Vulnerable Adult Pilot Project: Program Evaluation

Prepared for Emergency Medical Services Division Public Health- Seattle & King County

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Table of Contents

EXECUTIVE SUMMARY

The EMS Vulnerable Adult Pilot Project was implemented on September 12, 2014 and has run for nine months. The project is a coordinated effort between the Seattle Fire Department (SFD), Aging and Disability Services (ADS), Adult Protective Services (APS), Seattle Police Department (SPD), the Emergency Medical Services (EMS) Division, Seattle area hospitals, and the University of Washington (UW) to improve the identification and reporting of vulnerable adult abuse and neglect, to increase care coordination and communication among involved agencies, and to improve health outcomes of vulnerable adults in Seattle, King County.

Nine months of data was collected via a SharePoint Vulnerable Adult Reporting Form and analyzed for this evaluation. SFD reported 212 cases of vulnerable adult abuse/neglect in this time period, with 37 duplicated patients. This is an increase of approximately five reports per month compared with the nine months previous to the pilot. The most common impression for filling out the reporting form by SFD was neglect/self-neglect (77.4% of cases). ***Of the 171 unduplicated reports to APS, 107 (62.6%) had no social services in place at the time of reporting, demonstrating that SFD is uniquely identifying patients not already linked in with state social services***. Out of the 171 unduplicated reports, 137 (80.1%) patients enrolled in some type of services through ADS. Of those 137 patients who were enrolled, 92 (67.2%) did not have social services in place at initial reporting while 45 (32.8%) received expanded services. Of the 212 reports, ***ADS was able to close 63 (29.7%) of the cases by the end of the nine month pilot project***. Of those 63 cases, 41 (65.1%) were closed due to residential placement of the patient. Of the 161 patients initially reported by SFD as neglect/self-neglect patients, 106 (65.8%) were found by APS to have an outcome of neglect or self-neglect, validating the SFD reports of neglect/self-neglect. Of these 106 patients, 5 (4.7%) were found to be experiencing neglect by APS and the remaining 101(95.3%) were found to be experiencing self-neglect.

Qualitative data was collected via interviews with major stakeholders and SFD stations for analysis of program strengths and areas for improvement. Major strengths identified were having a dedicated case manager for patient follow up, data collection via the Vulnerable Adult Reporting Form, and communication among stakeholders. Areas identified for improvement were increased training for SFD members on identification of vulnerable adult abuse/neglect and access to reference sheets on site for SFD to reference reporting guidelines.

Based on these findings, it is recommended that this program continue in Seattle and be expanded regionally to King County. Recommendations for expansion include uniform training for regional mandated reporters, and regional adoption of a uniform reporting form. Implications for expansion include resolving how to support case management for the increased workload from the additional fire departments in King County. However, continuity of this program with the included recommendations and continuous evaluation will increase the recognition of these patients among mandatory reporters and further improve the health outcomes of vulnerable adults in the entire King County region.

INTRODUCTION

Vulnerable adult abuse is defined by the US Department of Justice as "physical, sexual or psychological abuse, as well as neglect, abandonment, and financial exploitation of a vulnerable adult by another person or entity, that occurs in any setting (e.g., home, community, or facility), either in a relationship where there is an expectation of trust and/or when a person is targeted based on age or disability."[1] Elder abuse affects about 5 million Americans per year, however, just 1 in 24 cases is reported to authorities.[1] It is estimated that roughly two thirds of those harming a vulnerable adult are family members, most often with financial dependence on the vulnerable adult.[2] The combination of lack of reporting as well as the intimacy of vulnerable adult abuse makes it a difficult epidemic to truly quantify, recognize, and prosecute. The King County Prosecuting Attorney's office handles about 500 cases a year involving vulnerable adult neglect, abuse, and financial exploitation.[3] According to the National Center on Elder Abuse (NCEA), signs of elder abuse are often missed by professionals due to lack of training on detecting abuse. EMTs visit approximately 10% of community residents annually, providing the opportunity to witness and report cases of vulnerable adult abuse and neglect. [4]

The Emergency Medical Services Division of King County (EMS) Vulnerable Adult Pilot Project was designed in partnership with Seattle Fire Department (SFD) and Aging and Disability Services (ADS) to improve health outcomes of vulnerable adults by improving the identification and reporting of patient neglect and abuse, as well as coordination of care with ADS for case management. The pilot was launched in September 2014 and involved training of SFD members to identify vulnerable adult patients that have been victims of neglect or abuse and the process for reporting these cases as mandated by Washington State Law (RCW 73.34.020 and RCW 74.34.035). For a detailed project model, see Appendix 1. The EMS Vulnerable Adult Pilot Project was developed in partnership with EMS, APS, ADS, SFD, Seattle Police Department (SPD), Seattle area hospitals, and University of Washington (UW). For more information on project stakeholders, see Appendix 2.

The EMS Vulnerable Adult Pilot Project is focused on the vulnerable population of elderly adults and adults with disabilities in Seattle, King County, and the detection and reporting of abuse or neglect by first responders in these communities, and is a part of the EMS Vulnerable Population Strategic Initiative. The mission of the EMS Vulnerable Population Strategic Initiative is to conduct programmatic, scientific, and case-based evaluations to ensure that the interface between EMS and vulnerable populations is of the highest quality. This assessment supports that mission by evaluating nine months of data for the pilot project reporting of

[1] US Department of Justice. (2014). *The Elder Justice Roadmap: A Stakeholder Initiative to Respond to an Emerging Health, Justice, Financial, and Social Crisis.*
[2] https://www.dshs.wa.gov/altsa/home-and-community-services/types-and-signs-abuse
[3] Councilmembers advocate prevention of elder abuse. (2013, June 10). Retrieved April 1, 2015, from http://www.kingcounty.gov/council/news/203/June/elderabuse.aspx
[4] http://www.ncea.aoa.gov/Library/Data/index.aspx#problem

vulnerable adult abuse and neglect patients by SFD members. The aim of this report is to identify strengths and weaknesses of the already established program and to recommend strategies to improve the program and expand it to other areas of King County in order to make this program the highest quality it can be.

BACKGROUND INFORMATION

Elders 65 years and older made up 10.9% of the population of King County in 2010 with 210,507 residents aged 65 and over, and is forecasted to rise to 18.3% by 2030. [5] The percentage of residents aged 65 and over in Seattle, King County in 2010 was 10.8% (65,495). Further, the percentage of King County residents under the age of 65 years of age living with a disability between the years 2009 through 2013 was 6.2%.[6] The table in Appendix 3 shows a breakdown of elders aged 65 and over by area in King County and the percentage of the total population of each neighborhood in 2010.

Aging and Disability Services (ADS), a division of the Seattle Human Services Department, works in partnership with King County and United Way to:[7]

- Improve the health and quality of life for seniors and adults with disabilities;
- Connect seniors and adults with disabilities with helpful resources; and
- Provide help and support for caregivers.

According to the 2014 demographic profile, ADS provides services to 38,664 unduplicated clients. Of those 38,664 unduplicated clients, 1,095 (2.83%) are under 60, 15,704 (40.62%) are between the ages of 60-74, and the remaining 21,865 are over 74 years of age or of unknown age. [8]

The Washington State Legislature under RCW 74.34.020 defines Vulnerable Adult as a person:[9]

- Sixty years of age or older who has the functional, mental, or physical incapacity to care for himself or herself; or
- Is 18 year old and older who is found incapacitated; or
- Who has a developmental disability; or
- Admitted to any facility; or
- Receiving services from home health, hospice, or home care agencies licensed; or required to be licensed; or
- Receiving healthcare services from an individual provider; or
- Who self-directs his or her own care and receives services from a personal aide.

[5] Aging and Disability Services. 2013. Area Agency on Aging of Seattle and King County
[6] http://www.census.gov/quickfacts/table/DIS010213/00,53033. Accessed 10 July, 2015.
[7] www.agingkingcounty.org. Accessed 05 July, 2015.
[8] http://www.agingkingcounty.org/docs/DemoProfile2014.pdf. Accessed 10 July, 2015.
[9] Apps.leg.wa.gov/RCW/default.aspx?cite=74.34.020. Accessed 04 July, 2015.

Per RCW, vulnerable adult abuse is defined as "the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a vulnerable adult. In instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish". Abuse includes physical abuse, mental abuse, and sexual abuse of a vulnerable adult. Specific definitions are listed in Appendix 4.

The Legislature finds under RCW 74.34.005 and RCW 18.130 that the department of social and health services (DSHS) and appropriate agencies must be prepared to receive reports of abandonment, abuse, financial exploitation, or neglect of vulnerable adults, and that the department must provide protective services in the least restrictive environment appropriate and available to the vulnerable adult.[10] It is the duty of SFD as mandatory reporters to report vulnerable adult abuse/neglect, and the duty of the state to provide protective services for reported cases.

In 2009, the King County Prosecutor's Office received a grant from the U.S. Department of Justice, Office of Violence Against Women (OVW) to create a more coordinated response to abuse of elders and adults with disabilities in King County. Formal training of law enforcement, judges, prosecuting attorneys and direct service providers was offered during a three year period. Subsequently, a needs assessment of the community was conducted and case management was identified as the highest priority. In 2011, ADS was awarded the victim services portion of the OVW grant to work with survivors aged 50 and older who were experiencing abuse, neglect and exploitation and in need of assistance to navigate state and local social, healthcare, and legal services. This work coincided with renewed efforts by the Seattle Fire Department to report suspected abuse of vulnerable adults as required.

