APS Leaders Institute
Case Management Statewide Survey Results

Anonymized Data

53 Counties Participated

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We create experiences that transform the heart, mind and practice.

APSWI is a program of the Academy for Professional Excellence, and a project of San Diego State University School of Social Work.

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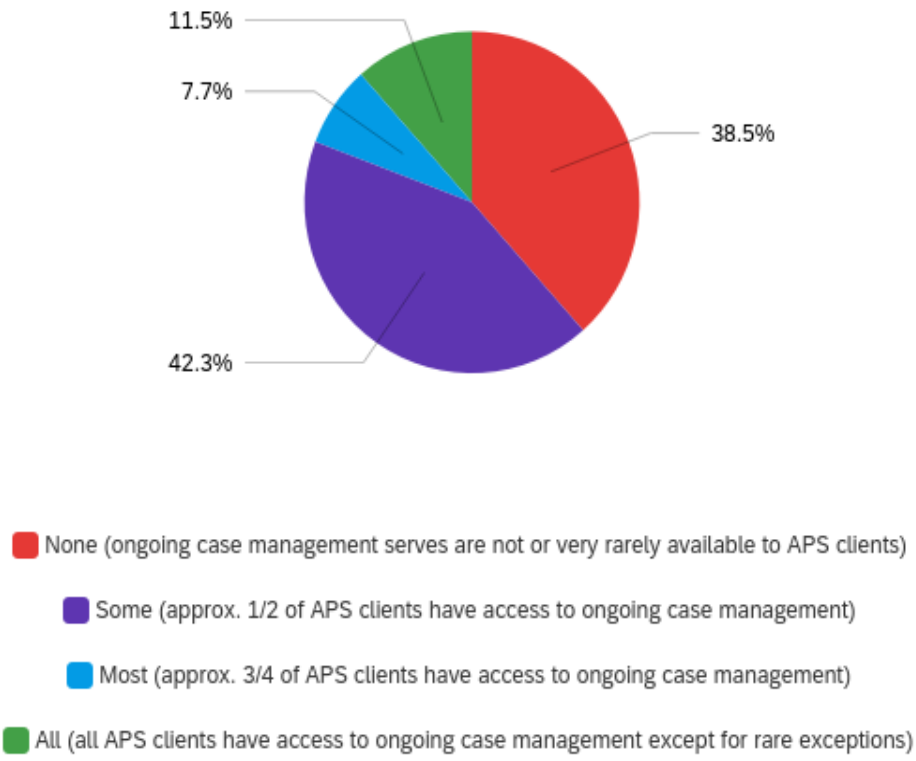
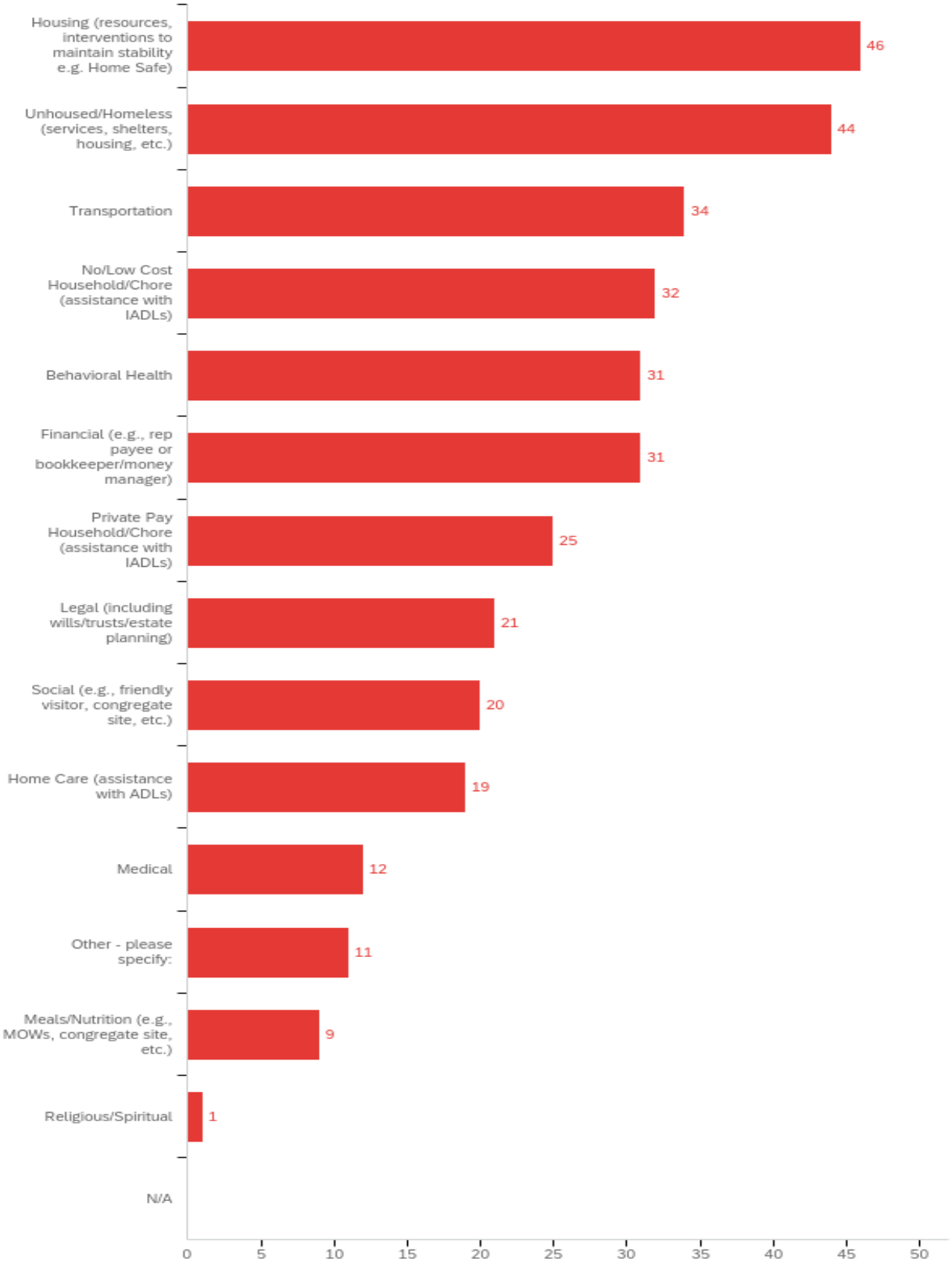
Q3. In your county, approximately how many APS clients, who need extended services, have ready access to ongoing case management services (case management services that meet the needs of the client without a waiting list)? (n=52)

Please note: "Ongoing case management" is defined as APS clients needing extended services beyond the initial APS investigation, service plan, case closure and/or short-term services typically offered by APS programs.



	Percentage of Counties	*Number of Counties*
None (ongoing case management serves are not or very rarely available to APS clients)	38.5%	20
Some (approx. 1/2 of APS clients have access to ongoing case management)	42.3%	22
Most (approx. 3/4 of APS clients have access to ongoing case management)	7.7%	4
All (all APS clients have access to ongoing case management except for rare exceptions)	11.5%	6
TOTAL	100%	52

Q4. In your county's APS program, what types of service(s) are currently a challenge to find for APS clients? (select all that apply) (n=53)



