Final Performance Report

Project Title: Rapid Response Expert Team

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Executive Summary

The purpose of the Rapid Response Expert Team (RRET) project was to improve the effectiveness of a multi-disciplinary team (MDT); improve client outcomes by integrating medical practitioners into the Adult Protective Services (APS) delivery system; and utilize the Tool for Risk, Interventions and Outcomes (TRIO) for assessing risk and measuring outcomes. The target population was elders/dependent adults served by APS and the MDT with difficult to resolve complex medical and mental health issues who agreed to participate in an in-home evaluation and recommendations by a medical practitioner(s). The scope of the project was an 18-month study. The project exceeded its objectives by demonstrating improvement in effectiveness and functioning of the MDT, eliminating or reducing the protective issue in 91% of the sample and determining the validity and reliability of the TRIO. An important lesson was that the increased time spent by APS social workers during collaboration and consultation with the medical practitioners was outweighed by the sense of efficacy, increased job satisfaction and improved client outcomes. A key product of the RRET project is the TRIO and accompanying research findings. One finding indicated that the prognosis of non-recurrence had significant and substantial association with actual 180-day recidivism with a high degree of accuracy by the APS social worker in distinguishing which clients are most likely to return to the system. The RRET project has implications for practice and public policy. Utilizing a risk assessment tool that is person centered versus allegation driven ensures a more comprehensive investigation. For policy, a bifurcated social work/medical/mental health driven APS system is unlikely to meet the needs of the aging population. By measuring outcomes, APS is poised to meet the challenges of unstable funding. Although the findings from the project supported our hypothesis, replicating the model in other systems would ensure the results are consistent and inspire continued interest in advancing the field of study in elder and dependent adult abuse and neglect.

Introduction

Provide a brief overview, background info necessary to understand project planning strategies, goals, objectives, activities and findings

The Rapid Response Expert Team (RRET) project began on July 1, 2010 and ended December 31, 2011. A six month no cost extension was requested to ensure cases that came into APS in the months of May and June of 2011 were included in the study.

The APS team is comprised of 12 seasoned multi-cultural, bi-lingual social workers and one Public Health Nurse. Many of the social workers have advanced degrees. The team has little if any turn-over and is managed by one APS Coordinator and one supervisor. The average age of the team is about 45.

In 2008, the County of Ventura Human Services Agency Adult Protective Services Program recognized the critical nature of funding in California's APS delivery system and the importance of developing strategies to meet the needs of the changing landscape of the aging population. Researchers and social workers with direct experience and knowledge of the field support the perspective that the needs of this population are becoming more complex and that these complexities are magnified in the at-risk elder/dependent populations served by APS programs. The premise for the project was that a traditional social work/social service driven system alone would not be sufficient to keep pace with the needs of the population and that APS would remain at a disadvantage for sustainable funding to support a comprehensive approach to APS service delivery without an empirical and integrated approach relating risk assessment, interventions and measurable outcomes.

The elderly population is expanding and although many remain vibrant, healthy and active into their later years, some are not so lucky and require outside intervention to maintain their safety, stability, health and wellbeing. Many of these are referred to APS and enter with a

myriad of complex medical, mental health and social issues. Although people are living longer than previous generations, chronic disease is rising to epidemic proportions and untreated or under-treated chronic health conditions including mental health issues is common within the APS target population. If this were not enough, the economic downturn significantly impacts the financial stability of elders and dependent adults and some choose to sacrifice health and safety for food and shelter while others become targets for predators. Research from Brenda Plassman, Ph. D *Annals of Internal Medicine,* 2008, suggests that over a fifth of seniors has measurable cognitive deficits not due to Alzheimer's disease and do not reach the clinical threshold for dementia and from our experience, it is this decline that expose the aging population and in particular the at-risk elder to abuse and neglect by others and self-neglect.

The goal of the project was to reduce or eliminate the protective issue with improvement in health, safety and stability for elders 65 and older and dependent adults age 18-64 with difficult to resolve complex medical and mental health risk indicators served by Adult Protective Services and the Rapid Response Multi-Disciplinary Team. The project had three objectives:

1. Utilize the County of Ventura TRIO (Tool for Risk, Interventions and Outcomes)
2. Conduct in-home assessment by medical/mental health practitioners
3. Increase medical/mental health resources to the existing Rapid Response Multi-Disciplinary Team

The findings of the project exceeded our expectations. During the course of the project, the TRIO was converted from paper to an electronic tool that can be used easily in the field or office. The TRIO is available to other state or county entities at no cost. Training is required to ensure reliable outcomes and is offered at no cost.

Introduction section contributed by David H. Sommerfeld, Ph. D and Gregory A. Aarons, Ph. D; University of California San Diego

Study Context and Goals:

Ventura County, California, Human Services Agency designed and developed the Tool for Risk, Intervention, and Outcomes (TRIO) and partnered with a team of investigators from the University of California, San Diego and San Diego State University to conduct a multi-faceted assessment of the initial APS data collected via the TRIO. The examination of the TRIO data was designed to accomplish the following primary four goals:

1. Provide a detailed assessment of the TRIO data for APS clients.
2. Identify distinct risk and intervention profiles from the TRIO data.
3. Assess the relationship between TRIO risk, interventions, and outcomes.
4. Test the validity and reliability of the TRIO tool for APS practice.

Assessment of APS Client TRIO Data

Data for this study came from the 2,505 Ventura County APS dependent adult and elder adult episodes with a TRIO completed between 11-1-2009 and 6-30-2011. During the study timeframe 73.5% of the episodes involved elder adults (age 65 and over) and 26.5% involved dependent adults (age 18-64). The distribution of TRIO risk items indicated that the types of risks experienced by the clients varied substantially between allegation and disposition categories. For both elder adult and dependent adult episodes, there appeared to be a core set of TRIO intervention indicators received by many APS clients. Clients with the most clearly documented need for services (i.e., those with confirmed allegations), received the widest range of intervention services. Among elder adult and dependent adult episodes with confirmed

allegations, positive financial, health, and/or safety/stability outcomes were achieved in the majority of the episodes however, approximately 25-30% had an unresolved protective issue at episode closure.

As part of the TRIO, social workers recorded a determination of the client's prognosis for non-recurrence that ranged from "poor" to "excellent" at the close of each episode. For elder adults, this measure of prognosis was found to be associated with actual 180-day recidivism indicating that the social workers were frequently able to successfully identify the clients most likely to return back into APS.

Identification of TRIO Risk and Intervention Profiles

Latent class analysis (LCA) techniques were used to derive meaningful risk profiles for each elder adult confirmed allegation type. The LCA results indicated that there were four risk profiles evident among the self-neglect episodes, four risk profiles for abuse-by-other episodes, and two different risk profiles for episodes of clients with both self-neglect and abuse-by-other confirmed allegations. While some individual characteristics might be evident in more than one risk profile, the constellation or cluster of risk indicators made each risk profile distinct. The risk profiles used to characterize APS clients were frequently related to specific APS outcomes.

LCAs conducted with the TRIO intervention data for each of the 10 risk profiles generally identified two distinct groups of clients – those that indicated extensive engagement in APS interventions and those with limited participation in APS interventions. The clients in the higher intervention participation group were often associated with achieving more favorable financial, health, and safety related outcomes and were much less likely to have an unresolved protective issue.

Relationship between Risks, Interventions, and Outcomes

Results of the multivariate regression analyses provided additional support for the finding that distinct sets of clients share particular risk factor characteristics and that these risk profiles were directly related to client outcomes. Additionally, low participation in APS interventions was a strong predictor of unresolved protective issues and unresolved protective issues were found to be related to a poorer prognosis for non-recurrence and increased 180-day recidivism. Clients with a better prognosis for non-recurrence had much lower odds of recidivating within 180 days than clients with a poor prognosis.

TRIO Validity and Reliability

This study also assessed the validity and reliability of the newly developed TRIO. Since there was no single measure available with which to assess the validity of the multi-faceted TRIO, we utilized principles from three different approaches: content validity, concurrent validity, and predictive validity. Overall, the examination of the validity of the TRIO data indicated that, where feasible to assess, the TRIO data were consistent with expectations and suggestive of a valid measurement tool. The strong results from the inter-rater reliability test in which APS workers reviewed specially created case narratives and completed a TRIO for each one provided evidence that the TRIO can likely be consistently and reliably completed when appropriate training has been provided.

Policy and Practice Implications

Several important implications for policy and practice were generated by the results of this study. Given the finding that APS social workers have the ability to identify clients most likely to recidivate back into APS, providing additional longer term services to the high risk clients may

help reduce preventable APS recidivism and promote the ongoing well-being of the vulnerable populations traditionally served by the APS system. Future study is needed to examine the role that longer-term follow-up and support can play in reducing APS recidivism.

The findings suggest that APS client engagement and retention strategies warrant explicit attention to help promote maximum client participation and favorable outcomes. In addition, the individual TRIO risk indicators and the identified risk profiles highlighted the diverse range of risks and their complex interactions found among the APS clients. To adequately address these concerns the APS system must have the capacity to provide a wide range of services and develop partnerships with affiliated agencies for expertise not regularly available within the APS system and outside the scope of traditional social work practice.

Finally, the development of tools like the TRIO can help to further research partnerships within the field of APS by collecting an extensive amount of data regarding client risk indicators, interventions received, and outcomes attained. Such data are important for developing a better understanding of the needs of APS clients and the role that specific interventions can play in promoting more positive client outcomes and a reduction of future, preventable APS recidivism.

(End of work submitted by University of California San Diego)

Integrating medical practitioners into an existing multi-disciplinary team improved both the effectiveness and functioning of the team as suggested by the results of the Integrated Team Monitoring & Assessment survey. Three surveys were conducted throughout the project showing slight improvement in team functioning from the pre-survey to the mid-survey. However, when compared to the initial survey, the overall score for the final survey increased by over 18 percentage points. This indicates a positive overarching improvement in team functioning over

time. The project increased the capacity of the existing multi-disciplinary team by 68% demonstrating strong support for the project by community partners.

Most striking was the results of medical practitioners working with the APS social worker and conducting in-home assessments. Of the 152 cases presented to the Rapid Response Expert Team, 102 clients or 67% of the total cases agreed to the in-home assessment and participated in the services recommended. Of those, 91% had an elimination or reduction in the protective issue and showed improvement in health, safety and stability far exceeding our anticipated outcome of 70%.

The project employed a number of strategies for the planning and implementation of the project. One of the successful strategies was seeking and obtaining the commitment and support of the Human Services Agency Director who placed APS as one of the priority program areas for the agency. The second successful strategy was the creation of the Project Work Group comprised of key members of the agency's Adult & Family Services Department and Adult Protective Services management that was responsible for the design and implementation of the project. Key to the success of the project was frequent communication between the Project Work Group and the APS social work team. As such, the APS social workers were essential to the development and implementation of the TRIO and to ensuring fidelity to project goals and objectives.

The Project Work Group met once a month to track progress, identify problems, address challenges and issues and design solutions. An agenda was used for every meeting. Other strategies used by the Project Work Group that proved to be successful was the strict adherence to time line and commitments in the work plan, frequent communication about the project through various mediums; staff training; presentations to stakeholders; use of surveys; regularly

scheduled meetings with medical practitioners and monthly phone conference calls with the research team at the University of California San Diego.

It is important to note that the use of surveys during the course of the project was an important strategy to capture information about the work, provide opportunity for involvement and to gauge opinions, concerns and preferences. All surveys were conducted by the agency's Office of Strategic Management. This is an independent unit of the agency responsible for strategic planning and data collection and analysis. The surveys were anonymous.

The work of the Project Work Group was documented throughout the entire period of the project and reviewed periodically at regularly scheduled project status meetings.

Activities and Accomplishments

What measurable outcomes did you establish for this project and what indicators did you use to measure performance? To what extent did your project achieve the outcomes?

The Rapid Response Expert Team project established one measurable outcome for each of the three objectives:

Objective 1: Utilize the County of Ventura TRIO (Tool for Risk, Interventions and Outcomes)
Measurable Outcome 1: Establish a standardized approach in Adult Protective Services to risk assessment, intervention and measurable outcomes

Objective 2: Conduct in-home assessments by medical/mental health practitioners (experts)
Measurable Outcome 2: Of those cases presented to the Rapid Response Expert Team with difficult to resolve complex medical/mental health risk indicators, 70% who agree to participate will show a reduction or elimination of the protective issue with an improvement in health, safety and stability.

Objective 3: Increase medical/mental health resources to the Rapid Response Multi-Disciplinary Team
Measurable Outcome 3: Positive increase in statements on the Integrated Team Monitoring & Assessment survey from pre-test to post-test related to increasing resources: 1) the team has the right membership to achieve its objectives and 2) the team is adequately resourced and supported to achieve its objectives.
This next section is a discussion of the accomplishments of each of the three objectives.

Measurable Outcome 1: Utilize the County of Ventura TRIO

The most critical task for Adult Protective Service programs is to determine whether the allegation of abuse or neglect can be substantiated and if so, assess the extent of the risk and design interventions to ensure the safety and protection of the elder or dependent adult. It is a complex task because elder/dependent abuse/neglect does not appear to be a spontaneous event but rather, occur subtly over time in a deteriorating and progressive nature. The social worker also has to continually navigate the line between the client's self-determination and direction that is legitimate and desirable.

The lack of a standardized instrument used by field social workers to investigate the allegation and assess probable underlying causes is detrimental to ensure reliability and accuracy in determining the appropriate response and need for protection. Training of social workers in understanding abuse/neglect is not a substitute for such an instrument. Instruments do exist for medical providers, clinics and community based service providers to assess if a referral to APS is warranted. However, there is no valid or reliable instrument for APS social workers that links risk assessment with interventions, outcomes and prognoses. A lack of consistency in investigation and assessment leads to variability and inconsistent outcomes for the client. More importantly, the inability to measure the effectiveness of APS response and intervention undermines sustainable funding. Constant managing of staffing resources to meet budget demands is one of the greatest threats to serving the at-risk population.

The TRIO, formerly called the RAI (Risk Assessment Tool), was initially designed in 2008 and remained in Alpha testing until late 2009. It was designed based on field observations that left unattended, elder/dependent adult abuse and neglect worsens over time. This observation is supported in one of the research recommendations contained in the *Elder Mistreatment: Abuse, Neglect, and Exploitation in an Aging America* (Richard J. Bonnie and Robert B. Wallace

Editors, National Academy of Sciences, 2003.) that suggests that elder mistreatment appears to follow a predictive path of progression similar to chronic illness. Without appropriate intervention, elder abuse/neglect often results in premature need for facility care, preventable hospitalizations, homelessness and early death as a result of preventable illness, falls and general decline in health and well being.

Fundamental to the design of the TRIO are core social work values and practice. The key components of the TRIO are as follows:

1. Contains established definitions embedded into the application to ensure consistency
2. Standardizes an approach to assessing risk that focuses on the whole of the person versus allegation driven
3. Maintains the necessary rapport during face-to-face contacts
4. Forms a client profile based on the clustering of risk indicators that guides the interventions
5. Measures the goal of eliminating or reducing the protective issue
6. Measures improvement to health, safety and stability
7. Measures prognosis of non-recurrence at the time of case closure
8. Utilizes social worker training, skills, judgment, and expertise.

During the course of the project, two surveys were completed by the APS social workers on their experience using the TRIO. The surveys were developed by the Office of Strategic Management.

The first survey on the use of the TRIO was conducted when the TRIO was in paper form. The second TRIO survey was conducted in October 2011 after the TRIO was converted to a web-based application (see Appendix G).

Response to the TRIO is positive in both surveys. There is a slight improvement in the surveys from the paper format of the TRIO to the electronic version. A few of the highlights from the second survey indicate that APS social workers agree that with proper training, the TRIO is easy to use and believe overwhelmingly (100%) that the TRIO is worth the time it takes to use. Ninety-two percent (92%) of respondents strongly agree or agree that using the TRIO increases work satisfaction and 100% of the respondents strongly agree or agree that the TRIO increases the ability of the social worker to assess a case more thoroughly. Finally, 83% of the social workers feel the TRIO has positively changed how they approach and think about cases.

Research Findings on the TRIO by University of California San Diego Written by David H. Sommerfeld, Ph. D & Gregory A. Aarons, Ph. D

Study Context and Goals

To address the need for a standardized approach to risk assessment and codifying interventions provided and outcomes achieved for the adult protective service (APS) system, the Ventura County, California, Human Services Agency designed and developed the Tool for Risk, Intervention, and Outcomes (TRIO). After implementing the TRIO into APS practice, Ventura County partnered with a team of investigators from the University of California, San Diego and San Diego State University to conduct a multi-faceted assessment of the initial APS data collected via the TRIO. In particular, the examination of the TRIO data was designed to accomplish the following four goals:

1. Provide a detailed assessment of the TRIO data for the overall APS client population and relevant subgroups.
2. Identify distinct risk and intervention profiles from the TRIO data.
3. Assess the relationship between TRIO risk, interventions, and outcomes.
4. Test the validity and reliability of the TRIO tool for APS practice.

Assessment of APS Client TRIO Data

Data for this study came from the 2,505 Ventura County APS dependent adult and elder adult episodes with a TRIO completed between 11-1-2009 and 6-30-2011. During the study timeframe 73.5% of the episodes involved elder adults (age 65 and over) and 26.5% involved dependent adults (age 18-64). The distribution of TRIO risk items indicated that the types of risks experienced by the clients varied substantially between allegation and disposition

categories. Differences in the risk patterns were generally consistent with expectations as clients who experienced abuse-by-other episodes tended to have a high prevalence of risk items related to conflicts with others, exploitation, and declarations of specific abuse types. In contrast, risk items related to poor health and hygiene were more common among self-neglect episodes. Persons with both confirmed abuse-by-other and self-neglect allegations exhibited the highest average number of risk items of all allegation and disposition types.

For both elder adult and dependent adult episodes there appeared to be a core set of TRIO intervention indicators received by many APS clients. These interventions included accepting education/information, establishing a bond with the social worker, accepting that a problem existed, referral to services, and working with the client's support system. It was not uncommon for these core APS interventions to be provided in 60% to 80% of the episodes with a confirmed allegation. However, most of the other interventions were provided to a limited or targeted subset of clients as they were often evident in fewer than 10% of the episodes. The provision of in-home nursing assessments represented a fairly intensive intervention that was conducted with substantial number of clients, particularly those with confirmed self-neglect or both confirmed self-neglect and abuse-by-other allegations (~30% of these episodes). Overall, episodes with confirmed allegations received the highest number of different APS interventions, which indicates that APS workers were utilizing a wider range of services to support clients with the most clearly documented needs for APS services.

As with TRIO risk and intervention indicators, there was substantial variation in the prevalence of outcomes between allegation and disposition categories. A detailed assessment of APS outcomes for elder adult and dependent adult clients with confirmed mistreatment allegations indicated that APS workers achieved positive outcomes in most of their cases. For both elder adults and dependent adults, approximately 10% of the episodes resulted in the

achievement of a finance related outcome, 25% the achievement of a health related outcome, and a majority (60%) indicated the achievement of a safety or stability related outcome. A substantial majority of the confirmed allegation episodes closed with a reduction or elimination of the protective issue that prompted APS involvement, however approximately 25-30% of elder adult and dependent adult episodes indicated an unresolved protective issue at episode closure. The percentage of episodes that closed with an unresolved protective outcome did not differ based upon allegation type (i.e., self-neglect, abuse-by-other, and both self-neglect and abuse-by other confirmed episodes).

As part of the TRIO, a social worker recorded a determination of the client's prognosis for non-recurrence at the close of each episode. Prognosis was measured on a 6-point scale that ranged from "poor" to "excellent". Collapsing prognosis into a three level indicator revealed that the majority of episodes for both elder adults and dependent adults were assigned the middle category ("fair" or "good" prognosis for non-recurrence) at the close of the episode. The low category ("poor" or "guarded" classifications) was the next most common (~1/4 to 1/3 of episodes) followed by the most positive prognosis ("very good" or "excellent") with approximately ~15% of the episodes. Significant differences in prognosis existed for the allegation types, with abuse-by-other episodes generally having the most favorable prognosis among both elder adult and dependent adult APS clients.

Recidivism back into APS services was an important APS outcome examined in the study. To allow sufficient cases from our study period to be included in an analysis of recidivism while still providing a meaningful duration of time from which to evaluate recidivism, we assessed recidivism using a standardized 180-day observation period following the closure of an initial APS episode. Multiple recidivism rates were calculated using different types of allegations and dispositions to define the specific type of initial and follow-up interaction with

APS. The most general way of measuring APS recidivism (defined as including any type of unfounded, inconclusive, or confirmed initial and any type of follow-up involvement with APS) resulted in a 15.6% 180-day recidivism rate for elder adults and a 10.1% recidivism rate for dependent adults. Among elder adults, it was more common for clients with confirmed allegations to recidivate with a subsequent confirmed allegation (12.7%) than for clients with inconclusive episodes to progress into a more severe subsequent confirmed allegation (8.1%) or for clients with unfounded allegations to have a more severe subsequent inconclusive or confirmed allegation (6.4%). This pattern was not evident among dependent adults as clients with all three initial allegation dispositions (unfounded, inconclusive, or confirmed) exhibited an approximately 7% 180-day recidivism rate. Among elder adults, clients with both confirmed self-neglect and confirmed abuse-by-other initial allegations exhibited the highest recidivism rates (~40%).

Identification of TRIO Risk and Intervention Profiles

One of the primary goals of this study was to identify and test whether specific risk profiles could be generated from the extensive array of available TRIO risk items. We utilized Latent Class Analysis (LCA) techniques to derive meaningful risk profiles separately for each elder adult confirmed allegation type. The LCA results indicated that there were four risk profiles evident among the self-neglect episodes, four risk profiles for abuse-by-other episodes, and two different risk profiles for episodes including clients with both self-neglect and abuse-by-other confirmed allegations. A summary of the primary characteristics for each of the resulting 10 risk profiles is presented in Figure 1.

Statistical evaluation of the measures of fit indicated a high degree of confidence in the construction of the specific profiles.

Figure 1. Distinguishing Risk Factors by Risk Profile

CONFIRMED ELDER SELF-NEGLECT

Profile 1(Precursor/Multi-Bio-Psycho-Social)
- Lives alone
- High poor judgment
- Nearly universal diminished health and hygiene
- Relatively high hoarding
- Nearly universal unclean/unsafe environment

Profile 2 (Precursor/Biological/Social)
- Nearly universal poor judgment
- High confusion
- High risk behaviors
- Relatively high refusal of help
- Relatively high money mismanagement
- Relatively high failure to respond to disease
- No/low hoarding

Profile 3 (Precursor/Psychological)
- Universal mental health services
- High evidence of psychiatric disorder
- Relatively high depression/anxiety
- Relatively low prevalence of biological

Profile 4 (Precursor/Diffuse Bio/Social)
- Relatively high physical disabilities
- Relatively low history of referrals
- Relatively lower prevalence of most other risk indicators

CONFIRMED ELDER ABUSE BY OTHERS

Profile 5 (Precursor/Biological/Social)
- Lives with others
- History of referrals
- High confusion
- High disability/ADL
- Relatively high alcohol in caregiver/others
- Economically dependent adult in the home
- Relatively high diminished health/hygiene

Profile 6 (Social)
- Evidence/declaration of exploitation
- Relatively high money mismanagement
- Relatively low marital/family conflict

Profile 7 (Precursor/Psychological)
- High levels of marital/family conflict
- High poor judgment
- Relatively high psychological distress (self blame, passive, anxiety, depression)
- Relatively high history of violence/abuse/ neglect

Profile 8 (Bio-Psycho:Declarative)
- Relatively high declaration of psych abuse
- Relatively high declaration of phys/sex
- Relatively lower prevalence of most other risk indicators

CONFIRMED BOTH ELDER SELF AND BY OTHERS

Profile 9 (Precursor/Psychological/Social)
- Universally lives with others
- High levels of marital/family conflict
- High history of violence/abuse/neglect
- Economically dependent adult in the home
- Relatively high mental health distress
- Relatively high alcohol in client/caregiver/environment
- High unclean/unsafe environment

Profile 10 (Precursor/Social)
- Mostly lives alone
- High confusion
- Relatively high risk behaviors
- Relatively high evidence/declaration of exploitation
- Relatively high misuse of money

The distribution of risk indicators across the risk profiles underscores the substantial differences in the type of risks associated with each profile. While some individual characteristics might be evident in more than one risk profile, the constellation or cluster of risk indicators made each risk profile unique. As empirically derived risk profiles from the TRIO data, the multi-faceted nature of most risk profiles highlighted the challenge of providing APS services to clients with diverse set of risk factors that often intersect in complex ways.