The EMS Vulnerable Adult Pilot Project was implemented on September 12, 2014 by major stakeholders meeting and working with a University of Washington Graduate Student, Inderpal Virk, to assess the current state of vulnerable adult abuse and neglect identification and reporting. Mr. Virk conducted a program analysis to identify improvements in the system and worked with stakeholders to identify the following areas for improvement:

1. Enhance the Seattle Fire Department web-based Vulnerable Adult Reporting Form;
2. Train EMTs on the updated reporting procedures and instructions on completing the enhanced form; and
3. Create a feedback loop to the Seattle Fire Department with a follow up form with actions taken by the ADS case worker, APS, and SPD.

Utilizing the recommendations above, stakeholders enhanced EMS training, they subsequently enhanced the Vulnerable Adult Reporting Form (see Appendix 5), expanded the SharePoint site with the Vulnerable Adult Reporting Form in order to collect data, and designed

[10] Apps.leg.wa.gov/RCW/defauly.aspx?cite=74.34.005. Accessed 04 July, 2015.

and initiated a communication feedback loop via e-mail between the ADS case manager and SFD reporters. Local hospitals were included in the project via Emergency Room (ER) social workers. ER social worker's role in the project is to forward the Vulnerable Adult Report to an assigned inpatient social worker for increased coordination of care and to facilitate care planning. Hospital reports were also added to SharePoint forms for future incidences of repeat vulnerable adult ER visits.

The objectives of the pilot project were to:

1. Improve the outcomes for the elderly population and adults with disabilities at risk for abuse and neglect by improving the identification and reporting of abuse/neglect;
2. Improve the communication and coordination of agencies that serve the vulnerable adult population;
3. Develop a better idea of the needs of the population, as well as how to identify and stabilize the at-risk vulnerable adult population;
4. Increase services provided to vulnerable adults without services;
5. Expand services provided to vulnerable adults where needed; and
6. Improve health outcomes of vulnerable adults.

DATA COLLECTION METHODS

Data was collected via SharePoint beginning September 12, 2014 through June 11, 2015 (nine months). Data compiled via the SharePoint site includes patient demographics, SFD reports, ADS follow-up, APS follow-up, SPD follow-up, and hospital information. With names removed, SharePoint data was exported to an Excel spreadsheet for evaluation.

Interviews were conducted with low and high reporting SFD stations (stations 2, 18, 20, 21, 28, 33, 35, and 39) (see Appendix 6 for location of SFD stations). Interviews were also conducted with six top SFD reporter, as well as six core stakeholders from Emergency Medical Services (EMS), Seattle Fire Department (SFD), Aging and Disability Services (ADS), Seattle Police Department (SPD), and Northwest Hospital & Medical Center. Qualitative data from interviews was evaluated for trends in perceived strengths and weaknesses of the program. Qualitative data for this program evaluation was essential for assessing the state of the program from the perception of the involved entities, as well as areas that could be improved for all involved entities

RESULTS

Demographics

During the nine month pilot project, SFD reported 212 cases of vulnerable adult abuse or neglect, of which 37 of these reports (17.4%) were for repeat patients. For a breakdown of reporting by date, see Appendix 7. The minimum age on the reports was 28 years and maximum

age was 99 years, with an average age of 71 years. The majority of reports made were for males (60.8%), who are white (92/129 or 71.3%), and live in a private residence (121/129 or 93.8%). Males were more likely than females to be reported more than once, with 25 out of 37 repeat reports being male (67.7%). See Table 1 for full patient demographics.

Table 1: Patient Demographics

Characteristic	N (%)
Gender	**N=212**
Male	129 (60.8%)
Female	83 (39.2%)
Race	**N=186**
White	146 (78.5%)
Black	27 (14.5%)
Asian	4 (2.2%)
Other	4 (2.2%)
American Indian/Alaska Native	3 (1.6%)
Hispanic	2 (1.1%)
Language spoken	**N=190**
English	186 (97.9%)
Other	4 (2.1%)
Russian	1 (0.5%)
Living situation	**N=212**
Private apartment	107 (50.5%)
Private home	86 (40.6%)
Licensed care facility	19 (9.0%)

Seattle Fire Department

Data was collected for the number of reports by SFD station for the nine month pilot. Figure 1 shows a graph of reporting by station number (please reference Appendix 6 for station locations).

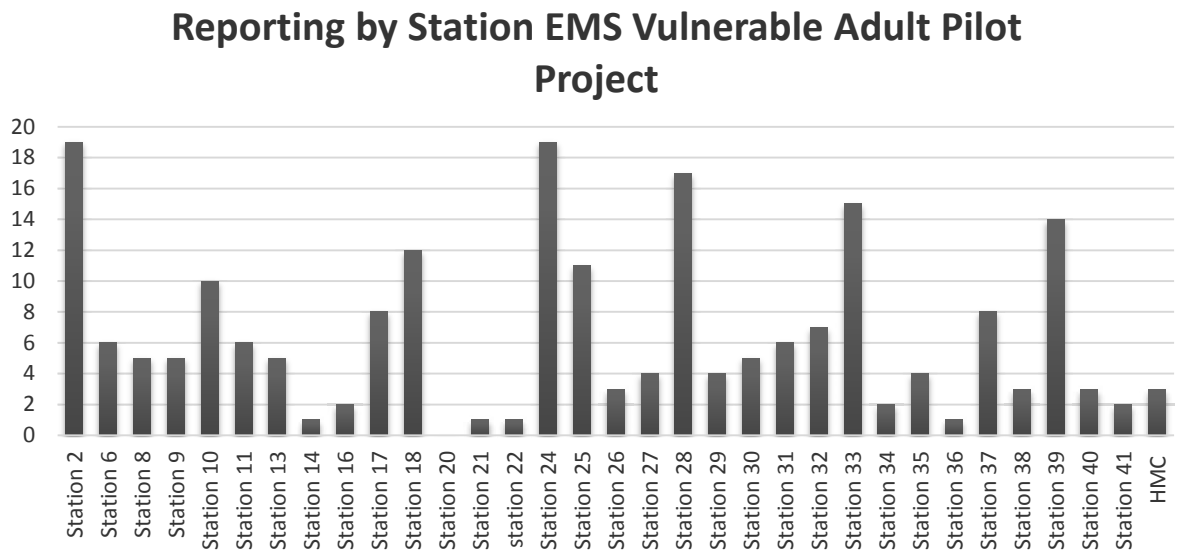


Figure 1

Initial impressions warranting SFD reporting were: neglect/self-neglect, abandonment, physical abuse, financial exploitation/exploitation, and other. The options for neglect/self-neglect were not separated due to the difficulty in separating recognition of these two problems at initial encounter. The Vulnerable Adult Reporting Form allows users to select one or more initial impression. Neglect/Self-Neglect was the highest reported initial SFD impression for reporting with 77.4% of reports containing Neglect/Self-Neglect as a reason. Table 2 shows the initial impressions for reporting by SFD over the nine month pilot project period. The results do not account for patients reported for more than one reason.

Table 2: Initial Impression for reporting, n=208 (excludes reports missing data)

Category	N (%)
Neglect/Self-neglect	161 (77.4%)
Other	88 (42.3%)
Abandonment	5 (2.4%)
Exploitation/Financial exploitation	4 (1.9%)

SFD also reported on initial patient condition, home environment, and SFD operations actions while on site. The top reported patient conditions were frail/weak, poor hygiene/unbathed, soiled clothing, and the top reported home environments reported were unsanitary home, no assistance in home, and foul odor. These reported conditions are synonymous with signs of neglect and self-neglect, thus validating the large reports of initial impression of neglect/self-neglect. Figure 2 shows the top reported patient conditions and home environment. Appendix 8 shows full data for patient condition, home environment, and SFD operation actions.

