

*County Of Sacramento  
Elder Death Review Team  
2006 Report*





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# Acknowledgements

Production of this report was made possible by the efforts of the staff of the Department of Health and Human Services, Senior and Adult Services Division and the District Attorney's Office.

We gratefully acknowledge the entire membership of the Sacramento Elder Death Review Team who contributed to the content of this report. A subcommittee of team members provided direct oversight and approved the final report. The devotion and dedication of the subcommittee members that spent many hours researching and writing the material in this report is monumental.

The EDRT Report Subcommittee members are as follows:

- Mark Burstiner, ASO, Coordinator Elder Death Review Team, Sacramento County DHHS/SAS/APS
- Peter Dixon, Deputy County Counsel, Sacramento County Office of the County Counsel
- Stephany Fiore, MD, Forensic Pathologist, Sacramento County Coroner
- Janet Heath, Commissioner, Sacramento County Adult and Aging Commission
- Chris Hicks, Licensing Program Manager, Department of Social Services
- James Kelleher, Continuum Administrator Leader Sacramento Valley (Continuum of Care), Kaiser Permanente
- Deidre Kolodney, APS Oversight, Adult/Aging Commission
- Debra J. Morrow, Program Manager, Sacramento County DHHS/SAS/APS
- Sharon Rehm, Program Manager, Sacramento County DHHS/SAS/IHSS
- Jeff Rose, Assistant Chief Deputy DA, Sacramento County District Attorney
- Susan Schwendimann, Program Manager, Sacramento County DHHS/SAS/IHSS
- Bernice Zaborski, Program Coordinator, Mental Health, Sacramento County DHHS/Mental Health

For information regarding the Elder Death Review Team or additional copies of this report visit [www.edrtsac.org](http://www.edrtsac.org) or contact:

Mark Burstiner  
EDRT/SacFAST Coordinator  
4875 Broadway, DHHS-SAS-APS  
Sacramento, CA 95820  
916-874-3183

# ***EDRT 2006 Report***

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# Executive Summary

The Sacramento County Elder Death Review Team (EDRT) was formed in 1999. It was the first such effort in the nation. It created a multi-disciplinary committee focused on reviewing questionable deaths of elders in Sacramento County. This was a cooperative effort launched by the Sacramento County District Attorney, Jan Scully and the Director of Health and Human Services, Jim Hunt, in collaboration with other concerned community leaders.

EDRT examines the responses of Adult Protective Services, law enforcement officers, prosecutors, victim services, health care providers, and others involved with victims of elder abuse and/or neglect.

Since the inception of EDRT, significant progress has been made. Communication and cooperation among agencies has been enhanced and a clear focus on the victims of elder abuse has been fostered. EDRT continues to focus attention on the systems and agencies responsible for assisting and protecting the elderly. EDRT advocates for system changes to improve the response to victims and prevent reoccurrence in the future.

EDRT has reviewed more than 100 cases since January 2004. For this report, we reviewed twenty-one cases. Information on each case has been appended to this report. Of those cases, 90 percent had a paid care provider, were living in a skilled nursing facility or board and care, or were self-care.

This 2006 EDRT Report focuses particular attention on the County's In-Home Supportive Services (IHSS) program. IHSS was designed to provide domestic and personal care services to low-income elders and persons with disabilities so they may remain safely in their homes, instead of being placed in more costly institutional settings. Six of the cases included IHSS recipients with family members as the paid care providers.

Based on the case review data, the report identifies critical challenges for both IHSS and other agencies and organizations. Important topics of note include:

- Issues impacting safety of the elderly
- Provider capacity and accountability
- Adequacy of training, skill development and information gaps
- Problematic discharge planning issues
- Cross-communication among involved agencies

Recommendations are attached to this report to spur action in response to some of the critical concerns raised through the EDRT process. We hope the readers will pay particular attention to those issues that affect them or their organization and will join EDRT in its efforts.

The First Annual Elder Death Review Team Committee Report was published January 2005 and contained the EDRT Protocols, which defined the roles and responsibilities of EDRT. It served as a tool to help replicate EDRT in other jurisdictions. This report includes, as an appendix, the 2006 Revised EDRT Protocols.

EDRT's goal is to eradicate elder abuse by fostering changes that improve the community's response to the needs of older victims of abuse and neglect. After careful consideration, the EDRT Reports will be revised as follows:

- The EDRT Reports will be issued biennially, allowing for more in depth review prior to publication. EDRT will continue to scrutinize, examine and analyze suspicious deaths of elderly and vulnerable adults.
- Each report will continue to be based on the Committee's critical reviews of suspicious deaths of our elderly and vulnerable citizens.
- Each report will provide a view of one of the many agencies within the protection services system, detailing how the agency works and focusing on areas for improvement.
- Recommendations will be directed to specific entities, thus providing impetus and responsibility for completion.
- Recommendations will be specific, ensuring that outcomes and success can be tracked over time.
- Recommendations of the EDRT will fall into two categories:
  1. Those to be completed or implemented by the EDRT.
  2. Those requiring leadership by the County of Sacramento.

There are many people who contribute to the success of the Sacramento County Elder Death Review Team. As chairperson, I am thankful to each and every one of the EDRT committee members for their valuable contribution. Each case presentation provides an opportunity to expand our knowledge and improve systems of protection for vulnerable and abused elderly.

The continuing success of this effort is dependent on the time, talent and commitment of those individuals and agencies participating. They deserve both our respect and thanks for their participation.

Finally, thank you for your interest in the Sacramento County Elder Death Review Team. We invite your feedback and suggestions.

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Jeff Rose, Assistant Chief Deputy District Attorney  
Sacramento County District Attorney  
Chair, Elder Death Review Team

# 2006 Elder Death Review Team Report

The death of one of our elderly is tragic. It adversely impacts families, friends and the community. If the senior is alone, it is a final and sad step in an isolated existence. While the figures are not yet available for the number of elder deaths in Sacramento County in 2005, the number of deaths in 2004 was 9,637. Unfortunately, a small percentage of those cases require extra attention because the death appeared to have occurred under questionable circumstances. There may be issues of neglect or abuse, or self-neglect, in thus they warrant further scrutiny.

That is the mission of the Elder Death Review Team (EDRT):

1. To examine deaths associated with suspected elder abuse and/or neglect; and
2. To identify and implement prevention strategies to protect Sacramento County's elders.

The Sacramento County EDRT was formed in 1999. It was the first such effort in the nation. It created a multi-disciplinary committee focused on reviewing questionable deaths of elders in Sacramento County. This cooperative effort was launched by the Sacramento County District Attorney, Jan Scully and the Director of Health and Human Services, Jim Hunt, in collaboration with other concerned and committed community leaders. Since January 2004, EDRT has reviewed more than 100 cases.

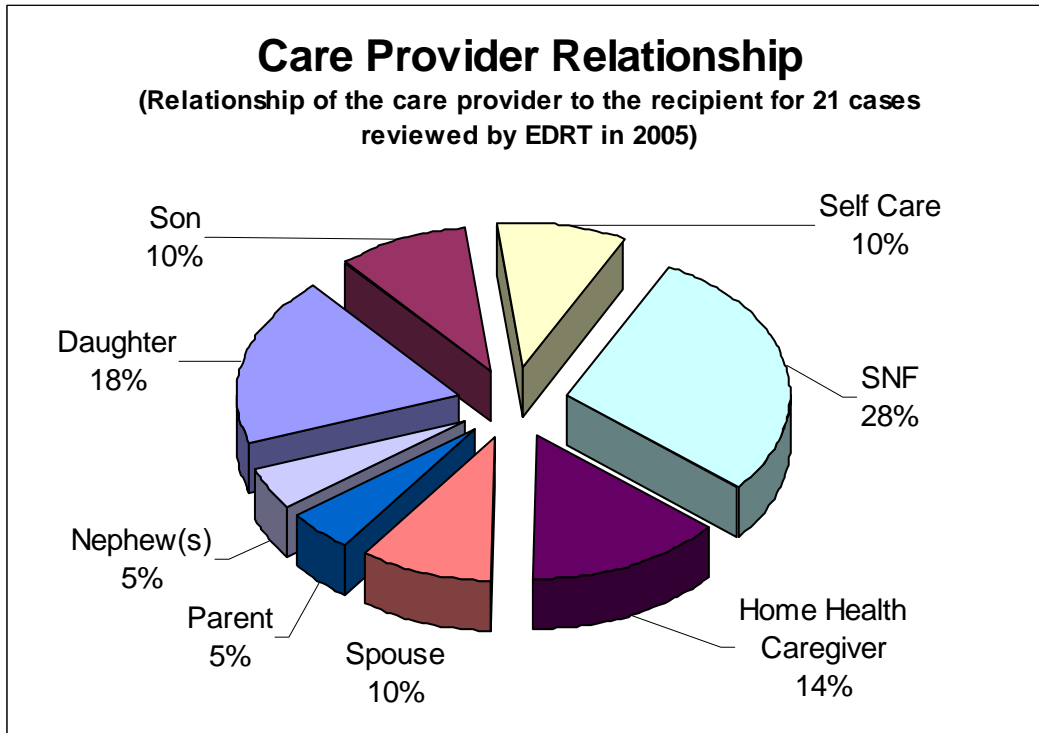
In the last two years, the Committee has altered its focus, in part, to look at cases in which a senior had been involved with provider agencies, to focus attention on specific community services and to ensure there is an avenue for implementing the Committee's recommendations. For this report, EDRT focused on cases where the individual was involved with Sacramento County's In-Home Supportive Services (IHSS). IHSS provides services to elderly and disabled individuals so they can remain safely in their own homes instead of requiring institutional care such as skilled nursing facilities. This program was selected due to the extensive service it provides to older adults and their increased risk of abuse or exploitation due to physical, mental or cognitive impairment. A more complete description of IHSS is attached to this report as Appendix 1.

