ELDER ABUSE FORENSIC CENTER DEVELOPMENT & EVALUATION

A TOOLKIT

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I. INTRODUCTION

Over the past decade, elder abuse has become widely recognized as a pervasive problem and a growing concern (Acierno, 2010; Bonnie & Wallace, 2003; Connolly, 2010; Dressin, 2000; Heisler, 2000; Laumann, 2008). It is increasingly recognized as having major consequences for victims, their family members, and society. Older adult victims may incur serious physical injuries, emotional pain and suffering, shame, depression, shattered trust, financial ruin, and increased risk of mortality (Comijs, Penninx, Knipsheer, & Tilburg, 1999; Lachs, Williams, O'Brien, Pillemer, & Charlson, 1998).

In addition to breaking the covenant to honor our elders, consequences for society at large include the expenditure of billions of dollars in avoidable health care costs, the loss of billions of dollars in defrauded retirement savings, mortgage failures, and an expanded Medicaid earmark. Despite increased attention to the problem, elder abuse is still shrouded in uncertainty, with little information available to inform policy makers and community leaders on the effectiveness of interventions (Bonnie & Wallace, 2003; Ploeg, Fear, Hutchison, MacMillan & Bolan, 2009).

Strides have been made in several areas of elder abuse research, including studies to determine how much elder abuse occurs in a given time frame and overall (incidence/prevalence) as well as improvements in the measurement of elder abuse. Over the last three decades, a number of studies have been conducted to determine the incidence/prevalence of elder abuse. Early well designed studies (Pillemer and Filkelhor, 1988; Podnieks, 1992) suggested that the rate of abuse was about 3-4% of the older adult population. Two decades later a review of incidence and prevalence studies by Cooper, Selwood, and Livingston (2008) identified 49 studies conducted in more than a dozen countries. Focusing on the seven studies that used validated measures, they found a wide variety of prevalence rates, ranging from 3.2% to 27.5% with response rates from 10% to 100%.

The most recent study by Acierno et al. (2010) was funded by the National Institute of Justice and was nationally representative of adults age 60 and older. The researchers noted that the literature supports using comprehensive, behaviorally defined descriptions of interpersonal conflict with close-ended questions to produce accurate predictions. Using random digit dialing across geographic strata, they analyzed data from 5,777 respondents. One-year incidence of abuse was 4.6% for emotional abuse, 1.6% for physical abuse, 0.6% for sexual abuse, 5.1% for potential neglect (Acierno, et al., 2010). They also found a rate of 5.2% for current financial abuse by a family member (Acierno et al., 2009).

Progress is also occurring in the area of measurement. Conrad and his colleagues have developed and tested approaches to measuring several different types of elder abuse including financial, psychological, and self-neglect (Conrad, Iris, Ridings, Fiarman, Rosen, & Wilber, 2011; Conrad, Iris, Ridings, Langley, & Anetzberger, 2011; Conrad, Iris, Ridings, Langley, & Wilber, 2010; Conrad, Iris, Ridings, Rosen, Fairman, & Anetzberger, 2011; Iris, Ridings, & Conrad, 2010). Using expert panels of practitioners and researchers, they identified possible items that reflect abuse and applied an approach called concept mapping to organize these items into domains. The instruments developed from this method were then field tested. They are currently developing the Elder Abuse Decision Support System (EADSS, www.eadss.org). These instruments and related approaches offer the promise of providing standardized measures to better assess elder abuse and compare findings across different settings and geographic areas.

In addition to growing interest in prevalence and improved measures to detect and study abuse, leaders in the field have called for increased examination of the promising approach to address abuse. Elder justice, defined as freedom from abuse, neglect, and exploitation, requires that adequate resources and evidence-based interventions are in place to prevent, detect, treat, intervene, and, where appropriate, prosecute abuse offenders (Breaux & Hatch, 2003). Yet a comprehensive report on elder abuse by the National Research Council (NRC) noted that efforts to understand and address elder mistreatment were about 20 years behind similar work in child abuse and intimate partner violence (formerly called domestic violence) (Bonnie & Wallace, 2003).

In addition to the need for basic research to determine prevalence and risk factors, the NRC report identified a need for evidence-based interventions and suggested promising approaches that could be applied to elder abuse. The report recommended that novel, scientifically grounded interventions be supported, and that resources be made available to thoroughly evaluate such interventions. It identified as priorities those interventions that emphasize specialized professional training and interdisciplinary collaboration. Similarly, a convening of experts in 2010 by the National Institute on Aging and the National Academy of Sciences identified a need for research on interventions to prevent and to address abuse (The National Academies Committee on National Statistics, 2010).

One of the difficulties in responding to elder abuse, neglect, and exploitation is that cases can be exceedingly complex. Although Adult Protective Services (APS) is the agency charged with receiving and investigating reports of abuse in community settings, the complexity of some elder abuse cases means that one type of professional cannot do the job alone. Diverse areas of expertise (e.g., law enforcement, health and mental health, protective services) are required to address complex cases. Unfortunately, it is not uncommon for a variety of service sectors to be working in parallel fashion on behalf of an elder who is a victim of mistreatment, without knowing that other professionals are also involved. When they do work together, professionals may struggle to understand each other's professional language, values, methods of working, and goals for the case.

For these reasons, elder abuse cases that involve a web of medical, social, legal, and/or financial issues, are often understood more fully, and responded to most effectively, when these various disciplines work together (Connolly, 2010). One possible means to address this problem is an elder abuse multidisciplinary team (MDT) (Bonnie and Wallace, 2003; Connolly, 2010; The National Academies Committee on National Statistics, 2010; Teaster, Nerenberg, and Stansbury, 2003). Over a decade ago, Wolf and Pillemer (1994) identified elder abuse MDTs as an important means to address the complexities of elder abuse. An MDT offers a way to bring professionals together to work on cases, improve protocols and service delivery approaches, and develop team-based problem solving strategies.

In California, where the Forensic Center evaluation was conducted, the law permits APS to share information with MDT members without violating victim/client/patient confidentiality. Specifically, the California Welfare and Institutions Code (Section 15610.55) defines "multidisciplinary personnel team" as any team of two or more persons who are trained in the prevention, identification, and treatment of abuse of elderly or dependent adults and who are qualified to provide a broad range of services related to abuse of elderly or dependent adults (California Legislature, 2011). Given broad parameters, a number of different elder abuse MDT models have been developed, including the Fiduciary Abuse Specialist Team (FAST), Vulnerable Adult Specialist Team (VAST), fatality review team, and elder abuse task force.

Experts contend that MDTs, offer a promising, albeit largely untested intervention to aid APS and law enforcement investigations (Brandl, et al., 2007; Connolly, 2010; Schneider, Mosqueda, Falk, & Huba, 2010). Because MDTs can be superimposed on current delivery systems, they can improve communication and problem solving, without fundamentally altering the service delivery structure (Reuben, 2002). Given the range of professionals needed to address complex cases of elder abuse, and the diverse communities that are interested in enhancing their response to elder abuse, it is important to develop flexible and effective approaches to tap into these diverse systems. The information in this document is provided as an educational "toolkit" for professionals who wish to develop an elder abuse MDT in their communities. The toolkit contains information on team development, guidelines for how to conduct case reviews, and documentation evaluating the outcomes of the case review process.

II. BACKGROUND

II.A. History & Development

The first Elder Abuse Forensic Center was established in Orange County California in 2003. In response to enthusiasm over the potential for the Center MDT model to improve outcomes for victims of abuse, the Archstone Foundation funded several Forensic Centers in California: the original program in Orange County (OC), the Los Angeles County Elder Abuse Forensic Center (LA), the San Francisco Elder abuse Forensic Center (SF), and the Hope Team in San Diego (SD). The total population and area served by each of the four Center's is shown below in Figure 1.

Figure 1. Service Area and Population of CA's Elder Abuse and Neglect Forensic Centers

Since the start of the first Center in OC, three more Centers have been launched throughout California. In January 2011, the four California Centers, all of which had received funding under the Archstone Foundation's Elder Abuse Funding Priority, received additional two-year grants from the Archstone Foundation. The Centers have received national attention. Elder Abuse Forensic Centers were identified in the Elder Justice Act as a promising approach to combat elder abuse; the legislation authorizes $26 million for the development of both mobile and stationary Centers.

II.B. Conceptual Model

An Elder Abuse Forensic Center ("Center") is a MDT that includes participants from social services, criminal justice, and health services (Schneider et al., 2010). Compared to other MDTs in elder abuse, a distinguishing feature is that Centers are staffed full-time, and have the capacity to address cases beyond consulting during scheduled meetings. Centers offer an evidence-based resource to address complex cases of mistreatment of elders and persons with disabilities. Cases may include physical, psychological, financial, neglect, and self-neglect or any combination of these abuse types. By using a team-based approach as a means to reduce fragmentation and improve communication and problem solving, the Centers change the way elder abuse is investigated, mitigated, and prosecuted.

As shown below in Figure 2 of the Los Angeles Forensic Center (Navarro, Wilber, Yonashiro, Homeier, 2010), Centers offer a one-stop setting for professionals from a variety of disciplines. Through weekly face-to-face interactions, team members discuss cases, make recommendations and address problems using a team-based approach. Team members also provide ongoing services (e.g., client assessment, compiling and reviewing evidence, reviewing medical records, etc.) within their scope of practice and the constraints of their roles and the organizations involved (Schneider, Mosqueda, Falk, & Huba, 2010).

Figure 2. Los Angeles County Elder Abuse Forensic Center Model[1]

The model builds upon an adaptation of Wagner's Chronic Care Model designed to interpret the chronic care services established by the Care Advocate Model (Alkema, et al., 2007).

Although participants represent an array of diverse organizations, they expect to be involved not only in weekly meetings but occasionally during the other hours in the work week.

For example, members of the Forensic Center may make home visits or consult with each other as cases are investigated and resolved outside of meeting hours.

II.C. Key Components

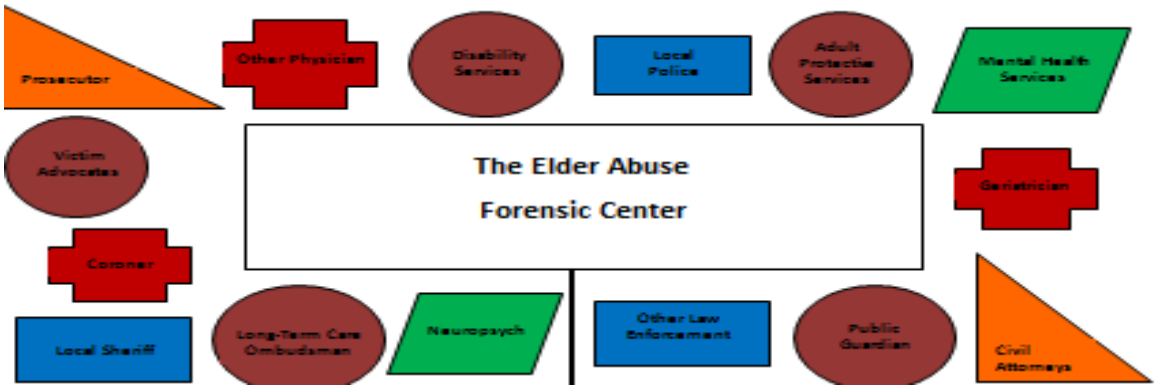
Centers bring together core team members at regularly scheduled meetings to hear cases, make recommendations and carry out plans to address the case. While locations differ among centers, all are able to accommodate a variety of professionals in a shared facility for regular meetings and ongoing collaboration. Across the four Centers, 19 different disciplines have been identified as Center participants. As shown in Table 1 below, Center teams are comprised of core members (roles that are seen at each Center) and ancillary members (those represented at some Centers based on the Center's specific needs).

Table 1. Core and Ancillary Members.

