

MICHIGAN'S ADULT ABUSE AND NEGLECT PREVENTION
TRAINING PROGRAM

FINAL REPORT

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The statements contained in this report do not necessarily reflect the views or policies of the Centers for Medicare & Medicaid Services. The awardee assumes the responsibility for the accuracy and completeness of the information contained in this report.

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Executive Summary

In 2004, Michigan was selected by the Centers for Medicare & Medicaid Services (CMS) to participate in the Background Check Pilot Program and was awarded \$1,500,000 additional funding to deliver a comprehensive abuse prevention training program. The Michigan Workforce Background Check Program and the Adult Abuse & Neglect Prevention Training Program shared the overarching goal of reducing abuse and neglect of vulnerable adults in Michigan. These programs represent two specific, complementary strategies for abuse reduction, 1) a standardized, improved system of criminal background checks for all long-term care direct access staff, and 2) a direct access staff-training program on the identification, reporting and prevention of elder abuse. This report summarizes the implementation and research findings of the training project.

A main goal of the training project was to expand existing abuse and neglect prevention curricula to incorporate methods of staff empowerment, culture change and person-centered care. The curriculum specifically addresses modifiable aspects of staff work and life that might contribute to abuse or abuse prevention and in which they have some measure of control. For example, strategies for how to recognize and defuse stress and how to engage in active listening are taught. The training empowers staff with skills they can use to make a difference in their own lives as well as the lives of those for whom they provide care. The distinguishing feature of the training project is the added focus on prevention, specifically on how individual direct access staff can prevent abusive situations from occurring. The curriculum is delivered using principles of adult learning, which are highly interactive, case-based and reflective, enabling learners to build on their existing knowledge and fit learning into real life practices.

Organizations eligible for the training included skilled nursing facilities, long-term care hospitals, and intermediate care facilities for individuals with mental retardation, psychiatric hospitals, hospices, assisted living facilities (including adult foster care homes and homes for the aged), home health agencies, and others. Each setting is characterized by a varying array of work and personal demands, abuse reporting requirements, and training objectives.

The Michigan training program was successfully implemented due in large part to an important state-academic-community partnership that included Michigan State University/College of Human Medicine, Michigan Office of Services to the Aging, and BEAM, a wholly owned subsidiary of MPRO and a major culture change organization. BEAM was primarily responsible for developing and executing all training operations. Michigan State University led the evaluation component. The Michigan Office of Services to the Aging provided oversight and served as liaison to the Michigan Department of Community Health and Centers for Medicare & Medicaid Services. Two committees were established to support activities. The Curricula Committee, comprised of long-term care experts, wrote and revised the curricula. The Advisory Committee, with broad representation from provider associations, advocates, government agencies, and researchers, provided ongoing input on curricula and product development throughout the project period.

The primary products developed because of these partnerships include:

- Eight-hour *Adult Abuse & Neglect Prevention (AANP)* Training Program
- Four-hour *Preventing Adult Abuse and Neglect (PAAN)* Training Program

- Supervisor Training – *Supervisor Neglect and Adult Abuse Prevention (SNAAP)*
- One-hour *Facilitator Instruction Modules (FIMS)*
- A research report on Michigan’s formal system for reporting abuse. This report provides in-depth analysis of the reporting practices of six key state agencies responsible for abuse reporting. Key recommendations include establishing a unified definition of abuse, one central agency or portal to handle the routing of all adult abuse complaints, one toll-free phone number, and a centralized electronic database.

The scope of the training program was far-reaching. In total, 156 provider entities scheduled either eight- or four-hour training sessions, 459 trainings were held, and 7,804 direct access staff were trained. Eight-hour trainings were scheduled by 107 entities and 358 eight-hour trainings were held, representing 6,012 direct access staff trained across all settings from April 2006 through July 2007. Four-hour trainings were held from July 2007 through August 2007 with 49 entities scheduling trainings and 101 four-hour trainings held representing 1,792 direct access staff trained across all settings. By the end of the project period, both the eight- and four-hour trainings were taking place throughout the entire state of Michigan. Since 2005, BEAM has had a web page available as an additional tool for disseminating information about training opportunities, providing online registration, scheduling trainings, and other support services. Curriculum materials are now available online at www.mibeam.org and the site links to the OSA website at www.michigan.gov/miseniors, substantially extending access to a broad audience.