Currently, IHSS serves over 18,000 recipients (16,697 in 2005) and services are provided by over 17,500 paid care providers. The majority of providers are family members or friends, while the remaining are hired care providers previously unknown to the recipient. In December 2005, there were 16,697 IHSS consumers. Fifty-three percent of recipients were over the age of sixty-five and sixty-two percent had family members as their care provider.

IHSS provides recipients with support services based on a functional assessment of a recipient's capacity to care for themselves in specific activities of daily living. Services are provided in the following categories:

Housework	Judgment	Transportation to Medical
Shopping & Errands	Ambulation In-Home	Appointments
Laundry	Memory	Repositioning & Skin Care
Dressing	Bowel & Bladder Care	Feeding
Meal Preparation	Bathing & Grooming	

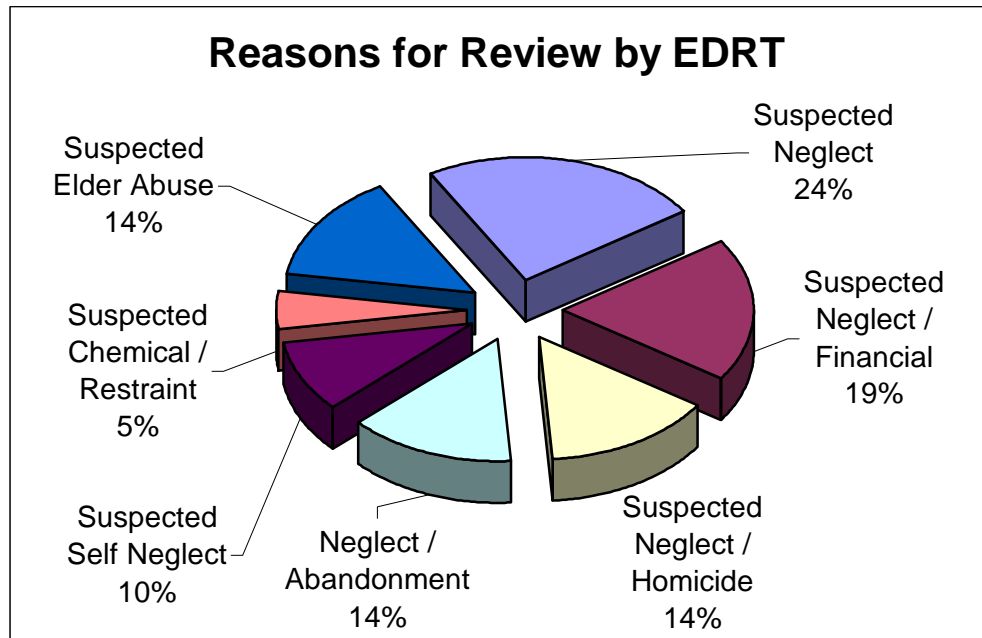
During the case review process, which culminated in this report, EDRT reviewed twenty-one cases. A third of the cases reviewed were IHSS recipients, with paid care providers. Of the IHSS cases, 90 percent had a paid care provider who was a family member. The remaining cases were handled by: other agencies (3); skilled nursing facilities (6); or were self-care (2).



Son – 2; Daughter – 4; Nephew – 1; Parent – 1; Spouse – 2; Home Health Caregiver – 3;  
SNF – 6; Self Care – 2

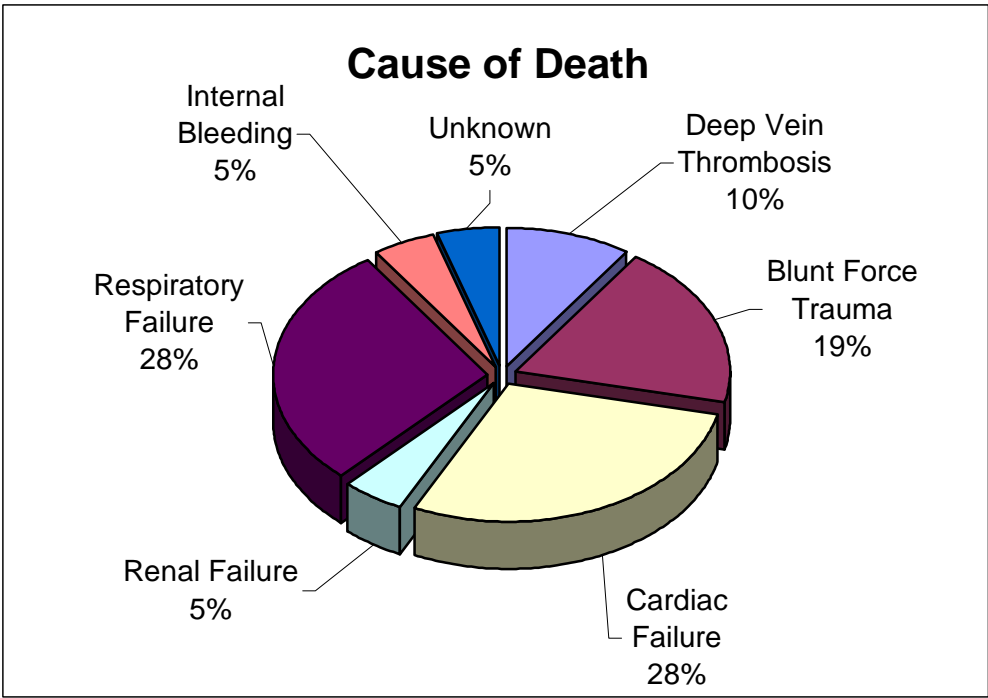


Each of the twenty-one cases came to the attention of EDRT because there were suspicions of abuse or neglect as potential contributory factors in the death of the individual.

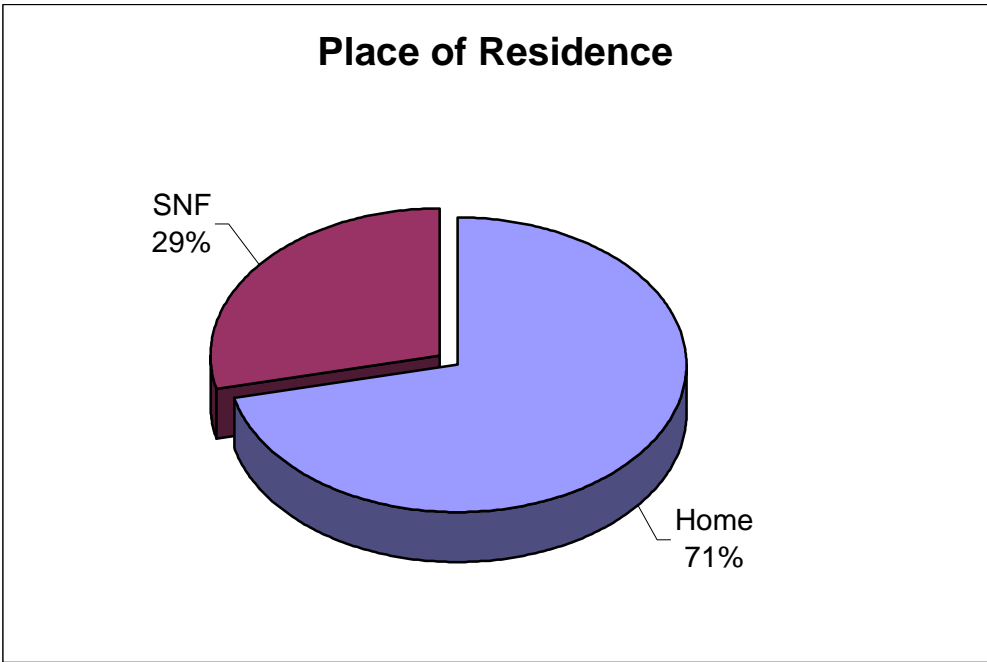


Suspected Neglect – 5; Suspected Neglect/Financial – 4; Suspected Neglect/Homicide – 3;  
Suspected Neglect/Abandonment – 3; Suspected Self Neglect – 2;  
Suspected Chemical/Restraint – 1; Suspected Elder Abuse - 3