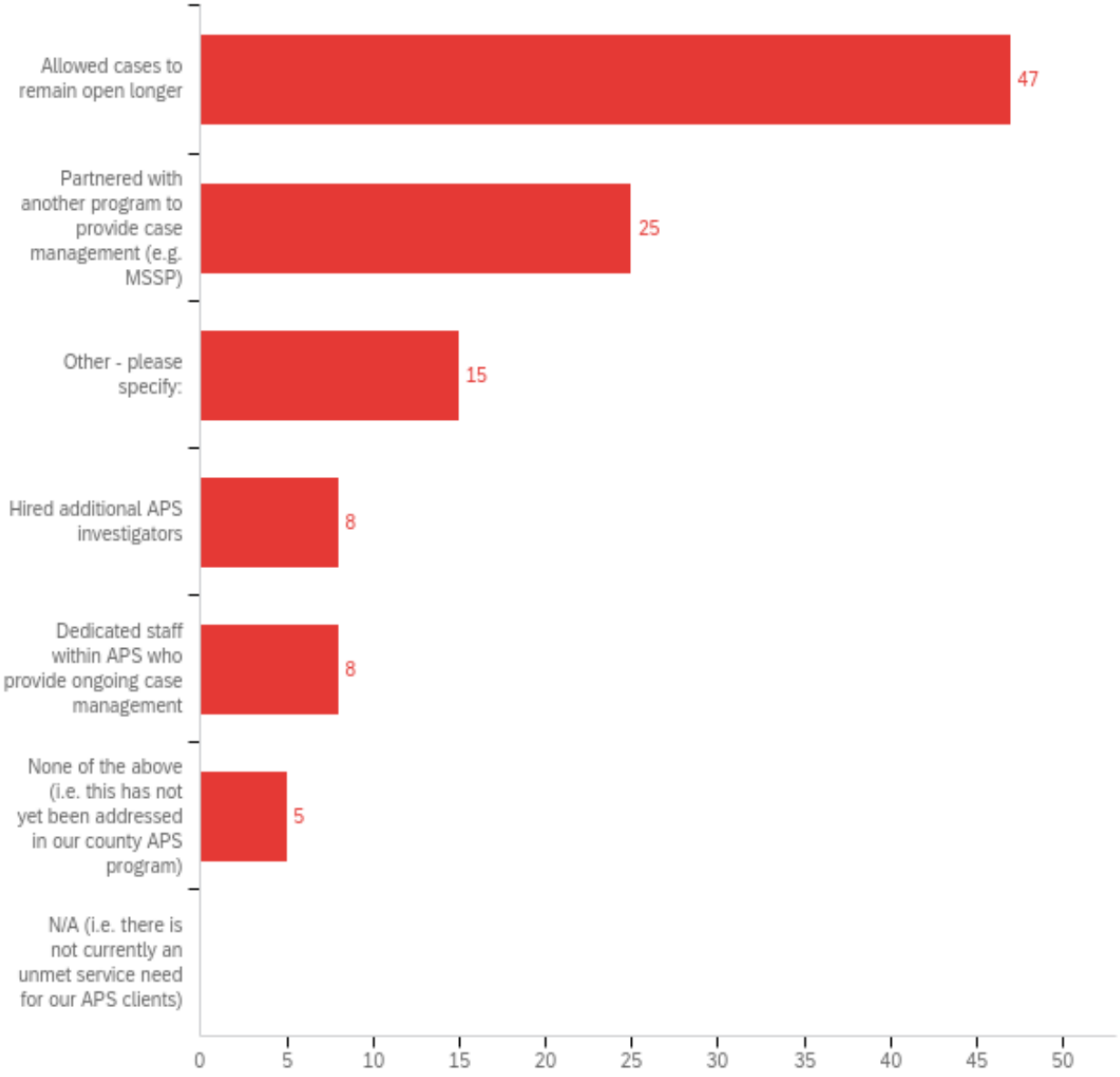
	Percentage of Counties	*Number of Counties*
Housing (resources, interventions to maintain stability e.g. Home Safe)	86.8%	46
Unhoused/Homeless (services, shelters, housing, etc.)	83.0%	44
Transportation	64.2%	34
No/Low Cost Household/Chore (assistance with IADLs)	60.4%	32
Behavioral Health	58.5%	31
Financial (e.g., rep payee or bookkeeper/money manager)	58.5%	31
Private Pay Household/Chore (assistance with IADLs)	47.2%	25
Legal (including wills/trusts/estate planning)	39.6%	21
Social (e.g., friendly visitor, congregate site, etc.)	37.7%	20
Home Care (assistance with ADLs)	35.8%	19
Medical	22.6%	12
Other - please specify: *(see below)*	20.8%	11
Meals/Nutrition (e.g., MOWs, congregate site, etc.)	17.0%	9
Religious/Spiritual	1.9%	1
N/A	0.0%	0

Other - please specify: (n=11)

- Rural county, hence transportation for more rural areas; housing and related issues probably greatest challenge; additional legal services are also needed (we have Senior Legal but need additional funding/staffing)
- We also need shelter services that address the needs of older or dependent adults with partners, with pets and or with physical disabilities.
- ADA housing. Physicians making house calls for home bound clients.
- Restitution
- Medication management services and services for our TBI clients.
- 1) Services for clients that do not qualify for Medi-Cal and/or who do qualify but the share of cost is too high. 2) Services for cognitively impaired who don't meet regional center criteria (TBI: or undiagnosed ID w/no records prior to 18
- Home Care for those who do not qualify for IHSS or cannot afford a Medi-Cal SOC for IHSS. Unable to pay for care with a lower income but an income too high to be eligible for Medi-Cal

- Neurologists that accept Medi-Cal and that understand Dementia. We don't have any Public Health Services in our county for our clients.
- Increase need for assisted living waivers, services for dementia/cognitively impaired clients and their family or support system
- Placement options for clients who need a higher level of care
- We DO NOT have Meals on Wheels program due to the rural location. The temperature of the food cannot stay within regulations due to the distance that the drivers have to go to deliver meals to the homes.

Q5. How has your county's APS program worked to address the service need(s) identified above? (select all that apply) (n=53)



	Percentage of Counties	*Number of Counties*
Allowed cases to remain open longer	88.7%	47
Partnered with another program to provide case management (e.g. MSSP)	47.2%	25
Other - please specify: (see below)	28.3%	15
Hired additional APS investigators	15.1%	8
Dedicated staff within APS who provide ongoing case management	15.1%	8
None of the above (i.e. this has not yet been addressed in our county APS program)	9.4%	5
N/A (i.e. there is not currently an unmet service need for our APS clients)	0.0%	0

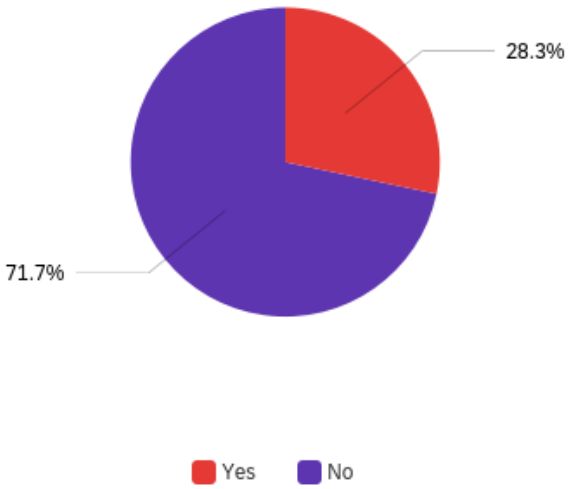
Other - please specify: (n=15)

- Working on the homeless shelter needs.
- We continually advocate for additional staffing resources, however unsuccessful to date. Approach for such a small program is more of "whatever it takes" to try to address the needs of clients/families.
- A few cases remain open longer, though not long enough.
- We are referring cases to the AAA when applicable however, this does not address the bigger picture of care centered services and services for dependent adults. We have partnered in the past however we are trying to identify funding for integrated care services for APS clients not case management. In a large county it would be an issue for workers to keep cases open for a year or two and continuing to get more and more cases daily. The bigger issue is client-centered services that is the integrated care service that an APS client should receive which is not case management.
- Our county does what we can with the resources we have been our county is limited.
- We plan to dedicate staff to provide ongoing case management
- Funding (e.g., Home Safe)
- Collaborate with the DA through Financial abuse specialist team (FAST) Home Safe pilot
- 1) Home Safe grant money used to contract with SV Independent Living Center 2) Interagency agreement with county behavioral health for a BHD clinician to be co-located with APS and is available to go out on visits, assess and provide brief treatment and/or connect with resources or BHD for APS clients
- 1) Monthly and if needed case specific MDT to work with partner agencies in community to address service needs.

2) Working on collaborations with Social Security to improve Rep Payee services and Behavioral Health-mobile crisis for outreach and education about service needs and services available

- We have limited resources available
- Through ACL grant and our Elder Abuse Forensic Center, we now have limited case management through 5/2020
- Obtained Home Safe Grant
- Referral to Rep Payee and/or conservatorship services for those who consent or meet criteria
- Cases with Home Safe are kept open longer and case managed by the same SW. This is a burden on staff to investigate new referrals timely and hold open long-term cases. We have Home Safe but no dedicated staff to handle all the case management that goes along with the pilot program. We partner with IHSS as much as possible to provide in home care and case management by county social worker.

Q6. Has your county's APS program developed any type of ongoing case management services? (n=53)



County	Yes	No
Total	15	38

Q7. Please describe the ongoing case management service(s) your county's APS program developed and the need it fills. (n=15; includes only those counties that answered yes to Q6 above)

- ***County 1***: APS SW will provide case management service to clients if and when there is a need to help the client follow up with community providers.