ALL Teams Have:	Most Teams Have:
• Adult Protective Services • Medical Personnel • Prosecuting Attorney • Victim Advocate • Law Enforcement • Public Guardian/Conservator	• Long-Term Care Ombudsman • Gero/Neuro-psychologist • Mental Health Services • Senior Legal Aid
	Some Teams Include:
	• Developmental Disability Services • Coroner/Medical Examiner • Community Care Licensing • Intimate Partner Violence (IPV) Services

LA has the highest representation of all potential team members with 15 of the 19 possible professions/agencies represented. Reflecting diversity across Centers, OC has 12, SF has 11, and SD has 8. Although representation differs according to the unique needs and available resources, in addition to having a coordinator staff the Center, core team roles must be present and actively participating in the meetings to be considered a forensic center and not another type of elder abuse MDT. Figure 3 depicts the core team members at the Los Angeles Forensic Center. Each shape and color represents a different discipline.

Figure 3. Centers bring together diverse professionals.



II.D. Case Processing

There is no consistent pattern across Centers related to who presents cases. Although APS workers are the most likely to bring and present cases, LA and OC both report a variety of presenters including DA, Victims Advocate, Public Guardian, and Law Enforcement. Similarly, APS workers are the sole presenters at the SF center. This seems to be the most logical referral source as APS is the reporting agency for elder abuse cases.

At the Los Angeles Forensic Center, the team hears two to four new cases each week and receives updates on previous cases. Planning time is set aside monthly, as needed, for problem-solving structural and procedural issues, discussing member agency protocols, managing administrative issues, coordinating special trainings, and organizing annual retreats. Although all member agencies are invited to present, the majority of cases are presented by APS case workers. There has been some fluctuation over time but in general APS presents about 60% of the cases, law enforcement presents about 30% and other team members present the remaining 10%. Regardless of who presents, all cases must be cross reported to APS and most cases that have been crossed referred to law enforcement are presented jointly by APS and law enforcement together. Because APS feedback indicated that Center presentations add travel and preparation time, the Center added teleconference capability, allowing APS case workers and their supervisors to present from their area offices, as they deem appropriate.

Prior to presenting a case at the LA Center, the person bringing the case provides the Center's project manager with preliminary information on the client and perpetrator characteristics and the history and background of the case. At the time of the presentation, Center team members receive a redacted copy of the client referral sheet. During the presentation, the presenter gives an informal case presentation to Center team members, providing a brief background of the case, along with history of the interventions completed or attempted.

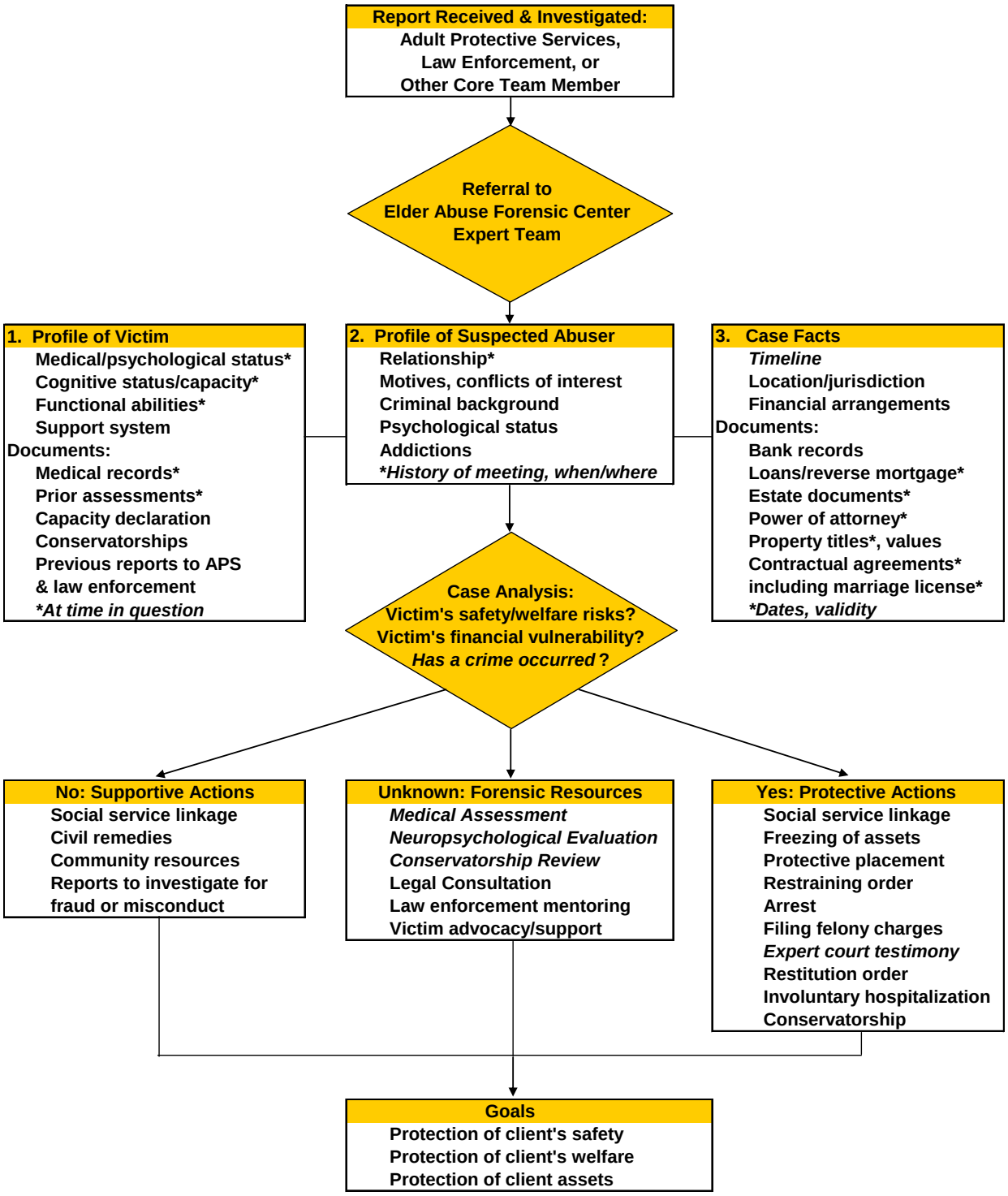
Case presenters are questioned about the case to clarify information, establish the timeline, and learn additional facts. When specific information that the team considers important is not available, presenters are requested to conduct further evaluation and update the Center, since these facts may be pivotal in determining next steps. Presentations include a brief background and history of the problem with descriptions of interventions attempted or

completed. Following the case discussion, attendees identify case goals and recommend next-steps for investigating and intervening to resolve the reported abuse. In addition to participating in the weekly meetings, team members assist those working the case (usually APS and law enforcement) through such activities as assessing the client's health status, capacity, and need for health/mental health care or social services; reviewing medical records; conducting home assessment; doing neuropsychological testing; and proving ongoing case consultation.

In addition to hearing cases and making recommendations, team members may be asked to bring their individual areas of expertise to the case. In Los Angeles, health care professionals include the Center's geriatrician, who attends each meeting, as well as a physician or nurse representing the mental health agency GENISIS. If recommended by the team, the geriatrician conducts forensic reviews of medical records, conducts home visits, contacts the victim's physician, assesses the victim's health and cognitive capacity and, when appropriate completes capacity declaration forms. During case discussions she also provides input and educates the team members in such areas as implications of diagnoses, medications, and case history. The Center's forensic neuropsychologist is focused on testing the victim's cognitive capacity, especially as it relates to medical and legal decisions and ability to manage their finances. Center professionals collaborate with the client's medical and psychological service providers when necessary, streamlining information-sharing processes and providing APS case workers, investigators, and prosecutors with knowledge about health status, cognitive capacity, and the health care system. When needed, these providers function as a bridge to outside providers of similar professional affiliation, facilitating communication, access to records, and/or specific interventions.

Law enforcement representatives are expert investigators, and are frequently in the role of educating and mentoring presenters. They share insights about collecting evidence, furthering investigations, and are integral in facilitating work with APS staff at the station-level. Prosecutors (DA and CA) provide suggestions on what information is necessary for filing a criminal case. The Center's deputy district attorneys decide which cases should be pursued criminally, when a case is ready for filing, and what information is necessary to move the case forward. The involvement of prosecutors and law enforcement officers at Center meetings facilitates communication and referrals to public entities. Attorneys from a legal service agency (Bet Tzedek) are available to address civil matters related to financial abuse, such as undoing home title transfers or other real estate matters. The case presentation and decision process at the LA Forensic Center is presented below in Figure 4.

Figure 4. Conceptual Map of the Los Angeles County Elder Abuse Forensic Center Decision Processes



Italicized terms reflect unique forensic elder abuse center activities

III. ESTABLISHING AN ELDER ABUSE FORENSIC CENTER

III.A. Development of a Forensic Center

III.A.1. Sample Timeline

Table 2 is a sample two year timeline for development of a forensic center. It is provided by the LA County Elder Abuse Forensic Center and was submitted with the original grant to the Archstone Foundation.

Table 2. Los Angeles County Elder Abuse Forensic Center Development Timeline

Year 1

Activity by Quarter	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Prepare Center Space	X			
Develop MOUs	X			
Pre-program Coordination	X			
Recruitment and Hiring of Staff	X			
Develop Research Protocols	X			
Conduct Research		X	X	X
Develop and Document Procedures and Protocols	X	X	X	X
HIPAA Training	X			
Occupy Forensic Center		X		
Forensic Team Meetings		X	X	X
Clinic and Home Evaluations		X	X	X
Track Case Data		X	X	X
Track Process Data	X	X	X	X
Develop Educational Curriculum	X	X		
Conduct Education and Training		X	X	X
Participate in Archstone Foundation Convenings		X		X
Develop and Implement Sustainability Plan	X	X	X	X

Year 2

Activity by Quarter	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Forensic Team Meetings	X	X	X	X
Clinic and Home Evaluations	X	X	X	X
Develop and Document Procedures and Protocols	X	X	X	X
Track Case Data	X	X	X	X
Track Process Data	X	X	X	X
Conduct Research	X	X	X	X

Conduct Annual Evaluation		X		
Disseminate and Publish Evaluation		X	X	X
Conduct Education and Training	X	X	X	X
Develop and Implement Sustainability Plan	X	X	X	X
Participate in Archstone Foundation Convenings				X

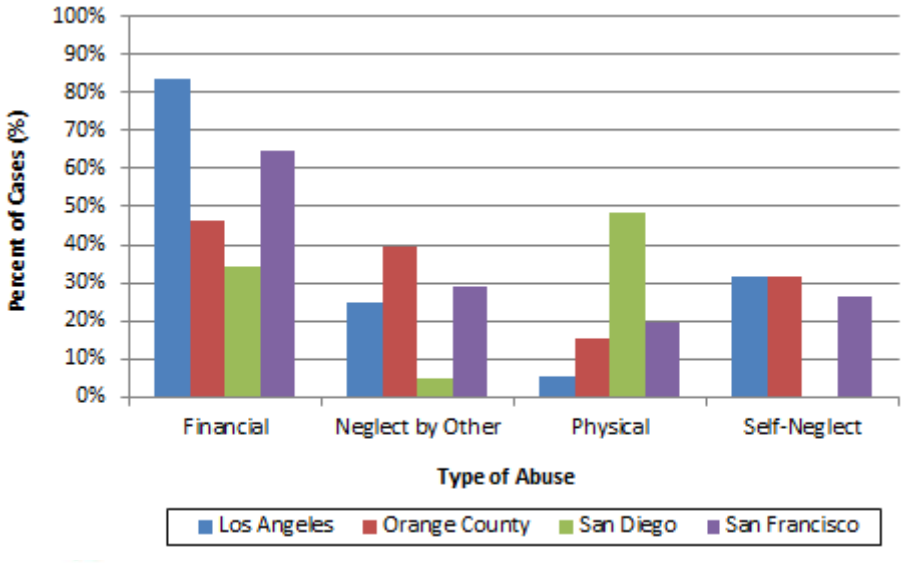
III.A.2. Strategic Purpose and Direction

Each Center developed unique mission, vision and goal statements to meet the needs of their community. In keeping with the core mission of multidisciplinary teams, all four Centers prioritize safety and protections for vulnerable adults. Common key words in mission and vision statements are: collaboration, prevention, education, access to justice, and research. Common goals fall into 6 thematic areas:

1) Direct services
2) Education/outreach/training
3) Evaluation/research
4) Quality improvement/best practices
5) Team building (collaboration/communication)
6) Sustainability.