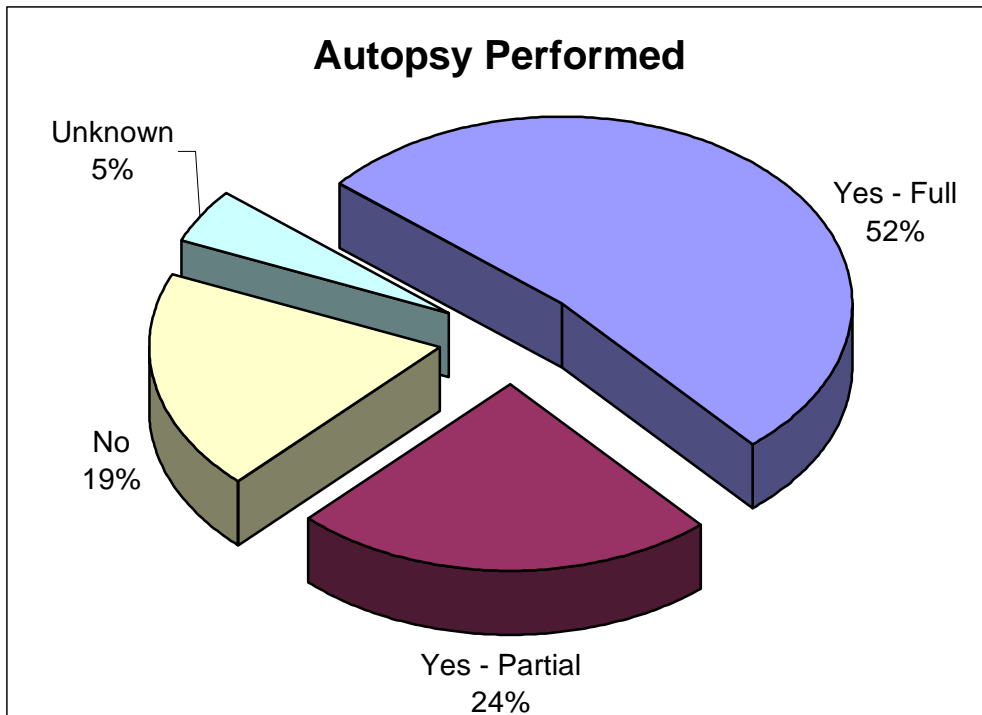
As one can see from the list above and the causes of death noted below, the concerns raised by these cases are grave and the review process provides an important venue to shed light on ways agencies and the community can provide a more effective safety net for our elder citizens. Reviewing cases provides insight for affecting positive change within support agencies and the community as well as to help identify patterns that lead to fatal outcomes. In those instances where further investigation is warranted, members of the Committee, including law enforcement and the District Attorney’s Office can and do provide critical follow up.



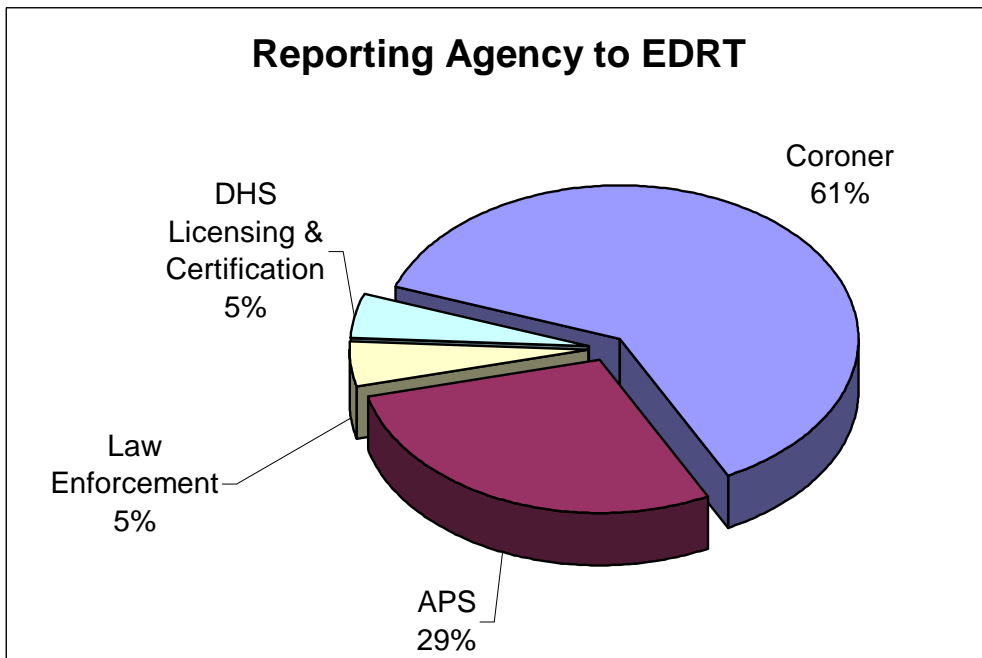
At the time of their deaths, the majority of the individuals were residing in their own homes, with six living in skilled nursing or board and care facilities.



There were full autopsies done on just over half of the identified cases, with seventy-five percent getting either a full or partial autopsy. A partial autopsy is a visual inspection of the body. There was no autopsy on four of the cases and one was unknown as the body was transferred out of the County.



The Coroner's Office made the majority of referrals to EDRT followed by Adult Protective Services (APS) and law enforcement.



Attached to this report are four examples of cases that were reviewed by the Committee. While these cases do not encompass the totality of issues presented to EDRT, they are illustrative of some of the complex issues that arose during the 2005 review. Over the course of the year, cases are referred to the Committee from numerous sources. In this round alone, there were referrals from the Coroner, APS, law enforcement and the public.

Issues presented in these cases have caused the Committee to reflect on concerns such as: protocol for referrals from hospitals to the coroner regarding abuse and neglect; discharge planning issues impacted by questionable caregivers; the rights of individuals to refuse services or even how an individual gains access to services when they are at risk; cross-jurisdictional reporting concerns and the potential interference of HIPAA in getting access to adequate information to conduct a comprehensive case review.

All of these issues raise concerns. Many of them can directly impact the health and safety of some of our most fragile and at-risk citizens. Yet, there are often no clear-cut answers. The importance of this group is that it brings all of the critical players together to have the discussions and, hopefully, begin to generate ideas that will overcome the hurdles and improve lives in the future.

### **IHSS Challenges**

For In-Home Supportive Services, the key issues are client health and safety in the home. In fact the program is predicated on providing supportive services that will allow recipients to remain in their homes safely, enjoy the best quality of life possible and avoid institutionalization.

IHSS assesses the physical needs and constraints of recipients and authorizes service hours to ensure they receive adequate care. The recipients hire care providers, who are paid to provide the authorized services. It is important to note that statutorily IHSS recipients are the employers of record and therefore in charge of hiring, training, supervising and firing their providers. This right has been vigorously asserted and protected by some consumer advocates.

Throughout the course of the case reviews in 2005, four elements were observed that impacted IHSS's ability to provide adequate oversight:

1. Lack of a clear protocol or procedure that ensures providers understand their critical responsibilities and how to provide the care authorized.
2. The incapacity of the system to hold providers accountable for their assigned work hours and to monitor the quality of care delivered to the IHSS consumer.
3. The need for more comprehensive and substantial training for all providers to increase their skills and capacity to meet the recipients' service needs.
4. The difficulty in addressing a recipient's inability or refusal to hire appropriately trained care providers when discharged from a hospital or other institution.