- ***County 2:*** Quite often the initial APS referral is made but many other issues are uncovered. Quite helpful has been working with our partner agencies mainly hospitals and emergency services to meet and discuss clients with high needs. We then develop a safety plan to address these issues with client and have been quite successful doing this

- ***County 3***: In the past APS had an array of case management services. However, with cases increasing the need for more workers were the priority. However, we are in the process now of developing a client centered approach to provide APS clients an integrated care services program. We are trying to see the needs by doing surveys with staff on needs and then seeing the utilization of the linkages program that we have in the AAA (that is not a CDA program). We are in the process of developing this and identifying funding from cost saving initiatives that we have implemented so that the needs of APS clients are addressed. Our goal is to prepare and clear a statement of work and release a work order to determine who within our Aging Network can provide these services.

- ***County 4:*** Cases are assessed on an as needed basis. APS social workers continue to meet with and monitor clients for up to 90 days when there are no other available services to resolve their problem. Social workers will provide transportation, assist with submitting housing and benefit applications. Social workers will continue to seek resources and make appropriate referrals for service throughout the case plan period.

- ***County 5:*** We provide on-going case management for those cases that we cannot resolve all the protective issues within our 30-day guideline. Some cases remain open as the Service Plan requires linking cases with resources (i.e., Social Security rep payee program, housing, health and safety issues at the residence, medical, referral to PG/PC, etc.). We conduct home visits at least one time a month, phone calls weekly, and multiple interventions with these long-term on-going case management. Often these cases involve isolation, financial self-neglect, medical self-neglect. APS social workers fill the gap for advocacy to link with needed resources. APS attempts to complete a "warm hand off" to services as the client agrees to. We close a case as it is confirmed that the victim has been picked up by the resource and APS is no longer needed.

- ***County 6:*** With our case management coming to a close through our Elder Abuse Forensics Center, we have begun to bring ongoing case management in house. We also now have an MDT with Kaiser so Kaiser clients can get linked to case management

- ***County 7:*** We have a specialized Intensive Services Unit that manages cases that are pending conservatorship due to a referral to the Public Guardian. This specialized unit will provide ongoing support services needed until conservatorship has been established and/or the client is safe. This specialized unit also allows the general investigative social workers to concentrate on their remaining cases that can be resolved within a standard time frame. We also have two Crisis Response and

Intervention Services units. These specialized units investigate and provide case management services to homeless and unstably housed APS clients. They have a lower caseload than the investigative social workers to allow them to keep the cases open longer and increase the likelihood that stability/permanent supportive housing is established.

- ***County 8:*** Developed Alzheimer's Response Team that provides longer term case management in certain parts of the county to client's and family/involved persons struggling with dementia. Also, developed APS Continuing Services that provides extended APS case management services to those who meet certain criteria (including impairment in one or more ADLs, etc.) and have a need for extended services (criteria can be shared upon request). Until Dec 2019 there was a grant to provide extended case management to APS clients who had been abused by another. This wonderful grant and services have now ended.

- ***County 9:*** With "ongoing case management" as described in the email, we have developed longer-term case management services since mid-2017--first as a High Risk Self-Neglect and Eviction Prevention Unit, and then transformed the unit under the Home Safe pilot to provide longer-term case management in collaboration with a Community-Based Organization (IOA). In this model, we provide Intensive Case Management (ICM) that lasts an average of 4.5 months, and then the APS clients receive an additional term of ICM through IOA, that so far has been over 3months. In cases where we "patch" the cost of a Residential Care Facility for the Elderly, the case management from IOA is indefinite. Also, our Financial Abuse Virtual Unit provides longer-term case management, averaging 3-4 months per case. The unit worked about 50 cases in 2018 and over 100 in 2019. This is a hands-on collaboration with law enforcement and civil interventions.

- ***County 10:*** Our County can provide ongoing case management for up to 6 months on a case-by-case basis. We do sometimes extend beyond this as needed for the case. This meets the needs of some of our most critically vulnerable clients, however, we recognize some clients need ongoing case management and we are not able to fill this need. We recognize that clients repeat through the system who could otherwise be helped through more ongoing, intensive case management.

- ***County 11:*** MSSP, CCI, Linkages, are long-term case management programs. MSSP, CCI is for low-income clients with Medical.

- ***County 12:*** We have not necessarily developed a program with set guidelines and business processes, rather based on the need and/or lack of resources cases may remain open for ongoing CM.

- ***County 13:*** TLC (Transforming Lives with Care) is long-term care model that is client-centered, utilizes evidence-based practices, fosters client strengths and support systems, and promotes psycho-social, environmental and physical well-being. We hired two PHNs and one LCSW (mental health) with SPMP funding. They take referrals from IHSS and APS. They provide ongoing case management to our most vulnerable clients. They also consult on cases and support social workers as needed.

- ***County 14:*** We received the Home Safe grant which helps to keep clients housed.

- ***County 15:*** Our APS program is integrated in an Adult Services unit that also includes In-Home Supportive Services (IHSS) and Public Guardian/Conservator, which provide

ongoing supportive and case management services to those who qualify for Medi-Cal/IHSS and/or consent to Representative Payee (money management) services or meet conservatorship criteria.

Q8A. In your county's APS program, are ongoing case management services offered to select population(s) of APS clients? (n=15; includes only those counties that answered yes to Q6 above)

County	*Yes*	*No*
Total	12	3

Q8B. Please choose the population(s) of APS clients served. (select all that apply) (n=12; includes only those counties that answered yes to 8A above)

	Percentage of Counties	*Number of Counties*
Public Guardian referral	91.7%	11
Complex cases (e.g., medical, behavioral health and dementia issues)	75.0%	9
Self-neglect	50.0%	6
High vulnerability/high risk	50.0%	6
Behavioral Health	50.0%	6
Frequent consumers of APS services	41.7%	5
Dementia	41.7%	5
Financial abuse/exploitation	41.7%	5

	Percentage of Counties	*Number of Counties*
Homeless	41.7%	5
Other - please specify: (see below)	33.3%	4
Hoarding	25.0%	3
Intellectual and developmental disabilities (IDD)	25.0%	3
Medically fragile	25.0%	3
Victims of crime	16.7%	2

Other - please specify: (n=4)

- ***County 1:*** The majority of CM provided is to clients who have no support network.
- ***County 2***: Complex IHSS/APS cases
- ***County 3:*** Reach out for criteria for the extended APS case management
- ***County 4:*** TBI clients; Difficult cases awaiting placement.

Q9. How are these ongoing case management services being funded? (select all that apply) (n=13; includes only those counties that answered yes to Q6 above)

	Percentage of Counties	*Number of Counties*
County Realignment Funds	69.2%	9
County-specific General Funds	38.5%	5
State General Fund	15.4%	2

Other - please specify: (see below)	15.4%	2
Behavioral Health Funding (e.g. Mental Health Services Act (MHSA)	7.7%	1
Older Americans Act (OAA)	0.0%	0
Victims of Crime Act (VOCA)	0.0%	0
Medicaid	0.0%	0
Social Services Block Grant (SSBG) - Regional Centers	0.0%	0

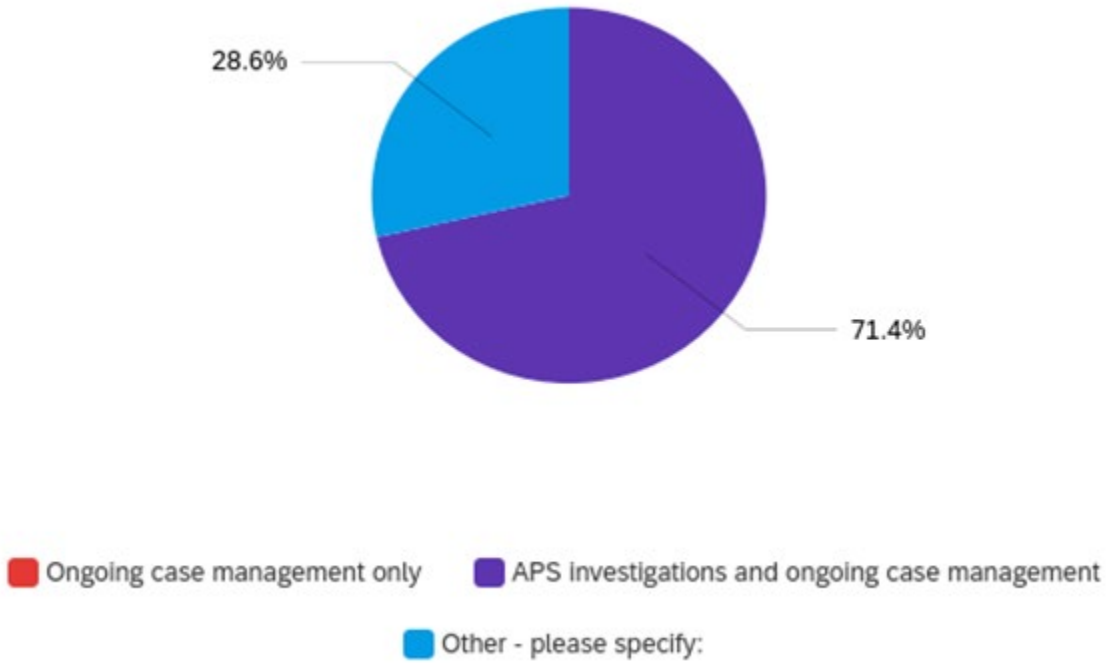
Other - please specify: (n=2)

- ***County 1*** Home Safe
- ***County 2***: We do not have a specific funding or budget, this has become part of our services based on need.