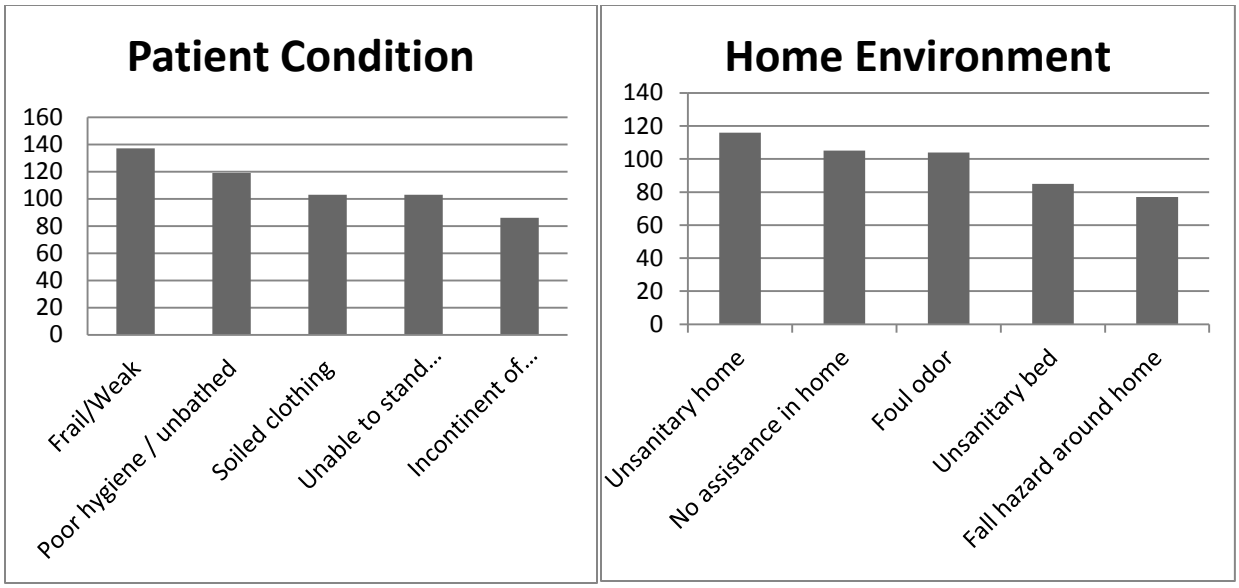


Figure 2

Of the 212 SFD visits, 131 (61.8%) of the patients were transported to the hospital for further evaluation. Emergency room social workers at the hospitals were forwarded the SharePoint reporting form as well for care coordination between hospitals and agencies. Figure 3 shows the hospitals the 131 patients were transported to during the pilot project, excluding 52 reports that were missing data.

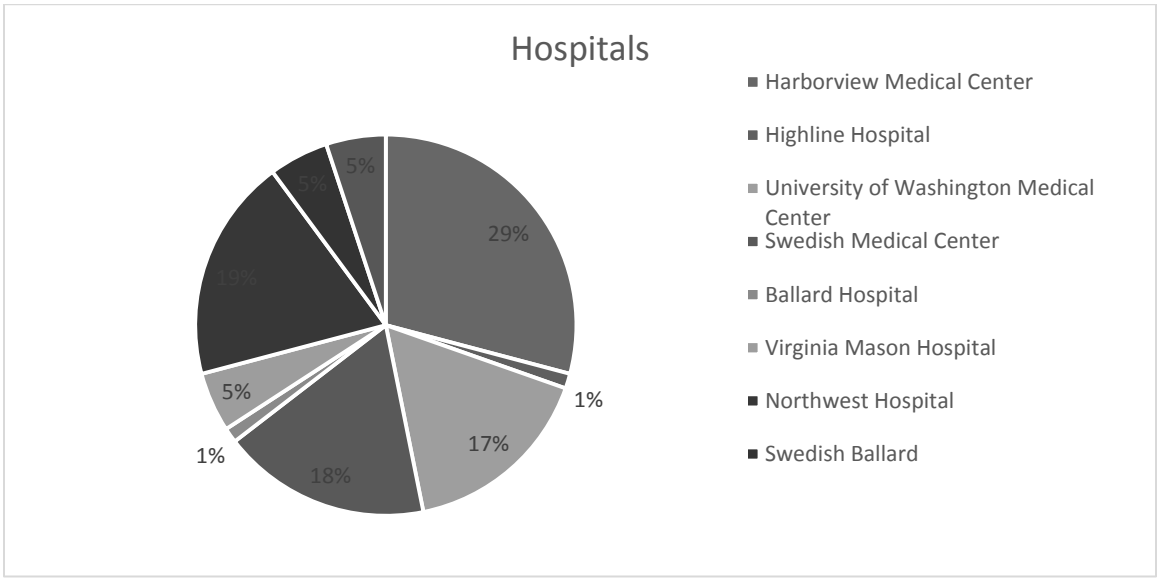


Figure 3

Aging and Disability Services (ADS)

Of the 175 unduplicated reports, 107 had no social services in place at the time of reporting, showing us that over half of SFD's unduplicated reports are patients that were not already linked in with state social services. Four of the cases were reported out to RCS and

therefore had no ADS data, leaving 62.6% of patients with no initial social services in place. Of the 171 reports, 64 (37.4%) already had social services in place at the time of reporting.

Out of the 171 unduplicated reports made to ADS, 137 (80.1%) patients enrolled in services through ADS as a result of follow up from the Vulnerable Adult Reporting Form during the pilot project time. The patients that were not enrolled in services were either in an assisted living facility, unable to be contacted, or refused services when contacted. Of those 137 patients who were enrolled in ADS services, 92 (67.2%) did not have any social services in place at initial reporting, thus receiving their first social services via the pilot project. 45 (32.8%) did have services at initial reporting, thus receiving expanded services via the pilot project. Table 3 shows the top ADS services patients were enrolled in who had no services in place at initial reporting. Table 4 shows the ADS services received by patients who received expanded services compared with initial services that were in place for these patients. Expanded services include increased case management hours and initiating referrals to appropriate services for the patient in order to provide the level of care needed to stabilize that patient. Appendix 9 has expanded ADS data.

Table 3: New services received for clients with no services at initial reporting (N=92, does not account for patients enrolled in more than one service)

Services received	N (%)
Case management	90 (97.8%)
State contracted in home services	3 (3.3%)
Residential care	3 (3.3%)

Table 4: Expanded services received for clients with services at initial reporting (N=45, does not account for patients enrolled in more than one service)

Initial services in place (at time of reporting)	N (%)	Expanded services received	N (%)
Case management	36 (80.0%)	Case management	42 (93.3%)
State contracted in home services	32 (71.1%)	State contracted in home services	25 (55.6%)
Other	12 (26.7%)	Other	11 (24.4%)
Private pay in home services	7 (15.6%)	Mental health services	7 (15.6%)
Mental health services	6 (13.3%)	Private pay in home services	3 (6.7%)
Guardian/POA	2 (4.4%)	Alcohol and substance use services	2 (4.4%)
Alcohol and substance use services	1 (2.2%)	Guardian/POA	2 (4.4%)
Hospice	1 (2.2%)	Home health care	1 (2.2%)

Adult Protective Services (APS)

APS is responsible for taking the reports and investigating to determine if the adult fits the "vulnerable adult" criteria. They are then responsible for investigating if abuse or neglect are present. Cases that do not fit vulnerable adult criteria are screened out by APS. Figure 5 shows the actions taken by APS for all cases, showing only 11% of reported cases were screened out.

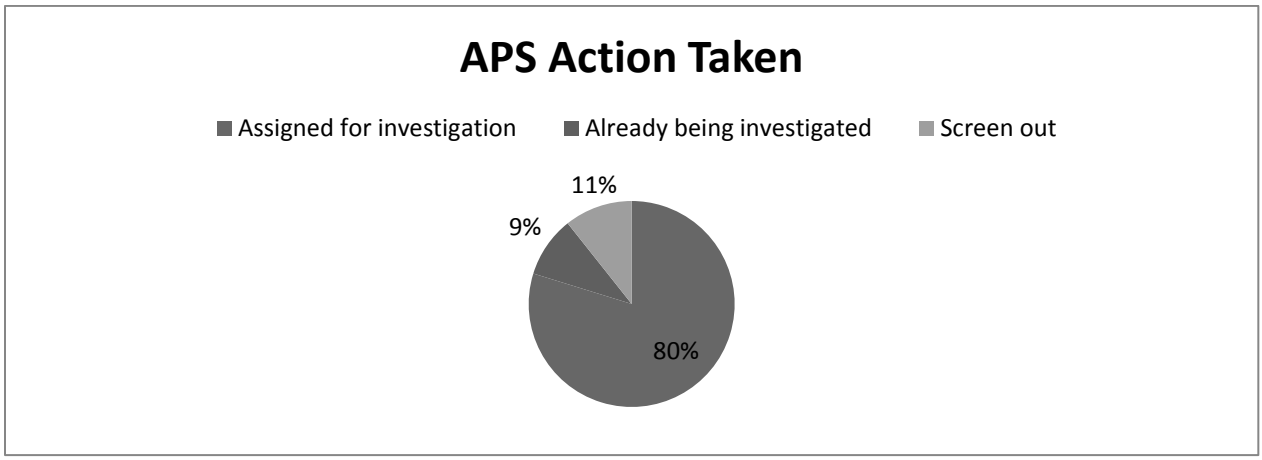


Figure 4

ADS/APS Outcomes

Of the 212 reports, ADS was able to close 63 (29.7%) of the cases by the end of the nine month pilot project, obtaining stabilization for these patients. Of the 107 patients with no initial ADS services in place, 49 (45.8%) had their case closed by the end of the pilot project. Of those 63 cases, 41 (65.1%) were closed due to residential placement of the patient. Table 5 shows the reason for all closed cases. "No longer needed" covers cases that were being provided services through other agencies as well as patients who declined services from ADS.

Table 5: ADS Closed Cases

Closed Cases	N (%)
Placement	41 (65.1%)
Other	26 (41.3%)
Death	19 (30.2%)
Services no longer needed	17 (27%)

Of the 161 patients initially reported by SFD as neglect/self-neglect patients, 106 (65.8%) were found by APS to have an outcome of neglect or self-neglect, validating the SFD reports of neglect/self-neglect. Of these 106 patients, 5 (4.7%) were found to be experiencing neglect by APS and the remaining 101(95.3%) were found to be experiencing self-neglect. Table 6 shows full data for APS outcomes.