One of the strengths of the Adult Abuse & Neglect Prevention program is an emphasis on evaluation. From the onset, evaluation was considered a valuable component based on the following principles:

- Program changes should relate to performance, measured against program values and standards;
- Empirical evidence of program impact can determine sustainability; and
- Baseline data related to elder abuse could ultimately inform state policy and abuse reduction initiatives.

Multiple methods of evaluation were used. Levels of assessment were focused on the scope of participation, changes in learner knowledge and behavior, program implementation and performance, and product need, dissemination and availability. For the training itself, evaluation included continuing education evaluations, a trainer survey, a provider survey, and a formal Michigan State University evaluation all of which are described separately in the full report.

Continuing education credits were secured for nurses and administrators/licenseses of adult foster care homes. Findings from the continuing education credit evaluations indicate that participants in both the eight- and four-hour trainings overwhelmingly agreed on its applicability and relevance to their work. More than 98 percent responded that they agreed or strongly agreed that the trainer was effective.

A survey administered to the trainers found that they perceived the train-the-trainer sessions to have adequately prepared them to conduct trainings; materials were appropriate and valued; and communication between trainers and BEAM staff was adequate to meet trainer needs. Concerns were expressed regarding excessive preparation time and scheduling of training

sessions. However, responses also indicated that these concerns were alleviated over time as BEAM staff incorporated trainer feedback into operations.

A provider survey was conducted to identify factors contributing to provider decisions to hold a pilot training, such as training length, cost, whether or not it was mandatory, and other factors. Responses were received from providers who had registered staff for the training as well as those who did not. Although the provider response rate was low, findings provide initial insight into the value providers place on the program and their perceptions of training preferences and needs. This important information will help guide decisions related to program access and sustainability. Key findings indicate the following:

- Among respondents who had registered staff for the project trainings, the majority were either “very satisfied” or “satisfied” with the program (94 percent).
- More than half of respondents who registered staff indicated that they noticed a positive change in staff behavior or performance as a result of the training, particularly related to direct access staff/client relationships.
- 60 percent of those who had some staff trained stated that they did not have all staff trained due to the need to cover client care.
- 49 percent of those who did not register for the training indicated that they had obtained abuse training from another source.
- Among the entire sample of respondents, provider preferences regarding length of training are for one-hour, two-hours, four-hours and then eight-hours.
- Among the entire sample, provider preferences regarding method of training are for on-site sessions with an outside presenter, video presentations, and then facilitator-guided instructional materials.

The primary goal of the formal Michigan State University evaluation was to determine the impact of the training program on direct access staff knowledge and work behavior related to abuse. The research design involved two arms. The first arm consisted of a pre-post knowledge test administered to each direct access staff member that participated in the training. The specific aim of this arm was to assess change in direct access staff knowledge related to the training. The second arm involved a paid, longitudinal, automated phone survey conducted with a voluntary subset of the training program participants. The specific aim of this phone survey was to determine if 1) direct access staff knowledge gained during the training was sustained, and 2) the extent to which the training had an impact on actual work performance related to abuse.

Overall, the research findings provide empirical evidence to support the conclusion that the Adult Abuse & Neglect Prevention training program successfully met its goal to increase Direct Access Staff knowledge of abuse. Key findings of the pre-post knowledge test include the following:

- Significant improvements in knowledge occurred across all three curricular domains: identification, reporting, and prevention of abuse. A positive change was noted on more than half of the items, many of these by a substantial degree. For example, when asked if not placing a call light in a client’s reach when in a hurry is a form of abuse, the correct responses from pre- to post-test jumped from 5.2 percent to 91.8 percent.

- The vast majority of participants (92.7 percent) indicated that they felt they had learned new ways to handle stressful situations. This held true across all settings, positions, and length of time on the job.

Although the response rate to the longitudinal phone survey was relatively low, findings suggest that staff may be retaining the knowledge gained during the pilot project trainings and translating it into actual job performance and behavior.