Q10A. Do you have dedicated staff within your APS program who provide ongoing case management services? (n=14; includes only those counties that answered yes to Q6 above)

County	*Yes*	*No*
Total	7	7

Q10B. What is the primary role of your dedicated staff? (please select one) (n=7; includes only those counties that answered yes to Q10A above)



Other - please specify: (n=2; 28.6%)

- ***County 1:*** Ongoing case management for APS or IHSS clients as well as consultations and other support to social workers.
- ***County 2:*** Soon to be case management and case assignment

Q11. What is your current Fiscal Year (FY 19-20) budget for ongoing case management services? (n=10; includes only those counties that answered yes to Q6 above)

- ***County 1:*** 00.00
- ***County 2:*** Not dedicated funding
- ***County 3:*** Just beginning, so 2.0 FTE lower classification APS Social workers
- ***County 4:*** We have dedicated 10 social workers and 3 supervisors from our traditional APS budgeted FTEs - in addition we've allocated approximately $40,000 in contracts
- ***County 5***: There is no separate budget for our continuing services model, for ART the approximate budget is 1,205,000
- ***County 6***: $1.5 million (Home safe, Heavy Cleanups, Emergency Placement, and RCFE Patches)
- ***County 7***: $150,000

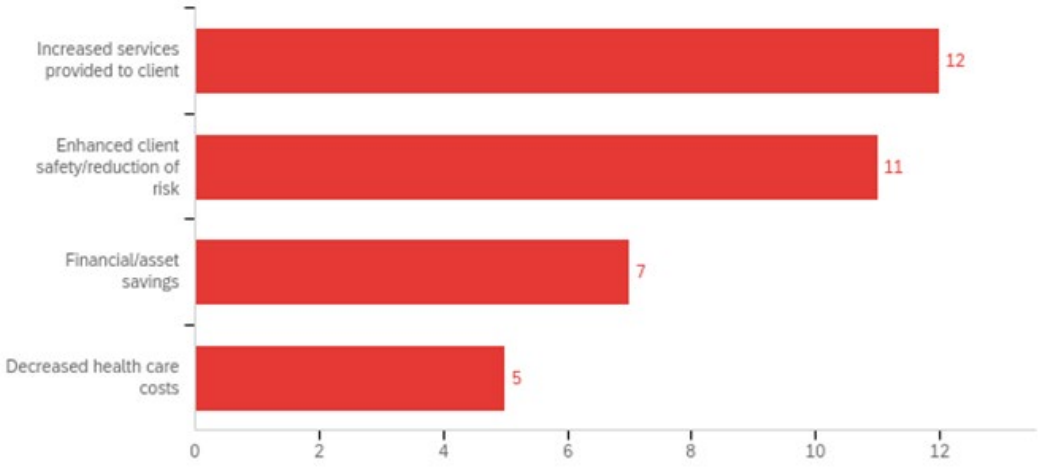
- ***County 8***: No budget is set aside specifically for Case Management.
- ***County 9***: $333,000 (staffing only)
- ***County 10***: $138,251

Q12. Last Fiscal Year (FY 18-19), approximately how many clients were provided with ongoing case management services? (n=11; includes only those counties that answered yes to Q6 above)

- ***County 1***: varies
- ***County 2***: 300
- ***County 3***: 100
- ***County 4***: only have stats from our EAFC case management and for 2019 it was 45 clients
- ***County 5:*** 320
- ***County 6***: 200 (70 of these for ART)
- ***County 7***: 150
- ***County 8***: Not sure
- ***County 9***: Approximately 630
- ***County 10***: N/A The program started in the current FY 19-20
- ***County 11***: 40

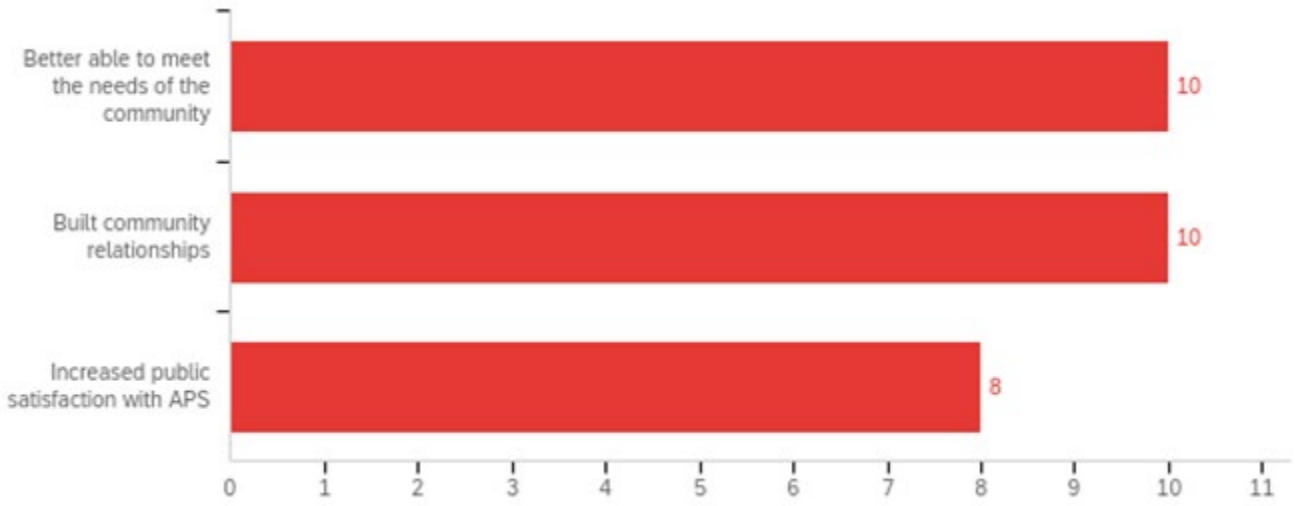
13. What have been the benefits of your APS program providing ongoing case management services? This is a multi-part question (select all that apply - individual selections can be made under each benefit header) (n=13; includes only those counties that answered yes to Q6 above)

13A. Client Benefits (n=13)



	Percentage of Counties	*Number of Counties*
Increased services provided to client	92.3%	12
Financial/asset savings	53.8%	7
Enhanced client safety/reduction of risk	84.6%	11
Decreased health care costs	38.5%	5
Total	100%	13