In three of the IHSS cases reviewed questions were raised about the provider's capacity to respond to the recipient's healthcare or wound needs. Two cases raised concerns about hospital discharge planners sending patients back to homes where they had provider concerns. One case noted that the substitute care provider said they did not know they were responsible for the bathing and repositioning needs of the recipient, which contributed to bedsores and severe health changes.

Some of the issues raised through this ongoing discussion are systemic and will require statutory changes. Regulatory changes are needed to address some of the concerns regarding provider accountability and skill development. The Committee is committed to support the efforts, on both fronts, as they move forward.

# **Recommendations**

1. **Consumer Safety** – In-Home Supportive Services (IHSS) consumers are often extremely vulnerable. It is crucial that the care provider have no history of inflicting abuse or exploitation. Currently, IHSS consumers have the right to request a background check on prospective providers through the Public Authority, without cost to the consumer.

EDRT recommends that the Sacramento County Board of Supervisors support legislation mandating state funded background checks on all care providers and require that all care providers pass the background check. Anyone failing such a background check would not be eligible to become a paid care provider.

2. **IHSS Training for Care Providers** – IHSS recipients have the right to hire their own care providers. They are the employer of record. There is no IHSS requirement for special knowledge or skills for working with elderly or disabled recipients.

EDRT recommends that the Sacramento County Board of Supervisors support legislation for State funding for mandatory training of care providers. Training of IHSS care providers would require satisfactory completion of a regimen of health and safety training such as: basic medical care, CPR, First Aid, and specialized training to meet the specific consumer's requirements. In addition, they should receive information on mandated reporting requirements. The basic curriculum must be completed prior to becoming an eligible paid IHSS care provider.

3. **Provider Fraud, Abuse and Neglect** - EDRT recommends that the Sacramento County Board of Supervisors support legislation authorizing IHSS to remove and block individuals from serving as paid care providers when substantial evidence of neglect, abuse or financial exploitation of an IHSS recipient exists.

4. **Community Outreach** – It is critical that agencies and advocates continue to publicly address issues that affect the well being of the elderly. Prevention and intervention requires a comprehensive approach actively supported by the entire community.

EDRT recommends expanding community awareness of elder issues through educational campaigns supported by volunteers from both public and private agencies. They will provide training and materials at facilities and organizations that serve the elderly - retirement communities, churches, etc. Materials on topics such as financial abuse, scams targeting the elderly, drug and prescription interaction or medical conditions that affect the elderly will be prepared by the EDRT with assistance from known health and safety experts.

5. **Public Awareness** - EDRT recommends developing and disseminating a resource brochure with information relevant to the elderly and their caretakers. The brochure will describe agencies that provide assistance, contact numbers and website information. The brochure would provide information about alternate and emergency housing, in-home care, assisted living facilities, medical concerns, and the reporting of suspected financial or elder abuse. Once completed the brochure would be translated to meet the needs of Sacramento's multi-ethnic community.

EDRT recommends expanding the Sacramento Elder Death Review Team's website. This website provides information on the mission and operations of the EDRT. Enhancement will add documents of interest on issues of elder abuse and reports pertinent to professionals working in the field. This will create a "one-stop-shop" with an interdisciplinary approach to elder abuse, financial abuse, available services and other applicable resources.

- 6. Hospital/APS/Coroner Protocol** – Currently there is limited communication among public and private agencies within the county which contributes to delays in the investigation of suspicious deaths of the elderly.

The EDRT recommends funding and implementing a new communication protocol allowing Adult Protective Services, the Coroner's Office and local hospitals to share information related to patients with APS involvement. This shared data will expedite investigations of suspicious deaths.

The protocol would require medical facilities to immediately notify the Coroner's Office of a death of an APS client. The Coroners Office would provide APS with a list of people aged 65 and older who died during the previous twenty-four hours. APS staff would cross check these deaths and send pertinent data back to the Coroners Investigators for possible investigation.

The protocol would also require medical facilities to immediately notify APS if a client/patient is discharged, including situations where the patient leaves the hospital against medical advice. This will help to ensure that APS clients are monitored appropriately and reduce the likelihood of their return to a hazardous or unsafe environment without adequate support.

- 7. Law Enforcement Staffing** – Local law enforcement is hampered by the limited number of detectives assigned to elder and disabled adult issues. Currently two detectives are assigned to the Sacramento Sheriffs Departments Elder Abuse Detail. Each detective has a caseload of over forty cases. Child abuse detectives by comparison average ten cases and the sexual assault detectives average twelve to fourteen cases. Because of current staffing, response time is often delayed. Priority is given to cases where danger is imminent or a death has occurred. Other cases are addressed only as time permits.

In addition, Sacramento County's projected elder and dependent adult populations will more than double in the next few years, exacerbating the problem. The ability of law enforcement to meet the needs of this vulnerable population is a significant concern. Protecting this expanding population against crimes perpetrated on them will be a huge challenge without additional manpower.

EDRT recommends that the Sacramento County Board of Supervisors dedicate more resources to expand the capacity for criminal investigations of elder abuse and to provide funding for the District Attorneys needed to prosecute these often complex cases.

**2006 EDRT Spotlight Agency:**

**COUNTY OF SACRAMENTO  
DEPARTMENT OF  
HEALTH & HUMAN SERVICES  
OVERVIEW OF  
IN-HOME SUPPORTIVE SERVICES  
(IHSS)**



This report highlights the Sacramento County Department of Health and Human Services, In-Home Supportive Services (IHSS) program. This program was selected due to the extensive service it provides to older adults and their increased risk of abuse or exploitation due to physical, mental or cognitive impairment. In December 2005, there were 16,697 IHSS consumers. Fifty-three percent were 65 years of age or older. Sixty-two percent of IHSS consumers have family care providers.

## History

Beginning in the 1950's, the Federal government addressed the care giving needs of older adult, blind and disabled individuals through the Old Age Assistance, Aid to the Blind and Aid to the Totally Disabled Programs. In the late 1970's, In-Home Supportive Services (IHSS) was created to serve the elderly, blind or disabled individuals who were not able to remain in their homes without assistance. Those currently served by IHSS include persons with developmental disabilities, mental illness, severe cognitive impairments, such as dementia, and those who have severe physical disabilities requiring the use of assistive devices.

## Funding

Federal, State and County governments fund IHSS.

## Eligibility

IHSS is a state mandated and regulated program, operated at the county level in accordance with the California Welfare and Institutions Code (W&IC) and overseen by the California Department of Social Services. Both Federal and State laws serve to make IHSS an entitlement program that serves individuals who meet the financial and functional need criteria for services.

An eligible person must:

- 1) Be a California resident;
- 2) Live in a private residence  
(Does not include acute hospital, skilled nursing facility, intermediate care facility, community care facility or a board and care.); and
- 3) Receive Social Security Income benefits (SSI/SSP) or have Medi-Cal income eligible status and may also pay a monthly share of cost.

## Demographics

As of December 2006, Sacramento County provided services for more than 18,000 recipients. Approximately 60% of the recipients are female and about 40% are male. The charts below list the age and ethnicity demographics of the IHSS recipients.

<b>Years of Age</b>	<b>Number of Recipients Within age range</b>
0 – 6	126
7 – 18	564
19– 44	2589
45– 64	5161
65 – 79	5895
80 years	3808
<b>TOTAL</b>	<b>18,143</b>

<b>Ethnicity</b>	<b>Summary IHSS Population</b>
White	8392
Hispanic	1636
Black	3672
Other Asian / Pacific Islander	417
American Indian / Alaska Native	102
Filipino	425
Chinese	872
Cambodian	60
Japanese	32
Korean	42
Samoan	22
Asian Indian	245
Hawaiian	8
Guamanian	7
Laotian	1470
Vietnamese	573
<b>Total</b>	<b>17975</b>

The difference between the totals in the above charts is due to ethnicity data not being entered into the database at case application but after the case has been assigned and the application process has been completed by the social worker.

## **Assessment of Recipient/Consumer**

### **IHSS Social Worker responsibilities include:**

- Conducting initial and annual home assessments;
- Performing assessment of needs in consultation with the IHSS recipient, utilizing the California Department of Social Services regulations, and the uniform assessment tool, to evaluate the recipient's functioning ability in activities of daily living;
- Calculating and authorizing hours and tasks to be done by care providers; and
- Assessing potential for consumer abuse.

The IHSS assessment is based upon the recipient's functioning level and need, rather than diagnosis. A five-point scale is used to rank functional ability for tasks for every recipient.