The LCA identified risk profiles used to characterize APS clients represented meaningful distinctions that were often related to specific outcomes. For example, the level and type of positive improvement outcomes achieved (e.g., financial, health, and safety) varied by risk profile, particularly for abuse-by-other episodes. The risk profiles also helped identify which client groups may be most likely to have unresolved protective issues. Prognosis for non-recurrence also varied by risk profile for all three types of confirmed elder adult allegations. Risk profiles that appeared to have less favorable prognoses tended to be the risk profiles that also exhibited elevated levels of unresolved protective outcomes. The 180-day recidivism analyses did not identify any statistically significant differences between the risk profiles, but the variations in recidivism matched expectations based on the characteristics of the risk profiles. For example, Profile 1 (Precursor/Multi-Bio-Psycho-Social) would likely be considered a high risk group and it exhibited the highest recidivism rate among the self-neglect risk profiles. Conversely, Profile 4 (Precursor/Diffuse Bio/Social) appeared to be a relatively low risk group based on the pattern and frequency of risk items and it experienced the lowest recidivism rate. A similar pattern was evident among the abuse-by-other profiles. Additional research with larger sample sizes will be needed to adequately test the apparent variations in recidivism by risk profile.

We were also able to conduct LCAs with the intervention data from the TRIO for each risk profile to determine if there were particular clusters of intervention services provided by APS workers. The overall pattern evident from the different intervention LCAs was that clients were generally divided into two distinct groups within each of the previously identified 10 different risk profiles - those that indicated extensive engagement in APS interventions and those with limited participation in APS interventions. Additional analyses demonstrated meaningful distinctions in that the group of clients with high levels of intervention participation tended to be associated with more favorable financial, health, and safety related outcomes and were much less likely to have an unresolved protective outcome compared to the group of low intervention participation clients within each risk profile. This highlights the importance of client engagement for a voluntary service system since clients are less likely to achieve positive outcomes and more likely to have an unresolved protective issue if they chose not to participate in and receive APS intervention services.

Relationship between Risks, Interventions, and Outcomes

The study identified important relationships between the different measures from the TRIO. For instance, among elder adult episodes, the prognosis for non-recurrence, as determined by the social worker at the closure of the episode, was shown to be related to actual recidivism back into APS within 180 days for almost all allegation and disposition categories examined. For example, clients from 22.0% of all confirmed allegation episodes with a poor/fair prognosis recidivated back into APS with a subsequent confirmed allegation within 180 days, compared to 12.2% with a fair/good prognosis and only 1.0% with a very good/excellent prognosis. The findings suggest that among elder adult APS clients, the social workers were able to successfully identify the clients which were most likely to return to back into APS. As discussed in more

detail below, the capacity of APS workers to appropriately identify the high risk clients may allow for targeted longer term assistance to and follow-up with these clients to reduce future preventable APS recidivism.

We also examined the relationship between the individual TRIO risk indicators and the three primary outcome measures assessed in this study: 1) unresolved protective issues, 2) prognosis for non-recurrence, and 3) 180-day recidivism. For the assessment of unresolved protective issues, TRIO risk indicators demonstrated both significant positive and negative associations. This suggests that APS has been particularly successful working with clients who exhibit certain precursor risk characteristics (e.g., physical disabilities and confusion) such that the presence of that precursor risk factor was associated with a reduction in the likelihood of having an unresolved protective issue. For some risk indicators, the nature of the relationship with unresolved protective issues may be dependent upon the type of allegation. For example, living alone was associated with a higher prevalence of unresolved protective issues for self-neglect episodes, but a lower prevalence within abuse-by-other episodes. For abuse-by-other episodes it appeared that living alone may actually have a beneficial effect and facilitate APS making progress on the protective issue. The risk indicator of refusing help was consistently identified with an increased prevalence of unresolved protective issues for multiple types of elder and dependent adult allegations.

Most of the individual TRIO risk items significantly related to the prognosis for non-recurrence were unique to a specific allegation type for either elder or dependent adults. However, the following precursor risk indicators consistently demonstrated significant, negative correlations for many types of APS clients: history of APS referrals; refusal of help; marital/family conflict; history of violence, abuse, or neglect; and poor judgment.

Relatively few TRIO risk indicators exhibited a significant relationship with 180-day recidivism among elder adults and essentially none were found among dependent adults. Some of the difficulty in finding significant relationships may be related to the fact that the recidivism samples were smaller due the methodological restrictions with the 180-day observation period. Future research on recidivism using larger samples and longer observation periods is necessary.

The final set of analyses simultaneously incorporated a range of demographic, risk, intervention, and outcome indicators to identify the significant predictors associated unresolved protective issues, prognosis for non-recurrence, and 180-day APS recidivism. The results provided additional support for the finding that distinct sets of clients share particular risk factor characteristics or profiles and that these risk profiles were directly related to client outcomes. For example, among elder adults with confirmed abuse-by-other allegations, clients in Risk Profile 7 (Precursors+Psychological) tended to have poorer outcomes and clients in Risk Profile 6 (Social) generally had better outcomes. Risk Profile 7 clients were significantly more likely to have an unresolved protective outcome than clients in the other risk profiles. Additionally, Risk Profile 6 and Risk Profile 8 (Bio-Psycho Declarative) clients had significantly better estimated prognosis than Risk Profile 7 clients. Finally, clients from Risk Profile 6 were significantly less likely to recidivate within 180-days than the other three risk profiles.

Other key factors emerged in the analyses as well. Low participation in APS interventions was a strong predictor of unresolved protective issues for self-neglect and abuse-by other clients. Unresolved protective issues were then also related to a decreased prognosis for non-recurrence and increased 180-day recidivism. These findings highlight the importance of engagement in APS interventions and provide evidence to support APS efforts to increase client service engagement as it may result in fewer episodes with unresolved protective outcomes, potentially better prognosis at case closure, and ultimately lower APS recidivism. The fact that

achievement of a safety outcome had an independent and significantly positive relationship with prognosis suggests that even when the protective issue was unresolved, some progress can still be made on other safety outcomes which can slightly improve the non-recurrence prognosis for the client.

An examination of the individual TRIO risk items across the models indicated both areas of similarity and difference between self-neglect and abuse-by-other episodes. Refusing help was a significant predictor of elevated risk for unresolved protective issues among both elder adult self-neglect and abuse-by-other episodes. Living alone increased the risk for unresolved protective issues for self-neglect episodes, but decreased the risk for abuse-by-other episodes. For the elder adult self-neglect episodes, a history of APS referrals was found to be a significant predictor of an increased likelihood of unresolved protective issues and decreased prognosis. The only individual TRIO risk item significantly related to 180-day recidivism was the lack of social support among self-neglect episodes.

The multivariate analyses also identified a significant and substantial relationship between the social worker determined prognosis for non-recurrence and actual 180-day APS recidivism. Clients with a better prognosis for non-recurrence have much lower odds of recidivating than clients with a poor prognosis. This indicates that the APS social workers can often distinguish between high and low risk elder adult clients at the time of episode closure and predict which clients are most likely to return into the APS system.

TRIO Validity and Reliability

The final set of analyses reported on in this study concerned the TRIO instrument itself and an assessment of the validity and reliability of the newly developed tool. Since there was no single, simple measure available with which to assess the validity of the multi-faceted TRIO, we utilized

principles from three different approaches, content validity, concurrent validity, and predictive validity, to examine the TRIO. Based on the development process of the TRIO and its purposeful comprehensiveness when documenting risks, interventions, and outcomes, it was determined that the TRIO generally exhibited high levels of content validity. While the availability of tools to concurrently assess the validity of the TRIO was limited, we compared the APS findings from the allegation disposition with the pattern of TRIO precursor risk factors to see if there were areas of consistency. Overall, the findings indicated that the TRIO produced variations in the frequency of client precursor indicators that would be anticipated based on the specific type of confirmed allegation. For example, episodes with confirmed abuse-by-other allegations demonstrated a higher prevalence of conflict oriented precursors. Also confirmed self-neglect episodes were more likely to exhibit living alone and other factors commonly associated with self-neglect. This provides some support for the validity of the TRIO data as it reflected patterns that were consistent with the independent investigation of the allegation. Finally, the predictive capacity of aspects of the TRIO has been highlighted throughout the presentation of the study findings as one area of the TRIO (e.g., risks or interventions) has been associated with other areas of the TRIO (e.g. outcomes) or external measures. For example, the strong relationship between the prognosis for non-recurrence measure and actual 180-day recidivism indicated a high level of predictive validity for this component of the TRIO. The examination into the validity of the TRIO data indicated that, where feasible to assess, the TRIO data were generally consistent with expectations and suggestive of a valid measurement tool.

Strong results from an inter-rater reliability test in which the Ventura County APS workers reviewed and completed a TRIO for three specially created case narratives provided evidence that the TRIO can be consistently and reliably completed. The training that APS workers received regarding how to appropriately complete the TRIO as well as the development

and dissemination of explicit definitions for the TRIO items likely contributed to the high levels of inter-rater reliability achieved. The inter-rater reliability test results coupled with the detailed training and guidance offer evidence that the TRIO can be reliably utilized in the "real world" to document the risks, interventions, and outcomes of APS clients.

Policy and Practice Implications

Several important implications for policy and practice were generated by the results of this study. First, the prognosis of non-recurrence measure was shown to have a significant and substantial association with 180-day recidivism. Given the ability to identify clients most likely to recidivate back into APS, clients designated as high risk would likely benefit from additional longer-term support and monitoring services that could help prevent future APS encounters requiring acute or crisis services. In this way, APS services, at least for clients determined to have a high risk of recidivism, could be adapted to function more like a chronic care model with regular, less intensive involvement and hopefully less emphasis on responding to clients after they are already in severely compromised situations that require immediate attention. Such a model could promote and maintain well-being among the vulnerable populations traditionally served by the APS system. Future study is needed to examine the role that longer-term follow-up and support can play in reducing preventable APS recidivism.

The study findings also highlighted the importance of engaging clients in intervention services, which can be challenging given that APS services are voluntary and some clients may not recognize the need for or want help from others. The multivariate analyses demonstrated a strong relationship between participation in APS interventions and a reduction in the likelihood of an unresolved protective issue at the close of the episode. This is a critical relationship since unresolved protective issues were also related to a poorer prognosis and to higher actual APS

recidivism. This suggests that promoting strategies to increase client acceptance of and engagement in APS intervention services will contribute to more clients reducing or eliminating their protective issue and ultimately to fewer clients returning for APS services due to future mistreatment by self or others. Strategies may include evidence-based-practices such as motivational interviewing as well as establishing protocols that encourage APS workers to continue to follow-up with potential clients even if initial contact is refused.

The study results from the assessment of the risk items collected by the TRIO highlighted the diverse range of individual risk indicators found among the APS clients. To adequately address these concerns the APS system must have the capacity to provide a wide range of services and develop partnerships with affiliated agencies for expertise not regularly available within the APS system and outside the scope of traditional social work practice.

The development of tools like the TRIO can help to further research partnerships within the field of APS by collecting an extensive amount of data regarding client risk indicators, interventions received, and outcomes attained. Such data are important for developing a better understanding of the needs of APS clients and the role that specific interventions can play in promoting more positive client outcomes and a reduction of future, preventable APS recidivism.

Measurable Outcome 2: Conduct in-home assessments by medical/mental health practitioners (experts)

Of those cases presented to the Rapid Response Expert Team with difficult to resolve complex medical/mental health risk indicators, 70% who agree to participate will show a reduction or elimination of the protective issue with an improvement in health, safety and stability.

Beginning first with demographics of the RRET study sample, the average age of the project sample is 74.2. Of these, 70% are male and 30% female. The ethnic composition of the study group is consistent with the general population of APS. Seventy-one percent (71%) are White, 21% Hispanic, 3% Japanese, 2% Middle Eastern and 3% African American. Compared to the demographics of the community, except for the Hispanic population, all of the other populations are over represented in the sample.

Table 1 represents the composition of the cases presented to the RRET. Of the 152 cases presented, 102 (67% of the total presented to the RRET) agreed to the in-home assessment(s) and agreed to services, therefore, were included in the study sample. This was a higher percentage than anticipated. Because of the voluntary nature of APS and because our target study sample was the most difficult to serve we were expecting a participation rate of about 50%. Thirty -three percent (33% rounded) of the cases presented to the Rapid Response Expert Team was excluded from the study. Of those, 12% agreed to the in-home assessment but refused to accept any services or recommendations resulting from the assessment or in some cases began the assessment but then halted prior to completion. Sixteen percent (16%) were excluded from the study for other reasons that included no protective issue, whereabouts were unknown, left the area, placed in a facility prior to deployment of the team, or the client passed away prior to the deployment of the team. Of all of the cases presented to the Rapid Response Expert Team, only

7 cases or 4.6% of the total cases refused the in-home assessment by a member of the medical team.

Table 1: Cases Presented to the Rapid Response Expert Team

# of Cases	% of Total	Status of Cases
102	67%	Study sample
18	12%	Agreed to in-home assessment but refused all services and recommendations-excluded from study
24	16%	Excluded from study for other reasons *
7	4.6%	Refused to accept the in-home assessment-excluded from the study
1	<1%	Has a valid capacity declaration for severe dementia but has not completed the court process as of March 1, 2012
152	100%**	Total cases presented to the Rapid Response Expert Team

*unable to locate; passed away; hospitalized and then placed in a higher level of care prior to the completion of the assessment; no evidence of a protective issue; placed in a facility prior to the assessment or completion of the assessment. ** With rounding errors

There is one case that would have been included in the study because the client agreed to in-home assessments by the public health nurse and completed the evaluation by the neuropsychologist. Based on the findings, this client met criteria for severe and persistent dementia and was referred to the Public Guardian. At the time of the writing of this report, this case is still in the court process and therefore not resolved. Adult Protective Services has the case open for monitoring and will close the case upon the decision of the Superior Court.

Tables 2 and 3 represent the protective issue outcomes of the project sample. The most compelling outcome of the project was in the elimination or reduction of the protective issue. Based on prior success of the existing Rapid Response Multi-Disciplinary Team without the resource of an additional Public Health nurse, physician, clinical social worker and a neuropsychologist, the team was successful in eliminating or reducing the protective issue in 65 % of the cases presented. The results of the project exceeded our anticipated outcome of 70% with a 91% elimination or reduction of the protective issue in the study sample. Regardless of the resources, 9% of the cases in the project sample had a poor outcome with no resolution to the

protective issue. In most of these cases, significant alcohol use and chronic alcoholism, sub-clinical cognitive impairment and moderate to severe mental health issues not meeting criteria for involuntary hold were characteristic factors.

The TRIO was used to measure this outcome with the definitions embedded into the tool to ensure consistency and reduce variability. As indicated in the findings from University of California San Diego investigation of the TRIO, overall the inter-rater reliability is substantial at .95. To determine the outcome of this measure, the following criterion was required:

Protective Issue Eliminated: The interventions by the APS social worker or members of the team are sufficient to eliminate the protective issue. At the time of case closure, the client is no longer in harm's way. Examples may include the arrest and removal of the alleged perpetrator; guardianship/conservatorship is obtained; client is placed in a safe and secure environments; the client receives the necessary services to eliminate the risk.

Protective Issue is reduced: The interventions by the APS social workers or members of the team are not sufficient to eliminate the protective issue but are sufficient enough to stabilize the client, reduce the rate of decline or diminish the potential for harm at time of case closure. An example would be the client who is oriented to all 4 spheres but requires facility care to eliminate the risk and refuses this intervention. Instead, the client agrees to and accepts in-home assistance, meals on wheels program and installation of safety devices in the home to prevent falls. Although less than desirable, the client's partial acceptance of services will stabilize and reduce the rate of decline.

Protective Issue unresolved: At case closure, the identified protective issue is not resolved and poses a current risk to the client.

Table 2: Measurable Outcomes of the Project Sample

Outcomes	# of Cases	% of Total*
Protective Issue Eliminated	39	38%
Protective Issue Reduced	54	53%
Total Combined Protective Issue eliminated or reduced	**93**	**91%**
Protective Issue Unresolved	9	9 %
Total cases in the study sample	102	100%

* With rounding errors

It is important to note that this outcome is based on the facts of the situation at the time the case is closed. Concern about the client's ability to sustain the safety plan or concern about future harm is documented in the prognosis.

Although not part of the measurable outcome for the project, we tracked cases in the project sample by service level accepted and the outcome to the protective issue related to the level of engagement. This data is represented in Tables 3 and 4.

Table 3 is a description of the project sample by the level of service accepted by the client – all services or partial services. To understand the definition of terms: if the recommendation after completion of the in-home assessment includes four (4) services, but the client agrees to only three (3), then that meets the criteria for partial services. If the recommendation is for four (4) services and the client agrees to four (4) services, then that meets criteria for all services. Table 4 displays the outcome to the protective issue based on level of service accepted.

It is noted in Table 3 that 50% of the project sample agreed to only partial services. Because the project sample is comprised of the most difficult to resolve cases and most resistant to

outside intervention, it was anticipated that less than 50% of the sample would agree to any service. So, it is striking that 50% of the project sample agreed to all service recommendations.

It does suggest that our hypothesis may have merit. It is well documented in the literature that major barriers exist for our population in accessing services. Barriers include transportation issues, deficits in sensory abilities that keep people homebound, fear of falling and prohibitive intake procedures for health and mental health services that require fairly high degree of problem solving and communication skills. In our hypothesis, if these barriers can be mitigated by providing in-home assessment this population is open to help.

Twenty-six (26%) of those clients in the project sample who had completed an in-home assessment and was participating in the recommendations experienced a significant health or safety issue resulting in an immediate placement out of the home. We refer to this type of intervention as an external intervention. It is impossible to hypothesize about the needs of this sub-group within our sample, but it does suggest the need for earlier interventions and services before a tipping point event occurs that escalates the decline like falls, influenza, pneumonia, and undiagnosed or unrecognized dementia. This group also includes those who were conserved by the Superior Court as a result of grave, persistent and pervasive cognitive impairment leading to the inability to provide for their own basic needs.

Table 3: Level of Service Accepted in the Project Sample

Level of Service	# of Cases	% of total
Client agreed to all services	27	26.5%
Client agreed to partial services	48	47.0%
Client had an external intervention	27	26.5%
Total Project Sample	102	100%*

* with rounding

Table 4 represents the outcome to the protective issue when comparing those clients in the project sample who accepted all services with those who accepted partial services. The data suggests that when clients are able to agree to all of the service recommendations from the Rapid Response Expert Team, outcomes are better.

Table 4: Outcome to the Protective Issue by level of service accepted in project sample

Level of Service	#	Eliminated	Reduced	Unresolved
Client agreed to all services	27	44% (12)	56% (15)	0%
Client agreed to partial services	48	2% (1)	79% (38)	19% (9)
Client had an external intervention	27	100% (27)	0%	0%
Total Project Sample	102			

* with rounding errors

Table 5 represents the cases in the project sample referred to the Public Guardian's Office and outcomes for this most vulnerable group. In Ventura County, the Public Guardian's office requires a valid capacity declaration for referrals. Upon receiving a referral, the Office begins its investigation within 2 days.

This table is significant in reinforcing the importance of the Rapid Response Expert Team project because prior to the integration of a neuropsychologist into APS and the Rapid Response Expert team, this sub-group of our population often was left with the protective issue unresolved with a poor prognosis for non-recurrence. Primary Care Physicians in Ventura County are often reluctant to write capacity declarations and if the client is not willing to leave the home for an evaluation by a neuropsychologist or another skilled professional, these clients are never deemed incapable of informed consent or undue influence. This leaves them susceptible to repeated occurrences of abuse and neglect and progressive decline to their health and safety.

It is also important to note that of the total number of clients in the study sample with an external intervention, 60% met criteria for a guardianship under the jurisdiction of the Superior

Court. Of the total 102 sample study population, 16% met criteria for a guardianship. This supports our hypothesis and the purpose of the study that without access to a practitioner who can conduct in-home neuropsychological evaluations for mental capacity, APS is challenged to meet its mission in providing safety to the most vulnerable within our community.

Table 5: Referrals to the Public Guardian Office and Outcomes

Total clients referred to the Public Guardian Office	27
Clients conserved by the Superior Court	16
Clients pending resolution of the petition for guardianship	1
Client's petitions withdrawn or denied	8
Client's deceased prior to petition	2

Results of APS Social Worker's Survey about Medical Disciplines

A survey was developed by the Office of Strategic Management to seek the APS social workers' opinions about the relative value of each of the medical disciplines represented on the Rapid Response Expert Team project. The Project Work Group was interested in knowing which discipline the social workers found to be most important in assisting them with the investigation, assessment and elimination or reduction of the protective issue. (See Appendix H)

As evidenced in the following survey results, the APS social workers overwhelmingly agreed that integrating medical practitioners is essential to their work. Although little differences exist among the APS social workers experiences with each of the four (4) disciplines in terms of importance or value to the work, the APS social workers identified the neuropsychologist as the most critical to their ability to meet the mission The survey results are as follow in descending order with the most essential discipline first:

1. Neuropsychology
2. Public Health Nursing
3. Medical Doctor
4. Licensed Clinical Social Worker

When asked about the results of the survey, the APS social workers identified a secondary need for our target population: in-home treatment for both medical and mental health issues. Had the physician and mental health clinician been able to provide treatment, the value of their work to the APS social worker would have dramatically increased. Although in-home treatment would have greatly benefited the client, this service was not within the scope of the project and would have required extensive work on managing liability and malpractice issues. The assessment by both the medical doctor and licensed clinical social worker proved to be invaluable for the APS team and the Rapid Response Expert Team but also provided a necessary linking function to difficult to access clinic based services.

Case Studies (all names and identifying information changed)

Case Study 1: Mrs. Lansky

Mrs. Lansky is a 91 year old woman who lives with her adult son in a home she owns. Mrs. Lansky is originally from Poland and lived in Nazi-occupied Poland. During the war, she lived in England and worked for the resistance but soon left to come to the United States.

APS first became involved with Mrs. Lansky in 2007 with a report that Mrs. Lansky's son was verbally abusive and neglectful and that she was having delusions and neglecting her own care. By the end of 2010, there were 8 more of these same allegations. All allegations were confirmed but Mrs. Lansky continually refused services while she and her son denied that any

problems existed. Both stated she was independent from needing care. Cross reports were made to law enforcement but it was determined that not enough evidence existed to make an arrest for criminal neglect.

Mrs. Lansky has a history of colon cancer. After surgery, she needed to have a colostomy bag that she manages herself. She had a hip replacement in the past and used a walker and a cane for ambulation. She had no regular physician, took no medications and used the emergency room for her health care needs. Mrs. Lansky exhibited symptoms of possible dementia, fixed delusions and paranoia. She had images of seeing trucks carting people away never to be seen again. These images caused her marked anxiety, agitation and disturbance. She frequently stated that a man named Ralph lived in her attic and he stole her food, money and constantly harassed her.

Mrs. Lansky believed that Ralph and his girlfriend Kelly lived in the neighborhood and would drive through the neighborhood taking children away. She felt threatened by them and thought they would enter her home, drug her and take her away. This seemed reminiscent of her fears and experiences in Poland during occupation and likely the cause of her fixed delusion. Mrs. Lansky called 911 regularly, as much as 40 times a year, sometimes several times a day, to report stolen items and harassment. When law enforcement responded, no evidence of her claims existed. She had been placed on an involuntary hold at least three times in the past two years but this never translated to a guardianship/conservatorship as she did not meet criteria and was released.

It took collaboration and intervention by all of the members of the medical team working with the APS social worker to finally provide the needed interventions. Initially, the APS social worker and the Public Health Nurse transported Mrs. Lansky to the VA Hospital for evaluation. She was linked to a psychiatrist who made the appropriate diagnosis. Mrs. Lansky‘s son was

educated about her mother's mental health status. Mrs. Lansky returned home and after a period of time, the situation worsened and Mrs. Lansky started calling law enforcement again with complaints about Ralph, the imaginary attic dweller.

Mrs. Lansky was declining and not able to manage her colostomy bag as she had before. The medical doctor from the Rapid Response Expert Team went to the home and completed an assessment of Mrs. Lansky's health, safety, pain level, continence, vision, hearing and future needs. During the assessment, the physician discovered that Mrs. Lansky was not wearing her colostomy bag and didn't seem to be aware of it. The physician discussed this with the son and Mrs. Lansky and educated the son on the care of the bag. It was also recommended by the Rapid Response Expert Team to deploy the neuropsychologist to assess Mrs. Lansky's cognitive functioning and complete a capacity declaration for a possible referral to the Public Guardian's Office for guardianship/conservatorship.

The situation continued to decline with Mrs. Lansky's son leaving her alone without assistance, no contact information and unknown return date. This caused his mother's anxiety and delusions to escalate. Law enforcement was called several times over one weekend who found Mrs. Lansky in a panic state each time. Mrs. Lansky was very agitated stating that someone had stolen her son from the home during the night. Law enforcement and the Behavioral Health Crisis Team responded and she was again taken on an involuntary hold.

Mrs. Lansky was placed on a 14-day hold at a geriatric inpatient facility. Due to the lack of concern and ability to be an appropriate care giver for Mrs. Lansky, the APS social worker presented a referral to the Public Guardian's Office for conservatorship based on the capacity declaration from the neuropsychologist. The referral to the Public Guardian's Office enabled the inpatient unit to place Mrs. Lansky in a facility pending court decision. During that time,

Mrs. Lanksy was placed on the appropriate medication where her condition stabilized and improved. The court rejected the petition for guardianship.