- *Identifying Abuse:* 280 (92.11 percent) respondents indicated that the training improved their ability to recognize abuse and more than half (205/67.43 percent) indicated that they recognize abuse more often since the training.
- *Reporting Abuse:* Nearly half of direct access staff respondents (147/48.36 percent) stated that they actually report suspected abuse more often because of the training. The vast majority of respondents (all but three) indicated they knew to whom to report abuse.
- *Preventing Abuse:* 278 (91.45 percent) of direct access staff perceived that the training improved their ability to prevent potentially abusive situations from developing; 183 direct access staff (60.20 percent) indicated that they had actually used prevention techniques learned in the training, since the training; and of these, 95.63 percent indicated that the techniques helped prevent an abusive situation from occurring.

A secondary aim of both the pre-post test and the phone survey was to begin to establish baseline data on abuse prevalence based on what staff members have actually observed rather than relying only on suspected abuse that has been officially reported to reporting agencies. Questions were asked regarding the frequency and type of abuse witnessed or suspected over the course of their career as well as within the past month. Of interest was the degree to which these observations varied by employment longevity, work setting and/or position. Key findings are consistent with what is reported in abuse literature.

- Approximately 20-23 percent of respondents indicated they had witnessed abuse.
- Actual witnessing of abusive situations increased linearly with work longevity. A positive relationship exists between years working in health care and the likelihood that an individual has witnessed an abusive situation. The same was true for reporting abuse.
- Licensed and professional staff as well as managers were the most likely to have witnessed abuse compared to other positions. This may be due to added training as well as greater longevity in health care resulting in greater awareness of requirements and more opportunity to witness cases of abuse.
- Verbal or emotional abuse was the most common type of abuse witnessed. Sexual abuse was the least common. No noted differences were seen in the types of abuse when compared across work setting, longevity or job position.

In addition to the findings from the various methods of evaluation conducted, the project team determined a number of unexpected outcomes and *Lessons Learned* from developing and implementing the pilot training. These lessons are relevant to those who may wish to replicate the program and include the following:

- State-academic-community partnerships among leaders in Michigan's long-term care system were pivotal to the project's outcomes.

- BEAM's affiliation with the corporate division of its parent company, MPRO, was valuable. It allowed the project to access quality accounting, human resources, web design, graphics and editing on a fee-for-service basis and helped make the project cost-effective.
- Pre-ordering of printed materials should be approached with caution as it limits the ability to modify products and can add additional costs for reproduction when changes occur.
- Realistic goals need to be set with regard to the number of individuals to be trained and the amount of resources needed to effectively accomplish project goals. The Adult Abuse & Neglect Prevention program began with minimal staffing. It later increased in both size and skill-set to accommodate effectively the workload of the project.
- BEAM developed a system to address the complex scheduling of the trainings with providers and direct access staff.
- Multi-method marketing was important and included bulk United States mail and email to providers and organizations, word-of-mouth, presentations, newsletters and networking with the Advisory Committee.
- Trainers were provided a train-the-trainer course and once trained, became a critical extension of the staff with good communication that ensured the trainings were held in a quality manner.
- Required databases should be identified and developed in advance of start-up to adequately track operations and performance.
- Development of multiple products and delivery methods to ensure that all providers can use some or all components of the curricula is critical to sustainability.
- A website dedicated to the program became an invaluable communication and dissemination tool.

The project team also identified Best Practices including the following:

- Develop strong state-academic-community partnerships to guide and execute the project from its start to final products.
- Incorporate a strong evaluation component.
- Provide comprehensive curricula that are focused on prevention, person-centered care, and empowering direct access staff to take a direct, active role in abuse prevention.
- Utilize adult learning principles in all teaching delivery methods.
- Select Specialized Trainers using high standards, provide a quality train-the-trainer program and maintain close communication with all trainers throughout the project.
- Establish a partnership with an organization equipped to execute training operations.