Specific Center activities to meet these goals are described in detail throughout this toolkit. As shown in Figure 5 below, Centers also focus on different types of abuse. For example, the LA Center hears predominantly financial abuse case, whereas almost half the cases heard by the SD Hope Team are physical abuse cases.

Figure 5. Reported abuse types across Center sites (n = 801).



III.A.3. Assembling the Forensic Center Team

The importance of relationship building among team members is central to the success of a forensic center. Several approaches were discussed that foster a sense of collaboration. Ongoing team building activities to orient new members to the team process was a practice shared by all centers. It should be recognized that team development is a process and that it takes time to learn each other's language, vantage points, occupational culture, and decision-making process.

Team building approaches that foster team development facilitate orderly, well-run and well-attending team meetings. Barriers to relationship building stem from the fact that law enforcement, social service agencies, and public guardianship officials may have differing or competing priorities and ideas of what constitutes a "good" case outcome. Team building activities such as annual retreats, roundtable discussions on how to enhance the team, and other structured meeting activities serve as ways to find common ground and bring members closer to the shared goals of Center.

An issue identified by several Centers early on regarding the reluctance of APS workers to present cases to the forensic center team has been mitigated over the years through ongoing team building activities. One team member observed, "our team is only as effective as our partnerships are strong", and it is the ability of good staff to facilitate and nurture these partnerships.

III.A.4. Best Practices from California's Forensic Centers

The four California Centers were asked what advice they would give to a new center regarding getting core team members to the table. Below are some of the responses:

- Understand that relationship building is a key component to building a forensic center and that there will be both strong and weak partnerships, depending on who is representing each agency.
- Find inroads to partner agencies at as high a level as possible.
- A good coordinator is essential to keep activities organized and on track.
- Invite potential members to attend a meeting
- If possible, allow for the voice of the elder to be heard throughout the process.
- Getting core team members to the table is a collaborative effort that relies heavily on the interpersonal relationships between team members. One team member may have a stronger relationship to a perspective core member and it may be advantageous to have that team member extend the invitation to the table.
- It is important to continually establish connections in the community as time passes and needs of the center change and evolve.
- It is important to develop professional relationships with the leaders of the organizations the center wishes to invite.
- It is not so much the *quantity* of the membership as it is the *quality* of membership and organizational relationship.
- Invest time at the beginning allowing each agency involved to feel they are an important part of the team.

Centers were also asked what advice they would give to a new center regarding appropriate cases. Below are some of the responses:

- Though it is important for a new center to have clear guidelines regarding which cases they deem appropriate, that decision will need to be made once the forensic center has clearly identified its goals and objectives and becomes operational.
- While everyone on the team is working toward the same goal, every agency has their own limitations in getting the client to that goal. For example, while PD may have prosecution in mind, APS may have conservatorship or client's rights in mind.
- Appropriate cases are those that may have hit a road-block for resolution, can benefit from input for the forensic center team, and/or need assistance to expedite the transition of the case to the next level. Having a physician, prosecutor and other organizations on the team is very valuable for cases like this, as all members are present at the same time and communication can be expeditiously facilitated
- Be there for your team and talk about the kinds of cases that come up often. Don't define your work by what other centers are doing. Do the work that is needed in your community.

Finally, Centers were also asked what advice they would give to a new center looking for funding. Below are responses:

- Be creative and find partners
- Make it a priority to continuously look for potential funding opportunities and not wait until one source of funding is about to expire.
- Have realistic expectations of staff when drafting proposal for funding as it will be of no benefit to the center or the funder if what is promised is not delivered
- Capitalize upon the most interested potential members

- Start small. There is no need to have all the "ducks in a row"
- Look at what items are available for no-cost (e.g. meeting space)
- Consider the possibility of funding most of the forensic center services through existing resources (APS, DA, County medical services) if they understand the value of the team.
- Proper data collection illustrating an improvement in case outcomes is very important to funders, both private and public.
- Understand and plan for costly components of the model (e.g. neuropsychiatry, geriatrician).

III.B. Daily Forensic Center Function

III.B.1. Daily Activities

Each Center prioritizes specific activities to address elder abuse during and outside of meetings. These activities are listed by site in Table 3.

Table 3. Case Activities at the Four Center Sites in California

	Center Specific Activities
Los Angeles	• Victim evaluation • Testifying in civil or criminal court • Case advice/consultation by telephone • Meetings (outside of weekly meeting) regarding cases • Report/grant preparation (for court preparation or center sustainability
Orange County	• Documentation, database management, scheduling • Assessments, medical records review • Training • Outreach • Sustainability
San Diego	• Home visits • Court hearings • Finding community resources • Case research • Networking/community outreach
San Francisco	• Psychological evaluations • Capacity declarations • Medical exams/record reviews • Case updates • Community outreach

III.B.2. Team Meetings and Case Review and Work-Up

A central element to a successful Center is the ability for team members to share case information across agencies without violating provisions of the Health Insurance Portability and Accountability Act (HIPAA) or other privacy laws. It is standard practice for each center to

obtain a Memorandum of Understanding (MOU) with core team members (see sample in Appendix A); however, those needing an MOU varies across centers because of different core membership. All four Centers report formal MOUs with three team members: District Attorney (DA), Adult Protective Services, and Law Enforcement. LA has four additional MOUs with the City Attorney, Victim Advocate, Mental Health Services, and Real Estate District Attorney. SD has five additional MOUs with the City Attorney, Victim Advocate, Public Guardian, Free Legal Aid for Seniors, and Client Advocate. OC has eight additional MOUs with the geriatrician, Victim Advocate, Ombudsman, Public Guardian, Neuro/Geropsychologist, Mental Health Services, Free Legal Aid for Seniors, Intimate Partner Violence (IPV) team member, and DSS/Community Care Licensing. SF's only other MOU is with APS.

Teleconferencing at the LA Center allows workers from distant APS Centers to access the forensic team. San Diego utilizes WebEx as a tool for facilitating meetings by electronically presenting meeting notes and materials in real-time, allowing those who are unable to physically attend the meeting to share in the team meeting collaborative process.

III.B.3. Data Collection

A major challenge expressed by each Center was gathering and maintaining case data in a systematic and functional manner. Each Center collects and maintains their own program data using a collection of data management tools including multiple Excel spreadsheets alone or in conjunction with a Microsoft ACCESS database. LA uses a case "update file" in which meeting notes, minutes, goals, recommendations, and case updates are maintained and updated to-date. Additionally, they use Excel spreadsheets to manage client referral information, track services provided and document case outcomes. OC uses a *CaseKeeper* spreadsheet to track case characteristics, recommendations, and progress. Case recommendations are followed up at subsequent meetings, but outcomes are often not identified until months later. SF uses a Microsoft ACCESS database that tracks client information. SD uses paper-only documentation that they keep in case files while they await implementation of a system-wide web-based program that has been delayed numerous times over the course of the project.

Standardized Intake/referral

The ability to triage cases was reported by all Centers as pivotal to running an efficient weekly or bi-weekly team meeting. This requires determining which cases are most urgent, which are routine, and which can be addressed without presentation to the entire team, increasing the Center's efficiency and productivity. Over the course of the USC research team's evaluation, all four Centers reported that missing information on the intake/referral form hampers the flow of the forensic meetings and case processing efforts. A common approach has been to complete the intake form as much as possible prior to the meetings without any updating of information.

Developing a standardized intake form with relevant fields for all four Centers was identified as important goal and an essential step in facilitating cross-Center case tracking. The form itself was completed working with the Center of Excellence before the four-site evaluation began (see Appendix D). This form consists of five sections including: (1) which team members are requested to consult on the case, (2) the referring agency, (3) client information, (4) perpetrator information, and (5) abuse information with a field for additional information in narrative style. The form was put into operation by each Center between January 2011 and June 2011.

All Centers report that they consistently use the standardized form. Center staff is responsible for inputting referral form information into their respective Excel or Access data management systems. Overall, Centers are happy with the standardized form, but some glitches are still reported concerning incomplete/incorrect intake data by participating partners, especially regarding physician contact and medications, and tracking of prosecution outcomes.

III.B.4. Management of Cases

A cornerstone of the forensic model is the ability to work in real time to process and follow cases from intake through case resolution, whatever the outcome. The ability to follow cases as they progress through the medical, social, and legal systems requires a case tracking system that can be continuously updated with new and changing information. Tracking what happens apart from and in addition to weekly meetings helps keep cases on track and moving toward case resolution.

Because Centers use multiple files to manage their data and track case progress, they report that the process of managing cases and keeping cases up-to-date is cumbersome, requiring manual data entry and updating in multiple locations. Each Center expressed the need for a single database that can be used to gather and track case information and generate aggregate case data. All four Centers report that their ability to systematically track case information such as recommendations, next steps or action items, and case outcomes is too time-consuming given the limited and inadequate data tracking systems they have been using.

With input from each Center, the USC evaluation team developed a standardized approach to data tracking. The development of a single forensic center database makes it possible to efficiently track information for use not only to process cases, but also for future evaluation of the effectiveness of the forensic center model on measurable outcomes. A common data management and collection system allows cross-Center comparisons and specific data extraction to examine various program aspects among current and future Centers.

III.B.4.i Challenges of Developing a Universal Database

Developing a single database for use among all four Centers proved to be surprisingly complicated and labor intensive. The main barrier to finalizing this database and rolling it out to the four centers was achieving the balance between standardization and flexibility (i.e., delivering a database with a minimum dataset for comparison purposes and building enough tailored specificity so that it is functional and useable by each Center. For example, each center needs different searchable functionality built into the program so that they can search on case fields important to how they track cases. Therefore, the database must have searchable capability for various queries and reports including client demographics, suspected abuser information, case characteristics, goals, activities, etc. Also, case goals and activities must be carried over from one meeting to the next in order to track activities and have reminders of outstanding tasks for each case and a way to close out outdated recommendations.

An unanticipated barrier to implementing the common database was the difficulty of incorporating the ACCESS database into existing data collection systems without creating further data management work by case coordinators. Two of the Centers are implementing the data management changes (LA and OC), however SD and SF have complex organizational

issues that impede this process. SD's HOPE project is part of a larger agency that is in the planning stages of implementing a new data tracking system. SF currently has a complex data tracking system that they hope to streamline with the ACCESS database, but they have requested more flexibility to modify the form. While there is flexibility in the approach, there is concern that if the form is modified too much to meet individual Center needs, it may lose its function as a cross-Center evaluation tool.

III.B.4.ii The Universal Forensic Center Database

After a number of pilot tests and various iterations, a final database was implemented across Centers. The Forensic Center database is a one-stop data management system that allows Centers to manage information related to cases and daily operations (See Table 4.)

