Establishing & Evaluating Elder Abuse MDTs: Tips for Communicating Team Function & Effectiveness

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Agenda

- Multidisciplinary Teams (MDTs) & Evaluation Overview
- Example 1: Los Angeles Center
- Example 2: Denver Forensic Collaborative
- Group Discussions
  - When and how to use MDTs?
  - What data and outcomes should be tracked?
  - How to integrate person-centered approaches?
- Lessons Learned & Recommendations

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What are Multidisciplinary Teams?

- Broad term: elder abuse "Networks"
- MDT is a type of elder abuse network
  - A team that is comprised of professionals from a variety of disciplines working together on an ongoing basis to combat elder abuse.
- Specifically look at **case review** elder abuse MDTs

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Who's in the Audience?

- Role?
  - APS caseworker
  - APS supervisor
  - Other agency
- State?
- Experience with elder abuse case review MDTs?
  - Core team member
  - Presented/attended
  - Aware of one near you

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MDT Types (some examples)

- Hospital-based (e.g., Geriatric/Medical Assessment Team)
- Financial Abuse Specialist Team (FAST) – sometimes "Fiduciary"
- Vulnerable Adult Specialist Team (VAST)
- Elder Abuse Forensic Center (EAFC)
- Fatality Review Team
- Hoarding Team
- "Multidisciplinary Teams" (also I-Teams)
  - Wide variation
- Enhanced Multidisciplinary Team (E-MDT) in New York & elsewhere

- What others models are you aware of?

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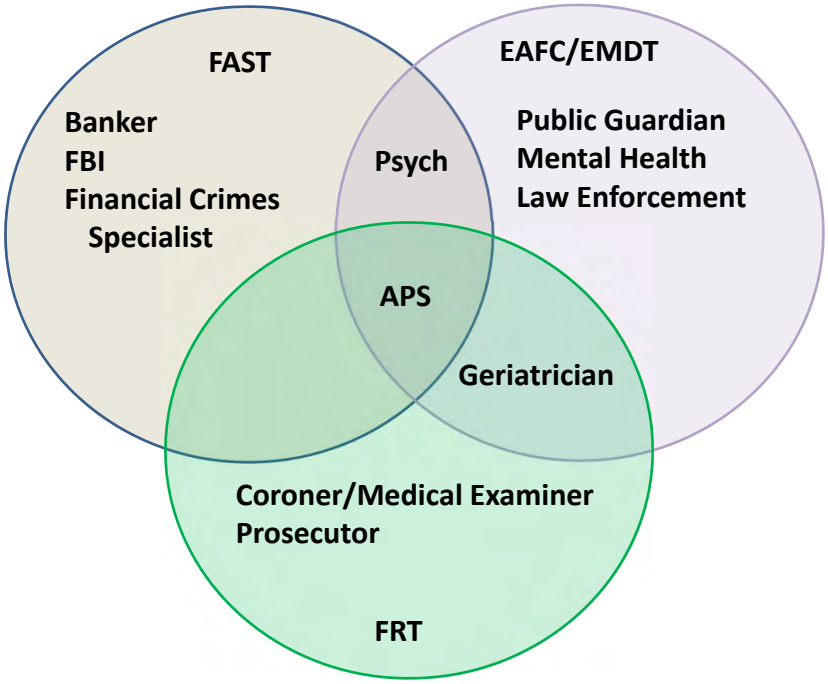

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Establishing an MDT

- Department of Justice's Elder Justice Initiative
  - MDT Technical Advisor: Talitha Guinn-Shaver
  - https://www.justice.gov/elderjustice/mdt-tac
- **Mission:** to provide tools, resource materials, and individualized consultations to facilitate the expansion of elder abuse case review multidisciplinary teams (MDTs) across the nation.
- MDT Guide & Toolkit: https://www.justice.gov/elderjustice/mdt-toolkit
  - Info on establishing, running, and evaluating an MDT