### **Functional Task or Service Categories are:**

Housework	Memory
Shopping & Errands	Bowel & Bladder Care
Laundry	Bathing & Grooming
Dressing	Transportation to Medical
Meal Preparation	Appointments
Judgment	Repositioning & Skin Care
Ambulation In-Home	Feeding

Respiration - Respiration is limited to non-medical services such as assistance with self-administration of oxygen and cleaning oxygen equipment and machines.

Transfers - Assisting from standing, sitting, or prone position to another position and/or from one piece of equipment or furniture to another. This includes transfer from a bed, chair, couch, wheelchair, walker, or other assistive device generally occurring within the same room.

Orientation - Is aware of time, place, self and other individuals in one's environment.

Paramedical - Activities:

- 1) Which persons would normally perform for themselves but are unable due to their functional limitations
- 2) Which due to the recipient's physical or mental condition are necessary to maintain the recipient's health
- 3) Which include the administration of medications, puncturing the skin or inserting a medical device into a body orifice, activities requiring sterile procedures, or other activities requiring judgment based on training given by a licensed health care professional.

Protective Supervision due to Mental Impairment – Is available to safeguard the recipient against injury, hazard or accident by observing the behavior of non-self-directing, confused, mentally impaired or mentally ill person. For a person identified by an IHSS social worker to potentially need Protective Supervision, an "Assessment of Need for Protective Supervision for In-Home Supportive Services Program," must be completed by a physician or other appropriate medical professional and returned to the County.

Protective Supervision (or this service) is not available in the following instances:

- 1) When the need for protective supervision is caused by a physical condition rather than a mental impairment;
- 2) For friendly visitation or other social activities;
- 3) When the need for supervision is caused by a medical condition and the form of supervision required is medical;
- 4) In anticipation of a medical emergency (such as seizures, etc);
- 5) To prevent or control antisocial or aggressive recipient behavior.

### **Alternative Resources**

The IHSS social worker will arrange for the delivery of alternative resources, as necessary, when they are available.

### **IHSS Recipient/Consumer responsibilities include:**

- Consults with IHSS social worker on needs, limitations, service assessment
- Interviews, hires and terminates their own provider
- Directs and supervises provider on tasks
- Signs provider's timesheet twice per month
- Reports to IHSS social worker any changes, complaints, request reassessment

The IHSS regulations determine the range of services provided to the recipient, yet it is the recipient who drives the program. The recipient decides how, when, and in what manner IHSS services will be provided. Sacramento County provides the “recipient responsibilities” form to consumers, listing their responsibility as employers.

### **Care Providers**

There are 16,793 care providers in Sacramento County.

- Care Providers are hired by IHSS recipients at their sole discretion. The Care Provider can be a family member, spouse, friend, neighbor, professional care provider or whomever the IHSS recipient chooses regardless of their ability to provide the care needed.
- IHSS Family Service Workers assist consumers with finding a provider
- The Public Authority manages a database of registered providers, and conducts a provider background check upon request from the recipient
- Current rate of pay in Sacramento County is \$10.40 per hour with a maximum number of hours per month of 283 to be used in any configuration.

Processing of the care provider’s timesheets is handled by IHSS. Checks are issued from the State. IHSS Payroll Staff process more than 16,800 timesheets twice a month (33,000-35,000 monthly).

### **Background Checks**

Current law states that an IHSS recipient has the right to obtain the criminal background record (if one exists) of their potential care provider from the State Department of Justice. Requesting a criminal background check is the recipient’s choice and not mandatory. If a background check is requested through the Public Authority Registry, there is no fee to the recipient.

### **Application Process**

An IHSS screening social worker will conduct an initial phone interview to begin the application process. Once meeting the application requirements, the case is assigned to a case-carrying social worker.

If the applicant is income eligible but is not receiving Medi-Cal benefits, a Medi-Cal application packet will be sent to their home for completion. Processing of the application takes approximately 45 calendar days. Once approved by Medi-Cal, the case will be assigned to a social worker.

Anyone can refer a potential consumer including a neighbor, family member, hospital staff, senior center staff, physician office personnel, home health agency staff and community organizations. Self and family referrals are the most frequent types.

### **Priority Assessments**

Sacramento County is unique in that it has designated social workers to respond to priority intake assessments.

**Criteria** for priority assessments include:

- Hospice patients
- Institutional patients (acute care, skilled nursing facilities, board & care) preparing for discharge home with or without a provider in the home
- Individuals who are 80+ years of age, who are medically compromised and/or isolated

### **Fair Hearing/Administrative Law**

If a recipient has a disagreement with the services authorized by the social worker, they may file for a fair hearing. An administrative law judge will determine the services for which the IHSS recipient may be eligible.

### **Disaster Preparedness Plan**

The caseload Disaster Preparedness (DP) assessment provides a safety check for all elderly and disabled IHSS consumers who might be unable to care for themselves, or even call for help, in the aftermath of a disaster. The IHSS social workers assess every consumer as to their need for contact in a disaster situation.

Codes are assigned to consumers based upon:

- Lacking social support systems
- Living in an isolated area
- Bed bound/wheelchair bound
- Severely mentally disabled
- Special impairments
- Dependent upon medical equipment (in need of tubes/suctioning)

A complete client listing is sent by the state directly to IHSS. A list of at-risk consumers, in Sacramento County, is generated and distributed monthly by the county's Municipal Services Agency to IHSS and other agencies that respond to health related emergencies as well as the Sacramento County Emergency Operation Center for use in the event of a disaster.

### **Quality Assurance**

With the passage of Senate Bill 1104, a quality assurance component oversees program integrity in IHSS. Sacramento County IHSS has a dedicated unit of social workers who perform case reviews on a regular basis. Another issue addressed by SB 1104 was fraud prevention. IHSS has a working relationship with the Department of Human Assistance and their Fraud Investigators.

### **Challenges in the IHSS Program**

Over the past several years, there have been some significant challenges in administering the IHSS program. IHSS has had to balance the increasing number of people needing services with the lack of caseworkers and limited funding.

In an effort to be more responsive to consumers, the number of stakeholders, including agencies that affect or are affected by IHSS, has also increased. The myriad of stakeholders include: consumers, care providers, state health, aging and disability programs, Public Authorities and regional centers, all of which add to the complexity of effective communication and coordination among agencies.

Fraud continues to be a problem. IHSS respects the recipient's rights of self-determination and as the employer of record. For the majority of consumers this arrangement works extremely well. However, there are a small percentage of consumers who are more vulnerable to provider fraud. According to the January 2003 County Welfare Directors Association of California report, "fraud may manifest as phony time sheets or consumers approving hours for care providers that were not provided due to intimidation and/or fear of losing the care provider on whom the consumer depends".

Another smaller fraud problem occurs when mentally competent consumers work in concert with the caregivers to knowingly approve phony or incorrect timesheets. Additionally, some recipients do not pay the share of cost to the care provider resulting in a higher turnover rate.

### **Organizational Chart**

County of Sacramento, Senior and Adult Service Division, IHSS Program

Two current locations:

- Broadway & 49<sup>th</sup> Street, South County
- Watt Avenue & Freedom Park, North Highlands, North County
- Planned third site in the east county area

### **Total IHSS staff 178.8 FTE:**

2 Clerical and 2 Payroll Units

1 Fraud Investigation Unit

1 Screening/Intake Application Unit

1 Quality Assurance Unit

1 Hearings Unit

10 Case Carrying Social Work Units with 8 –9 in each Unit

1 Family Service Worker Unit – 9 FSWs

1 Public Health Nurse Unit – 13 PHNs

1 Department of Human Assistance Eligibility Specialist Unit – 11 Specialists

# **Elder Death Review Team**

## **In-Home Supportive Services Case Reviews**

The following four anonymous cases chosen to illustrate the type of information reviewed by EDRT. One case falls outside of the timeframe of this report, but was used to show the variety of issues EDRT reviews regularly.

# Elder Death Review Team

## In-Home Supportive Services Case Review #1

**IHSS Case Summary:** Client was a 76-year-old female who lived in a private residence with her son and the son's girlfriend, who was the Care Provider (CP). Client had multiple health problems including diabetes, history of heart attacks and stroke, incontinence and asthma. Client was non-ambulatory and needed extensive assistance with domestic and personal care. The client, after moving to Sacramento to live with her son, applied for IHSS. IHSS hours increased from 188 to 264 hours over a 3-year period due to the client's declining health. The IHSS social worker noted at the client's last reassessment that she appeared to be receiving good care.