Table 6: APS outcomes, N=163 (excludes reports missing data)

Outcome	N (%)
Self-neglect (substantiated, unsubstantiated, inconclusive, no APS, and still open)	116 (71.2%)
Screen out	17 (10.4%)
Neglect, unsubstantiated	10 (6.1%)
CRU only	10 (6.1%)
Too soon for outcome	6 (3.7%)
Guardianship is being pursued	2 (1.2%)
In process	1 (0.6%)
Financial exploitation, inconclusive	1 (0.6%)
Physical, unsubstantiated	1 (0.6%)

Qualitative Data

Of the 38 SFD personnel interviewed (including top SFD reporters and reporters across high and low reporting stations), all 38 were aware of the Vulnerable Adult Project for reporting vulnerable adult abuse/neglect. Those interviewed knew of the project via quarterly trainings as well as via SFD members. Of the 38 SFD personnel interviewed, 26 (68.4%) have filled out a Vulnerable Adult Reporting Form. 11 out of 38 (28.9%) SFD personnel interviewed did not find any barriers to filling out the Vulnerable Adult Reporting Form. The three major barriers identified by multiple interviewees were:

1. Amount of time it takes to fill out/Length of form/Amount of information requested- 22/38 (57.9%);
2. Lack of training on what constitutes a "vulnerable adult"/Unsure when form should be filled out- 9/38 (23.7%); and
3. Remembering the information after a run in order to fill out the form- 4/38 (10.5%).

Of the 26 officers who filled out Vulnerable Adult Reporting Forms, 21 (80.8%) recalled receiving feedback on their report. 18 out of the 21 (85.7%) reporters found the feedback useful in filling out future forms. They reported this as being useful due getting feedback on patient outcomes giving them motivation to fill out future forms.

Strengths of the vulnerable adult pilot project identified by SFD included:

1. Receiving case feedback- 24/38 (63.2%);

2. Getting people the help they need- 23/38 (60.5%);
3. Knowledge that there is an assigned case manager to your report- 5/38 (13.2%); and
4. Receiving memos with case outcomes- 4/38 (10.5%).

Interviews conducted with major stakeholders revealed collaboration among entities as well as care coordination as major strengths. The interview conducted with an involved Seattle area hospital social worker revealed that the program has been very successful in increasing care coordination for vulnerable adults that come into the hospitals as it allows them to see what services are already in place, whether or not social services have already been contacted, if there is an assigned case manager for the patient, and where would be best to discharge patient too. As 131 (61.8%) of the patients were transported to a hospital, including hospital social workers in the pilot has increased care coordination for over half of the patients reported out by SFD.

Another major collaboration strength identified via interviews was notification to ADS of clients who were already enrolled in services having a visit from an EMS personnel. Clients and their caregivers will often not report to ADS when they've needed to call emergency services. This project has led to communication to ADS to show that these specific clients may need expanded or different services then what they are already receiving, allowing ADS to reach out and provide necessary services that they would have been unaware of the client needing without the vulnerable adult report.

PROGRAM EVALUATION

The EMS Vulnerable Adult Pilot Project has been very successful. Objectives set forth by stakeholders for this program included:

1. Improve the outcomes for the elderly population and adults with disabilities at risk for abuse and neglect by improving the identification and reporting of abuse/neglect;
2. Improve the communication and coordination of agencies that serve the vulnerable adult population;
3. Develop a better idea of the needs of the population, as well as how to identify and stabilize the at-risk vulnerable adult population;
4. Increase services provided to vulnerable adults without services;
5. Expand services provided to vulnerable adults where needed; and
6. Improve health outcomes of vulnerable adults.

Objective 1: Improve identification and reporting of vulnerable adult abuse/neglect

Increased recognition and reporting of vulnerable adult abuse/neglect by SFD members was seen after training as well as memos released to SFD twice in the nine-month period. Data received on vulnerable adult abuse/neglect reporting forms during the nine-month period preceding the study had a total of 165 SFD reports compared with 212 reports during the study

period, an average of approximately five more reports per month. Release of periodic memos that reminded personnel of the program increased the monthly reporting totals.

SFD members have higher motivation to report vulnerable adult abuse/neglect when receiving case manager feedback as evidenced by the following quotes from interviews with SFD reporters:

> *"The members of my company are very impressed with how the vulnerable adult program gives us a way to help out where in the past we've felt helpless. I really appreciate your effort and I also want to thank you for following up with us. This is honestly one of the best improvements that the Seattle Fire Department has been a part of since I joined in 1998."*

> *"Not only are the citizens well served by your diligence (in the program) but it is a great contribution to provide such excellent and positive feedback to the department as a whole. Good work!!"*

> *"On behalf of the crew, I would like to pass on our extreme appreciation for your efforts and awesome feedback. It really makes a difference and further motivated our vulnerable adult submissions."*

Objective 2: Improve communication and coordination of agencies

The pilot project was very successful at bringing together stakeholders involved in the care of vulnerable adults in Seattle, King County. Stakeholder interviews identified one of the key positives of this program as the involvement of all stakeholders (SFD, ADS, APS, SPD, Seattle hospitals) and are all looking forward to continued program development and coordination of care.

Increased care coordination was specifically seen via hospital ER social worker supervisors, who received vulnerable adult reports and were able to forward them to inpatient social workers working with a vulnerable adult. With 61.8% of the patients being transported to a hospital, this coordination of care is vital for appropriate care planning and continuity of care from all services. Increased care coordination was also seen via feedback loop from ADS case manager back to SFD. 63.2% of SFD reporter interviewed found one of the major strengths of the program to be feedback, and stated that feedback motivated them to fill out future forms as they then knew action was being taken on their reports.

Objective 3: Develop a better idea of the needs of the population, as well as how to identify and stabilize the at-risk vulnerable adult population

Stakeholders were able to see via data collected the main reasons for initial reporting (neglect/self-neglect in 77.4% of reports) as well as the outcome found by APS (self-neglect in 71.2% of the cases). This data identifies where the greatest needs are in the vulnerable adult

population and allows for stakeholders to provide appropriate services and screenings for needs that are highly reported. This data also validates that SFD is reporting the appropriate impressions for ADS/APS follow up with 65.8% of patients with reported neglect/self-neglect by SFD having an outcome of neglect or self-neglect with APS.

SFD initial impressions of patient's conditions and home environment also provide opportunity to see what services are needed in the vulnerable adult population. Unsanitary conditions; including unsanitary home, patient incontinence, poor hygiene, and foul odor; were the highest reported initial conditions. This provides data that these conditions are signs of neglect/self-neglect and also provides opportunities for services that assist with in home and patient unsanitary conditions.

Objective 4: Increase services to vulnerable adults without services

This objective has been very successful in the pilot project time. SFD identified 107 patients with no services in place at the time of reporting. Of these patients, 92 (86%) were enrolled in services through ADS, and 49 (45.8%) had their case closed by the end of the pilot project time period. Only 15 (14%) patients did not receive services that did not have services in place at initial reporting. Of these 15 patients, 13 were in a SNF or assisted living facility, so were likely receiving services via Residential Care Services (RCS) and would not require ADS services.

Objective 5: Expand services to vulnerable adults where needed

This objective has also been met in the pilot project. SFD identified via vulnerable adult reports 64 patients who already had ADS services in place. Stakeholder interviews identified this as one of the major strengths, as they would previously be unaware of these patients needing different or expanded services. Of these 64 patients with services in place at initial reporting, 45 (70.3%) were enrolled in additional new services via ADS during the pilot project time period. This shows that the project has been successful in identifying patients who are not receiving the necessary level of care from their current services and has also been successful in expanding services to meet the necessary level of care.

Objective 6: Improve health outcomes of vulnerable adults

According to stakeholders involved, especially Seattle area hospital social workers, increased care coordination leads to better care planning for patients. Increased identification of these patients leads to increased services, either initial or expanded, which in turn lead to better health outcomes for this population. Although there is not concrete data on the health outcomes of this population there is a push in healthcare towards increased care coordination, which has been a large strength of this program. A large component of the Affordable Care Act of 2010 is care coordination for high healthcare dollar patients. According to the Act "The ACA incentivizes care management, health promotion, patient transition care, referral to social support

services, and information technology by funding health homes with a 90% federal matching rate for the first two years."[11] This project increased case management to vulnerable adults (97.8% of patients with no initial services at reporting that were enrolled in services were enrolled in case management), patient transition of care was improved through communication with hospital social workers, and referral to social support services were achieved via SFD referrals to APS and ADS.

PROGRAM RECOMMENDATIONS

Program Strengths

After evaluation of the EMS Vulnerable Adult Pilot Project, the following areas have been recognized as strengths of the program to date. It is recommended that these areas continue on a city level as well as regional level if expansion occurs.

SFD Liaison: Having a dedicated SFD member to follow up on cases and serve as a point person for the program has been successful for SFD involvement and representation for how the form and program are working for those who are actually doing the reporting. Having a dedicated SFD liaison in partnership with an ADS case manager with clear roles and responsibilities has been hugely successful for a strong partnership and for ensuring the highest quality program.