Since her return home, Mrs. Lansky's showed remarkable decrease in the presenting symptoms. There were no phone calls to law enforcement and has no mention of the previous delusions. When her son needed to leave, he made arrangements for a care giver.

At the time of case closure, Mrs. Lansky was living in her home of 40 years with her son and cat. Her son was providing her necessary care. Substantial interventions with the son occurred during the course of this case. Each of the medical practitioners in concert with the APS social worker worked with the son about his mother's situation, needs for care, medication monitoring and regular appointments with her care providers and need for a regular schedule and attention. The process of seeking a conservatorship and the numerous interventions by the other members of the team had a significant effect on the son's awareness of the serious nature of his mother's situation and his responsibility to provide for her care and protection.

Through the Rapid Response Expert Team and access to in-home assessments by a team of medical practitioners, Mrs. Lansky's protective issue has been reduced. She has stabilized and her rate of decline has been diminished. Her health and safety has improved and her son is meeting her needs. Her prognosis is good

Case Study 2: Sashimi

Sashimi is a 75 year-old Japanese woman living in one of the cities in Ventura County. She came to the United States from Japan in the 1970s as part of a group "called by their faith" to bring the Japanese culture to people in America. She traveled with a pastor and a group of seminary students to Hawaii. Sashimi studied in Seminary and became a minister and moved to Ventura County over 14 years ago, where she obtained a position teaching Japanese, a job that

brought her much success. She was also an active member a church. Sashimi is a kind and caring woman.

Sashimi was first referred to APS in July of 2009 for alleged financial abuse by foreign lotteries. In becoming acquainted with Sashimi, APS discovered that her brother had been a famous music producer in Japan and that he had bequeathed her a sizeable inheritance which she parlayed into lucrative annuity investments. APS received a total of 6 referrals for Sashimi all consisting of the same financial abuse allegations. In February 2010, Sashimi had given $10,000 to the Philippine lottery. Upon further investigation, it was also discovered that she had borrowed over $20,000 from 3 different financial institutions to send to the foreign lotteries as well as completely draining her savings accounts. APS cross reported her case to the local police department who took an incident report but were unable to take the investigation further as this particular crime falls under the FBI's jurisdiction. The FBI Victim Advocate responded and provided education to Sashimi about foreign lottery scams being criminal endeavors that are not helping people but rather hurting those like her who participate. As these perpetrators operate outside of the United States, the FBI was not able to provide the leverage to protect Sashimi. Both the FBI Victim Advocate and the Officer with the local police department met with Sashimi and reinforced sound advice: "Don't send money to anybody, ever!"

Unfortunately, Sashimi did not heed the wise advice from Officers and, even though she promised not to send anymore money to foreign lotteries because she was "broke," she proceeded to do just that over the next 2 years, with the amounts of money she was sending continuing to escalate. Despite the fact that FBI Advocate continued to educate and try to convince her not to participate, Sashimi was driven to continue sending money and be perpetually victimized resulting in the loss of another $40,000 to the Philippine lottery.

During one home visit with the APS social worker, Sashimi called one of the perpetrators and conducted a financial transaction. Her behavior had the appearance of a compulsion with the inability to comprehend the consequences of her actions. She also began to suffer other repercussions from her participation in the foreign lotteries, such as letting her health insurance premium lapse which prevented her from taking her medications regularly, as she stated she could no longer "afford" them.

The APS social worker conducted a memory screening tool to assess any cognitive impairment that might have manifested since the previous visits. Sashimi's score was slightly below normal which prompted a presentation to the Rapid Response Expert Team and a referral to our neuropsychologist for an in-depth assessment. Although the neuropsychologist determined that while Sashimi had problems with processing new information, she did not have dementia significant enough to warrant a referral to the Public Guardian for probate guardianship/conservatorship. Reluctantly, her case was closed.

Another referral was received only two months later in April. By this time, Sashimi had already sent $160,000 to the foreign lotteries since the initial referral. Sashimi stated that she was now behind on her rent and car payment. Her participation in the lottery scams had resulted in her pawning belongings for cash. This time, unlike other times in the past, Sashimi was extremely anxious about the state of her finances. She had been laid off from her work as a result of budget cuts.

Again numerous interventions were offered including presentation to the Rapid Response Team and a visit by the physician. Although Sashimi accepted the in-home assessment, Sashimi refused to follow-through with given recommendations and would no longer accept phone calls or visits by the APS social worker. Again, the case was closed with the protective issue unresolved with a poor prognosis.

The final referral came to APS in August 2011. By this time, Sashimi had lost all of her retirement assets, totaling $200,000, her car was being repossessed, and she was being evicted in two weeks. Her situation was critical. She was experiencing severe anxiety about her situation and she appeared to be more confused. In the past, she remembered the APS social worker but this time she could not.

Sashimi was more desperate than ever to find money to dig her self out of her financial hole. She had already borrowed several thousand dollars from 6 members of her church. During one visit, she asked the APS social worker for a loan of $1,000. The APS social worker observed numerous pay day loan slips and tickets from pawn shops. Sashimi emphatically stated that she had stopped all participation in the foreign lotteries because she no longer had any money to send. She had lost all of her Japanese antiques. However, her church supporters reported that Sashimi was still sending her Social Security and unemployment benefits to the scammers. She was in arrears to the IRS and Franchise Tax Board and credit card debt totaling $35,000.

Sashimi continued to show some processing of information deficits but these were intermittent and she lacked any evidence of cognitive impairment to meet criteria for protection under the Superior Court. The confusion was deemed to be more related to her anxiety than to cognitive deficits.

By this time, there were 2 factors that could be used to intervene and provide leverage to assist Sashimi in stemming the tide of abuse: highly motivated church members and Sashimi's unrelenting anxiety over the loss of her home and tax debt. In consultation with the medical practitioners, a decision was made to facilitate an intervention much like the interventions that are used for people with addictive behaviors.

The church members agreed to meet with the APS social workers and the mental health clinician from the Rapid Response Expert Team with the goal of confronting Sashimi about her

gambling problem and the urgency of her current circumstances. Thankfully, Sashimi was accepting of the intervention and Sashimi was able to see how much the members of her church cared about her and wanted to help. Sashimi was willing to accept the services of a professional fiduciary and an agreed upon safety plan for the promise of avoiding homelessness.

The ARRA Homeless Prevention and Rapid Re-Housing Program (HPRP) assisted Sashimi in providing funds to relocate her to another residence in order to prevent Sashimi from becoming homeless. A social worker from the Homeless Services Team expedited the application to the HPRP program and to ensure available funds for the move. The members of Sashimi's church generously paid for the moving van and services. An appropriate professional fiduciary was introduced to Sashimi and Sashimi accepted the assistance in assuming responsibility over her finances and to coordinate care in the home.

Sashimi moved to a studio apartment located in a near-by city in September 2011. The APS social worker visited her in October and she had already settled into her apartment and appeared very happy. She had started teaching Origami to the other tenants of the apartment complex, which makes her proud. Thanks to the outstanding coordination and cooperation of the community partners and professionals, Sashimi's protective issue is eliminated with a prognosis for non-recurrence as good. This case took the coordination and collaboration of the Rapid Response Expert Team, community partners, a strong social network and dogged perseverance by APS.

Measurable Outcome 3: Increase medical/mental health resources to the Rapid Response Multi-Disciplinary Team

Positive increase in statements on the Integrated Team Monitoring & Assessment survey from pre-test to post-test related to increasing resources: 1) the team has the right membership to achieve its objectives and 2) the team is adequately resourced and supported to achieve its objectives.

To measure the effectiveness of expanding the pre-existing Rapid Response Multi-Disciplinary Team by integrating four medical practitioners into the team resulting in the Rapid Response Expert Team, the members were asked to complete an on-line anonymous survey at three key points during the project. The results were aggregated by a member of the Office of Strategic Management, an independent unit of the Human Services Agency responsible for strategic development, data collection and statistical analysis.

Description of the Survey Assessment Tool

The Integrated Team Monitoring & Assessment (ITMA) was developed by the Department of Health Care Services Improvement Partnership Networks to assist local agencies to assess team effectiveness. The ITMA is based on 30 customized measures based on validated research findings and best practices. The assessment enables an appraisal of the health of the team by presenting questions related to internal functioning and external factors that impact the team dynamic. The assessment includes statements grouped around five main Principles: Principle 1-Clear Purpose & Mission, Principle 2-Securing Ownership & Trust, Principle 3-Robust Working Arrangements, Principle 4-Learning & Review, and Principle 5-External Links & Support.

Methodology

Each Rapid Response Exert Team Member received an email containing a link to the ITMA and all assessments were completed online via the Internet. The assessment was administered during

three different intervals to enable monitoring and evaluation of team effectiveness over time. The baseline assessment was administered in May 2010, followed by a second assessment in January 2011 and a final assessment in July 2011. All team members accessed the online survey tool and were asked to respond to 30 statements. For each statement, team members were asked to provide their opinion by indicating a response of Strongly Agree, Agree, Disagree or Strongly Disagree. Responses were automatically assigned point values from Strong Disagree (1 point) to Strongly Agree (4 points).

Overall Results

The baseline assessment was completed by the 14 original Rapid Response Team Members. Subsequent assessments were completed for 11 out of the 14 original Rapid Response Expert Team Members. Direct comparison between the initial and second ITMA results should be made with some caution due to differences in team members/number of respondents. For example, the original District Attorney for the RRET was transferred and a new DA was assigned to the RRET under routine rotation in the DA Office. The individual scores of the team members were aggregated to provide a complete picture of how the whole team is working. In comparison to an optimal total score of 120, the overall score for the initial assessment (87) increased slightly compared to the second assessment (88) and indicated the team is developing well but is in need of some further action. However, compared to the initial assessment, the overall score for the final assessment (103) increased by over 18 percentage points indicating a positive overall improvement in team functioning over time. (See Appendix I)

Comparison of TRIO Outcomes for Selected Interventions

Chart 1 below compares selected interventions related to the use of an MDT and integrating medical providers into Adult Protective Services. Overall, APS social workers are able to

eliminate stabilize the situation or reduce the rate of decline in 69% of confirmed cases for abuse or neglect. When cases present a medical or health issue, a Public Health Nurse is deployed for assessment and intervention. When nurses are part of the investigation, assessment and intervention, there is a substantial increase in eliminating or reducing the protective issue (82%). A sub-set of the ASP target population are those cases that present with difficult to resolve complex biological-psychological and social impediments to the resolution of the protective issue. These are the most entrenched cases within the APS system. Historically, APS has used Public Health Nurses as part of this team. As shown in Chart 1, the Rapid Response Team successfully eliminates or reduces the protective issue in 65% of the cases presented. When 4 additional medical practitioners were added to APS, client outcomes improved to 91%.

Please note that the 102 cases in the study were not included in this chart for the MDT. If the 102 cases from the study are included in cases that are presented to the Rapid Response team, the success of the Rapid Response improves to 74%.

Chart 1

TRIO Outcomes for Selected Interventions
Confirmed Cases November 1, 2009- February 27, 2012

	All Cases	**Cases with In-Home Nursing**		**Difficult Cases Presented to Rapid Response MDT with In-Home Nursing Only**	**Difficult Cases Presented to Rapid Response MDT with an Integrated Medical Team**
	n = 2,007	n= 333		n = 109*	n = 102*
Protective Issue **unresolved**	31%	18%		35%	9%
Protective Issue **eliminated or reduced**	69%	82%		65%	91%
Total (rounding with	100%	100%		100%	100%

rounding errors)					

p=<.001

David H. Sommerfeld, Ph. D conducted an analysis of the outcomes for difficult cases (the last 2 columns) and found the differences to be statistically significant as indicated.

Challenges

What, if any, challenges did you face during the project and what actions did you take to address these challenges?

Early in the project, the Project Work Group addressed four major challenges to the implementation of the project. The most complex challenge was role clarification of the mental health expert and the role differentiation between the public health nurse and the physician. The role of the neuropsychologist appeared to be clear to the APS social workers and required little if no clarification.

The APS social workers needed assistance in knowing when to consult outside of the RRET and to pinpoint the question that needed answering. Working with a medical team required APS social workers to articulate the key concern and the question that needed to be addressed by the medical team. We did not view this challenge as unexpected or unusual. Integration of new members to a team particularly those with expertise beyond the scope of social workers and a language specific to that discipline generally will have a period of adjustment, understanding and clarification. The Project Work Group met numerous times and held meetings with the mental health clinician, Public Health Nurses, physician and neuropsychologist to crystallize the issue. The Project Work Group developed the following questions to assist the social workers and the medical experts:

1. Is there a medical/mental health condition that is the underlying reason for the abuse/neglect? (for example: severe depression that affects the client's ability to perform basic care needs, etc; or a cognitive problem that interferes with the client's ability to make appropriate decisions and provide for basic needs; or an untreated or undiagnosed illness that prevents the client from taking care of basic needs including safety needs) If

there is, is there something the APS social worker or RRET, or the medical/mental health practitioner, or community service can do to intervene?

2. Is there a medical/mental health condition that perpetuates the risk for harm? (A long standing problem keeps the person at risk for abuse/neglect) For example, a past trauma that is unremitting and perpetually keeps the client at risk? If so, is there anything the APS social worker or, RRET, medical/mental health practitioner or community service can do to intervene?

3. If there are no active symptoms of abuse or neglect as indicated on the TRIO, are there precursors that in the future place our client at risk for harm? For example, the APS SW cannot confirm abuse or neglect, but the client has early signs of cognitive problems, high blood pressure, under weight, a mental health disorder that will compromise the client's ability to adequately provide for their own basic needs. If so, what recommendations might you make to the APS social worker to reduce the rate of decline? Is there anything you can do to assist the social worker?

The solution to this challenge was training the APS social workers to improve skills in the how, when and what of consultation with the medical team pre and post the RRET. This training was conducted by the APS Coordinator.

Another major challenge was ensuring the medical practitioners at the Rapid Response Expert Team meeting had enough information and the right information to make a recommendation for deployment of the team or another type of intervention. Maximizing the use of time at the Rapid Response Expert Team meeting was the challenge. The solution was the

concept of "curb side consulting". With the mental health clinician, 2 public health nurses and the physician on site, curb side consulting was efficient, effective and easy. This was developed to encourage the APS social workers to seek consultation prior to the meeting of the RRET and to provide the medical practitioners the needed background information. The results of this strategy were quite remarkable as follows:

1. Improved the efficiency of the team by having more information about the client at the time of the presentation
2. Increased the understanding of the client's behavior and situation by framing the client's behavior and functional abilities in a more holistic framework and an environment-person-fit perspective vs. a more narrow view.
3. Enhanced the response and strategies from the team by going beyond the protective issues singularly to the bio-psycho-social-cultural approach.
4. Improved the response by the team by adding specificity to the presenting problem.
5. Broadened the perspective of the team that is mostly comprised of advocates and legal disciplines.

Although not a major challenge, new policies or procedures always require the use of change management strategies. Issues of understanding what is new and clarifying expectations and new processes requires high visibility of the project leadership, provision of venues for the APS team to review policies, procedures and practices, provision of venues to ask questions, seek feedback and get input to how the project is progressing. The Project Work Group was vigilant to ensuring frequent and open communication and discussions about the project,

problems, solutions and input. As a result, the APS social workers acknowledged that their work and input was valued.

A major challenge for the agency that was not considered at the start of the project was the potential impact on the Public Guardian's Office. The Public Guardian is a unit within the Human Services Agency and practices under the California State Welfare and Institutions Code and Probate Code. With the added resource of a neuropsychologist to the APS team, the Public Guardian's office experienced an 87% increase in viable referrals over the preceding years. This had a work load impact on the Office. Because there were no funds to expand the personnel in this office, the work was shared with other trained staff in the office. One result was a slight delay in processing probate referrals through the court system.

About mid-point in the project, in consultation with the neuropsychologist and APS social workers, the Project Work Group changed the tool used to screen for cognitive impairment. The team began using the Montreal Cognitive Assessment (MoCA) tool. This required training of the APS social work team by the neuropsychologist and has proven to be a more effective screening tool for our population. We also began using a screening tool for IADLs to improve our effectiveness in identifying and documenting clients with possible impairment. As a result of this project, the APS social worker completes a MoCA and/or an IADL on every client and documents the score in the Panoramic APS case management system. This allows us to easily capture the number of clients in our population with cognitive impairment. To date, 871 episodes of elders 65 and older have been screened resulting in 39% of those demonstrating mild to severe cognitive impairment. Of those, 26% demonstrate moderate to severe cognitive impairment.

To track and monitor the change of cognitive status of our population, we approached our vendor, Panoramic Software, Inc. to add a function to our APS case management system to

record the score of the MoCA as well as the IADL screening tool. This allows us to track cognitive status in recurring cases and to establish a baseline of functioning.

The project was expected to end June 30, 2011 but to ensure all of the cases were captured for study and to allow University of California San Diego time to complete their research, a 6 month extensive was requested and approved. Our medical practitioner left the county for a new position in August 2011. We were not able to find a replacement for the time period August 2011 to December 2011. Locating a physician with expertise with this population, time to commit to the work and an approach that fit into the culture of the teams proved to be a challenge we could not overcome by the end of the project. We attempted to engage the services of a family residency program through a local hospital. Our physician and the Project Leader met with the Director of the Residency Program, the physician presented her work to the curriculum committee and the Director attended one of the hosted lunches and training by the neuropsychologist. Although complimentary of our work and the value to the client, the curriculum committee of the Residency Program could not make the recommendation that rotating Residents through APS and the Rapid Response Expert Team was core to their mission of physician training. As an interim, a private physician in the community who makes home visits began accepting some of our most crucial APS clients into his practice.

With the added resource of the medical practitioners, more cases were presented to the Rapid Response Expert Team. With a 68% increase of cases, the team did not have enough time to listen to the presentation and strategize a response within the allotted time. As a solution, the team unanimously agreed to expand their time by 30 minutes to allow for the increased number of cases.

Except for the neurophysiologist, the three (3) new medical team members had office space on site within APS program. The addition of four (4) new members to the team was an

additional work load for the APS social workers. Curb side consulting took more time and integrating recommendations by the Rapid Response Expert Team and medical practitioners added more work. However, without one exception, each social worker reported the increased work load and time was valuable and worthwhile. This sentiment was captured in the APS social worker survey. (See Appendix G)

The final challenge for the project was facilitating a larger team and a team that had to re-form with new membership. The team also had to accommodate the increase in the number of cases presented. One reason for the success of the RRET was the ability of each of the new members to understand their role on the team and to fit within the existing structure. The second reason for the success was the ability of the team leader to navigate these changes.

Facilitating a multi-disciplinary team is an art and a skill. Contrary to popular belief that a high functioning team can operate regardless of the leadership, our experience has not always supported that belief. Any team requires a skilled facilitator who can ensure the following:

1. Every voice is heard.
2. Every opinion is welcomed.
3. Every meeting has a focus and purpose with expected outcomes.
4. Every meeting starts and ends on time.
5. Every meeting results in action plans for the strategies developed.
6. Every member of the team respects and abides by the rules of the group.
7. Every meeting has a tone and feeling of collaboration and support.
8. Every case is presented in a way that clearly states the purpose of the consult and question needed to be addressed by the RRET.
9. Every member has equal status regardless of titles, degrees and expertise.

In our experience to date, 3 key factors are essential to ensuring a high functioning team. The first is leadership that is strong and firm but not dictatorial. The second is the leader's ability to keep the discussion on focus and the third is the spirit of good humor and collaboration created by the leader. Finally, it is our experience that facilitation by the leader of the APS program is important to reaching the mission of the multi-disciplinary team. Creating a safe and supportive environment for social workers or any member of the team to present difficult to resolve cases is essential in order to meet the mission of the team.

Impact and Lessons Learned

What impact do you think this project has had to date? What lessons you learned from undertaking this project?

The Rapid Response Expert Team project made a significant impact on the practice of social work in the Adult Protective Services program. The project increased the social worker's ability to ensure the health and safety for the clients who needed an evaluation but could not leave their home, had no regular physician or health care provider or had a physician who was unaware of the living conditions of the client. This increased the effectiveness of the program and enhanced the social workers' sense of efficacy.

Although there was an increased work load for the APS social workers to consult with the medical practitioners, present cases to the RRET and to follow-up with recommendations, the time spent by the APS social workers was more efficient. Instead of attempting to wend their way through complicated health systems to gather information or to access services, the medical practitioners could serve this function with relative ease and with better outcomes for the client. For example, the physician was able to access and review medical charts, evaluate the client in their home setting and then discuss the client's current condition with the primary care physician or hospital physician. The mental health practitioner's ability to evaluate the client in the home setting and share impressions with the APS social worker and the other medical practitioners allowed for better understanding of the client's behavior for a more targeted intervention and linking to services. With keen knowledge of the mental health system, the mental health clinician often assisted the clients who presented with moderate to severe mental health issues with navigation of the intake process. Under best circumstances, this is not an easy task. With at risk elders, this task becomes more daunting. These roles as described are time consuming and require in-depth knowledge and medical/mental health skill. All of the medical practitioners on

the team expedited access to necessary services that the client would not otherwise have accessed, resulting in better outcomes for our target population. Often, our clients do not leave the home for needed care because of fear, anxiety, reduced sensory ability and often diminished cognitive capacity resulting in increased confusion. The medical team was able to spend time with the client in their home setting, establish rapport and trust in order to improve investigations, assess possible underlying causes and to facilitate the out of home treatment necessary.

One of the most significant impacts of the project was the ability to conduct an in-home evaluation for cognitive capacity. In Ventura County, a referral to the Public Guardian Office requires a valid and complete capacity declaration. Prior to the onset of the project, clients who scored below normal on cognitive screening tools and needed comprehensive testing to ascertain the actual extent of cognitive capacity, were not able to be served unless the primary physician or family took the initiative. For our population, this was a rare occurrence. This gap left vulnerable elders with unresolved protective issues and a poor prognosis for non-recurrence.

Integrating medical practitioners into APS maximized the expertise of each discipline. APS social workers could work more efficiently and effectively and the medical practitioners found the work meaningful. To underscore this point, Dr. Esther Yoon, MD and Maria Arvelo, MSW LCSW, two members of the medical expert team, crafted letters to the Board of Supervisors as part of one of our presentations. Excerpts from these letters follow:

June 14, 2011

Dear Board of Supervisors,

Thank you for this opportunity to share what I have learned through my time with the Adult Protective Services as a consultant medical physician. I am proud to be a part of a landmark team that seeks to bring the expertise of law enforcement, medicine, neuropsychology, behavioral health, social work, public health nursing, and elderly area agencies together at one table. As you are well aware, we can only expect to see that our seniors are on pace to comprise a large segment of our county. To this end, I believe that we need to continue this type of collaboration in order to meet the complex needs of this population.

As a physician, I have been able to provide a timely medical in home assessment to largely homebound seniors. I have cut down the response time that socials workers face when trying to schedule an urgent appointment with their physician. For most of us, a scheduled appointment takes 3-5 weeks. Often, it is not a safe situation to let our seniors languish without timely care assessments.

My medical expertise allows the Adult Protective Services team makes more informed decisions on how to continue to preserve independence and autonomy despite the clients' decline. I work as a real time advisor to cases that the social workers and public health nurses see. I am able to share my medical knowledge so that they are quickly equipped to construct an appropriate solution to the complex medical conditions that often complicate our clients' cases. Also, I am able to bridge communication between hospitals and other medical providers to obtain the records and follow up for clients. I have seen the benefit of this team to solve complex medical social cases, but also do it in a more efficient manner.

Dr. Esther Yoon

Las Islas Urgent Care physician, Ventura County Medical Center system

Adult Protective Services, consultant physician

June 14, 2011

Dear Board of Supervisors,

I have been privileged to be the mental health practitioner, for the federally funded innovative multidiscipline services delivery model, piloted by Ventura County's Adult Protective Services (APS) this fiscal year, entitled the Rapid Response Expert Team (RRET), and the development, utilization and research of the APS TRIO – Tool for Risk, Interventions and Outcomes, an instrument designed to standardized practices. The RRET was charged with assisting APS by providing in home medical assessments, consulting and generating recommendations, optimum response interventions and plans to help reduce or eliminate the existing protective issue that threatened the safety and wellbeing of APS clients. My role on the team was to provide in home mental health assessments to determine if the individual was additionally hindered as a result of suffering from sub-clinical or clinical symptoms e.g. minor or major depression and to facilitate client linkage to available needed services.

As I fulfilled my duties, I was profoundly impacted by my experiences and will highlight 3 resulting points:

The first point is that there are significant gaps in the needed services on the continuum of care for elders in our county and likely California perhaps nationally.

The second point is that elders are more responsive to having services provided in their home. When services are offered in the elder's home, the elder is able to maintain their dignity, comfort and safety which contribute to sustaining their sense of mastery in the face of inevitable losses and related challenges. Services provided in the home also reduce the elder's societal and generational stigma associated with having any mental health needs enhancing their ability to accept services.