**Care Provider Relationship:** Girlfriend, age 27, of the client's son.

**Why Was Case Referred To EDRT?** Open APS case with alleged neglect by caretakers. The care provider and her boyfriend left on a vacation leaving the recipient in the care of a teenage grandson who had no experience caring for someone with complicated medical conditions. This action resulted in the rapid decline of the recipient's health and subsequent admission to the hospital.

**Concerns Addressed By EDRT:** The son and his girl friend (the CP) left town on a vacation leaving a grandson and family friend to care for client. The HHA nurse called the son and asked him to return home due to client's deteriorating physical condition. Client was transported to an acute care hospital via ambulance. Client was treated with antibiotics for an alleged urinary tract infection and after two days showed no significant improvement. A CT scan of client's head revealed a subdural hematoma. Client was also noted to have several stage III and IV decubitus ulcers. Law enforcement was notified of possible elder abuse and neglect. IHSS was notified that client was hospitalized and would be discharged to a skilled nursing facility therefore IHSS terminated their case. Client lived another month in the Skilled Nursing Facility and subsequently died.

The cause of the subdural hematoma is unknown.

**Findings:**

1. The decision to leave client with a grandson who was not familiar with her care needs was not in the best interest of the client.

**Recommendations:**

1. Care providers should be prohibited from having an untrained person care for the recipient in their stead while they are being paid to provide the service themselves.
2. Standardized training is needed for care providers and their relief staff. Care providers need to have a mechanism that allows for temporary care of their IHSS recipient when they are unable to perform their duties either due to an illness or vacation. Temporary care can be provided at a facility where the recipient can have care needs provided or a qualified staff person who is trained to temporarily relieve a care provider in the recipient's home.



# Elder Death Review Team

## In-Home Supportive Services Case Review #2

**IHSS Case Summary:** Client was a 73-year old man who was non-ambulatory for 21 years due to a spinal cord injury. He also suffered from diabetes, history of strokes, cognitive deficits due to developmental disability, and kidney failure requiring dialysis. Client initially received 130.2 hours based on his need for domestic assistance, personal care and transfers. Over the ensuing years the client's IHSS hours increased to 199 as more paramedical assistance was needed for medication management. APS was involved twice: once for suspected drug abuse by caregiver and another for a large decubitus ulcer.

**Care Provider Relationship:** Client's 51 years old niece had been the sole live-in care provider for the last 2 years of her life.

**Why Was Case Referred To EDRT?** Adult Protective Services (APS) referred the case to EDRT due to alleged neglect by care provider. The hospital reported multiple decubitus ulcers on the client upon admission to the hospital. The hospital failed to notify the Coroner, APS nor law enforcement upon this client's death.

**Concerns Addressed By EDRT:** Did the alleged neglect by the care provider result in bedsores, which hastened or caused the client's death?

Why was death not reported to the coroner?

What information, if any, was available from the dialysis center, which treated him three times per week?

**Findings:** This case presented a learning opportunity regarding mandated reporting responsibilities. Suspected neglect identified on hospital admission must be reported to law enforcement or APS for investigation. The coroner was not notified that the client died during hospitalization. This resulted in the delay or absence of an autopsy.

**Recommendations:**

1. To improve communication between investigating agencies and hospital staff, the hospital chart should be "flagged" to alert hospital staff of APS or law enforcement involvement and to contact the appropriate agency when a client is pending discharge. The hospital must notify both APS and law enforcement upon suspicion of neglect or abuse and notify the coroner in the case of a suspicious death or one in which there is an open investigation case.
2. Education is needed for hospital staff on the issue of contacting law enforcement or APS. Mandated reporters need to understand that submitting law enforcement or APS referrals are not the same as an accusation but rather providing information as part of an investigation in cases of suspected elder abuse or neglect.

# Elder Death Review Team

## In-Home Supportive Services Case Review #3

**IHSS Case Summary:** The client was an 81-year-old male with a diagnosis of multiple sclerosis, arthritis in both hands, and lower extremity weakness. Client did not have any known family. He lived with a female roommate/care provider for 10 years and a male care provider for 2 years. Client applied for IHSS to receive assistance with domestic services, shopping for food and errands. The client was assessed and initially authorized 33.9 hours. His need gradually increased as his functional status decreased over the next 10 years resulting in an increase to 112.2 hours of service.

**Care Provider Relationship:** A variety of roommates and care providers over a 10-year period.

**Why Was Case Referred To EDRT?** Case reported by IHSS Public Health Nurse to APS as suspected physical abuse. Client was found with a swollen right hand and several thumb size bruises on the wrist. Death was reported to the Coroner's office as suspected neglect. APS case open at time of death.

**Concerns Addressed By EDRT:** Case reviewed as open APS case. The EDRT suspected probable financial exploitation. Client appears to have died from natural causes and not as a result of lack of care.

**Findings:** Client had a live-in female care provider 10 years. A male cared for client intermittently over the 10 years, then moved in with client during the last 3 years. In addition, IHSS provided 5 different care providers during the 10-year period that did not live with the client. Client appeared to receive adequate care from male care provider noted above. IHSS case notes did not include any information regarding suspicions of financial abuse. No findings.

**Recommendations:**  
None. \*

\*Due to the complex nature of many cases there may not be a recommendation.

# Elder Death Review Team

## In-Home Supportive Services Case Review #4

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<b>IHSS Case Summary:</b>	Client was a 78 year-old female with multiple medical problems, including obesity, which rendered her bed bound. Her weight was approximately 350 pounds and she lived alone. The client received IHSS domestic and personal care services for over 27 years. Her care needs and hours gradually increased due to her deteriorating health; she was granted the maximum number of hours, 283, 2 years prior to her death. At this time, the client developed chronic foot ulcers and received wound care from a variety of home health agencies. APS was involved on two occasions, both for suspicions of neglect.
<b>Care Provider Relationship:</b>	Client's ex-husband was the primary IHSS care provider for 11 years until he had one leg amputated and became mostly wheelchair dependent. The client then hired two female care providers who cared for the client until she fired them after only a few months of service. Following the termination of the female care provider's, the client's ex-husband moved in with the client and became her sole care provider until her death, despite his own disability.
<b>Why Was Case Referred To EDRT?</b>	Case was referred to EDRT for alleged abuse. The client's husband, functioning as the care provider, injected the client with his own insulin when the client apparently suffered a string of seizures. Client was not an insulin dependent diabetic. The care provider knew of someone with diabetic seizures and thought that the client was suffering from the same condition. When she did not respond to the insulin, he called a medical transport company for medical assistance.
<b>Concerns Addressed By EDRT:</b>	Client lived alone until her ex-husband moved in with her. Client had multiple health problems related to obesity and rheumatoid arthritis. She appeared well cared for until she developed foot ulcers and her health status declined. A short time prior to her death, the client was admitted to the hospital after her ex-husband reportedly injected her with his insulin after she appeared to be having a seizure. He stated he was just trying to save her life. A month later, the client was discharged home, back to the care of the ex-husband. The ex-husband reported the client was in a coma for two weeks prior to her passing away.
<b>Findings:</b>	The ex-husband's actions were deemed as unintentional. He was described as naïve and lacked the ability to make sound medical decisions. The hospital record noted that the client wanted to be discharged home to the care of her ex-husband. No evidence of physical neglect, or foul play. Insulin levels performed were normal. Evidence of congestive heart failure due to hypertensive heart disease was found at autopsy. No evidence of foul play by coroner's investigation. Death ruled natural.

**Recommendations:**

None\*

However, it was noted that mandated training and the availability of emergency nurse attendants via telephone might have assisted this care provider in making better decisions for the consumers care.