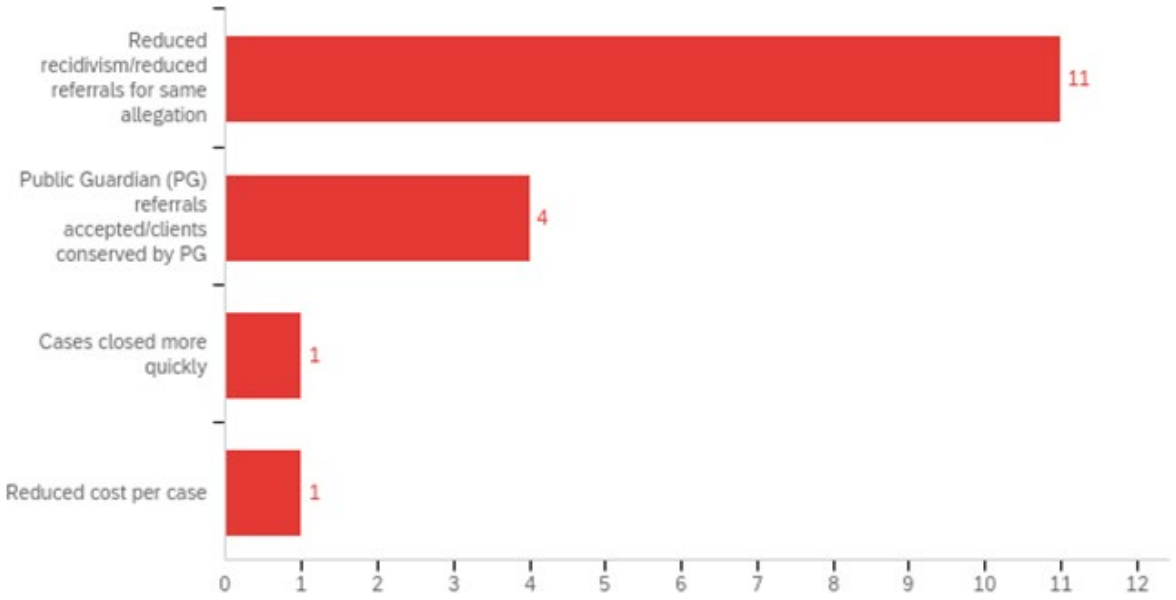
Q13B. Community Benefits (n=12)



	Percentage of Counties	*Number of Counties*
Better able to meet the needs of the community	83.3%	10
Built community relationships	83.3%	10

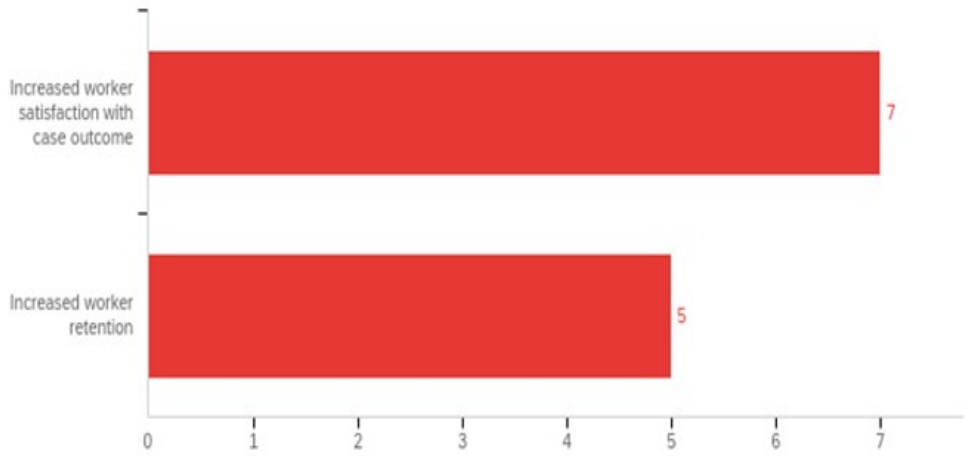
Increased public satisfaction with APS	66.7%	8
Total	100%	12

Q13C. Program Benefits (n=11)



	Percentage of Counties	*Number of Counties*
Reduced recidivism/reduced referrals for same allegation	100.0%	11
Reduced cost per case	9.1%	1
Public Guardian (PG) referrals accepted/clients conserved by PG	36.4%	4
Cases closed more quickly	9.1%	1
Total	100%	11

Q13D. Worker Benefits (n=7)



	Percentage of Counties	*Number of Counties*
Increased worker satisfaction with case outcome	100.0%	7
Increased worker retention	71.4%	5
Total	100%	7

Q13E. Other Benefits (please specify other benefits, if applicable) (n=3)

- ***County 1:*** Without assistance for dedicated SW for case management, this backlog creates burnout for social workers, high caseloads, and infrequent turn over. Frequently the referrals to the PG office are denied, this causes APS social workers to work the case longer and harder to attempt to stabilize the victim. This causes more stress and case management for the APS social worker. Benefits for CM are deduction in risk factors, reduced recidivism, development of relationship with government staff, less isolation, more services are connected with victims, and victims often become more resourceful themselves.

- ***County 2:*** The primary benefit is the increased client safety and linkages to longer term support by being able to stay involved longer for clients who do not or did not fit any other model of services because of complex needs or no services (especially for

those with dementia)

- ***County 3:*** Keeping client's housed, and homelessness prevention.

Q14. What have been the challenges of your APS program providing ongoing case management services (i.e. areas for improvement)? (n=12; includes only those counties that answered yes to Q6 above)

- ***County 1:*** The number of Social Workers we have dedicated to just APS referrals in our County are two. The challenge is as the population ages we are receiving more referrals.

- ***County 2:*** There needs to be a comprehensive program that addresses the needs of APS clients. APS clients have a multitude of needs and case management services should not be offered by APS workers. For counties that are large counties this concept does not work as they are almost seen as case carrying workers like an eligibility worker who carries cases and does renewals yearly. In order to address the issue of need, integrated care services need to be provided. If we are able to release a SOW and have bids come in from subject matter experts within the Aging Network in X county services could be provided to this population without referring to AAA and have the issue of capacity. Also under the WIC referring case management services out is a violation of the APS program. Therefore, we are planning to develop a client-centered approach of services that are care services instead of case management. The APS client would still handle all the APS requirements however, the care services piece that enables the client to remain stable and not return to APS is the ultimate goal. The challenge is having the resources in order to provide the services that are needed.

- ***County 3:*** Not enough staff. Limited funding and limited resources.

- ***County 4:*** Having the time for longer term CM, working OT, APS trainings needed for dealing with resistant/difficult victims, organizing and running MDTs, limited resources in our rural locations, limited transportation, small budgets for expenses, high stress to social workers, and burn out.

- ***County 5:*** Through our EAFC case management, we saw a slow start to APS referring clients and the case manager understanding OC resources. Not sure of challenges yet for our in-house case management as it has not started yet.

- ***County 6:*** One of the challenges has been not being able to serve all the unstably housed or homeless clients within the specialized units. The clients have such complex needs and high vulnerability that there is a need to keep the case open for up to 12 months in order to stabilize the client. This has limited the number of cases the specialized units can take and has resulted in some of these cases having to be

absorbed by the regular APS units where there is less expertise. Another challenge is the specialized case management caseload takes APS social workers off of the regular investigative caseload, increasing the burden on the standard APS staff. Additionally, the lack of resources countywide (e.g. affordable housing) impacts our ability to successfully transition a client to permanent housing.

- ***County 7:*** Determining ideal caseload numbers, Purchase of services needs for those requiring longer term support, hiring staff who can manage investigations and case management responsibility, identifying the appropriate referrals and support to assist client, hiring support staff, making extended case management a priority even when traditional caseloads continued to rise (knowing it is needed but not yet having the foundation to provide a different model of APS services and support).

- ***County 8:*** To get more medical and mental health outreach to our victims of self-neglect, and to establish an improved immediate intervention collaboration with our Public Guardian's Office.

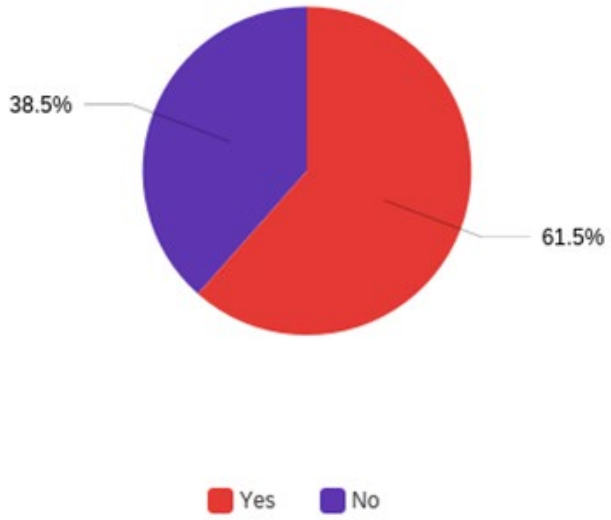
- ***County 9:*** The complexity of APS cases, lack of resources for homeless elderly population, few resources for elders, who need repairs done on their home. The lack of support for APS workers, who deal with the challenges of complex APS cases. Budget cuts to the county.

- ***County 10:*** Providing ongoing CM services has increased workers caseloads, at times to unmanageable levels. Other challenges include staffing levels, lack of resources and client resistance.