The third point is that virtually every elder I met was in the process of finding meaning in their life choices and experiences – whether consciously aware or not. They did this by sharing their life story, either nostalgically reminiscing, or courageously revisiting

unresolved pain, unrecognized trauma, or discouraging experiences that may have rigidified into their burden of despair. This process of coming to terms with their life choices and experiences, though possible a source of pain, denial and suffering, is not a mental health condition but instead a natural task at this stage of life.

This process in fact is a golden opportunity to resolve the tension of the 8th stage of development – integrity verses despair (Erik Erikson). The successful resolution of this life task can be vital contributor to one's sense of well being, functioning preventatively support the elders' ability to "age in place", remaining in their home as long as safely possible. When this life task is fraught with unresolved matters, it is more difficult to navigate when one is isolated and unable to access the needed assistance. Of the APS clients I met with, 69% lived alone, having minimal to no support, constricted by their fears, mental health stigmas, and the current office based service delivery models leaving the elder to suffer in isolation.

The APS innovative multidiscipline service delivery model which includes medical practitioners, utilization of the APS TRIO, partnering with the Interagency Rapid Response Team has set the stage for a comprehensive approach that attends to the multifaceted dynamics that contribute to elder abuse and neglect. I am hopeful that this Board of Supervisors recognizes the prophetic role it can play in allocating resources for APS to continue these innovative practices and begin to develop the foundation for needed policy changes. Thank you for this opportunity to share my experiences and related perceptive.

Maria Arvelo L.C.S.W.

HSA, Adult and Family Services, Adult Protective Services mental health consultant

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The project had significant impact on increasing the skills and knowledge of the APS social workers and members of the RRET. It is essential when working with elders in particular to understand dementia, differential diagnosis and the proper use of screening tools like the MoCA. Often, a barrier for APS social workers is the ability to communicate with other disciplines in the language of that discipline. As a result of the project, the APS social workers improved their skills in understanding and articulating to medical providers the differences between emergent, urgent and routine medical issues.

The RRET project energized the existing team with increased knowledge and skill in approaching complex cases from a comprehensive perspective. It also increased the visibility of the APS program and its role in the safety net structure of the county and the needs of this population this had another effect in that the credibility of APS improved. Previous recurring cases were now being resolved. Respected medical practitioners demonstrated admiration for the work of APS social workers and this message reverberated throughout the community. One result was the acknowledgement by the Ventura County Adult Abuse Council who honored the APS Team at its annual award ceremony. In November 2011, APS accepted the "Shooting for the Stars" award. A member of the Board of Supervisors presented APS with a proclamation as well as a proclamation from US Congresswoman, Lois Capps.

The newly forged relationship with California University Northridge MSW program has already demonstrated a significant impact by introducing first and second year MSW students to the aging population and to Adult Protective Services. According to the NASW, a projected gap will exist in the field of social work to meet the need of the aging population. This was documented in the 2006 NASW and Center for Work Force Studies*: Assuring the Sufficiency of a Frontline Work Force: A National Study of Licensed Social Workers: A Special Report Social Work Services for Older Adults.* The continued relationship with the University will help to meet

this need by training new social workers in this important field. The RRET project was one stated reason for the interest in APS program as a learning site for MSW students.

There are potential policy implications of the RRET project. Standardizing risk assessment is essential to ensuring comprehensive investigations, assessment of underlying causes and designing the right intervention at the right time. Standardizing risk assessment improves consistency, reduces variability and improves outcomes for the client. The TRIO is a step in this direction. The TRIO brings the added component of measuring outcomes that is essential to the field of Adult Protective Services. The research on the TRIO will inform both the practice of social work in adult protective service programs and policy on how these services are delivered.

Secondly, the process of aging is changing and the needs of this emerging population require a different approach in Adult Protective Services programs. Although the sample is relatively small, the client outcomes and survey results suggest that integrating medical practitioners into APS programs and multi-disciplinary teams is efficient and effective. From an experiential perspective, it appears as if the cost savings of recurring hospital admissions, emergency room visits and premature admissions to long term care facilities as well as ensuring the dignity and quality of life is worth study. Replication of this project is important to test whether the outcomes achieved are consistent in other systems and environments. The results would have great potential for a change in public policy on how APS programs are delivered. The cost of the replication could be accomplished with less than the original grant funding. It is estimated that the study could be replicated with $200,000-$300,000. The cost is dependent on a number of variables including whether the medical practitioners are full- time or part- time. In our model, the Public Health Nurse was full-time. The physician and mental health clinician were part-time and the neuropsychologist was on an as needed basis.

The University of California San Diego identified a number of policy and practice implications from their research and investigation on the TRIO and this information is repeated here for emphasis:

1. Several important implications for policy and practice were generated by the results of this study. Given the finding that APS social workers have the ability to identify clients most likely to recidivate back into APS, providing additional longer term services to the high risk clients may help reduce preventable APS recidivism and promote the ongoing well-being of the vulnerable populations traditionally served by the APS system. Future study is needed to examine the role that longer-term follow-up and support can play in reducing APS recidivism.

2. The findings suggest that APS client engagement and retention strategies warrant explicit attention to help promote maximum client participation and favorable outcomes. In addition, the individual TRIO risk indicators and the identified risk profiles highlighted the diverse range of risks and their complex interactions found among the APS clients. To adequately address these concerns the APS system must have the capacity to provide a wide range of services and develop partnerships with affiliated agencies for expertise not regularly available within the APS system and outside the scope of traditional social work practice.

3. The development of tools like the TRIO can help to further research partnerships within the field of APS by collecting an extensive amount of data regarding client risk indicators, interventions received, and outcomes attained. Such data are important for developing a better understanding of the needs of APS clients and the role that specific

interventions can play in promoting more positive client outcomes and a reduction of future, preventable APS recidivism.

4. A final potential impact of the project is highlighting the importance of research in APS programs and elder/dependent abuse and neglect. The aging population of today is different than the aging population a generation ago. There are many reasons for this that are well documented in the literature but includes the advances in pharmacology, advances in technology for diagnostic purpose, improvements in public health, prevalence of chronic illness and expanded life span. To meet the challenges of this population, linking research institutions to APS programs is vital to understanding who we are serving, how the changes in the population affect risk for abuse and neglect, what interventions are effective and what are the outcomes of the interventions provided.

Sustaining the Project

What will happen to the project after this grant has ended? Will project activities be sustained? Will project activities be replicated? If the project will be sustained or replicated what other funding sources will allow this to occur? Please note your significant partners in this project and if/how you will continue to work on this activity.

With the positive results of the RRET project, Ventura County APS was awarded a grant from the Archstone Foundation. Established in 1986, Archstone Foundation is a private, non-profit foundation whose mission is to prepare society for the growing needs of an aging society. Under the leadership of president and CEO Joseph F. Prevratil, J.D., the Archstone Foundation grants up to $5 million annually, primarily in Southern California. The Archstone Foundation's funding priorities include: fall prevention, elder abuse and neglect, end-of-life issues, and emerging needs among the elderly. Ventura County APS is proud of this award.

The funding from the Archstone Foundation grant sustains the second Public Health Nurse and the neuropsychologist for an additional 18 months. The Board of Supervisors, the governing board for the county, is continuing to fund the original Public Health Nurse and voted unanimously to identify funding for the project in the budget for fiscal year 2012-2013 that begins July 1, 2012. The results of this will not be known until June 2012. The mental health clinician was integrated into the budget of the agency.

A private physician in the community makes home visits to his patients when necessary. This physician accepts referrals from APS for new patients as his practice allows. Our desire is to explore other physicians in the community and within the county system who have the vision for home-based treatment services. At the final writing of this report, a physician from Public Health expressed interest in joining our team. Elder abuse and neglect is considered a public health issue and as the number of referrals rise, interest in the public health rises in concert.

Ventura County Human Services Agency and Public Health have a long standing and established relationship for partnerships and sharing the vision of improving the health and well being for all people who live and work in Ventura County.

The University of California San Diego, a significant partner in the project, is committed to the work on the TRIO and will continue its research on the tool beyond the project end date. Gregory A. Aarons, Ph.D and David H. Sommerfeld, Ph. D will submit their research for possible publication in fall 2012 and presentation at the Gerontological Society of America Annual Conference in November 2012.

The Rapid Response Multi-Disciplinary Team expanded its membership with the inclusion of both Ventura County and City of Ventura Code Enforcement. The other 5 Code Enforcements expressed their commitment to the team when cases in their jurisdiction are being presented. Although Code Enforcement agencies historically were good partners with APS, their interest in and support of the Rapid Response Team is an indication of the success of the project.

As evidenced in the surveys conducted throughout the project, the members and agencies represented on the team are highly motivated and dedicated to the mission and goals of the team. The members have a shared commitment to serving vulnerable and at risk elders and dependent adults and remain devoted to the work of a community multi-disciplinary team partnership collaborative.

A new partnership with California State University Northridge Master of Social Work program is a direct result of the work on the project. Three M.S.W students chose our site to be a part of the work of APS and to learn the skills to work within an integrated and multi-disciplinary environment. This program will continue beyond the end of the project and will be important to the future of preparing clinical social worker to work with the aging population.

Integrating M.S.W Interns into APS is a preliminary step generated to meet a facet of the existing gap of needed in-home services for at-risk elders.

One outcome of the project's focus on public presentations was educating employees of the Gas Company and pharmacies about identifying possible elder abuse and neglect. Although these entities are not members of the RRET, they have increased understanding of the role and mission of APS and how to make a referral. This type of outreach to perhaps the non-traditional referring sources to APS will continue after the project ends.

Another important outcome of the project was the private/public partnership with Panoramic Software, Inc. Panoramic converted the paper form of the TRIO into an easy to use electronic version. Although Ventura County holds rights to the content of the tool to ensure fidelity to the research, Panoramic is offering the TRIO at no cost to any entity. Training on the TRIO is offered at no cost by Ventura County.

Key Publications, Communications, and Activities

Over the entire project period, what were the key publications and communications activities? How were they disseminated or communicated? Products and communications activities may include articles, issue briefs, fact sheets, newsletters, survey instruments, sponsored conferences and workshops, websites, audio visuals, and other informational resources.

A key strategy to ensure the success of the RRET Expert Team project was frequent communication about the goals, objectives, outcomes and value to APS social work practice and public policy in adult protective service programs. The project leader collaborated and consulted with other members of the Project Work Group on a regular basis with the Human Services Agency Office of Strategic Management. This internal unit is responsible for data collection, data and statistical analysis, reporting, and internal and external communications. During the planning phase of the project, the Project Work Group made a strategic decision to utilize an array of mediums to disseminate the work of the project.

Each type of communication met the following objective: By using multiple mediums, the Project Work Group will educate, share and inform all stakeholders on the goals, objectives, outcomes and value to public policy and social work practice. We believe we met our objectives in every category and opportunity.

Media

We had exposure to our work through print media. An article in the local newspaper, the Ventura County STAR (www.VCSTAR.com) first appeared in August 2010 at the start of the project. The article described the project, funding source, etiology of the hypothesis to be tested and expected outcomes. The newspaper did 2 follow-up stories about the project. (see Appendix D)

The second story in May 2011 highlighted the *Aging Population Summit* presented by the project leaders to share the status of the RRET project and its importance to the field of aging. This article coincided with Elder Abuse Prevention Month 2011. A similar presentation is planned for Elder Abuse Prevention Month 2012.

The third and final story appeared in April 2011. The focus of this story was the financial abuse of Mickey Rooney, who lives locally, and his testimony to the California legislators. This story allowed us to articulate the importance of an integrated medical team with APS and our hypothesis that financial abuse does not occur as an isolated incident but within the complex bio-psycho-social and cultural dynamics of families and the individual.

Published Materials

In February 2010, the Human Services Association magazine, *Policy and Practice*, published an article titled, *Standardizing Risk Assessment in Adult Protective Services,* written by the Project Leader (see Appendix A). This article highlighted the need for standardizing risk assessment in APS programs, the core task of APS. The article defined a pilot tool created by Ventura County previously called the RAI (Risk Assessment Instrument). Since the time of the article, the RAI pilot has expanded as a result of the research conducted by University of California San Diego and the name changed to the TRIO; the Tool for Risk, Interventions and Outcomes.

The RRET project and TRIO were highlighted in the County of Ventura Human Services Agency Annual Report 2010-2011. This report is available online and was made available in print to community leaders, political leaders; community based organizations, non-governmental organizations, other county agencies and county employees.

All materials, project progress reports, power points on the RRET project were placed on the agency web page and accessed through Adult Protective Services page. In the event other

states or counties wanted to replicate or learn about the project, information about goals, outcomes, challenges and solutions would be readily available.

The University of California San Diego completed a report of their research on the TRIO for all episodes with a start date between 11-1-2009 and 6-30-2011. For recidivism rates, the research was restricted to 180 day recidivism with and end date between 11-1-2009 and 3-31-2011. In brief, the research finds the TRIO to have content, predictive and concurrent validity and finds the inter-rater reliability of the TRIO to meet substantial reliability. When used properly, the TRIO reliably measures risk in elders and is accurate between social workers. UCSD will submit a paper for publication on their findings and recommendations for further study in 2012.

Presentations, Workshops and Training

The Project Leader conducted training for Napa County January 6, 2011 and Tulare County on May 10, 2011 on the Risk Assessment Instrument renamed the Adult Protective Services Tool for Risk, Interventions and Outcomes (APS-TRIO).

The project leader conducted training for the APS social workers on the differential construct between services and interventions on February 3, 2011. It was well received and improved the use and consistency in the APS-TRIO. This was shared with participating pilot counties who found the description very useful. The project leader conducted a second training on June 16, 2011 on differentiating between elimination of the protective issue and the reduction and the link to prognosis. It was well received and provided the social workers an opportunity to discuss the type of cases that pose challenges in assessing the protective issue outcome.

The Human Services Agency sponsored the *Aging Population Summit* for community stakeholders, Board of Supervisor members and other elected officials on May 4, 2011 to present

the impetus for our work and preliminary outcomes. Our key sponsor, a representative from US Representative Elton Gallegly attended. We had an excellent response to our work. As a result, we were invited to speak to the California Congress for Seniors, a non-profit organization since 1977 under the leadership of State President Hank Lacayo.

The Project Leader made a presentation to the Board of Supervisors on May 3, 2011 for Elder Abuse Prevention Month that highlighted the need for an integrated approach to APS, the importance of a tool like the TRIO and the value of a multi-disciplinary team. We were invited to speak again to the Board of Supervisors in June 2011 about the status of the project and outcomes. The Board voted unanimously to direct the CEO office to identify funding sources to sustain the RRET in FY 2011-2012 budget cycle.

The Academy of Professional Excellence invited the Project Leader to conduct a webinar for the Western Region of NAPSA February 3, 2011. The topic for the webinar was "A Framework for Assessing Risk in Adult Protective Services." The Western Region is comprised of Washington, Oregon, California, Hawaii and Guam. A survey of participants indicated an average rating of 4.5 (out of 5) on the presentation. Five indicates high success of the webinar.

A key member of our RRET team was Dr Yoon. Dr. Yoon is a practicing physician currently in Los Angeles County. During the project Dr Yoon was a physician in one of the outpatient clinics in Ventura County. Dr. Yoon presented to the curriculum committee of the VCMC Family Residency Program to share her experience with APS. Dr. Yoon believes her experience with APS is a valuable learning experience for physicians. She also believes that in-home assessment by a physician who can coordinate and link to the primary physician reduces the risk of further decline and improves the health of the client.

Erik Lande, Ph.D the neuropsychologist on the team conducted 3 training presentations during the course of the study. Dr Lande provided training to the APS team and the Director of

the Ventura County Family Residency Program on differential diagnosis, understanding dementia and use of the Montreal Cognitive Assessment scale (MoCA). This training proved to be invaluable in training social workers on identifying risk as a result of cognitive impairment and increased the skill and knowledge of the team. As members of the RRET, each of the medical practitioners provided information in their area of expertise resulting in a better informed team.

We were selected to present our work at the NAPSA conference in New York in September 2011. Both the project leader and David H. Sommerfeld, Ph. D, lead investigator from University of California San Diego presented on the TRIO and outcomes of the project. We were selected to present our work on the RRET and TRIO at the Aging Conference sponsored by the American Society on Aging in March 2012.

The Project Leader presented the work on the TRIO at the California Association of Area Agencies on Aging as a member of a panel on promising and best practices in APS programs in November 2011. The presentation focused on the need to standardize the approach to risk assessment and the importance of measurable outcomes for program integrity and sustainable funding.

As a member of the Alzheimer Association of Ventura County, the Project Leader was invited to present to the general membership and the Medical Board. Of particular interest to these groups was the standardization of risk assessment, measuring outcomes and the importance of conducting in-home assessments for clients who appear to be at risk as a result of moderate to severe cognitive impairment. This is interesting to the Alzheimer Association because of their work on the increasing prevalence of dementia in our target population.

The Project Leader and APS Coordinator presented the purpose, goals, objectives and outcomes of the project to the Ventura County Adult Abuse Prevention Council in July 2011.

This community based group advocates for at risk elders and shares information about elder abuse and neglect throughout the county. As a result of our work, the Council chose our Adult Protective Services team to be honored at their annual gala event. This event was attended by members of the Council, guests, and political leaders in the county. The event raised over a thousand dollars for APS tangible service fund. This fund pays for emergency services to mitigate risk and to keep elders and dependent adults safely in their home. It was an honor to be chosen for this award.

The project leader applied to present on the study at the NASW conference to be held in July 2012. At this writing, selections have not been announced. If selected, the presentation will focus on the importance of the TRIO in measuring outcomes. In a parallel process, both the client and the APS social worker must confront integrity vs. despair, the final life stage in the Erik Erikson model of human development. By standardizing risk assessment and measuring outcomes, ASP social workers have a renewed sense of effectiveness and hope.

Measuring the effectiveness of the RRET with the added medical practitioners as a resource was an objective of the project. As previously mentioned we conducted an anonymous survey of the RRET prior to the start of the project and then repeated the same survey mid-project and post-study. This was an online survey conducted by a member of our Office of Strategic Management. The online survey is the Integrated Team Monitoring & Assessment tool (ITMA) that was developed by the Department of Health Care Services Improvement Partnership Networks to assist local agencies to assess team effectiveness. The results of the surveys can be found in Appendix I.

In addition to the presentations and training by members of the medical team, the Project Leader conducted quarterly training to the APS social workers on elements of the TRIO. This training proved to be invaluable in the proper use of the tool and in shifting the focus of

investigations and assessment from an event, allegation drive focus to a comprehensive bio-psycho-social approach. One training workshop focused on the use of intuition in social work practice. This 4-hour workshop is based on the work of Gavin De Becker (used with permission) and reinforces the use of intuition in keeping social workers safe in the field and guiding the investigation. Key to this training is the emphasis that intuition can only guide the social worker but cannot be used to confirm an allegation. This distinction is a key element in the reliability and validity of the TRIO. The Project Leader also provided training to Tulare and Napa Counties in California.

The Rapid Response Expert Team manual (see Appendix C) was completed early in the project and is used to guide the actions and practice of the team. The Project Leader provided a written status report to the Rapid Response Expert Team in October 2011 to communicate progress toward goal and objectives and summary of activities and accomplishments.

The APS Coordinator trained over 3,108 community partners during the study period about the mission and goals of APS and purpose of the multi-disciplinary team project. Of importance is informing the community on how to identify possible indicators of elder/dependent abuse and neglect and the process for making a referral to the hotline.

Finally, in October 2011, APS sponsored a workshop on Hoarding conducted by Mark Odom, LCSW. His work can be found at www.MarkOdomLCSW.com. This workshop focused on the most recent research on hoarding behaviors and use of the HOMES and Clutter scales. This workshop was well attended by members of our Board of Supervisors, community and county partners and six of the seven code enforcement agencies in the county. A positive result was the addition of 2 code enforcement agencies as members of our RRET and joint home visits. This new partnership is essential to the APS program's ability to mitigate risk in this population. Joint home visits and participation in the RRET maximizes resources.

In closing, the results of the study exceeded our expectations and the response by community partners and stakeholders has been impressive. The commitment by University of California San Diego to the research on the TRIO speaks to the potential for informing and adding to the field of knowledge on elder/dependent adult abuse and neglect and the practice of social work in APS programs. We are grateful to have had been a part of this study and to the experience that has strengthened and improved our ability to serve this vulnerable population. The Rapid Response Expert Team project allowed us to deliver the right intervention, at the right time for the right reason; thus improving the health, safety, stability and wellbeing of the people we serve.

Future Considerations

The TRIO is proving to be an invaluable tool to define the populations served by Adult Protective Services and inform practice and policy in designing the appropriate and targeted intervention leading to eliminating or reducing the protective issue. We believe that establishing goals and outcomes that answers the question – Does APS make a difference in the lives of people served? – is essential to meeting the mission of APS as a safety net service for vulnerable elders and dependent adults. Certainly, legal prosecution is vital to keeping people safe but a social safety net approach is as valuable as evidenced in the outcomes of the RRET project

Funding for research in this field is important to keep pace with the changing landscape of aging. Ventura County welcomes any opportunity to partner with agencies at the Federal or other State levels for continued investigation and research of the data collected in the TRIO.

Acknowledgements

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Marcy Snider, APS Coordinator and Facilitator Rapid Response Expert Team

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Carey Aldava, APS Social Worker

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Appendix - include a copy of each project product as a separate attachment and identify each by capital letters in sequence A, B, C - As follows.

Appendix Items Included:

Appendix A
Article on the TRIO (formerly called the RAI)

By Linda Henderson

Linda Henderson is the deputy director of Adult and Family Services at the Ventura County Human Services Agency.

Standardizing Risk Assessment In Adult Protective Services

Adult protective services programs are at a critical juncture. While the elderly population is increasing rapidly, APS programs remain at a disadvantage for stable funding and growth without a standardized approach to risk assessment and intervention that leads to measurable outcomes. Armed with objective data, adult protective services will be poised to meet the complex needs of a growing population. Recognizing the need for greater consistency in identifying risk among vulnerable adults, Ventura County has designed a risk assessment instrument. The RAI standardizes the approach to assessing risk, correlates the assessment with interventions, and measures outcomes in the areas of health, safety and the elimination or reduction of harm.

A team of Ventura County's APS program managers and social workers designed the RAI based on the theory that elder/dependent abuse/neglect may follow a path of progression similar to the disease process. This parallel structure was first suggested in the keystone work, Elder Mistreatment: Abuse, Neglect, and Exploitation in an Aging America edited by Richard J. Bonnie and Robert B. Wallace and published by the National Research Council and National Academies Press in 2003. Models from the fields of alcoholism and chronic pain are the foundation for the design of the RAI. In these, assessment and intervention are not discrete functions but integrated and correlated to anticipated or expected outcomes and prognosis for recurrence.

The RAI is built on the premise that elder abuse/neglect does not occur spontaneously. Rather, it occurs subtly over time in a deteriorating nature punctuated by periods of stability. Recurrence is a normal stage in the process of many diseases and is common in abuse/neglect, particularly in self-neglect cases. Tracking recurrence and prognosis are methods used in the RAI to measure not only program effectiveness but also client response to interventions. More importantly, these outcomes provide valuable information to managers and social workers about trends in the population and gaps in the service delivery system.

Precursors are those risk factors that play a crucial role in the onset and course of a disease and increase susceptibility to a particular illness. Medical practitioners consider both risk factors and active symptoms when diagnosing illness. This assessment model is standardized within the RAI. The RAI incorporates a set of biological, psychological and social precursors that appear to predispose a person to harm. The instrument also standardizes a set of factors that indicate actual occurrence of abuse/neglect. These elements were selected from research conducted by University of California at Berkeley School of Social Welfare and from direct social work field experience.

In a disease process, risk factors and active symptoms cluster together to form a profile of a disease. Although some symptoms may carry more meaning than others, it is the cluster of symptoms that lead to the diagnosis. Research on the RAI is testing the viability of this approach in elder/dependent abuse/neglect. The hypothesis is that certain clusters of precursors and risk indicators may lead to an anticipated or expected outcome and prognosis, and that some clusters may be higher risk than others. An anticipated outcome of the testing is confirming whether a predictive pathway similar to the progression of disease exists in abuse/neglect.

The RAI is revealing itself to be a promising practice in assessing risk, designing interventions and measuring outcomes. The RAI guides the process of assessment and intervention in a consistent and standardized manner but does not prescribe or structure the decisions the social worker made. Comparing abuse and neglect to how a disease manifests and progresses has had a positive effect on our team. Our social workers are finding the RAI advances a systematic and comprehensive biological, psychological and social analysis of the client's situation and needs. The RAI fosters the perspective that each case unfolds as a process comprised of the interrelationship between the clusters of precursors, risk indicators, interventions and outcomes. Ultimately, achieving a better understanding of this pathway will enable social workers to deliver more targeted, successful interventions.