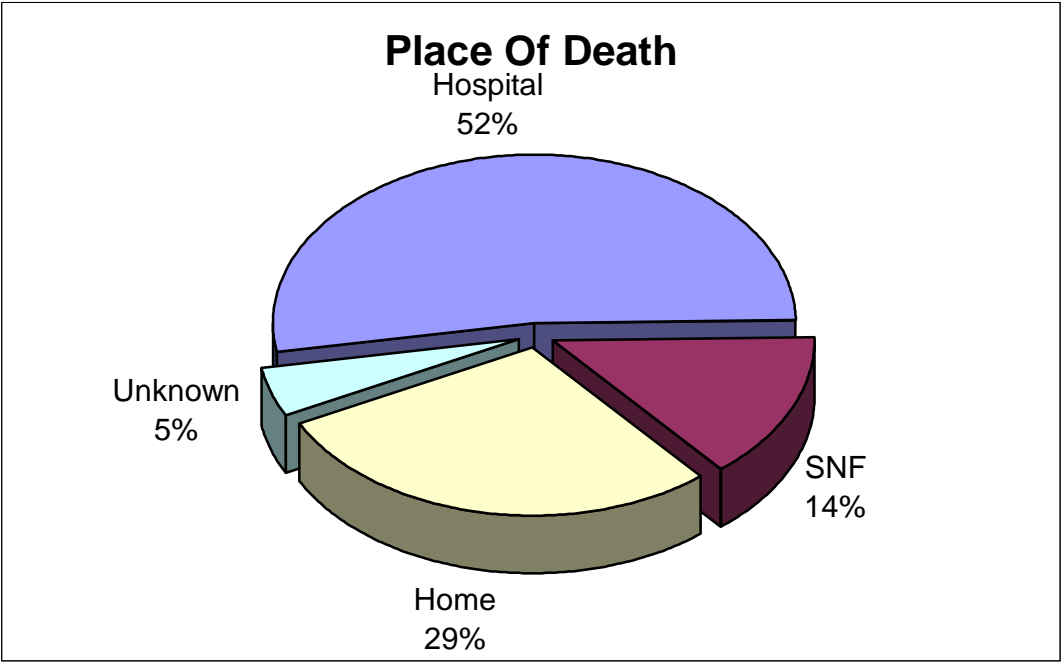
This case presented a good example of the conflict of allowing a recipient to keep a care provider regardless of their competency.

\*Due to the complex nature of many cases there may not be a recommendation.

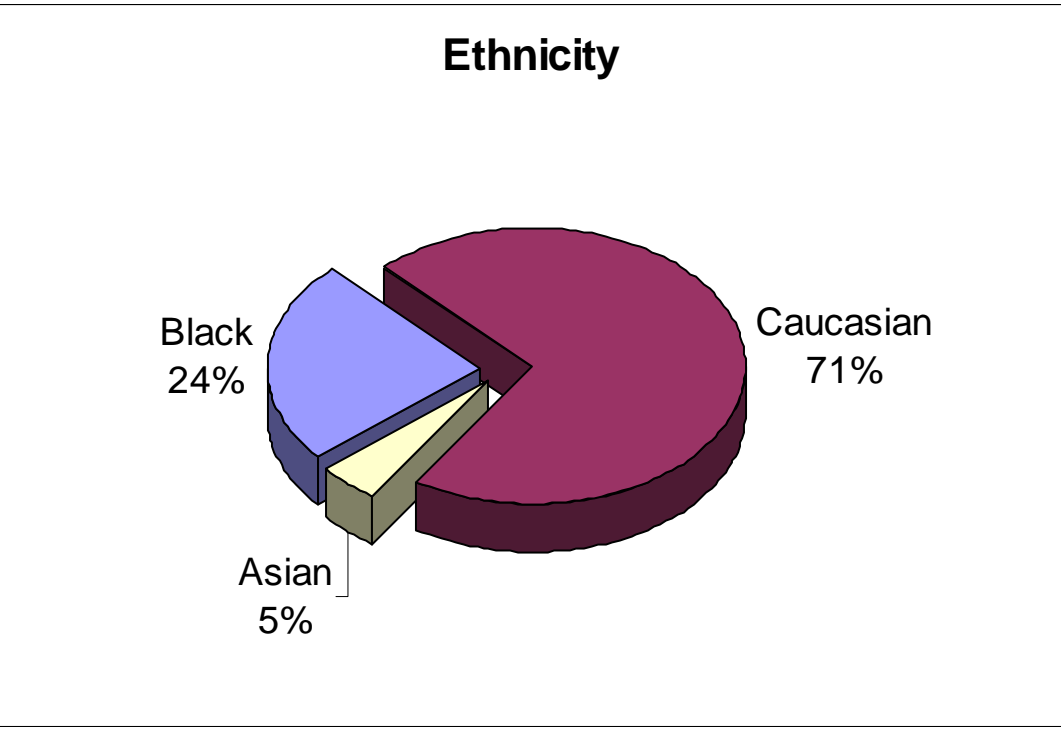
# **EDRT 2005 Statistics**

## **Based on Place of Death and Ethnicity**

In 2005 EDRT reviewed 21 cases and collected statistical data. Following is a breakdown of information regarding the data elements collected on the cases reviewed. Below each graph is the actual number of cases for each identified data element.



Hospital – 11; Skilled Nursing Facility – 3; Home – 6; Unknown - 1



Asian – 1; Black – 5; Caucasian - 15

**County of Sacramento  
Elder Death Review Team  
"EDRT"  
Protocol**

Revised November 2006

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# Introduction

## **Establishment of an Elder Death Review Team**

In July 1999, Sacramento County District Attorney, Jan Scully and Director of Health and Human Services, Jim Hunt collaborated to address elder neglect and abuse. The concept of an Elder Death Review Team (EDRT) is an outgrowth of that collaboration.

The primary role of the EDRT is to serve as a multidisciplinary case investigating committee providing in-depth analyses of the possible contribution of abuse and neglect to deaths of elders in Sacramento County. EDRT also serves to strengthen system policies and procedures, and to identify prevention measures to stop future incidents of elder abuse-related injuries and deaths.

There are child death review teams (CDRTs) and domestic violence review teams (DVRTs) successfully operating throughout the state. Sacramento County is in the forefront in bringing the same type of critical analyses to elder deaths.

## **Elder Death Review Team Protocol**

The EDRT Protocol states the “Mission and Goals” of the Sacramento County Team. The Protocol defines policies and procedures to follow in addressing issues that include: identifying team membership; deciding which cases to review; exchanging confidential information; and, collecting and accessing data.

This protocol is intended to be used as a guide for the EDRT.

# Purpose of the Elder Death Review Team

## Mission Statement

The Sacramento Elder Death Review Team (EDRT) will examine deaths associated with suspected elder abuse and/or neglect.

The EDRT recognizes that the responsibility for responding to, and preventing, elder abuse and neglect fatalities lies within the community, and not with any single agency or entity. The EDRT further recognizes that a careful examination of the fatalities provides the opportunity to develop education and prevention, as well as “develop concepts and strategies to assist public and private agencies in the investigation and prosecution of perpetrators of elder abuse” that will lead to improved coordination of services for families and Sacramento County’s elder population.

## Goals

The specific goals that the EDRT will use as the basis to achieve this mission are:

- Prevent elder abuse fatalities.
- Examine and/or investigate deaths of elders with suspected elder abuse and/or neglect.
- Identify patterns that lead to fatal outcomes.
- Discuss whether reviewed deaths may have been preventable and make suggestions for corrective action.
- Develop and implement prevention strategies.
- Increase awareness of health care providers’ responsibility to consider abuse or neglect as contributing to death.
- Increase awareness of health care providers’ responsibility to refer cases arising from suspected abuse or neglect to the appropriate agencies including, but not limited to: coroner, adult protective services, state licensing department, ombudsman, and law enforcement.
- Improve system responses by identifying gaps in delivery of services.
- To gather and share information which the District Attorneys office, outside of this committee, may use to initiate an investigation.
- Develop intervention strategies to reduce fatalities and eliminate ongoing abuse and/or neglect of the county’s elder population.

# Team Membership

## Core Members

The Sacramento County Elder Death Review Team will consist of representatives of law enforcement, public health, social service agencies and health-care providers including, but not limited to, the following:

- Office of the District Attorney
- Office of the Coroner
- Law Enforcement
  - Sacramento County Sheriff's Department
  - Sacramento City Police Department
  - Citrus Heights Police Department
  - Elk Grove Police Department
- Department of Health & Human Services (DHHS)
  - Adult Protective Services
  - In-Home Supportive Services
  - Public Administrator/Public Guardian/Public Conservator
  - Public Health
  - Mental Health
  - Adult & Aging Oversight Committee
- Health Care Professionals
  - Hospital Emergency Room
  - Mercy Hospital
  - Sutter Hospital Senior-Care
  - Kaiser Hospital
  - Kaiser Permanente Home Health, Hospice & Palliative Care
  - Sutter Health
  - Nurses, Pharmacists
- California Department of Social Services Community Care Licensing
- State Department of Health Services Licensing And Certification
- Ombudsman
- Alta California Regional Services
- Sacramento City Fire Department
- Sacramento Metropolitan Fire Department
- California Attorney General's Office, Bureau of Medi-Cal Fraud And Elder Abuse
- Sacramento County Counsel
- California Attorney General's Office, Elder & Dependent Adult Abuse Unit

## **Other Members**

This list is not inclusive, and other individuals may provide valuable insight for certain reviews. These representatives might include:

- Emergency Medical Technician (EMT)
- Gero-Psychologist
- Geriatric Network
- University Of California Davis Medical Center, Psychiatry
- University California Davis Medical Center, Division Of General Medicine

## **Team Leadership**

A representative of the District Attorney's Office, the DHHS Senior and Adult Services Division, or the Coroners Office will chair EDRT. The chairperson will serve for a minimum of one year. At the end of that time, the team may ask the current chairperson to continue in that position, or select a new chairperson.