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Support for MDT Activities

- DOJ's MDT TA Center
- New York City Elder Abuse Center (NYCEAC)
  - TA, including monthly Peer Leadership Group
  - https://nyceac.org/clinical-services/mdts/technical-assistance/
- Soon to come: OVC-funded MDT Training & TA Center

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Evaluation of MDTs

- Why evaluation?
  - Tell the story of MDTs
  - Justify collaboration across organizations
  - Improve effectiveness and functioning
  - Often needed for funding & sustainability
  - Offers guidance throughout development of MDTs
    - Needs assessments say 'why needed'
    - Formative Evaluation say 'how developed'
    - Process evaluations say 'how done'
    - Outcome evaluations say 'what impact'
    - Implementation evaluations say 'how others may do'

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Evaluation Process

Needs Assessment →	Formative Evaluation →	Process Evaluation →	Outcome Evaluation →	Implementation Evaluation
Who needs? What safety, health, & well-being needs are unmet? What services already exist? What motivations drive starting a MDT?	Who involved? Who leads and what coordination support is needed? What expectations for participation? What structures of meetings? What agreements are needed (MOU's, confidentiality agreements)?	How would one describe the MDT? What does the MDT do? How is the MDT monitored? How is quality assurance tracked?	Does the MDT work? Does the MDT cause any harm? What outcomes are improved?	Questions of: - Acceptability - Cultural adaptability - Accessibility - Feasibility - Fidelity - Expansion, spread, & scaling up - Sustainability

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Evaluation Consideration #1:

Hierarchy of Evaluation Design Rigor

1. Systematic reviews & meta-analyses
2. Multi-site replications of randomized experiments
3. **Randomized experiments (with control group)**
4. **Quasi experiments (with comparison group)**
5. Correlational Studies
6. Others (Anecdotal case reports, pretest-posttest studies without comparison group, qualitative descriptions of client experiences, client satisfaction surveys)

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Evaluation Considerations #2:

Sources of Data

- ***Who***? victim-focused, collaterals, existing service data, MDT service providers, other
- ***How?*** surveys, interviews, observation, abstracting from existing data
- ***When***? frequency: baseline/pretest, post-test, follow-up (3 months, 6 months, 12 months)
- ***What outcomes?*** Health, safety, well-being, prosecution Result, service use
    - Use of standardized measures for outcomes

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Evaluation Consideration #3:

Resource & Competing Demands

- What is feasible?
  - Example: Client Satisfaction Surveys are really popular and feasible in health & social services, yet may be limited in effectiveness or appropriateness for MDTs
  - Donabedien (1988): **Structure -> Process -> Outcome** indicates that client satisfaction may be a 'necessary process' to achieve the outcome.
  - Data collection & analysis staff and consultants may be needed
- Given multiple organizational partners in MDTs, what do each of their organizations prioritize as an outcome?
  - Health, safety, well-being, prosecution results, service use, **cost, & person-centeredness**

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Evaluation Consideration #4

Person-Centered Approaches

- Institute of Medicine (2001) major aim of increasing patient-centered care:
  - "… respectful of and responsive to individual patient preferences, needs, & values and ensuring the patient values guide all clinical decisions"
  - For MDTs: client acceptance of services, tensions between safety and self-determination, consideration of least restrictive environments, considerations of competency and capacity for decision-making
  - For Evaluation: Goal Attainment Scaling (Burnes, 2018)

Have client rate goal attainment as:

Much less than expected	Somewhat less than expected	Expected client outcome	Somewhat better than expected	Much better than expected
-2	-1	0	+1	+2

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Example 1:
Los Angeles County Elder Abuse Forensic Center

- Research Collaborators:
  - Kate Wilber, PhD, LCSW
  - Diana Homeier, MD
  - Adria Navarro, PhD
  - Jeanine Yonashiro-Cho, PhD
  - Julia Rowan, PhD
  - Melanie Gironda, PhD
  - Gerson Galdamez, BSG
  - Liz Avent, MS

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Forensic Center Goals & Activities