Looking forward, professionals in the field agree that elder abuse/neglect is under-reported and the occurrence rate, more than likely, will increase over the next several decades. APS programs already experience difficulties in keeping up with the demand for service and the lack of resources required to resolve complex medical, mental health, cognitive and social needs of the people we serve. Those of us who serve elderly and dependent adults have a desire to improve the quality of life for these vulnerable populations. Standardizing the approach to risk assessment linked with measurable outcomes is vital to informing policymakers about the value and effectiveness of APS programs. We believe that implementing the RAI is a step toward meeting this goal.

Appendix B
E-version of the TRIO on the web

Access video and demo account at http://www.panosoft.com/

PANORAMIC
SOFTWARE

support@panosoft.com
1-(877)-558-8526

TRIO: Ensure Consistency and Improve Protective Outcomes

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Cross platform support gives you access to your data wherever you are and whenever you need it.

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Appendix C
Rapid Response Expert Team Manual

County of Ventura
Rapid Response Expert Team

Human Services Agency
Adult & Family Services
2010

4-26-2010:LBH

Table of Contents

County of Ventura Rapid Response Expert Team

I. Introduction

The County of Ventura Human Services Agency recognizes that the health, safety and well-being needs of dependent adults and the elderly in our community are diverse and often go unnoticed or unaddressed. Adult Protective Service (APS) programs are not mandated and therefore operate under state and local customs and practices. Because of the increasing demand to protect one of the many vulnerable populations within our community, APS has grown. However, there continues to be a lack of federal statutes to regulate the delivery of services; no mechanism on a national level to collect data related to abuse and neglect leading to best practices and no designated sustainable funding to support this vital program.

The lack of a federally driven system with unified definitions, best practice guidelines, field-use assessment tools and funding compels local governmental agencies to develop their own best practice approaches to address dependent and elder abuse and neglect.

In spite of the best efforts and dedication of the members and agencies represented on the Rapid Response team, dependent and elder abuse and neglect remains a hidden problem. Research from the Ohio Elder Abuse Interdisciplinary Team (Elder Abuse Task Force 2004) and other medical literature indicates the following reasons:

1. Elder abuse is seen as a family problem; outside interference is not needed or tolerated.

2. Elder abuse often occurs in private homes outside the view of the public. Children attend school and participate in other activities that provide opportunities for mandated reporters or other caring persons to report suspected abuse or neglect. Dependent adults and elderly persons remain at home hidden from the watchful eye of the neighborhood, community and public.

3. Elders are reluctant to report abuse by relatives or caregivers because they fear reprisal, abandonment and institutionalization. They also feel guilty and ashamed to report a family member particularly if the report results in an arrest. They may feel that no one can help or not realize that help is available.

4. Medical personnel fail to recognize signs and symptoms of abuse and neglect. Without proper training particularly in geriatric medicine, medical personnel attribute symptoms of abuse as normal signs of aging or may be concerned about interfering in their patient- doctor relationship. Ageism affects the ability of medical personnel to appropriately identify abuse or neglect.

5. Dearth of information in the medical literature about elder abuse and neglect.

6. Denial that elder and dependent adult abuse and neglect exists.

7. Lack of knowledge about how to make a report and fear of the aftermath of a report: how it might affect relationship with hospital, care facility, families, patient.

8. Medical providers lack access to the elder or dependent adult because they do not seek preventive or regular medical care.

9. Fear of confronting the alleged perpetrator.

10. Medical symptoms of abuse or neglect maybe present in a subtle form and not alert the physician or health care provider about the abuse or neglect.

11. Elder abuse is mistakenly viewed as a product of caregiver stress or a lack of caregiver training and not as a crime against the person.

12. Cases of financial abuse are not recognized by financial institutions and therefore, not reported.

13. Not unlike the laws and perceptions about domestic violence many years ago, Law Enforcement agencies may view elder abuse and neglect as a social or family problem and therefore, a civil issue versus a criminal one.

When adult protective service social workers respond to allegations of abuse and neglect, they often encounter dependent adults and elders with an array of complex risk indicators that severely impact their ability to live safely. Clients often have varying degrees of mental incapacity from mild to severe; a multitude of physical and emotional impairments and moderate to severe health risks and live in unsafe environments Some are isolated and lack a support network while others are embroiled in unhealthy family relationships or permit transients in their home. These factors increase their vulnerability to self-neglect and abuse by others leading to premature need for facility care, preventable hospitalizations, premature death, preventable illness, financial exploitation and homelessness.

Many APS cases present with difficult to resolve risk indicators, in particular those associated with self-neglect. This is due in part to the voluntary nature of the program and that many factors contribute to a client's acceptance of the services offered. Self-neglect is labor and time intensive because adult protective service social workers must be patient, pleasantly persistent and demonstrate superior interpersonal skills as they attempt to form a bond of trust with resistant, fearful and/or uncooperative clients. In many instances, the social worker must find creative ways to approach generational and entrenched family relationships that inhibit a positive outcome. An added complication is that adult protective service social workers constantly navigate the line between protecting the health, safety and well-being of the client and the client's right to self-determination.

II. The Multi-Disciplinary Team

Multi-disciplinary teams are effective when clients present with complex bio-psycho-social problems and interface with more than one agency or organization. The County of Ventura has two successful teams that come together to address difficult and complex APS cases:

The Financial Abuse Specialist Team (FAST) addresses financial abuse cases within our target population. Although financial abuse is the single most reported category within Adult Protective Services, medical and health related categories outweigh financial abuse issues. The Rapid Response Team is an established multi-disciplinary/agency group that meets twice a month under the coordination and facilitation of Adult Protective Services. The purpose of the group is to discuss difficult APS cases and strategize possible interventions leading to a positive outcome. Prior the development of the Expert Team, a single Public Health nurse provided expert consultation on those cases with health needs that compromise the safety of the APS client.

The Rapid Response Expert Team is designed to address those cases with difficult to resolve complex medical, health and mental health issues by adding medical expertise to the group. Funding for the Expert Team comes from Federal ear mark 1 year funding through Congressional support. The funding supports the expansion of the Rapid Response team. The US Office of Elder Rights oversees the outcome of the program.

III. Mission of the Rapid Response Expert Team

The mission of the Rapid Response Expert Team is to provide case consultation and in-home assessments for clients with difficult to resolve complex medical and mental health risk indicators within Adult Protective Services target population. As time is available, consult on cases not under the jurisdiction of APS is provided.

IV. Purpose of the Rapid Response Expert Team

The Rapid Response Expert Team is an expansion of the Rapid Response team- a multi-disciplinary/ multi-agency team that addresses the complex medical and mental health risk indicators of the Adult Protective Services target population. The purpose of the Rapid Response Expert Team is to bring medical/mental health and health perspective and consultation to the existing team. The medical team provides consultation to the team and conducts in-home evaluations when indicated to the clients referred to the Rapid Response Expert Team. The medical team does not provide treatment or services to the client and does not enter into a doctor-patient relationship.

V. Target Population

The Rapid Response Expert Team focuses on the clients of Adult Protective Services: dependent adults and elders 65 and older with difficult to resolve complex medical and mental health risk indicators. The team at times consults about cases outside the jurisdiction of APS. The medical team can consult on those cases but will only conduct home assessments on those clients served by Adult Protective Services.

VI. Description, Members and Role of the Rapid Response Expert team

The Expert Team will add medical and mental health practitioners to the existing Rapid Response team to be called the Rapid Response Expert Team. The team meets twice a month for 2 hours to discuss, consult and design intervention strategies on cases referred to Adult Protective Services. As resources allow, cases outside the jurisdiction of Adult Protective Services are discussed. Members of the Rapid Response team include AAA, Public Health, Public Guardian, Law Enforcement, Behavioral Health, District Attorney, LTC Ombudsman and Tri-Counties Regional Center (non-exclusive). Other members for consideration could include representation from the faith based community, animal control, domestic violence and code enforcement.

With the advent of the medical expertise added to the team, membership expands to include an MD, a second Public Health nurse, a neuropsychologist and a licensed mental health clinician.

VII. Benefits of the Rapid Response Expert Team

- Support and validation for social workers and case managers
- Increase knowledge of community resources
- Enhance options and alternative solutions for consideration
- Increase coordination of inter-agency efforts
- Enhance networking among agencies who share similar focus and mission
- Provide a holistic approach to dependent and elder abuse and neglect (issues across the lifespan)
- Increase awareness of dependent and elder abuse and neglect
- Improve relationships among agencies who serve the target population

VIII. Knowledge, Skills and Abilities Required for All Team Members

Members of the Rapid Response Expert Team must possess core characteristics and skills to ensure the purpose and mission of the team is met. These include the following:

- Positive communication and active listening
- Problem analysis
- Relationship building
- Genuine care and interest in the elderly and dependent adult/vulnerable populations
- Awareness of community resources
- Knowledge of the special needs of dependent and elderly persons

IX. Membership Requirements

Regular attendance at the twice monthly meetings and active participation is essential to the success of the group. The Rapid Response Expert Team leader is tasked with ensuring appropriate cases are selected and prepared for each meeting, setting the agenda and ensuring appropriate follow-up on cases presented.

Members must commit to keeping discussions about specific cases confidential. Each member signs a confidentiality statement. All materials are collected at the close of the meeting and maintained appropriately at Adult Protective Services.

X. Role of the Medical Practitioners

A. Physician

A geriatrician or a physician skilled in assessing and working with the elderly and dependent adult population is a critical member of the County of Ventura, Rapid Response Team Expert Team. The team physician provides a number of services for the members of the Rapid Response Team especially Adult Protective Services and law enforcement. For example, a physician may review medical records in a case brought by APS, or he/she may look over a list of medications for the DA to indicate whether or not the medications might have affected the person's capacity to sign a legal document. The team physician makes home visits with the APS social worker, Public Health nurse or other members of the team to conduct a medical evaluation. The team physician may follow up with the elder's physician as needed. Because of a limit on resources and time, the physician is not likely to be available as a forensic witness in a criminal proceeding.

The physician serves a vital role in assisting APS and other members of the Rapid Response Team in helping their clients. In this model, the physician works on behalf of the Rapid Response Team, not the client. In most cases, Adult Protective Services works on behalf of the client. This is an important distinction because the physician is not a treating physician and does not enter into a patient- doctor relationship.

The physician does not become the physician of record for the elder or adult with a disability. The physician may conduct a non-intrusive physical examination with written permission by the client but does not provide treatment or medical interventions. All treatment needs are referred to the primary care physician of record. If the person does not have a primary medical provider on record, the physician works with Public Health nurse to identify an appropriate clinic or physician in the community. The physician will keep notes on the assessment that becomes part of the APS file. The physician does not keep a separate medical file.

B. Scope of Practice for the Physician

1. Reviews medical records
2. Reviews a list of medications
3. Consults with Adult Protective Services social workers about cases
4. Collaborates with Public Health nurses and other medical members of the team about cases
5. Makes home visits within desired time (usually 3-5 days) to assess mental status, Activities of Daily Living (ADL's), overall health, medical needs, medical issues affecting the abuse or neglect
6. Consults with primary medical provider as necessary
7. Attends Rapid Response Team and provides consultation to the team
8. Trains or informs medical personnel about identifying possible abuse and neglect
9. Provides case consultation to Adult Protective Service social workers on cases that would not be presented to the Rapid Response Team only as time permits

C. The Medical Evaluation

1. The medical examination is a non-invasive evaluation.
2. No blood or urine samples are taken.
3. A stethoscope is used to listen to the heart and lungs.
4. Blood pressure readings are taken on occasion.
5. Hands-on examinations are done depending on the circumstances or allegations. The scenario guides the exam.
6. The client signs a consent form for the examination by the physician.
7. The physician asks permission to examine the client's skin, checking for injuries and decubitus ulcers which may include asking them to remove some of their clothing as long as an appropriate witness is present.
8. The physician conducts gait and balance exams and observes the home and living environment.
9. The physician reviews the medication by looking at the actual bottles vs. a list of medication. Often, bottles are kept in numerous locations throughout the home.
10. The physician may contact the primary care physician and may facilitate the hospital/ER visit but usually through 911.
11. The physician does check capacity and will complete the capacity declaration as needed in consultation with the Neuropsychologist and or the mental health clinician.
12. The physician does not prescribe medications and does not diagnose.
13. There is no billing of health insurance and no co-pays.
14. The client does not have to sign any documents for the Rapid Response Expert Team

D. Neuropsychologist

Neuropsychology is a specialty profession that focuses on the brain's cognitive functioning such as attention, language and memory. The neuropsychologist for the Rapid Response Expert Team conducts in home visits under the same boundaries and limitations of the physician. The key element of the role is to evaluate the client for dementia and to rule out other causes for memory loss and confusion. The neuropsychologist provides consultation to the Rapid Response Expert Team conducts an in-home evaluation and may conduct standardized testing leading to a capacity declaration as needed. The neuropsychologtist does not provide services or treatment to the client. Notes are maintained in the APS file.

E. Mental Health Clinician

Working under the same boundaries and limitations of the physician, the mental health clinician conducts in-home assessments to identify mental health issues that may cause or contribute to the referral to Adult Protective Services. The clinician may initiate an involuntary hold (5150) when the client meets criteria of imminent danger to self or others. The clinician works in consultation with the physician, public health nurse,

neuro-psychologist and other members of the team to provide the best services to APS and the Rapid Response Expert Team. The clinician does not provide treatment or services to the client but connects the client to treatment services in the private or public sector as appropriate. Notes are maintained in the APS file.

F. Rules for Medical Team Members

1. The medical practitioner is never the provider of record
2. The medial practitioner works on behalf of the Rapid Response Expert Team as a consultant
3. The medical practitioner may conduct in-home evaluations to assist the Rapid Response Team
4. The medical practitioner conducts the in-home evaluation with another member of the team- usually the Adult Protective Services social worker or Public Health nurse unless otherwise discussed and agreed upon by the team.
5. The medical practitioner gets written consent by the client to conduct the in-home evaluation.
6. The medical practitioner completes the required notations that become part of the Adult Protective Services record.
7. The medical practitioner does not provide treatment

G. Public Health Nursing

It is important to note that the Public Health nurses works within their scope of practice that may include providing services in the home to the client per the existing Memorandum of Understanding between HSA and Public Health.

XI. Goals, Objectives and Measurable Outcomes of the Rapid Response Expert Team for the project year 2010-2011

Goal: Reduce or eliminate the protective issue with improvement in health and safety of dependent adults and elders 65 and older who have difficult to resolve complex medical and mental health risk indicators and are served by Adult Protect Services and the Rapid Response Multi-Disciplinary Team.

Objectives	Measurable Outcomes
Utilize the County of Ventura Risk Assessment Curve	Establish a standardized approach in Adult Protective Services to risk assessment, intervention and outcomes
Conduct in-home assessments by medical/mental health experts	Of those cases presented to the RRET with difficult to resolve complex/mental health risk indicators, 70% who agree to participate will show a reduction or elimination of the protective issue with an improved outcome in health and safety
Increase medical/mental health resources to the Rapid Response Multi-Disciplinary Team	Positive increase in statements on the Integrated Team Monitoring & Assessment survey from pre-test to post- test related to increasing resources: 1) the team has the right membership to achieve its objectives and 2) the team is adequately resourced and supported to achieve its objectives
	Products
Disseminate findings and results of the project for possible replication and further study	Submit a final report on the design, development and efficacy of the County of Ventura Risk Assessment Curve. Submit a final report on the promising practice of an integrated medical/mental health multi-disciplinary team. Post project plan, design and findings on the County of Ventura Human Services Agency Intranet

XII. Adult Protective Services Risk Assessment Curve Instrument

The most critical task for adult protective service programs is to determine whether the allegation of abuse and neglect can be substantiated and if so, assess the level of risk and design interventions to ensure the safety and protection of the dependent adult or elder. It is a complex task because dependent adult and elder abuse and neglect are not spontaneous events but occur subtly over time in a deteriorating and progressive nature.

The lack of a standardized instrument used by field social workers to assess level of risk within adult protective service programs statewide is detrimental in ensuring reliability and accuracy in determining the appropriate response and need for protection. Training of social workers in understanding abuse and neglect is not a substitute for such an instrument. Instruments do exist for medical providers, clinics and community based service providers to assess if a referral to adult protective service is needed. However, there is no instrument for adult protective service program social workers who work in the field.

The County of Ventura Human Services Agency developed a risk assessment instrument and has been piloting the tool since October 2008. Early indications of its viability as a field-ready, reliable instrument is positive. The instrument was developed by observing the progressive nature of elder mistreatment which shares similar patterns to chronic diseases; one in particular is the addiction model.
Like addictions or other chronic illnesses, abuse and neglect follows a predictive path of progression. Without intervention, elder abuse and neglect often results in premature need for facility care, preventable hospitalizations, homelessness and early death. Using the research from chronic illness models and research on indicators of elder abuse and neglect, the Human Services Agency designed, developed and tested a field instrument that shows potential in accurately identifying the type of abuse and neglect and designing the appropriate service based on the clustering of risk indicators. Rigorous testing by a university or research center is the next step to validate the instrument.

XIII. Legal Authority

The Rapid Response Expert Team functions under the authority of the California “multi-disciplinary personnel team” for elderly and dependent adults as defined in the Welfare and Institutions Code 15610.55. Information sharing among designated agencies is contained in the Welfare and Institutions Code 15633-15633.5, 15754.

The Health Insurance Portability and Accountability Act of 1996 ensures the privacy and confidentiality of an individual’s protected health information with defined exceptions. One of these exceptions is the release of medical information to Adult Protective Services. Medical providers are required to release up-to –date medical information without authorization or court order to ensure the health and safety of those persons under the jurisdiction of Adult Protective Services. Confidentiality within the RRET is imperative to meeting the legal mandates for a multi-disciplinary team and for the maintenance of the integrity of the team.

XIV. Case Selection Criteria*

Type of Case	Why Case Would Be Appropriate for Expert Team Discussion
Chronic case	Social Worker cannot think of any other direction to help resolve the case
Ethics regarding self-determination	Social Worker faces ethical dilemma regarding interventions that may conflict with self-determination
Teaching issue for the expert team	Case has interesting issue(s) that will teach the team members more about dependent adult/elder abuse and/or the value of the team approach
Easy case	Case has an easy solution and will give the Rapid Response Exert Team a feeling of success to prevent burn-out and encourage participation and use
Needs specialized expertise	Special skills or knowledge of particular Expert Team members are needed
Update	Current status of previously discussed case (information only)
Follow-up	Social Worker seeks follow-up discussion on previously discussed case
Access denied	Social Worker needs assistance in identifying ways to gain access to alleged victim
APS client (victim) refused services	APS client (victim) refuses all interventions by social worker
Abuser refuses services	Abuser refuses all interventions offered by social worker
Caregiver refuses services	Caregiver (who is not the abuser) refuses all interventions offered
Environmental problems	APS client has unmet needs for heat, water, housing or other environmental problem

*based on the Ohio I-Team model (page 13 of the I-Team Manual)

Acknowledgments

The Human Services Agency wishes to express appreciation to Dr. Mosqueda and the Orange County Forensics Team for inviting our planning group to visit one of their multi-disciplinary team meetings and for the generous sharing of information and documents. We also acknowledge the Ohio Elder Abuse Interdisciplinary team, Elder Abuse Task Force 2004 for sharing their I-Team manual. Many of the concepts and materials contained in this document are a result of the work completed by the Ohio team. Their manual is supported by the Ohio Attorney General's Office and the Ohio Department on Aging 2004. We also acknowledge the work of Drs. Swagerty, Takahashi and Evans in their article*, Elder Mistreatment* published in the American Family Physician, May 15, 1999.

Finally, we wish to acknowledge the dedication of the members of the Rapid Response Team who give of their time and expertise to help each other to better serve dependent adults and elders.

A.

County of Ventura Rapid Response Team
Action Plan

Client: _____ Date of Consultation: _____

Summary of Issues:

Next Steps		
Action	**Agency/Individual**	**Follow Up Due/Re-staff Date**

B.

County of Ventura Rapid Response Team
Action Plan Follow Up

Client: _____ Date: _____

Summary of Follow Up:

Next Steps		
Action / Intervention	**Agency/Individual**	**Follow Up Due/Re-staff Date**

Outcomes:

In Home Assessment Attempted		**In Home Assessment Completed**	
☐ Medical Doctor	☐ Public Health Nurse	☐ Medical Doctor	☐ Public Health Nurse
☐ Behavioral Health	☐ Neuropsychologist	☐ Behavioral Health	☐ Neuropsychologist

☐ Improved Health and Safety	☐ Reduced or Eliminated Protective Issue

C.

County of Ventura Rapid Response Team
Confidentiality Statement

CONFIDENTIALITY STATEMENT

The purpose of the Rapid Response Expert Team is to provide consultation to members of the team on difficult to serve cases and as needed, members of the Expert Team will conduct in-home assessments and evaluations. In order to assure a coordinated response that fully addresses all systemic concerns surrounding these cases; the Rapid Response Expert Team must have access to pertinent existing records on each person's elder abuse and/or neglect referral or case. This includes any social services reports, court documents, police records, mental health records, hospital or medical related data, and any other information.

With this purpose in mind, I the undersigned, as a representative of the agency listed below agree that all information secured in this review meeting will remain confidential, and will not be used for reasons other than that which it is intended. No material will be taken from the meeting with case identifying information.

_____
Print Name of Agency Represented

_____
Print Name & Sign

_____
Date

D.

County of Ventura Rapid Response Team
In Home Visit Cover Sheet – Medicine, Psychology, Mental Health

Date of Visit: _____

Name of Evaluator involved:_____ Discipline: _____

Name of Client: _____

Other people scheduled to go along on the visit: _____

Case Summary: _____

_____

_____

_____

_____

_____

_____

_____

Forms attached:
___ Map

___ Medical Assessment forms

___ Permission to be seen

___ Other _____

Client Address and phone number: _____

_____

E.

County of Ventura Rapid Response Team
Medical Assessment of Alleged Elder Abuse and Neglect

Client name:

Date of birth:

Referring source/name:

Type of alleged abuse:

Purpose of evaluation:

Background Narrative (reason for referral to the Rapid Response Expert team):

Date of evaluation:

Persons present:

Location:

Written/Verbal Permission granted: _____acting as a witness.

Pertinent Medical History:

Medications

Medications	Doses	How Administered	Compliance

Function

Activities of Daily Living

	Independent	Partial Assist/Reason	Total Assist/Reason
Dressing			
Bathing			
Feeding			
Toileting			
Transferring			

_____ Independent with ADLs

Intermediate Activities of Daily Living

	Independent	Partial Assist/Reason	Total Assist/Reason
Shopping			
Telephoning			
Finances			
Cooking			

_____ Independent with IADLs

Environment:

Results of physical exam:

Cognitive assessment (see attached form for actual test):

MMSE Total _____

Errors Include

Clock draw total _____

Interview with client:

Medical Record Review (Facility/Dates) (If applicable):

Assessment:

Recommendations:

Name: _____

F.

County of Ventura Rapid Response Team
Permission to be Seen

Name of Physician: _____

Name of Mental Health Clinician: _____

County of Ventura Rapid Response Expert Team
1001 Partridge
Ventura CA 93003

PATIENT NAME:_____

PROCEDURE

I hereby give my permission to be seen by one of the above indicated physicians and/or psychologists in order to evaluate my condition. I understand that by agreeing to be seen by any of the above individuals, I consent to any information obtained being shared with representatives from adult protective services, law enforcement, the district attorney's office, and/or the referring party.

I understand that I may revoke this authorization at any time and may refuse examination by any of the above individuals. I also understand that this is not consent to any treatment, only examination and evaluation.

SIGNED: _____ DATE: _____
PATIENT

SIGNED: _____ DATE: _____

G.