The co-chairperson will be a member from the community, such as a representative from the Department of Health & Human Services, a geriatrician, a skilled nursing facility representative, or others.

## **Staffing**

The EDRT is staffed by one half-time EDRT Coordinator.

## **Meeting Schedule**

The EDRT will meet once a month at the District Attorney's Office at 901 "G" Street on the fourth (4<sup>th</sup>) Thursday of every month at 1:30 p.m. Members shall designate an alternate in the event the member cannot attend a meeting. The alternate should be knowledgeable about the case placed on the agenda for review at that meeting.

## **Statutory Authority**

Penal Code Section 11174.5.

- (a) Each county may establish an interagency elder death team to assist local agencies in identifying and reviewing suspicious elder deaths and facilitating communication among persons who perform autopsies and the various persons and agencies involved in elder abuse or neglect cases.
- (b) Each county may develop a protocol that may be used as a guideline by persons performing autopsies on elder adults to assist coroners and other persons who perform autopsies in the identification of elder abuse, in the determination of whether elder abuse or neglect contributed to death or whether elder abuse or neglect had occurred prior to but was not the actual cause of death, and in the proper written reporting procedures for elder abuse or neglect, including the designation of the cause and mode of death.

# Case Review

## Definitions

Penal Code Section 368 Defines Elder Abuse, Neglect, And Financial Abuse.

368(b)(1) any person who knows or reasonably should know that a person is an elder or dependent adult and who, under circumstances or conditions likely to produce great bodily harm or death, willfully causes or permits any elder or dependent adult to suffer, or inflicts thereon unjustifiable physical pain or mental suffering, or having the care and custody of any elder or dependent adult, willfully causes or permits the person or health of the elder or dependent adult to be injured, or willfully causes or permits the elder or dependent adult to be placed in a situation in which his or her person or health is endangered, is punishable by imprisonment in a county jail not exceeding one year, or by a fine not to exceed six thousand dollars (\$6,000), or by both that fine and imprisonment, or by imprisonment in the state prison for two, three, or four years.

368(c) when the circumstances or conditions cited above are “other than those likely to produce great bodily harm or death” the offense is a misdemeanor. A second or subsequent violation of this subdivision is punishable by a fine not to exceed two thousand dollars (\$2,000), or by imprisonment in a county jail not to exceed one year, or by both that fine and imprisonment.

368(d) any person who is not a caretaker who violates any provision of law proscribing theft, embezzlement, forgery, or fraud, or who violates section 530.5 proscribing identity theft, with respect to the property or personal identifying information of an elder or dependent adult, and who knows or reasonably should know that the victim is an elder or dependent adult, is punishable by imprisonment in a county jail not exceeding one year, or in the state prison for two, three, or four years, when the moneys, labor, goods, services, or real or personal property taken or obtained is of a value exceeding four hundred dollars (\$400); and by a fine not exceeding one thousand dollars (\$1,000), by imprisonment in a county jail not exceeding one year, or by both that fine and imprisonment, when the moneys, labor, goods, services, or real or personal property taken or obtained is of a value not exceeding four hundred dollars (\$400).

368(e) This section is identical to 368(d), above, with the exception that it applies to “non-caretakers”, while 368(e) applies to “caretakers”.

## **Criteria**

The Sacramento County EDRT will review cases of death of any individual 65 years and older, that meet any of the following criteria:

- Previous calls to the residence for violence or abuse including, but not limited to: Adult Protective Services (APS), Ombudsman; Community Care Licensing (CCL), Department of Health Services (DHS) Licensing, and law enforcement;
- Open or closed case involving abuse or neglect from agencies including, but not limited to: Adult Protective Services (APS), CCL, law enforcement, DHS Licensing and Certification, and Ombudsman;
- Cases referred by health care providers, protective services agencies, and regulatory agencies;
- Any case of blunt force trauma;
- Any case wherein the attending physician requests review of the death;
- Suspicious deaths in long-term care facilities;
- Accidental death from asphyxiation, toxicity, or overdose;
- Signs of abuse or neglect in the home;
- Any death where there was disagreement between investigating agencies regarding the cause of death; or
- Any suspicious death of undetermined cause.

## **Case Information**

Once a case is identified for review, the EDRT coordinator will send case information to the EDRT members via a confidential email prior to scheduling the case for review at an EDRT meeting. The email will include the following information: name of the victim, date of birth, date of death, and name of the facility that has been involved with the victim. If a member needs additional information, they should contact the EDRT coordinator. The EDRT members should gather necessary information pertaining to the specific case, complete the EDRT data collection form, and send it to the coordinator prior to the EDRT meeting.

At the EDRT meeting, members will review the facts and information gathered for each case.

Written materials generated from the meeting, such as case summaries or notes, pertaining to the case will be collected by the coordinator or the chairperson. After material has been used to formulate recommendations, all notes and written materials will be shredded. All data collected for future reference shall be encoded to ensure confidentiality.

# **Confidentiality in the Case Review Process**

## **Confidentiality Issues**

EDRT members recognize that confidentiality is essential to the EDRT process. Confidentiality must be approached on two levels: team confidentiality and member confidentiality. Team confidentiality includes all activities that occur during an EDRT meeting. Written information will be disseminated and reviewed, and collected at the end of the meeting for shredding.

Each EDRT member must keep any information that is given out about specific cases confidential. EDRT should not share or speak about case information with anyone else, including others in his or her organization. Information should not leave the room.

Confidentiality as it relates to the EDRT process will be implemented according to the following guidelines:

- Dissemination of information beyond the purpose of the review team is prohibited
- Case information is limited to the actual review process to enlist inter-agency cooperation
- Use of any material for reasons other than which it was intended is prohibited
- EDRT members are prohibited from creating any files with specific case identifying information

## **Breaching Confidentiality**

Should a breach of confidentiality be discovered, the EDRT chair will investigate it. If substantiated, the representative responsible will be asked to resign from the team, and action shall be taken to prevent further breaches.

**SACRAMENTO COUNTY ELDER DEATH REVIEW TEAM  
“EDRT”**

**Confidentiality Agreement**

I, as a member of the Sacramento County Elder Death Review Team (EDRT), agree to keep confidential all information disseminated prior to or discussed at the death review team meetings. I understand that any verbal or written communication, or a document shared within or produced by the EDRT, or provided by a third-party to the EDRT is confidential and not subject to disclosure or discovery by a third party. (Penal Code sections 11174.4 - 11174.9.)

I also agree that should I have any personal connection that may result in a conflict of interest with any case being brought forward to the EDRT that I will advise the chairman of such conflict of interest in writing, and remove myself from attendance at that particular meeting.

I also agree to return to the chairperson of the EDRT, all outside case information received prior to, or in any meeting involving decedents, at the end of that meeting.

Date \_\_\_\_\_

Printed Name \_\_\_\_\_

Organization \_\_\_\_\_

Signature \_\_\_\_\_



# Data Collection

Data will be collected and summarized by the EDRT to identify patterns or trends, and to ensure consistent and uniform results. This data should include:

- Details of the incident (including where it occurred)
- Information as to whether an autopsy was performed
- Summary of the case
- Any suspicious physical findings or indicators
- Alleged abuser information
- Elder medical information including prescriptions, cognitive status, dependency in assisted daily living needs
- Description of the elder's contact with medical professionals
- Financial information regarding net worth, home ownership, trusts and wills
- Information on POA and advanced directives
- Agencies involved with the elder
- Relationships and ages of parties involved
- Any prior history of the perpetrator and the victim
- Alcohol or drug use
- Use of weapons
- Prior intervention contacts with the system
- Conclusions and recommendations
- Other pertinent information on a case-by-case basis

The data will be used to formulate recommendations for changes in system policy and procedures, and to identify elder abuse prevention strategies.