Division of Senior and Adult Services

Innovation in Motion, The Emergency Intervention Team

Services and Solutions for Better Living

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2016

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What you need to know

- Cuyahoga County's population - 1,280,122
- It is the largest county out of 88 in Ohio
- 151,395 residents are over the age of 60
- In 2015, there were 2,028 unduplicated cases opened in APS
- Over 4,000 allegations were investigated (Self-neglect: 40%, Neglect: 25%, Exploitation 15%, Abuse 11%, Bed Bugs: 5% Hoarding: 4%
- 1 Senior Supervisor, 4 APS Supervisor, 27 APS Workers – largest in the state
- Mandate is for 60 and older, must have an allegation, must have an impairment, must be in the community
- We pursue **Guardians** and use **Protective Service Orders**
- We have a Centralized Intake (20% of cases accepted meet ER criteria)

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Opportunity

- Cuyahoga County receives $30,000 per year to run APS from the State
- APS in Cuyahoga County has a 3.8 million budget
- Rely heavily on a Health & Human Services Levy, some Title XX
- 2015 State allocated a one –time budgeted 10 million (HB 483) state wide for APS programs
- 39 Ohio Counties lack a full time APS staff person
- Counties could apply for a capacity grant
- Counties could apply for an innovation grant
- CORE training mandated for all APS staff (funds given for completion)
- Planning grants (Letter of Attestation, I – Team development, Plan of Cooperation, MOUs)
- State was to implement a statewide APS hotline and data collection reporting system
- Ohio's senior population is growing (by 2030 in Cuyahoga County 31% of population will be over 60)

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The forming of the Emergency Intervention Team

The goal of the Cuyahoga County APS Emergency Intervention Team (EIT) project is to stabilize and improve the safety and well-being of approximately 225 at imminent risk victims of maltreatment by better engaging individuals in Adult Protective Services and providing holistic, wraparound services to reduce recidivism, reduce unplanned emergency room visits and ensure those without regular healthcare are connected with a medical home. The EIT will investigate and provide enhanced screenings and assessments of adults who are suspected to be at high risk of harm due to maltreatment and unstable medical and/or mental health disorders, in order to initiate a timely protective plan that reduces harm and stabilizes the victim

Current State - Problems to be Addressed

- Lack of active connection with a medical doctor to coordinate healthcare
- Long delays in scheduling comprehensive geriatric evaluations for victims without a PCP (and with)
- Inability to request Probate Court involvement due to absence of evidence
- Delays in the completion of the Statement of Expert Evaluation (SEE) due to insufficient medical expertise
- Difficulties in accessing medical care for uninsured / underinsured
- Delayed protective service plans due to lack of a legal surrogate decision maker for victims with diminished capacity
- Overutilization of 911 and ER Departments to assist in medical assessments
- Assessments done in a hospital setting may miss vital subjective evidence that is observed in victims home environment
- Many victims are unsafely discharged from hospital settings
- People with diminished capacity are often unreliable self reporters
- Cases resulting in guardianship take more than twice as long to resolve than non-guardian cases (143 days vs 71 days)
- Drain on APS staff who oversee the scheduling, ensuring and following-up with appointments

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Innovation Begins…….

- Create an interdisciplinary team comprised of Intake, APS Staff, DSAS RN, and when needed, a mobile geriatrician from local hospital networks
- Investigates reports on clients appearing to suffer from severe cognitive impairments, diminished capacity at risk of serious harm if no action is taken
- Takes into account all types of dementia, mental health and other illnesses that contribute to difficulties with memory, attention, impaired judgement and concentration
- Addresses issues where clients have refused to cooperate
- This is an alternative to hospitalization
- The Team works to stabilize imminent risk quickly
- Provides the necessary wraparound services, link to community support(s) and minimizes the need for hospitalizations
- If hospitalization is necessary, the doctor and nurse can help ensure this occurs

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Client Criteria

- Screened in via Intake, can also be identified after case assigned to APS
- New or additional reports of alleged mistreatment (abuse, neglect, self neglect and/or exploitation)
- Inability to protect self from the alleged maltreatment due to severe cognitive/physical impairments
- Instability or the lack of a social support system
- Complex/unstable medical condition
- Unstable psycho-social factors
- Unstable neuropsychiatric symptoms

