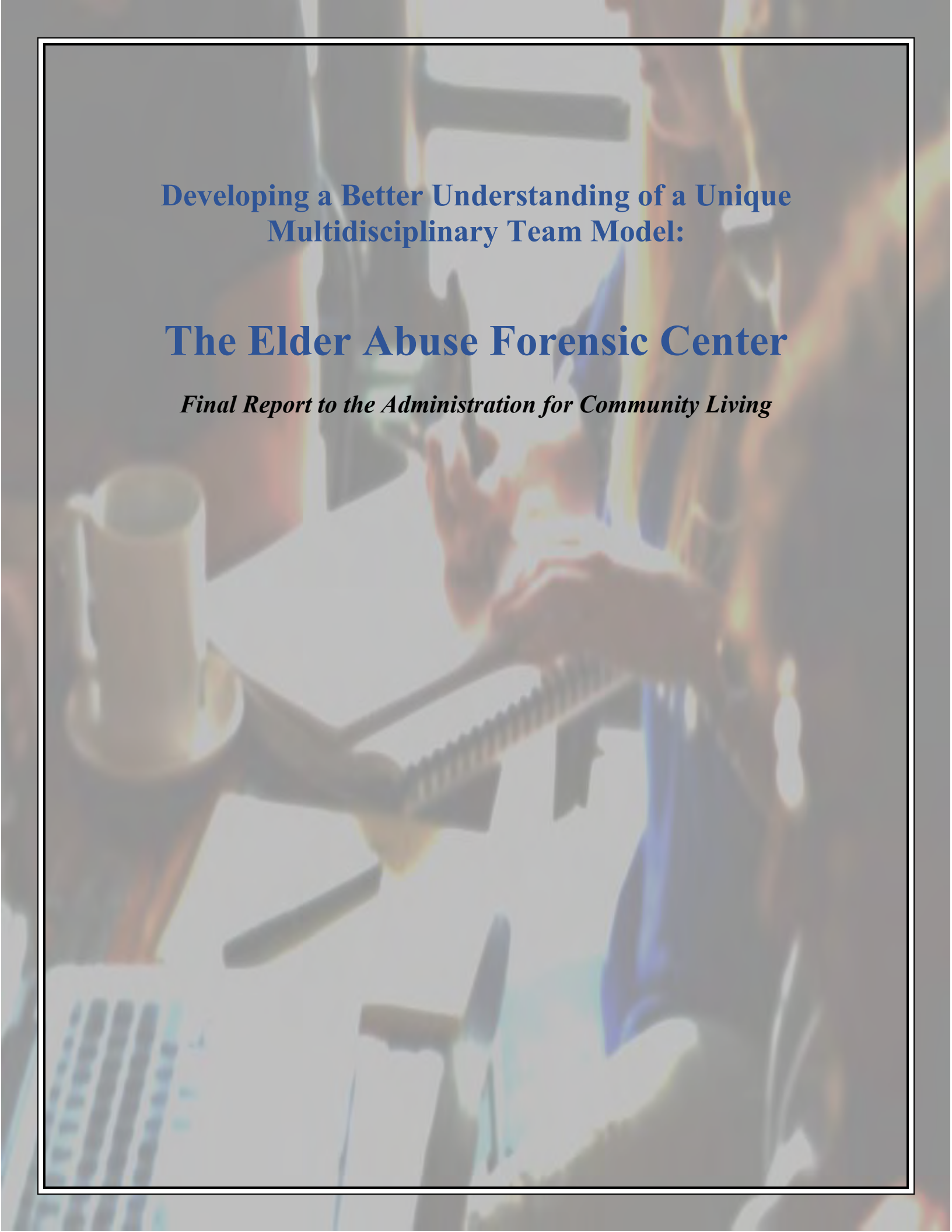

Developing a Better Understanding of a Unique Multidisciplinary Team Model:

The Elder Abuse Forensic Center

Final Report to the Administration for Community Living

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EXECUTIVE SUMMARY

This final report describes the approach and findings of a three-year project aimed at increasing our understanding of the Elder Abuse Forensic Center model, a type of multidisciplinary team that was prioritized in the Elder Justice Act. Multidisciplinary teams have been recognized as an important tool to address the growing problem of elder abuse. Building on a foundation of several decades of research, this project sought to systematically gather information about the national landscape of multidisciplinary teams, before focusing on the Forensic Center model.

The objectives of the study were to: (1) Convene and receive guidance throughout the project from an Expert Panel; (2) Inventory and survey elder abuse multidisciplinary teams; (3) Conduct site visits of elder abuse forensic centers and survey their members; (4) Develop and disseminate products on the study to inform existing programs, and those who wish to develop a team. The project's work was undertaken in four stages, completed sequentially from the summer of 2017 to the Spring of 2020, each of which provided important findings:

First, a national-scale survey of multidisciplinary teams was conducted that identified 324 teams in the United States. Most multidisciplinary teams are housed within a host agency (77%), and half of these are in a healthcare organization. This study showed that the majority of surveyed elder abuse professionals and affiliates considered multidisciplinary teams to be a valuable resource in addressing case outcomes (84%), and over half saw positive impacts on recurrence and overall elder abuse occurrence in communities. The most valued aspects of meetings were work on individual cases, (case review [41%] and follow up [7%]), followed by networking (35%).

Second, multidisciplinary team coordinators (identified in stage 1) were asked to complete a detailed survey of their teams, which was then used to identify the characteristics that distinguish forensic centers from other multidisciplinary teams. This second stage revealed three categories of multidisciplinary teams across the U.S., and confirmed that the Forensic Center model exists in locations across the country. The characteristics that distinguished this model from other multidisciplinary teams were: formal staff, meeting at least twice monthly, determination and documentation of case recommendations, case activity follow-up, and case tracking.

Third, team members were surveyed to capture their perspectives and insights. This stage provided new insights on team members' motivations, practices, and characteristics to facilitate better team recruitment and development. Based on stage 2, we found that the most common professions in attendance were APS (100%) and law enforcement (96%). Two-thirds of teams had case managers, medical personnel, mental health services, prosecutors, and victim advocates in attendance. Of respondents of survey 3 who were involved in developing the team, most reported that member and agency recruitment and lack of funding were major challenges. Most team members were motivated to join by desire for assistance with professional work and employer mandates; motivation for remaining on the team was that it was a gratifying experience. This suggests that recruiting and retaining members requires professional value that is relevant and visible to agency management, and also ensures an enriching experience for those who attend.

Fourth, site visits to four diverse forensic center teams were conducted, to gain in-depth information about effective processes, practices, and structures. Site visits captured rich qualitative content that enhances our understanding of team startup, operations, and model replication. Building on what was learned from the first three stages, site visits illuminated that the value of

case reviews and networking were: support on cases, learning and training, and cross-agency awareness. Multidisciplinary team managers explained how to facilitate case reviews that result in case recommendations and follow up, and strategies in addressing top barriers and challenges such as team member recruitment, engagement and team funding. Success for multidisciplinary team members extended beyond the assistance and direct benefits on cases of elder abuse, to process elements of participating on an effective team. Applied learning, creative and innovative solution-making, and access to technical support and camaraderie were all considered aspects of major success.

Each stage of this project contributed important information on types, characteristics, and assessments of multidisciplinary teams upon which strategic replication and more targeted and nuanced research can be built. A national perspective of common challenges in the development and sustainability of multidisciplinary teams, alongside knowledge of what is needed for the highest levels of functioning, can inform national policies to help build capacity for teams across the country. Leaders in elder justice can use findings on most valued aspects of teams, and strategies used by successful team managers, to support multidisciplinary teams in their own communities and engage in a more effective implementation process. We describe, in more detail than before, the benefits and impacts of multidisciplinary teams that extend far beyond the individual cases reviewed and improve the professional capability of members, which is spread to their colleagues and organizations. The findings described in this report lay a foundation for future evaluation research of different multidisciplinary team process, outcomes, outputs, and costs.

In addition to the four states, funding was provided to four innovative pilot projects. Two of the projects examined the role of the Forensic Account in multidisciplinary teams:
Lifespan of Greater Rochester and The Riverside Center for Excellence in Aging and Lifelong Health's Peninsula Elder Abuse Forensic Center (PEAFC) addition and evaluation of a Forensic Accountant (FA). The FA helped prevent or stop exploitation, by providing advice on asset protection as well as streamlining the process of referral and expediting FA review and reporting. It was important to recognize that submitting cases, requires practice, communication, and teamwork. The evaluation relied on close collaboration between researchers and multidisciplinary team coordinators, and found that the FA was valued by the team.
Meritan's Coordinated Response to Elder Abuse developed a Rapid-Response model, aligning APS and the Senior Protection Coalition Multidisciplinary Team. Workflow was analyzed to identify and reduce duplication in screening, expedite case review and case planning and identifying what did and did not need to be considered by the team as a whole. Lessons learned were the importance of stakeholder buy-in, a central approach in this project.
The Los Angeles County Elder Abuse Forensic Center's Service Advocate Program: Implementation of Goal Attainment Scaling (GAS) sought to implement GAS to work more effectively with clients on the preferences and goals. Elder abuse victim goals were, in some cases, different from team goals. However, focusing initially on client goals enabled rapport development and deeper understanding of client priorities, which illuminated pathways for moving to risk reduction. GAS as a measurement tool was not possible with many clients. Challenges included client goals that changed throughout the course of engagement with the Service Advocate, and difficulty scaling goals in clients with cognitive impairment who had no reliable caretaker to assist in the goal setting and scaling process.

BACKGROUND/PROJECT RATIONALE

Elder abuse is a devastating public health problem that is thought to affect 1 in 10 older adults in the U.S. (Acierno et al., 2010). The negative consequences of elder abuse include physical and mental costs to the victim, as well as health, legal, and social systems that are impacted by increased need for services and supports and recurring cases of abuse (Dong et al., 2015). Elder abuse is difficult to identify and resolve, and input from diverse disciplines and agencies is often required to do so. Recognition of this need inspired the creation of elder abuse multidisciplinary teams, which bring together a variety of social, legal, and medical professionals to join efforts on addressing individual cases, and designing system-wide solutions.

Multidisciplinary teams offer a promising approach for addressing elder abuse, with the potential to provide more holistic assessments of cases and more efficient case resolution (Breckman, 2015). These teams have also been identified as a way to educate members, increase timely access to information, and reduce duplication (Navarro, Wilber, Yonashiro, and Homeier, 2010). There are many types of multidisciplinary teams, and among them, the *Elder Abuse Forensic Center* model, which has been nationally prioritized for replication. Previous studies, focused on the Los Angeles County Elder Abuse Forensic Center, found significantly higher prosecution and conservatorship (called guardianship in most state) rates compared to usual care (Navarro et al., 2013; Gassoumis et al., 2015). However, before studies are launched to examine evidence on the role of multidisciplinary teams in successfully improving victim outcomes, the field needs to come to consensus on what outcomes should be used to measure success.

Building on several seminal studies (Teaster, Nerenberg, and Stansbury, 2005; Anetzberger, 2011; Breckman, 2015; Yonashiro-Cho, Rowan, Gassoumis, Gironda, and Wilber, 2019), the aim of this research was to provide foundational knowledge to support the development, enhancement, and dissemination of research on elder abuse multidisciplinary teams with specific attention to the Elder Abuse Forensic Center model. To improve our understanding of multidisciplinary teams, we conducted a nationwide survey of existing teams, systematically studying their features (e.g., structure, function, processes, and outputs) and using in-person site visits for a more in-depth picture of diverse teams.

Report Roadmap

This report is organized into four sections, reflecting the stages used to conduct our research. For each of the four sections, we present the research questions, a brief summary of the methods, and a description of the findings. The sections are:

(1) ***Laying the foundation*** describes the process of enlisting experts to help frame the study, and decide on the best approaches. This section describes our initial findings, from our initial survey, including how many multidisciplinary teams were identified in the United States, what states they were in, and how effective they were believed to be.

(2) ***Learning from the Leaders*** describes results from our survey of the person in charge of the day-to-day running of each team, referred to in this report as the manager, coordinator, or facilitator, interchangeably. Team managers provided information on the characteristics of their multidisciplinary teams that allowed the classification of teams into types.

(3) ***Team Members' Perceptions and Insights*** were elicited in stage 3 by surveying team members identified in the prior stage for their assessments of teams' processes and outcomes.

(4) ***Lessons from the Field*** offers a detailed perspective about what was learned from visiting, observing, and meeting with elder abuse forensic centers in four communities. This section also includes a summary of subawards, to four teams who competed for pilot funding to develop multidisciplinary team innovations.

We end with summaries of the findings, implications for policy and practice and thoughts on next steps. For readers looking for more detail, we offer in-depth information on our literature review, methods, and instruments in the appendices.

PROJECT FINDINGS

We began the project by selecting members for an expert panel to provide input on the project's overall study design, sampling, data collection instruments, analysis and implications. Experts were selected by the research team based on leadership in elder justice and expertise in multidisciplinary teams. The panel comprised a broad range of disciplinary expertise, including victim services, psychology, geriatric medicine, law enforcement, elder abuse prosecution, social services, legal analysis, and research, and represented different geographic areas of the U. S. (Appendix 1).

To ensure shared awareness of state-of-the-art knowledge, we also conducted a literature review on elder abuse multidisciplinary teams, enlisting a team of five researchers with expertise in gerontology, geriatrics, psychology, and policy, along with experience developing, facilitating, participating on, and/or studying elder abuse multidisciplinary teams. Results of the literature review were summarized for presentation to the expert panel, organized by two framing topics: (1) barriers and drivers of multidisciplinary teams, and (2) indicators of multidisciplinary team success.

Expert Panel Convening

The panel met for two consecutive days in March 2017 in Pasadena, California. A summary of the literature review and discussion topics and questions were provided in advance (Appendix 2). The convening began with a presentation of the literature review, followed by an update on member's current work on elder abuse multidisciplinary teams. Panel members were also asked to provide suggestions and feedback on a draft for the first survey instrument. Three members of the research team took comprehensive notes. Panel members agreed to provide feedback on subsequent approaches and instruments throughout the project.

Table 1. Respondent Characteristics (n=263)

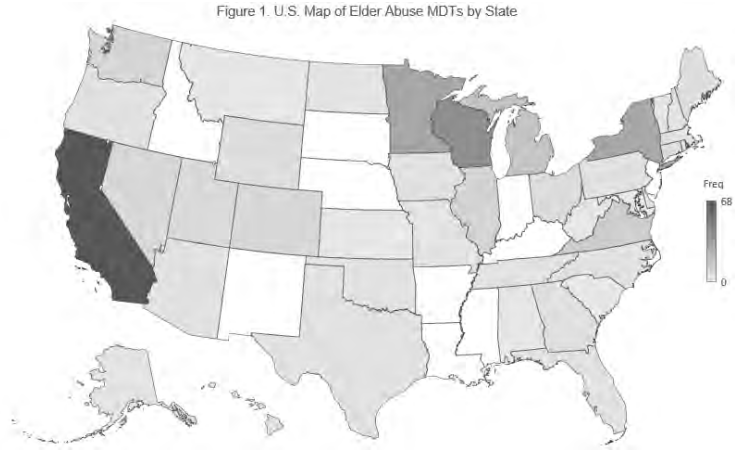
	%
Profession	
APS	42
Other Governmental Agency	18
Social Services Agency (not APS)	13
District Attorney	8
Legal Services	8
Healthcare	6
Law Enforcement	3
Family Violence	2
Financial Institution	2
Experience in elder abuse	
11+ years	56
2-5 years	26
6-10 years	26
Less than 1 year	7
Primary role in meetings	
Team Member	58
Coordinator/Adminstrator/Facilitator	32
Presenter	19
Observer	14
Attended multidisciplinary team meeting	
Yes	80
No	20
Attendance	
Attend frequently	71
Attend occasionally	17
Attend rarely	6
Attended once	5

Stage 1: *Laying the Foundation*

The objective of the first stage was to identify and gather information on elder abuse multidisciplinary teams nationwide to learn: (1) how many exist and where they are located, (2) how they are structured, and (3) respondent's perception of roles, processes and outcomes of these multidisciplinary teams. Invitations to take the online survey were sent through elder abuse and criminal justice listservs, giving respondents the option to remain anonymous (survey 1 instrument detailed in Appendix 3). To maximize response rates, a snowball sampling technique was used in which the first wave of

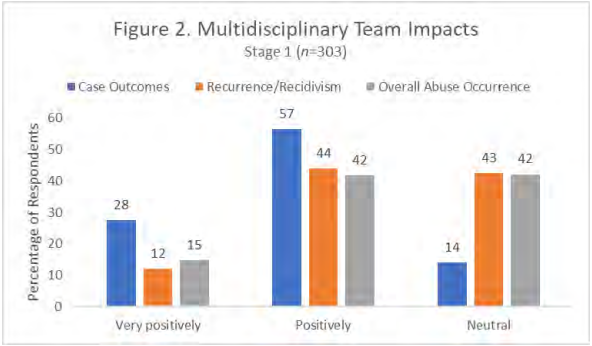
recipients had the ability to forward the survey link to other individuals working in elder abuse. Expected number of responses was 100; 524 responses were received. Characteristics of survey respondents are detailed in Table 1.

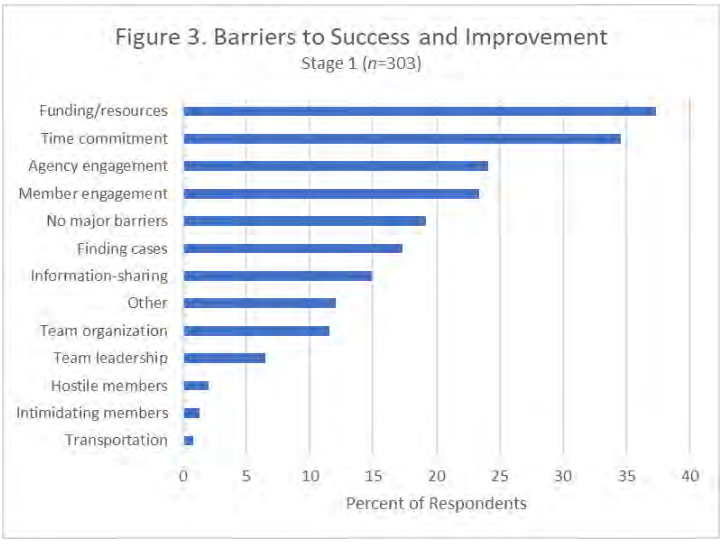
Findings: *Multidisciplinary teams are perceived as a valuable resource*



Stage 1 identified 324 unique multidisciplinary teams (Figure 1). The states with the most multidisciplinary teams included California (68), Wisconsin (42), Minnesota (31), New York (30), and Michigan (17). No multidisciplinary teams were identified in Idaho, New Mexico, South Dakota, Nebraska, Arkansas, Louisiana, Mississippi, Indiana, Kentucky, and New Jersey.

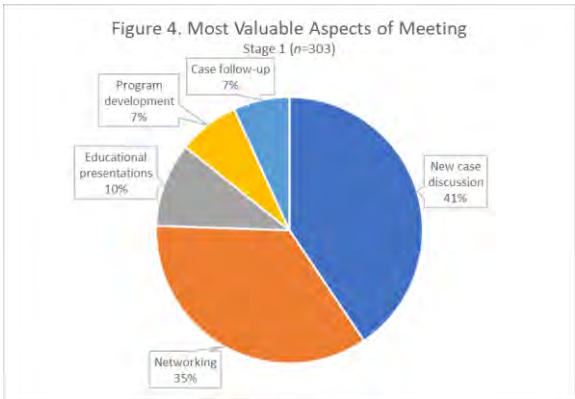
Overall, teams were perceived to have substantially positive value. We captured perceptions of the impact of multidisciplinary teams on three potential metrics of success: outcomes, recurrence, and overall occurrence. Over three-fourths of respondents indicated that their multidisciplinary team positively impacted victim outcomes, and half indicated that their team helped reduce recurrence (cases and that return after they are closed) and occurrence (new cases) (Figure 2).





Although most respondents felt their teams were successful in assisting cases of elder abuse, they also described a variety of barriers to team success and improvement (Figure 3). The most frequent barrier was funding and resources (37%), followed by time commitment (35%). Related to commitment, a quarter of respondents observed problems with the engagement of both members and agencies. The last set of barriers described issues with team operation, including difficulty obtaining cases for review (17%), inability to share information (15%), and poor team organization (12%). One fifth of respondents reported no major barriers.

The most valued aspect of multidisciplinary teams was work on cases, according to almost one half of respondents, including new case discussion (41%), and follow-up (7%), depicted in figure 4. Networking was rated the most valuable aspect of meetings by more than a third of respondents (35%). A smaller number of respondents perceived educational presentations (10%) and program development (7%) as most important to their multidisciplinary team.



Summary of Stage 1 Key Findings:

- We identified 324 teams in 40 states, which was many more teams than we anticipated.
- Multidisciplinary teams have value, offering support for those interested in launching new programs and continuing to enhance existing teams.
- Underscoring previous studies, the majority of respondents thought teams had positive impacts on elder abuse cases, and that case review and connecting with other team members were the most valued aspects of participation.
- The most common barriers were funding, time commitment, and effective engagement of members, providing direction on what is needed.

Stage 2: *Learning from the Leaders*

The objective of the second stage was to identify different types of teams including forensic centers, from the multidisciplinary teams identified in Stage 1. To do this we sought to: (1) describe characteristics distinguishing elder abuse forensic centers from other multidisciplinary teams and (2) identify which teams fit the criteria of the elder abuse forensic center model.

