a-522c (effective October 1, 2014)

Summary: This statute was amended recently to require that a nursing home administrator must designate one staff person to make recommendations concerning residents with dementia including factors which affect person-centered care; wellness indicators; and staff training programs for dementia care capability. The administrator shall also ensure that all staff receive training upon employment and annually thereafter in Alzheimer's disease and dementia symptoms and care.

Connecticut General Statutes Annotated
Title 19A. Public Health and Well-Being
Chapter 368v Health Care Institutions

§ 19a-522c. Chronic and convalescent nursing homes and rest homes with nursing supervision: In-service training

(a) A nursing home administrator of a chronic and convalescent nursing home or a rest home with nursing supervision shall ensure that all facility staff receive annual in-service training in an area specific to the needs of the patient population at such facilities, including patients' fear of retaliation from employees or others. A nursing home administrator shall ensure that any person conducting the in-service training is familiar with needs of the patient population at the facility, provided such training need not be conducted by a qualified social worker or qualified social worker consultant. A nursing home administrator shall ensure that the in-service training in patients' fear of retaliation includes discussion of (1) patients' rights to file complaints and voice grievances, (2) examples of what might constitute or be perceived as employee retaliation against patients, and (3) methods of preventing employee retaliation and alleviating patients' fear of such retaliation.

(b) A nursing home administrator of a chronic and convalescent nursing home or a rest home with nursing supervision shall designate one staff person in each such home to review and make recommendations to the administrator concerning residents with dementia, including, but not limited to: (1) Factors which affect person-centered care, (2) wellness indicators, and (3) staff training programs for dementia care capability. The designated staff person shall monitor implementation of approved recommendations.

(c) A nursing home administrator of a chronic and convalescent nursing home or a rest home with nursing supervision shall ensure that all facility staff receive training upon employment and annually thereafter in Alzheimer's disease and dementia symptoms and care.

(d) In accordance with section 19a-36, the Commissioner of Public Health shall amend the Public Health Code to implement the provisions of this section.

Conn. Gen. Stat. § 19a-562 (2007)

Summary: This statute governs Alzheimer's special care units in nursing facilities, residential care homes, assisted living facilities, adult congregate living facilities, adult day care centers, hospice and adult foster homes, and requires disclosure of special staff training requirements.

Connecticut General Statutes Annotated
Title 19A. Public Health and Well-Being
Chapter 368v Health Care Institutions

§19a-562. Alzheimer's special care units or programs. Definitions. Disclosure requirements.

(a) As used in this section and section 19a-562a, "Alzheimer's special care unit or program" means any nursing facility, residential care home, assisted living facility, adult congregate living facility, adult day care center, hospice or adult foster home that locks, secures, segregates or provides a special program or unit for residents with a diagnosis of probable Alzheimer's disease, dementia or other similar disorder, in order to prevent or limit access by a resident outside the designated or separated area, or that advertises or markets the facility as providing specialized care or services for persons suffering from Alzheimer's disease or dementia.

(b) On and after January 1, 2007, each Alzheimer's special care unit or program shall provide written disclosure to any person who will be placed in such a unit or program or to that person's legal representative or other responsible party. Such disclosure shall be signed by the patient or responsible party and shall explain what additional care and treatment or specialized program

will be provided in the Alzheimer's special care unit or program that is distinct from the care and treatment required by applicable licensing rules and regulations, including, but not limited to:

(1) Philosophy. A written statement of the overall philosophy and mission of the Alzheimer's special care unit or program that reflects the needs of residents with Alzheimer's disease, dementia or other similar disorders.

(2) Preadmission, admission and discharge. The process and criteria for placement within or transfer or discharge from the Alzheimer's special care unit or program.

(3) Assessment, care planning and implementation. The process used for assessing and establishing and implementing the plan of care, including the method by which the plan of care is modified in response to changes in condition.

(4) Staffing patterns and training ratios. The nature and extent of staff coverage, including staff to patient ratios and staff training and continuing education.

(5) Physical environment. The physical environment and design features appropriate to support the functioning of cognitively impaired adult residents.

(6) Residents' activities. The frequency and types of resident activities and the ratio of residents to recreation staff.

(7) Family role in care. The involvement of families and family support programs.

(8) Program costs. The cost of care and any additional fees.

(c) Each Alzheimer's special care unit or program shall develop a standard disclosure form for compliance with subsection (b) of this section and shall annually review and verify the accuracy of the information provided by Alzheimer's special care units or programs. Each Alzheimer's special care unit or program shall update any significant change to the information reported pursuant to subsection (b) of this section not later than thirty days after such change.