Health Services

- In-home Medical Evaluations
- In-home Neuropsych Evaluations
- Medical Record Reviews
- Capacity Declarations
- Expert Testimony

Legal Services

- Prosecution
- Appropriate Conservatorships
- Civil Litigation
- Restraining Orders

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Structure/Process: Conceptual Model v1

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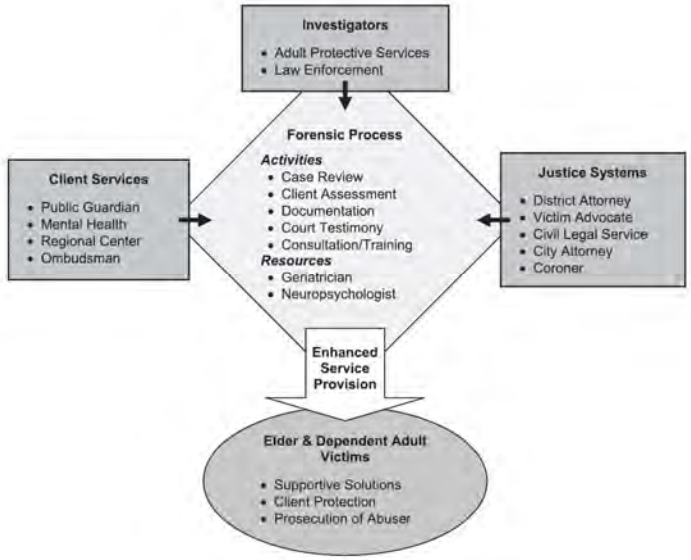
Structure/Process: Conceptual Model v2



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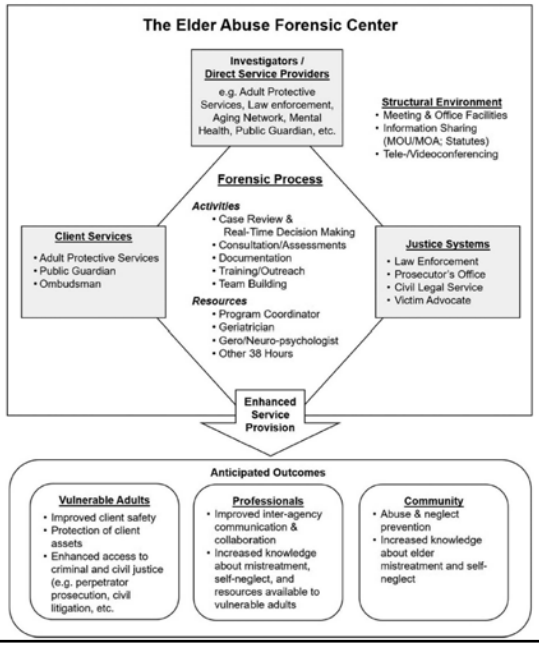
Structure/Process: Conceptual Model v3



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Time for Outcomes

- Ideal approach: RCT
- APS powers-that-be signed off on it
- Grant proposal was submitted
- Funds received
- But then… County Counsel!!!

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Quasi-experimental approach

- Propensity score matching
  - Group of Forensic Center cases
  - Match them with usual care cases based on:
    - Age
    - Gender
    - Race/ethnicity
    - APS Office (geographic categories)
    - Service dates
    - Type(s) of abuse
    - Referral source(s)

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Promising Results from the Forensic Center Model

- Looked at two outcomes:
  - Prosecution
  - Conservatorship (a.k.a. Guardianship)
- But what aspect of each process?