The grant project operated successfully within the annual budgeted allowance over the three consecutive years of the project. In year three, Centers for Medicare & Medicaid Services approved scope of work changes and the reallocation of available funds. This was for the development of the Preventing Adult Abuse and Neglect, Supervisor Neglect and Adult Abuse Prevention, and Facilitator Instruction Modules training products, implementation of a provider survey, and a no-cost extension of the project into 2008 for the purpose of analysis and reporting. Access to the existing infrastructure and resources of BEAM's parent company proved to be very cost-effective and contributed to the program's success in terms of containing cost and being able to meet the program's full potential. Communication between multiple partners was challenging

but critical. Sharing a common understanding of budget forms and reporting processes was essential. Reporting and follow-up activities will continue into the 2008 fiscal year using a no-cost extension utilizing remaining funds. Detailed itemized costs for key aspects of the project are provided in the full report. A final cost report will be provided at the end of the grant project.

Plans to sustain Michigan's training program have been discussed by the project team and Curricula and Advisory Committees over several months. The merits of the hands-on training with small class sizes emphasizing person-centered care, prevention, communication, and how to report abuse are supported by the Michigan State University evaluation findings. All agree that there is value in sustaining the training program. Sustainability action plans include the following (*see Actions to Sustain section for updates*):

- Continue online posting of free training resources.
- Explore fee-for-service facilitated trainings.
- Establish a task force to explore ways in which to implement recommendations outlined in the reporting systems research report.
- Explore opportunities for external grant funding that builds upon existing state-academic-community relationships.
- Michigan State University to continue with more in-depth data analyses, share findings with BEAM and Michigan Office of Services to the Aging, and explore future research and joint projects.
- Present findings at national conferences regarding the state-academic-community partnership experiences of this project and how other states can utilize the "lessons-learned" to create and maximize collaborative relationships for a common goal.
- The Michigan Long-Term Care Advisory Commission's Workforce Workgroup and Michigan Office of Services to the Aging are actively exploring the potential for adding the Adult Abuse & Neglect Prevention training into the current nurse aides' certification curricula.
- Provide national access to the training tools through partnership with organizations and resources such as the National Center on Elder Abuse, Administration on Aging, and the National Institute for Health – Medline Plus.

In conclusion, the Michigan Adult Abuse & Neglect Prevention pilot training program has been highly successful in terms of meeting and exceeding its stated goals. In the course of the three-year project, the Adult Abuse & Neglect Prevention team has achieved multiple and lasting accomplishments including but not limited to the following:

- Established state-academic-community partnerships that are strong and upon which ongoing projects can be sustained and future projects launched.
- Established an infrastructure that has supported the training of nearly 8,000 Direct Access Staff and, with adequate resources, has the capacity to train thousands more for years to come.
- Recruited and trained over 76 highly specialized trainers of which more than half have expressed desire to continue training Direct Access Staff using the Adult Abuse & Neglect Prevention curricula.
- Developed a model curriculum that has empirical evidence to support its positive impact on Direct Access Staff knowledge related to identifying, reporting, and preventing abuse.

- Developed multiple methods of delivering this proven curriculum so that access is provided to the widest possible audience.
- Collected important data on Direct Access Staff observations of actual and suspected abuse. If such data collection was sustained, patterns and trends related to abuse prevalence and reporting could be identified that could inform state policies and resource expenditures directed at reducing abuse of vulnerable adults.
- Conducted extensive research on the formal abuse reporting systems in Michigan that provides an unprecedented understanding of the overall system and underscores the need for coordination. Discussions have already taken place on how to move ahead with implementing the recommendations outlined in this report.

All of these accomplishments now represent potential for making an indelible impact on abuse reduction in Michigan. Indeed, the lessons learned in Michigan can be applied most anywhere. By incorporating methods of staff empowerment, culture change and person-centered care, emphasizing prevention, and using adult learner methods of curriculum delivery, Direct Access Staff have been given practical tools to prevent abuse. The skills they have gained are applicable not only with the adults they care for in their professional lives, but also in relationships outside of the work environment. Ensuring that all direct access staff receive comparable training is a goal worth championing. Moreover, with an infrastructure already in place, trainers standing ready, and momentum established because of the Centers for Medicare & Medicaid Services funded pilot project, the window of opportunity is open. The Adult Abuse & Neglect Prevention team is committed to working with others to leverage this opportunity while it exists. Every aspect of the training program contributes to a culture change, from recognizing the importance of building relationships with organizational partners, clients and co-workers to raising awareness of individual strengths and needs, both workers and clients. Additional work is needed to continue to advance and measure such culture change at an organizational level.