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Role of APS Worker

- Assess the level of risk and danger
- Take immediate action to protect victim
- Collect evidence and testimony to validate mistreatment
- Assess need for protective services to reduce victims' risk
- Provide Crisis intervention
- Alleviate emotional distress
- Meet immediate needs
- Arrange for needed medical, legal, financial services
- Advocate to ensure victims' needs are met and rights are respected
- Provide testimony in legal proceedings (legal protections if necessary)
- Assist with health insurance and other benefits applications

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Role of DSAS Nurse

- Evaluate medical necessity and on-going need for medical care
- Assess need for skilled nursing care
- Assess need for non-medical community based services
- Assist in the transition of care admission and discharge from an acute care setting (care planning)
- Prevent medical complications / worsening condition resulting in repeated ER visits, hospitalizations and facility placements
- Collaborate with community partners and resources to assist clients in getting needs met
- Teach client / caregiver chronic disease management

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Role of Mobile Physicians

- Conduct in-home geriatric consult / evaluation
- Evaluate memory, physical and mental capacity, fall risk, level of care
- Establish primary medical care and management of chronic illness
- Provide prescription refills
- Arrange for testing or specialist visit
- Provide palliative consult, assist with end-of-life discussion and determine goals of care
- Facilitate and coordinate needed health services (i.e, emergency departments, hospitals and establishment of medical homes) to ensure continuity of care

What we anticipate…..

- An alternative to hospitalizations
- Holistic approach – one stop shop, client centered
- Quick stabilization of imminent risks
- Services will be coordinated, enhanced and expedited
- Recidivism rates will be reduced (32% to 26%)
- Length of non-guardianship cases reduced by 10 days (compared to avg. of 78 days)
- Length of guardianship cases reduced by 25 days

- Reduction in cases closed due to “client knowingly refused” (7 to 5%, staff involvement is greater)
- Reduce Probate Court petitions for Protective Service Orders
- Reduce number of unplanned ER visits
- Increase cases closed with an effective protection plan (75% to 80%)

Budget

Project activity	Grant Funds	In-Kind Funds	Line Total Funds
Equipment	$4,500	$0	$4,500
Purchased Services	$45, 650	$6,033	$51,593
Other	$99,850	$100,989	$200,748
Total Cost	$150,000	$106,931	$256,931

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Budget Narrative: $256,931

EQUIPMENT: $4,500 – Purchase 3 laptops ($1,500)

PURCHASED SERVICES: $45, 650

Partner with Cleveland Clinic and University Hospitals to provide a mobile physician based on the victim's health insurance, preference and/or geographical location. Uninsured and underinsured patients will be billed to DSA. Projection ($250 x 8 visits per month = $2,000 x 9 months = **$18,000**)

Contract with Benjamin Rose Institute / Margaret Blenker Research Institute to conduct evaluations of the project = **$16,650**

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Budget Narrative continued…..

Professional Development for staff involving best practice models related to Mental Health, Geriatric Assessments, Communication with Older Adults, Elder Maltreatment Screenings; $1,500 per session x 8 sessions = **$12,000**

OTHER: $99,850

Personnel: 1 FTE Registered Nurse Supervisor - $25.76 x 2,080 (standard annual work hours) = $53,600. Fringe benefits (1 FTE) consists of payroll taxes, workers compensation2%, FLEX benefits 23.3%, PERS 14% and Medicare cost of 40.75% (rounding to 41%) = $21,976 for a grand total of **$75,576**

Emergency Funds: Subsidy payments limited to $500 per client to help offset cost for things like food, clothing, incidentals, pharmaceutical and dental services, goods and services for

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Budget Narrative Continued….