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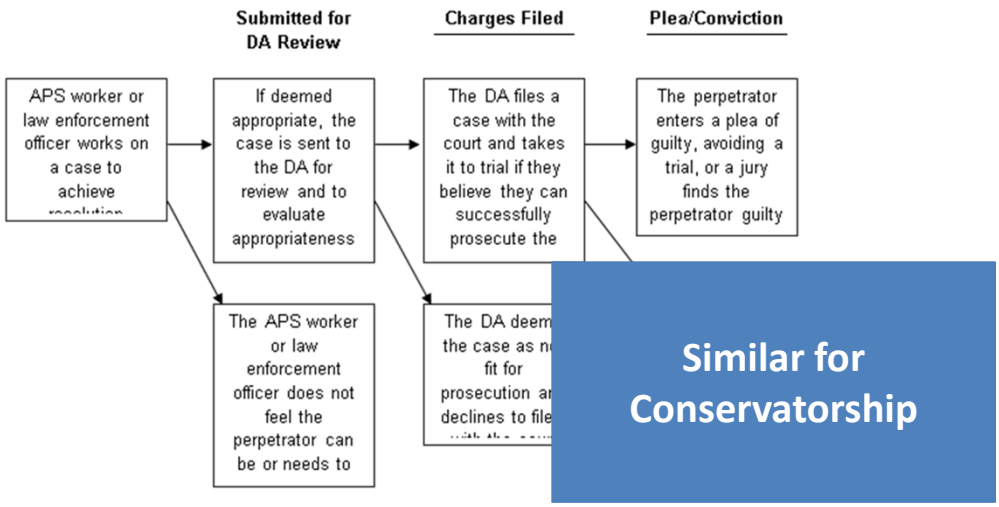
Prosecution Process



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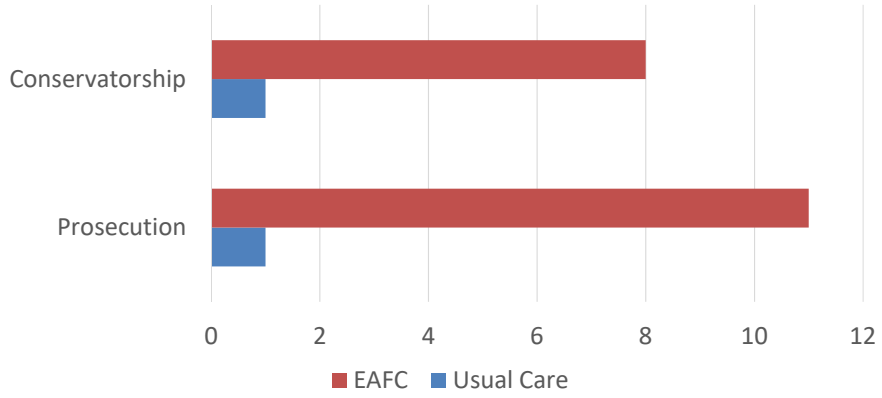
Outcomes Results

- Higher "odds" of referral for:



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Comparing California's 4 Forensic Centers

- Shared core professional groups:
  - FC Program Coordinator
  - FC Program Assistant
  - Geriatrician or Healthcare Provider
  - Geropsychologist or Neuropsychology
  - Adult Protective Services
  - Law Enforcement Agencies
  - Prosecutorial Agencies
  - Public Guardian
  - Victim Advocate
- Not pervasive, but very common:
  - Senior Legal Aid (Non-Profit)
  - Community Mental Health Services

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Example 2: Denver Forensic Collaborative

Acknowledgements

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Denver Forensic Collaborative: MDT

- Mandated reporting law started in 2014, as did the Denver Forensic Collaborative (DFC)
  - City Attorney's Office, District Attorney's Office, Police, Adult Protective Services, Geriatrician, Victim Advocates, Social Services, Community Mental Health, and many more
  - Staffed cases on abuse, neglect, and/or financial exploitation affecting an older adult (60+ years) and involved an alleged perpetrator in a position of trust

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Evaluation: The Design

Evaluation Goal: To test the impact of a forensic collaborative on responses to the abuse, neglect, and/or financial exploitation of older adults.