Introduction: Background and Significance

In 2004, Michigan was selected by the Centers for Medicare & Medicaid Services (CMS) to participate in the Background Check Pilot Program and was awarded \$1,500,000 in additional grant funds to create and deliver a comprehensive training program for abuse prevention. The Michigan Workforce Background Check Program and the Adult Abuse & Neglect Prevention (AANP) Training Program shared the overarching goal of reducing abuse and neglect of vulnerable older adults in Michigan. The roots and levels of abuse are complex as are the potential solutions. Through the CMS grant, Michigan had the opportunity to develop two specific, complementary strategies for abuse reduction, 1) a standardized, improved system of criminal background checks for all Direct Access Staff (DAS) and 2) a DAS training program on the identification, reporting, and prevention of elder abuse. This report summarizes the implementation and findings of the AANP program.

Abuse and neglect of older adults is seriously underreported; and, therefore, justice for the victims and channeling of limited resources to the most effective programs is difficult to achieve. There are no official national or state statistics to provide definitive rates of elder abuse. This lack of data is due to many factors including problems with identifying unreported cases, informant reliability, varying definitions of abuse, and no uniform reporting systems. Nevertheless, despite serious challenges to collecting such data, empirical findings are mounting and indicate widespread prevalence of adult abuse and neglect which is expected to grow substantially as the population ages (National Center on Elder Abuse (NCEA), 2000; NCEA, 2005). The National Research Panel to Review Risk and Prevalence of Elder Abuse and Neglect estimates that between one and two million persons over age 65 have been abused by individuals responsible for their care (The National Research Panel to Review Risk and Prevalence of Elder Abuse and Neglect, 2003). Depending on sampling and survey methods, prevalence rates of elder abuse currently vary between 2 and 10 percent (Lachs and Pillemer, October 2004). Moreover, it is believed that for every reported case, five others go unreported; and, therefore, the magnitude of the problem is far greater than actual reports indicate (NCEA, 1998; NCEA, May 23, 2005). Estimated prevalence rates are often referred to as “the tip of the iceberg.”

In Michigan, elder abuse is recognized as a major public health issue. Governor Jennifer Granholm appointed the Governor’s Task Force on Elder Abuse in 2005, which was charged with “examining issues relating to elder abuse and to assist the state in identifying new resources, best practices, and necessary changes in law and policies to assist in the prevention of elder abuse.” The Task Force’s report, released in 2006, mirrors the findings of current research and affirms a state commitment to systems changes that will establish Michigan as a leader in the effort to combat elder abuse (Michigan Office of Services to the Aging, August 23, 2006). Simultaneous to the work of the Task Force, the two CMS funded demonstration projects, the Michigan Workforce Background Check Program and the Michigan AANP, were implemented and provide substantive, concrete examples of this commitment.

The AANP: A Collaborative Model and Underlying Principles

Several distinguishing features of the Michigan AANP training program are worth noting at the outset. The first is that it represents an important state-academic-community partnership. From its beginning, multiple organizations have been involved in every aspect of the planning,

development, execution and evaluation (Appendix A). Successful long-term working relationships and structures have now been established upon which future initiatives can be built. The core team included representatives from each key area of partnership: administration, operations and evaluation. It was comprised of individuals from Michigan State University (MSU)/College of Human Medicine, Michigan Office of Services to the Aging (OSA), and BEAM, a wholly owned subsidiary of MPRO and a major culture change organization. BEAM was primarily responsible for developing and executing all training operations. MSU led the evaluation component. OSA provided oversight and served as liaison to the Michigan Department of Community Health and CMS. Together, the core team maintained close communication on all aspects of the program and shared decision-making. Two committees were established. The Curriculum Committee is described in detail herein. The Curricula Coordinator was involved in all key decisions. The Advisory Committee, with broad representation from provider associations, advocates, government agencies, and researchers, met near monthly throughout the duration of the project. Their input was considered invaluable and shaped the AANP progress and end products.