Table 4. Types of Information Managed Through the Universal Forensic Center Database

Case Management	
Client Information	Client contact information, communication needs, demographic background, physician contact information, type of insurance, physical and cognitive functional status, living setting, and known illnesses, addictions, and medications
Suspected Abuser Information	Suspected abuser name, organization, relationship to client, contact information, demographic information, caregiver role, living setting, communication needs, and known addiction or mental illnesses
Referral Source Information	Contact information for the referring individual
Abuse Information	History of present and past abuse, types of alleged abuse perpetrated, other agencies involved, reporter relation to the client, and others with knowledge of the abuse
Case Status	Tracking case progress as it is worked-up or processed for APS intervention, prosecution, or conservatorship
Case Goals	Team goals for the client and case
Case Recommendations	Team-recommended action steps, the team member responsible for taking the action, follow-up dates, and completion status
Services Provided	Medical and psychological assessments and evaluations, follow-up by law enforcement agencies, linkages with community and social services, civil legal remedies, and client and asset protection.
Case Outcomes	The final disposition of cases, including types of conservatorship awarded, prosecution of suspected abusers, institution of restraining orders, and the legal outcomes of any civil remedies sought
Miscellaneous	Additional documentation or information relevant to the client or

Other Documents	case, including capacity declarations, electronic bank statements, expert reports, correspondences, and applications for client services.
Forensic Center Management	
Correspondence Tracking	Management of communication efforts, including the reason for attempted contact, dates of attempted contact, and outcome of attempted contact. Users can filter the results to identify unfulfilled correspondence attempts
Forensic Center Roster	Roster of current and past Forensic Center team members and visitors
Agency Attendance	Tracking the attendance of Forensic Center team agencies

The universal Forensic Center database is designed to be compatible with the universal Referral Form; it allows users to import baseline client and case information from the Universal Referral Form, saving time and avoiding redundancy. Information is now consolidated in a central location, eliminating or greatly reducing the need to move between several documents. Through the use of many-to-one relationships, the database also includes data collection enhancements that allow users to link cases with information on multiple suspected abusers, Center meetings, case notes, goals, and recommendations.

The database also generates several reports that provide users with descriptive statistics on their Center's data. In the past, this type of analysis would be extremely time-consuming, requiring users to tally and tabulate the information. With the new database, reports can be generated for a user-defined time period and include statistics on client, suspected abuser, and case characteristics; case referral source and outcomes; and Center attendance. Information generated encompasses several of the most commonly requested statistics used by the California Forensic Centers to seek funding, report on activities, and demonstrate their productivity and efficacy in addressing reports of elder abuse and neglect.

We encourage any individuals who plan to adopt the Forensic Center model in the future to consider using the universal database. Broad implementation of the database will ensure that Centers are using standardized categories and definitions to collect information, allowing for increased power and strength in future cross-center data analyses. It will also permit unified reporting of Forensic Center impact to policymakers, should future support for the model be encouraged on a federal level.

Centers can use the Universal Database to generate data reports that provide basic descriptive statistics. Raw data is easily exportable into Microsoft Excel if additional analysis is needed. To increase ease of collaboration with researchers, users can also export a redacted raw data set that will exclude the client's last name, date of birth, address, and telephone number. Database features include password-protection and search capabilities that allow users to search by client, suspected abuser, and case presenter name.

III.B.5. Replicability and Variation

This section compares and contrasts the four Centers' structure including affiliation, location, personnel, and technology. The structure of a Center plays an important role in facilitating its goals and activities. Structure also influences the type of cases Centers receive and process. Each Center has a unique mission, which leads to various expressions and

interpretations of the model presented in Figure 2. Although there is variation across Centers, distilling the core components of structure is important to those interested in replicating the model.

Two of the centers, LA and OC, are affiliated with medical center campuses and two centers (SD and SF) are affiliated with aging/social services agencies. San Diego's team meetings are held at the court house where they have access to an internal data base, making team meeting highly efficient for on-the-spot sharing of critical case information. Holding meetings at this location allows the team access to background data (police reports, arrest history, pending criminal prosecution) that informs how to proceed with the case. San Diego uses WebEx to present meeting notes and other case material electronically, allowing those not physically present to fully participate in collaborative process.

Both SF and OC are advantaged by being physically located at facilities that house APS staff, creating easy access to case information. The San Francisco Center is housed in the Department of Aging and Adult Services (DAAS); the OC Center occupies a space within Orange County's APS building. These strategic co-locations allow for strong interaction, consultation, and relationship building.

LA is located in a relatively central area with easy access from a number of freeways in order to serve a large catchment area. To move beyond what might have been a geographical barrier given the County's large geographic size, conference calling is available to presenters who have difficulty getting to the meeting site and computers are available to quickly access medical and legal data important to moving cases forward.

As shown in Table 5 below, there is also variation across the Centers in the number of meetings, the time spent and the cases heard. Meetings per month ranged from 2-4, and the length of the meetings ranged from 1-2 hours. The LA Center had the most new cases per quarter (36), which it accommodated by meeting for two hours each week.

Table 5. Average Number of Meetings & Presentations at the Four Centers in California

	LA	OC	SD	SF
Meetings per month	4	4	2	3
Hours per meeting	2	1	1.5	1.5
New Cases per Mtg.	3-4	1-2	4-5	2
New Cases per Qtr.	36	22	29	9

Abbreviations: LA=Los Angeles; OC=Orange County; SD=San Diego; SF=San Francisco.

In addition to the project coordinator, core participants vary across the four Centers. LA's team meetings always include a geriatrician or gerontologist, a district attorney, a law enforcement representative, a public guardian, and a neuropsychologist. OC always has a geriatrician or gerontologist, an APS worker, an ombudsman, and a neuropsychologist. SD's core team is made up of a civil attorney, a victim advocate, a free legal aid representative, a client advocate, and most distinct, a client. Because of its structure, SF is able to accomplish its goals and activities with a smaller team with core membership from APS, law enforcement, and a gero-psychologist.

III.B.6. Best practices from California's Forensic Centers

Exploring how each Center defines and measure success is important to identifying measurable outcomes. What may be an important outcome to one Center may not be as important or pertinent to another, depending on a number of factors including the type of clients served.

A list of "good case outcomes" were generated from the Archstone quarterly reports. Centers were asked to rank order the outcomes according to what is important to the goals of their Center. Client safety and/or protection is given the highest priority ranking by all centers. The goal of Centers is to keep clients safe not only from present harm, but also from future harmful situations. Because SD works solely with clients who have the capacity to make their own decisions, client's self-agency and self-sufficiency was given a high priority. In contrast, the other three Centers serve professionals who bring case material about clients rather than having the clients directly involved. As a result, clients in these three Centers include people who have cognitive impairment. For these centers, a good outcome for some of the cases might be conservatorship rather than self-agency in order to achieve client protection for those who lack capacity. If prosecution is considered an important outcome, it is supported when there are med/psych reports and guidance from the DA to ensure that the detectives do everything possible to collect and document relevant information. Table 6 includes common outcomes, usable by a variety of Centers.

Table 6: "Good Outcomes" identified by Centers

	LA	**OC**	**SD**	**SF**
Safety/Protection	X	X	X	X
Prosecution	X	X	X	
Further investigation, Linkage to resources, Proper treatment (medical/psychiatric)	X	X	X	
Restraining order/Legal remedies			X	X
Self-sufficiency			X	
Preservation of assets				X

Abbreviations: LA=Los Angeles; OC=Orange County; SD=San Diego; SF=San Francisco.

In keeping with the core mission of multidisciplinary teams, all four Centers prioritize safety and protections for vulnerable adults. Respondents in LA, OC and SD regard prosecution as a good outcome. The fact that SF did not identify this as an outcome is most likely due to the infrequent attendance of a District Attorney at their meetings. Unlike SD where meetings are held at the court house, providing easy access to legal services, SF has had a harder time bringing legal services to the table. The ability to follow-up on cases--providing further investigation, needed resources, and proper medical and/or psychological treatment--is seen by three of centers as necessary to a good case outcome. The reason SD does not identify this as an important outcome is that their model emphasizes the direct support they give to the client to becoming self-sufficient and pro-active in seeking out services for themselves rather than being provided with these services. While only one center (SF) identified preservation of assets as a good outcome, through narrative information in quarterly reports it is apparent that other Centers

see this as an important outcome, particularly those that have a large proportion of financial abuse cases (LA and OC).

Repeated themes related to approaches to challenges included case finding, case tracking, and moving cases forward. Centers reported that their relationship with APS is important to good case finding and referral. For example, SF stated that by discussing issues of last minute case cancellations with APS, they are now more aware of the disruption this causes. SD is unique in that they must turn away victims from outside their catchment area and so they have begun to identify pro-bono attorney services for these victims. Practices to facilitate good case tracking include hiring a project assistant to track the cases, contacting the original presenter for follow-up and enter the new information into the database, and formalize the practice of having the DA report to APS about prosecution outcomes. Responsive medical and psychological evaluations were also cited as helping to move criminal and conservatorship cases forward by helping APS in appropriate care planning and helping detectives work more efficiently.

III.B.7. Funding and Sustainability

III.C. Tools

Sample tools to use when operating a Center and managing case referrals and discussions are presented as appendices. These documents include a sample Memorandum of Understanding (MOU; Appendix A), sample case discussion guidelines and rules (Appendix B), a sample what to refer to the Center (Appendix C), the Universal Case Intake template (Appendix D) and a sample letter of support for grant funding (Appendix E). Links to the Center's universal case intake database can be found at our website: www.usc.edu/projects/wilberlab.

IV. EVALUATION OF AN ELDER ABUSE FORENSIC CENTER

In addition to funding the Centers in 2006, the Archstone Foundation also later funded an evaluation component to identify and examine the structure and process of the Forensic Center Model in Los Angeles (Navarro, Wilber, Yonashiro, & Schneider, 2010). The main purpose of the cross-Center evaluation was to improve the quality of life of older adults by advancing understanding of a program designed to address elder abuse: the Elder Abuse Forensic Center model.

Evaluating four Centers located in geographically distant and diverse parts of California required a mixed methodological approach using qualitative and quantitative analyses of information gather from a variety of sources. Evaluation materials included quarterly reports, information from biannual convening, conference calls, interviews with APS workers and other team members, Center visits, and survey data.

IV.A. Adapted Team Effectiveness Inventory

To gain a better understanding of which team members contribute which specific elements to the investigative process, as well as how team members viewed strengths and areas that need work, the team effectiveness inventory was adapted for forensic centers by Navarro

and colleagues (2010). The Team Effectiveness Survey (Appendix A) was used to study the interactions between team members and the resulting level of effectiveness. The 24-item survey assesses the team members' sense of mission, goal achievement, empowerment, communication, adoption of positive roles and norms, and overall effectiveness. In addition to the standard questions, Forensic Center members were asked to consider how their participation in the Center affects their everyday professional practice.

There are seven aspects of team effectiveness: Team Mission, Goal Achievement, Empowerment, Open Honest Communication, Positive Roles and Norms, Environment, and Overall Effectiveness & Added-Value. These areas were assessed on a 4-point Likert scale, ranging from 1, strongly disagree to 4, strongly agree. The survey was briefly introduced by a member of the evaluation team during a Center visit and administered by the Center coordinators to all team members present at the meeting. Most participants needed 5-10 minutes to complete the paper inventory.

In addition to the written Inventory, team members were also asked to consider how their participation on the team affects their work outside of meetings. On the back of their Inventory, members wrote responses to the open-ended question: "How has your involvement with the Forensic Center changed the way you practice?"

IV.B. Evaluation by Forensic Center Members

Information from two convening meetings provided an opportunity to identify challenges, discuss possible solutions and promising practices, and work on areas of interest to all four Centers. In addition, the second convening included members of each Center's core team, which encouraged a representative voice from a variety of professionals and disciplines. For this convening, the evaluation group assigned participants to specific groups according to professional affiliation and/or discipline.

During breakout sessions each group was given 5 open-ended questions: (1) What is it you would like the rest of us to know about what you do and how you work?; (2) What are the two most significant barriers your discipline faces as you do your work?; (3) Which of these barriers does the Forensic Center help you overcome?; (4) What does the Forensic Center help you do that you can't do on our own?; and (5) Thinking about the Forensic Center model, what works well for your discipline? Responses were shared with the larger group following the breakout sessions and were documented by the evaluation team.