ADS Case Manager: Having a dedicated ADS case manager has been a huge success for this project. It has increased care services to vulnerable adults as well as improved the feedback loop between reporters and agencies. As reported via interviews, reporters find the feedback to be invaluable and motivational for continual reporting of vulnerable adult abuse/neglect.

Vulnerable Adult Reporting Form/Data Collection: Although lengthy, the form covers vital information for care coordination between stakeholders. It also creates opportunity to collect data to track vital information such as the number of vulnerable adult reports, where referrals were made (ADS, APS, RCS), and what patient outcomes were to ensure the ability to continue to evaluate the program for success and to make improvements where necessary.

Memos Released to SFD: The memos released to SFD, including reporting totals and patient outcomes have increased reporting and provide a necessary reminder to SFD personnel to continue to report.

Communication between Stakeholders: Monthly meetings with EMS, ADS, and SFD provide opportunity to look at reporting data, discuss the program, re-evaluate strengths and weaknesses and make adjustments when needed, and collaborate on ways to best operate and collaborate for each entity involved. Input from all entities involved on a monthly basis would be a great opportunity for continued improvement in communication.

[11] Patient Protection and Affordable Care Act. Pub. L. No. 111-148, 124 Stat. 119 (2010).

Hospital Social Worker Involvement: This involvement has provided excellent care coordination for vulnerable adults who are frequently hospitalized. According to interviews conducted with Seattle hospital social worker, the ER social worker involvement allows for hospital workers to see what services are in place for the patients and to proceed with care/discharge plans in accordance with the patient's already established services.

Recommendations for Program Model Improvements

After evaluation of the EMS Vulnerable Adult Pilot Project, the following have been recognized as opportunities for improvement:

Increased training of mandatory reporters: Several SFD members identified lack of training as an area for improvement. It is recommended that training be provided in several different formats. Some suggestions include:

- A training session for station supervisors be set up with an area expert for training on how to recognize vulnerable adult abuse/neglect.
- A training video on guidelines and procedures for reporting vulnerable adult abuse/neglect be made for SFD stations to play at roll call.
- Training on vulnerable adult abuse/neglect and the reporting process be included in SFD quarterly trainings.

Station feedback: It is recommended that feedback be provided to the station as a whole as opposed to one single SFD member. Several of the SFD members interviewed identified log-ons as an issue when filling out the form. A barrier they face is that if another person is logged into the computer, the form is automatically filled out as that person as opposed to the real reporter. A generic station feedback would help mitigate this and would also allow for each station to hear follow up of all reported cases. One suggestion on how to do this is to create generic e-mail addresses for each station, i.e. station24@seattle.gov. With a generic e-mail address, feedback can be provided to the station as a whole as opposed to a single officer.

Continued involvement from all stakeholders: Interviewed stakeholders identified inter-agency coordination as a major program strength. Thus, it is recommended that monthly operations meetings continue and that each participating stakeholder have a representative involved in the discussions to help coordinate and troubleshoot.

Creation of a reference sheet for SFD to take on runs: Several SFD members identified a barrier to filling out the form as being memory of what to look for while on a call. It is suggested that a form with key things to look for/remember for reporting be created for firefighters to take on scene.

Ability to see repeat patient forms: When reporters go to fill out a form, it would be beneficial for them to be able to see if a form has been filled out for that patient in the past. If a form has

been filled out, it would be helpful to know when and for what reason, and what actions have been taken to date. SFD members stated that they would prefer to know if other officers have already filled out a form for a specific patient before entering their information.

If resources allow, the following is recognized as an ideal program improvement:

Tablets: For the highest level of reporting, it is recommended that SFD responders have a tablet to take on calls with the Vulnerable Adult Reporting Form. This would allow for reports to be made in real time and for first responders to be able to answer all questions while on scene. Memory of what was seen on a call was identified as a barrier to filling out the form, and tablets would eliminate this barrier. Tablets would also eliminate the suggestion for a reference sheet for SFD as this could be stored on the tablet.

Recommendations for Expansion

The EMS Vulnerable Adult Pilot Project has been very successful in Seattle for recognition and reporting of vulnerable adult/abuse and for getting necessary services to this population. Thus, it is recommended for the program to continue in Seattle and to expand to the rest of King County. Based on the evaluation, the following are considerations for regional expansion:

Vulnerable Adult Reporting Form: It is recommended that a regional option for use of a reporting form be considered for use by all King County EMS/Fire Department workers to report vulnerable adult abuse/neglect. This form should also be accessible by ADS, APS, local hospitals, and local police departments in King County.

Expanded Training: It is recommended that training be provided to all King County EMS responders on how to identify and report vulnerable abuse/neglect. It is recommended that this training follow the model of training provided to SFD per recommendations above.

Dedicated Case Manager and Fire Department Liaison: It is recommended that ADS continue with dedicated case management to follow up on fire department reports. Implications for expansion include resolving how to support case management for the increased workload from the additional fire departments in King County. It is also recommended that depending on the size of the fire department, a liaison be assigned as a point person for the program. The role and responsibilities can be determined locally.

CONCLUSION

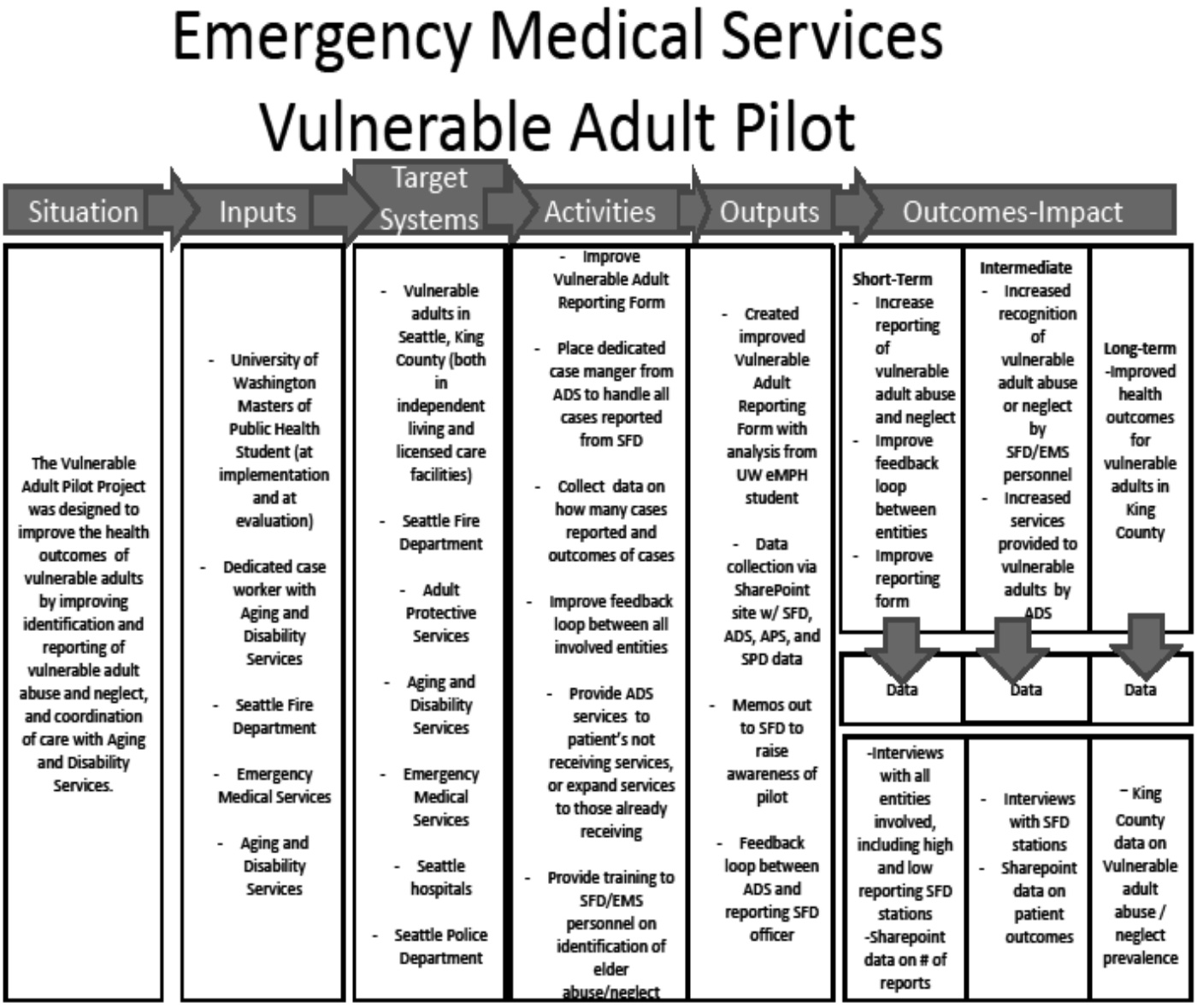
This program has taught stakeholders more about the vulnerable adult population in Seattle, King County. These reports show that the majority of vulnerable reporting is happening for males (60.8%), who are white (92/129 or 71.3%), and live in a private residence (121/129 or 93.8%). Males were more likely than females to be reported more than once, with 25 out of 37 repeat reports being male (67.7%). The most common impression for reporting was neglect/self-

neglect and the most common outcome discovered by APS was self-neglect. Males were much less likely than females to have ADS services in place at initial reporting (86% of males had no initial services in place). Both males and females were equally likely to enroll in services through ADS and to have their case closed due to placement (58.5% placed were males vs. 41.5% female).