The Michigan AANP undertook the development of multiple products. In addition to the initial eight-hour training program, the team developed other on-site options including a four-hour training as well as curriculum specifically targeted to supervisors; online educational resources based on the AANP curricula; and research on Michigan's formal systems for reporting abuse. Further, the team made a commitment to incorporate an evaluation component into nearly every product for several important reasons. These included, 1) program changes should relate to performance, measured against program values and standards, 2) evidence of program impact can determine sustainability, and 3) the AANP provided an opportunity to collect baseline data related to elder abuse that could ultimately inform state policy and abuse reduction initiatives. Successfully meeting such ambitious goals is a direct testimony to the commitment of the core team and advisory committee to the collaborative model.

Finally, the AANP team recognized that there are multiple reasons for why adult abuse occurs, many of which cannot adequately or effectively be addressed by training DAS. Therefore, for example, there are societal and economic conditions that lead to abuse. Similarly, long-term care funding mechanisms that affect staffing patterns and limited resources for home care may contribute to abusive environments. DAS have little control over these factors. The team therefore made an intentional decision to design training curricula that addressed modifiable aspects of DAS work and life related to abuse and more likely within their control. For example, central to the trainings was information on how to recognize and defuse stress or how to engage in active listening. The training centered on empowering DAS with skills that they themselves can use to make a difference in their own lives and the lives of those for whom they provide care.

The curricula are rooted in the evidenced-based literature on staff empowerment, culture change and person-centered care. Historically, adult abuse training programs have typically focused on identification and reporting of abuse, both important topics. The distinguishing feature of the AANP is the added focus on prevention, specifically on how individual DAS can prevent abusive situations from occurring. Further, it uses principles of adult-learning, e.g. highly interactive, case-based and reflective so that learners can build on their existing knowledge and fit learning into real life practice.

Key Elements of Curricula Including Strengths and Unique and Creative Aspects

The Development of the AANP Training Curricula: Strength in Diverse Partnerships

As stated, the AANP represents a strong state-academic-community partnership and this is reflected in the diversity of the Curricula Development Team. The Curricula Team was established in February 2005 and included representatives from Citizens for Better Care, PHI (formerly Paraprofessional Health Institute), the Michigan Home Health Association and Michigan Hospice and Palliative Care Organization, Michigan Department of Human Services Office of Adult Services, Wayne State University Department of Developmental Disabilities, BEAM, and other culture change consultants. With a shared commitment to ending abuse and neglect in long-term care settings, the members of the team brought individual expertise and perspective to the development of the training, which resulted in a training curriculum widely applicable across many levels of DAS and long-term care settings from home to hospice.

The curricula team met monthly, at a minimum, during the development of the original eight-hour training. At the project's inception, a model upon which to build the AANP program was selected, based on its merits and use at the time: "Competence with Compassion: an abuse prevention training program for long-term care staff," (The Center for Advocacy for the Rights and Interests of the Elderly [CARIE], 1999). This curriculum was chosen because it focuses on abuse prevention through employee empowerment and utilizes adult-learning strategies. The CARIE model was designed in 1999 for staff educators and trainers to increase staff awareness of abuse, neglect, and potential abuse in long-term care settings as well as appropriate stress and conflict intervention strategies. The Curricula Committee updated the CARIE model to include curricula that reflects the AANP commitment to organizational culture change and the principles of person-centered care.

One of the greatest challenges in developing the AANP trainings was to accommodate a wide range of providers and caregivers in multiple long-term care settings. Direct access staff (DAS) are defined as anyone coming in contact with adults requiring long-term care services. This includes nurses, nurse aides, physicians, therapists, housekeepers, maintenance staff, janitorial, dietary, Home Help workers, and all levels of home health care staff. Age, levels of education, and life and work experiences are highly varied. Likewise, organizations eligible for the training included skilled nursing facilities, long-term care hospitals, intermediate care facilities for individuals with mental retardation, psychiatric hospitals, hospices, assisted living facilities (including adult foster care homes and homes for the aged), home health agencies, and others. The settings themselves represent different work and personal demands, abuse reporting requirements, and training objectives. Therefore, it was important to develop a training program to educate DAS from all disciplines, across a spectrum of long-term care services. The diversity of the Curricula Committee resulted in successfully achieving this goal.