Case Consultation Form

REFERRAL INFORMATION

DATE	RRET CASE NUMBER

TYPE OF REQUEST/RRT CASE CONSULTATION

- ☐ Case consultation
- ☐ Criminal consultation
- ☐ Other: _____

RRT MEMBERS REQUESTED

- ☐ AAA
- ☐ Public Health Nurse
- ☐ Public Guardian
- ☐ Law Enforcement
- ☐ Behavioral Health
- ☐ Adult Protective Services
- ☐ District Attorney
- ☐ LTC Ombudsman
- ☐ Medical Doctor
- ☐ Neuropsychologist
- ☐ LCSW

TYPE OF REQUEST/QUESTIONS

CLIENT INFORMATION

VICTIM NAME (LAST NAME, FIRST NAME)	AGE	DATE OF BIRTH	SSN	GENDER	ETHNICITY	LANGUAGE (CHECK ONE) ☐ ENGLISH ☐ NON-VERBAL ☐ OTHER:

ADDRESS	CITY	ZIP CODE	TELEPHONE ( )

PHYSICIAN NAME	TELEPHONE ( )	INSURANCE CARRIER	MEDICATIONS

ILLNESSES

PRESENT MARITAL STATUS	PHYSICAL FUNCTIONAL STATUS	COGNITIVE AND PSYCHOLOGICAL STATUS

RESIDENCE TYPE	LIVES WITH (SPECIFY RELATIONSHIPS)	CARE ARRANGEMENT

REFERRING AGENCY INFORMATION

NAME	AGENCY	TELEPHONE ( )	EMAIL

TYPES OF ABUSE (CHECK ALL THAT APPLY)

- ☐ Self-Neglect (skip to Narrative section)
- ☐ Perpetrated By Others
  - ☐ Physical - Assault/Battery
  - ☐ Physical - Constraint or Deprivation
  - ☐ Physical - Chemical Restraint
  - ☐ Physical - Medication
  - ☐ Sexual
  - ☐ Neglect
  - ☐ Abandonment
  - ☐ Abduction
  - ☐ Financial
  - ☐ Isolation
  - ☐ Psychological
  - ☐ Other:

SUSPECTED ABUSER

RELATIONSHIP OF SUSPECTED ABUSER	GENDER	ETHNICITY	RESIDENCE ☐ IN CLIENT'S HOME ☐ OUTSIDE HOME

BRIEF DESCRIPTION OF PROBLEM

ADDITIONAL INFORMATION

OTHER AGENCY INVOLVEMENT/CONTACTS MADE

-

Note: This form is to be used for referrals to the Rapid Response Expert Team case consultations. **Please fax to (805) 650-1521**

Appendix D
Newspaper Articles

a) Elder Abuse the Subject of Research, Katheen Wilson ï Ventura County Star

b) Determining Elder Abuse is not an Exact Science, Kim Lamb Gregory ï Ventura County Star

c) Rapid Response Team Helps Seniors in Need, Kim Lamb Gregory ï Ventura County Star

vcstar.com
VENTURA COUNTY STAR

Printer-friendly story
Read more at vcstar.com

Elder abuse the subject of research

$654,000 grant to fund project

By Kathleen Wilson

Friday, August 27, 2010

Armed with one of the largest federal awards ever made to combat elder abuse, Ventura County social workers are joining with researchers to test ways to reduce its impact.

The $654,000 award funds a project that sends medical specialists into the homes of vulnerable adults and assesses what difference the specialists make.

Another goal is to find out whether elder abuse follows a course similar to that of chronic disease.

“Over time, it gets worse without intervention,” said Linda Henderson, deputy director in the county Human Services Agency.

The National Academy of Sciences conducted a large research project that suggested the link with chronic disease, but it has not been proven, Henderson said.

Researchers at a yet-to-be selected university will test that theory by looking at the effectiveness of an assessment tool that Henderson and county social workers developed in 2008. If validated, it could provide something that social workers handling adult protection cases now lack in California, she said.

“There is really no instrument that assesses the level of risk and ties that to the interventions we provide and the outcomes,” Henderson said. “What we want to find out is if there is a particular profile based on this instrument that leads to a particular outcome over another.”

The project will primarily focus on seniors and disabled adults younger than 65 who neglect to take care of basic needs for shelter, nutrition and healthcare as their conditions deteriorate.

The problem, known as self-neglect, is common in complaints of adult abuse and neglect. Of the 2,271 complaints reported to a hotline last fiscal year in Ventura County, about 40 percent involved self-neglect.

Henderson said proper medical attention is key to getting better results, but many of these individuals are so isolated and fearful that they won’t seek it on their own.

They don't eat properly, won't leave their homes and may not have seen a doctor for years. They forget to pay their bills. Their thinking may be confused, although they're not suffering full-fledged dementia or Alzheimer's disease.

Social workers visit these vulnerable adults but lack the legal authority to force them to go out to see a doctor.

Now, however, a physician, a psychologist with special training in neurological disorders, a licensed clinical social worker and public health nurses are making home visits.

"This is a very exciting thing because we keep seeing people so vulnerable," said Marcy Snider, who oversees adult protective services.

Managers already have seen some success since the program began in July, supplementing the work done by a multi-disciplinary team that includes law enforcement, mental health and senior agencies.

A doctor visited an elderly woman, found she had been ill in a hospital emergency room but had failed to get a prescription filled.

"We delivered it that day," Henderson said.

Rep. Elton Gallegly, R-Simi Valley, helped the county get the federal funding as an earmark.

Some have criticized earmarks as "pork barrel" projects benefiting a congressman's district, but, Henderson said, this initiative could have national implications in advancing knowledge on elder abuse.

Gallegly said he was pleased to help secure the funding, calling the program comprehensive and cost-effective.

Preliminary results are due by the end of January.

vcstar.com
VENTURA COUNTY STAR

Determining elder abuse is not an exact science

By Kim Lamb Gregory

Monday, April 18, 2011

Elder abuse is on the rise in Ventura County due to a number of factors, according to Ventura County Adult Protective Services deputy director Linda Henderson.

"It's due to the baby boomer population, people living longer and elderly people living by themselves more often," Henderson said. "It's also the economy. We've got family members moving back in with elderly parents. I think that puts lots of stresses on families."

Adult Protective Services investigates any reports of elder abuse and neglect in Ventura County. Between July 2009 and February 2010, it found instances of abuse and neglect an average of 323 times a month. (Some cases lasted more than one month, and would figure into the average for the next month, as well.) In that same period of 2010-11, it found an average of 381 instances a month, an increase of 18 percent.

Most of those involved financial elder abuse, according to the agency.

Elder law attorneys agree elder abuse is a serious problem, but cautioned that the rise in elder abuse also means an increase in the number of false claims.

"We've been getting calls from people saying their parents have been abused because they have been put into assisted living," said elder abuse attorney Mitchell Karasov, who handles cases in Los Angeles and Ventura counties.

Ventura elder law attorney Gregory Johnson says he gets about 10 calls a week suggesting abuse.

"Ninety percent of the calls do not result in cases," Johnson said. "It's usually a case of miscommunication."

Certainly, many claims of financial elder abuse are legitimate, according to Karasov, but sometimes it's just a lack of education. A family member who doesn't realize how expensive it can be to care for a parent may accuse a caregiver of taking money, he said, until they understand what it actually costs.

"People not having all the facts in certain situations may be claiming elder abuse," Karasov said.

In other cases, a sibling's motives may not be as pure, he said.

"What I'm seeing is people calling up and saying it's elder abuse sometimes when it's to their benefit," Karasov said.

Siblings sometimes figure if they can show that an adult sibling caring for a parent is abusing them by, for example, spending too much on caregiving, they can get the caregiver sibling disinherited.

"It goes from Thanksgiving, kiss, kiss everybody loves each other to, 'Wait a minute; you're spending my inheritance on Mom and Dad,' " Karasov said.

Actor Mickey Rooney, 90, who lives in Westlake Village, went before the U.S. Senate Special Committee on Aging on March 2 in an effort to increase the public's awareness about the issue of elder financial abuse.

"If it can happen to me, it can happen to anyone," Rooney told lawmakers.

Rooney had alleged elder abuse when he secured a temporary restraining order in February against his stepson, Christopher Aber, 50. The Los Angeles Superior Court did not rule on whether Rooney was the victim of elder abuse when the matter was settled out of court.

"The clients have agreed to cooperate with each other," said Aber's attorney, John O'Meara, adding that there was no truth to the allegations of elder abuse.

Karasov represents Rooney's wife, Jan Rooney, 67, to make sure her interests are protected as this issue gets resolved.

Mickey Rooney now has a conservator who will go before the court in about two months with a plan to handle Rooney's assets.

Everyone ages differently, Henderson said, but some seniors experience an erosion of their executive brain functions, making them less risk-averse and more vulnerable to financial abuse. It is the most common type of abuse she sees coming through her office.

Henderson said it's hard to isolate one type of abuse because humans are complex. One vulnerability in a senior is usually an indicator of other vulnerabilities.

"No one being financially abused is healthy," Henderson said. "If you have financial abuse, it never exists in a vacuum."

To help identify and assess seniors and dependent adults for physical, emotional and financial abuse or neglect, Henderson and the Adult Protective Services staff put together a program using a $654,000 grant from the U.S. Administration on Aging.

Adult Protective Services was directed to put together a pilot program called the Rapid Response Expert Team, which was launched in July 2010. The team is a group of

experts from a number of disciplines to help intervene when there might be elder abuse or neglect.

The agency already had a team of social workers, but the grant money was used to add a physician, a nurse, a mental health clinician and a neuropsychologist. A standardized testing method was developed so the team can make better diagnoses.

The federal grant funds the program through June 30, but the group hopes to find funding to extend the project for six months.

On May 4, the group will meet for a status report on how well the program is working and where it needs adjusting. Henderson said she has already visited other counties to share this model of care.

Henderson described the team as "groundbreaking" because it has integrated medical experts. These experts are able to consider the whole person, physically, emotionally, financially and mentally.

"You can't address elder abuse and neglect by ignoring or not having access to a medical component, because it's all interrelated," Henderson said.

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VENTURA COUNTY STAR

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Rapid response team helps seniors in need

By Kim Lamb Gregory

Originally published 05:41 p.m., May 4, 2011
Updated 05:48 p.m., May 4, 2011

"Mrs. L" is a 91-year-old woman who lived in Nazi-occupied Poland before escaping to England and then to the United States. She now lives in Ventura County with her adult son and shows signs of dementia.

"Mrs. L frequently states there is a man in her attic stealing her food, that he lives in the neighborhood and takes neighborhood children away," said Marcy Snider, a Ventura County Adult Protective Services case worker.

Snider presented the case study before an audience of about 50 who gathered Wednesday at the Ventura County Public Health Department in Oxnard to hear a report on the Rapid Response Expert Team.

The team is a pilot program formed in July to help vulnerable seniors and dependent adults get the help they need. The team of experts was put together by Adult Protective Services staff using a $654,000 grant from the U.S. Administration on Aging.

Linda Henderson, deputy director of the county's Adult and Family Services Department, said the grant was the largest in county history for a program preventing elder mistreatment.

The agency already had a team of social workers, and the grant money was used to add a physician, nurse, mental health clinician and neuropsychologist.

Henderson said the results have been excellent. Using a Power Point presentation Wednesday, Henderson showed how the right mix of experts for each specific situation resulted in a satisfying resolution.

In the case of "Mrs. L," the adult son living with her failed to see a problem with his mother, although she was calling 911 as many as four times a day and had to be put on a 72-hour psychiatric hold.

"The son denied any problems existed," Snider said.

The team can send certain experts to a senior's home, Henderson said.

"Calling people up is not as successful as knocking on the door," said Grace Deisler, a social worker with Adult Protective Services and a team member.

Frail elders frequently have transportation problems and can't get to the resources they need or may have undiagnosed cognitive problems that keep them from getting help, Henderson said.

Geriatric physician Dr. Esther Yoon might be called if the senior is experiencing medical problems. Yoon literally makes a house call.

"They allow you to examine them and talk to them in their homes," she said. "Usually I take two to three hours per patient. ... I try to get them to sign a consent form so I can send it to their physician."

Yoon was on the team that responded to Mrs. L, who had suffered from colon cancer as well.

"Dr. Yoon discovered she wasn't even wearing her colostomy bag," Henderson said.

Henderson also detailed the new system Adult Protective Services developed to help assess the needs of each of the 87 cases that have been handled by the team between July 2010 and April 2011. The standardized tool contains 56 biological, social and psychological indicators as well as early signs that could point to an elder in need of assistance.

"This goes one step further in making sure the problem with the elder is improved," she said.

Henderson said her agency hoped to see improvement in 70 percent of the cases. The results were even better —improvement in 89 percent.

In Mrs. L's case, Yoon and a neuropsychologist on the team got her the right medication and psychiatric attention. A social worker worked with the son to get him to understand his mother's cognitive problems.

Now, Mrs. L is living independently in her home with her son, and the calls to 911 have stopped.

The team's funding runs out June 30, so Henderson and Adult Protective Services staff are trying to get a new grant or other funding. She believes she can keep it going with $200,000.

One suggestion came from audience member Dr. Lanyard Dial, executive director of the Livingston Memorial Visiting Nurse & Hospice Association. "I think the county could hire a full-time geriatric physician to do this and it would save the county a lot of money," Dial said.

Dial said Yoon or someone with her specific qualifications would be ideal.

Henderson said she liked the idea and planned to follow up with Ventura County Health Agency Director Dr. Bob Gonzalez and the county's top executive, Mike Powers.

Appendix E
Human Services Agency FY 2010-11 Annual Report -RRET Spotlight

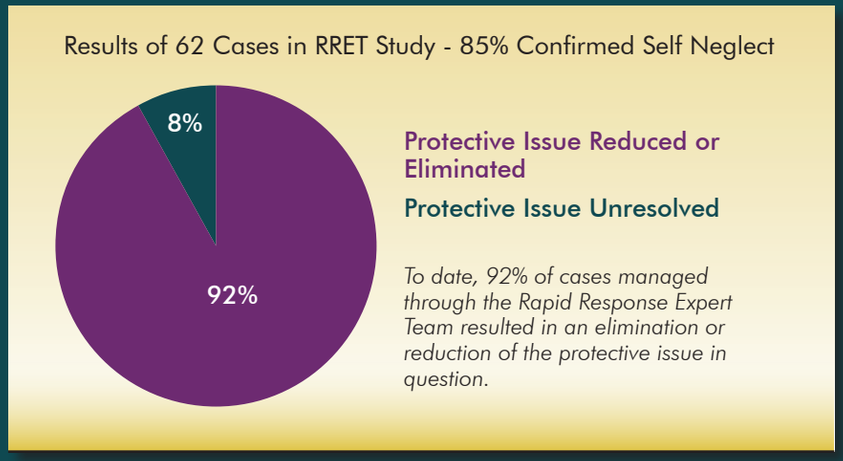
PROGRAM**SPOTLIGHT**

RAPID**RESPONSE** *Expert Team*

In recognition of the need for innovative approaches to serving vulnerable adults, the federal Administration on Aging awarded grant funding to the Human Services Agency to pilot a new Rapid Response Expert Team service model. The model integrates medical professionals into a multi-disciplinary team dedicated to assisting vulnerable adults with complex medical and mental health risk indicators that have traditionally been very difficult to resolve. To date, 92 percent of cases managed through the Rapid Response Expert Team resulted in an elimination or reduction of the protective issue in question.

Additionally, the Human Services Agency is piloting a risk assessment instrument, the Adult Protective Services Tool for Risk, Interventions & Outcomes (APS-TRIO). The TRIO standardizes the approach to assessing risk, correlates the assessment with interventions, and measures outcomes in the areas of health, safety, and elimination or reduction of harm. The TRIO is helping social workers to deliver more targeted and successful intervention in cases of abuse and neglect.

Experts working in the field of Adult Protective Services are increasingly challenged to meet the complex needs of a growing elderly population. Ventura County's innovative approach has garnered interest nationwide, with a presentation scheduled in September 2011 at the annual conference of the National Adult Protective Services Association. Additionally, the project was piloted in Alameda, Contra Costa, and Stanislaus counties while Napa and Tulare are implementing the TRIO. Outcomes of the project are being researched by the University of California at San Diego. The Human Services Agency is actively pursuing future funding and a recently awarded grant from the Archstone Foundation will help to partially fund the program as it moves forward.



Elimination:
The interventions by the APS social worker or members of the team with resulting services needed to assist the client are sufficient to eliminate the protective issue

Reduction:
The interventions by the APS social worker or members of the team with resulting services stabilize the client, reduce the rate of decline or diminish the potential for harm

Adult Protective Services Tool for Risk, Interventions & Outcomes
APS-TRIO

PRECURSORS
1. History of referrals to APS
2. Lives alone
3. No regular Physician
4. Lacks social support, isolation
5. Refuses help from others
6. Lack of resources or homeless
7. Marital, family conflict, co-dependency
8. Prior or current mental health services
9. Severe physical disabilities / dependent for all ADLs
10. History of violence, abuse, neglect
11. Alcohol, substance abuse by client / caregiver / environment
12. Evidence of psychiatric disorder
13. Economically dependent adult living in the home / transient in, out of home
14. Confusion or evidence of cognitive impairment
15. Poor or impaired judgement, poor decision-making
16. Evidence of high risk behavior

BIOLOGICAL INDICATORS
17. Unclean physical appearance, poor hygiene
18. Odor of feces or urine
19. Vague reference to sexual assault or unwanted advances
20. Vague or illogical explanation for injury
21. Under or overuse or confusion about prescriptions or OTC medications
22. Repetitive hospital admissions due to probable failure of heath care surveillance
23. Failure to respond to warning of obvious disease
24. Painful body movements; limping, trouble sitting or standing (not illness related)
25. Underweight, frail or weak, frequent falls
26. Inadequate food or meal preparation supplies in the home
27. Various stages of healing of any bruising or fractures
28. Evidence of injury / unexplained bruising, welts, wounds, broken bones, sprains
29. Presence of dehydration or decubiti
30. Alert, oriented declaration by elder, adult of physical, sexual abuse

PSYCHOLOGICAL INDICATORS
31. Self-blame for current situation or makes excuses for partner or caregiver behavior
32. Feelings of shame, guilt, fear or loneliness / depression
33. Sense of resignation and hopelessness with vague reference to mistreatment
34. Appears anxious / clinging / afraid of someone or something
35. Behavior that is passive / helpless / withdrawn
36. Hoarding
37. Alert, oriented declaration of psychological abuse

SOCIAL INDICATORS
38. Poorly maintained animals, odor of feces or urine
39. Communication cut off from family or friends
40. Lack of access, availability or reliability of medical care or home health care
41. Unclean or unsafe environment / infestation
42. Inadequate utilities; lack of heat, cooling, water, electricity, toilet facilities
43. Lack of access, availability or reliability of transportation
44. Dependent on alleged perpetrator or vice versa for care of finances
45. Left alone in unsafe environment for extended periods of time without adequate support
46. Evidence of exploitation by others
47. Precipitous withdrawal of care by caregiver without adequate alternate arrangements
48. Overpayment for goods or services
49. Misuse of money
50. Reports of demands for goods in exchange for services
51. Unexplained changes in power of attorney, wills or other legal documents
52. Neglect of household finances; unpaid bills; unopened mail
53. Inability to account for money, property, utility shut off / eviction
54. Alert, oriented declaration by elder, adult of exploitation
55. Alert, oriented declaration by elder, adult of neglect by others
56. Alert, oriented declaration by elder, adult of abandonment

Allegation/Disposition

____ Abandonment ____
____ Abduction ____
____ Financial ____
____ Isolation ____
____ Neglect by Other ____
____ Other - Psychological/Mental ____
____ Physical ____
____ Sexual ____
____ Self Neglect

1) Physical ____ 2) Medical ____ 3) Health/Safety ____
4) Malnutrition/Dehydration ____ 5) Financial ____ 6) Other ____

Dates of Face to Face:

_____
_____

Client _____ **Case #** _____

Social Worker _____

INTERVENTIONS*
Establishing bond of trust, engage with social worker .2
Accepts education, information .1
Client accepts that a problem exists .3
Referral / linking to services .4
Tangible support used to purchase necessary items .5
Client's support system works with APS .6
Client agrees to case management services .7
Presentation to Rapid Response Team (MDT) .8
Consultation with mental health expert .9
Consultation with medical expert .10
In-home nursing assessment completed .11
In-home / medical evaluation by a physician completed .12
In-home / mental health / psychological evaluation completed .13
Presentation to Financial Abuse Specialist Team .14
Restraining order sought .15
Conservatorship sought .16
Recoup financial loss or property loss .17
Financial stability .18
Linked to public assistance .19
Client demonstrates self advocacy .20
Linked to housing .21
Stable and safer home environment .22
Restraining order obtained .23
Conservatorship obtained .24
Short-term / Long-term care placement .25
Safety net services in place .26
Decrease in hospital use .27
Improved functional status .28
Improved nutritional status .29
Improved physical health, medical condition .30
Improved mental health .31
Reduce, eliminate use of alcohol, substance abuse .32
Accepts case closure .33
Agreed to partial services .34
Refused all services .35

OUTCOMES
Protective issue eliminated .39
Protective issue reduced .38
Protective issue unresolved .37
No protective issue evident .36

PROTECTIVE OUTCOMES

Prognosis of Non-Recurrence at closure:

1. Excellent ____
2. Very good ____
3. Good ____
4. Fair ____
5. Guarded ____
6. Poor ____
7. Client deceased ____

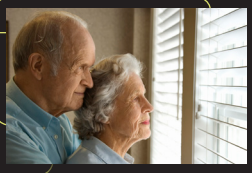
Death due to critical injury / health / suicide
Preventable LTC & involuntary commitment
Homeless / incarceration

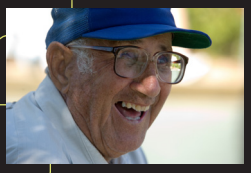
***Triage Intervention**

1. Call or cross report to Law Enforcement
2. Call for hospitalization
3. Call for involuntary hold 5150
4. Pursue capacity declaration
5. Call Code Enforcement
6. Call 911

HSA APS Rev. 9-6-11 V. 25

Appendix F
Agenda for the Aging Population Meeting





WORKING TOGETHER TO
MAKE A DIFFERENCE FOR OUR

aging population

AGENDA

Wednesday, May 4, 2011
9 - 11:00 a.m.

9:00 a.m. Welcome & Introductions ..... Linda Henderson
Deputy Director, Human Services Agency
Adult & Family Services

9:10 Presentation of the RRET Project ..... Linda Henderson

9:30 Case Study ..... Marcy Snider

9:45 Panel Discussion with Q&A ..... Linda Henderson
Moderator

<u>Panel Members</u>

Kathleen Lincthcum, PHN ..... Public Health
Dr. Esther Yoon ..... Las Islas Clinic, Health Care Agency
Maria Arvelo, LCSW ..... Human Services Agency
Scott Jones ..... Superior Court
Monica Neece ..... Area Agency on Aging
Grace Deisler, LCSW ..... Adult Protective Services

10:45 Closing & Final Thoughts

HUMAN SERVICES AGENCY
INTEGRITY • COMPASSION • EMPOWERMENT
COUNTY OF VENTURA

Appendix G
APS Social Worker Surveys

Adult Protective Services Social Worker
Medical Expert Team Survey Results

Q1. 93% of respondents consulted with a member of the Medical Expert Team 6 or more times.

Q2. 57% of respondents have referred cases 3 to 5 times to the RRET in order to access a Medical Expert's services.

Q3a. 100% of respondents have referred cases to the Public Health Nurse.

Q3b. 79% of respondents have referred cases to the Neuropsychologist.

Q3c. 79% of respondents have referred cases to the Licensed Clinical Social Worker.

Q3d. 86% of respondents have referred cases to the Medical Doctor.

Q4. 86% of respondents Strongly Agree or Agree the Medical Expert Team has improved their ability to assess the needs of their APS clients.

Q5. 86% respondents Strongly Agree or Agree the Medical Expert Team has improved their ability to reduce or eliminate the protective issues of APS clients.

Q6a. 100% of respondents report working with the Medical Expert Team has been easy.

Q6b. 100% of respondents report working with the Medical Expert Team has been collaborative.

Q6c. 71% of respondents report working with the Medical Expert Team has been more work.

Q6d. 100% of respondents report working with the Medical Expert Team has been helpful.

Q6e. 100% of respondents report working with the Medical Expert Team has been practical.

Q7. 100% of respondents Strongly Agree (86%) or Agree (14%) the Medical Expert Team should be a permanent part of APS.

Q8. 93% of respondents Strongly Agree or Agree the Medical Expert Team's services should be available for any case, not just cases presented to the RRET.

Q9. 54% of respondents Strongly Agree or Agree the Medical Expert Team services should be utilize for all cases except unfounded cases.

Q10. 69% of respondents Strongly Agree or Agree the Medical Expert Team's personalities are of equal importance as the knowledge and experience they bring.

Q11. 75% of respondents Strongly Agree or Agree the Medical Expert Team is adequately resourced and supported to achieve its objectives.

Q12. 77% of respondents Strongly Agree or Agree the Medical Expert Team has the right membership to achieve its objectives

Q13. What other Expert(s) would you want to add to the Medical Expert Team?

- 5150 writer (2 responses)
- Another PHN
- Law enforcement and Psychiatrist
- Financial
- Behavioral Health

Q14a. 100% of respondents indicated the Public Health Nurse is necessary.

Q14b. 58% of respondents indicated the Licensed Clinical Social Worker is necessary.

Q14c. 73% of respondents indicated the Neuropsychologist is necessary.

Q14d. 83% of respondents indicated the Medical Doctor is necessary.

Q15. 92% of respondents believe consulting with the Medical Expert Team improves the outcome for clients.

Q16. 92% of respondents believe the Medical Expert assessment improves the outcome for clients.

Q17. The Medical Expert Team would function better….

- “if it had more personnel"
- “if we got to keep then around linger than one year"
- "if they were available for a greater number of cases"
- "if they were permanent"
- "if weekly meetings are possible"
- "more PHNs"
- "if they had more ability to directly work with clients and permission and releases of information."

Q18. Without the Medical Expert Team my job….
The majority of respondents report their job would be more difficult and they would not have access to the necessary resources and information to fully assist their clients.

- “would be more difficult in seeking medical information, resources”

- “would be more frustrating. Although at times the team increases the work I do on a case, the work is more efficient and I am not finding myself "running in circles" trying to get different services to work."