IV.C. Case Tracking & Outcomes

Although there are a number of ways to measure "successful" elder abuse case outcomes, the USC evaluation team focused on three positive outcomes suggested by Center participants: prosecution, conservatorship, and recurrence. Outcomes of interest for prosecution of elder abuse offenders were: 1) whether the case was submitted to the DA's office for review; 2) whether criminal charges were filed; and 3) whether guilt was established by plea or conviction. Sentencing outcomes were collected for cases in which the perpetrator was found guilty,

measured as years of probation and/or confinement in jail or prison. Finally, two case resolution times were calculated: 1) among those cases that the DA filed for prosecution, the number of days from the time the case was opened with APS to the DA filing charges; and 2) among those with successful prosecution outcomes, the number of days from the DA filing to a successful prosecution.

Two outcomes were examined for conservatorship: 1) whether APS cases were referred to the Office of the Public Guardian (PG), and 2) whether referrals resulted in conservatorship. For conservatorship, those who were referred but died before an outcome could be determined were excluded. This was not the case for prosecution, as the case could proceed even if the victim was deceased.

Prosecution and conservatorship responses to cases of elder abuse vary considerably based on the type of abuse. Some types of abuse (e.g., psychological aggression) are not typically amenable to these outcomes, whereas other types (e.g., financial abuse) often require the pursuit of one or both of these remedies. Because the vast majority of cases in the study sample (over 80%) involved financial abuse, either alone or in conjunction with another type of abuse, we reported prosecution and conservatorship results for just these cases (n=475). This allowed for a more straightforward presentation and interpretation of the results, as it creates a level bar against which to compare the outcomes for these cases.

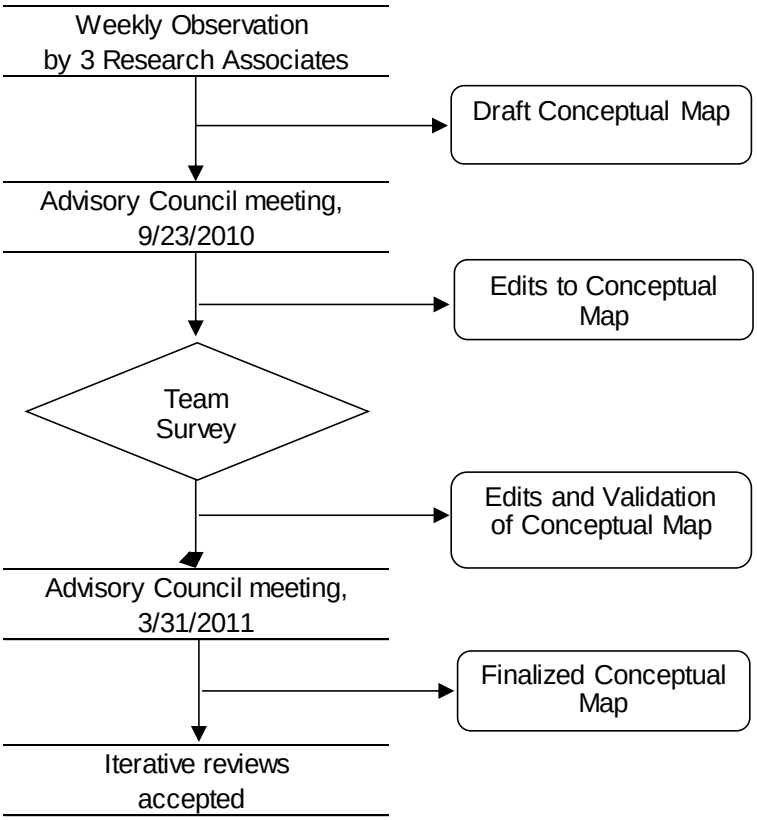
Recurrence of cases in the APS system was analyzed using cases involving all types of abuse. The sample used for these analyses was limited chronologically, however, to just those cases that had data on prior cases occurring within a one-year prior to the referral of the baseline case and at least one year of follow-up data (n = 356). We first identified which cases had been referred to APS on one or more occasions during the year immediately prior to the baseline referral and during the year immediately following the baseline case's closure. This information was used to compare rates of recurrence for both Center and usual care cases, both before and after baseline.

IV.D. Case Processing Analysis

To prepare for the Cost Study, a decision tree was developed to serve as a framework for understanding the forensic processing of cases. This work identifies key processes and distinguishes the Center from other MDTs. Decision trees, sometime referred to as conceptual maps are powerful knowledge representation tools, useful to inform practice, policy, and further research (Novak, 2004).

To map the processes, an iterative approach was used (see Figure 7), in which the evaluation team first mapped decision making during the meeting based on observation. Three investigators independently collected data by observing four meetings each, taking notes on the Center activities. For the next step, they integrated their findings using a strategy called pattern matching to form a draft of the conceptual map of the Center processes. The proposed concept map was then presented to an Advisory Council comprised of experts from a number of different professional disciplines. The Advisory Council provided feedback on the strengths of the proposed model and identified other activities which were not already articulated in the draft model.

Figure 7: Developing a conceptual map



To further refine and validate the conceptual map, core team members were asked to respond to three hypothetical financial exploitation cases. Administration of the survey took place during a routinely scheduled Center meeting, with 14 of 16 (88%) core team members completing the survey. Respondents were asked to identify professionals required to collaborate on each of the hypothetical case examinations and to provide specific case recommendations (see Appendix G: Los Angeles County Elder Abuse Forensic Center Survey – December 2010).

The three hypothetical case vignettes were constructed to collect varied forensic approaches by representing different types of elder financial abuse; in which victims' ages, types of abuse, and living situations were varied. For each scenario, respondents were asked which disciplines should be in attendance to review the case and what actions needed to be implemented.

Of the 16 core team members approached for survey, ten members completed the survey during the meeting, two requested more time due to their schedules on the day of administration, and two were contacted after the meeting and subsequently emailed the survey. Two members, despite follow up email reminders, did not complete the survey; however, because other representatives from their agency did complete the survey, all core roles were represented.

Respondents had a mean of 10.8 years of elder abuse experience. They held diverse professional positions; two respondents identified as physicians, three as attorneys (one criminal, two civil), and one as a doctor of neuropsychology. Together respondents represented the fields of health, mental health, social services, gerontology, victim advocacy, law enforcement, civil and criminal law, and guardianship. Several had been participating with the Center since it

began in 2006 (mean participation 3.7 years), and the average frequency of attendance was between two and three meetings per month (mean meeting per month 2.6).

Respondents provided a comprehensive list of disciplines needed for each hypothetical case; in most cases indicating their own discipline was needed to hear the case (see Table 11). Disciplines that did not mention their own role were the Center's program manager and the Victim Advocate. The representative from the Office of the Public Guardian was selective regarding his involvement, as Case B might have Regional Center involvement and Case C was an inpatient at a skilled nursing facility; both areas where they have a boundary regarding their role. Because the following participants do not participate as core team members—Ombudsman, Regional Center, and Coroner—they were not surveyed, which may have decreased their specific representation in the results.

Based on these responses the conceptual map was modified to reflect survey recommendations and taken back to the Advisory Council for additional feedback. Once again, the Advisory Council provided critical feedback which was integrated in the refined final model. The resulting conceptual map (Figure 4) can be used to describe the decision process during case review.

Table 11. Requested Disciplines for Three Vignettes

Vignettes:	A	B	C
		n (%)	
Disciplines:			
Law Enforcement	13 (93)	14 (100)	12 (86)
Adult Protective Services	13 (93)	13 (93)	11 (79)
Neuropsychologist	12 (86)	12 (86)	13 (93)
Physician	11 (79)	4 (29)	10 (71)
Prosecuting Attorney	11 (79)	11 (79)	14 (100)
Public Guardian	10 (71)	7 (50)	7 (50)
Civil Attorney	6 (43)	5 (36)	8 (57)
GENESIS/mental health	2 (14)	5 (36)	0
Ombudsman	0	0	4 (29)
Regional Center	0	11 (79)	0
Coroner	0	0	0

The steps designed to create this tool can be especially helpful for other Centers to identify how they process cases. In addition, as growing evidence supports the achievement of positive outcomes in Los Angeles County, this conceptual map provides a model of the decisional process of an effective MDT, as they respond to cases of financial abuse. Having a conceptual mapping of the Center decisions also provides the foundation for future research to analyze the costs associated with specific decisions and outcomes, helping to understand and to refine this promising intervention.

IV.E. Comparison of Propensity-Score Matched Samples

Propensity score matching has been used in health and social science research to estimate the probability that each individual in a broad comparison sample would be in the targeted

intervention group, all other things being equal (Braitman & Rosenbaum, 2002; D'Agostino, 1998). This approach was chosen to evaluate differences in case outcomes and cost effectiveness between the Forensic Center intervention and the "usual care" APS model in lieu of conducting a randomized controlled trial (RCT). A RCT would have required randomly selecting elder abuse referrals in LA to either receive the Forensic Center intervention or continue through the usual care APS process. Legal and ethical concerns were raised by some members of the Center team, who argued that an RCT would not be appropriate because it necessitated withholding Center services from the control group. Therefore, a decision was made and approved by all parties to use a propensity score matching approach.

The classic propensity score (P score) is defined as a predicted probability, computed from an estimated logistic regression model (Guo & Fraser, 2010; Rosenbaum & Ruben, 1985). This method uses a "nearest neighbor" algorithm to match each case to case within recommended calipers, using 25% of the standard deviation, so every "intervention" case has one matched "comparison" case to create the full sample (Braitman & Rosenbaum, 2002; Guo & Fraser, 2010).

The specific approach used to implement the propensity match was based on guidance and a macro published by Lori Parsons (2004) for using SAS to generate propensity scores and match cases. This approach includes the use of backward variable selection in the calculation of propensity scores, which removes variables from the model that are not statistically significant. The Parsons macro has been used broadly, particularly in health research (e.g., Fonarow, Albert, Curtis, et al., 2012; Kim, Kim, Park, & Kawachi, 2008; Vohr, Stephens, Higgins, et al., 2012).

Our evaluation started with the 32 variables available in the dataset, which represented seven conceptual domains (age, gender, race/ethnicity, number of abuse types, individual abuse types, abuse type interactions, APS office); after the backward variable selection, 27 variables remained, representing six of the original conceptual domains (all but gender). Our construction of the model was an iterative process, during which we decided to exclude five additional conceptual domains due to methodological and data limitations: living status (alone vs. with others), marital status, referral source (who reported the case to APS), when the abuse occurred (quarter in which referral was made), and location (zip code). Of these, living status and marital status were difficult to include due to an abundance of missing data. Zip code was too granular a geographic region to be informative in the propensity matching process. Because APS has 16 different offices to accommodate Los Angeles' large geographic size, APS office was used as an acceptable and more informative alternative.

Given the relatively short period of reports included in this study, we did not include a temporal variable. Replication efforts that use data from a longer period of time may benefit from adding such a variable to their analysis structure. Furthermore, given the number and diversity of referral sources, we decided that it was best treated as a predictor variable in the regression models on our outcome variables rather than a variable in the propensity model. An analysis of the region of common support broadly supported the resultant propensity scores (Thoemmes & Kim, 2011). Although the scores for the usual care group skewed lower, the vastly larger nature of the usual care sample meant that there were still an adequate number of data points with higher propensity scores to support the common support region.

The sample for the analysis was constructed using administrative data, which was compiled from various sources: the Los Angeles County Elder Abuse Forensic Center; the Los Angeles County Community and Senior Services department, Adult Protective Services division; and the Los Angeles County Office of the Public Guardian. Inclusion criteria consisted of

individuals referred between April 1, 2007 and December 31, 2009 who were aged 65 and over. The core intervention sample was drawn from those older adults whose cases were heard at the Center during the study period, a total of 316 possible intervention cases.