The Elder Abuse Forensic Center Conceptual Model (Appendix 2) was used to guide multidisciplinary team classification into: not a forensic center, some forensic center characteristics, most or all forensic center characteristics. The core domains that exist in this model (organizational goals, cases, multidisciplinary team responsibilities, agency participation, and multidisciplinary team functions and services) were used to group multidisciplinary teams based on shared characteristics. We used a statistical technique called Latent Class Analysis to distinguish the group of multidisciplinary teams that qualified as elder abuse forensic centers.
Data were collected through a survey developed with feedback from the Expert Panel. Surveys were sent to "key informants"—typically multidisciplinary team leaders or coordinators—identified in the survey responses in stage 1. Key informants were sent a personal survey link through Qualtrics that could not be shared with other individuals. Out of 220 survey requests, 117 (53%) were completed and used to describe the programs. Multidisciplinary teams included were those currently operating and conducting case review. Eighty-one responses were complete enough to be used for the Latent Class Analysis.

Findings: *The Elder Abuse Forensic Model exists nationally*

The multidisciplinary teams surveyed fell into three distinct categories. First, forensic centers were teams that closely aligned with the elements of the Elder Abuse Forensic Center Model. Second, semi-forensic centers were teams that somewhat resembled forensic centers, with about half of these elements. Third, non-forensic centers, or "basic multidisciplinary teams," had few or none of the characteristics believed to be integral to a forensic center. Most of these distinguishing characteristics were related to team activities (Appendix 7).

Of the 81 multidisciplinary teams, 26 were determined to be elder abuse forensic centers, 24 were semi-forensic centers, and 31 were not forensic centers.

Forensic Center Distinguishable Characteristics

Dedicated Staff. Forensic Centers had some form of dedicated program staff, including those that were paid, or volunteers (excluding multidisciplinary team members).

Meeting Frequency. Forensic Centers met more than once per month.

Formal Case Recommendations and Documentation. These are two distinct but closely related characteristics of Forensic Centers: (1) the vast majority, if not all, case reviews resulted in formal recommendations from the team, and (2) the recommendations were summarized and documented for the case presenter.

Case Follow-Up. Forensic Centers follow up on status of assigned case recommendations, which was one of the strongest indicators separating Forensic Centers from other multidisciplinary teams**.** The level of influence of certain indicators for distinguishing Forensic Centers can be found in Appendix 7.

Success Tracking. Tracking success of cases reviewed was paramount to elder abuse Forensic Centers. Indicators of success related to victim outcomes, grouped by type of team, are displayed in Table 2.

As depicted in Table 2, half of the forensic centers identified were at least 10 years old, while 35% were 1-5 years old. Slightly over one third of teams (39%) were primarily urban, and the remaining were primarily rural (31%) or a rural/urban combination (31%). Nearly half (42%) of participants in forensic centers receive formal training. Half of forensic centers operate with no budget, while over a sixth (17%) operate with over a $9000/month budget. Funding was noted as a much-needed resource, primarily for staffing. In terms of information routinely recorded about cases, case narrative (88%), client demographics (88%), case timeline (77%), and alleged abuser information (73%) were the most prevalent. The top indicators of success were a decreased level of risk to the client, improvement in client quality of life, and prevention of recurring elder abuse or victimization.

Table 2. Characteristics of three types of multidisciplinary teams (*n*=81)

Characteristic	*Forensic Center* (*n*=26)	*Semi-Forensic Center* (*n*=24)	*Non-Forensic Center* (*n*=31)
	%		
Years in operation			
1-5 years	35	9	19
6-10 years	15	36	24
10+ years	50	55	57
Geography			
Combination of rural and urban	31	50	43
Primarily rural	31	33	33
Primarily urban	38	17	23
Participants receive formal training	42	38	32
Operating costs (including salary)			
No budget	50	71	83
Less than $500/month ($6,000/year)	13	17	10
$500-$2,000/month ($6,000-$24,000/year)	13	4	3
2,000-$5,000/month ($24,000-$60,000/year)	4	4	3
$5,000-$9,000/month ($60,000-$108,000/year)	4	4	--
Over $9,000/month ($108,000/year)	17	--	--
Information routinely recorded about cases			
Case narrative	88	75	77
Demographics (client)	88	71	61
Case timeline	77	63	58
Information about the alleged abuser(s)	73	63	58
Finances (client)	69	58	42
Medical assessment (client)	65	50	35
Psychological assessment (client)	62	50	26
Personal statements from client	46	38	19
Personal statements from others	31	29	16
Other	23	17	13
Resources needed			
Funds for staffing	46	21	39
Physical infrastructure	8	4	3
Technology	12	17	13
Office supplies	8	4	6
Other	8	17	16
Indicators of success			
Decreased level of risk to client	96	96	77
Improvement in client quality of life	92	96	71
Preventing recurrence of abuse/victimization	88	92	77
Improvement in client health status	85	83	55
Legal remedies/services provided to client	81	92	52
Housing secured	81	88	52
Improvement in client mental health status	77	79	52
Achieving person-centered outcomes	77	71	55
Guardianship/conservatorship	69	75	45
Prosecution or plea	65	58	48
Restitution	65	58	26
Other	12	4	6

Survey respondents also described the disciplines on their multidisciplinary team. APS (100%) and Law Enforcement (96.3%) were the most common professions in attendance at multidisciplinary teams, followed by Case Manager (67.9%), Non-Physician Medical Personnel (66.7%), Community-based Mental Health Services (65.4%), Prosecuting Attorney (63%), and Victim Advocate (63%) (Figure 5).

Much of the existing literature on elder abuse forensic centers and team classification has focused on participation of certain disciplines (e.g., prosecutors, physicians, neuropsychologists, forensic accountants) as essential participants enabling specific outputs, such as the acquisition of in-depth assessments for use in pursuing legal interventions (e.g., prosecution, restitution orders, guardianship). Yet, statistical classification revealed that the key features of forensic center teams are management and coordination of the team, and accountability within the case review process.

Team members are unarguably the essential ingredient in multidisciplinary teams and, based on Stage 1 findings, challenges enlisting and maintaining members is a top-rated barrier. To better understand why, Stage 3

delves further into the member perspectives.

Summary of Stage 2 Key Findings:

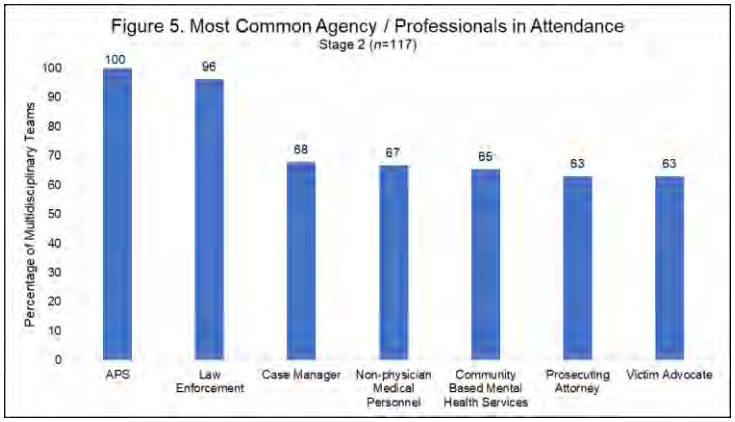
- Based on their characteristics we separated teams into three categories.
- The categories were teams that closely aligned with the elements of the Elder Abuse Forensic Center model; teams that had some elements of the model; and non-forensic center teams, or "basic multidisciplinary teams," that had few or none of the characteristics of the forensic center.
- Forensic center key characteristics included: a dedicated staff apart from team members, meetings that took place monthly or more often, written documentation of team recommendations and case tracking of follow-up of activities over time.

Stage 3: *Team Members' Perceptions and Insights*

Table 3. Member Characteristics (*n* =75)

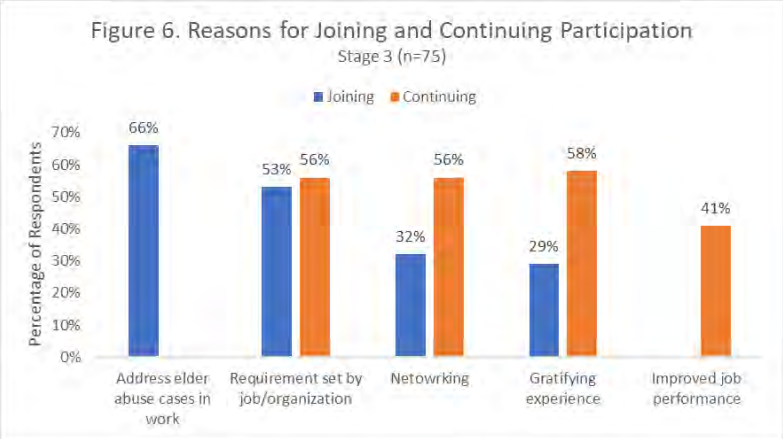
	n	%
Education		
High school	2	3
Bachelor's degree	32	43
Graduate degree	40	54
Agency		
Social	61	81
Legal	12	16
Medical	2	3
Involved in other multidisciplinary teams		
Yes	20	27
Length of participation		
Less than 1 year	22	30
1-2 years	24	32
3-5 years	24	32
6+years	4	5
Meeting attendance		
Weekly	3	4
2-3 times per month	11	15
Once per month	31	42
Every other month	8	11
Other	21	28
Elder abuse experience before participation		
Never	18	24
Less than 1 year	8	11
1-2 years	11	15
3-5 years	13	18
6+ years	24	32
How member became aware of the team		
Job/organization	61	84
Email from the MDT	2	3
Internet search	1	1
Other	9	12

Whereas Stage 2 surveyed team leaders (directors or coordinators), Stage 3 surveyed team members to get their input about (1) member characteristics, (2) case processes, (3) perceived value and impacts, and (4) multidisciplinary team creation (Appendix 5). Team members were identified by contacting the elder abuse multidisciplinary team coordinators who had responded in Stage 2. Two approaches were offered. We asked for contact information for their team members willing to respond to a survey. These individuals were then sent an anonymous survey link through Qualtrics. Team coordinators were also sent the survey link to forward to members who were not willing to share their contact information. A total of 136 survey links were sent directly or through coordinators to team members, with 75 responses (55%).



Findings: *MDT participation changes members approach to elder abuse, and improves workplace performance*

Results showed a wide range of multidisciplinary team member years' experience with elder abuse, and level of education, from high school, to graduate and professional level educations (Table 3). A quarter of respondents had no experience in elder abuse before participating in their MDTs. Respondents worked primarily in the social services field (81%), and one quarter were involved in other MDTs.



Team members were motivated to join the teams due to a need for help in their professional work, and from employer mandates. When asked about reasons for staying on the team, however, respondents indicated gratification and improved job performance were contributing factors (Figure 6).

Table 4a. Case Review: Top priority in decision making (*n*=75)

	Team Perspective	*Agency Perspective*	*Personal Perspective*
Priority		**%**	
Client safety/protection	70	56	59
Supporting client self-determination	10	18	23
Facilitating client wishes	--	3	1
Cost effectiveness	--	1	--
Legal action	3	3	1
Client desires/wishes	--	3	1
Client's physical and mental health	7	10	8
Other	5	5	5
Don't Know	5	1	--

Client safety and protection was consistently rated as the top priority in case decision making, regarding the multidisciplinary team's priorities, the priorities of the agency they represent, and their personal beliefs (Table 4a). This was followed by "supporting client self-determination", which was also consistent across the multidisciplinary team, agency, and personal beliefs.

Top priority in decision making is client safety and protection. Case plans are adjusted to align with the client's wishes.

Although client wishes were not a top priority in decision making, they were included in case discussions. If case plans countered client wishes, it was adjusted at least sometimes, according to half of respondents, and 44% reported frequent adaptations of case plans to align more closely with client preferences.

Table 4b. Case Review: Client Wishes (*n*=75)

	n	**%**
Case discussions include client wishes		
Yes	69	95
Case plan adjusted if client wishes contradict		
Always	3	4
Often	26	38
Sometimes	37	54
Rarely	2	3
Never	1	1

When disagreements arise, multidisciplinary teams are a forum for discussion and reevaluation.

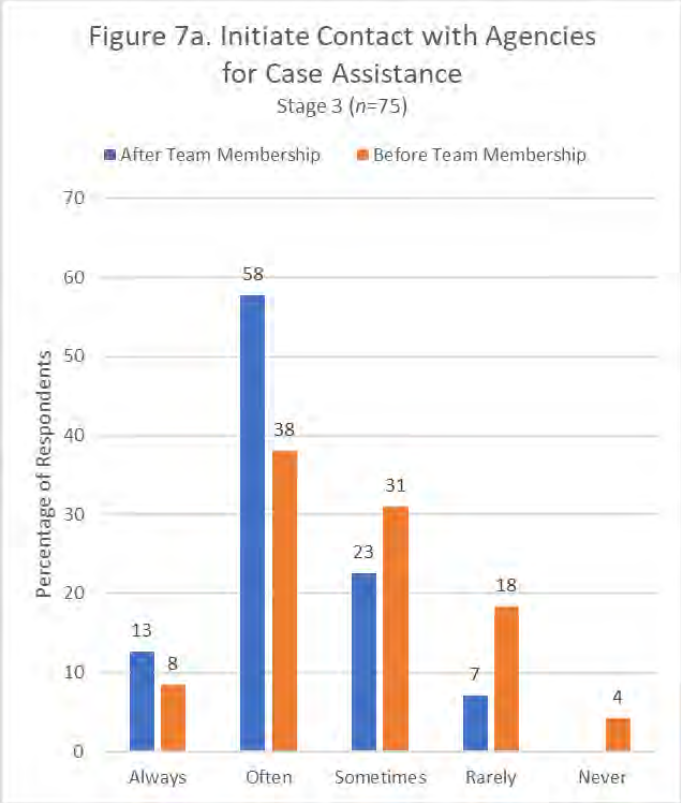
Team members rarely disagreed with case decisions, and most of those who did, made their disagreements known to the multidisciplinary team (Table 4c). If a member or agency voices dissent, the case decision is reevaluated by the team.

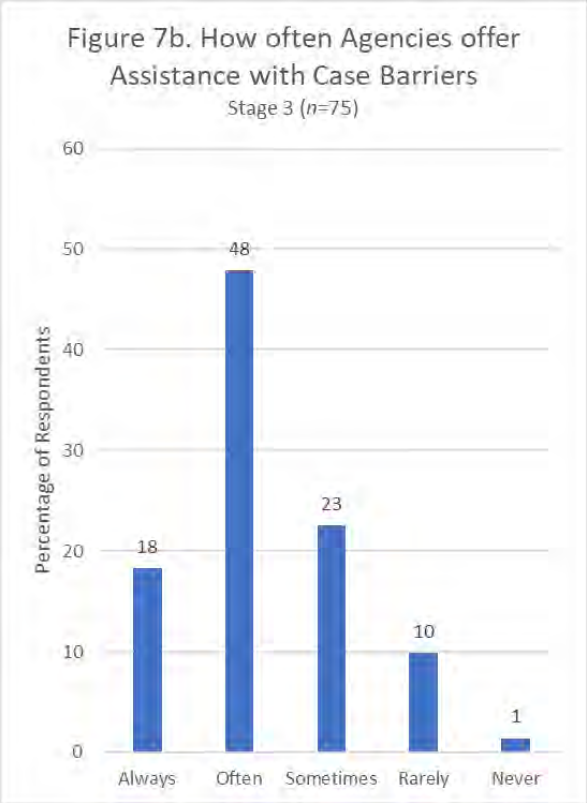
When faced with case barriers during team discussion, other agencies generally contribute to solutions (Figure 7b). Notably, team members reach out to other agencies on the team for help on cases, a higher proportion when compared to cross-disciplinary help-seeking prior to joining the team (Figure 7a).

Offering and seeking help is common between members, both within, and outside of meetings.

Table 4c. Case Review: Disagreement (*n*=75)

	n	%
Disagrees with case decisions		
Always	--	--
Often	3	4
Sometimes	18	26
Rarely	40	57
Never	9	13
Disagreements are made known		
Always	4	20
Often	5	25
Sometimes	10	50
Rarely	1	5
Never	--	--
If member dissagrees, decision is reevaluated		
Strongly agree	6	9
Agree	42	60
Neutral	21	30
Disagree	1	1
Strongly disagree	--	--





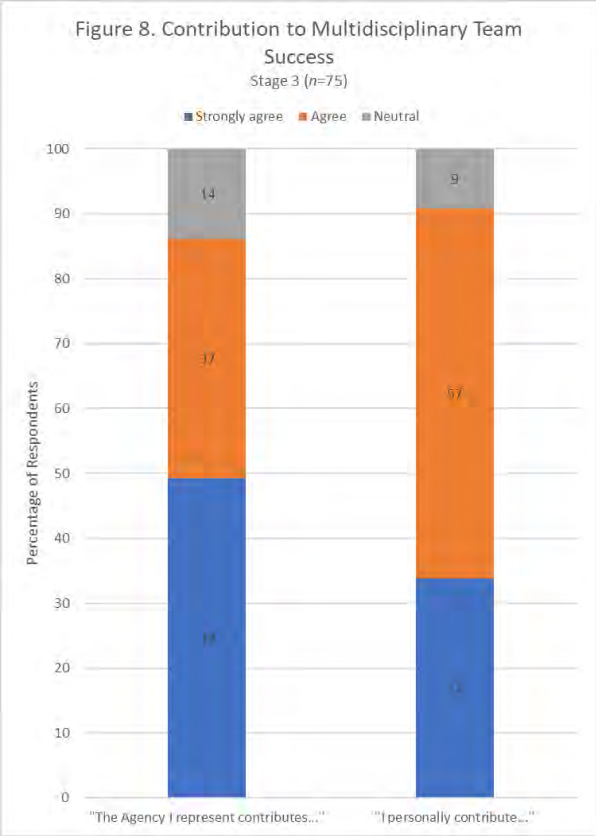
Members are committed to their teams, even if leadership changed. Their participation contributes to the success of team, and impacts their professional practice.

Table 5. Member Perpectives (*n* =75)

	n	%
With Multidicsiplinary team leadership change:		
Team would remain operational		
Strongly agree	33	45
Agree	24	33
Neutral	10	14
Disagree	5	7
Strongly disagree	1	1
Member would continue to participate		
Yes	62	87
Multidisciplinary team level of success		
Very successful	13	19
Successful	43	62
Somewhat successful	10	14
Neutral	2	3
Somewhat unsuccessful	1	1
Unsuccessful	--	--
Very unsuccessful	--	--

Most team members (78%) indicated their multidisciplinary team would remain operational in the event of a leadership change, and that they would personally continue to participate (87%) (Table 5). Team members believed their multidisciplinary team was at least somewhat successful, with 19% believing their multidisciplinary team was very successful.

Most agreed that they personally contribute to this success, as does the agency they represent (Figure 8). Team members indicated that their work and practice was impacted by the relationships they built in multidisciplinary teams (98.6%), and by their overall participation in the multidisciplinary team (97%), as shown in Figure 9.



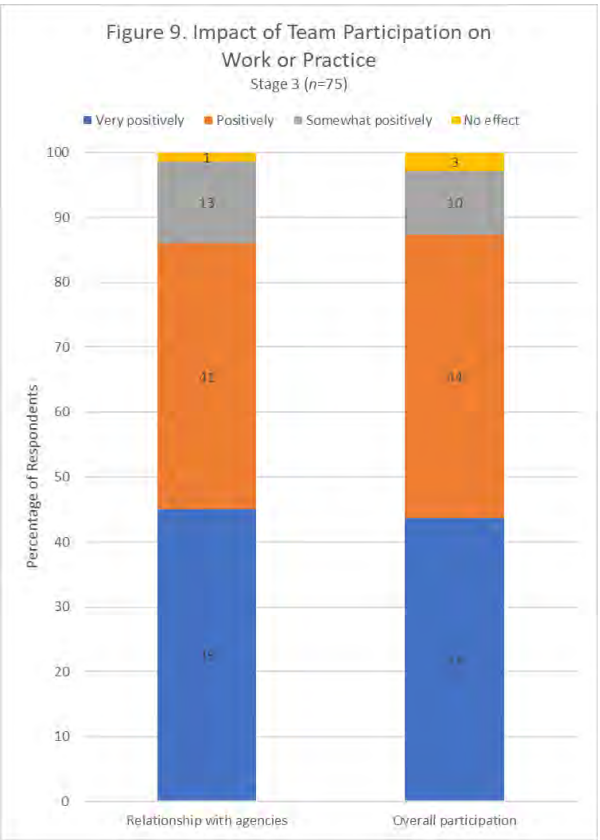


Table 6. Member Perspectives on Team Establishment

	n	%
Aware of resources to start multidisciplinary teams		
Yes	21	34
Involved in creation of multidisciplinary team		
Yes	23	36
Challenging to create multidisciplinary team		
Extremely challenging	3	13
Challenging	8	35
Somewhat challenging	11	48
Not challenging	1	4
Major barriers in establishing multidisciplinary team		
Recruiting participating agencies	32	50
Acquiring sufficient funds	18	28
Finding cases to review	18	28
Developing an effective team envioronment	12	19
Establishing support from policymakers	11	17
Navigating confidentiality	11	17
Other	7	11
There were no barriers	5	8
Conflict over mission and purpose	--	--

When asked about the establishment of their multidisciplinary team, slightly over a third of respondents participated in the creation (table 6). Of these, almost all said it was challenging. The most common barrier was member recruitment (50%), followed by funding (28%) and finding cases for review (28%).

Agency recruitment is the most common challenge of creating a multidisciplinary team.

Based on these member perspectives, participation on a multidisciplinary team improves not just knowledge of elder abuse, but also overall job performance. A driving factor appears to be connectivity with team members: those on a team more readily reach out to individuals from other agencies and disciplines after involvement on the team, which impacts their professional practice. In addition to connectivity with individuals of diverse expertise, members find participation a gratifying experience, and view their participation, and their agency, as directly contributing to team success.