Data from the EMS Vulnerable Adult pilot project has shown improvement in the system of vulnerable adult abuse/neglect reporting. Reporting rates have risen in Seattle, King County by an average of 5 reports per month. Partnerships and increased communication among stakeholders has resulted in increased services to this population in Seattle, King County, and thus improved health outcomes. With increased education provided to mandatory reporters, the rates of vulnerable adult recognition and reporting will almost certainly continue to rise. Standard reporting procedures should be adopted across all of King County for data collection to recognize the prevalence of this issue as well as the needs of this population. Standard education and reporting procedures across King County will also increase the recognition of this issue among mandatory reporters, leading to further improvement in the health outcomes for vulnerable adults.

APPENDICES

I.



II. Project Stakeholders

Seattle Fire Department: http://www.seattle.gov/fire/

Emergency Medical Services: http://www.kingcounty.gov/healthservices/health/ems.aspx

Adult Protective Services: http://www.napsa-now.org/get-help/help-in-your-area/washington/

Aging and Disability Services: http://www.agingkingcounty.org/

Seattle Police Department: http://www.seattle.gov/police/

University of Washington School of Public Health: http://sph.washington.edu/

III. 2010 Elder Population in King County by area; Source: 2010 US Census Data

Neighborhood	Total Population	Population 65 + (% of total population)
Algona	3,014	197 (6.5%)
Auburn	70,189	7,159 (10.2%)
Beaux Arts Village	299	62 (20.7%)
Bellevue	122,363	17,061 (13.9%)
Black Diamond	4,151	416 (10%)
Bothell	33,505	4,064 (12.1%)
Burien	33,313	4,253 (12.8%)
Carnation	1,786	107 (6%)
Clyde Hill	2,984	549 (18.4%)
Covington	17,575	1,105 (6.3%)
Des Moines	29,673	4,388 (14.8%)
Duvall	6,695	300 (4.5%0
Enumclaw	10,669	1,593 (14.9%)
Federal Way	89,306	9,237 (10.3%)
Hunts Point	394	96 (24.4%)
Issaquah	30,434	3,875 (12.7%)
Kenmore	20,460	2,443 (11.9%)
Kent	92,411	8,131 (8.8%)
Kirkland	48,787	5,299 (10.9%)
Lake Forest Park	12,598	1,903 (15.1%)
Maple Valley	22,684	1,497 (6.6%)
Medina	2,969	540 (18.2%)
Mercer Island	22,699	4,423 (19.5%)
Milton	6,968	834 (11.9%)
Newcastle	10,380	934 (9%)
Normandy Park	6,335	1,341 (21.2%)
North Bend	5,731	540 (9.4%)
Pacific	6,606	473 (7.2%)
Redmond	54,144	5,121 (9.4%)
Renton	90,927	9,164 (10.1%)
Sammamish	45,780	2,614 (5.7%)
SeaTac	26,909	2,606 (9.7%)
Seattle	**608,660**	**65,495 (10.8%)**
Shoreline	53,007	8,003 (15.1%)
Skykomish	198	37 (18.7%)
Snoqualmie	10,670	413 (3.9%)
Tukwila	19,107	1,521 (8%)
Woodinville	10,938	1,210 (11.1%)
Yarrow Point	1,001	196 (19.6%)
Total	**1,931,249**	**210,679 (10.9%)**

IV. Definitions

A. ***"Physical abuse"*** means the willful action of inflicting bodily injury or physical mistreatment. Physical abuse includes, but is not limited to, striking with or without an object, slapping, pinching, choking, kicking, shoving, prodding, or the use of chemical restraints or physical restraints unless the restraints are consistent with licensing requirements, and includes restraints that are otherwise being used inappropriately.

B. ***"Mental abuse"*** means any willful action or inaction of mental or verbal abuse. Mental abuse includes, but is not limited to, coercion, harassment, inappropriately isolating a vulnerable adult from family, friends, or regular activity, and verbal assault that includes ridiculing, intimidating, yelling, or swearing.

C. ***"Sexual abuse"*** means any form of nonconsensual sexual contact, including but not limited to unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, and sexual harassment. Sexual abuse includes any sexual contact between a staff person, who is not also a resident or client, of a facility or a staff person of a program and a vulnerable adult living in that facility or receiving service from a program authorized whether or not it is consensual.

D. ***"Neglect"*** is defined as a pattern of conduct or inaction by a person or entity with a duty of care that fails to provide the goods and services that maintain physical or mental health of a vulnerable adult, or that fails to avoid or prevent physical or mental harm or pain to a vulnerable adult; or an act or omission by a person or entity with a duty of care that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult's health, welfare, or safety.

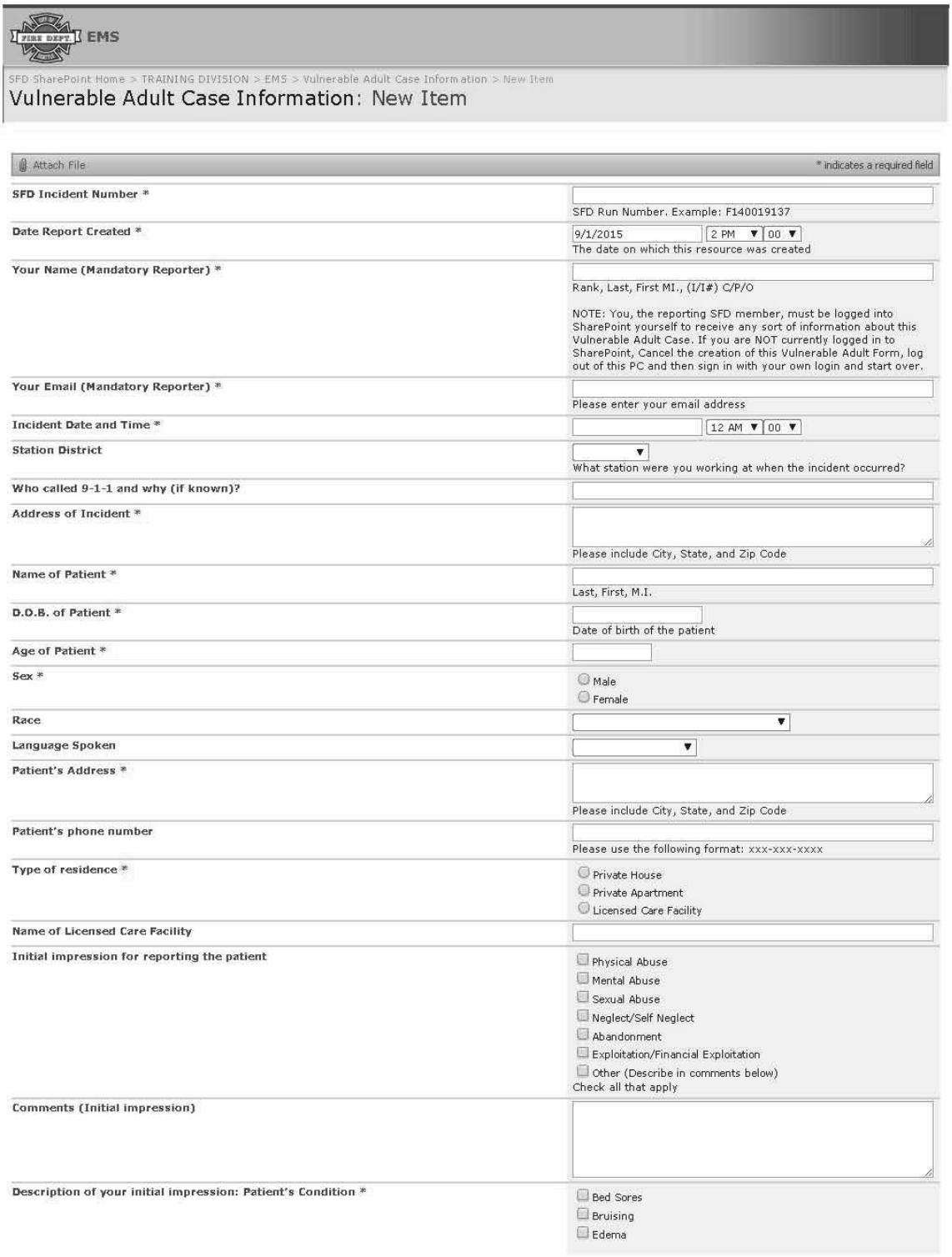
E. ***"Self-neglect"*** means the failure of a vulnerable adult, not living in a facility, to provide for himself or herself the goods and services necessary for the vulnerable adult's physical or mental health, and the absence of which impairs or threatens the vulnerable adult's well-being. This definition may include a vulnerable adult who is receiving services through home health, hospice, or a home care agency, or an individual provider when the neglect is not a result of inaction by that agency or individual provider.

F. ***"Abandonment"*** is defined as action or inaction by a person or entity with a duty of care for a vulnerable adult that leaves the vulnerable person without the means or ability to obtain necessary food, clothing, shelter, or health care.