Of the 316 cases, 287 met all study criteria for the propensity score matching, including having received service from APS. A small number of intervention cases brought to the Center by law enforcement or other team members were not cases served by APS, so they were excluded from the sample (*n*=29). Cases included in the study could have been referred to the Center by APS or another team member (e.g., law enforcement), as long as there was APS involvement in the case at some point, either before presentation at the Center or following the case's presentation at the Center.

The comparison group consisted of older adults, aged 65 and older, who were referred to the Los Angeles County APS program for suspected elder abuse, neglect and/or financial exploitation. Types of referrals include physical abuse, sexual assault, financial exploitation, isolation, neglect, and self-neglect. It was not uncommon for referrals to have more than one type of abuse indicated. Referrals were received through the APS centralized intake unit (commonly referred to as the Elder Abuse Hotline) from various sources. Referral sources included: hospitals, other health and social service providers, public and private programs, law enforcement, financial institutions, relatives, friends and neighbors, self-referrals and unknown sources. Inclusion criteria for comparison group cases consisted of individuals aged 65 and over, with an APS referral between April 16, 2007 (the earliest date for which data were available) and December 31, 2009.

Prior to matching, all cases ever heard at the Forensic Center (March 2006 through December 2010) were removed from the sample of potential APS comparison group cases. Matching variables were selected from available APS administrative electronic data. The APS data, extracted from an Oracle database, provided the following measures for matching:

- Age (continuous and coded categorically)
- Gender
- Reported as a racial/ethnic minority
- APS Office (geographic categories)
- APS service dates
- Type(s) of abuse (discrete, multiple types)
- Referral sources (who reported the case to APS)

Although the use of propensity score matching attempts to create a comparable group by determining which subjects have the highest probability of being in the treatment group, some unmeasured differences may occur. One area that is not measured per se is overall case complexity. It is likely that the most complex cases are the most likely to be referred to the Forensic Center. Cases are also more likely to be referred to the Forensic Center based on the assumption that referral is likely to lead to the desired outcome. For example, *ceteris paribus*, an APS worker will refer a case in which prosecution is sought because she recognizes that the Forensic Center resources will be more likely to support the outcome than if she were to refer the case through her supervisor to the DA. Face-to-face contact simplifies the referral process, with referrals made immediately during the meeting instead of having to go through the standard system of administrative checks before the referral can be sent to the DA. Moreover, observations of team meetings suggest that the Forensic Center team appears willing to

recommend moving ahead with cases for prosecution and conservatorship that they might not consider when a paper referral is presented.

Data were initially cleaned and coded by APS prior to being delivered to the research team. Cases were recoded with an observation number assigned by APS allowing them to link each case to additional records with which to track outcomes and provide redacted files.

Prosecution outcomes were collected from the Los Angeles County District Attorney's Office and linked to the existing dataset. Conservatorship referrals and outcomes (client and asset protection) were obtained from the Los Angeles County Office of the Public Guardian. Under the study design, systematic processes were established for the Center's project manager to provide the link to Center team members for specific outcomes.

V. CONCLUSION

This document describes the Elder Abuse Forensic Center model and outlines approaches used to evaluate the Centers in Los Angeles, Orange County, San Diego, and San Francisco. The implementation of these evaluation approaches has resulted in the careful study of the FC model and its protocols, procedures, and outcomes.

Our findings indicate that this intervention can be successfully implemented and adapted to meet the needs of different types of communities and their unique service delivery system. Amidst a field that encompasses several different professional perspectives and approaches to investigating, halting, and resolving cases of abuse, the Center builds crucial personal and professional relationships through inter-disciplinary communication and camaraderie while also expanding the professional perspectives and expertise of team members and allowing them to better develop a "forensic eye" for their work (Navarro, Wilber, Yonashiro, & Homeier, 2010; Wiglesworth, Mosqueda, Burnight, Younglove, & Jeske, 2006).

The Forensic Center model has also demonstrated effectiveness in achieving its programmatic mission to be a working group assisting in the investigation, cessation, and resolution of elder abuse cases. As such, team members assess clients and situations and provide the necessary evidence to identify and implement an appropriate course of action. Compared to usual-care APS cases, cases presented at the Center had ten times greater odds of being submitted to the District Attorney's office for review (Navarro, Gassoumis, & Wilber, 2013). Although odds of case filing and successful plea or conviction were statistically similar between Forensic Center and usual care cases, the higher rate of referral resulted in a greater number of cases actually obtaining positive outcomes. Moreover, the similarity supports the appropriateness of these cases for prosecution, confirming that the use of this tool is not used too liberally within the Forensic Center context.

Recognizing conservatorship as a critical tool that is sometimes necessary for protecting incapacitated and vulnerable elders, the Forensic Center referred appropriate cases to the Public Guardian's office for investigation at much higher rates than Adult Protective Services workers providing usual care (30.6%, n=72 vs. 5.9%, n=14,$p<0.001$; Gassoumis, Navarro, & Wilber, 2014). Actual rates of conservatorship were not statistically different among the Forensic Center and usual care cases, suggesting that the Center accurately, effectively, and conservatively refers cases to the Public Guardian's office but selects only those truly in need of protection through conservatorship.

The sum effect of the enhanced degree of service provided to Forensic Center cases was a reduction in the rate at which the cases re-entered the APS system. Recurrence was significantly reduced for Center cases, to a degree that was not seen in the usual care APS cases. This aspect of Forensic Center functioning has important implications for not just the quality of life of the elder but also for a reduction in system-wide costs.

These findings demonstrate the effectiveness of the Forensic Center model and strongly support its implementation as an evidence-based elder abuse intervention. The replication and use of such interventions has been called for by the National Research Council in its landmark report on elder abuse (Bonnie & Wallace, 2003). The use of such evidence-based practices is becoming increasingly important as organizations and funders seek to obtain efficient and dependable outcomes through their investments.

Yet perhaps the greatest support for the implementation of the Forensic Center model lies in federal legislation under the Elder Justice Act to establish Elder Abuse Forensic Centers (Elder Justice Act, 2010). Although there are currently no appropriations to fund the Center formation or activities, this crucial conduit allows for the distribution of funds should they ever become available.

As the Baby Boomers enter old age, the number of mistreated and vulnerable individuals will undoubtedly grow, requiring communities to find effective and efficient interventions for investigating, halting, and resolving cases of abuse. The Forensic Center model has been shown to meet these purposes in the diverse communities and settings in which it has been implemented. We hope that this toolkit will provide a degree of guidance to anyone attempting to replicate and evaluate this important model, in an attempt to improve the services provided to victims of elder abuse and neglect in communities across the country.

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VII. APPENDICES

Appendix A. Los Angeles County Elder Abuse Forensic Center Memorandum of Understanding/Agreement

Los Angeles County Elder Abuse Forensic Center

MEMORANDUM OF AGREEMENT

A. PURPOSE / SCOPE OF SERVICE:

The Los Angeles County Elder Abuse Forensic Center is a multidisciplinary team of professionals that protects vulnerable elders and dependent adults from abuse and neglect. The Core Team members, who work collaboratively to fulfill this mission, are as follows: University of Southern California Keck School of Medicine, Los Angeles County District Attorney's Office, Los Angeles City Attorney's Office, Los Angeles County Adult Protective Services, Los Angeles Sheriff's Department, Los Angeles Police Department, Victim-Witness Assistance Program, GENESIS (Department of Mental Health), Los Angeles County Office of the Public Guardian and a Forensic Neuropsychologist. The Core Team's efforts are reinforced by other authorized advocacy organizations and service providers, as needed. Additional members provide consultation on a case by case basis and include: Los Angeles County Department of Coroner, Frank Lanterman Regional Center, Wise Senior Services Long-Term Care Ombudsman, Bet Tzedek Legal Services, and District Attorney Real Estate Fraud Division.

The Core Team works to enhance the effectiveness of the investigation and prosecution of all types of elder abuse cases. This collaborative effort strengthens each agency's individual efforts to protect elder and dependent adult victims from further abuse. The Team is working to educate those professionals who regularly work with elders and dependent adults, as well as the community at large, about elder abuse crimes and the best methods of intervention. In addition, a rigorous research protocol has been established to evaluate the effectiveness of the forensic center and to identify specific outcomes of victims of abuse.

B. CONFIDENTIALITY:

The Los Angeles County Elder Abuse Forensic Center Team agrees to comply with State and Federal Law to maintain confidentiality of all records discussed or maintained as cases are brought to the center and tasks are accomplished for these cases.

C. SERVICE AREAS:

The Los Angeles County Elder Abuse Forensic Center will provide services on accepted cases that are referred by participating agencies and have either a current Adult Protective Services (APS) report or Long-Term Care Ombudsman report. Cases will be accepted throughout the entirety of Los Angeles County.

D. SERVICES:

Each Core Team Agency / Member agrees to:

1. Commit a staff member to attend the Forensic Center each week for four hours. During this time, the team member will attend the Forensic Center weekly meeting, consult on elder and dependent adult abuse cases, and, when necessary, investigate and document a current case.
2. Work on the Forensic Center cases, with other authorized participating agencies and related agencies, with a goal of eliminating the abuse or neglect and improving the safety of the elder or dependent adult involved.
3. Communicate with other authorized personnel within our professional field as needed regarding cases that are brought to the forensic center in an effort to resolve the case.
4. Provide a professional opinion and advice on how to proceed with the cases presented.
5. Provide assessment or investigation on a presented case of elder or dependent adult abuse, when required.
6. Provide an alternate member when the regular team member is unable to attend the weekly meeting. The attendance of all team members is essential to allow the forensic center to be as effective and useful as possible.
7. Maintain the confidentiality of all clients whose cases are presented and discussed at the center. Materials related to the cases will be maintained in the Center.
8. To the extent possible, assist in educating the public and other stakeholders about the issues of elder and dependent adult abuse, as well as inform the community about the work of the Los Angeles County Elder Abuse Forensic Center.
9. Be a willing partner with the research team at the Forensic Center. This may include completing surveys and/or answering questions.
10. Interact with team members and presenting guests at the forensic center in a respectful and professional manner.
11. Agree to follow individual parent agency's Code of Ethics.
12. The term of this agreement shall be effective immediately when both parties sign and continue for an indefinite period of time. This agreement may be amended by mutual written consent of both parties.
13. This agreement may be terminated at any time, without cost to either party, upon giving at least 30 days prior written notice to the other party.

Each agency also understands that their individual team member's participation on the forensic center team is as a representative of our agency/organization. In the event that he/she ceases to be associated with the agency/organization, the agency will designate another representative, with similar expertise, to serve as a core team member.

The Los Angeles County Elder Abuse Forensic Center agrees to provide the following:

1. A workstation for each core team agency, so that he/she may be able to perform duties for many of the cases he/she may be working on.
2. A conference space for all forensic center meetings.
3. An exam/interview room for the purposes of investigating cases of elder abuse and neglect.
4. A secretary and project manager who will work full time at the center to provide support on Forensic Center cases.

_____ _____

Print Name of Core Team Member Signature of Core Team Member

_____ _____

Title Date

_____ _____

Agency Telephone Number

_____ _____

Mailing Address E-mail

_____

Fax

_____ _____

Print Name of Official of Agency Signature of Official of Agency

_____ _____

Telephone Number Date

Los Angeles County Elder Abuse Forensic Center

_____ _____

Center Director Date

Title

Appendix B. Los Angeles Elder Abuse Forensic Center Presentation Guidelines

Los Angeles Elder Abuse Forensic Center Presentation Guidelines

It is clear that the number of cases that may require our multidisciplinary assessment necessitates some planning and forethought prior to a presentation. However with that being said, the Forensic Center aims to create an inviting atmosphere for you to receive assistance with your case.