Conn. Gen. Stat. § 19a-562a (effective October 1, 2014)

Summary: This statute outlines the education and training requirements for staff members of Alzheimer's special care units or programs. It requires that all licensed and registered direct care staff and nurse's aides who provide direct care have at least eight (8) hours of dementia-specific training, and eight (8) hours of annual continuing education. In addition, direct care staff must have two (2) hours of pain recognition training. All unlicensed or unregistered staff must have a minimum of one (1) hour of dementia-specific training.

Connecticut General Statutes Annotated

Title 19A. Public Health and Well-Being

Chapter 368v Health Care Institutions

§19a-562a. Pain recognition and management training requirements for nursing home facility staff. Staff training requirements for Alzheimer's special care units or programs.

(a) Each nursing home facility that is not a residential care home or an Alzheimer's special care unit or program shall (1) annually provide a minimum of two hours of training in pain recognition and administration of pain management techniques, and (2) provide a minimum of

one hour of training in oral health and oral hygiene techniques not later than one year after the date of hire and subsequent training in said techniques annually thereafter, to all licensed and registered direct care staff and nurse's aides who provide direct patient care to residents.

(b) Each Alzheimer's special care unit or program shall annually provide Alzheimer's and dementia specific training to all licensed and registered direct care staff and nurse's aides who provide direct patient care to residents enrolled in the Alzheimer's special care unit or program. Such requirements shall include, but not be limited to, (1) not less than eight hours of dementia-specific training, which shall be completed not later than six months after the date of employment or, if the date of employment is on or after October 1, 2014, not later than one hundred twenty days after the date of employment and not less than eight hours of such training annually thereafter, and (2) annual training of not less than two hours in pain recognition and administration of pain management techniques for direct care staff.

(c) Each Alzheimer's special care unit or program shall annually provide a minimum of one hour of Alzheimer's and dementia specific training to all unlicensed and unregistered staff, except nurse's aides, who provide services and care to residents enrolled in the Alzheimer's special care unit or program. For such staff hired on or after October 1, 2007, such training shall be completed not later than six months after the date of employment and, for such staff hired on or after October 1, 2014, not later than one hundred twenty days after the date of employment.

Conn. Gen. Stat. § 20-206mm(e) (effective October 1, 2015)

Summary: EMTs will be recertified every three years by completing 30 hours of refresher training that shall include Alzheimer's symptoms and care education.

(e) An emergency medical responder, emergency medical technician, advanced emergency medical technician or emergency medical services instructor shall be recertified every three years. For the purpose of maintaining an acceptable level of proficiency, each emergency medical technician who is recertified for a three-year period shall complete thirty hours of refresher training approved by the commissioner or meet such other requirements as may be prescribed by the commissioner. The refresher training or other requirements shall include, but not be limited to, training in Alzheimer's disease and dementia symptoms and care.

Conn. Gen. Stat. § 45a-77 (effective October 1, 2014)

Summary: This statute was amended effective October 1, 2014, and requires that the Probate Court Administrator shall offer training to probate judges, paid conservators and other fiduciaries in Alzheimer's disease and dementia

Connecticut General Statutes Annotated
Title 45A. Probate Courts and Procedures
Chapter 801. Probate Court: Administrative Provisions
Part V. Probate Court Administrator

§ 45a-77. Powers and duties of Probate Court Administrator. Regulations. Review of probate court procedures. Examination of probate court records and files

(g) The Probate Court Administrator shall develop a plan to offer training to probate judges, paid conservators and other fiduciaries in diseases and disorders affecting the judgment of a person, including, but not limited to, Alzheimer's disease and dementia.

Regulations

Conn. Agencies Regs. § 17b-349e-8 (2012)

Summary: This regulation outlines the education and training qualifications for care providers.

Regulations of Connecticut State Agencies
Title 17B. Social Services
Department of Social Services
Connecticut Statewide Respite Care Program

Sec. 17b-349e-8. Provider qualifications and requirements

(b) Providers shall have demonstrated prior experience and training in delivering services to individuals with Alzheimer's disease and agree to provide services at the rates set by the department.

(d) Providers shall meet the requirements of provider participation of the specified services as established for the Connecticut Home Care Program for Elders, pursuant to section 17b-342-2 of the Regulations of Connecticut State Agencies to the extent that such requirements do not conflict with sections 17b-349e-1 to 17b-349e-9, inclusive, of the Regulations of Connecticut State Agencies.