G. ***"Exploitation"*** is defined as an act of forcing, compelling, or exerting undue influence over a vulnerable adult causing the vulnerable adult to act in a way that is inconsistent with relevant past behavior, or causing the vulnerable adult to perform services for the benefit of another.

H. ***"Financial Exploitation"*** means the illegal or improper use, control over, or withholding of the property, income, resources, or trust funds of the vulnerable adult by any person or entity for any person's or entity's profit or advantage other than for the vulnerable adult's profit or advantage.

V. Revised Vulnerable Adult Reporting Form



EMS

SFD SharePoint Home > TRAINING DIVISION > EMS > Vulnerable Adult Case Information > New Item

Vulnerable Adult Case Information: New Item

Attach File * indicates a required field

SFD Incident Number *
SFD Run Number. Example: F140019137

Date Report Created *
9/1/2015 2 PM 00
The date on which this resource was created

Your Name (Mandatory Reporter) *
Rank, Last, First MI., (I/I#) C/P/O

NOTE: You, the reporting SFD member, must be logged into SharePoint yourself to receive any sort of information about this Vulnerable Adult Case. If you are NOT currently logged in to SharePoint, Cancel the creation of this Vulnerable Adult Form, log out of this PC and then sign in with your own login and start over.

Your Email (Mandatory Reporter) *
Please enter your email address

Incident Date and Time *
12 AM 00

Station District
What station were you working at when the incident occurred?

Who called 9-1-1 and why (if known)?

Address of Incident *
Please include City, State, and Zip Code

Name of Patient *
Last, First, M.I.

D.O.B. of Patient *
Date of birth of the patient

Age of Patient *

Sex *
Male
Female

Race

Language Spoken

Patient's Address *
Please include City, State, and Zip Code

Patient's phone number
Please use the following format: xxx-xxx-xxxx

Type of residence *
Private House
Private Apartment
Licensed Care Facility

Name of Licensed Care Facility

Initial impression for reporting the patient
Physical Abuse
Mental Abuse
Sexual Abuse
Neglect/Self Neglect
Abandonment
Exploitation/Financial Exploitation
Other (Describe in comments below)
Check all that apply

Comments (Initial impression)

Description of your initial impression: Patient's Condition *
Bed Sores
Bruising
Edema

	☐ Tenderness with palpation ☐ Malnourished ☐ Dehydrated ☐ Old wounds ☐ Wounds in various stages of healing ☐ Soiled clothing ☐ Poor hygiene/unbathed ☐ Frail/weak ☐ Evidence of coercion/verbal abuse ☐ Unable to stand without assistance ☐ Frequent falls ☐ Incontinent of urine/feces ☐ Medication non-compliant ☐ Non injury or illness ☐ Evidence of sexual abuse ☐ Other (Describe in comments below) **Check all that apply**
Comments (Patient's Condition)	
Description of your initial impression: Home & Environment *	☐ No food ☐ Unsanitary home (explain below) ☐ Unsanitary bathroom ☐ Unsanitary bed ☐ Hoarding conditions ☐ Rodent/insect infestation ☐ Human/animal feces around home ☐ Fall hazard around home ☐ Fire hazards in home (explain below) ☐ Neighbors assist with daily living ☐ No assistance in home ☐ Care provider unable to assist patient ☐ Visible weapons ☐ Dangerous animals ☐ Visible drug paraphernalia ☐ Restraints ☐ Lack of appropriate medical equipment or supplies ☐ Foul odor ☐ Other (Describe in comments below) **Check all that apply**
Comments (Home & Environment)	
Operations Company Actions *	☐ Patient Exam ☐ Trauma Exam ☐ Vitals ☐ Initial assessment ☐ Detailed history ☐ Backboard/C-collar ☐ Wound care ☐ Transported to hospital ☐ Lift assist to position of comfort ☐ Assisted with bathroom duties ☐ Cleaned patient of feces and urine ☐ Prepared meal for patient ☐ Reduced/minimized fire hazards ☐ Reduced/minimized fall hazards ☐ Communicated with family/friends/neighbor/care provider ☐ Other (Describe in comments below) **Check all that apply**
Comments (Operations Company Actions)	

If the patient was transported, which hospital?	○ Harborview Medical Center ○ Highline Hospital ○ Northwest Hospital ○ Swedish Medical Center ○ University of Washington E.R. ○ Veterans Hospital ○ Virginia Mason Hospital ○ Other (Describe in comments below)
If patient was not transferred to the hospital, why?	○ Patient refused against medical advice ○ No medical necessity ○ Alternate (primary care physician, clinic) ○ Other (Describe in comments below)
Comments (Hospital)	
Does the patient have a care provider? *	○ Yes ○ No ○ Unknown
Name of care provider (if known)	
Care provider's contact information	
Care provider's relationship to patient	What is the relationship of the care provider to the victim.
Other persons present during incident? *	○ Yes ○ No
If yes, please provide Name, Contact Information, and Relation	
Was Seattle Police Department requested? *	○ Yes ○ No
If yes, please provide SPD Case Number	
APS, RCS, Notification *	☐ Private Residence (APS - Adult Protective Services, 1-206-341-7660, R2HCSAPSIntake@dshs.wa.gov) ☐ Licensed Care Facility (RCS - Residential Care Services, 1-800-562-6078, CRU@dshs.wa.gov) When the "OK" button at the bottom of the form is clicked, an email will automatically be sent to either APS or RCS (or both) based on the choice made in this field. Firefighters: you're done! Skip to the bottom and click on the OK

	button to save this report. . .
ADS - Vulnerable Adult Intake Form *	ADS Vulnerable Adult Intake Form ▼
ADS - At the time of the incident, were services in place?*	○ Yes ○ No
ADS - If Yes, what are the initial services that are being provided?	☐ Case management ☐ State contracted in home care services ☐ Home health care ☐ Hospice ☐ Residential Care ☐ Volunteer chore services ☐ Private pay in home services ☐ Alcohol and substance use services ☐ Mental health services ☐ Primary care provider ☐ Guardian/POA ☐ Other (Describe in comments below) **Check all that apply**
ADS - Additional Comments (initial services)	
ADS - Is there a case manager assigned to the patient?*	○ Yes ○ No
ADS - If yes, please provide Name and contact information of the case manager	
ADS - Does the patient have a care provider?*	○ Yes ○ No
ADS - If yes, please provide the name, address, and contact information of the care provider	. . . . -End of ADS Vulnerable Adult Intake Form-
ADS - Vulnerable Adult Assessment Form *	ADS Vulnerable Adult Assessment Form ▼
ADS - Patient enrolled in services?*	○ Yes ○ No
ADS - If yes, what services?	☐ Case management ☐ State contracted in home care services ☐ Home health care ☐ Hospice ☐ Residential care ☐ Volunteer chore services ☐ Private pay in home services ☐ Alcohol and substance use services ☐ Mental health services ☐ Primary care provider ☐ Guardian/POA ☐ Other (Describe in comments below) **Check all that apply**
ADS - Additional Comments (enrolled in services)	. .

-End of ADS Vulnerable Adult Assessment Form-

APS - Vulnerable Adult Feedback Form *

APS Vulnerable Adult Feedback Form

APS - Action taken by APS*

- ☐ Assigned for investigation
- ☐ Screen out
- ☐ Already being investigated
- ☐ Protective services being provided

Check all that apply

APS - Name and contact information of APS investigator if case assigned

-End of APS Vulnerable Adult Feedback Form-

SPD - Vulnerable Adult Feedback Form *

SPD Vulnerable Adult Feedback Form

SPD - Did SPD conduct site visit?*

SPD - If yes, what were the findings?

- ☐ Physical Abuse
- ☐ Mental Abuse
- ☐ Sexual Abuse
- ☐ Neglect
- ☐ Self Neglect
- ☐ Abandonment
- ☐ Exploitation
- ☐ Financial Exploitation
- ☐ Other (Describe in comments below)

Check all that apply

SPD - Additional Comments (findings)