Summary of Stage 3 Key Findings:

- APS and Law Enforcement were the most common team participants
- Member believe that participating on a team improves their understanding of elder abuse and their ability address it in the workplace
- Client safety and protection is a top priority as is support for client self-determination

Site Visits: *Lessons from the Field*

To build on the findings from the previous three stages, we selected four multidisciplinary teams from Stage 3 to visit in person to learn about team manager and member experiences. Areas of interest were (1) operational procedures, (2) meeting processes, (3) member dynamics, and (4) perceptions of benefits, challenges, and outcomes. Teams were selected to include, in aggregate, geographic dispersion across the U.S., representation from different levels of population density (rural, suburban, metropolitan), and a range of years in operation (Appendix 10, team characteristics). The criteria for team inclusion was having structural elements from the forensic center conceptual model (Appendix 2). During each visit, we observed an official meeting, reviewed the physical location, interviewed team managers and team members. Site visit protocol and instruments are in Appendix 9.

Findings: *Multidisciplinary teams are learning systems, and relationships are a driving force*

Site visits illuminated the processes and reasoning underlying key findings in stages 1, 2, and 3. Therefore, the findings are organized by first, referencing the key finding already described in detail above, followed by a discussion of explanatory context and details discovered through site visits. We focus on four topics: (1) The specific value of case reviews and networking; (2) Elements and processes supportive of forensic center criteria; (3) How teams have addressed common barriers and challenges; (4) How members define success of their work. Across all topics, we note innovative practices in teams, which are referenced and summarized in figure 5.

Value of Multidisciplinary Team Case Review and Networking

Case review and networking give members access to solutions, and saves time. They are more resourceful in their own work, and share knowledge with co-workers.

Survey 1 results showed that case reviews and networking were the most valued parts of meetings for attendees. Site visit teams explained why, and in what ways, case review and networking are valuable. The most emphasized benefit was the technical support that team members receive from the group on individual cases of elder abuse. Some explained that the support of the team, and ability to contact other members for help, contributed to their professional confidence. Learning was an important benefit, derived from observing and participating in case discussions, and from this came a working knowledge of services and role of other agencies in addressing elder abuse.

"We are not alone. We don't have to find a resolution on our own, we don't always have the answers. So, when we bring it to the team, we don't have all the answers, someone on the team has the answers for us. So, APS is not alone...we have support."
--Site visit team member, APS

Support on cases. Team members and managers agreed that the technical assistance on individual cases of elder abuse was invaluable for cases with diverse and interconnected needs, and for cases that are already involved in multiple service systems.

Team members value case discussions and networking because of improved access to, and quality of, assistance for elder abuse victims. Conversations with agency representatives who are knowledgeable about the specific issues faced by elder abuse victims results in practical advice on service enrollment and investigations. Case discussions save time and facilitate more comprehensive service and safety plans, which are believed to lead to improved options for the victim or client, and overcome challenges of siloed agencies.

"We are used to only getting evidence files from a police agency, so to be able to sit down at a table and know that there is much more to the story...an APS report, a history of 10 years...create[s] a better picture for prosecution and making a decision on what the defendant[s]...resolution should be."

--Site visit team member, Detective

Developing a plan without a team meeting would be too time-consuming, and in some ways, impossible to attain comparable results. Two reasons were given for this: first, the most

knowledgeable professionals are often in the field and therefore difficult to access for questions and advice; second, team discussions lead to creative problem-solving that would not occur with multiple one-on-one conversations.

Case discussions and networking with team members improved access to criminal justice professionals. Each of the four site visit teams emphasized that prior to participation on the multidisciplinary team, access to law enforcement agencies and prosecutors was minimal because of difficulty finding law enforcement professionals who were knowledgeable about elder abuse. Also, teams valued discussions on alternatives to criminal justice, in situations where the victim did not want law enforcement involved, or if criminal justice was not appropriate or applicable.

"Coming from a prosecutor's office...so many of the cases...are not appropriate for the civil or for the criminal justice system. So, having this amazing group of people representing other social service and governmental agencies...I can say, 'I may not be able to help you, but I know people who can.' And that is invaluable."
--Site visit team member, District Attorney Victim Advocate

Improved knowledge and access to experts heightened members' confidence and ability to address complex abuse. Case discussions also helped reduce the emotional impact of working on difficult cases, such as empathy fatigue (emotional impact of working closely with people who are facing difficult situations) and burden of conscience (strain from being unable to give clients the help that they actually need). All teams mentioned that there are some cases where little can be done to help the victim, even with the help of a multidisciplinary team. In these situations, case review assured that "no stone was left unturned," and also provided validation for the case worker attempts.

"I always learn something either about a service or...an approach...I learn about trends in the community or things that are going on. I take [this information] back to my agency and the team I work with of nurses and social workers."
--Site visit team member, physician

Education and Learning. Site visit teams explained that case discussion offered ongoing, informal training on elder abuse case options, including resources and services for victims. Several members described using this knowledge in their work outside the team, and sharing it with colleagues in their agency.

Cross-agency awareness. Case review and networking with members enable a specific area of learning that was emphasized: working knowledge about the disciplines and agencies of other team members. Discussions with professionals from different agencies (e.g., law enforcement, APS, prosecutors) creates an understanding of their priorities, process, and scope of services. This information facilitates collaborative relationships, where individuals know who to call in what situations. Subject matter experts, such as health care professionals and civil

"In these meetings, we break down the walls...it is reality-based in here. APS is not going to wave their magic wand and make it all better. The officers are not going to kick down a door and make it all better. So, I feel like in here we get closer to the truth of the situation."
--Site visit team member

attorneys were also mentioned as valuable to case discussion, and as sources of information. Members described experiencing a broadened view of elder abuse investigations and services, which allowed them to approach their own work with a cross-disciplinary perspective.

Elements Supportive of Forensic Center Criteria

To support the spread of forensic centers, the characteristics identified in Stage 2 analyses are described in greater detail, with examples and insights of implementation from the site visits. We focus on dedicated staff skillset and role; case review which includes determination of and documenting case recommendations, and case follow-up; and success tracking methods and use of data.

Dedicated staff skillset and role. Team managers described roles and responsibilities such as program development, team operation, member relations, and outreach to stakeholders and the community (figure 10). Educational and professional backgrounds in abuse or within a core multidisciplinary team agency (e.g., law, domestic violence, guardianship, APS, social work case management), and either experience or natural skill with group facilitation and managing relationships were described as instrumental for managers. Suggested education and skills are displayed in Figure 11.

Figure 10. Manager roles and responsibilities

Responsibility	*Specific Tasks*
Program Development	
	Research and Grantwriting
	Engage leadership for agency commitments and program design
	Policies and procedures
Operation and Oversight	
Case Consultation	Provide advice and referral on cases of elder abuse
Case Intake	Determine appropriateness of cases for team
	Collect needed information for team review
	Create documents for team review (forms, narrative, power point)
Meeting Coordination	Secure meeting location
	Distribute meeting materials and invites
	Prepare room for meeting
	Facilitate case discussion, victim centered solutions
Case Follow-up	Action plan summaries and distribution
	Reminders and follow-up on activity completion
	Connect team members to one another toward case activities
	Reminders to provide case updates
	Assure long-term safety plans in place
	Assist in case decisions on case closures
	Re-engage team with increases in victim risk
Manage MDT staff	Admin support, case managers
Member Relations	
	Support case presenters
	Screen and onboard team members
	Assure supportive team relationships
	Collaborate with, and support, other local MDT Managers
	Address issues among team members
	Know expertise of each team member
Outreach	
	Build knowledge on local victim services
	Establish and coordinate partnerships with stakeholders
	Attend MDT leadership board meetings

Figure 11. Manager education and skills

Experience and Skills
Knowledge of agencies involved in elder abuse
Meeting facilitation
Effective communication, conflict resolution
Engaging and interviewing volunteers
Leadership, discerning shared values and mission
Direct work with victims/clients
Education and Training
Social work
Law
Group work
Problem Solving Therapy

Case Review. To illustrate the groundwork needed for case discussions that result in recommendations that members are held accountable to, we summarize the site visit team case referral and intake procedure, preparation for case review, and approaches to case discussion and follow up procedures.

Case intake and preparation. Case referrals to the team were given a pre-consultation, prior to intake and preparation for a presentation at team meetings. The purpose of pre-consultations was to provide referral and advice, and assess for appropriateness for team review. Consults were done by the

team manager and, in some cases, supplemented with an in-person interview and assessment of the victim (Figure 12, Case Management).

Table 8. Site Visits: Case Criteria

	Team A	Team B	Team C	Team D
Abuse types				
Hoarding	x		x	x
Neglect	x	x	x	x
Abandonment		x		x
Financial exploitation	x	x	x	x
Physical abuse	x	x	x	x
Sexual abuse	x	x	x	x
Emotional/psychological abuse	x	x	x	x
Self-neglect	x			
Disability groups served				
Intellectual/developmental	x	x	x	x
Cognitive impairment	x	x	x	x
Significant physical disability	x	x	x	x
Age groups served				
Adults age 18 through 64	x			
Older adults age 65+	x			x
Older adults age 60+		x	x	

Decisions on selection for case review was guided by the team manager, but ultimately made by the person referring the case. Case criteria for site visit multidisciplinary teams are displayed in table 8. In addition to objective criteria (usually defined by funder priorities), and the referring agency's decision, case selection was guided by team managers, based on whether the needs of the case are a match for team member expertise. Specifically, the number of different agencies already involved was said to determine a need for team review. An added level of screening can be done by a core leadership group to discuss prior history and agency-specific goals for the case presentation.

Preparation for presentation to the team by the manager included collecting and summarizing case information. Information shared and format varied by site visit team, though all included victim and perpetrator characteristics, case facts, and questions/requests for the team. Three teams used projections of case fact patterns or relevant documents during discussion.

Case discussion and action plan. Facilitation techniques are essential to assure case discussions result in actionable recommendations. Team managers described the importance of maintaining a respectful tone, supporting case presenters and assuring team members are comfortable sharing information and asking questions (Figure 12, setting meeting tone). Several managers mentioned that familiarity with team member motivations, personalities, and agency requirements helped them facilitate productive case discussions. However, there was a balance between guiding team discussions, and allowing a free exchange of questions and ideas. All team participants understood that the intended result of case review is an action plan with items delegated to specific team members, and an agreement between members and team staff on the expectation of co-ownership and manner of follow up.

> *"We are here to develop a plan of action and not highlight any representative's mistakes. We try to make everyone feel comfortable. [This is] a safe place for everyone to present and make suggestions regardless of their role. Everyone is respectful of each other."*
> *--Site visit team manager*

Follow-up on recommendations. The strongest indicator distinguishing forensic centers is follow-up on case plans to hold members accountable. Site visit team managers accomplished this using email or telephone correspondence and some manner of tracking. They emphasized that follow-

up was not considered enforcement because they were not in a position of authority over team members.

Mutual respect and effective communication were essential for case discussions resulting in action plans and follow-up. Members appreciate being held accountable with supportive reminders.

Approaches were reminders to complete pending recommendations, offering additional resources for completion, or exploring an alternate course of action, if necessary. Some teams used shared tracking documents that were updated as activities were completed, including reports of case outputs (interventions or services) and outcomes (client status). Progress updates were reported, as needed, at subsequent meetings. One approach to follow-up was facilitating conference calls between meetings for additional discussion among those actively involved.

The team members discussed how accountability was essential to help victims, and also nurtured team trust and cohesiveness. Team members enjoyed communication between meetings and the sense of shared ownership on cases.

Success Tracking. Team managers and team members agreed that reports of case outcomes were morale boosters by demonstrating team efficacy, and were also used when applying for funding. Site visit teams described indicators such as victim safety, wellbeing, and mental status as a success for the victim, and completion of interventions or connection with services were also considered positive results, which aligns with findings of success tracking in surveys 2 and 3. Some teams described person-centered outcomes that honored victim wishes and enabled some form of empowerment. One team coordinator noted that the goals of team member agencies were a second priority to client preferences.

Addressing Barriers and Challenges of Multidisciplinary Teams

The top barriers of multidisciplinary teams identified in survey 1 were funding, time commitment, agency/member engagement. Relatedly, team member responses to survey 3 showed the most common challenges to starting a multidisciplinary team were member recruitment, funding, and finding cases for team review. These challenges and barriers overlap with one another, and are interrelated; site visit teams addressed multiple barriers using a single strategy.

Agency commitments are gained by engaging the highest-level management within that agency, and assuring the team will meet organizational needs.

Site visit teams focused on defining and prioritizing shared value (i.e., assuring the team meets members' needs), and relationships within the team, which enabled both case-finding and information-sharing among members. Specific examples addressing challenges and barriers are described, below.

Time Commitment and Funding. One team manager obtained high-ranking leadership to commit to the team by assuring the value for all stakeholders (Figure 12, Agency commitments). Several site visit teams created steering committees to ensure that the needs of each agency were considered, including information-sharing policies. Funding was obtained through grants, and other teams were institutionalized within agencies once the benefits were evidenced and

understood. One team explained that the human services department created the team manager position, partially funded by multiple agencies; another had a position designated to run the team, along with other agency responsibilities.

Member engagement is an ongoing process. Trust and team cohesion are built and sustained through cross-agency knowledge, addressing conflict early, and reminders of shared mission to help elder abuse victims.

Member recruitment and engagement. This challenge was addressed through careful team member selection, prioritizing relationships within the team, and striving to cultivate a team culture of trust, respect, and realistic expectations.

What makes a good team member? According to team managers, effective members were considered "team players," and were motivated to attend meetings, to assist clients, and collaborate with other members on solutions. Characteristics conducive to learning about and collaborating with other members include a passion for helping victims, a client-oriented mindset, willingness to discuss and ask questions, comfort respectfully pushing back in disagreement and an "open mind" to other opinions.

Prioritize relationships. Member relations were managed within and outside of meetings. Effective communication among members was a focus during meetings, and managers attended to any conflict in a manner that maintained relationships, where possible (Figure 12, Prioritizing Relationships). Described as a benefit of networking and case review, knowledge of agency scope (i.e., what each member can and cannot do) was described as foundational for mutual appreciation, effective collaboration, and trust, thereby creating a supportive environment to bring cases and troubleshoot solutions.

How do Multidisciplinary Teams Define Success?

During site visits, team managers and members were all asked to consider the question, "What is success?" Two categories emerged: success for elder abuse victims, and success for the team and members. Success for elder abuse victims was described above, as success tracking, and was defined as an improvement in the victim's state, a reduction of risk, and inclusion of the victim's preferences in how this would be achieved.

"It's not always about getting the arrests and getting the prosecution. A lot of victims don't want law enforcement's involvement...our success is based on what makes victims whole, and their view."

--Site visit team manager

Team success was described in terms of team cohesion, and benefits experienced by member agencies, which was measured by two teams with periodic team member satisfaction surveys. Team successes included constructive problem-solving and applying creative solutions in difficult cases.

Achievement of effective collaboration and learning among team members were, in and of their own, considered a success, especially when resulting in improved responses to cases outside of the

Figure 12. MDT Emerging Practices and Approaches

Practice or Approach	*Description*	*Example*
Universally Applicable		
Coordinated home visits	Select team members for a client home visit, where multiple agency or professional capability is needed to accomplish the goal.	APS is denied entry by a victim whose home is heavily hoarded. Coordination with code enforcement assures entry, and social worker assures person-centered, trauma-informed engagement.
Setting meeting tone	Create a "safe place" for case discussions.	Preface case discussions by reminding the team that all individuals in the room are distinctly valuable, and all questions and input are important.
Hub Teams	Multiple teams are housed within one agency.	MDT coordinators often oversee more than one team. The meetings are located in the region the team serves. Coordinators transfer lessons learned from one team to others. There is a community of MDT coordinators for peer learning and support.
Mandates	Abuse reporting and investigation mandates are divided among multiple key agencies.	One state created mandates that Law Enforcement receive elder abuse reports, and APS investigate. This counter-intuitive assignment of responsibility incentivized cross-agency partnership and collaboration.
Agency Commitments	Establishing commitment with the highest level of leadership within the organization.	One team gained support from top management of each core agency, and from elected county officials, ensuring that the team would be institutionalized in the region. Persistent, repetitive follow up and leveraging other relationships gained the attention of executive
Case Management	Creating a position within the MDT to offer longer-term case management.	Very complex cases with repeat entry into various public systems (e.g., APS, code enforcement, prosecution, mental health) are better served by assigning a case manager to understand the people invovled, and assist with needs. Case managers may also do in-person assessments prior to MDT case discussion, or serve as the main contact to the victim, for other members.
Prioritizing Relationships	Careful attention to subtle dynamics during team meetings assures managing conflict early on.	One team hired a consultant for team building as a first step in launching the MDT. This allowed members to become familiar with professional differences and collective mission, to assure team cohesiveness.
Rural Teams		
Ad-hoc Meetings	At team inception, schedule meetings as needed.	In some rural communities, gaining member commitment for a regularly scheduled meeting requires they have first-hand experience of the results. Call meetings only when needed, as cases arise. Once case volume and member interest warrant it, teams may transition to scheduled meetings.
Case Follow Up	Each meeting includes follow up on all open cases.	Rural communities may have small case volumes that allow brief updates for each one during team meetings.
Leveraging Relationships	Team members who have strong relationships can communicate effectively on hard cases.	Rural MDT members often have known each other since childhood. These relationships among members can enable direct communication, without harming the long-term relationships. If there are challenges with one member, there is recognition that limited alternate members means you have to address and rise above conflicts.

team. Another form of team success was members "thinking outside of their discipline," as a result of cross-agency exposure. Support provided to case presenters—including the emotional support of acknowledgement of work done, and assurance of comradery and assistance from an entire team—was perceived as success in aiding professionals working on difficult cases of abuse. Idea-sharing and the case presenter's improved morale were gratifying for the entire team.

"We can all sit here and not point fingers at one another, we all respect one another. And we realize what we can do, what we cannot do. We get help when we ask for it. I think that is a great success."

--Site visit team member

These notions of success may, or may not, lead to improved outcomes and reducing suffering among victims whose cases are received by the team. However, these benchmarks are regarded as notable achievements among the team managers and members. This indicates two ideas: 1) that concerted intention and effort are required to attain this high level of functioning in the team, and 2) that the benefits of the team extend beyond support for victims, to improving communication and systems where no prior avenues existed.

Teams are a way of overcoming silos without changing organizational structure or systems. Consistent points of contact and collaborative problem-solving build trust relationships among employees of organizations who may have little other contact. Through team participation, organizations communicate and commonage issues, circumventing a structural overhaul. multidisciplinary teams are a way to navigate, test, and improve this interorganizational connection. Additionally, the possible advantages of reducing professional silos and barriers go beyond elder abuse; overall services for older adults could synergize and become more efficient.

Summary of Site Visit Key Findings:

- Site visits underscored key findings from Stages 1, 2, and 3, and each team demonstrated unique approaches to establish similar processes of team functionality.
- Team synergy, cross agency awareness, and specialists on the team create environments conducive to learning and problem solving.
- Multidisciplinary teams are time effective and produce better case plans—collaborating without the team would be difficult and time-intensive.
- Common barriers of agency recruitment and member retention can be addressed by working with top-level management in participating agencies, and ensuring their aims are furthered through commitment to the team.
- Creating a culture of trust and open communication in multidisciplinary teams enables effective collaboration and member gratification.
- Two areas of team success are improving client safety and wellbeing, and team effectiveness. Improving client outcomes is a primary focus, and a shared priority among team members. Team effectiveness is the quality of the collaborative process, including the residual knowledge and skill acquisition of team members, which can be spread to their respective organizations.

Subawards: ***Innovations in Multidisciplinary Teams***

With additional funding provided by the Administration for Community Living, a request for proposals for emerging practices in elder abuse multidisciplinary teams was released and funded in 2017. Proposal review was blind, and scored independently by members of the USC research team and several members of the expert panel. Four existing elder abuse multidisciplinary teams were funded and evaluated, with focus on teams that were similar in process and structure to elder abuse forensic centers.

The evaluation was qualitative and developmental, to understand the process of implementing various MDT expansions into the elder abuser forensic center work. As part of the evaluation, one member of the project staff from the USC School of Gerontology provided periodic calls with subaward grantees to interact with and learn about each project and, if needed, facilitate technical assistance and problem-solving.

The emerging practice areas of focus were an exploration of person-centered outcomes for elder abuse, the implementation and evaluation of forensic accountant services in investigations of financial exploitation, and process improvement of case intake and review. Specific project goals and evaluation findings are described in more detail, below.

(1) Lifespan of Greater Rochester's Enhanced Multidisciplinary Teams (E-MDT) in Upstate New York State

Project: Evaluation of the role and utilization of a Forensic Accountant (FA)

Goals: To evaluate the role and added value of a forensic accountant assisting in cases of elder financial exploitation. Evaluation activities include survey of team members to explore outcome selection, data collection and extraction from case files, and summary of evidence on efficacy and effectiveness within the team model.

Findings: Respondents described on the value of the FA's expertise and reports in determining if exploitation had occurred and pursuit of criminal charges. The FA was beneficial in preventing exploitation, by providing advice on asset protection. Areas of improvements were identified, and included streamlining the process of referral, and expediting FA review and reporting. Some insights and learning of conducting a multi-site evaluation included the importance of collaboration between researcher and team coordinators, and adjustment of data collection to reduce the time burden of additional tasks on coordinators while fulfilling the evaluation requirements.

(2) The Los Angeles County Elder Abuse Forensic Center's Service Advocate Program

Project: Implementation of Goal Attainment Scaling (GAS)

Goals: To evaluate the effect of person-centered case management on complex cases of elder abuse. Activities include implementation of GAS into data collection and service provision, analysis of case documentation for client and provider goals, and a survey of Forensic Center MDT members who referred cases to the Service Advocate.