Special and unique circumstances **$16,871**

Printing: brochures, advertising, postage = $5,000. Travel covers general mileage for staff to perform duties. Calculated at $.445 per mile x 600 miles monthly x 9 months = $2,403 for a grand total of **$7,403**

IN-KIND FUNDS: $106,931

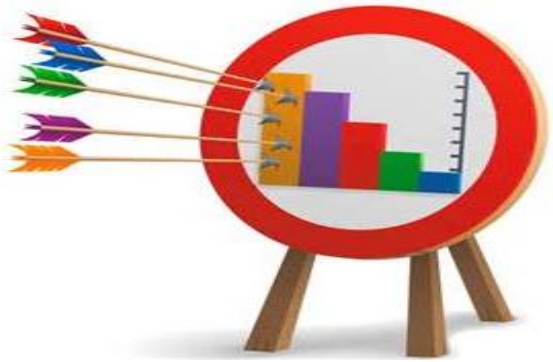
Include current DSAS staff salaries allocated at 10% = $71,558 + fringes (41%) = $21,976 + Benjamin Rose Institute $6,033

Outcomes

What we learned

- 98 cases were EIT clients (original projection was 225 - overestimated)
- EIT cases closed in 61 days compared to non-EIT cases in 69 days
- A higher percentage of EIT cases had a protective plan and secure placement (5.9% compared to 3.8%)
- A higher percentage of EIT cases had a protective plan with a guardian appointed (11.8% to 6.1%)
- Validation of allegation(s) for EIT cases was 57.4 % compared to 44.7% for non-EIT cases

Outcomes



- Reduction in Protective Service Orders occurred, PSOs were not needed due to EIT
- Recidivism **COULD NOT** be measured (***due to the project being time limited to 10 months, researchers did not feel this was a significant amount of time to get a true measure. 1 EIT cases did re-open within the 10 months***)
- We discovered that many of our clients did actually have billable insurance, our projection for this expense in the budget was too high
- There was difficulty getting all but one hospital system involved with its community based geriatrician (bureaucratic issues)
- Clients engaged in the EIT did not require emergency room visits during the process – which we anticipated would occur
- 911 cost is approximately $450 per call (savings of $44,100), not needed

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Can we Sustain What We Have Begun

Sustainability Costs	***Sustainability Strategies***
Contracted Physician Assessments- $250 per assessment	Will be billed to Medicaid/Medicare. Not insured and under-insured will be billed to agency's ER funds
Staffing cost APS staff	Currently incorporated in operating budget
Community – based nurse	Look to increase from billable Medicaid/Medicare dollars
Equipment costs	Incorporated into operating budgets of project partners
Operating costs	Incorporated into operating budget

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Questions

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APS Emergency Intervention Team

Date:

Client Name:

Allegation(s): Check all that apply

□Abuse □ Neglect □ Self-neglect □ Exploitation □ Hoarding

Reported cognitive/mental impairment(s): Circle all that apply

Increased memory lost	Poor decision-making	Increased depressive symptoms
Increased confusion	Cognitive changes	Increased manic symptoms
Poor judgment	Increase paranoid behaviors	Other; list

Reported Risk Factor(s): Circle all that apply:

Isolated from others	Requires total care	Lack of health insurance
Lack of 24 hour supervision	High risk environment	Unsafe discharge
Complex medical concerns	Homeless	No known primary care doctor
Complex mental health concerns	Recent loss of caregiver	Difficulty accessing medical care
Against medical advice (AMA)	Inadequate care giver	Financial crisis
Dependent care needs	Lives with alleged perpetrator	

Additional comments:

Action:

☐ Case assignment is appropriate for the APS EIT.
Case assign to the APS EIT.

☐ Additional information is needed before decision is made to assign the APS EIT.
Please identify the reason:

☐ Case is not appropriate for the APS EIT assignment because:
Please identify the reason:

APS EIT INTERDISCIPLINARY COLLABORATION FORM

Client Name:

APS Worker:

DSAS RN:

Review APS EIT Case/Concerns:

□ Intake	□ Mental Issues	□ Non-Urgent Medical Need
□ EIT Screen	□ Schedule Gero-psych Consult	□ Establish Medical Home Needs/Skilled Care
□ Risk Assessment	□ Schedule Primary Care	□ Establish Non-medical care
□ Medical necessity	□ Urgent Medical Need	□ Possible Probate Court Intervention

Discuss Client Service Safety Concerns (such as, unstable health, unstable mental health concerns and/or unstable environment):

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Summary of Outcomes:

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Client Service Plan addresses current safety concerns:

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Case Notes Supports Client Service Plan:

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