1. For each case the Center would request that the referring party fill out the standardized referral form and email to the Project Coordinator. If you are an APS Social worker, please email it, instead, to your APS Supervisor by Tuesday (at the latest) prior to the Thursday.
2. As each case is presented, participating core team members and referring partners will be seated at the conference table and throughout the room.
3. Presenters are not required to make a formal presentation to the group such as a Stand and Deliver or PowerPoint; this is a round table discussion.
4. New guests and presenters must sign a confidentiality agreement.
5. New guests should please leave their full contact information for our records on the sign in sheet or provide the Special Project Manager with your business card.
6. Guests are invited to observe one Forensic Center meeting. Repeat visits are not encouraged unless that person is from a Core Team agency or is invited to become a Core Team or ad hoc member. Another exception for guests to attend more than once is by presenting a case. However guests cannot be primary presenters (though they can participate) and they must have an open APS or law enforcement case. The Forensic Center requests APS or law enforcement to be the primary presenter.
7. Presenters are invited to give their presentation via conference call. The Special Project Manager will call you when it is your time to present, which will be arranged prior to the meeting. Please allow 15 minutes of extra time if another case or discussion runs longer than anticipated.
8. For cases that require a neurological evaluation, please try to obtain any medical records prior to coming to the Forensic Center (though not required to present). This will help expedite scheduling.

Case Presentation: Primary presenter will take the lead:

- Case name (first name only*) and brief demographics
- What are the allegations of abuse? And what do you need from the Forensic Center?
- Case chronology of incidents and then any team partners will share their relationship to case.
- Please return all presentation materials including any evidence and referral forms. The agenda and minutes are your copy.
- Presenters and relevant team members will need to provide an update of the case within a reasonable time frame (about 4 weeks). Updates will be noted on future agendas. The Project Manager will notify the primary presenter one week prior to the scheduled update.

Relevant questions that may be asked during your presentation (not including those on referral form):

1. Current support system, if any:
2. What interventions have been tried, and with what results?
3. What specific questions or requests do you have for the Forensic Center?
4. How did suspected abuser meet the client and when?
5. What agencies are involved and how?

** Please try to refrain from using last names in your presentations. Our project is being evaluated by USC and we must follow University Institutional Board Review procedures for confidentiality.*

Appendix C. Procedures to Fill Out a Forensic Center Referral Form

How to fill out a Forensic Center referral form

Thank you for referring a case to the Forensic Center. This document will guide you through the process of filling out a referral form by defining terminology and explaining each section. While case presentations are confidential, detailed information may be needed to assist the participating professionals in their roles. Confidentiality agreements are signed by meeting participants and all case documentation that is not directly needed by a professional assisting on the case is shredded.

Section 1 – Consultation Information (Members Requested)

For this section think about which professionals can assist you with your case. While most team members attend every meeting, is helpful to know in advance if they are going to be specifically asked to provide consultation.

- For example: Do you need a medical record review? If so, request the presence of a medical practitioner.

Section 2 – Referring Agency Information

This allows the FC team members to easily stay in-touch as the case progress.

- Be sure to fill in phone and email information.
- It is easy to miss the request for "Referring Case Number." Please provide the case number that your agency uses to identify this case

Section 3 – Client Information

This section provides demographic and medical information. Please be as complete and accurate as possible.

Physical and Cognitive Status - The descriptions for physical and cognitive impairments, along with degrees of severity ("mild," "moderate," "severe," and "fluctuates"), will assist you with completing this section of the form in an accurate manner. Below are definitions and examples to illustrate the definitions.

- **Cognitive Impairments -**affect your ability to think, work, and make critical decisions.
- **Physical Impairments -**are the partial or complete functional loss of a body part, organ, or system.

Intact - Functioning or communicating without deficiencies

- Examples of "Intact Physical Function"
  - *Mobility* – Ambulatory without needing assistance (including equipment or holding on to things)
  - *Toileting* – Able to get to bathroom in time; rarely has accidents.
  - *Dressing* – Able to dress self in reasonable amount of time.

- Examples of "Intact Cognitive Function"
  - *Memory* – Able to recall recent events.
  - *Judgment* – Able to understand, deliberate, make decisions based on stable (i.e. long-
  - standing) values and goals.
  - *Communication* – Understands completely and is able to make self understood.

Mildly Impaired - Interferes with normal activities but only minimally

- Examples of "Mild Physical Impairments"
  - *Mobility* – Ambulates with cane or might be slightly unsteady, but rarely falls
  - *Toileting* – Uses toilet but needs help in getting to the bathroom on time or getting clean, for example
  - *Dressing* – Able to dress self but is slow

- Examples of “Mild Cognitive Impairments”
    - *Memory* – Able to recall some recent events, but not all.
    - *Judgment* – Has limited understanding and reasoning abilities, but knows what’s important to them.
    - *Communication* – Has some difficulty understanding comprehending what you say or ask. Word finding difficulties when speaking.

Moderately Impaired - Activities such as eating and ambulation are done, but with significant difficulty.

- Example of “Moderate Physical Impairments”
    - *Mobility* – Ambulates with walker or has an unsteady gait; may have frequent falls
    - *Toileting* – Needs assistance to use to toilet.
    - *Dressing* – Needs assistance with putting on some clothes, such as socks or pants.

- Examples of “Moderate Cognitive Impairments”
    - *Memory* – Poor/little recall of recent events.
    - *Judgment* – Very limited ability to understand and reason.; gets confused when asked to explain rationale for decisions.
    - *Communication* – Very limited comprehension; able to express basic thoughts, needs, decisions.

Severely Impaired - Extreme difficulty (or unable) with performing activities.

- Example of “Severe Physical Impairments”
    - *Mobility* – Uses a wheelchair. Can’t get out of bed or chair without assistance.
    - *Toileting* – Diapers or dependent on others.
    - *Dressing* – Needs assistance with all dressing.

- Examples of “Severe Cognitive Impairments”
    - *Memory* – Unable to recall recent or remote events.
    - *Judgment* – Cannot reason or comprehend.
    - *Communication* – Cannot comprehend. Unable to express themselves.

Fluctuate – variable status.

- Example of “Fluctuating Physical Impairments”
    - Ability to do activities such as walking, getting in/out of bed, getting dressed is variable. At times they may be able, at other times they may require assistance or the amount of assistance they require varies dramatically at different times.
- Examples of “Fluctuating Cognitive Impairments”
    - Seems to have good memory or judgment at one moment and then seems impaired at other times. The degree of impairment is inconsistent, getting better and worse at different times.

Section 4 – Alleged Abuser Information

Let the team know as much about the abuser as possible. Demographic information will be useful in the development of this case, and will help your center collect data that can be used in research projects with the potential to advance the field of elder abuse by helping to answer such questions as, “Who are abusers?”, and “Who gets abused?”

- See if you can find out information about the suspected abuser’s mental health status and possible addictions.

Section 5 – Abuse Information

In this section, you are asked to select the type(s) of abuse that your client is experiencing and to explain the situation in the narrative.

- **Written Narrative** - This is your opportunity to explain the situation clearly to the team.
    - Provide a concise statement of
        - What you need or want from the FC team.
        - Names, relationships, and roles of all key players involved in the current situation

    - Please consider the following questions. If they are relevant to your case you may choose to either include this information in your written narrative **or** come prepared to speak to these points during your oral presentation.
        - What is the nature of the current presenting problem? What have you seen or learned in your home visit or encounter with the victim? (i.e., bruising, bank statements, discussions with suspected abuser, etc.)
        - What is your client's social history? Are there notable support systems in place? (If there is any family, explain their involvement.)
        - What is the client's financial background? (i.e., income and assets.)
        - When did the abuse begin? How long has it been occurring?
        - What has already been done; what are your goals and obstacles?
        - Are there any safety concerns?

- **Types of Abuse** - Check the box next to all types of abuse that apply to this case. For further explanation see the elder abuse definitions listed below.

What is abuse?

Elder abuse is any form of mistreatment that results in harm, or the threat of harm, to the health and/or welfare of an elder. It is generally divided into the following categories:

Abandonment

Abandonment is the desertion or willful forsaking of an elder or a dependent adult by anyone having the care or custody of that person under circumstances in which a reasonable person would continue to provide care and custody.

Abduction

Abduction is the removal from California of any elder or dependent adult who does not have the capacity to consent to such removal, or the removal of a conservatee without the consent of the conservator or the court.

Emotional

Emotional abuse is the infliction of psychological distress through verbal or nonverbal acts, such as threatening, intimidating, humiliating, harassing, or isolating an elder or dependent adult.

Financial – Other

Financial abuse is the illegal or improper use of an elder's or dependent adult's money, property, or assets. Examples include cashing a person's checks without permission, forging a signature, misusing or stealing money or possessions, coercing or deceiving a person into signing any document (e.g., contracts or will), and the improper use of legal documents.

Financial – Real Estate

Abuse as described above in relation to real estate transactions, mortgages, liens, etc.

Isolation

Isolation violates the personal rights of an elder or dependent adult, and can take the form of false imprisonment, restraint, preventing delivery of mail, intercepting telephone calls, and/or restricting visits from family, friends, and service providers.

Sexual

Sexual abuse is any non-consensual sexual contact of any kind, including sexual contact with any person incapable of giving consent.

Self-neglect

Self-neglect is present when an elder or dependent adult is unable or unwilling to provide for his or her own health or safety. This generally manifests as a refusal or failure to provide self with adequate food, water, clothing, shelter, personal hygiene, medication, or appropriate safety precautions.

Neglect by Others

Neglect is the refusal or failure to fulfill any part of a person's obligations or duties to an elder or dependent adult by not providing life necessities such as food, water, clothing, shelter, personal hygiene, medicine, comfort, or personal safety. Neglect is also the failure of a person who has responsibility to provide care (e.g., pay for necessary home care services) or the failure of an in-home service provider to provide necessary care.

Physical – Assault/Battery

Physical abuse Includes physical force that may result in bodily injury or physical pain. It includes acts such as striking, hitting, beating, pushing, shoving, shaking, slapping, kicking, pinching, and burning. As well as, inappropriate use of drugs and physical restraints, force-feeding, and physical punishment are also examples.

Physical – Chemical Restraint

Chemical restraint is the inappropriate use of drugs or withholding of drugs to exercise control or influence over another person, or to otherwise inflict harm; including the inappropriate use of drugs to sedate someone.

Physical – Constraint or Deprivation

Constraint or deprivation is the result of physically restraining someone against their will and or best interest, by the improper use of constraints, or prolonged or continual deprivation of food or water.

Undue Influence

Undue influence deprives a person of freedom of choice or substitutes another's choice or desire for the person's own.

Other

Report suspected abuse that is not described above in this section with a description of your observations.