Findings: This project provided key findings about person-centered goals: elder abuse victim goals were, in some cases, different from service provider goals. However, focusing initially on client goals enabled rapport development and deeper understanding of client priorities, which illuminated pathways for the completion of provider goals. Survey of Service Advocate referral sources showed that this longer-term approach may prevent repeat utilization of short-term services such as APS. GAS as a measurement tool was not possible with many clients. Challenges included client goals that changed throughout the course of engagement with the Service Advocate, and difficulty scaling goals in clients with cognitive impairment who had no reliable caretaker to assist in the goal setting and scaling process.

(3) Meritan's Coordinated Response to Elder Abuse (CREA)

Project: Development of a Rapid-Response model, aligning APS and the Senior Protection Coalition (SPC) Multidisciplinary Team

Goals: To improve coordination of services and activities between APS and the SPC, this project aims to decrease response time from intake to case planning, increase organizational capacity, and thereby improve overall standard of care. Primary focus is analysis of current workflow, to identify and reduce duplication in screening and expedite case review and case planning.

Findings: A new process was agreed upon by all stakeholders: rescheduling two separate MDT meetings from alternating weekly to bi-monthly and sequential, which was more efficient for all members. Agenda content criteria, including cases reviewed, were refined to reduce content that did not require attention of the entire team. Case workflow was redesigned to reduce duplication and gaps of service provision within the organization. Lessons learned were the importance of stakeholder buy-in, which was not adequately done during prior phases of program development, and was a central approach in this project.

(4) The Riverside Center for Excellence in Aging and Lifelong Health's Peninsula Elder Abuse Forensic Center (PEAFC)

Project: Integration of a Forensic Accountant into the PEAFC

Goals: To implement and evaluate the use of a FA into case investigations, this project will explore cases in which Forensic Accountant expertise was utilized, with focus on case typology, efficacy, and outcomes. PEAFC team member satisfaction of the PEAFC and the Forensic Accountant will also be elicited and assessed.

Findings: The PEAFC enlisted two FAs for consultation on cases of financial exploitation, in their first year of operation. The coordinator and team members refined case criteria for FA consultation. The satisfaction survey showed that the PEAFC was perceived to provide valuable direction on complex cases, yet for some, submitting cases was felt to be a burden. This finding initiated closer collaboration between the MDT coordinator and the agency manager to adjust timing of case requests, and adding supports to case presenters. A lesson learned was the importance of understanding internal barriers, and acknowledgement that participation on an MDT, and submitting cases, requires practice, communication, and teamwork.

Multidisciplinary Team Implementation: *Lessons for the Field*

The findings suggest that the Forensic Center model—client services, investigators/direct service providers, and justice systems—exists across the country. This demonstrates an existing infrastructure of elder abuse forensic centers nationwide to build on and further developed by addressing the barriers identified in these studies. Members of teams that are not forensic centers should consider if moving in this direction with increased development is a shared goal among team members. While building a forensic center from an existing team is one approach, several of the forensic centers studied were built as forensic centers from the ground up.

Findings include most common challenges, and suggest guidelines for overcoming them. **Funding, agency engagement, and time commitments were the most common barriers to multidisciplinary team establishment, improvement, and sustainability.** The barrier of funding is particularly crucial, considering the majority (70%) of multidisciplinary teams operate with no funding. **We highlight potential benefits for local agencies: multidisciplinary team members and agency leaders' experience professional development, and potential organizational benefits.** However, regions with already limited resources will require additional funding and technical support from existing multidisciplinary teams. With the aim of bolstering forensic center criteria and processes in existing teams, this funding would be useful for having paid staff overseeing team activities and keeping members connected in between meetings.

The nationwide survey results showed that individuals looking to start new teams should expect challenges overall, particularly in member recruitment, engagement, and case acquisition. Engaging valued professionals—particularly law enforcement, medical professionals, and prosecutors—in addition to fostering regular attendance and participation among members overall is a challenge that has been discussed in prior literature. Solutions for the barrier of agency engagement were largely related to member motivations and priorities. **We found that most respondents are motivated to join teams** *due to job requirements and a need for help with professional work.* **Respondents were motivated to stay** on the multidisciplinary team for the same reasons, along with an additional reason: *their participation is a gratifying experience*. Ensuring that member participation is a valuable and gratifying experience is nuanced and likely to differ between professional groups, yet our findings show that a majority of members believe they contribute to the team's success. Nurturing team members by facilitating awareness of roles and effective communication will aid shared sense of value among team members.

The top priority in case decision making was aligned between multidisciplinary team, agency, and member: client safety and protection. Site visit team managers used shared priorities to galvanize multidisciplinary team members in moments of disengagement or conflict. Although disagreements between members can be a catalyst for improving case plans, shared priority of client wellbeing is a cornerstone of multidisciplinary teams. **Time should be spent assuring there are shared priorities and values among participating agencies and professionals,** to spur coalescence during difficult moments.

Several states have passed legislation related to elder abuse interventions (CA, MN, WI), and results showed a high number of elder abuse multidisciplinary teams in these states. In effect, mandates for multidisciplinary teams is a successful approach to increase the number of teams.

Whether organically developed or policy driven, **the need for a multidisciplinary team in an area must be assessed prior to moving forward with implementation**. For example, an unfunded multidisciplinary team mandate may result in a team that exists only to fulfill legislative requirements, not the needs of the community, and ultimately may not be a wise allocation of resources. This is a particularly important consideration given that funding and resources were identified as primary barriers to multidisciplinary team success and improvement. **Needs assessments should explore not just the needs of the region, but also core agency needs.** Designing the team to address these core agency needs may also encourage engagement.

Most multidisciplinary teams identified were housed within a host agency, and half operate within a healthcare organization. Those seeking to establish teams may benefit from identifying an entity to oversee the team, and ensure this arrangement meets the needs of the team. **Establishing a team within a host organization can provide support in the form of a meeting place, visibility/legitimacy, program staff, and team members**.

CLOSING THOUGHTS

Multidisciplinary teams are a fertile ground for innovation: a place for those involved in elder justice to present problems and develop new ideas about how to address them. Rather than ignoring or circumventing complexity of cases due to silos and overwhelming workloads, multidisciplinary teams are a powerful tool to address issues head on. They allow for members to present and ask for what they need and use the team as an expanded lens to examine issues through multiple perspectives.

The focus of this project was developing a better understanding of the Elder Abuse Forensic Center Model. The project was successful in this regard, but the study also revealed valuable information about multidisciplinary teams in general. Most importantly, the forensic center model is just that—a model, which can be adapted to various degrees of fidelity. In approaches to implementation, teams must incorporate enough flexibility for adaptation and innovation. Through this project it is clear that the elder abuse forensic center can be a self-learning model. It should be left to the discretion of local communities and individual teams to decide what aspects of the elder abuse forensic center model work for their caseload, team composition, and community needs. This also highlights the importance of connecting teams across the country, which can offer valuable insights on different approaches to the model and save valuable time in building on the learning that is already taking place.

This project has helped advance the conversation on the future of multidisciplinary teams. It has revealed an overwhelmingly impressive effort nationwide to address elder abuse and mistreatment, in addition to the gaps and needs in this effort. The effectiveness of teams in terms of case outcomes remains nebulous, however, and while impact on victims remains crucial, we have learned this focus may be too narrow. Multidisciplinary teams foster shared learning, revolutionize approaches to professional work, and challenge the way we approach elder justice.

NEXT STEPS

The findings in this study make clear the need for multidisciplinary team technical support, and show that some written materials are available to guide multidisciplinary teams. While written and recorded material are helpful resources, it is possible that augmenting this with interpersonal, individualized support and ongoing telephonic coaching may be effective. Efforts such as the Department of Justice multidisciplinary team Technical Assistance Center's individualized consultations and the New York City Elder Abuse Center's peer support should be made accessible to teams nationwide. Additionally, connecting multidisciplinary teams in the US through forums can provide a platform to exchange ideas and improve systems. **Policymakers and multidisciplinary team advocates should explore avenues for communication between elder abuse multidisciplinary team efforts nationwide.**

Improved knowledge and facilitation of victim preferences is another key direction of elder justice. Multidisciplinary teams are a recommended avenue for incorporating victim preferences into practice (AGS, 2016), and therefore a strong infrastructure of elder abuse multidisciplinary teams, which value understanding and supporting victim preferences to the extent possible, has the potential to promote person-centeredness in elder justice efforts. As participating agencies are exposed to person-centered approaches to cases, they bring this framework to their own professional practices and organizations. Multidisciplinary teams are a potentially effective way to demonstrate person-centeredness to those who are either skeptical or need to see it in practice.

Multidisciplinary teams are dynamic and complex systems. As such, evaluation methods should account for aspects of complexity such as non-linearity, dynamic change, emergent learning, and unpredictability. Findings from these evaluations may carry important lessons for other teams but are nuanced nonetheless and may not be completely applicable to teams with different caseloads, approaches, members, or regions. Development and implementation of multidisciplinary teams should be concurrent with evaluation, with short- and long-term feedback. Understanding the needs of individual teams and communities is crucial for long-term sustainability, and potentially for team effectiveness.

Most teams studied in this project operated with no budget. Notably, half of the teams that qualified as elder abuse forensic centers operate with no budget, compared to 83% of non-elder abuse forensic centers. Enhancing the power and scope of these teams with budget support should be a priority with the creation of completely new teams.

Finally, as discussed throughout this report, it is important to continue the dialog on what successful outcomes in elder abuse are. Systematic evaluation of the effectiveness of teams will require some degree of consensus on what outcomes are desired and how they should be measured.

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APPENDICES

APPENDIX 1: EXPERT PANEL

Risa Breckman, LCSW: Risa Breckman, is the Director, New York City Elder Abuse Center (NYCelder abuseC), housed within Weill Cornell Medicine's Division of Geriatrics and Palliative Medicine. Since 1982, she has been at the forefront of developing innovative responses to elder mistreatment, including developing multidisciplinary teams in NYC and providing technical assistance to nascent and established multidisciplinary teams around the country. She also writes articles, educational materials and thought pieces for the elder justice field, including co-authoring the Elder Justice Roadmap Report and Elder Abuse Multidisciplinary teams: Planning for the Future, which provides recommendations from a 2014 symposium NYCelder abuseC co-sponsored on multidisciplinary team replication, sustainability and research.

Shelly Carlson, MPA: Shelly Carlson is the Criminal Justice Systems Manager for the Minnesota Elder Justice Center. During her 22-year career, Ms. Carlson has worked in the non-profit and government sectors as well as in a university setting as: Victim/Witness Director, Crisis Intake Coordinator, Campus Violence Prevention Program Coordinator, Criminal Justice Systems Advocate and Training & Development Specialist. In her position at the ND Domestic Violence/Sexual Assault coalition she developed model policies for ND Law Enforcement on Domestic Violence Response and Officer Involved Domestic Violence. She also helped establish four Safety and Accountability Audit Sites in ND. Most recently, Ms. Carlson coordinated two separate federal elder abuse grants which created systemic and sustainable change in the Fargo, ND / Moorhead, MN communities. Ms. Carlson has trained nationally for the Federal Law Enforcement Training Center, the National Sheriff's Association and the National Clearinghouse on Abuse in Later Life as well as internationally (Serbia, Latvia and Lithuania) for the Advocates for Human Rights and Global Rights for Women. Ms. Carlson earned both her Master's Degree in Public Administration and her Bachelor of Science degree in Legal Assistance from Minnesota State University – Moorhead, where she has been adjunct faculty. Ms. Carlson is also a 2001 graduate from the National Victim Assistance Academy.

MT Connolly, JD: Marie-Therese Connolly received a bachelor's degree from Stanford University where, while taking an undergraduate course in mental health law, MT shifted from a medical focus to a focus on elder justice issues of abuse, neglect and exploitation. Since receiving a J.D. from Northeastern University Law School, she has devoted her career to the largely hidden but immense problem of elder abuse and mistreatment. Connolly was instrumental in the drafting and passage of the Elder Justice Act, the first piece of federal legislation to address the issue specifically. As director of the Department of Justice's Elder Justice and Nursing Home Initiative, MT developed new legal theories of liability, investigation and litigation strategies that overcame loopholes in federal statutes. She has brought together various stakeholders in the fragmented elder justice field — including researchers, law enforcement officials, social workers, advocates, legislators, and clinicians to advocate for, detect, and intervene in the mistreatment of older adults. Although Congress has passed major comprehensive laws relating to child abuse, no similar elder abuse law exists. However, MT was fortunate to work with the Senate Special Committee on Aging, to draft the Elder Justice Act, the first comprehensive bill to address elder abuse. The Elder Justice Act was first introduced in

2002 and eventually rolled into the Affordable Care Act. MT is currently working to finish a book that elder abuse that aims to propel change by raising public awareness and serve as a resource and catalyst for policy-makers, researchers, practitioners and the public.

Detective Adam Gibson: Detective Gibson is a 19-year veteran of the Quincy, Illinois Police Department. Detective Gibson received his training from the University of Illinois Police Training Institute. He has served the department as a motorcycle officer, narcotics officer, canine handler, and since 2013 have been assigned to the detective division. While assigned to detectives his primary area of responsibility are crimes against the elderly, however he has extensive experience handling homicides, sexual cases and all other areas of general criminal investigations. Currently detective Gibson's primary focus is the area of suspected elder abuse cases such as financial exploitation and fraud. Detective Gibson also conducts training to the community on prevention of financial elder abuse.

Sheri Gibson, PhD: Dr. Gibson received her Ph.D. in Clinical Psychology in 2013 with a curricular emphasis in Geropsychology from the University of Colorado, Colorado Springs (UCCS). She completed her internship at the V.A. Palo Alto Healthcare System and her post-doctoral fellowship at the University of Colorado, Colorado Springs, and at Rocky Mountain PACE. Dr. Gibson is currently employed as Director of Behavioral Health Services for Rocky Mountain PACE and BrainCare programs. She is faculty affiliate with the UCCS Gerontology Center as an instructor for integrated care in geriatric clinical settings. Dr. Gibson has published works in the area of elder financial abuse for which she has received national recognition for her research and has presented lectures at national, local, and regional conferences. She serves on the editorial board for the Journal of Elder Abuse & Neglect, is Chairperson for the Colorado Coalition for Elder Rights and Abuse Prevention (CCERAP), and has volunteered for the Pikes Peak Elder Abuse Coalition (PPelder abuseC) since 2007. She is the 2015 Business Professional recipient of the Senior Resource Counsel's Joe Henjum Award for her commitment to improving the lives of older adults in the Pikes Peak Region.

Aleen Langton, JD: Principal Deputy County Counsel, Los Angeles County. Aleen Langton was admitted to the California State Bar in 1994. She earned her J.D. at Glendale University, College of Law, where she was the Student Body President. She started her government career as an intern in the District Attorney's Office. In 1996, she began earning her keep as a trial attorney in the Dependency Division of the Office of the County Counsel (the single greatest day of her father's life). She remained in the Dependency Division for 12 years, working as a trial attorney, a lead attorney, and in the Appellate Section. In 2008, Aleen transferred to the Social Services Division and has remained there, since. She currently advises numerous County departments including, but not limited to, the Workforce Development, Aging, and Senior Services, the Los Angeles Homeless Services Authority, and the Department of Children and Family Services. Aleen is also a full-time mother. She has three boys: 17-year-old identical twins, and a 12-year-old that runs circles around his big brothers. Aleen is happily married to Joseph Langton, also a Principal Deputy County Counsel, who advises the Los Angeles County Sheriff's Department.

Stacey Lindberg, MSW: Stacey Lindberg received her Masters in Social Work from California State University at Long Beach and her undergraduate degree from University of California – Los Angeles. She has worked for the County of Orange Social Services Agency since 1997 and

since 2010; she has been the Program Manager for Adult Protective Services. Stacey co-chairs the County of Orange Financial Abuse Specialist Team (FAST) as well as co-chairs the California Welfare Director Association (CWDA) sub-committee Protective Services Operations Committee. Stacey has presented recently at the following conferences: 2016 CWDA annual conference, 2016 CDSS Elder Abuse Awareness Event, 2016 4th District World Elder Abuse Awareness conference and the California Narcotic Officers Association conference.

Veronica LoFaso, MD. Dr. LoFaso is the Director of Medical Education for the Division of Geriatrics and Palliative Medicine at Weill Cornell Medical College. In this role, she is involved in the development and implementation of core didactic topics to medical students throughout the 4 years of training. She is an Associate Course Director for new the Lelder abuseP course, which pairs medical students with patients throughout their four years of medical school. She is also the director of the Geriatrics Area of Concentration, the Geriatrics Elective and the co-director of the Medical Student Summer Scholars Research program in Geriatrics. She has received several awards for excellence in teaching form the medical college. Dr. LoFaso's experience as a nurse practitioner before attending medical school gives her a broad and valuable range of experience in patient care. She founded the Division of Geriatrics House Call Program and served as it's medical director for over a decade. In this role Dr. LoFaso mentored hundreds, residents and fellows in the art of the home visit, emphasizing humanistic and patient centered care. She is a two- time recipient of the Leonard Tow Humanism in Medicine Award. Dr. LoFaso is also active in advancing research to protect older adults from abuse, neglect and financial exploitation. She is on the board of the New York City Elder Abuse Center and serves as the physician representative on two multidisciplinary teams meeting weekly to improve the delivery of services to vulnerable older adults. She is currently involved in research in the forensics of elder abuse with the hope of establishing a clinical decision tool that will help physicians and other health providers recognize elder abuse and neglect more easily. This work has led to lecturing across the country to train health care workers, law enforcement and prosecutors about this important topic.

Page Ulrey, JD: Page Ulrey is a Senior Deputy Prosecuting Attorney at the King County Prosecutor's Office. She graduated from Amherst College and Northeastern University School of Law. Page was appointed to the newly-created position of elder abuse prosecutor in the Criminal Division of her office in 2001. In that position, she prosecuted cases of elder and vulnerable adult neglect, financial exploitation, sexual assault, physical assault, and homicide. She also founded and chaired the King County Elder Abuse Council and Criminal Mistreatment Review Panel. Since September, 2007, Page has been working as an elder abuse prosecutor in her office's Economic Crimes Unit, where she specializes in the prosecution of cases of elder financial abuse and neglect. For the past seven years, she has worked on protocol development and been a member of the national training team on elder abuse investigation and prosecution for the Office on Violence Against Women. She has conducted trainings for the National District Attorneys Association, the Office for Victims of Crime, and the National Institute of Justice. She has testified before the U.S. Senate Special Committee on Aging, has spoken twice at White House conferences on Elder Justice, and is currently involved in the production of videos on elder abuse prosecution for the Department of Justice.

APPENDIX 2: LITERATURE REVIEW

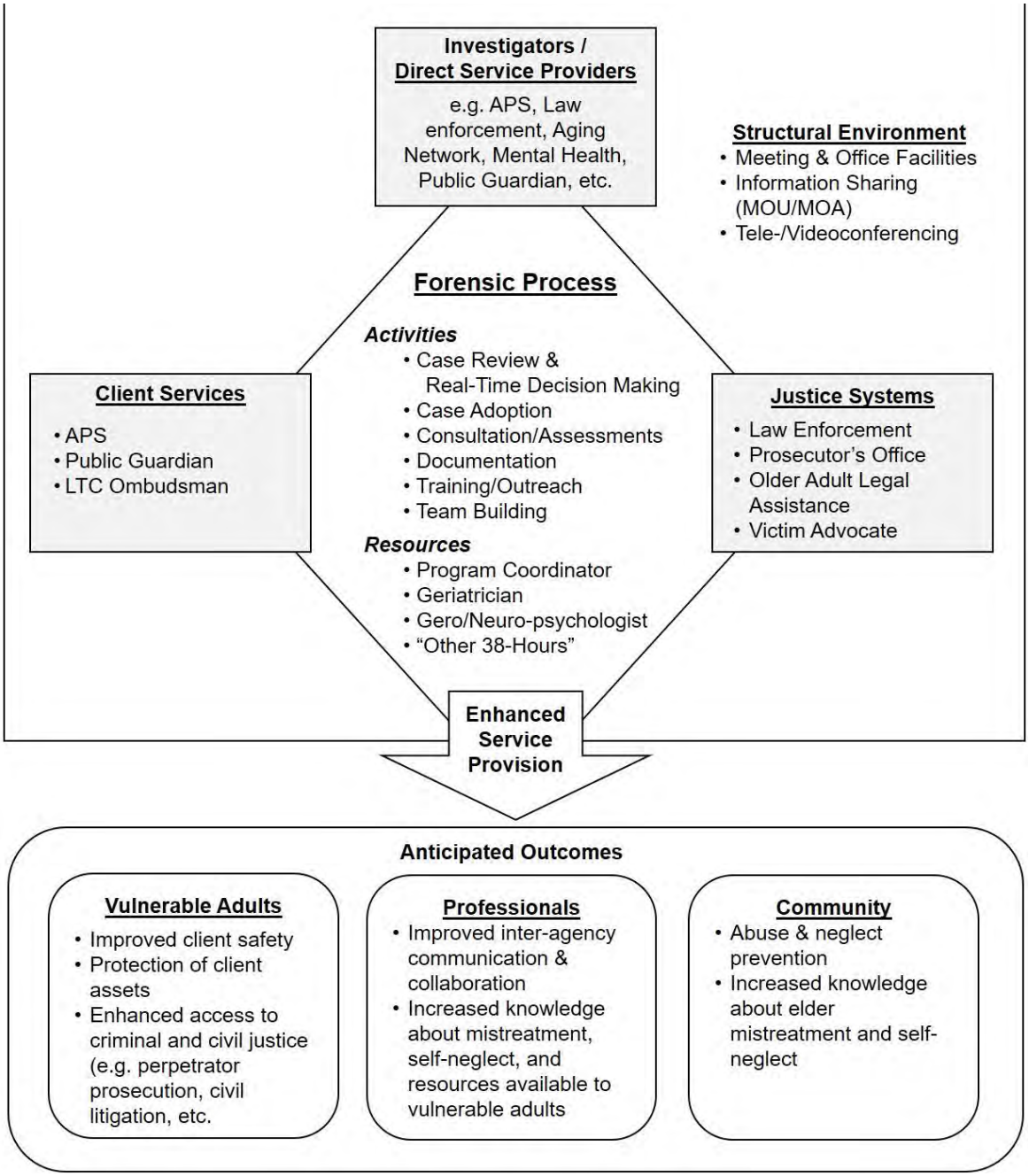
Elder Abuse Multidisciplinary teams: Overview