- “would be more stressful, as I rely on their consultation and expertise to effectively handle my cases."

- “would be so much harder and left unresolved. Having the medical expert team has allowed me the ability to address the needs of each client to the fullest."

- "Will be more difficult and will be more time-consuming"

- "It would almost be possible to resolve some of the most chronic APS cases and would result in increased caseloads for the APS social worker by having to try and find experts willing to consult about the situations pertaining to the protected issue (s)."

- “I greatly appreciate Dr. Yoon providing The VCMC and Hillmont records, and the patient education materials".

- "would be more difficult with less effective results."

- "would not be as enhanced and several of my clients would not have resources, mental health services, functioning or placement without their help. The assessments and/or consultations have been very valuable."

Adult Protective Services Social Worker
Tool for Risk, Interventions and Outcomes (TRIO) Second Survey

The TRIO satisfaction survey was first administered to APS Social Workers during March 2011 when used in paper form. The survey was designed to assess staff satisfaction utilizing the TRIO formerly called the TRIO. The TRIO was administered again on October 2011 to assess the impact of a new electronic TRIO and to measure Social Worker perceptions over time. The first survey was completed by 14 respondents, compared to 12 respondents that completed the second survey. Therefore, direct comparisons between the two assessments should be made with caution.Consistent with previous results, 100% of respondents Strongly Agree or Agree all the TRIO training required to use the TRIO is worth it.

Q1. Consistent with previous results, 100% of respondents Strongly Agree or Agree that with proper TRIO training the TRIO is easy to use.

Q2. 100% of respondents Strongly Agree or Agree using the TRIO is worth the time it takes to complete compared to 92% of respondents in the initial survey.

Q3. 100% of respondents Strongly Agree or Agree the TRIO increase the ability to assess a case more thoroughly, compared to 92% of respondents in the initial survey.

Q4. 92% of respondents Strongly Agree or Agree using the TRIO increased work satisfaction, compared to 77% of respondents in the initial survey.

Q5. Consistent with previous results, 92% of respondents Strongly Agree or Agree the TRIO risk indicators guide referrals and interventions.

Q6. 83% of respondents Strongly Agree or Agree the TRIO is more worthwhile used throughout the course of a case, compared to 92% of respondents in the initial survey.

Q7. 75% of respondents *Strongly Disagree or Disagree they* would prefer to use the TRIO on selected cases instead of every case, compared to 93% of respondents in the initial survey.

Q8. Consistent with previous results, 92% of respondents Strongly Agree or Agree the TRIO precursors identified in a case will impact the case prognosis.

Q10. 83% of respondents *Strongly Disagree* or *Disagree* the TRIO is only needed for difficult cases, compared to 85% respondents in the initial survey.

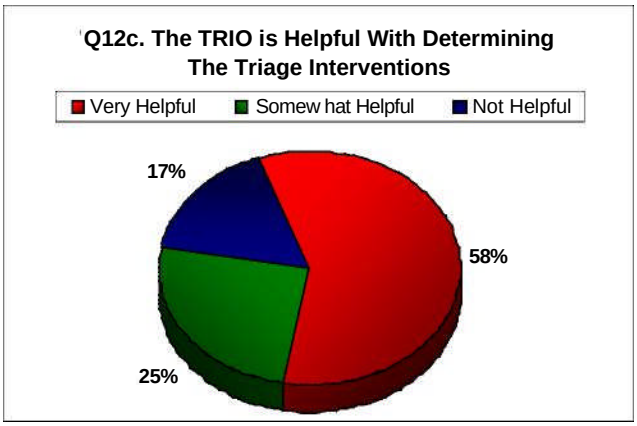
Q11. Consistent with previous results, 92% of respondents *Strongly Disagree* or *Disagree* the more social work experience staff have the less beneficial it is to use the TRIO.

Q12a. 83% of respondents find the TRIO Very Helpful with determining the precursors, compared to 73% of respondents in the initial survey.

Q12b. 83% of respondents find the TRIO Very Helpful with determining the risk indicators, compared to 73% of respondents in the initial survey.

Q12c. 58% of respondents find the TRIO Very Helpful with determining the triage interventions, compared to 50% of respondents in the initial survey.

Q12d. Consistent with previous results, 58% of respondents find the TRIO Very Helpful with determining the interventions.



Q12e. 83% of respondents find the TRIO Very Helpful with determining the outcomes, compared to 67% of respondents in the initial survey.

Q12f. 83% of respondents find the TRIO Very Helpful with determining the prognosis, compared to 82% of respondents in the initial survey.

Q13. 83% of respondents feel the TRIO has changed how they approach and think about cases, compared to 82% of respondents in the initial survey.

For respondents that feel that the TRIO has changed how they approach and think about cases - Why?

- "It provides a process and Focus to the cases. It allows me to think about other aspects of the case that may be precursors or risk indicators"
- "It focuses my assessment and allows me to think succinctly about certain facets of a case. It is a good "snapshot "assessment"
- "gives a broader picture"
- "Seeing when the client is most at risks, helps in targeting more effective interventions, thus reducing the likelihood of recidivism"
- "It gives me a clearer picture of the situation when assessing risks because of the layout"
- "My assessments reflect what I enter on the TRIO"

14. What do you like ***most*** about the TRIO?

- "The ease of use and the ability to have definition. It helps with thinking of progression"
- "It is helpful to think of elder abuse as a disease progression that gets worse if left untreated. It also helps me see a visual representation of the risks and what was done or tired to mitigate the risks"
- "Panoramic's effort /support"
- "It helps to put a case in perspective and provides oversight of all bio-psycho-social issues, so as to be more accurate with interventions"
- "It helps me to look at all the interventions we have used. It gives me a history on the client"
- "the ease with which it is used"

15. What do you like ***least*** about the TRIO?

- "Just having to spend time completing and printing it"
- "It is time consuming when entering the info into the data base"

Appendix H
APS Survey on the Medical Practitioner

The RRT APS Medical Practitioners Survey

The Adult Protective Services (APS) Medical Practitioners joined the Rapid Response Team (RRT) – in July 2010. The Medical Practitioners included were 2 Public Health Nurses, a Licensed Clinical Social Worker, a Neuropsychologist, and a Medical Doctor.

In an effort to ascertain your response to their involvement in the RRT please complete one anonymous and confidential survey and turn it in prior to your leaving the meeting. Thank you for your participation.

1. The APS Medical Practitioners are valued resources to the RRT.

O	O	O	O
Strongly Agree	Agree	Disagree	Strongly Disagree

2. The Medical Practitioners improved the RRT's ability to comprehensively approach and respond to cases.

O	O	O	O
Strongly Agree	Agree	Disagree	Strongly Disagree

3. The APS Medical Practitioners improved the effectiveness of the RRT.

O	O	O	O
Strongly Agree	Agree	Disagree	Strongly Disagree

4. The APS Medical Practitioners should be a permanent part of the RRT.

O	O	O	O
Strongly Agree	Agree	Disagree	Strongly Disagree

5. Separately rank the contribution each medical discipline brings to the RRT.
   (Please do not score the personalities of medical practitioners)

   (1) Minimal to no contribution (2) Helpful contribution (3) Essential Contribution

   _____ Public Health Nurse _____ Neuropsychologist

   _____ Licensed Clinical Social Worker _____ Medical Doctor

Please add any additional comments about the APS medical practitioner's RRET project

COUNTY OF VENTURA ADULT PROTECTIVE SERVICES

Rapid Response Team Medical Practitioners Survey

Overview

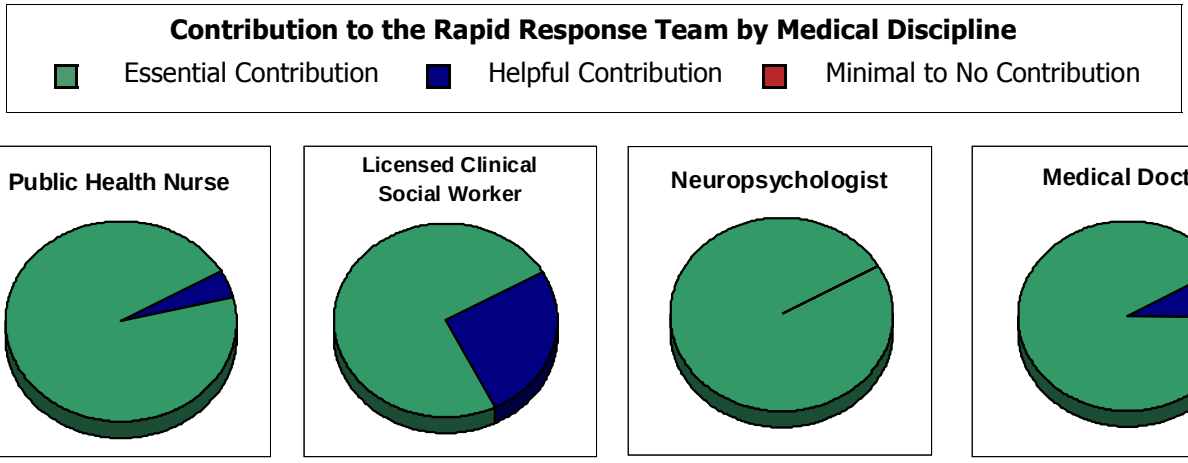
The Adult Protective Services (APS) Medical Practitioners joined the Rapid Response Team (RRT) in July 2010. The Medical Practitioners included were two Public Health Nurses, a Licensed Clinical Social Worker, a Neuropsychologist, and a Medical Doctor. In order to obtain feedback regarding the Medical Practitioners, surveys were distributed to the RRT on April 27th and May 11th, 2011. A total of 24 surveys were collected across both administration dates. The survey included questions related to the effectiveness and contribution of the Medical Practitioners. Survey results were positive and respondents agree that the Medical Practitioners provide value and improve effectiveness to the RRT.

100% of respondents strongly agree that the Medical Practitioners are valued resources to the Rapid Response Team.

Results

Respondents indicated their response on a four-point scale from "Strongly Agree" to "Strongly Disagree":

- 100% of respondents strongly agree that the APS Medical Practitioners are valued resources to the RRT.
- 100% of respondents strongly agree or agree that the Medical Practitioners improved the RRT's ability to comprehensively approach and respond to cases.
- 100% of respondents strongly agree or agree that the APS Medical Practitioners improved the effectiveness of the RRT.
- 100% of respondents strongly agree or agree that the APS Medical Practitioners should be a permanent part of the RRT.
- 100% of respondents reported that the Medical Practitioners (Public Health Nurse, Licensed Clinical Social Worker, Neuropsychologist and Medical Doctor) provided a helpful or essential contribution to the RRT. Respondents were asked to rank the Medical Practitioner's contribution to the RRT by indicating "1" for minimal to no contribution, "2" for helpful contribution, and "3" for essential contribution (see below).



Appendix I
Integrated Team Monitoring & Assessment Survey

Integrated Team Monitoring & Assessment

What is ITMA?

ITMA is a tool to assist those working in and responsible for integrated teamworking – one of the key proposals arising from the 2006 White Paper, Our health, our care, our say. Such teams need to know how well they are working, and they need to be able to improve, but assessing how a team is working is a complex process. The most appropriate action is to undertake regular audits.

The Purpose of ITMA?

The purpose of ITMA is to provide a relatively simple and cost-effective way of assessing the effectiveness of team working. It enables a rapid appraisal of the 'health' of a team and identifies areas of difficulty covering both internal functioning and external factors, thereby enabling a focus upon remedial action commensurate with the significance of the problems.

ITMA can do three main things:

- provide material to conduct an assessment on the current effectiveness of team working;
- with repeated use, allow changes in team functioning to be charted over time;
- provide a common framework and vocabulary for team members to develop a jointly owned approach to tackling some of the barriers to effective team working

On its own it will not reveal how problems associated with poor team working in any particular team should be addressed. Where ITMA findings expose weaknesses, tailored interventions will need to be used that reflect local needs and circumstances. The framework is generic and the purpose is to ascertain from team members how far they feel the contents of the framework characterise their own working arrangements. In particular, it will be important to distinguish between the internal functioning of the team (Principles 1-4) from external factors (Principle 5), since responsibility for action will probably involve different people.

The Four Stages of ITMA?

Stage 1: Preparation

It is important at the start of the process that partners agree the reasons for using the tool. Is the process to be mainly developmental, more of a routine audit or part of a more extensive remedial programme? Opening up this initial debate is often an important step in individual partners becoming more honest in their views about the workings of the team.

Stage 2: Gathering Data

At the heart of ITMA is the process of gathering data about the team through answers to a questionnaire. Team members are asked to respond to 30 statements by reflecting on their experiences and selecting from a range of possible responses.

Stage 3: Analysis and Interpretation of Data

The individual scores of team members are brought together to provide a picture of how the whole team is working, and to compare the responses of different types of team member.

Stage 4: Action Planning for Alternative Findings

Finally, an assessment has to be made about what the scores mean about the team, and what action to take in the light of this exercise. This will involve determination of priorities and drawing up action plans to ensure change happens.

Stage 1: Preparation

Stage 1: Preparation

For ITMA to work properly there needs to be clear agreement about the reasons for using it. There are several possibilities:

- to undertake a series of regular 'health checks' as part of a wider programme of service monitoring and review
- to explore and expose problems or to confirm apparent success
- a prospective exercise undertaken by partners just embarking on team working with a view to identification of ‘success’ factors
- a retrospective exercise by partners renewing or revising their joint working arrangements.

Whatever the purpose, it is important that everyone affected has the chance to discuss the reasons for using the tool and what is expected to be achieved. Facilitation of the process is important at two stages in particular:

- in introducing partners to the wider teamworking partnership context and the assessment process, and in helping them become familiar with the tool
- in analysis of findings across the partners, examination of issues arising and action planning

Often this facilitation will be conducted internally by someone from one of the parent agencies. Where this is the case, then it should be made clear to participants that this activity has the strong support of senior managers and policy-makers. Sometimes, and especially where it is expected to be difficult or sensitive, it may be better facilitated externally by agencies or individuals with experience in this area. Another important preliminary step is to be clear about - and to communicate - what will conclude the process in terms of feedback and action planning. Those participating need to be assured not only that taking the trouble to undertake the assessment is worthwhile but that they can be, and should be, frank and honest in their responses.

Stage 2: Collecting Data

Stage 2: Gathering Data

This is the main part of the exercise. In this section you will find 30 statements about team working grouped around four principles. In relation to each statement you are being asked to do three things:

- answer the question realistically: make a judgement about how you think the team actually is, not how you would like it to be;
- give your opinion as an individual: this is about what you think, rather than trying to reflect what the team thinks;
- make your comments: next to each score box there is room for comment in an expanding box, and the more you use this box the better ITMA will be an accurate tool

In each section you are asked to respond to a number of statements about the integrated team. All you have to do is decide your opinion on these statements by choosing one of four options, each of which carries a score which we would like you to insert in the appropriate box:

- Strongly Agree [SA] – Score 4
- Agree [A] – Score 3
- Disagree [D] – Score 2
- Strongly Disagree [SD] – Score 1

Principle 1 - Clear Purpose & Mission

Strongly Agree [SA]	Agree [A]	Disagree [D]	Strongly Disagree [SD]
Score 4	Score 3	Score 2	Score 1

Statement	SA	A	D	SD
The reasons for the team's creation and function are understood and appreciated				
There is wide support within the team for the team's mission				
The team is working towards clear aims and objectives				
Team members are clear about the new policy agenda and the importance of integrated teams				
Team members appreciate that by working together they can achieve more than by working separately				
Team members receive adequate training and development for working together				
Please briefly suggest ways in which you think performance on this principle could be improved:				
Total Score				

Principle 2 - Securing Ownership & Trust

Strongly Agree [SA]	Agree [A]	Disagree [D]	Strongly Disagree [SD]
Score 4	Score 3	Score 2	Score 1

Statement	SA	A	D	SD
There is a strong commitment across the team to making integration work				
Team members feel that their contributions are equally respected and valued				
Team members know they can rely on each other				
Team members ask each other for help and support and receive it				
Team members meet together sufficiently often to share information and views about service delivery				
Team members mix together socially as well as professionally				
Please briefly suggest ways in which you think performance on this principle could be improved:				
Total Score				

Principle 3 - Robust Working Arrangements

Strongly Agree [SA]	Agree [A]	Disagree [D]	Strongly Disagree [SD]
Score 4	Score 3	Score 2	Score 1

Statement	SA	A	D	SD
The roles and responsibilities of each team member are well understood				
Effective arrangements for management and leadership of the integrated team are in place				
Arrangements for accessing the team by users and fellow professionals are clear and understood				
Team members are willing to work on tasks not normally seen as within their professional remit				
All team members use the same electronic system for recording and sharing data				
The team has the right membership to achieve its objectives				
Please briefly suggest ways in which you think performance on this principle could be improved:				
Total Score				

Principle 4 - Learning & Review

Strongly Agree [SA]	Agree [A]	Disagree [D]	Strongly Disagree [SD]
Score 4	Score 3	Score 2	Score 1

Statement	SA	A	D	SD
Regular team meetings are held for peer support and sharing of good practice, and to monitor activity and performance				
The team knows when it is working successfully and records its achievements				
There are clear and effective arrangements for separate professional supervision and support where this is needed				
The team encourages members to use their own learning and development skills in order to support each other				
The team has clear ideas on how it can further improve performance				
There are clear and effective arrangements for involving users and carers in the review process				
Please briefly suggest ways in which you think performance on this principle could be improved:				
Total Score				

Principle 5 - External Links & Support

Strongly Agree [SA]	Agree [A]	Disagree [D]	Strongly Disagree [SD]
Score 4	Score 3	Score 2	Score 1

Statement	SA	A	D	SD
Parent agencies support the team and value what it is trying to achieve				
The team is adequately resourced and supported to achieve its objectives				
Partner agencies have laid down a clear and realistic timetable for the team to achieve its aims and objectives				
The functioning of the team is not affected by organisational restructuring within the partner agencies				
External performance management requirements are consistent with the aims and objectives of the team				
The team is confident about its continuing existence and is able to make plans for the future				
Please briefly suggest ways in which you think performance on this principle could be improved:				
Total Score				

Stage 3: Analysis & Interpretation of Data

Having filled in the scores for each section of ITMA Readiness Tool, you now need to interpret the meaning of the scores for each section, as well as the aggregate score. This is detailed in the boxes below.

Principle 1: Clear Purpose & Mission

SCORE	INTERPRETATION
A: 21-24	The reasons for the team's creation and function are understood and appreciated
B: 16-20	There is wide support within the team for the team's mission
C: 11-15	The team is working towards clear aims and objectives
D: 10 or less	Team members are clear about the new policy agenda and the importance of integrated teams

Principle 2: Securing Ownership & Trust

SCORE	INTERPRETATION
A: 21-24	There is a strong commitment across the team to making integration work
B: 16-20	Team members feel that their contributions are equally respected and valued
C: 11-15	Team members know they can rely on each other
D: 10 or less	Team members ask each other for help and support and receive it

Principle 3: Robust Working Arrangements

SCORE	INTERPRETATION
A: 21-24	The roles and responsibilities of each team member are well understood
B: 16-20	Effective arrangements for management and leadership of the integrated team are in place
C: 11-15	Arrangements for accessing the team by users and fellow professionals are clear and understood
D: 10 or less	Team members are willing to work on tasks not normally seen as within their professional remit

Principle 4: Learning & Review

SCORE	INTERPRETATION
A: 21-24	Regular team meetings are held for peer support and sharing of good practice, and to monitor activity and performance
B: 16-20	The team knows when it is working successfully and records its achievements
C: 11-15	There are clear and effective arrangements for separate professional supervision and support where this is needed
D: 10 or less	The team encourages members to use their own learning and development skills in order to support each other

Principle 5: External Links & Support

SCORE	INTERPRETATION
A: 21-24	Parent agencies support the team and value what it is trying to achieve
B: 16-20	The team is adequately resourced and supported to achieve its objectives
C: 11-15	Partner agencies have laid down a clear and realistic timetable for the team to achieve its aims and objectives
D: 10 or less	The functioning of the team is not affected by organisational restructuring within the partner agencies

Aggregation of Data

A final step in data interpretation is to form an overall view on the significance of the aggregate ITMA scores in order to decide what further steps – if any – to take. The first step here is to complete the aggregate scoring box below, and compare these with the following table on how these scores should be interpreted.

ITMA PRINCIPLE	MAXIMUM SCORE	ACTUAL SCORE
Principle 1: Clear Purpose & Mission	**24**	

Principle 2: Securing Ownership & Trust	**24**	
Principle 3: Robust Working Arrangements	**24**	
Principle 4: Learning & Review	**24**	
Principle 5: External Links & Support	**24**	
TOTAL SCORE	**Maximum = 120**	**Actual =**

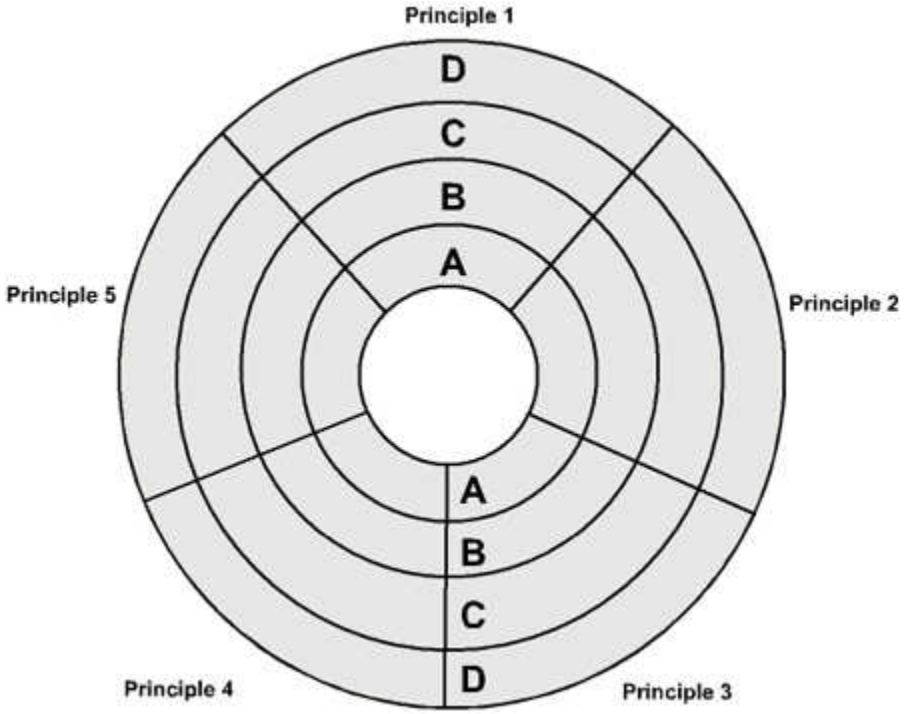
Interpretation of Aggregate ITMA Score

SCORE	INTERPRETATION
105 +	A highly integrated team that represents a model of good practice
80-104	A team that is developing well but is in need of some further support
55-79	A partially developed team that needs significant improvement
54 or less	A fragmented team that shows no real prospect of improvement

The Dartboard Presentation

The final scores and their interpretation can be accessed pictorially on an integration dartboard, along with a summary analysis of team functioning.

Put the total score for each principle in the appropriate segment below and shade that segment



The profile shows overall performance across all five principles. The nearer the shading is to the centre of the diagram then the healthier is the assessment of team performance. It is possible for a team to be doing relatively well on some aspects and less well on others.

Stage 4: Action Planing for Alternative Findings

The principal aim of ITMA is to enable generic assessment of teamworking. It cannot offer detailed prescriptions for addressing the problems identified in any particular relationship. How team weaknesses or problems are tackled – or how strengths are reinforced and replicated – must depend upon local circumstances and is likely to require specialist organisational development expertise. What is clear generally, however, is that whatever the findings, the assessment process must be seen to conclude with a plan for action. Three broad alternative scenarios are outlined below.

ACTION PLANNING FOR ALTERNATIVE FINDINGS

4a	4b	4c
Assessment suggests the team is working well; members only need to consider how often to build in a regular review	Assessment suggests the team is working well in some respects, but there are concerns about others. Members need to decide how to address these areas of concern	Assessment highlights significant areas of concern that require urgent attention and a detailed plan of action

Taking the first case (4a) if the findings show a broad consensus about the general strength and 'health' of team working, the action planning may need to consist of little more than agreeing how and when to undertake the next assessment. This could be a repeat exercise with the same individuals, or it could also entail assessments at different levels in the partner organisations. There might also be an agreement that no further formal assessment takes place unless there are important changes within the team or the context within which it operates. Whatever the apparent success of current team working, it will be worthwhile acknowledging that even the healthiest should have regular health checks.

In the case of the second broad scenario (4b) where some problems or weaknesses are identified, the action planning will focus on these areas. Where there is little sensitivity about the issues raised – whether individual or organisational – more detailed analysis of what underlies the assessment findings may well be conducted internally and informally. Where there is greater sensitivity, external facilitation may be preferable. Such exercises should help to provide:

- structured information about people's perceptions throughout the team and the contributing partners;
- opportunities to compare and contrast the views of different team members, thereby providing an opportunity to plan remedial action;
- a process which in itself opens up a debate that introduces more openness and transparency about partners' views on team working.