For further information and California legal definitions of abuse see the following resources

California Welfare and Institutions Code 15610

Undue Influence

Steve Riess - resource for legislative updates regarding elder abuse

Appendix D. A Sample of the Universal Case Intake Template

Office Use Only ☐ Urgent ☒ Routine Date: 1-1-13 Case Number: 0000

LOS ANGELES COUNTY ELDER ABUSE FORENSIC CENTER REFERRAL

Section 1 – Consultation Information (Members Requested)

☒ Adult Protective Services	☒ GENESIS	☒ D.A.	☐ Regional Center
☐ Coroner/ME	☒ Law Enforcement	☒ Attorney Other	☒ Psychologist
☒ Medical Practitioner	☒ Ombudsman	☐ Public Guardian	☐ Other (describe):

Section 2 – Referring Agency Information Referring Case Number300000

First Name	Last Name	FC Team Member	E-mail
Sally	Social-Worker	APS other: Anonymous	ssocialworker@government.gov

Office Phone	Office Fax	Mobile Phone	Supervisor Name
213.000.0000	213.000.0000	213.000.0000	Susan Supervisor

Section 3 – Client Information

First Name	Last Name	Age	DOB	Language	Translation/Communication Needs
John	Doe	80	1-1-1900	English	

Level of Education	Ethnicity	Gender	Marital Status
High school graduate	Caucasian, non-Hispanic	Male	Widowed

Address	City	Zip Code	Telephone
New Home SNF, 1111 Anonymous Street	Los Angeles	90007	213.000.0000

Physician Name	Physician Telephone	Insurance	Medications and Dosage
Dr. Jones	310.000.0000	Kaiser	Namenda 10 mg Atenolol 5 mg bid

Illnesses and Addictions
Alzheimer's dementia & hypertension

Physical Functional Status: Appears...	Cognitive Status: Appears...
Moderately Impaired	Severely Impaired

Living Setting	Lives With
Skilled Nursing Facility	Alone

Previous Reports of Abuse
☐ No ☒ Yes **Yes, explain**Allegations that another resident assaulted him

Section 4 – Alleged Abuser Information

First Name	Last Name	Organization	Age/Decade of Life	DOB
Mary	Smith	Visiting Nurses	40s	

Ethnicity	Gender	Language	Translation/Communication Needs
Caucasian, non-Hispanic	Female	English	None

Relationship to Client	Primary Caregiver?	Lives with Client	Mental Illness
Non-family but well-known to client	☒ Y ☐ N	☐ Y ☒ N	Unknown if yes:

Addiction - Alcohol	Addiction – Illicit Drugs	Addiction – Prescription	Addiction -Other
☐ Y ☐ N ☒ Unknown	☐ Y ☐ N ☒ Unknown	☐ Y ☐ N ☒ Unknown	

Address	City	Zip Code	Telephone
2222 Los Angeles Street	Los Angeles	90000	213.000.0000

Section 5 – Abuse Information

Other Agencies Involved	Reporting Party	Others with knowledge of abuse
LAPD, Ombudsman & Bet Tzedek	Family/Friend	New Home SNF staff

Types of Abuse (Check all that apply)

☐ Abandonment	☒ Financial – Other	☐ Self-Neglect	☐ Physical – Constraint or Deprivation
☐ Abduction	Est. loss $	☐ Neglect by Others	☒ Physical – Medication
☒ Emotional	☐ Isolation	☒ Physical – Assault/Battery	☒ Undue Influence
☐ Financial – Real Estate	☐ Sexual	☒ Physical – Chemical Restraint	☐ Other

Narrative (attach additional pages if necessary) – Chronological order with dates appreciated

The client is a 80-year old male with advanced Alzheimer's dementia living in a Skilled Nursing Facility. The SA is a contracted LVN from the Visiting Nurses contract nursing company. The SA intimidates the client and attempts to isolate him from his family, telling his children that they should avoid visiting because it causes him distress and exacerbates his dementia-related aggressive behavior. She has also had the client sign $50,000 worth of checks to her & her husband as gifts and payment for chores.

Appendix E. A Sample Letter of Support for Grant Funding

SUBJECT: On-going Support for the Elder Abuse Forensic Center

Dear Forensic Center Director:

On behalf of the Los Angeles County District Attorney's Office, I am writing to express our enthusiastic support for the Los Angeles County Elder Abuse Forensic Center at the Keck School of Medicine of USC. The Forensic Center is a composed of a multidisciplinary team of professionals which provides expert and comprehensive case examination, documentation, consultation and prosecution of elder and dependent adult abuse cases in Los Angeles County. In doing so, the Center protects vulnerable elders and dependent adults from abuse and neglect.

The Los Angeles County District Attorney's Office is the largest local prosecutorial agency in the nation and prosecutes felony crimes throughout the county. Deputy district attorneys also prosecute misdemeanor crimes in unincorporated areas and in the vast majority of County cities. In support of the significant and critical work conducted by the Center, the Los Angeles County District Attorney has designated Deputy District Attorneys from the Elder Abuse Unit to participate at the Forensic Center's weekly meetings. Deputy District Attorneys also participate in the Center's Elder Death Review Team.

Through the Forensic center, the Los Angeles County District Attorney's Office will improve communication and coordination of intervention activities among public agencies and private parties involved in the struggle against elder abuse. Staff will continue to collaborate with the Center's experts to generate innovative methods and practices for combating elder abuse, improving the lives of vulnerable adults, and achieving justice for abuse victims. Staff will also continue to utilize the Center as a resource for expert consultation on their cases for the benefit of the victims.

[*Please insert examples(s) of how the Forensic Center has changed the way in which your office approaches your cases/clients. For example, does it change the way in which your agency thinks about cases with a more holistic approach; do the meetings and collaboration assist in the cross-education and communication between agencies; has the Center evolved in a such a way that it allows your office to become more comfortable in working with other agencies; does it allow your office to prosecute cases which would not be possible without the Center, etc*.]

We support your efforts to secure funding and look forward to continuing to building a strong relationship with the Center. By securing funds to continue this center, coordination and communication between the agencies charged with the investigation of crimes against the elderly will continue to grow and improve. The treatment and protection of elders will also be enhanced.

We are pleased to be a supportive partner in this vital effort and we wish you continued success.

Sincerely,

Name
Title

Appendix F. A Survey of Team Effectiveness

Elder Abuse Forensic Center Core Team: LA, OC, SD, SF (*circle one)* Date: _____

Please check the box that best describes how long you have been on this team:

1-3 meetings 4-6 meetings 6-10 meetings 11 or more meetings

TEAM EFFECTIVENESS INVENTORY

Using the scale below, circle the number that corresponds with your assessment of the extent to which each statement is true about your team:

1=strongly disagree, 2=disagree, 3=agree, 4=strongly agree

1	Everyone on my team knows why our team does what it does.	1	2	3	4
2	The facilitator consistently lets the project members know how we are doing in accomplishing the process.	1	2	3	4
3	Everyone on my team has significant say or influence on the team's decisions.	1	2	3	4
4	If outsiders were to describe the way we communicate within our team, they would use such words as "open", "honest", "timely", and "two-way".	1	2	3	4
5	Team members have the skills and knowledge to contribute to the task we have been assigned.	1	2	3	4
6	Everyone on this team knows and understands the team's priorities	1	2	3	4
7	As a team, we work together to set clear, achievable, and appropriate goals.	1	2	3	4
8	I would rather have the team decide how to do something rather than have the team leader give step-by-step instructions.	1	2	3	4
9	As a team, we are able to work together to overcome barriers and conflicts rather than ignoring them.	1	2	3	4

Appendix G. Case Review Survey

Los Angeles County Elder Abuse Forensic Center
Case Review Survey

This survey is designed to clarify the case review process from the perspective of the core team members routinely attending meetings. Please complete each section and return to the USC Evaluation Team.

I. Information about you:

1. Affiliation:

□ APT/Geriatrician	□ Neuropsychologist	□ Regional Center
□ Adult Protective Services	□ Los Angeles Police Dept	□ Ombudsman
□ Public Guardian	□ Los Angeles Sheriff Dept	□ Coroner/Medical Examiner
□ GENESIS/DMH	□ City Attorney	□ _____
□ District Attorney	□ Civil Attorney	

2. Years in this position: _____

3. Years working with elder abuse, neglect and exploitation: _____

4. Years attending the Forensic Center meetings: _____

5. In general my attendance at Forensic Center meetings:

□ 1 – 12 times a year
□ 13 – 24 times a year
□ 24 – 36 times a year
□ more than 36 times a year

II. Case scenarios (A, B, C) – please read each case scenario and answer the questions that follow:

Case A - Mabel & son

- 82 year-old Caucasian female, has no physical impairment but doesn't remember the social worker from one visit to another.
- Son lives with the client, is unemployed, and the neighbors state he has a history of alcohol abuse.
- Son convinced client to get a reverse mortgage on her home, to pay off deferred home maintenance, and offered to manage the finances and repairs. (cont'd)

- Bank reported the case to APS after the son received checks with a total amount of around $200,000. He refuses to give the Adult Protective Services social worker an accounting of this money.
- Client knows about the reverse mortgage and says she trusts her son with her finances. She was not aware of the checks that the son received.
- Case presenter is bringing this to the team for help getting the money back to the client and protecting her assets from future loss.

Questions (A):

A1. Who needs to provide input on this case presentation?

□ Physician	□ Neuropsychologist	□ Regional Center
□ Adult Protective Services	□ Law Enforcement	□ Ombudsman
□ Public Guardian	□ Civil Attorney	□ Coroner/Medical Examiner
□ Mental Health	□ Prosecuting Attorney	□ _____

_____

A2. What, if any, additional information would be important to know? Please list up to five (5) questions you would ask the case presenter:

_____

_____

_____

_____

_____

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A3. Please list the information or evidence that would be necessary to move the case toward the presenter's goal of restitution and future protection of assets:

_____

_____

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_____

A4. What additional goals or concerns do you have:

_____

_____

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_____

Case B – Lou & new wife

- 26 year old Hispanic male who lives in the home he grew up in, his parents have been deceased for nearly 3 years, the home is in an upscale neighborhood.
- Client presents well, but reportedly has a low IQ (70) and some difficulty recalling the sequence of recent events.
- Neighbor has been checking in on client and became aware of a new friend who suddenly has become his wife and has moved in with client. The client has no known remaining family.
- Client's savings account funds have been withdrawn over $100,000 in 3 months. When client is asked where the money has gone, he responds that he bought his wife a new car so that she can drive him places. (cont'd)

- She is in her mid-20s with no known criminal history, but is not cooperative with APS when they visit.
- Bank tellers noticed that the client's wife was hiding the amount of withdrawal from him; however, the bank manager will not turn over any account documentation to the Adult Protective Services worker.
- The case presenter thinks that the wife is taking advantage of him and wants to know if there's anything that should be done.

Questions (B):

B1. Who needs to provide input on this case presentation?

□ Physician	□ Neuropsychologist	□ Regional Center
□ Adult Protective Services	□ Law Enforcement	□ Ombudsman
□ Public Guardian	□ Civil Attorney	□ Coroner/Medical Examiner
□ Mental Health	□ Prosecuting Attorney	□ _____

_____

B2. What, if any, additional information would be important to know? Please list up to five (5) questions you would ask the case presenter:

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_____

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B3. Please list the information or evidence that would clarify the presenter's suspicion that the wife is taking advantage and what should be done:

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B4. What additional goals or concerns do you have:

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Case C – Lorraine & financial planner:

- 92 year old Caucasian female lives at a skilled nursing facility because a recent fall left her wheelchair bound and in need of 24-hour care. She has difficulty recalling any of the details of her finances.
- The case was reported by concerned family members who allege financial abuse by the client's certified financial planner, who is now the sole beneficiary and trustee of the client's estate.
- The client still owns her home, which is where the financial planner has been living. The approximate value is $800,000 and there are no liens on the property.

(cont'd)

- The financial planner visits her frequently, and has access to her bank accounts as her agent under power of attorney. He withdraws $15,000 a month from the client's accounts and insists that this is her payment to him for his estate planning and financial management services.
- Case presenter is a detective who would like to file this case for prosecution and is asking the Forensic Center for guidance.

Questions (C):

C1. Who needs to provide input on this case presentation?

□ Physician	□ Neuropsychologist	□ Regional Center
□ Adult Protective Services	□ Law Enforcement	□ Ombudsman
□ Public Guardian	□ Civil Attorney	□ Coroner/Medical Examiner
□ Mental Health	□ Prosecuting Attorney	□ _____

_____

C2. What, if any, additional information would be important to know? Please list up to five (5) questions you would ask the case presenter:

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C3. Please list the information or evidence that the detective would need to collect to be able to file this case for prosecution:

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C4. What additional goals or concerns do you have:

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Thank you for taking this time to inform the field about the valuable work you do!