- **History:** Multidisciplinary perspectives to elder protection and elder justice recognized as necessary since 1961; evidence of multidisciplinary teams (multidisciplinary team) conducting elder abuse case diagnosis and planning appeared in 1971 (Anetzberger, 2011).
- **Definition and purpose:** "Groups of professionals from diverse disciplines who come together to review abuse cases and address systemic problems" (Daly, 2005).
- **Structure**: Elder justice multidisciplinary teams vary in auspice, legal basis (mandatory or optional), formality of membership, abuse orientation, and task level (from recommendations to active case processing) (Anetzberger, 2011; Breckman, 2015)
- **Types of multidisciplinary teams** (Anetzberger, 2011; Navarro, 2011; Teaster, 2005; Twomey, 2010):
    - *General multidisciplinary team*: An entity which gathers professionals from multiple fields to address an issue.
    - *Financial Abuse Specialist Teams (FAST)*: Provides reviews exclusively on financial abuse cases.
    - *Medical multidisciplinary teams (VAST):* Provides medical assessments, mental status assessments, and review of medical records/photography.
    - *Fatality Review Teams:* Provides reviews exclusively on cases with fatal outcomes.
    - *Elder Abuse Forensic Centers:* Provides review of cases through "case examining, documentation, consultation/training, prosecution".
- **Perceived benefits** (Anetzberger, 2011; Breckman, 2015) :
    - Holistic case assessment and comprehensive solutions
    - Improved awareness and education, access to information, and cross-training of members
    - Better understanding of member roles and reduced duplication of efforts
    - Decreased APS recurrence
- **Key elements of a successful multidisciplinary team** (Anetzberger, 2011; Twomey, 2010)
    - Capable leadership and skilled meeting facilitation
    - Belief in collaboration and the value of input from others
    - Strong infrastructure
    - Mutual accountability, honest communication
- **Challenges** (Anetzberger, 2011; Twomey, 2010)
    - Group dynamics, lack of trust among members, lack of participation
    - Communication issues across disciplines or systems with differing goals
    - Sustainability and lack of administrative support
    - Decline in cases referred to team

The Forensic Center Model

- **Definition of Elder Abuse Forensic Centers (elder abuse forensic center):** teams have full-time staff and the resources to provide case consultation and direct assistance outside meetings. Services include assessment, evidence-building, documentation review, and an emphasis on evidence-based methods (Schneider, Mosqueda, Falk, & Huba, 2010; Wilber, 2013)

The Elder Abuse Forensic Center Model



- **Mission Statements of four Forensic Centers (FC)** (Wilber, 2013)
    - *Orange County* - Through collaboration of professionals in law, medicine, and social services the Elder Abuse Forensic Center is designed to prevent and combat abuse, neglect, and exploitation of at-risk older and disabled adults; educate professionals; advance awareness of elder abuse through research; and create a new standard for interventions that are effective in combating and preventing mistreatment of older adults.
    - *Los Angeles* - The Los Angeles County Elder Abuse Forensic Center is a multidisciplinary team of professionals that protects vulnerable elders and dependent adults from abuse and neglect.
    - *San Francisco* - The San Francisco Elder Abuse Forensic Center will prevent and combat abuse, neglect and exploitation of elders and dependent adults in San Francisco. This will be accomplished with the following strategies:
        - Improve communication and coordination among the legal, medical, social services professionals who investigate and intervene in cases of elder and dependent adult abuse.
        - Increase access to potential remedies and justice for those who have been victimized.
        - Educate policy makers, professionals, caregivers, older adults and their families about preventing, reporting, and stopping elder and dependent adult abuse.
    - *San Diego* - It is the mission of the Center for Community Solutions to end relationship and sexual violence by being a catalyst for caring communities and social justice.
- **Elder abuse forensic center Membership** (Wilber, 2013):
    - Core team membership includes: APS, Medical Personnel, Prosecuting Attorney, Victim Advocate, Law Enforcement, Public Guardian / Conservator
    - Most teams also include: LTC Ombudsman, Gero/Neuro-psychologist, Mental Health Services, Senior Legal Aid
    - Some teams may include: Developmental Disability Services, Coroner / Medical Examiner, Community Care Licensing, Intimate Partner Violence Services
- **Criminal Justice Role**
    - Police, sheriff, civil/city/district attorneys, victim advocates play role in justice prosecution
- **Activities:**
    - LA elder abuse forensic center study showed that the Center reviewed 2-4 cases per week (met weekly, 2 hours)
    - Team breakdown: 77% public entities, 15% private non-profits, 8% private for-profit (neuropsychologist).
    - Outcomes (note: no benchmark exists for determining success in elder abuse interventions):
        - 39% of cases recommended for review by DA have been filed and prosecuted
        - 33% of cases assessed by Office of the Public Guardian

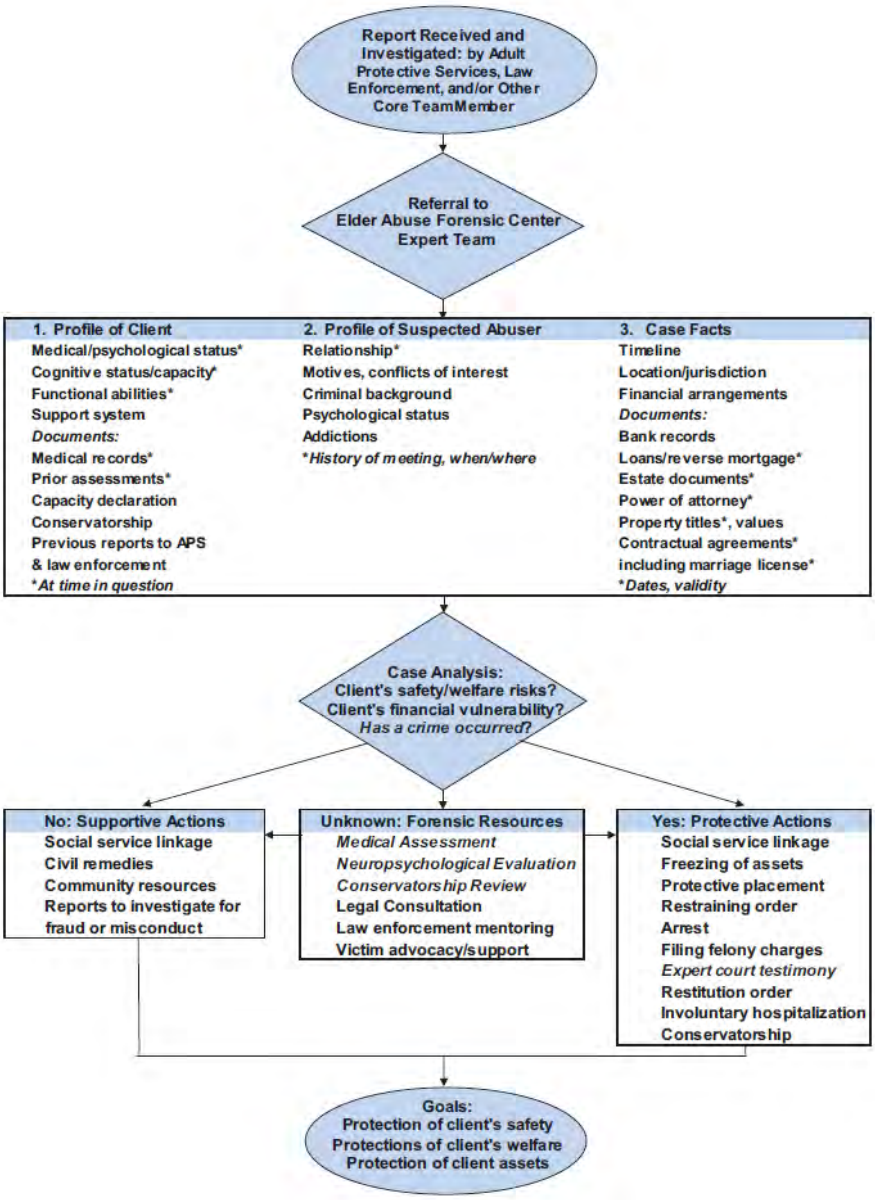
        - 31% received neuropsychological assessment
        - 24% received home-based medical assessment

Evaluation of the Forensic Center Model

- There is little research testing the effectiveness of the elder abuse forensic center model. Most published work is descriptive, summarizes member satisfaction, and perceived efficacy.
- **Member Satisfaction:** team survey of the Los Angeles County Elder Abuse Forensic Center indicated several positive themes: frequent meetings, multidisciplinary collaboration, readily available info, coordinated intervention, communication between groups, and availability of VAST (Vulnerable Adult Specialist Team) clinicians
- Four Center Evaluation examined heterogeneity and homogeneity across four centers in Orange County, Los Angeles County, San Francisco, and San Diego (Wilber, 2013). Key accomplishments:
    - "Good Outcomes" prioritized by team members
        - Safety / Protection
        - Prosecution
        - Further investigation, resource linkage, treatment
        - Legal remedies / restraining order
        - Self-sufficiency
        - Asset preservation
    - Best practices
        - Ongoing collaboration outside of meetings
        - Use of technology (electronic records, teleconferencing)
        - Team building
        - Cross-disciplinary training
    - Recommended a standardized data collection tool
- **Case Review Process:** evaluation of FC case reviews of elder financial exploitation used a field study approach using observation, qualitative survey analysis, and expert panel review. Findings showed 3 main components to the case review process:
    - Information needed: (1) client profile, (2) relationship and profile of suspected abuser, (3) case facts and timeline
    - Case discussion themes: (1) client safety / welfare, (2) financial vulnerability, (3) determination of adequate evidence for criminal activity
    - Protective goals: (1) client safety, (2) client welfare, (3) client assets.
- **Outcomes:** evaluation of prosecution, conservatorship, and APS recurrence outcomes compared APS "usual care" to FC cases. Control group selected with person-to-person propensity score matching. Findings:
    - Prosecution (Navarro, 2012)
        - FC center cases have significantly higher rates of submission for prosecution (22%, n=51 FC; 3%, n=7 control; $p<.001$).

- FC intervention resulted in almost 10 times greater odds of submission (OR=11.00, CI: 4.66-25.98, p<.001).
- Among those submitted, there were similar rates of charges, pleas, and convictions in usual care and forensic center cases.

- Conservatorship (Gassoumis, 2015)
  - Elder abuse forensic center cases have significantly higher rates of submission to the district attorney for prosecution (22%, n=51 FC; 3%, n=7 control; p<.001).
  - FC intervention resulted in nearly seven times greater odds of referral for conservatorship (OR=7.85, CI:3.86 – 15.95, p<.001).
  - Of the cases referred, there was no significant difference in proportion of conservatorships granted.



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APPENDIX 3: STAGE 1 INSTRUMENT

What type of organization/agency do you work for?

- ❍ Adult Protective Services
- ❍ Law Enforcement
- ❍ District Attorney or similar (e.g., City Attorney, Commonwealth's Attorney)
- ❍ Legal Services
- ❍ Healthcare
- ❍ Family Violence
- ❍ Social Services Agency (other than APS)
- ❍ Clergy
- ❍ Financial Institution
- ❍ Other Governmental Agency (please specify) _____
- ❍ Other (please specify) _____

What is the primary state in which you perform your professional duties?

For this survey, we are interested in finding out about various types of elder abuse multidisciplinary teams and other elder abuse networks. We are interested in multidisciplinary teams (multidisciplinary teams) that engage in case review for elder abuse cases as well as any other multidisciplinary teams or networks that address elder abuse.In this survey, you will be asked to identify multidisciplinary teams you are familiar with. You will also be asked to identify Networks you are familiar with. For each multidisciplinary team you identify, you will be asked a set of questions specific to that multidisciplinary team. For each Network you identify, you will be asked a set of questions specific to that Network. Here are some definitions to help you understand what we are looking for.
Elder Abuse: Abuse, neglect, or financial exploitation of an elder. The abuse could be physical abuse, sexual abuse, or psychological/emotional/mental abuse.
Elder Abuse Multidisciplinary team (multidisciplinary team): A team that is comprised of professionals from a variety of disciplines working together **ON AN ONGOING BASIS TO COMBAT ELDER ABUSE**.
Network: Broadly defined as any group of professionals involved in addressing elder abuse. These could be highly structured or more unstructured, and would include groups such as community collaboratives, coalitions, consortia, triads, task forces, and many other models.
Case Review: Reviewing and addressing individual cases of elder abuse, with a goal of providing action steps and recommendations specific to that case.

How long have you worked on elder abuse issues?

- ❍ Less than 1 year
- ❍ 2-5 years
- ❍ 6-10 years
- ❍ 11+ years

Are you aware of any elder abuse multidisciplinary teams in your area that engage in case review?

- ❍ Yes
- ❍ No

Are you aware of any other elder abuse networks in your area?
- ❍ Yes
- ❍ No

Display This Question:

If Are you aware of any multidisciplinary teams in your area that engage in case review? Yes Is Selected

For each elder abuse multidisciplinary teams that engages in case review in your area, please list the title of the team (or the sponsoring agency, if there is no official team title). Your response here will be referenced later in the survey when we ask you for more information about each multidisciplinary team.Note: Complete one box for each multidisciplinary team you're aware of. Leave all other boxes blank.

Display This Question:

If Are you aware of any other elder abuse networks in your area? Yes Is Selected

For every other elder abuse network in your area, please list the title of the network (or the sponsoring agency, if there is no official network title). Your response here will be referenced later in the survey when we ask you for more information about each network.Note: Complete one box for each network you're aware of. Leave all other boxes blank. Do not include networks you've already listed in the multidisciplinary team question.

Now we would like to ask you some questions specifically about the multidisciplinary team you identified.

Is [multidisciplinary team name] housed within or affiliated with a host organization/agency?
- ❍ Yes (please specify) _____
- ❍ No

Who would be the best person for us to contact about [multidisciplinary team name] (if known)?

If you know the physical address for this multidisciplinary team, please provide below:
- ❍ _____
- ❍ N/A - no physical address exists for this multidisciplinary team

If you know the phone number for this multidisciplinary team, please provide below:
- ❍ _____
- ❍ N/A - no phone number exists for this multidisciplinary team

If you know the website for this multidisciplinary team, please provide below:
- ❍ _____
- ❍ N/A - no website exists for this multidisciplinary team

Have you ever attended a meeting of this multidisciplinary team?
- ❍ Yes
- ❍ No

Condition: No Is Selected. Skip To: Have you ever been asked to attend th....

How would you describe your attendance in this multidisciplinary team?

- ❍ Only attended once
- ❍ Attended rarely
- ❍ Attended occasionally
- ❍ Attended routinely
- ❍ Frequently

When was the last time you attended a meeting of this multidisciplinary team (${lm://Field/1})?
- ❍ Within the last year
- ❍ 1-3 years ago
- ❍ More than 3 years ago

What was your primary role in attending meetings of this multidisciplinary team? (mark all that apply)
- ❑ Observer
- ❑ Team Member
- ❑ Presenter
- ❑ Coordinator/Administrator/Facilitator

How would you classify this multidisciplinary team? (select all that apply)
- ❑ General multidisciplinary team
- ❑ Financial Abuse Specialist Team (FAST)
- ❑ Elder Abuse Forensic Center (elder abuse forensic center)
- ❑ Fatality Review Team
- ❑ Hospital-based multidisciplinary team
- ❑ Other (please specify) _____

What types of cases does this multidisciplinary team see? (mark all that apply)
- ❑ Physical abuse
- ❑ Sexual abuse
- ❑ Psychological/emotional/mental abuse
- ❑ Financial abuse/exploitation
- ❑ Neglect by other
- ❑ Self-neglect
- ❑ Other (please specify) _____

Of these types of abuse, which type of case does this multidisciplinary team see the MOST?
- ❍ Physical abuse
- ❍ Sexual abuse
- ❍ Psychological/emotional/mental abuse
- ❍ Financial abuse/exploitation
- ❍ Neglect by other
- ❍ Self-neglect
- ❍ Other (please specify) _____

Has participating in this multidisciplinary team changed how you address elder abuse cases?

- ❍ Not at all (1)
- ❍ 2
- ❍ 3
- ❍ 4
- ❍ A lot (5)

To what extent do you believe this multidisciplinary team changes outcomes for elder abuse cases? Very positively

- ❍ Positively
- ❍ Neither positively nor negatively
- ❍ Negatively
- ❍ Very negatively

Do you believe that this multidisciplinary team reduces the occurrence of elder abuse?

- ❍ Yes
- ❍ No

Which of the following describe major barriers to this multidisciplinary team's success? (check up to 3 options)

- ❑ Funding/resources
- ❑ Team organization
- ❑ Team leadership
- ❑ Time commitment
- ❑ Transportation to multidisciplinary team meeting
- ❑ Difficulty identifying appropriate cases
- ❑ Member engagement (members who refuse to be actively involved)
- ❑ Agency engagement (organizations that refuse to participate)
- ❑ Perceived inability to share information (due to perceived legal restrains)
- ❑ Other (please specify) _____
- ❑ No major barriers exist for this multidisciplinary team

Display This Question:

If Have you ever attended a meeting with this multidisciplinary team? No Is Selected

Have you ever been asked to attend this multidisciplinary team?

- ❍ Yes
- ❍ No

Display This Question:

If Have you ever attended a meeting with this multidisciplinary team? No Is Selected

If you made the decision not to attend a meeting of this multidisciplinary team, which of the following best describes the reason? (check all that apply)

- ❑ I would like to attend, but I am too busy
- ❑ My organization/employer does not provide me with time to participate
- ❑ My organization/employer does not permit me to attend
- ❑ Not a good use of time
- ❑ Not relevant to the work that I do
- ❑ Hostile/disagreeable relationships with one or more multidisciplinary team members
- ❑ The multidisciplinary team members can be intimidating
- ❑ Disorganization within the multidisciplinary team
- ❑ Other (please specify) _____

Display This Question:

If Have you ever attended a meeting with this multidisciplinary team? No Is Selected

Now we would like to ask you some questions specifically about the network you identified.

Is ${lm://Field/1} housed within or affiliated with a host organization/agency?

- ❍ Yes (please specify) _____
- ❍ No

Who would be the best person for us to contact about ${lm://Field/1} (if known)?

If you know the physical address for this Network, please provide below:

- ❍ _____
- ❍ N/A - no physical address exists for this Network

If you know the phone number for this Network, please provide below:

- ❍ _____
- ❍ N/A - no phone number exists for this Network

If you know the website for this Network, please provide below:

- ❍ _____
- ❍ N/A - no website exists for this Network

Have you participated in any activities of this network?

- ❍ Yes
- ❍ No

What types of cases does this network (${lm://Field/1}) deal with? (mark all that apply)

- ❑ Physical abuse
- ❑ Sexual abuse
- ❑ Psychological/emotional/mental abuse
- ❑ Financial abuse/exploitation
- ❑ Neglect
- ❑ Self-neglect
- ❑ Other (please specify) _____

Of these types of abuse, which type of case does this network (${lm://Field/1}) deal with the MOST?

- ❍ Physical abuse
- ❍ Sexual abuse
- ❍ Psychological/emotional/mental abuse
- ❍ Financial abuse/exploitation
- ❍ Neglect
- ❍ Self-neglect
- ❍ Other (please specify) _____

How has participating in this network changed your approach to your job?

- ❍ Very positively affected
- ❍ Positively affected
- ❍ Neither positively nor negatively affected
- ❍ Negatively affected
- ❍ Very negatively affected

Do you believe that this multidisciplinary team improves outcomes for cases of elder abuse?

- ❍ Yes
- ❍ No

Do you believe that this multidisciplinary team reduces the occurrence of elder abuse?

- ❍ Yes
- ❍ No

If you could raise three comments, suggestions, or questions regarding elder abuse multidisciplinary teams in general, what would they be?

APPENDIX 4: STAGE 2 INSTRUMENT

1. Is [multidisciplinary team name] still functioning?
   - ❑ Yes
   - ❑ No

If "No" if chosen:

N1. How long as it been since the last time the multidisciplinary team was convened?
   - ❑ Less than 1 year
   - ❑ 1-2 years
   - ❑ 2-5 years
   - ❑ 5-10 years
   - ❑ More than 10 years

N2. Why is this multidisciplinary team no longer functioning (choose all that apply)?
   - ❑ Lack of funding
   - ❑ Lack of participation from multidisciplinary team members
   - ❑ Absence of cohesion/effective cooperation between multidisciplinary team members
   - ❑ Lack of cases being referred
   - ❑ Lack of support from parent organizations
   - ❑ Lapse in leadership
   - ❑ Inability to share information between organizations
   - ❑ Perceived inability to help resolve cases
   - ❑ Other (please specify):_____

N3. Once we know more about multidisciplinary teams that are still functioning, we may reach out in the future to contact you. To help us in our contact efforts, please list the best phone number to reach you:

___

If "Yes" is chosen:

Y1. Name of multidisciplinary team:_____
City:
Your Name:
Email address:
Contact phone number:

Y2. Matrix #1: Please help us ensure that we have the best contact information for you. Please provide the best contact information to reach you, if different from the information listed above:

	Best Contact Info	Information Above is Correct
multidisciplinary team Name	❑ _____	❑
Contact Name	❑ _____	❑
Contact Phone	❑ _____	❑
Rough Location (City, State)	❑ _____	❑
Street Address	❑ _____	❑
Mailing Address	❑ _____	❑

Website	❑ _____	❑

Y3. We are helping to refine a directory of multidisciplinary teams compiled by the U.S. Department of Justice's multidisciplinary team Technical Assistance Center, which will be posted on their website (https://www.justice.gov/elderjustice/multidisciplinary team-tac). Please let us know what information about your multidisciplinary team we can pass on for inclusion in the directory.