- ***County 11:*** SPMP funding limits our work to clients who are MediCal eligible. We are still in the development stage, so defining the work of the team and managing caseloads are a challenge.

- ***County 12:*** Funding not sufficient to meet increased need Placement options are limited for those clients who need out-of-home care

Q15A. Do you have data/documentation to support the benefit/impact of your APS program providing ongoing case management services?
(n=13; includes only those counties that answered yes to Q6 above)

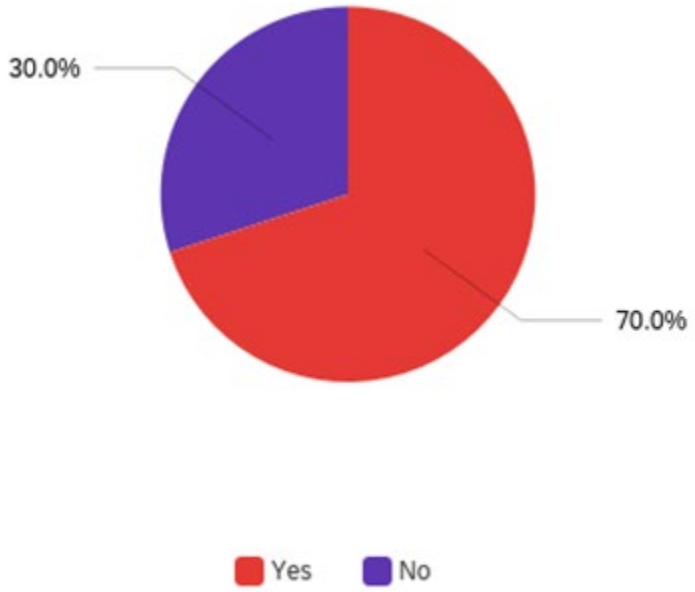


County	*Yes*	*No*
Total	8	5

Q15B. Would you be willing to provide/be interviewed for this project?
(n=8; includes only those counties that answered yes to Q6 above)

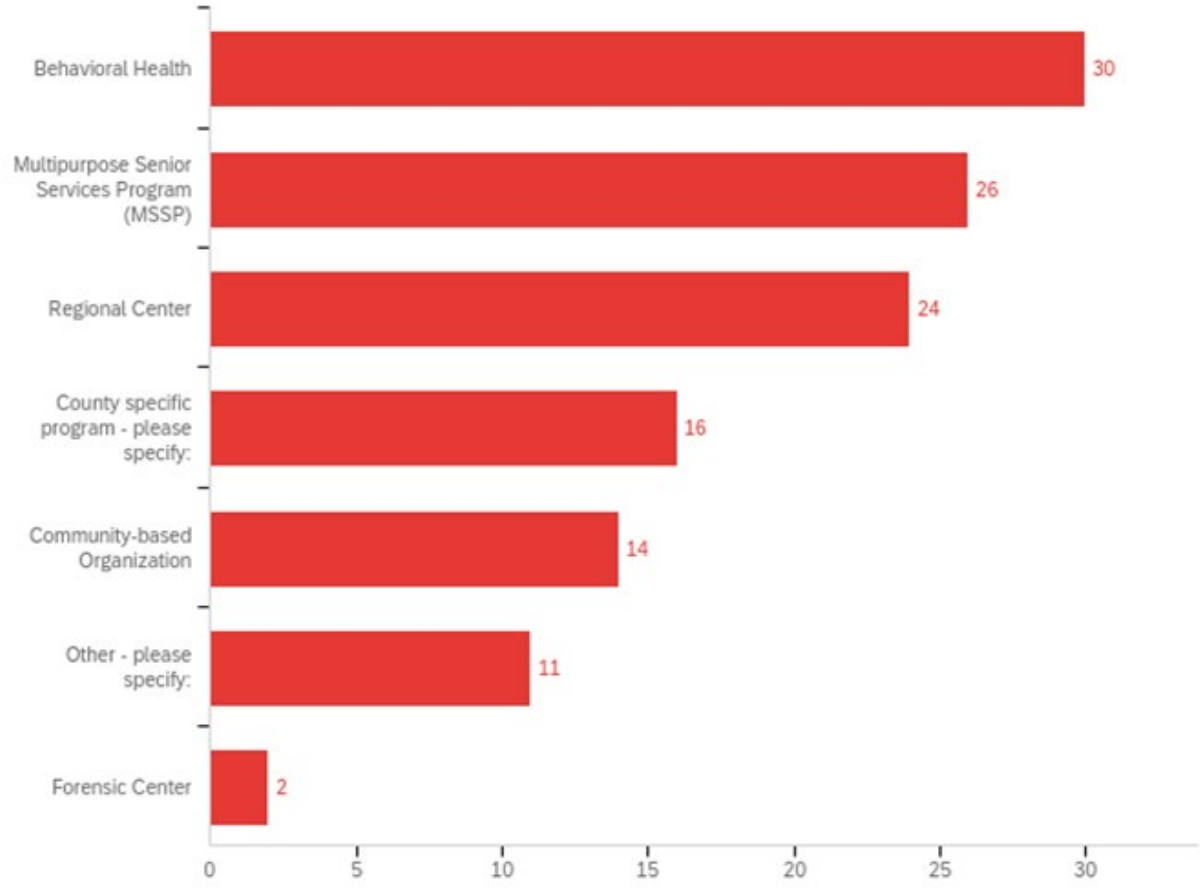
County	*Yes*	*No*
Total	8	0

Q16A. In your county's APS program, are external ongoing case management services (outside APS) offered to APS clients? (n=50)



	Percentage of Counties	*Number of Counties*
Yes	70.0%	35
No	30.0%	15
Total	100%	50

Q16B. To what agency/agencies do you refer APS clients for external ongoing case management services (outside of APS)? (select all that apply) (n=35)



	Percentage of Counties	Number of Counties
Behavioral Health	85.7%	30
Multipurpose Senior Services Program (MSSP)	74.3%	26
Regional Center	68.6%	24

County specific program - please specify: (see below)	45.7%	16
Community-based Organization	40.0%	14
Other - please specify: (see below)	31.4%	11
Forensic Center	5.7%	2
Total	100%	35

County specific program - please specify: (n=16)