The Eight-Hour AANP Training Program

The Curricula Committee's first product was the AANP eight-hour training (Appendix B). The curricula content covered three broad domains: Identification, Reporting and Prevention of elder abuse. The format was designed to engage participants using adult-learner principles of teaching, described in detail in the following section. The project team felt strongly that an all-

day session was necessary to achieve maximum benefit and long-term retention of the course materials. Especially since the subject matter is sensitive, it takes time to develop an environment in which participants feel safe enough to share their experiences related to abuse. Further, teaching such skills as “active listening” is not as effective through lecture as through role-play. Use of such interactive and reflective teaching methods contributes to the necessity of a time-intensive learning experience.

A typical session begins with a review of the course objectives and completion of the evaluation pre-test followed by a group warm-up designed to create a comfortable and engaging learning environment. This icebreaker involves participants lining up according to the number of years they have worked in health care and then discussing their different perspectives based on position and tenure. Person-centered care is then introduced through lecture and large group discussions of brief vignettes that illustrate the difference between medical and person-centered models of care. Mandatory reporting requirements are then reviewed. Quick reference handouts are provided that detail who needs to report suspected abuse, when, and to whom. Identifying abuse is taught in both a large group with DAS categorizing types of abusive situations and in a small group activity during which DAS draw pictures of abuse and talk about what an abused person might feel and say. Teaching methods are varied, sessions are kept relatively short, and breaks are offered regularly in order to sustain interest. After lunch, the topic of stress is introduced; particularly those events, situations or activities in daily life that can trigger a reaction to stress that may eventually lead to abuse. Triggers are classified as Life Influences, Job Challenges and Client Behaviors. The physical, social, emotional or job-performance signs of stress are reviewed such as sweaty palms, difficulty sleeping, and impatience. Through large and small group exercises, power point presentations, and a question and answer period, DAS are then asked to identify stress triggers and signs in their own lives. The final segment focuses on strategies to counteract these triggers. Active listening is emphasized as a key way in which to de-escalate abusive situations and is practiced through role play. The day concludes with the evaluation post-test and a “Learning Circle” which is an interactive session that gives DAS the opportunity to reflect on the day and what they have learned, inviting them to identify one concrete way in which they will apply their new knowledge.

Specific Learning Objectives: A Focus on Prevention

Traditional adult abuse training programs have focused on identification and reporting of abuse, both important topics. The distinguishing feature of the AANP is the added focus on prevention, specifically on how individual DAS can prevent abusive situations from occurring. Therefore, the specific learning objectives include the following:

- **Ensure everyone knows the designated avenues for reporting suspected abuse, neglect, and/or misappropriation of property.** All health care workers are mandatory reporters and therefore obligated by law to report suspected abuse. The AANP curriculum addresses responsibilities of mandatory reporting. DAS were advised to follow their organization’s policy for reporting suspected abuse and provided with reference material to make a report of suspected abuse to the appropriate state agency. Since participants were from a variety of health care settings, each with different reporting requirements, handouts included a color coded information sheet and corresponding card outlining the correct state agency with whom to file an abuse allegation.

- **Identify and define potential situations of abuse, neglect, and/or misappropriation of property.** Handouts were provided on the official definitions of abuse and neglect. Rather than being able to recite a legal definition, the main goal of the AANP was for the DAS to have a practical understanding of what constitutes abuse and neglect. Examples of abuse or potentially abusive situations were explored through group discussion and experiential activity. A key message was that the DAS responsibility, in most cases, is not to investigate allegations of abuse. It is, rather, to be alert to the signs and symptoms of suspected abuse and bring them to the appropriate person's attention.
- **Recognize situations and triggers that could lead to abuse.** A basic premise of the AANP training is that each caregiver is at risk to be an abuser if proper attention is not given to appropriate stress management practices. Identifying abuse triggers and developing skills to diffuse stressful situations is pivotal to empowering individuals. The AANP training outlined three categories of stress triggers, 1) Life influences including common stressors and learned coping behaviors, 2) Job challenges including limited resources, relationships with co-workers and supervisors, and client-family expectations, and 3) Challenging client behavior.
- **Implement practical tools that aid in the prevention of potential abuse.** Trigger signals are warning signs and if not properly addressed, could lead to abuse or neglect. They might include sweaty palms, difficulty sleeping, and a quick temper. During a time of self-reflection, participants discover individual stress triggers and signals. Practical tools for defusing potentially abusive situations are then emphasized. Constructive de-escalation with peers as well as clients with cognitive impairments is taught. Relationship building is considered a key preventative strategy so considerable time is devoted to such skills as active listening. An important benefit of the AANP program is how translatable these discussions and skills are to life outside of work. It was not uncommon for DAS to state that they would use their new knowledge at home.
- **Implement practical tools when abuse actually happens.** The AANP training includes a discussion on how to respond when abuse does occur. Participants learn the acronyms I CARE and WE CARE