	Do Not Include	Include Information You Currently Have	Corrected Contact Information:
multidisciplinary team Name	❑	❑	❑ _____
Contact Name	❑	❑	❑ _____
Contact Phone	❑	❑	❑ _____
Rough Location (City, State)	❑	❑	❑ _____
Street Address	❑	❑	❑ _____
Mailing Address	❑	❑	❑ _____
Website	❑	❑	❑ _____

Structure

2. Does your multidisciplinary team have a mission statement (i.e., core statement of purpose)? If yes, please paste it here: _____

Coordination/Program Management

3. Does your multidisciplinary team have any of the following:

- ❑ Dedicated program staff (paid)
- ❑ Dedicated program staff (volunteer: does not include multidisciplinary team members from participating agencies)
- ❑ Paid consultants
- ❑ None of the above

4. List anyone with a leadership or organizational role in your multidisciplinary team. This could include people paid by your multidisciplinary team as well as core team members who play a more substantial role in the team's leadership or organization? You can either use the person's name, initials, or a pseudonym when listing them – the important thing is that you know who each line represents.

Name	Please select this individual's principal role with the multidisciplinary team:	What is this person responsible for? *(Check all that apply)*
_____	❑ Paid staff ❑ A paid consultant (not paid by the multidisciplinary team) ❑ A volunteer (not paid by the multidisciplinary team)who ***is not*** a member of a participating agency	❑ Executive leadership (such as, Director) ❑ Schedules meetings ❑ Coordinates with presenters ❑ Moderates multidisciplinary team meetings ❑ Decides which cases to review

	❑ A volunteer who ***is*** a member of participating agency (please specify which agency)	
_____	[same as above]	[same as above]
_____	[same as above]	[same as above]

5. To be asked if any of the roles are not chosen for any of the identified people: You haven't identified anyone for [select category], is there someone at your multidisciplinary team who has this role? If so please go back, if not please continue.

6a. You identified multiple people as being responsible for [name of category]. How is this responsibility divided among these multiple people? (question will be repeated for all responsibility categories where multiple people are identified)

❑ They share the role concurrently

❑ They alternate

6b. If "alternate" is chosen: Generally, how often do they alternate?

- ❑ Every meeting
- ❑ Once a month
- ❑ Quarterly (four times a year)
- ❑ Once a year
- ❑ Other *(please describe)*: _____

7. Are there other people (not listed above) who fall into the following categories (check all that apply)

- ❑ Paid staff
- ❑ Paid consultants
- ❑ Volunteer (who is not a member of participating agency)

<u>Team Composition:</u>

8. Please list each agency that participate in your multidisciplinary team, and answer the five questions for each agency.

Agency	(Descriptive) Agency's relationship has been formalized through written agreement (MOU, MOA, etc.)	(Categorization) Agency provides professional services to your multidisciplinary team	(Descriptive) Agency provides monetary funding to your multidisciplinary team	(Categorization) Agency provides cases for multidisciplinary team review	How often does this agency attend meetings in this multidisciplinary team?
_____	❑ Yes ❑ No ❑ Not sure	❑ Yes ❑ No ❑ Not sure	❑ Yes ❑ No ❑ Not sure	❑ Yes ❑ No ❑ Not sure	❑ Never ❑ Rarely (less than 1/3 of the time) ❑ Sometimes (1/3 to 2/3 of the time)

					❑ Often (over 2/3 of the time) ❑ Always
_____	❑ [same]	❑ [same]	❑ [same]	❑ [same]	❑ [same]
_____	❑ [same]	❑ [same]	❑ [same]	❑ [same]	❑ [same]
MATRIX CONTINUED					
Agency	When this agency attends an multidisciplinary team meeting, how many individuals from this agency are present, on average?	When this agency sends someone, is it usually the same person/people, or does it change?	Rate the level of participation of this agency's representative(s) during multidisciplinary team case review meetings.	Rate this agency's overall level of participation (outside of normal meeting times) in multidisciplinary team cases.	
_____	❑ 1-10 (dropdown) ❑ More than 10	❑ Same person/people ❑ Person/people change(s)	❑ Present and fully engaged in the process, often adding comments and other input when appropriate ❑ Present and partially engaged in the process, rarely adding comments when appropriate ❑ Present (attends the meeting), but otherwise not engaged	❑ Fully engaged in cases, when appropriate and/or requested ❑ Partially engaged in cases, when appropriate and/or requested ❑ Not engaged in cases, even when appropriate and/or requested	
_____	❑ [same]	❑ [same]	❑ [same]	❑ [same]	
_____	❑ [same]	❑ [same]	❑ [same]	❑ [same]	

9. (Categorization) What professions participate in [multidisciplinary team name]?

- □ APS
- □ Physician
- □ Other Medical Personnel (Nurse, PA)
- □ Prosecuting Attorney
- □ Victim Advocate
- □ Law Enforcement
- □ Public Guardian / Conservator
- □ LTC Ombudsman
- □ Psychologist
- □ Mental Health Services
- □ Senior Legal Aid
- □ Developmental Disability Services
- □ Coroner/Medical Examiner
- □ Community Care Licensing
- □ Intimate Partner Violence Services
- □ Financial Industry Representatives/Personnel
- □ Other: _____

10. (Categorization) Do participants in your multidisciplinary team receive formal training to join the multidisciplinary team? This can include, but is not limited to: how to participate as a team member, procedures/systems within the multidisciplinary team, and education on elder abuse.

- ❑ Yes
- ❑ No

11. (Descriptive – move to survey 3) Are there students, interns, or fellows who attend meetings?

- ❑ Yes
- ❑ No

12. (Descriptive – move to survey 3) If yes, do these people receive formal training?

- ❑ Yes
- ❑ No

Geography:

13. (Descriptive) What community/catchment area does your multidisciplinary team serve? (please choose one)

- ❑ Single county:
- ❑ Multiple counties:
- ❑ Single city:
- ❑ Multiple cities:
- ❑ Tribal area:

14. (Descriptive) Would you best describe this service area as primarily rural, or urban?

- ❑ Primarily rural

- ❑ Primarily urban
- ❑ Combination of rural and urban

15. (Descriptive) How do team members participate in multidisciplinary team meetings? (Choose all that apply)
- ❑ In person
- ❑ By telephone conference line
- ❑ By video conference line

16. (Descriptive) How do presenters (who are not part of the team) participate in multidisciplinary team meetings? (Choose all that apply)
- ❑ In person
- ❑ By telephone conference line
- ❑ By video conference line

Client Population:

17. (Descriptive) Does your multidisciplinary team target and/or specialize in a specific population?
- ❑ No specific target population, everyone in catchment area is served equally
- ❑ Individuals with intellectual/developmental disabilities
- ❑ Individuals with significant physical disability/limited mobility
- ❑ Cognitively impaired individuals
- ❑ Older adults over 60
- ❑ Native/tribal populations (such as Native Americans, Alaskan/Hawaiian natives)
- ❑ African Americans
- ❑ Latinos/Hispanics
- ❑ Asians/Pacific Islanders
- ❑ None
- ❑ Other (please specify)

17b. Is your multidisciplinary team **limited** to the population specified above (i.e. your multidisciplinary team does not typically serve individuals outside of this population)?
- ❑ Yes
- ❑ No (please list any other specific population this multidisciplinary team serves): _____
- ❑ Don't know

18. (Descriptive) Please estimate the portion of clients you serve who demonstrate a degree of cognitive impairment?
- ❑ None
- ❑ Some (less than 50%)
- ❑ Most (more than 50%)
- ❑ All
- ❑ Don't know

19. (Descriptive – move to survey 3) Please estimate the racial/ethnic composition of the clients you serve? Please estimate the percentage of your clients that come from each racial/ethnic group.
- Native/tribal populations ___%
- African Americans ___%

- Latinos/Hispanics ___%
- Asians/Pacific Islanders ___%
- White ___%
- Other (please specify) ___%

Logistics

Team Meetings:

20. (Categorization) How often are meetings held? (Identify best answer)
    - ❑ Weekly
    - ❑ Once every two weeks
    - ❑ Once a month
    - ❑ Quarterly (four times a year)
    - ❑ Once a year
    - ❑ Check here if meetings are held periodically, with no regular meeting times
    - ❑ Other

21. (Descriptive) Approximately how long do meetings last?
    - ❑ Under 60 minutes
    - ❑ 60-90 minutes
    - ❑ Over 90 minutes

22. (Descriptive) On average, how many new cases are reviewed each meeting?
    - ❑ 1-2
    - ❑ 3-5
    - ❑ 6-10
    - ❑ 11-20
    - ❑ Over 20

23. (Descriptive) On average, how many new cases are reviewed per year?
    - ❑ 1-10
    - ❑ 11-30
    - ❑ 31-50
    - ❑ 51-100
    - ❑ Over 100

24. (Categorization) Please estimate the average amount of time in each meeting that is allocated to:
    - New case presentation ___%
    - Follow-up on previously presented cases ___%
    - Providing education to team members/meeting attendees ___%
    - Networking ___%
    - Other activities ___%
        - Please specify what these activities are:

Recommendations:

Note, two types:

-Recommendations to one or more team members

-Recommendations to the presenter

25. Following case presentation, does your multidisciplinary team make any formal recommendations for the case?

- ❑ Never
- ❑ Rarely
- ❑ (Sometimes)
- ❑ Often
- ❑ Always

26. If respondents choose anything except "never": Are those recommendations only for action by the case presenter, only for action by non-presenting team members, or both?

- ❑ Case presenter
- ❑ Non-presenting team members
- ❑ Both

27. This matrix will be displayed with one or both columns, depending on the answer to the previous question:

	Recommendations for action by the case presenter	**Recommendations for action by non-presenting members of the team**
Is a summarized list of recommendations created at the end of the case presentation?	❑ Never ❑ Rarely ❑ Often ❑ Always	❑ Never ❑ Rarely ❑ Often ❑ Always
Who, if anyone, track progress on team recommendations?	-No one tracks -[Drop down list of previous leader names] -Other (please specify)	-No one tracks -[Drop down list of previous leader names] -Other (please specify)
Which of the following best describes the tracking of progress on team recommendations? (categorization)	-Presenter is asked about the progress of the recommendation -Presenter is encouraged to complete any incomplete recommendations -Presenter is provided additional resources to assist in the completion of recommendations -Presenter is tasked with a new course of action in place of incomplete recommendations	-Non-presenting member is asked about the progress of the recommendation -Non-presenting member is encouraged to complete any incomplete recommendations -Non-presenting member is provided additional resources to assist in the completion of recommendations - Non-presenting member is tasked with a new course of action in place of incomplete recommendations
Are there any additional methods of tracking recommendations performed by your team?	-Free entry	-Free entry

In the event of conflict/disagreement among team members regarding a case recommendation, which best describes the course of action taken by your multidisciplinary team?	-The multidisciplinary team coordinator takes into consideration all accounts and makes an executive decision -The multidisciplinary team members debate the recommendation until a viable compromise has been reached -The case recommendation is suspended, to be debated at a later meeting date -Other (please specify)	-The multidisciplinary team coordinator takes into consideration all accounts and makes an executive decision -The multidisciplinary team members debate the recommendation until a viable compromise has been reached -The case recommendation is suspended, to be debated at a later meeting date. -Other (please specify)

27b. Please estimate how many times an average case is brought back to the team for re-review/case update?

- ❑ 0
- ❑ 1
- ❑ 2-3
- ❑ More than 3

Day-to-day Operations:

28. (Descriptive) Is there an official protocol regarding who can refer clients to your multidisciplinary team?

- ❑ Yes
- ❑ No

29. (Descriptive) Is there a formalized document laying out these requirements?

- ❑ Yes
- ❑ No

30. (Categorization) What types of cases are accepted?

- ❑ Self-neglect
- ❑ Hoarding
- ❑ Neglect
- ❑ Abandonment
- ❑ Financial exploitation
- ❑ Physical abuse
- ❑ Sexual abuse
- ❑ Emotional/Psychological abuse

Costs:

31. (Descriptive) Approximately how much does [multidisciplinary team name] spend on direct budgeted operating costs, including salaries from paid staff?

- ❑ No budget
- ❑ Less than $500/month ($6000/year)
- ❑ $500-2000/month ($6000-$24,000 /year)
- ❑ $2000-$5000/month ($24,000-$60,000/year)
- ❑ $5000-$9000/month ($60,000-$108,000)

- ❑ Over $9000/month ($108,000/year)

32. What resources are donated to your multidisciplinary team or provided in-kind by a participating agency or organization?

- ❑ Meeting space/rent
- ❑ Office space/rent
- ❑ Support staff/administrative staff
- ❑ Office supplies
- ❑ Recurring technology costs (such as internet, phone costs, teleconferencing costs, service contracts)

32b. If known, please provide the estimated value for each of the in-kind donations listed above.

- ❑ Meeting space/rent: _____
  - ❑ Don't know
- ❑ Office space/rent: _____
  - ❑ Don't know
- ❑ Support staff/administrative staff: _____
  - ❑ Don't know
- ❑ Office supplies: _____
  - ❑ Don't know
- ❑ Recurring technology costs (such as internet, phone costs, teleconferencing costs, service contracts) : _____
  - ❑ Don't know

33. (Descriptive) Estimate the value of "in-kind" staff time provided by multidisciplinary team member agencies based on the amount of time spent by team members, both in and out of team meetings (include operational costs): _____

Funding:

34. (Descriptive) **Not asked if "no budget" is reported:** From which of the following does your multidisciplinary team receive the most funding?

- ❑ Federal funds
- ❑ State funds
- ❑ Local government funds
- ❑ Private foundation/charity funds
- ❑ Other (please specify)

Needs:

35. (Descriptive) What resources do you still need?

- ❑ Funds for staffing
- ❑ Physical infrastructure
- ❑ Technology
- ❑ Office supplies
- ❑ Other (please specify)

Services

Activities:

36. (Categorization) Which of the following case-related activities do multidisciplinary team members engage in (outside of normal multidisciplinary team meeting times) **due to the case being presented to the team**? (check all that apply)

- ❑ Obtaining client/perpetrator records (such as bank statements, criminal records)
- ❑ Review of client records (such as medical records, legal documents)
- ❑ Direct services to clients (such as mental health counseling, estate planning)
- ❑ Home visit
- ❑ Capacity assessment
- ❑ Interviews with third parties
- ❑ Case documentation (such as report writing)
- ❑ Communication between agencies
- ❑ Other (please specify) _____

37. Apart from reviewing cases, what activities does your multidisciplinary team engage in outside of normal meeting times?

- ❑ Facilitating the flow of documents and other information between agencies/organizations
- ❑ Sharing best practices for investigatory approaches between agencies* (ripple effect)
- ❑ Education to the public
- ❑ Education to professional groups
- ❑ Retreats/workshops targeted to multidisciplinary team members
- ❑ Policy/public systems changes
- ❑ Data collection
- ❑ Other (please specify) _____

38. Does your multidisciplinary team have access to someone who can perform formal capacity assessments that could be used in a courtroom (criminal, civil, probate)?

- ❑ Geriatrician
- ❑ Psychiatrist
- ❑ Other Physician (specify specialty)
- ❑ Psychologist
- ❑ Other (please specify)

*Later downstream: Approximately how many assessments are conducted over the course of a year? Table with physician, psychologist, neuropsychologist

[FOR SURVEY 4, targeting individual team members] In the course of managing the case, are individuals from your agency required to make a judgment about the client's capacity to refuse services?

39. (Descriptive) What services are provided to clients, either by multidisciplinary team staff or paid consultants (direct services), or by participating agencies (indirect services)? (only if "direct services" is checked in previous question)

(DESCRIPTIVE)	Provided by multidisciplinary team staff/paid consultants	Provided by multidisciplinary team members from participating agencies
	❑	❑
Medical (such as prescribing medication, providing treatment)	❑	❑

Psychological	❑	❑
Case Management	❑	❑
Legal (such as estate planning, quit claim services, restraining orders)	❑	❑
Financial	❑	❑
Housing services (such as long term housing, emergency housing and placement, homelessness)	❑	❑
Other	Free entry	Free entry

Distinction: if there are multiple agencies involved

Case Tracking:

40. Does your multidisciplinary team start a case file (paper or electronic) for each case presented?
- ❑ Always
- ❑ Usually
- ❑ Rarely
- ❑ Never

41. (Descriptive) What system is used to collect information about cases? (Check all that apply)
- ❑ Paper-based systems
- ❑ Computerized spreadsheets (such as Microsoft Excel)
- ❑ Computerized database (such as Microsoft Access)
- ❑ Web/cloud-based data system
- ❑ Other data system (please specify)
- ❑ No data system is used

42. ***Skip if answer was "never" to 40** Are these files updated with new information about each case?
- ❑ Always
- ❑ Usually
- ❑ Rarely
- ❑ Never

43. (Descriptive) What system is used to track information about cases over time? (Check all that apply)
- ❑ Paper-based systems
- ❑ Computerized spreadsheets (such as Microsoft Excel)
- ❑ Computerized database (such as Microsoft Access)
- ❑ Web/cloud-based data system
- ❑ Other data system (please specify)
- ❑ No data system is used

44. (Descriptive) What type of information is routinely collected about cases presented to your multidisciplinary team?
- ❑ Demographic
- ❑ Financial
- ❑ Psychological assessment

- ❑ Medical assessment
- ❑ Personal statements from client
- ❑ Case narrative
- ❑ Case timeline
- ❑ Personal statements from witnesses/alleged abusers
- ❑ Other (please specify):___

45. (Descriptive) Is this information analyzed or used for any other purposes besides case review (please specify what this purpose is)?

- ❑ Yes (_____)
- ❑ No

Outcomes

46a. What does your team consider indicators of success? Which are monitored over time?

	(Descriptive) Considered indicator of team success? What do people expect to receive when they bring a case to your team? *(check all that apply)*	(Categorization) Is this outcome monitored/tracked over time? *(check all that apply)*
Improvement in client health status	❑	❑
Improvement in client mental health status	❑	❑
Improvement in client quality of life	❑	❑
Guardianship/Conservatorship	❑	❑
Legal services (counsel, aid) provided	❑	❑
Restitution	❑	❑
Prosecution	❑	❑
Preventing recurrence of abuse/victimization	❑	❑
Other	❑	❑

46b. When does the multidisciplinary team consider a case to be closed (the multidisciplinary team stops tracking the case)?

- ❑ If the client dies
- ❑ If case is closed by all member agencies
- ❑ If all desired outcomes are achieved
- ❑ Other (please specify): ____

History:

47. (Descriptive) What year was [multidisciplinary team name] established?