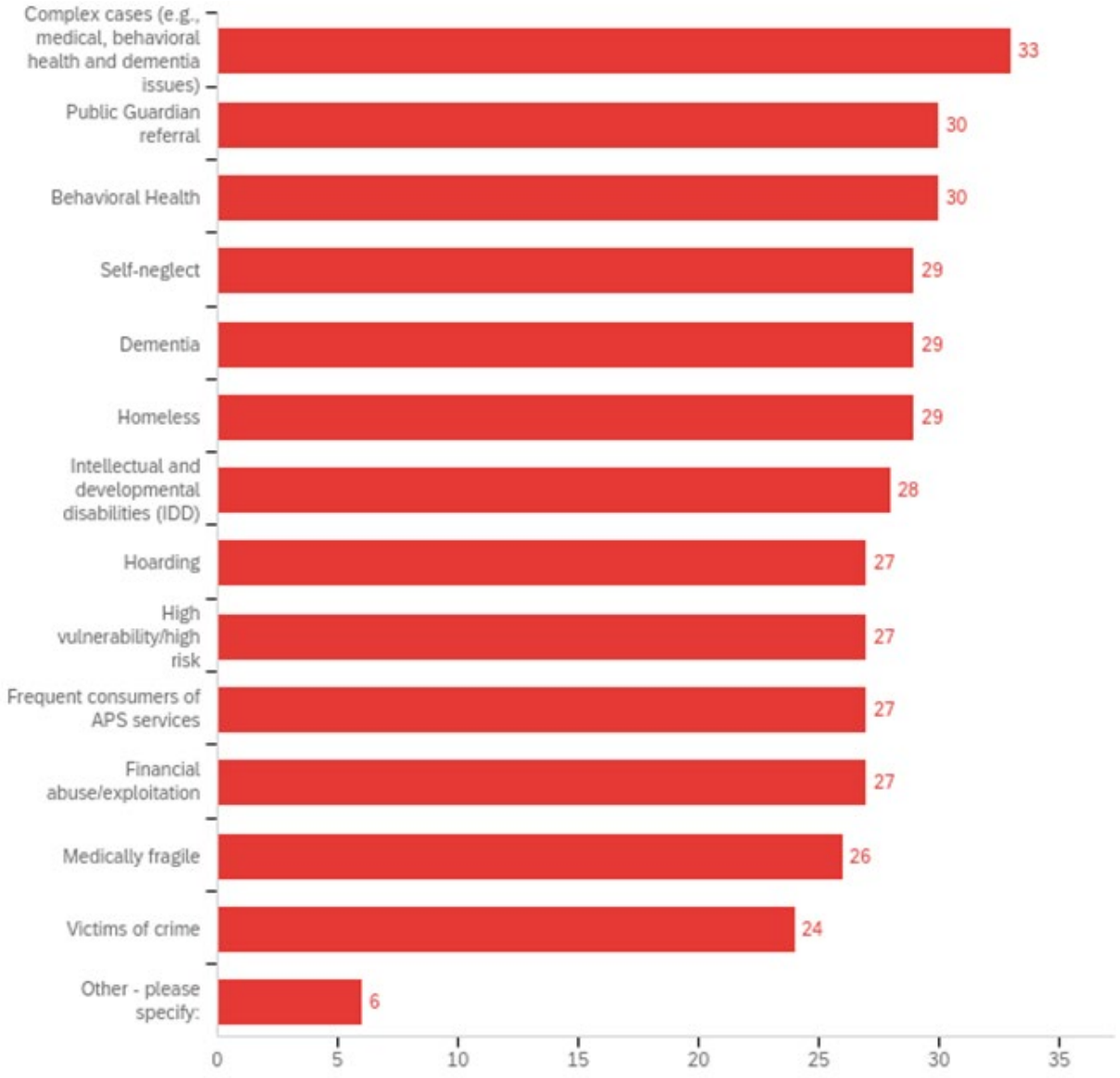
- Community Living Fund services administered by IOA, the Home Safe side of ICM provided by IOA.
- AAA case management, however they have a wait list.
- APS and AAA are together in Los Angeles. Therefore there are referrals made all the time to AAA contractors and AAA contractors refer to APS as well.
- Adult Day Out Centers
- Senior Nutrition
- Housing Disability Advocacy Program (HDAP)
- Mental Health: Older Adult MH, IHSS Winter Shelter
- ACL grant to provide dementia case management in some areas
- Public Health Nursing staff and County Veterans Services
- Family Services Agency - Senior CM services for victims of crime (VOCA grant)
- 1) Home Safe contracted agency (SVILC) 2) Institute on Aging- (community Living fund contracted agency)
- Victim Witness; Public Health; IHSS; Public Guardian. Home Safe Case Management- contracted through community based shelter for ongoing case management services of homeless APS clients
- Linkages
- Whole Person Care

- Lifemoves homeless outreach team
- Senior Center, Meals on Wheels, Victim Witness, Shelter, IHSS, Private Duty In Home Care, Scope (Sheriff monthly home visits), AAA, Public Assistance eligibility workers, DA, and the VA

Other - please specify: (n=11)

- Private case managers/fiduciaries
- Information and Assistance
- Transportation services thru our new freedom transportation grant for free transportation services. APS Home Safe Homeless Initiative D5 program for homeless and at risk of homelessness Department of Business and Consumer Affairs' Department of Mental Health District Attorney's Office Department of Health Services X City FOUND Dispute resolution program Human Relations -hate crime section
- Veteran's Services
- Central California Alliance for Health (CCAH) medical case management
- CenCal CM services (Medi-Cal recipients)
- Comment: MSSP however, only Medi-cal eligible clients qualify and they often have a waitlist therefore all CL are not provided this service.
- Other/Community-based would include Area Agency on Aging-Passages (includes MSSP, Connections, HIICAP, meals on wheels and nutrition); Adult Day Health Care; Legal Services; Social Security; Disability Action Center
- Kaiser
- Area Agency on Aging
- Medical case management from Kaiser or Sutter Health or UC Davis if applicable

16C. Please choose the population(s) of APS clients served. (select all that apply) (n=35)



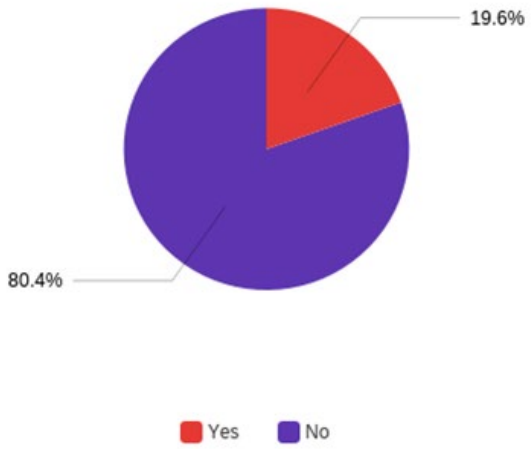
	Percentage of Counties	Number of Counties
Complex cases (e.g., medical, behavioral health and dementia issues)	94.3%	33
Public Guardian referral	85.7%	30

	Percentage of Counties	Number of Counties
Behavioral Health	85.7%	30
Self-neglect	82.9%	29
Dementia	82.9%	29
Homeless	82.9%	29
Intellectual and developmental disabilities (IDD)	80.0%	28
Hoarding	77.1%	27
High vulnerability/high risk	77.1%	27
Frequent consumers of APS services	77.1%	27
Financial abuse/exploitation	77.1%	27
Medically fragile	74.3%	26
Victims of crime	68.6%	24
Other - please specify: (see below)	17.1%	6
Total	100%	35

Other - please specify: (n=6)

- Neglect and/or abuse by others.
- Domestic violence within LGBT partners
- Those with no adequate support systems, living or appropriate relatives.
- Not sure I understand the question APS services all these clients
- High use EMS
- Civil matters with SO response and referrals to legal matters. APS deals with all the above and must wear a lot of hats.

Q17A. Do you have cases where ongoing case management services are managed jointly by your county's APS program and another entity such as a Financial Abuse Specialist Team (FAST) or Forensic Center? (n=51)



	Percentage of Counties	Number of Counties
Yes*	19.6%	10
No	80.4%	41
Total	100%	51

Q17B. Does the APS worker keep the case open? (n=10)

	Percentage of Counties	Number of Counties
Yes*	80.0%	8
No+	20.0%	2
Total	100%	10

Q17C. If your county does not have a FAST or Forensic Center, please describe any other agency/agencies your county's APS program partners with to provide ongoing case management services. (n=4)

- We do have a Forensic Center, but not for ongoing case management. For our Home Safe pilot, we partner with CBO IOA for Intensive Case Management, once the protective issues have been investigated.

- We have FAST team

- Multi-Disciplinary Team

- IHSS, Sheriff's Office, AAA, Shelter, DA

Q18A. In your experience, which ongoing case management service(s) are still needed for your APS clients? (select all that apply) (n=51)

	Percentage of Counties	*Number of Counties*
Housing (resources, interventions to maintain stability e.g. Home Safe)	88.2%	45
Unhoused/Homeless (services, shelters, housing, etc.)	88.2%	45
No/Low Cost Household/Chore (assistance with IADLs)	70.6%	36
Financial (e.g., rep payee or bookkeeper/money manager)	68.6%	35
Behavioral Health	64.7%	33
Transportation	58.8%	30
Home Care (assistance with ADLs)	49.0%	25
Legal (including wills/trusts/estate planning)	49.0%	25
Social (e.g., friendly visitor, congregate site, etc.)	47.1%	24
Private Pay Household/Chore (assistance with IADLs)	45.1%	23
Medical	35.3%	18
Meals/Nutrition (e.g., Meals on Wheels, congregate site, etc.)	25.5%	13
Other - please specify: (see below)	13.7%	7
Religious/Spiritual	7.8%	4
N/A	0.0%	0
Total	100%	51

Q18B. In your experience, which population(s) of APS clients are still not being served? (select all that apply) (n=48)

	Percentage of Counties	*Number of Counties*
Dementia	58.3%	28
Complex cases (e.g. medical, behavioral health and dementia issues)	56.3%	27
Behavioral Health	43.8%	21
Homeless	43.8%	21
High vulnerability/high risk	41.7%	20
Hoarding	37.5%	18
Financial abuse/exploitation	37.5%	18
Frequent consumers of APS services	35.4%	17
Medically fragile	27.1%	13
Self-neglect	25.0%	12
Intellectual and developmental disabilities (IDD)	20.8%	10
Public Guardian referral	18.8%	9
Victims of crime	16.7%	8

	Percentage of Counties	*Number of Counties*
Other - please specify: (see below)	14.6%	7
N/A	8.3%	4
Total	100%	48

Other - please specify: (n=7)

- We serve all populations to a certain extent but due to the limitations on resources and staff the amount of services is limited.
- Low/moderate income
- Substance abuse
- Client's with co-occurring disorders and TBI's
- Adults with brain injuries. Under 65 with early onset dementia. More services needed for these groups.
- Forensic conservatorships (Incompetent to Stand Trial (IST) with serious/violent felony charges
- Veterans: homeless veteran DA Prosecution for financial abuse

Q18C. Please feel free to share additional information or comments on unmet needs/service gaps for your APS clients. (n=26)

- ***County 1:*** Service gap in re: to dual diagnosis of mental health and dementia. Need for more placement options for individuals with complex care needs.