Arm 1

Arm 2

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Interviews with Older adults

ARM 1

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Arm 1

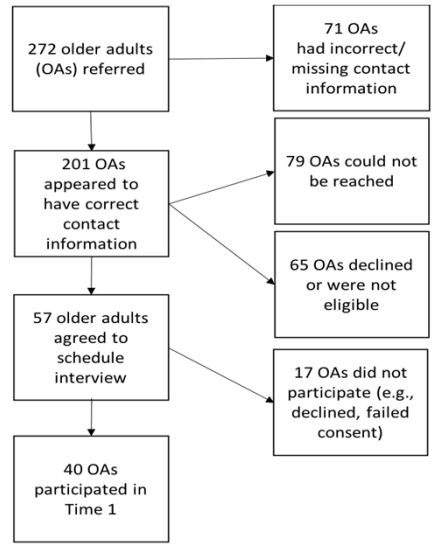

Figure 1. Recruitment flow since project start.

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Arm 1 Procedure

What happened during the interview part of the study?

- Consent "quiz" to assess understanding of consent materials
- Time 1 (T1):
  - Demographics, social support, physical and mental health, cognitive function, alcohol use, and service use and needs.
- Time 2 (T2; 1 month):
  - maltreatment history, post-traumatic symptoms, post-trauma appraisals, and beliefs and participation in the criminal justice system.
- Time 3 (T3; 6 month), Time 4 (T4; 9 month):
  - Social support, physical and mental health, cognitive function, alcohol use, post-traumatic symptoms, post-trauma appraisals, beliefs and participation in the criminal justice system, and service use and needs.
- Retention: 75% at T2, 70% at T3, and 58%

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Arm 1 Participants

Who participated in the interview part of the study?

- 76 years (average)
- 75% female
- 53% retired
- 38% Ethnic Minority
- 89% at least some college

N = 40

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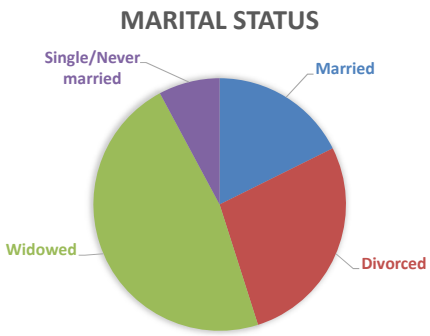
Who participated in the interview part of the study? *Cont*.



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Arm 1 Results

What were older adults' experiences of maltreatment?

51% reported lifetime physical mistreatment by family members

- 15% describing incidents in the previous year

43% reported neglect

- Majority faced unmet needs in the last month

52% reported financial exploitation (close friend or family member taking money or property without permission)

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Arm 1 Results

Did outcomes differ for DFC cases relative to Usual Care?

Did not detect effects of DFC on victim-focused variables, such as:

- Mental Health (e.g., depression and PTSD symptoms),
- Criminal Justice (post-crime appraisals, victim engagement, & perceptions of the criminal justice response, and
- service use and helpfulness

But, recall…

- Small sample size
  - Analyses compared 19 older adults reviewed by DFC and 19 older adults in UC

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Arm 1 Results

What service needs did older adults describe?

- 82% reported physical health limitations
  - "impairment in moderate activities and climbing several flights of stairs"
  - 24% reported limitations "all of the time"
- 70% reported pain interfering with normal activities
  - 24% reported pain "extremely" interfering with normal activities.
- 55% reported doing less due to emotional problems (e.g., feeling anxious or depressed).
  - At T2, 52% endorsed moderate to severe depression symptoms and 44% endorsed moderate to severe PTSD symptoms.

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Arm 1 Results: Older Adult Needs

What service needs did older adults describe?

68% reported needing "**some**" to "**a lot**" more help than currently received.

Help needed to find help

- Older adults described not knowing ***where*** to seek assistance or ***whether*** services existed to meet their needs.
- **Nearly 1 in 5** (19%) reported needing assistance finding and navigating services.

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Arm 1 Results: Older Adult Needs

What specific service needs did older adults describe?