48. (Descriptive, likely survey 3?) What steps were involved in the establishment of your multidisciplinary team? (choose all that apply)

- ❑ Performed needs assessment of the community
- ❑ Conducted strategic planning sessions

- ❑ Identified potential participating agencies
- ❑ Applied for funding
- ❑ Other (please specify)
- ❑ Don't know

49. Is your multidisciplinary team based on or a replication of an existing multidisciplinary team?
- ❑ Yes
- ❑ No
- ❑ Don't know

50. If yes: Which model was your multidisciplinary team based on? (free entry)

51. Are you aware of any resources that would guide someone trying to establish an multidisciplinary team similar to yours? (free entry)

52. Has the multidisciplinary team had significant changes to its structure, function since its inception?
- ❑ Yes (please provide brief description)
- ❑ No
- ❑ Don't know

Barriers:

53. (Descriptive) What barriers to program operation or growth have you encountered?
- ❑ Funding/resources
- ❑ Team organization
- ❑ Team leadership
- ❑ Team members or presenters unable/unwilling to commit adequate time to meetings
- ❑ Access to multidisciplinary team meeting (transportation, or capability to join meeting remotely)
- ❑ Difficulty identifying cases appropriate for presentation
- ❑ Member engagement (members who refuse to be actively involved)
- ❑ Agency engagement (organizations that refuse to participate)
- ❑ Perceived inability to share information (due to perceived legal constraints)
- ❑ Lack of cases
- ❑ Other (please specify) _____
- ❑ No major barriers exist for this multidisciplinary team

54. (Descriptive) Are there specific laws or policies that have created barriers to the team's work?
- ❑ Yes (please specify)
- ❑ No

55. (Descriptive) Are there specific laws or policies that have been helpful/supportive to the team?
- ❑ Yes (please specify)
- ❑ No

56. (Descriptive) What promising practices, if any, have arisen from your multidisciplinary team? (free entry)

57. Please rate your multidisciplinary team as you respond to the following statements and questions. Although the statements below may not apply to every single member of your multidisciplinary team, please choose responses that capture your multidisciplinary team **as a whole**.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
In general, members of this multidisciplinary team interact cooperatively with people outside of their professional discipline	1	2	3	4	5
In general, members of this multidisciplinary team communicate effectively	1	2	3	4	5
In general, members of this multidisciplinary team respect and appreciate each other's roles and expertise	1	2	3	4	5
In general, members of this multidisciplinary team feel safe bringing up concerns about roles and responsibilities on cases	1	2	3	4	5
In general, multidisciplinary team members' thoughts and opinions are heard and considered	1	2	3	4	5
In general, members of the multidisciplinary team are active listeners and pay close attention to the contributions of other members of the multidisciplinary team	1	2	3	4	5
In general, members of this multidisciplinary team can tolerate and are willing to work through conflict	1	2	3	4	5
This multidisciplinary team generally promotes camaraderie among team members (for example, by paying attention to important personal or professional events, celebrating achievements, acknowledging milestones)	1	2	3	4	5

APPENDIX 5: STAGE 3 INSTRUMENT

Purpose is to conduct a "process, practice, and impact" analysis of specifically-identified elder abuse multidisciplinary teams: of the multidisciplinary teams that are identified as Elder Abuse Forensic Centers, we ask specific, in-depth questions about processes, practices, and impacts/outcomes. **Team members are the target audience.**

1. What is your educational background (check all that apply)?
   - Less than high school
   - High school diploma
   - Bachelor's degree
   - Graduate degree

2. What agency do you represent?
   - Text entry

3. What is your role in this multidisciplinary team?
   - Text entry

4. How long have you personally participated in [multidisciplinary team name]?
   - Less than 1 year
   - 1-2 years
   - 3-5 years
   - 6+ years

5. How often do you attend meetings?
   - Weekly
   - 2-3 times per month
   - Once per month
   - Every other month
   - Other (please specify)

6. How long had you worked on cases of elder mistreatment before participating in [multidisciplinary team name]?
   - Never
   - Less than 1 year
   - 1-2 years
   - 3-5 years
   - 6+ years

7. How did you first become aware of this multidisciplinary team?
   - My job/organization
   - Email from [multidisciplinary team Name]
   - Internet search
   - Word of mouth
   - Other (please specify)

8. Why did you to join [multidisciplinary team Name] as a team member? (check all that apply)
    - Monetary compensation from the multidisciplinary team
    - Requirement set by my job/organization
    - Seemed like a gratifying experience
    - To help address difficult elder abuse cases in my professional work
    - Professional networking opportunities
    - Other (please specify)

9. What drives you to keep participating in [multidisciplinary team Name] as a team member? (check all that apply)
    - Monetary compensation from the multidisciplinary team
    - Requirement set by my job/organization
    - It is a gratifying experience
    - It has helped my job performance
    - Professional networking opportunities
    - Other (please specify)

10. If the leader of this multidisciplinary team were to be replaced, this multidisciplinary team would remain operational.
    - Strongly agree
    - Agree
    - Neutral
    - Disagree
    - Strongly disagree

11. If the leader of this multidisciplinary team were to be replaced, would you continue to participate as a team member?
    - Yes
    - No

12. What does this multidisciplinary team consider to be the top priority in case decision-making?
    - Client safety/protection
    - Supporting client self-determination
    - Facilitating client wishes
    - Cost effectiveness
    - Legal action
    - Client desires/wishes
    - Client physical and mental health
    - Other (please specify)

13. What does your job organization/agency consider to be the top priority in case decision-making?
    - Client safety/protection
    - Supporting client self-determination
    - Facilitating client wishes
    - Cost effectiveness

- Legal action
- Client desires/wishes
- Client physical and mental health
- Other (please specify)

14. What do you PERSONALLY believe should be the top priority in case decision-making?
    - Cost effectiveness
    - Client safety/protection
    - Client autonomy
    - Cost effectiveness
    - Legal action
    - Client desires/wishes
    - Client physical and mental health
    - Other (please specify)

15. Do case discussions include the client's desires/wishes
    - Yes
    - No

16. If the client's desire/wishes oppose the team's goals/action plan for a case, is the case plan adjusted?
    - Always
    - Often
    - Sometimes
    - Rarely
    - Never

17. How often have you disagreed with a decision made on a case, whether or not you expressed that disagreement to the team?
    - Always
    - Often
    - Sometimes
    - Rarely
    - Never

18. [if disagree with decision] How often do you make this disagreement known to the team?
    - Always
    - Often
    - Sometimes
    - Rarely
    - Never

19. How often do participating agencies offer each other assistance to work around case plan barriers? (e.g., APS is unable to contact an elder's physician, but an multidisciplinary team-participating physician offers help in contacting the elder's physician)

- Always
- Often
- Sometimes
- Rarely
- Never

20. How often do you reach out to other participating agencies for assistance with a case?
    - Always
    - Often
    - Sometimes
    - Rarely
    - Never

21. How has your relationship with participating agencies on the multidisciplinary team impacted your work/practice?
    - Very positively
    - Positively
    - Somewhat positively
    - No effect
    - Somewhat negatively
    - Negatively
    - Very negatively

22. BEFORE you joined this multidisciplinary team, how often did you reach out to other agencies for assistance with your work/practice?
    - Always
    - Often
    - Sometimes
    - Rarely
    - Never

23. How has your OVERALL participation in [multidisciplinary team Name] affected your work/practice?
    - Very positively
    - Positively
    - Somewhat positively
    - No effect
    - Somewhat negatively
    - Negatively
    - Very negatively

24. Have you ever felt unable to properly voice your opinion or suggestion during an multidisciplinary team meeting?
    - Yes
    - No

25. [If yes] Which best describes the reason for not being able to voice your opinion/suggestion? (check all that apply)
    - Other team members cut me off
    - Other team members dominate the conversation
    - I am not comfortable with public speaking
    - The meeting ran out of time
    - My opinion/suggestion would not have been received well by the team
    - Other (please describe)

26. If I/my organization voices an opposing opinion on a case decision at a team meeting, the decision is re-evaluated.
    - Strongly agree
    - Agree
    - Neutral
    - Disagree
    - Strongly Disagree

27. In your opinion, please rate this multidisciplinary teams level of success:
    - Very successful
    - Successful
    - Somewhat successful
    - Neutral
    - Somewhat unsuccessful
    - Unsuccessful
    - Very unsuccessful

28. How do you PERSONALLY measure this multidisciplinary teams success? (i.e., what are specific criteria you use to be able to say "this multidisciplinary team is successful" or "this multidisciplinary team is unsuccessful"?)
    - Text entry

29. The AGENCY I represent contributes to the overall success of [multidisciplinary team Name].
    - Strongly agree
    - Agree
    - Neutral
    - Disagree
    - Strongly disagree

30. I personally contribute to the overall success of [multidisciplinary team Name].
    - Strongly agree
    - Agree
    - Neutral
    - Disagree
    - Strongly disagree

31. Please describe how you and the agency you represent contribute to the overall success of [multidisciplinary team Name].
    - Text entry

32. Were you involved in the creation of this multidisciplinary team?
    - Yes
    - No

33. [If Yes] In your opinion, how challenging was it to establish [multidisciplinary team Name].
    - Extremely challenging
    - Challenging
    - Somewhat challenging
    - Not challenging

34. [If Yes] What was your role in helping to establish this multidisciplinary team?
    - Text entry

35. [If Yes] What were the major barriers in establishing this multidisciplinary team? (check all that apply)
    - Acquiring sufficient funds
    - Recruiting participating agencies
    - Finding cases to review
    - Establishing support from policy makers
    - Other (please specify)

36. [If Yes] Are you aware of any resources that would guide someone trying to establish an multidisciplinary team like yours?
    - Yes (please specify)
    - No

37. If there is any relevant information about your multidisciplinary team that was not captured in this survey, and you would like to share, please describe it below.
    - Text entry

The following matrix gives statements about the team effectiveness of your MDT. Please select one answer choice for each statement.

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
Everyone on my team has equal influence on the team's decisions					
Team members have the skills to contribute to the task we have been assigned					
Everyone on this team knows and understands the team's priorities					
As a team, we work together to set clear, achievable, and appropriate goals					
As a team, we are able to work together to overcome barriers and conflicts					
The team environment encourages every person on the team to be open and honest					
The team has the support and resources it needs to meet its goals					
The physical layout of the MDT promotes team interaction					
The team is supportive and provides essential mentoring for new people					
Overall, this MDT is effective					

APPENDIX 6: STAGE 1 FINDINGS

Characteristics of Respondents Involved in Elder Abuse (*N* =263)

	n	(%)
Profession		
APS	110	(41.83)
District Attorney	20	(7.6)
Family Violence	6	(2.28)
Financial Institution	4	(1.52)
Healthcare	15	(5.7)
Law Enforcement	7	(2.66)
Legal Services	20	(7.6)
Social Services Agency (not APS)	33	(12.55)
Other Governmental Agency	48	(18.25)
Other (please specify)	40	(15.21)
Missing	--	
Length of Time in Elder Abuse		
11+ years	148	(56.27)
2-5 years	68	(25.86)
6-10 years	68	(25.86)
Less than 1 year	19	(7.22)
Missing	--	
Primary Role in Meetings		
Observer	46	(14.11)
Team Member	189	(57.98)
Presenter	61	(18.71)
Coordinator/Adminstrator/Facilitator	103	(31.6)
Missing	443	
Has Attended MDT Meeting		
Yes	338	(80.09)
No	84	(19.91)
Missing	347	
Description of Attendance		
Attend frequently	234	(71.34)
Attend occasionally	57	(17.38)
Attend rarely	19	(5.79)
Attended once	18	(5.49)
Missing	10	
Has Been Asked to Attend a Meeting		
Yes	8	(10.96)
No	65	(89.04)
Missing	11	
Reason for Not Attending		
Hostile/disagreeable relationships	2	(4)
Willing but too busy	4	(8)
Organization/employer does not provide time	2	(4)
Not a good use of time	7	(14)
Other (please specify)	35	(70)
Missing	34	

Characteristics of Identified MDTs

	Weighted *n*	(%)
MDT Housed within a Host Agency		
Yes (please specify)	212.07	(77.12)
No	29.42	(10.7)
Unknown	33.52	(12.19)
Missing	298.99	
MDT Operates within a Healthcare Organization		
Yes	135.68	(49.73)
No	84.40	(30.93)
Unknown	52.76	(19.34)
Missing	301.16	
Type of Abuse Addressed		
Physical	229.67	(84.61)
Sexual	208.12	(76.67)
Psychological	215.19	(79.27)
Financial	244.81	(90.18)
Neglect	223.46	(82.32)
Self-neglect	195.85	(72.15)
Hoarding	164.75	(60.69)
Death	84.80	(31.24)
Other	30.28	(11.16)
Missing	302.54	
Number of Abuse Types Addressed		
1	27.42	(10.1)
2	10.50	(3.87)
3	10.55	(3.89)
4	10.57	(3.89)
5	18.98	(6.99)
6	41.78	(15.39)
7	84.31	(31.06)
8	67.36	(24.82)
Missing	302.54	
Number of Abuse Types Addressed (APS Consensus Guidelines)*		
1	21.06	(7.76)
2	5.97	(2.2)
3	12.70	(4.68)
4	14.07	(5.18)
5	38.29	(14.11)
6	166.38	(61.29)
Missing	302.54	

*Defined as "physical, emotional, sexual abuse; financial exploitation, neglect; and self neglect."

Elder Abuse Affiliates' Perceptions of Identified MDTs

	Weighted *n*	(%)
MDT Changes Outcomes for Elder Abuse Cases		
Very positively	59.37	(27.52)
Positively	121.99	(56.55)
Neutral	30.30	(14.05)
Negatively	0.05	(.02)
Very negatively	4.00	(1.85)
Missing	358.28	
MDT Impacts Recurrence/Recidivism of its Elder Abuse Cases		
Very positively	25.84	(12.04)
Positively	94.34	(43.96)
Neutral	91.37	(42.58)
Negatively	0.05	(.02)
Very negatively	3.00	(1.4)
Missing	357.48	
MDT Impacts Overall Occurrence of Elder Abuse In the Community		
Very positively	31.95	(14.75)
Positively	90.27	(41.69)
Neutral	91.25	(42.14)
Negatively	0.05	(.02)
Very negatively	3.00	(1.39)
Missing	357.48	

Table 2. Elder Abuse Affiliates' Perceptions of Identified MDTs

	Weighted *n* (%)
MDT Participation has Changed Respondents' Approach to Elder Abuse Cases	
A great deal	77.10 (49.04)
Somewhat	47.22 (30.03)
A little	22.34 (14.21)
Not at all	10.57 (6.72)
Missing	145.77
Most Valuble Aspects of MDT Meeting	
Educational presentations	33.00 (10.22)
Follow-up on previously presented cases	22.00 (6.81)
Networking	113.00 (34.98)
New case presentation/discussion	131.00 (40.56)
Program development/planning	24.00 (7.43)
Missing	15.00
Barriers to MDT Success/Improvement	
Funding/resources	81.45 (37.38)
Team organization	25.15 (11.54)
Team leadership	14.07 (6.46)
Time commitment	75.30 (34.56)
Transportation to MDT meeting	1.71 (.79)
Difficulty identifying cases for review	37.81 (17.35)
Member engagement	51.01 (23.41)
Agency engagement	52.47 (24.08)
Percieved inability to share information	32.47 (14.9)
Hostile/disagreeable relationships between MDT members	4.36 (2)
MDT members can be intimidating	2.80 (1.28)
Other	26.24 (12.04)
No major barriers	41.84 (19.2)
Missing	356.08

APPENDIX 7: STAGE 2 FINDINGS

Descriptive Statistics of Items Used for MDT Latent Classes (*N* = 81)

	Missing	Frequency
	N (%)	*N* (%)
Organizational Goals		
Legal & non-legal indicators of success	2 (.02)	66 (83.54)
Tracks indicators of success	8 (.1)	29 (39.73)
Cases		
Addresses 6 types of abuse (APS guidelines)	1 (0.01)	50 (62.50)
Provides formal recommendations on cases	0	50 (61.73)
Records recommendations for the case presenter	9 (.11)	51 (70.83)
Extensive follow-up on case recommendations	8 (.1)	18 (24.66)
MDT Responsibilities		
Has access to capacity assessment	6 (.07)	51 (68)
Members conduct home visits due to case presentation	2 (.02)	61 (77.22)
Agency Participation		
Medical, legal, & social services in attendance	0	71 (87.65)
MDT Functions and Services		
Facilitates the flow of documents between agencies	7 (.09)	45 (60.81)
Has dedicated program staff	0	45 (55.56)
Meets more than once per month	0	40 (49.38)

Item Response Probabilities for a 3-Class Model of EA MDTs (*N* =81)

	MDT Classes					
	EAFC		*Quasi-EAFC*		*Non-EAFC*	
	32%		30%		38%	
Characteristic	ρ	*SE*	ρ	*SE*	ρ	*SE*
Organizational Goals						
Legal & non-legal indicators of success	0.89	-0.07	1.00	-0.01	0.65	-0.10
Tracks indicators of success	0.78	-0.11	0.31	-0.11	0.13	-0.08
Cases						
Addresses 6 types of abuse (APS guidelines)	0.47	-0.11	0.91	-0.10	0.52	-0.10
Provides formal recommendations on cases	0.99	-0.02	0.88	-0.11	0.09	-0.12
Records recommendations for the case presenter	0.93	-0.06	0.82	-0.09	0.36	-0.12
Extensive follow-up on case recommendations	0.51	-0.11	0.16	-0.09	0.06	-0.06
MDT Responsibilities						
Has access to capacity assessment	0.75	-0.09	0.74	-0.10	0.56	-0.10
Members conduct home visits due to case presentation	0.88	-0.07	0.85	-0.12	0.62	-0.10
Agency Participation						
Medical, legal, & social services in attendance	0.81	-0.08	1.00	-0.02	0.83	-0.07
MDT Functions and Services						
Facilitates the flow of documents between agencies	0.78	-0.11	0.47	-0.12	0.57	-0.11
Has dedicated program staff	0.78	-0.09	0.39	-0.13	0.51	-0.10
Meets more than once per month	0.94	-0.06	0.16	-0.12	0.40	-0.10

Characteristics Conditional on MDT Class Membership (*N* =81)

Characteristic	MDT Classes (%) *EAFC* (*n* =26)	*Semi-EAFC* (*n* =24)	*Non-EAFC* (*n* =31)	χ^2	p-value	
Age of MDT				5.46	0.243	
1-5 years	35.00	9.09	19.05			
6-10 years	15.00	36.36	23.81			
10+ years	50.00	54.55	57.14			
Missing = 18						
MDT self-classification				17.61	0.225	
I-Team (Interdisciplinary Team)	19.23	45.83	40.00			
General MDT	19.23	20.83	16.67			
CCR (Coordinated Community Response)	3.85	20.83	10.00			
E-MDT (Enhanced MDT)	19.23	4.17	6.67			
FAST (Financial/Fiduciary Abuse Specialist Team)	11.54	--	10.00			
Fatality Review Team/Death Review Team	3.85	--	6.67			
Forensic Center	7.69	4.17	--			
Other (please specify):	15.38	4.17	10.00			
Missing = 1						
Geography				3.62	0.460	
Combination of rural and urban	30.77	50.00	43.33			
Primarily rural	30.77	33.33	33.33			
Primarily urban	38.46	16.67	23.33			
Missing = 1						
Participants receive formal training	42.31	37.50	32.26	0.62	0.735	
Operating costs (including salary)				14.92	0.135	
No budget	50.00	70.83	83.33			
Less than $500/month ($6,000/year)	12.50	16.67	10.00			
$500-$2,000/month ($6,000-$24,000/year)	12.50	4.17	3.33			
2,000-$5,000/month ($24,000-$60,000/year)	4.17	4.17	3.33			
$5,000-$9,000/month ($60,000-$108,000/year)	4.17	4.17	--			
Over $9,000/month ($108,000/year)	16.67	--	--			
Missing = 3						
Information routinely recorded about cases						
Case narrative ("what happened")	88.46	75.00	77.42	1.68	0.432	
Demographics (of the client)	88.46	70.83	61.29	5.35	0.069	
Case timeline ("what is currently happening to resolve the case	76.92	62.50	58.06	2.35	0.308	
Information about the alleged abuser(s)	73.08	62.50	58.06	1.43	0.489	
Finances (of the client)	69.23	58.33	41.94	4.37	0.112	
Medical assessment (of the client)	65.38	50.00	35.48	5.06	0.080	
Psychological assessment (of the client)	61.54	50.00	25.81	7.74	0.021	*
Personal statements from client	46.15	37.50	19.35	4.84	0.089	
Personal statements from witnesses/alleged abuser(s)	30.77	29.17	16.13	2.00	0.368	
Other (please specify):	23.08	16.67	12.90	1.03	0.597	
Missing = 11						
Type of abuse addressed						
Financial	88.46	100.00	83.87	4.07	0.131	
Physical	65.38	100.00	64.52	11.19	0.004	**
Neglect	65.38	100.00	64.52	11.19	0.004	**
Sexual	65.38	100.00	61.29	12.06	0.002	**
Emotional	61.54	95.83	61.29	9.85	0.007	**
Self-Neglect	53.85	100.00	54.84	16.13	0.000	***
Hoarding	50.00	87.50	51.61	9.60	0.008	**
Other	7.69	16.67	22.58	2.34	0.311	
Missing = 1						
Age groups served						
Children (<18 years old)	11.54	--	--	6.59	0.037	*
Adults age 18 through 64	69.23	87.50	74.19	2.47	0.290	
Older adults age 65+	96.15	91.67	90.32	0.74	0.690	
Other	7.69	4.17	9.68	0.60	0.740	
Disability groups served						
Cognitive impairment	100.00	91.67	96.77	2.46	0.292	
Significant physical disability/limited mobility/functional impairm	100.00	95.83	90.32	2.86	0.239	
Intellectual/developmental disabilities	88.46	95.83	87.10	1.28	0.528	
NO cognitive impairment, intellectual/developmental/physical d	69.23	54.17	64.52	1.27	0.531	
Other	11.54	4.17	19.35	2.91	0.234	
Missing = 1						
Resources needed						
Funds for staffing	46.15	20.83	38.71	3.67	0.160	
Physical infrastructure	7.69	4.17	3.23	0.64	0.725	
Technology	11.54	16.67	12.90	0.30	0.861	
Office supplies	7.69	4.17	6.45	0.27	0.872	
Other	7.69	16.67	16.13	1.13	0.567	
Missing = 41						

*p < .05. **p < .01. ***p < .001.

Table 5. Characteristics Conditional on MDT Class Membership, Cont. (*N* =81)

	MDT Classes (%)				
Characteristic	*EAFC* (*n* =26)	*Semi-EAFC* (*n* =24)	*Non-EAFC* (*n* =31)	χ^2	p-value
Length of Meeting Time				0.18	0.996
Under 60 minutes	7.69	8.33	9.68		
60-90 minutes	80.77	79.17	80.65		
Over 90 minutes	11.54	12.5	9.68		
Cases reviewed per year				25.27	0.001 ***
1-10	7.69	33.33	46.67		
11-30	42.31	54.17	43.33		
31-50	11.54	8.33	10		
51-100	26.92	4.17	--		
Over 100	11.54	--	--		
Missing = 1					
Cases reviewed per meeting				10.72	0.097
1-2	53.85	54.17	70.97		
3-5	19.23	41.67	22.58		
6-10	23.08	4.17	6.45		
11-20	--	--	--		
Over 20	3.85	--	--		
Method of participation team members				8.72	0.069
In person	65.38	87.5	87.1		
In person & telephone	34.62	8.33	9.68		
In person & video	--	4.17	3.23		
Method of participation presenters				13.70	0.090
Telephone	--	--	3.45		
In person	76	95.83	93.1		
In person & telephone	20	4.17	--		
In person & video	--	--	3.45		
In person & telephone & video	4	--	--		
Missing = 3					
				25.05	<.001
Tracks success	79.17	30.43	11.54		***
Indicators of success					
Decreased level of risk to client	96.15	95.83	77.42	6.69	0.035 *
Improvement in client quality of life	92.31	95.83	70.97	8.17	0.017 *
Preventing recurrence of abuse/victimization	88.46	91.67	77.42	2.50	0.286
Improvement in client health status	84.62	83.33	54.84	8.24	0.016 *
Legal remedies/services provided to client	80.77	91.67	51.61	12.19	0.002 **
Housing secured	80.77	87.5	51.61	10.15	0.006 **
Improvement in client mental health status	76.92	79.17	51.61	6.14	0.046 *
Achieving person-centered outcomes	76.92	70.83	54.84	3.37	0.186
Guardianship/conservatorship	69.23	75	45.16	6.01	0.050 *
Prosecution or plea	65.38	58.33	48.39	1.70	0.428
Restitution	65.38	58.33	25.81	10.29	0.006 **
Other	11.54	4.17	6.45	1.06	0.590
Missing = 2					

*p < .05. **p < .01. ***p < .001.