- ***County 2:*** Home Safe required counties to match dollars, which our county did not have. When seniors who present as a harm to self or others are taken by LE to our emergency room where they are assessed for a 51/50 hold they are released by behavioral health when they are found to have a diagnosis of dementia even though they may have a co-occurring mental health crisis or condition. They do not receive ongoing behavioral health for the same reason. We have a lack of clinicians that accept Medicare. We may have one.

- ***County 3:***
    - 1) We have a number of Housing Resources/interventions such as Home Safe but a lack of affordable housing is keeping individuals from being able to utilize these programs to the full extent.
    - 2) A lack of reliable Representative Payees has led to financial abuse/exploitation. Our county is attempting to work with Social Security on improving the Rep Payee pool but we have found it difficult to gain momentum in this area
    - 3) Clients with cognitive impairments who are not at the point where they would be conserved are challenging, especially when they might not be willing to participate in services available in the community. Ongoing extended case management (through APS) could be beneficial in some of these cases.
    - 4) The wildfire has created a greater need for resources in the community and strained the local system. This is especially true for medical personnel and services with service providers closing and staff moving away as a result of the fire.

- ***County 4:*** The populations are being served to the extent possible, however the resources are limited/non-existent in some of the areas indicated; particularly regarding housing/homelessness in the County. The County is working on these issues, however development takes time. Also needed are geriatricians/psychiatrists/neurologists in the County for evaluations, very limited resources in this area. Also, hoping to develop a FAST team in the future given the rate of financial abuse we see, but this is dependent on staffing resources.

- ***County 5:*** Lack of coordination or collaboration with behavioral and mental health services with cognitively impaired adults and IDD, regional center that is passive in provision of services, AAA services that are very minimal and/or underdeveloped.

- ***County 6:*** We have a limited amount of overtaxed services to refer clients to. We struggle with getting self- neglect cases to accept services with so many hurdles for them to jump even with a Social Worker assisting them. Same with Financial Abuse, once the money is gone we have very little resources that people will accept to help them cope with the loss, acceptance, and embarrassment of the crime.

- ***County 7:*** Current challenges are high referral rates and low staffing compared to need. We are obtaining additional temporary staff to assist with demand but this creates a high turnover.

- ***County 8:*** We are a small county and there are not many services available in our county to even offer our clients. We do not have payee services in our county for those that need it.

- ***County 9:*** As the mentally ill population ages they are deemed to have dementia as the main issue and no longer mental health is their primary. It's causing a problem

in attempting to locate housing and/or services for this population. In addition, our area has been hit very hard with fires since the 2015 wildfire and continuing throughout 2019. This leaves what little housing there is unaffordable to most of our clients

- ***County 10:*** There are no shelter services and or homeless shelters for older adults and dependent adults with cognitive impairments. There is a need for dementia waiver facilities and shelters that address the needs of older adults so that if there is a transition to conservatorship with no interruption of service and they fall into the cycle of homelessness.

- ***County 11:*** All clients are seen and assessed by APS when a referral is received but due to lack of funding for staff and resources, many are assisted with immediate crisis but not open to case management, in turn resulting in future abuse or neglect issues.

- ***County 12:*** There is a lack of funding and resources for APS clients who do not qualify for Medi-Cal and lack sufficient financial resources to pay for therapy and other support services.

- ***County 13:*** The ability to pay for caregiving and transportation when clients do not qualify for Medi-Cal, Internet services in our county are patchy at best. Resource placement during immediate response, respite for caregivers, Logistic Transportation thru Medi-Cal is super unreliable and frequently cancels leaving a client without medical transportation to their appointments, meals on wheels to the North County area, few Registry providers in IHSS, no mobile behavioral health on going treatment services in the home.

- ***County 14:***
    - 1. Lack of availability of beds in skilled nursing facilities.
    - 2. Lack of resources for people with dementia to get services needed in a home setting.
    - 3. Inability for clients with behavioral health issues to adhere to program guidelines.
    - 4. Lack of housing or placement options for 290 registrants.

- ***County 15:*** One service gap is lack of services for clients who have significant dementia/TBI/cognitive impairment and need ongoing support and care but do not have a good support network. They are gravely disabled and unable to care for themselves, but they do not meet criteria for 51/50 or Behavioral Health services because they do not have a psychiatric diagnosis. We also lack affordable and appropriate assisted living facilities for this population, and they often do not qualify for SNF placement unless they have additional medical conditions that require nursing care. These clients may also have additional complicating issues, such as hoarding, homelessness or high risk of homelessness, and/or financial exploitation.

- ***County 16:*** In our APS Program we take all referrals from above, we have no Public Guardian Division so APS takes this on which I feel is not fair and needs to be addressed.

- ***County 17:*** One area of unmet need is when the family system needs case management, not just one party. For example, a couple who both have needs but would be better served by a unified case management or a mother who has case management needs based on her age and health but who also has an intellectually disabled adult son. Trying to keep these family units housed together with support needed is a challenge.

- ***County 18:*** Mental health treatment for older adults is scant, and we need medical and mental health services that come to the place of residence of the elder, for initial intake and trust building.

- ***County 19:***
    - 1. Quick accessibility to affordable housing, in private settings and in residential care facilities.
    - 2. Accessibility to Psychiatrist and/or other professionals who conduct cognitive assessments in the client's home (we have some clients who do not have an MD and getting them/convincing them to go to a medical doctor's office is very difficult)
    - 3. Getting appropriate services to clients who have dual diagnoses (Dementia and DSM diagnoses such as schizophrenia).

- ***County 20:*** Affordable housing is an increasing need because we see more and more displaced seniors. Additionally, services for elders who have dementia who previously were diagnosed with a mental health condition are difficult to manage. Dual diagnosis of dementia and mental health can result in it being difficult to determine which agency will or should serve the client.

- ***County 21:*** Due to the nature of the role of APS certain circumstances require ongoing CM despite the program's budget and staffing levels. The lack of resources in the community makes it extremely challenging to appropriately address the needs of the clients to minimize or remediate risk factors.

- ***County 22:*** Despite the increases in the aging and disabled population currently and in the coming years, and increasing need for services, the aging and disabled adult populations are not a prioritized population for federal, state and county funding. APS programs have become the default agency to manage all aging and disabled adult population needs with no additional funding or support from the state. This is in stark contrast to other social services programs. This results in not enough APS workers to meet the state regulations and provide these much-needed services. In addition, it is extremely difficult to justify to county leadership the need for funding to add new positions and services because the state only minimally supports APS with data, but does not provide any analysis of population trends, diversity,

and service outcomes. APS client populations are typically an afterthought when legislation is passed to address social needs, for example, the state passes budget legislation for Homelessness, but the priority is serving families with children, and/or working age adults. No specific funds are designated for aging and disabled adults, to provide support service funding for them to stay in their own homes, which is a key factor in preventing homelessness. In fact, there is often public discussion about finding ways to get seniors out of their single-family homes so that families can move in. Or at the least, finding ways to get seniors to open their own homes to families, children and adults to solve the housing crisis.

- ***County 23:*** There needs to be a system of care for older adults with cognitive impairment (i.e. dementias, TBI, etc.)

- ***County 24:*** The number of APS cases reported in our County is increasing. We have noted a 33% increase in reported cases over the last 2 calendar years. There are repeat APS victims who need ongoing case management services as well as resources that are not easily obtained including housing, complex care clients, people with traumatic brain injuries and dementia for which there are limited services. Victims or financial abuse/exploitation are growing. We need purposeful prevention and education in our County to mitigate the risk of this type of abuse. Our Social Worker team does not have current capacity to long-term case management although we believe this would help keep our clients healthier and lead safer more stable lives.

- ***County 25*:** In addition to lack of services for the group I mentioned above, more resources are needed for Medi-Cal waiver board and care homes. Also, we need more IHSS providers.

- ***County 26:*** APS working hand in hand closely with law enforcement and district attorney office on criminal cases.

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