28%: mental health needs & social isolation, including help with depression and trauma symptoms

25%: financial assistance (e.g., help paying bills, managing taxes)

22%: household chores, yard work, and home maintenance

19%: transportation services (including help moving) due to inability to drive, scarcity of/distance to public transportation, and/or physical limitations

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Arm 1 Results: Older Adult Needs

What specific service needs did older adults describe?

Nearly **one in four** participants also faced challenges obtaining housing (23%) and food (28%).

Older adults described problems including:

- ❑ finding affordable or accessible housing
- ❑ long waitlists for housing
- ❑ food too expensive
- ❑ food stamps did not cover needs
- ❑ food inadequate (e.g. charity meal services not meeting nutritional needs).

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Arm 1 Results: Older Adult Needs

What barriers to services did older adults describe?

22%: don't know about existing services

22%: unable to afford services (e.g., surgeries or medications, home health care)

14%: found services inadequate when attempted to use

19%: did not engage in services even when aware of them

8%: felt too guilty or ashamed to engage services

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Collateral Surveys & Administrative Data

ARM 2

Victim Advocate

Criminal Justice Case Outcomes

APS

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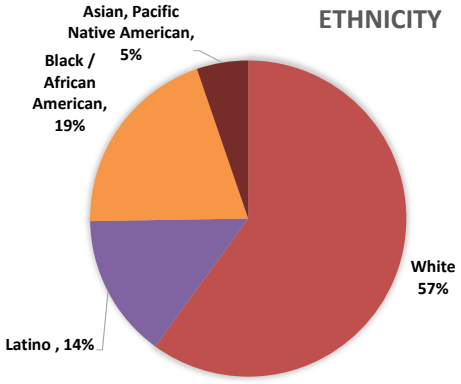
220 Cases

Victim Advocate

N = 220
Female (72%)



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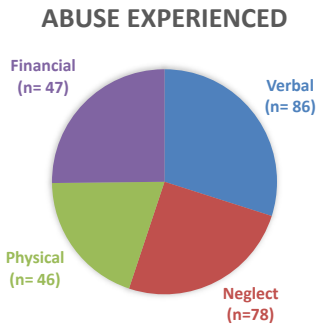
Cases (cont.)

Victim Advocate



Alleged Offenders

- 53% (n = 94) adult child of older adult
- 77% (n = 183) close friend or family member of older adult

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Victim Advocate

Arm 2: Victim Advocate Reports

What kind of contacts did these cases have across systems?

- 96% of cases had police contact
- 53% had **medical provider** contact
- 21% had **community provider** (e.g. community clinics) contact

- Relatively less contact with criminal justice offices:
  - 11% of cases had interaction with DA's office
  - <4% received any kind of legal services

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Arm 2: Victim Advocate Reports

What kind of contacts did these cases have across systems?

Victim Advocate

- Two-thirds of older adults were lost to additional contact with advocates (e.g., phone numbers changed, moved) .
- Prognosis of whether older adult would be in need of their services again
  - 53% responded either "guarded" or "poor" within the next month
  - 58% responded either "guarded" or "poor" within the next year,

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Arm 2: Victim Advocate Reports

What was impact of DFC relative to UC over time?

Victim Advocate

- Relative to usual care, DFC linked with:
  - Greater likelihood of *non-reoccurrence* in the next month; and next year
  - Higher across-agency coordination
  - Greater service types engaged in case
  - Nearly 3 times (2.8) higher odds of learning about cases through other means (e.g., coworker, other team members, consultation)

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Arm 2: Criminal Justice Case Outcomes

- New police reports
  - 16% of cases had a new police report
    - 17 of 118 DFC cases; 17 of 105 UC cases
    - Suggests ongoing justice and support needs for older adults involved in these cases
- Prosecution
  - Of 202 cases for which prosecution information was available, charges were filed in 19 (10%) of cases.
    - 67% were not presented to the DA
      - 23% were refused by the DA
    - Of those charged, prosecution outcome information was available for 13 cases.
      - Majority of cases resulted in a guilty plea or verdict (77%); the remaining cases were dismissed.