-End of SPD Vulnerable Adult Feedback Form-

ADS - Vulnerable Adult Outcome Form *

ADS Vulnerable Adult Outcome Form

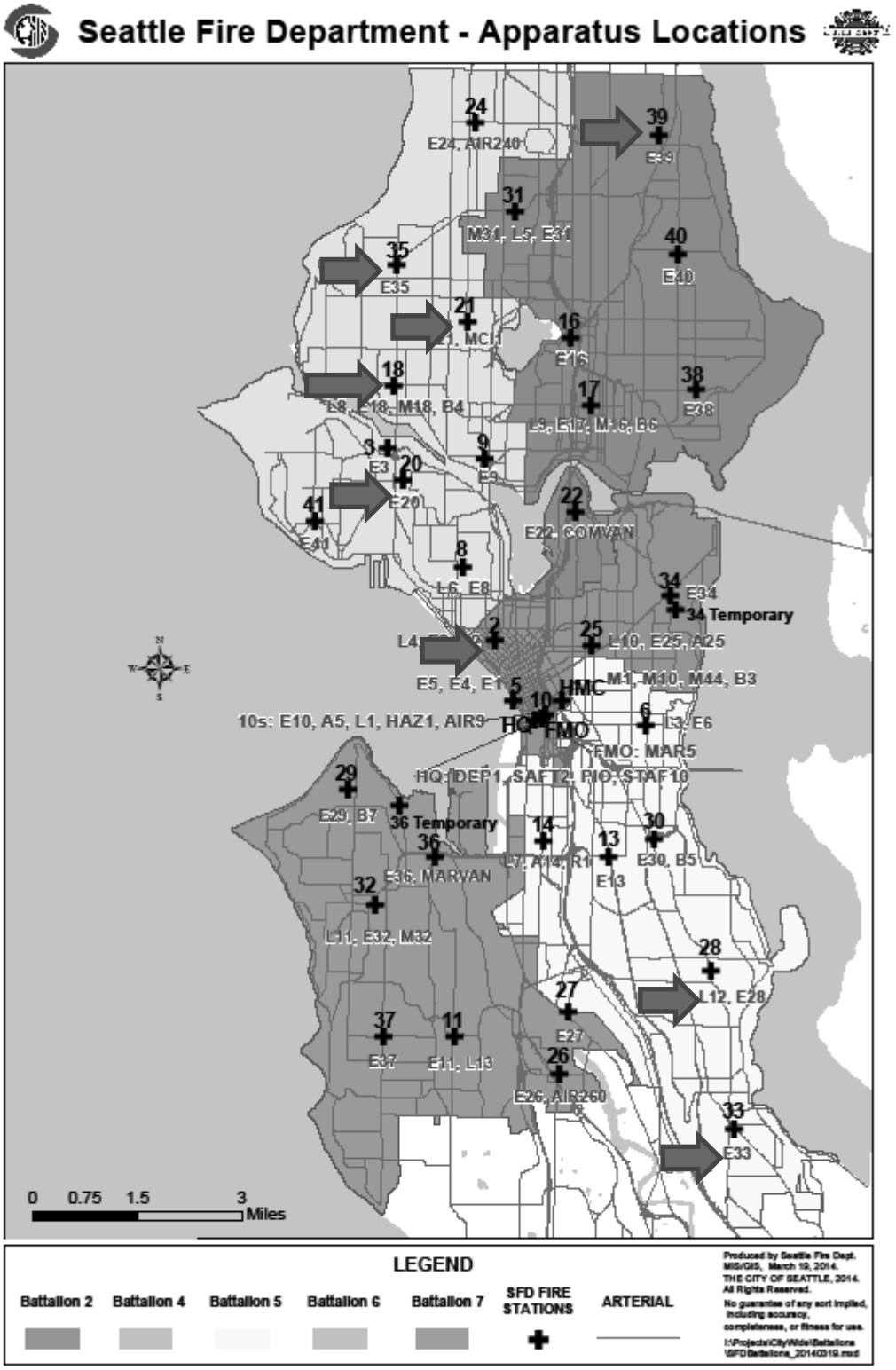
ADS - Patient Outcome*

- ○ Refused services
- ○ New services provided
- ○ Continued to receive services
- ○ Case closed
- ○ Unable to determine (too soon)
- ○ Other (Describe in comments below)

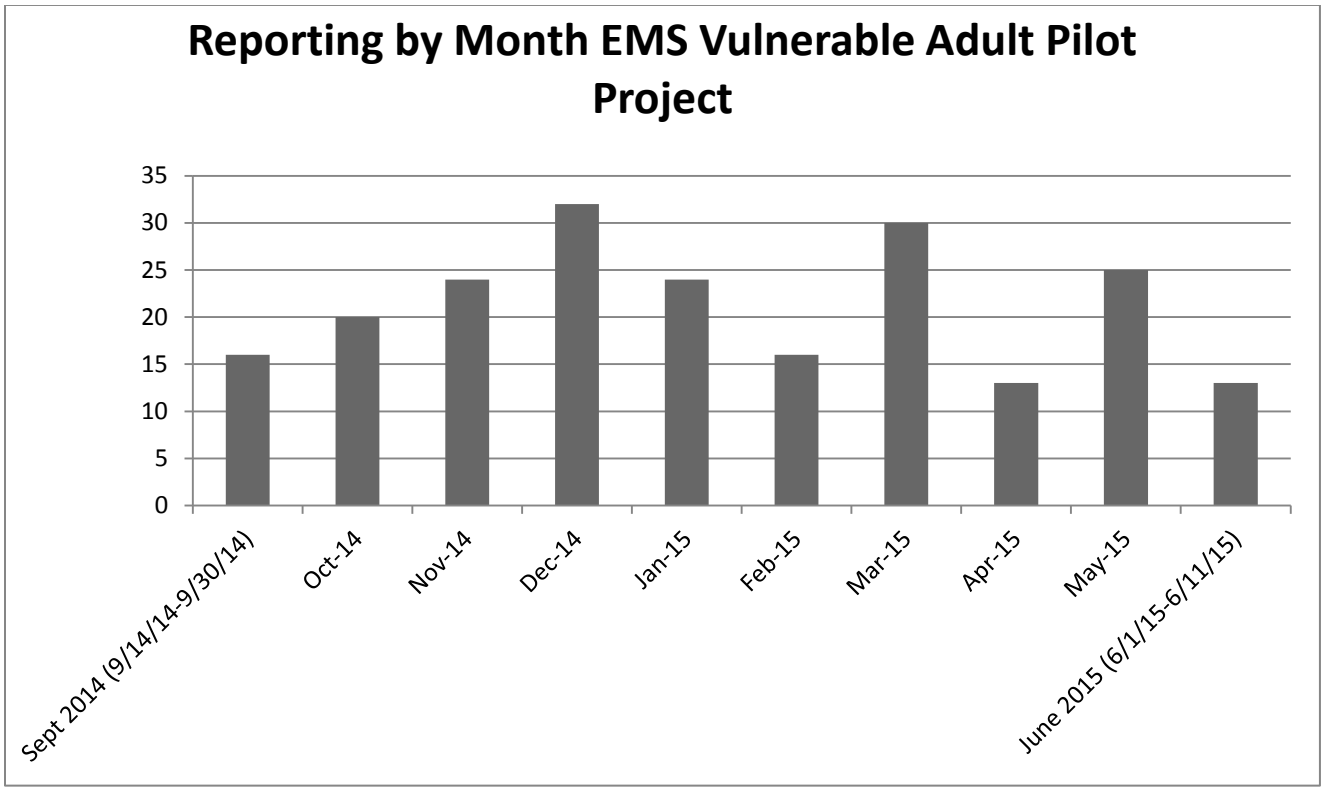
Comments (Patient Outcome)

ADS - If case closed, why?	○ No longer needed ○ Placement ○ Death ○ Other (Describe in comments below)
Comments (Case closed)	

VI. SFD Station Locations (Stations with arrows next to them represent stations that were interviewed for the pilot)



VII. Reporting Data By Month



VIII. Patient Condition, Home Environment, and Operations Actions (N=212)

Tables do not account for multiple conditions or actions in one patient report.

Patient Condition	N (%)
Frail/weak	137 (64.6%)
Poor hygiene/unbathed	119 (56.1%)
Unable to stand without assistance	103 (48.6%)
Soiled clothing	103 (48.6%)
Incontinent of urine/feces	86 (40.6%)
Frequent falls	61 (28.8%)
Malnourished	54 (25.5%)
Other	50 (23.6%)
Non-injury or illness	32 (15.1%)
Medication non-compliant	31 (14.6%)
Wounds in various stages of healing	29 (13.7%)
Old wounds	28 (13.2%)
Bruising	24 (11.3%)
Tenderness with palpation	22 (10.4%)
Edema	17 (8.0%)
Bed sores	13 (6.1%)
Evidence of coercion/verbal abuse	1 (0.5%)
Missing data	1 (0.5%)

Home Environment	N (%)
Unsanitary home	116 (54.7%)
Foul odor	114 (53.8%)
No food	109 (51.4%)
No assistance in home	105 (49.5%)
Unsanitary bed	85 (40.1%)
Fall hazard around home	77 (36.3%)
Human/animal feces around home	58 (27.4%)
Unsanitary bathroom	58 (27.4%)
Hoarding conditions	49 (23.1%)
Care provider unable to assist patient	47 (22.2%)
Fire hazards in home	44 (20.8%)
Other	44 (20.8%)
Rodent/insect infestation	32 (15.1%)
Neighbors assist with daily living	20 (9.4%)
Lack of appropriate medical equipment or supplies	16 (7.5%)
Visible drug paraphernalia	2 (0.9%)
Visible weapons	1 (0.5%)

Operation's Initial Actions	N (%)
Initial assessment	171 (80.7%)
Patient exam	170 (80.2%)
Vitals	154 (72.6%)
Transported to hospital	136 (64.2%)
Detailed history	97 (45.8%)
Communicated with friend/family/neighbor	87 (41.0%)
Lift assist patient to position of comfort	51 (24.1%)
Trauma exam	43 (20.3%)
Other	40 (18.9%)
Reduced/minimized fall hazards	16 (7.5%)
Reduced/minimized fire hazards	13 (6.1%)
Wound care	13 (6.1%)
Cleaned patient of feces and urine	9 (4.2%)
Assisted with bathroom duties	7 (3.3%)
Backboard/C-collar	3 (1.4%)
Prepared meal for patient	1 (0.5%)
Data missing	1 (0.5%)

IX. Expanded ADS Data

Tables are for patients who received ADS services during the pilot project