List of MDTs in Each Latent Class (*N*=81)

EAFCs	Semi-EAFC	Non-EAFC
Hennepin County Adult Protection/Law Enforcement Team	Columbia County I-Team	No Name Provided
Rapid Response Expert Team	Butler County Elder Safety Network	Dependent Elder Abuse Review and Elder Death Review Team (DEAR/EDRT)
Adult Protection Team	Standing Rock Elderly Protection Team	So. SLC APS MDT
Los Angeles Elder Abuse Forensic Center	Fond du Lac County I-team	Aging and Independence Services & Law Enforcement Brown Bag
Orange County Elder Abuse Forensic Center	York-Poquoson Adult MDT	Social Services
Cuyahoga County Adult Protective Collaborative	San Diego County Cross Regional MDT	Grant Co. Interdisciplinary Team
Elder Abuse E-MDT	Bronx Elder Abuse Multi Disciplinary Task Force	Marinette County EAN Team
Will County Adult Protective Services M-Team (Multi-Disciplinary Tear	South County MDT	Wood County I-Team
Ulster County E-MDT	Wyandotte County Crisis Response Consortium	Onondaga County E-MDT
Elder & Vulnerable Adult Abuse Multidiscplinary Team	Douglas County I Team	No Name Provided
Law Enforcement Staffing MDT	West Central Illinois MDT	No Name Provided
Clinton County Financial Exploitation MDT	Adults at Risk I-Team	Houston Financial Abuse Specialist Team
MDT (No Name Provided)	SB County MDT	Center for Prevention of Abuse
Elder and Vulnerable Adult Abuse Task Force	MDT (No Name Provided)	Adult Protection Team
Cass County Adult Protection Team	Multidisiplinary Team for Elder Abuse and Neglect	Central Coast Scams Against Seniors Working Group
Texas Elder Abuse and Mistreatment Institute	I Team Meeting (Interdisciplinary)	I-Team of Barron County
MID County MDT	Ashland County Interdisciplinary Team	Oklahoma County Coalition Against Financial Exploitation of the Elderly
EAFC (No Name Provided)	Catholic Charities, Diocese of Joliet	Brown County Adult Protectin Team
CREA (Coordinated Response to Elder Abuse)	Dodge County Adult Protective Services Interdisciplinar	Cobb County Elder Abuse Task Force
Financial Abuse Specialist Team	APS CROSS REGIONAL MDT	Ingham County Elder Abuse Coordinated Community Response Team
Isanti County Adult Protection Team	Adult Abuse Review Team (AART)	Denver Forensic Collaborative
Clinton County Financial Exploitation MDT	Denver Forensic Collaboarative for At-Risk Adults	James City County Multidisciplinary Team
Kalamazoo Hoarding Multidisciplinary Team	South County MDT	Rock County I Team
Guilford County Elder Justice Committee	S.A.V.E.	Trempealeau County I-Team
Coalition Against Exploitation of the Elderly (CAFEE)		Dependent Elder Abuse Review / Elder Death Review Team
Ontario County Enhanced Multidisciplinary Team		Jefferson County Abuse/Neglect of Elder/Vulnerable Adults Interdisciplinary Te
		Dss Protective Services for The Elderly
		Sacramento CountyElder Death Review Team
		Financial Abuse Specialist Team (FAST) of Ventura County
		Alameda County Financial Abuse Specialist Teams
		CAPE- Coalition for Abuse Prevention of the Elderly

MDT Professions and Meeting Attendance

	Frequency	Meeting Attendance					
Professions	*N* (%)	*Never*	*Rarely*	*Sometimes*	*Often*	*Always*	*Unknown*
Physician	16 (19.75)	2 (12.5)	1 (6.25)	2 (12.5)	5 (31.25)	6 (37.5)	- -
Other Medical Personnel (such as Nurse, PA)	54 (66.67)	1 (1.85)	3 (5.56)	5 (9.26)	20 (37.04)	23 (42.59)	2 (3.7)
Coroner/Medical Examiner	9 (11.11)	- -	2 (22.22)	2 (22.22)	2 (22.22)	1 (11.11)	2 (22.22)
Psychologist	14 (17.28)	- -	1 (7.14)	4 (28.57)	3 (21.43)	5 (35.71)	1 (7.14)
Community-based Mental Health Services	53 (65.43)	- -	7 (13.21)	8 (15.09)	25 (47.17)	12 (22.64)	1 (1.89)
Law Enforcement	78 (96.3)	1 (1.28)	9 (11.54)	14 (17.95)	22 (28.21)	29 (37.18)	3 (3.85)
Prosecuting Attorney	51 (62.96)	3 (5.88)	6 (11.76)	5 (9.8)	16 (31.37)	18 (35.29)	3 (5.88)
Consulting Attorney	30 (37.04)	1 (3.33)	3 (10.)	4 (13.33)	6 (20)	11 (36.67)	5 (16.67)
Non-prosecutory Attorney	26 (32.1)	- -	2 (7.69)	4 (15.38)	6 (23.08)	10 (38.46)	4 (15.38)
Senior Legal Aid	22 (27.16)	- -	1 (4.55)	1 (4.55)	9 (40.91)	10 (45.45)	1 (4.55)
Victim Advocate	51 (62.96)	- -	5 (9.8)	6 (11.76)	15 (29.41)	20 (39.22)	5 (9.8)
Public Guardian/Conservator	46 (56.79)	- -	7 (15.22)	4 (8.7)	10 (21.74)	23 (50)	2 (4.35)
LTC Ombudsman	40 (49.38)	1 (2.5)	5 (12.5)	4 (10)	5 (12.5)	21 (52.5)	4 (10)
Community Care Licensing	11 (13.58)	1 (9.09)	3 (27.27)	2 (18.18)	4 (36.36)	1 (9.09)	- -
Adult Protective Services (APS)	81 (100)	- -	1 (1.23)	- -	4 (4.94)	73 (90.12)	3 (3.7)
Case Manager	55 (67.9)	2 (3.64)	- -	4 (7.27)	12 (21.82)	34 (61.82)	3 (5.45)
MSWs (who perform capacity assessments)	19 (23.46)	2 (10.53)	- -	2 (10.53)	3 (15.79)	10 (52.63)	2 (10.53)
Intimate Partner Violence Services	24 (29.63)	- -	3 (12.5)	3 (12.5)	5 (20.83)	12 (50)	1 (4.17)
Developmental Disability Services	35 (43.21)	- -	1 (2.86)	7 (20)	15 (42.86)	11 (31.43)	1 (2.86)
Area Agency on Aging Representative	45 (55.56)	- -	2 (4.44)	- -	8 (17.78)	32 (71.11)	3 (6.67)
Elder Abuse Shelter Representative	14 (17.28)	- -	1 (7.14)	1 (7.14)	7 (50)	4 (28.57)	1 (7.14)
Financial Industry Representatives/Personnel	39 (48.15)	2 (5.13)	3 (7.69)	6 (15.38)	17 (43.59)	8 (20.51)	3 (7.69)
Forensic Accountant	8 (9.88)	- -	3 (37.5)	3 (37.5)	1 (12.5)	1 (12.5)	- -
Other (please specify)	25 (30.86)	- -	- -	2 (8)	5 (20)	4 (16)	14 (56)

APPENDIX 8: STAGE 3 FINDINGS

MDT Characteristics and Impacts

Item	Frequency	Percent
MDT would remain operational with leader change		
Strongly agree	33	45.21
Agree	24	32.88
Neutral	10	13.7
Disagree	5	6.85
Strongly disagree	1	1.37
Missing: 2		
Member would continue to participate with leader change	62	87.32
Missing: 4		
MDT level of success		
Very successful	13	18.84
Successful	43	62.32
Somewhat successful	10	14.49
Neutral	2	2.9
Somewhat unsuccessful	1	1.45
Unsuccessful	--	--
Very unsuccessful	--	--
Missing: 6		
Personal contribution to MDT success		
Strongly agree	22	33.85
Agree	37	56.92
Neutral	6	9.23
Disagree	--	--
Strongly disagree	--	--
Missing: 10		
Agency contribution to MDT success		
Strongly agree	32	49.23
Agree	24	36.92
Neutral	9	13.85
Disagree	--	--
Strongly disagree	--	--
Missing: 10		
Relationships with MDT agencies impacted work/practice		
Very positively	32	45.07
Positively	29	40.85
Somewhat positively	9	12.68
No effect	1	1.41
Somewhat negatively	--	--
Negatively	--	--
Missing: 4	--	--
Overall MDT participation impacted work/practice		
Very positively	31	43.66
Positively	31	43.66
Somewhat positively	7	9.86
No effect	2	2.82
Somewhat negatively	--	--
Negatively	--	--
Very Negatively	--	--
Missing: 4		

Member Perspectives on MDT Establishment

Item	Frequency	Percent
Aware of resources to start new MDTs	21	33.87
Missing: 13		
Involved in creation of MDT	23	35.94
Missing: 11		
Challenging to create MDT		
Extremely challenging	3	13.04
Challenging	8	34.78
Somewhat challenging	11	47.83
Not challenging	1	4.35
Major barriers in establishing MDT		
Acquiring sufficient funds	18	28.13
Recruiting participating agencies	32	50
Finding cases to review	18	28.13
Establishing support from policymakers	11	17.19
Conflict over mission and purpose	--	--
Navigating confidentiality and other coordination issues	11	17.19
Developing an effective team environment	12	18.75
Other	7	10.94
There were no barriers in establishing MDT	5	7.81
Missing: 11		

Results of Adapted Team Effectiveness Inventory

Item		Frequency	Percent
Everyone on my team has equal influence on the team's decisions			
	Strongly agree	11	15.71
	Agree	44	62.86
	Neutral	10	14.29
	Disagree	3	4.29
	Strongly disagree	2	2.86
Team members have the skills to contribute to the task we have been assigned			
	Strongly agree	23	32.86
	Agree	42	60
	Neutral	4	5.71
	Disagree	--	--
	Strongly disagree	1	1.43
Everyone on this team knows and understands the team's priorities			
	Strongly agree	15	21.43
	Agree	41	58.57
	Neutral	11	15.71
	Disagree	--	--
	Strongly disagree	1	1.43
As a team, we work together to set clear, achievable, and appropriate goals			
	Strongly agree	20	28.57
	Agree	34	48.57
	Neutral	13	18.57
	Disagree	2	2.86
	Strongly disagree	1	1.43
As a team, we are able to work together to overcome barriers and conflicts			
	Strongly agree	23	32.86
	Agree	35	50
	Neutral	11	15.71
	Disagree	--	--
	Strongly disagree	1	1.43
The team environment encourages every person on the team to be open and honest			
	Strongly agree	28	40
	Agree	35	50
	Neutral	6	8.57
	Disagree	--	--
	Strongly disagree	--	--
The team has the support and resources it needs to meet its goals			
	Strongly agree	7	10
	Agree	29	41.43
	Neutral	18	25.71
	Disagree	13	18.57
	Strongly disagree	3	4.29
The physical layout of the MDT promotes team interaction			
	Strongly agree	25	35.71
	Agree	35	50
	Neutral	8	11.43
	Disagree	1	1.43
	Strongly disagree	1	1.43
The team is supportive and provides essential mentoring for new people			
	Strongly agree	19	27.14
	Agree	32	45.71
	Neutral	16	22.86
	Disagree	2	2.86
	Strongly disagree	1	1.43
Overall, this MDT is effective			
	Strongly agree	30	42.86
	Agree	33	47.14
	Neutral	5	7.14
	Disagree	1	1.43
	Strongly disagree	1	1.43
	Missing: 5		

Differences in Responses by Respondent Education

Characteristic	Education: *Graduate Degree* (*n* =39)	*Bachelor's Degree* (*n* =31)	*High School Diploma* (*n* =2)	χ^2	p-value	
Reason for joining MDT						
Monetary compensation from MDT	--	--	--	--	--	
Requirement set by job/organization	43.59	70.97	--	7.65	0.02	*
Seemed like a gratifying experience	15.38	45.16	50	7.84	0.02	*
Help address elder abuse cases in professional work	58.97	74.19	50	1.98	0.37	
Professional networking opportunities	15.38	51.61	50	10.74	0.005	**
Other	7.69	16.13	50	3.77	0.15	
Missing: 3						
Reason for continued participation						
Monetary compensation from MDT	--	--	--	--	--	
Requirement set by job/organization	46.15	74.19	--	8.26	0.02	*
Gratifying experience	53.85	61.29	50	0.43	0.81	
Improved job performance	33.33	51.61	--	3.79	0.15	
Professional networking opportunities	46.15	67.74	50	3.29	0.19	
Other	15.38	16.13	--	0.38	0.83	
Missing: 3						
Disagrees with Decisions				13.11	0.04	*
Always	--	--	--			
Often	--	10	--			
Sometimes	18.92	33.33	--			
Rarely	72.97	40	--			
Never	8.11	16.67	50			
Missing: 6						
Member reaches out to agencies for case help				13.74	0.03	*
Always	5.26	23.33	--			
Often	71.05	46.67	--			
Sometimes	18.42	23.33	50			
Rarely	5.26	6.67	50			
Never	--	--	--			
Missing: 5						
Member reached out to agencies before joining MDT				21.29	0.01	*
Always	2.63	16.67	--			
Often	52.63	23.33	--			
Sometimes	26.32	33.33	--			
Rarely	18.42	20	--			
Never	--	6.67	50			
Missing: 5						
Overall MDT participation impacted work/practice				18.89	0.004	**
Very positively	50	36.67	--			
Positively	39.47	50	50			
Somewhat positively	10.53	10	--			
No effect	--	3.33	50			
Somewhat negatively	--	--	--			
Negatively	--	--	--			
Very Negatively	--	--	--			
Missing: 5						
Personal contribution to MDT success				20.44	<.001	***
Strongly agree	34.29	33.33	--			
Agree	57.14	62.96	--			
Neutral	8.57	3.7	100			
Disagree	--	--	--			
Strongly disagree	--	--	--			
Missing: 11						
Involved in the creation of MDT	47.06	22.22	--	5.19	0.07	
Missing: 12						

*p < .05. **p < .01. ***p < .001.

Differences in Responses by Respondent Elder Abuse Case Experience (Prior to MDT Membership)

Characteristic	Experience with Elder Abuse Cases: *6+ years (n=24)*	*3-5 years (n=13)*	*1-2 years (n=11)*	*Less than 1 year (n=8)*	*Never (n=18)*	χ^2	p-value	
Reason for joining MDT								
Monetary compensation from MDT	--	--	--	--	--	--	--	
Requirement set by job/organization	41.67	69.23	36.36	62.5	64.71	5.06	0.28	
Seemed like a gratifying experience	20.83	38.46	18.18	50	29.41	3.70	0.45	
Help address elder abuse cases in professional work	79.17	61.54	72.73	50	52.94	4.38	0.36	
Professional networking opportunities	37.5	38.46	18.18	25	29.41	1.79	0.77	
Other	4.17	38.46	9.09	12.5	5.88	10.45	0.03	*
Missing: 2								
Reason for continued participation								
Monetary compensation from MDT	--	--	--	--	--	--	--	
Requirement set by job/organization	37.5	76.92	36.36	75	70.59	10.01	0.04	*
Gratifying experience	58.33	61.54	54.55	75	47.06	1.89	0.76	
Improved job performance	37.5	46.15	36.36	62.5	35.29	2.12	0.71	
Professional networking opportunities	54.17	76.92	36.36	62.5	52.94	4.27	0.37	
Other	33.33	15.38	18.18	--	--	9.94	0.04	*
Missing: 2								
Involved in the creation of MDT	60.87	23.08	22.22	12.5	27.27	10.15	0.04	*
Missing: 12								

*p < .05. **p < .01. ***p < .001.

Differences in Responses by Respondent Professional Group

Characteristic	Professional Group			χ^2	p-value	
	Social (n=61)	*Legal (n=12)*	*Medical (n=2)*			
Reason for joining MDT						
Monetary compensation from MDT	--	--	--	--	--	
Requirement set by job/organization	62.71	16.67	--	10.86	0.004	**
Seemed like a gratifying experience	28.81	33.33	--	0.93	0.63	
Help address elder abuse cases in professional work	59.32	91.67	100	5.70	0.06	
Professional networking opportunities	30.51	41.67	--	1.52	0.47	
Other	13.56	8.33	--	0.54	0.76	
Missing: 2						
Reason for continued participation						
Monetary compensation from MDT	--	--	--	--	--	
Requirement set by job/organization	66.1	16.67	--	12.53	0.002	**
Gratifying experience	52.54	75	100	3.58	0.17	
Improved job performance	44.07	33.33	--	1.91	0.38	
Professional networking opportunities	61.02	41.67	--	4.15	0.13	
Other	15.25	25	--	1.09	0.58	
Missing: 2						

APPENDIX 9: Site Visit Protocol

Research Questions:

1. *What are the core components of each team? Essential resources, members, and activities?*
2. *What have teams learned from experience working as a team? Challenges identified and addressed? Best practices? What advice to teams that are starting up?*
3. *What success do team members observe? In victim outcomes? In team functioning? Ripple effect benefits?*

Prior to Site Visit:

- Secure site visit dates with team facilitator. Explain site visit components (interview/tour, meeting observation, focus group, follow-up interviews by phone), and schedule activities (see data collection procedure, below). Assure time for a 15-minute closing interview with the team staff.
- Check site completion of previous surveys (1, 2, 3a, 3b); request completion prior to visit, from team leads.
- Provide consent forms, team member surveys, focus group questions, and facilitator interview questions 2 weeks prior to visit. Include welcome packet/thank you/excited to meet you and learn more letter, with overview of purpose and content of visits
- Pull data from previous surveys prior to site visit; review and incorporate into site-specific interview materials.

Data Collection Procedure:

Interview with facilitator (1.5 - 3 hours).

- Content focused on operation, insight on team development, sustainability and evolution, activities, and success. Tour of the office, physical location, co-location.
- If time is limited during visit, schedule phone interview before meeting, with closing interview for any questions that arise in meeting observation and focus group.

Team Meeting observation (1 to 2 hours).

- Observation and note taking on content, dialogue, and other communication team dynamics (participation, tone, leadership, managing disagreement, etc.), as permitted by team policy.
- Observe meeting content, format of case presentation, behavior among team (e.g., group dynamics, participation, tension, and body language), member roles and participation, process and content of case discussion

Team Member Survey and Focus Group (45 minutes to 1.5 hours).

- Email main points of interviews one week prior to site visit, attach actual survey and time allotment for survey and focus group.
- Discuss benefits of participation, challenges, team dynamics and synergy, measuring success, ripple effects, and best practices

APPENDIX 10: Site Visit Team Descriptive Tables

Site Visits: MDT Program Characteristics

	Team A	Team B	Team C	Team D
Year established	2013	2013	2018	2017
Catchment area				
City	x	x	x	
County	x	x		x
Area types				
Primarily rural	x	x		
Primarily urban			x	x
Adaption of another MDT model				
Yes		x	x	
No				x
Unknown	x			
MDT classification				
E-MDT (Enhanced MDT)		x	x	x
CCR (Coordinated Community Response)	x			
Meeting frequency				
Once a month	x	x		
Once every two weeks			x	
Weekly				x
Meeting duration				
60-90 minutes	x	x		
Over 90 minutes			x	x
Proportion of total meeting time spent (out of 100%)				
New case discussion	60	68	30	95
Case follow-ups	10	30	50	5

Site Visits: MDT Staff, Leadership Structure, Membership

	Team A	Team B	Team C	Team D
Paid staff				
Dedicated program staff, paid (yes/no)	no	yes	yes	yes
Paid consultants (yes/no)	no	yes	yes	yes
Volunteers, excluding members (number)	4	0	0	6
Leadership/organizational responsibilities (number of staff in each role)				
Coordinate with presenter	3	2	1	1
Decide what cases to review	4	2	1	1
Schedule meetings	1	1	1	1
Moderates MDT meetings	2	1	1	1
Executive leadership	0	2	1	6
Membership				
Physician	x M O		x M O	x M O
Other Medical Personnel (such as Nurse, PA)	x M O		x	x O
Psychologist			x M	
Community-based Mental Health Services	x M O			
Law Enforcement	x M O	x M O	x M O	x M O
Prosecuting Attorney	x O	x M O	x O	x M O
Consulting Attorney				x M O
Non-prosecutory Attorney	x M O			x M O
Senior Legal Aid			x M O	
Victim Advocate	x M O	x M O	x M O	
Advocate		M O		
Public Guardian/Conservator	x M O		x M O	x
LTC Ombudsman	x M O			x
Adult Protective Services (APS)	x M O	x M O	x	x M O
Case Manager	x M O	x M O	x	x M O
Intimate Partner Violence Services	x M O	x M O	x M O	
Developmental Disability Services	x M O			
Area Agency on Aging Representative	x M O	x M O	x O	
Elder Abuse Shelter Represenative			x M O	
Financial Industry Representatives/Personnel		x M O	x O	
Forensic Accountant		x M O	x O	
Other	x M O	x M O		x

Legend:

x	Team member
	Regular attendance
	Same member attends
M	Fully engaged in meetings
O	Fully engaged outside meetings

Site Visits: Activities

	Team A	Team B	Team C	Team D
Case-related activities outside of normal meeting times				
Facilitating documents and information flow	x	x	x	x
Sharing investigatory best practices	x	x	x	x
MDT members retreats/workshops		x	x	x
Educating professional groups	x	x	x	x
Educating the public/public awareness	x		x	x
Policy/public systems change	x			x
Data collection	x	x	x	x
Client Services				
Medical (e.g., prescriptions, treatment)		x		
Case management	x	x		
Legal (e.g., estate, quitclaim, restraining orders)		x		
Financial (e.g., money management)		x		
Housing (e.g., long term, emergency, homeless)		x		
Other				

Legend:

Direct services to clients by MDT staff or paid consultants

x Client services by participating agencies