Criminal Justice Case Outcomes

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Arm 2: APS Administrative Data

- De-identified APS data from 669 APS case reports resulted in 302 cases that were screened in for investigation/assessment during the Arm 2 period.
- From these, 146 cases met study criteria, with 156 cases excluded for self-neglect only.
- APS data provided minimal demographic information beyond gender (female=58%, *n*=84) and age (average=77.24, *SD*=7.00).

APS

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Arm 2: APS Administrative Data

What does the APS data tell us about DFC Cases?

APS

- APS reports were available for 64 (66%) out of the 97 cases included in Arm 1. Only 6 (4 DFC; 2 UC) resulted in newly open APS cases and investigation, and therefore, documented outcomes.
- Challenges to APS involvement include:
  - Need to meet eligibility criteria for APS
  - Client's right to refuse APS services, when competent
  - That APS involvement may have preceded DFC response, sometimes by many years
  - Thus, APS may offer historic information, yet face barriers to engaging in current response

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IMPLICATIONS FOR DFC AND OTHER MDTS

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Plan for Severity of Cases in MDT and Evaluation

- Arm 1 Cases typically identified by a police report with severe & complex needs greater than our needs assessment (e.g., Gagnon et al., 2015)
  - PTSD and depression symptom severity appears to exceed national prevalence estimates
  - Older adults in this sample were living with physical health problems, cognitive difficulties, and/or unsafe home environments.
  - While challenges to engaging older adults who have cognitive impairment in services and outreach are well-documented (Anetzberger, et al., 2000; Dong et al., 2014), additional challenges related to housing safety and instability that have not yet been directly addressed in the older adult maltreatment literature.

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Coordination is Important

- Older adults were isolated with multiple service needs as well as reticent or uninformed about how to engage services by the time their cases came to DFC attention.
  - They had diverse service needs that went unmet, including housing concerns (e.g., affordability, availability).
- Per Victim Advocates, DFC clients had greater service coordination than usual care clients.
- MDTs often prioritize 'the most severe cases'. Yet, could coordination help prevent and reach older adults at-risk of mistreatment earlier?

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Prosecution Outcomes Matter

- Though prosecution rates were low overall, the involvement of the multidisciplinary team did not have a negative impact on prosecution, which can sometimes be a concern for communities establishing community-coordinated responses.

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Follow-Up Services are Needed

- Building on the positive coordination findings, communities may also want to consider protocols for **follow-up and engagement with older adults over time**, with particular attention to the role that community-based providers can play.
  - Arm 2 revealed that the majority of cases that initially came to the attention of the DFC did not have contacts a few months later. And yet, the older adults we interviewed face ongoing isolation, mental and physical health problems, and service needs.

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Discussion

- Your Questions?
- What influences decisions of when and how to create an MDT?
- What outcomes and data are important for evaluating MDTs?
- How could you integrate in the person-centered approach into evaluation of MDTs?
- Proposed discussion groups: needs assessment, new MDTs, more “mature” MDTs

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Summary

- Lessons Learned
  - Severity of cases & competing demands complicate evaluation of MDTs
  - Collaborating organizations want process, outcome, & implementation data
  - Evaluation is possible and often leads to more questions
- Recommendations
  - Get creative with designing comparison groups
  - Plan for multiple data sources and embed in existing contacts with clients, if possible
  - Incorporate *Goal Attainment Scaling* to improve acceptability and person-centeredness

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More Resources

- Georgia Anetzberger, 2011 – *The Evolution of a Multidisciplinary Response to Elder Abuse*
  - http://scholarship.law.marquette.edu/elders/vol13/iss1/1
- Schenider, Mosqueda, Falk, & Huba, 2010 – Elder Abuse Forensic Centers
  - https://doi.org/10.1080/08946566.2010.490137
- Secure Old Age lab at USC:
  - Publications: https://gero.usc.edu/secure-old-age/publications/
  - Resources: https://gero.usc.edu/secure-old-age/resources/

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Thank you!

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