In the case of the third scenario (4c) action planning will need to embrace extensive and possibly urgent remedial action. This may involve a thorough re–examination of the team, from aims and objectives through structures and processes to working practices. Indeed, if the problems are serious enough it may require that the team is dissolved and re-formed.

Whatever the outcome, it is strongly recommended that skilled and trusted external facilitators are used for scenarios 4b and 4c.

Once again, the benefits of using this assessment tool ought to be a clear indication of the nature and scale of problems, of where action is needed most and where it is required most urgently. And although it is a primarily diagnostic tool, the framework also provides a general prescriptive account of how team working can be strengthened. It is for those involved in particular team relationships to apply these general principles to their local circumstances.

Getting Further Help

In those cases where further help is needed, it will usually be best to bring in external support and facilitation. It is not appropriate in this tool to recommend any specific consultancies, though the tool has been devised by Professor Bob Hudson who can be emailed at bob@bobhudsonconsulting.com. Other sources of general support and information are:

- Integrated Care Network: www.integratedcarenetwork.gov.uk
- Care Services Improvement Partnership: www.csip.org.uk
- Social Care Institute for Excellence: www.scie.org.uk
- Local Government Association: www.lga.gov.uk
- Research into Practice (children's services): www.rip.org.uk
- Research into Practice for Adults: www.ripfa.org.uk
- Journal of Integrated Care: www.pavpub.com/pavpub/journals/JIC/index.asp
- Journal of Interprofessional Care: www.tandf.co.uk/journals/titles/13561820.asp
- Government Offices of the Regions: www.gos.gov.uk
- Strategic Health Authorities: www.nhs.uk/England/AuthoritiesTrusts/Sha

The design task for ITMA has been undertaken by Densen Digital Experiences: www.densen.co.uk.

Integrated Team Monitoring & Assessment

Assessment Tool. The Integrated Team Monitoring & Assessment (ITMA) was developed by the Department of Health's Care Services Improvement Partnership Networks to assist local agencies to assess team effectiveness. The ITMA is based on 30 customized measures based on validated research findings and best practices. The assessment enables an appraisal of the "health" of the team by presenting questions related to internal functioning and external factors that impact the team dynamic. The assessment includes statements grouped around five main Principles: Principle 1-Clear Purpose & Mission, Principle 2-Securing Ownership & Trust, Principle 3-Robust Working Arrangements, Principle 4-Learning & Review, and Principle 5-External Links & Support.

Methodology. Each Rapid Response Expert Team Member received an email containing a link to the ITMA and all assessments were completed online via the Internet. The assessment was administered during three different intervals to enable monitoring and evaluation of team effectiveness over time. The baseline assessment was administered in May 2010, followed by a second assessment in January 2011 and a final assessment in July 2011. All team members accessed the online tool and were asked to respond to 30 statements. For each statement, team members were asked to provide their opinion by indicating a response of Strongly Agree, Agree, Disagree or Strongly Disagree. Responses were automatically assigned point values from Strongly Disagree (1 point) to Strongly Agree (4 points).

Overall Results

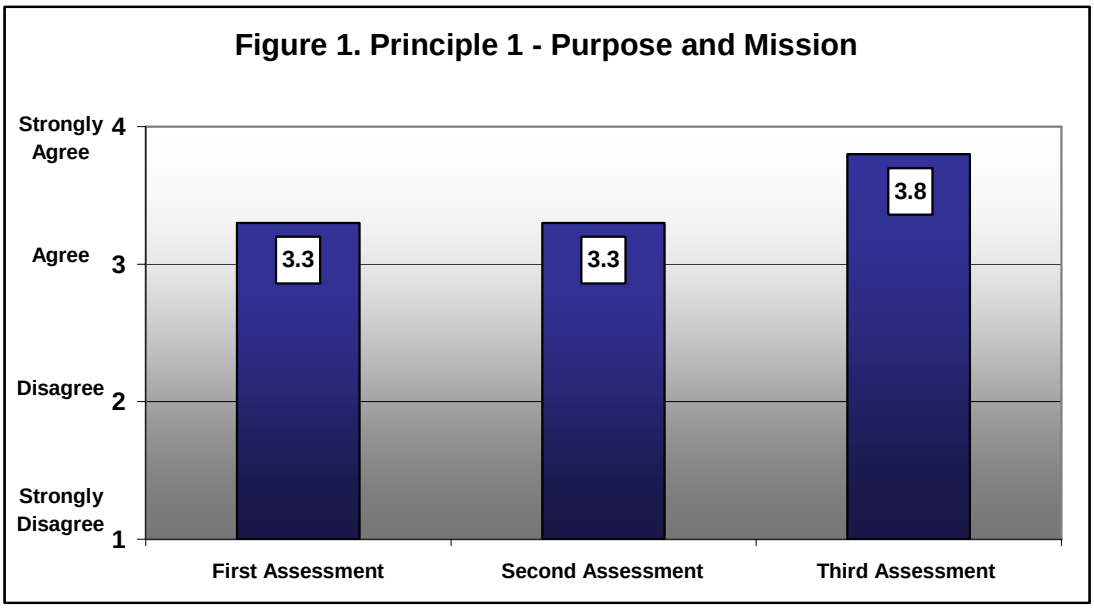
The baseline assessment was completed by the 14 original Rapid Response Team Members. Subsequent assessments were completed for 11 out of the 14 original Rapid Response Expert Team Members*. The individual scores of the team members were aggregated to provide a complete picture of how the whole team is working. In comparison to an optimal total score of 120, the overall score for the initial assessment (87) increased slightly compared to the second assessment (88) and indicated the team is developing well but is in need of some further action. However, compared to the initial assessment, the overall score for the final assessment (103) increased by over 18 percentage points indicating a positive overall improvement in team functioning over time.

Results by Principle

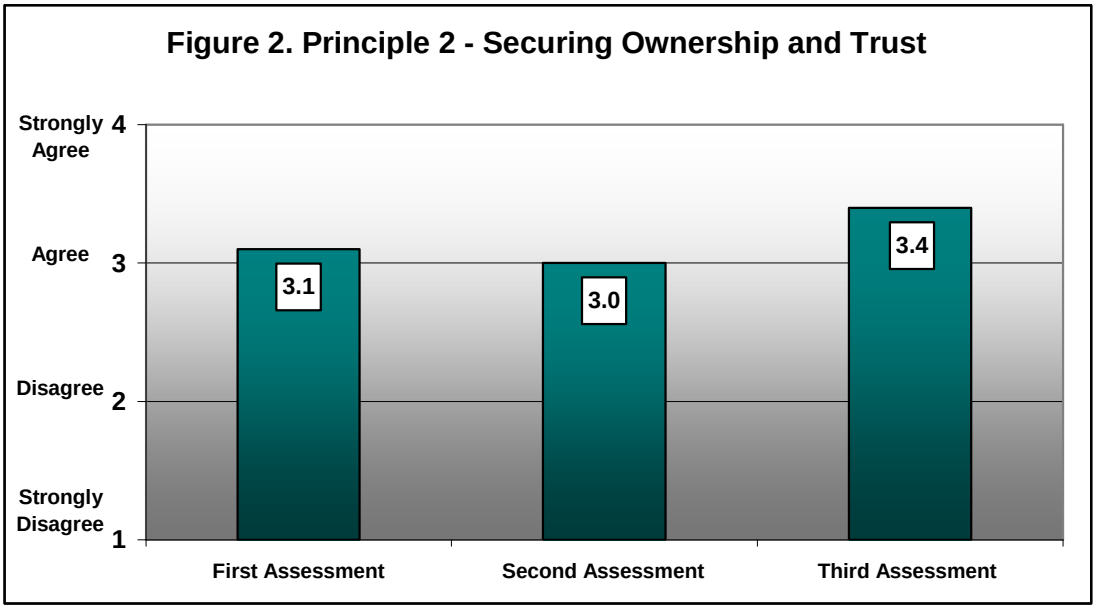
The ITMA included statements grouped around 5 Principles: Principle 1-Clear Purpose & Mission, Principle 2-Securing Ownership & Trust, Principle 3-Robust Working Arrangements, Principle 4-Learning & Review, and Principle 5-External Links & Support. Each Principle was comprised of six statements that directly relate to the Principle area and responses were assigned point values from Strongly Disagree (1 point) to Strongly Agree (4 points). Responses were assigned point values and higher averages indicate increased team member agreement and optimal team functioning. Results for each Principle were as follows:

* Direct comparisons between the initial and second ITMA results should be made with caution due to differences in team members/ number of respondents.

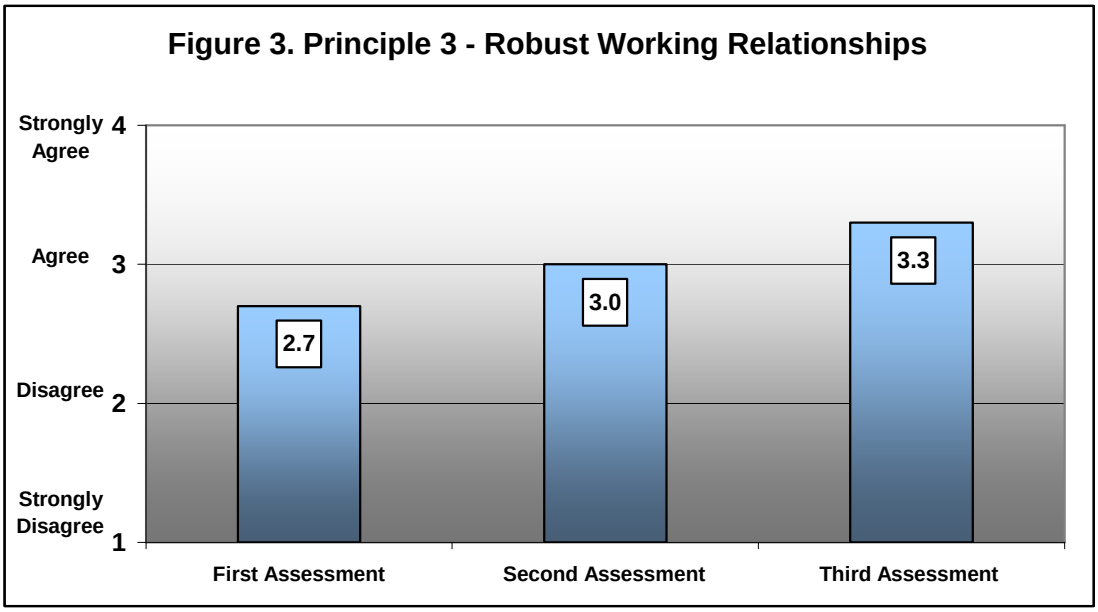
Principle 1 included statements that relate to Purpose and Mission. Consistent across all three assessments, respondents agree that the team has a clear purpose and mission (Figure 1).



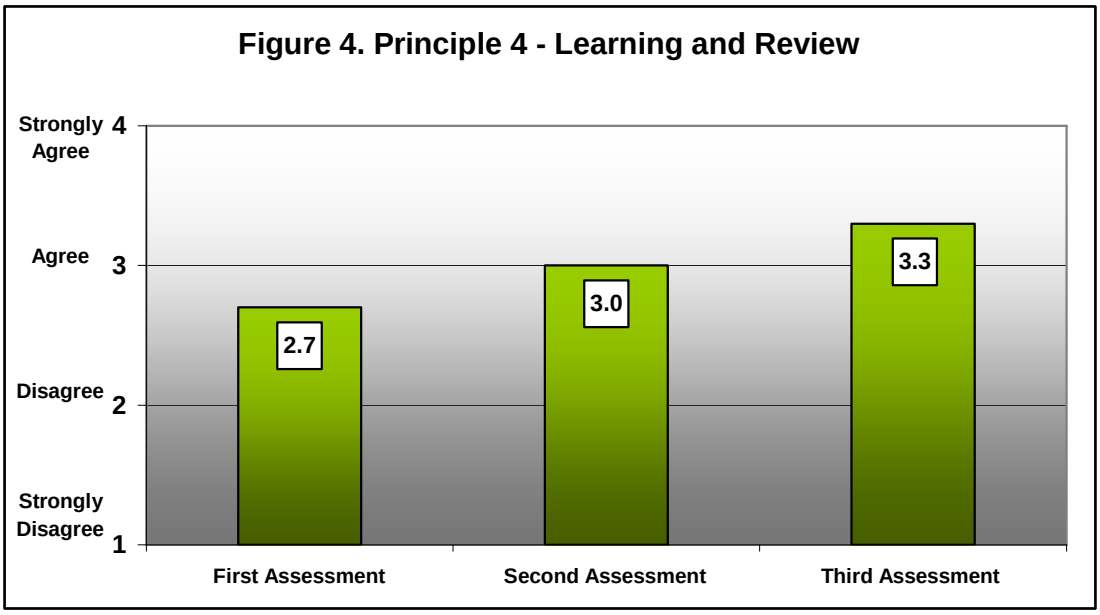
Principle 2 included statements that relate to Securing Ownership and Trust. Consistent across all three assessments, respondents agree that the team members are committed and supportive (Figure 2).



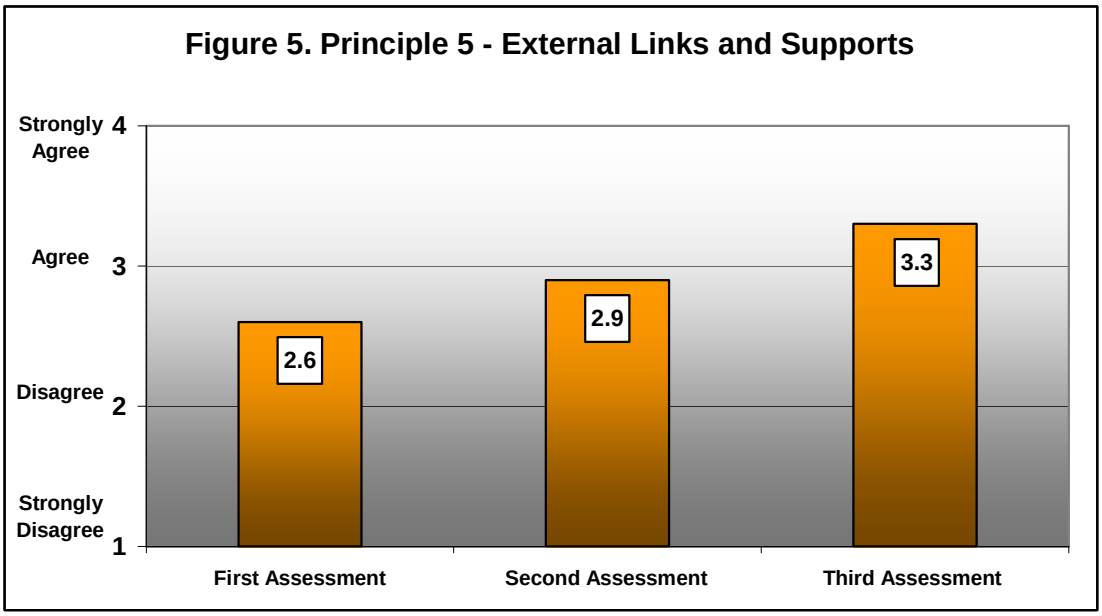
Principle 3 included statements that relate to Robust Working Arrangements. Responses ranged from 2.6 to 3.3. The final assessment average (3.3) showed that respondents agree that the team members understand roles and responsibilities (Figure 3).



Principle 4 included statements that relate to Learning and Review. Responses ranged from 2.7 to 3.3. The final assessment average (3.3) showed that respondents agree that the team recognizes when it's working successfully (Figure 4).



Principle 5 included statements that relate to External Links and Supports. Responses ranged from 2.6 to 3.3. The final assessment average (3.3) showed that respondents agree that the team is supported to achieve its objectives (Figure 5).

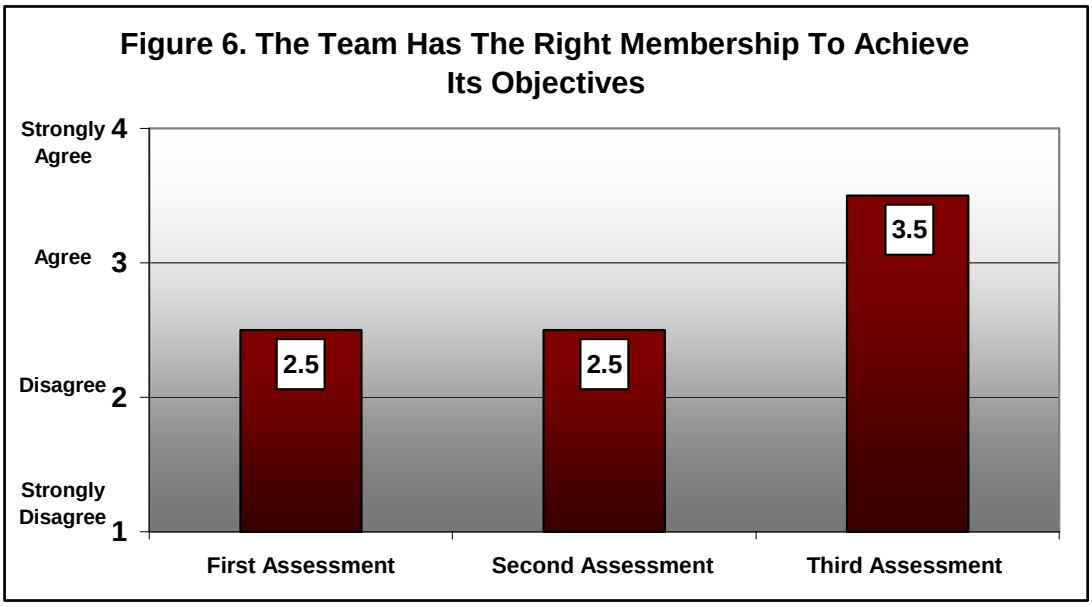


Highlighted Results

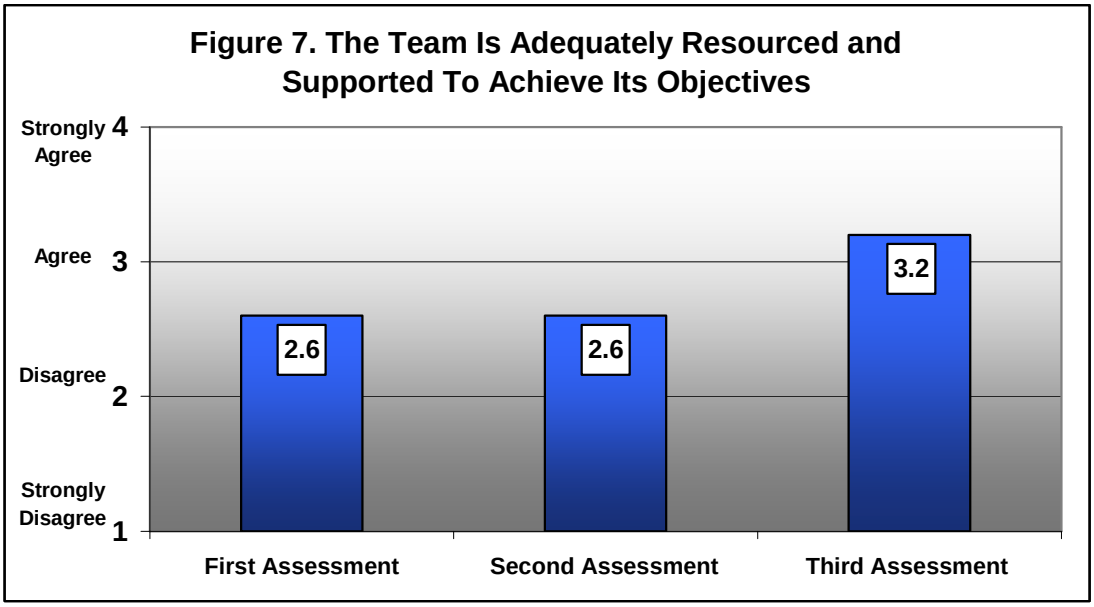
Specific statements regarding membership and resources were selected from Principles 3 and 5 as targeted focus areas for the Rapid Response Expert Team. In addition to overall improved team functioning, positive improvement across selected statements was individually assessed. For each statement, team members were asked to provide their opinion by indicating a response of Strongly Agree, Agree, Disagree or Strongly Disagree. Responses were assigned point values and higher averages indicate increased Team Member agreement and optimal team functioning.

Results for statements that directly highlighted the functioning of the team were as follows:

1) *The team has the right membership to achieve its objectives*. Responses ranged from Strongly Disagree to Strongly Agree with assessment averages ranging from 2.5 to 3.5 (Figure 1). The final assessment average (3.5) showed that respondents agree that team has the right membership to achieve its objectives.



2) *The team is adequately resourced and supported to achieve its objectives*. Responses ranged from Strongly Disagree to Strongly Agree with assessment averages ranging from 2.6 to 3.2 (Figure 2). The final assessment average (3.2) showed that respondents agree that team is adequately resourced to achieve its objectives.



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Appendix J
Flow Chart

RAPID RESPONSE EXPERT TEAM

Adult Protective Services (APS) Medical In-Home Multidisciplinary Consultation Team

Representatives from: Area Agency on Aging, Human Services Agency, Public Health, Public Guardian, Law Enforcement, District Attorney, Long Term Care Ombudsman, Behavioral Health, Superior Court, Tri-Counties Regional Center, Crisis Intervention Team, Victims Services and designated Medical Doctor, Neuropsychologist, and LCSW

Goal:

Reduce or eliminate the protective issue with improvement in health and safety of dependent adults and elders 65+, who have difficult to resolve, complex, medical and mental health risk indicators, who are served by Adult Protective Services (APS) and the Rapid Response Multidisciplinary Team.

Objectives:

1. Utilize the Ventura APS Tool for Risks, Interventions, & Outcomes (APS TRIO) interventions 8/9/10
2. Conduct in-home assessments by medical / mental health expert practitioners that include a physician (MD), Public Health Nurse (PH RN), Licensed Clinical Social Worker (LCSW), Neuropsychologist (PHD)
3. Increase medical / mental health resources to Rapid Response MDT
4. Disseminate findings and results of the project for possible replication and further study

Process

Prior to the scheduled RRET meetings (second and fourth Wednesday of each month), members generate a referral form to be sent to APS (fax 805-650-1521). At the RRET meeting, the referring party provides a brief case presentation, addressing relevant information, status of protective issue, identifying focus of consultation request, and associated questions. Team consults generate an action plan, which can include specific team member(s) interventions and recommendations to the referring party. The RRET facilitator documents the developed Action Plan. When the case is an OPEN APS CASE, the RRET can deploy the Medical and/or Mental Health expert(s) to provide an in-home evaluation. An MD, PH RN or LCSW in-home evaluation can be deployed, prior to the RRET consultation presentation, for the purpose of better facilitating the RRET's ability to formulate the action plan when warranted and possible. The APS Social Worker generates In-Home Evaluation Referral to recommended practitioners to be deployed. Consent to be seen by practitioner(s) is acquired. A Medical / Mental Health expert(s) consults with the referring APS Social Worker, the designated Point of Contact, and coordinates an in-home appointment. A Medical / Mental Health expert(s) is deployed within 3 to 5 business days of the RRET meeting, unless otherwise indicated (APS TRIO interventions 12 /13).

Agrees to Evaluation:

A Medical / Mental Health Practitioner initiates the in-home evaluation process. The APS client agrees to evaluation, signs consent. The Psychologist secures consent for evaluation and release of information authorization, as needed – using private practice forms. The MD and LCSW secure release of information authorization, as needed – using Ventura County consent form: specifying to and from information flow, and collateral contact names and/or agencies. The Practitioner provides evaluation; consults with collateral contacts and client as needed; generates written evaluation or summary report and APS TRIO contribution form; consults with APS Social Worker and/or Public Health RN (fax 805-650-1521); and may provide verbal follow up consultation with the client and direct feedback to the RRET. (All generated documents are maintained in the APS file.)

Refuses Evaluation:

A Medical / Mental Health Practitioner initiates the in-home evaluation process. The APS client refuses the evaluation. The Medical / Mental Health expert generates a summary of contact observations and consults with the APS Social Worker and/or Public Health RN. The Practitioner may provide direct feedback to the RRET. (All generated documents are maintained in APS file.)

Follow-up

APS Social Worker – Point of Contact reviews summary and recommendations to determine needed follow-up consultation(s), intervention / implementation strategy to reduce / eliminate protective issue(s). APS Social Worker consults with Program Manager / Supervisor providing ongoing status of case progress, facilitating APS Program Manager / Supervisor's ability to inform RRET of progress and status of case.

APS Program Manager / Supervisor and/or APS Social Worker, Medical / Mental Health expert(s) provide follow-up, reporting results of in-home evaluation(s), positive outcomes, case progress, and status of protective issues as the case evolves.