I I know my triggers; It's About Knowing Myself
 C Consider the other person – It's About Relationships
 A Activate skills – It's About Recognizing Signs in Others
 R Report – It's About Courage – Doing the Right Thing
 E Embrace change – It's About Person-Centered Care

W Welcome everyone's input – It's About Respecting and Valuing Each Individual
 E Establish support – It's About Standing with Those Doing the Right Thing
 C Consistent assignments – It's About Building Client and Staff Relationships
 A Activate teamwork – It's About Building Relationships Among Workers
 R Report – It's About Taking Responsibility and Ownership
 E Empower Others to Act – It's About Listening and Daring to Try

These objectives acknowledge the real challenges that DAS face in their own lives and on the job. By providing a safe and candid environment in which they can share personal examples, questions, and concerns, awareness is raised and tools for change can be taught.

Specialized Trainers

A comprehensive curriculum holds no value unless it is taught by competent trainers. While developing the project, the AANP team and Curricula Committee felt strongly that an organizational goal must be to develop a cadre of qualified specialized trainers committed to the process of training DAS statewide, in multiple settings, and sensitive to different training needs. To achieve this goal, a train-the-trainer program for “Specialized Trainers” was developed (Appendix C). This program covered all aspects of the AANP DAS curricula in addition to such topics as adult learning theory, dealing with difficult participants, understanding the range of provider types, and relevant Michigan law.

Skilled trainers who met AANP trainer qualifications were invited to submit an application and attend one of seven train-the-trainer sessions held across the state. Primary requirements included an ability to facilitate learning with a diverse audience, openness to non-traditional teaching methods, and a willingness to adhere to the AANP protocols. A goal was to ensure that every DAS receives the highest quality product through presenting all of the content as designed. The uniformity of training delivery was a necessary component for evaluation purposes as well. During the train-the-trainer sessions, potential trainers had the opportunity to “teach back” a section of the AANP curricula. Peer evaluations offered immediate feedback to the trainer on his/her effectiveness. Additionally, lead trainers evaluated each potential trainer’s skill in engaging the participants, leading a discussion, and teaching according to the written protocols. Based on this process, several candidates were not invited to become an AANP Specialized Trainer.

Ultimately, 76 Specialized Trainers were hired and trained and 55 of these Trainers stayed active in AANP throughout the duration of the project. The majority of them remain committed to the program should it be sustained long-term. During the pilot program, the Specialized Trainers fanned out across Michigan successfully training thousands of DAS. Drawing on their on-site experiences, the Curricula Team used them as advisors. They provided valuable feedback on the effectiveness of the program and its applicability across different settings. Their suggestions for improvement became “trainer tips,” which were shared with all of the Specialized Trainers and were subsequently incorporated into the revised training materials.

Continued Development for Increased Reach and Sustainability

One of the strengths of the Michigan AANP project is the curricula team’s dedication to continued growth, learning through listening to experts in the field, Specialized Trainers, DAS and others, and modifying the training as needed. A direct result of this has been the development of additional products including the following:

- PAAN (Preventing Adult Abuse and Neglect): This four-hour version of the AANP is geared toward organizations with limited financial or staff resources (Appendix D). The decision was made to develop a shorter version of the eight-hour AANP training for

several reasons. Although training evaluations for the eight-hour training were overwhelmingly positive, there was also feedback to indicate that this training length presented difficulties for some participants, providers, and trainers. For example, providers with small staff and limited resources indicated that it was financially prohibitive, even though the training was free. They had to pay the wages of those attending the training as well as of the employees needed to cover client care needs. Therefore, adequate client care coverage was a concern. This could potentially affect certain care settings in particular, such as small assisted living facilities. Some trainers also indicated that the extended training presented challenges such as maintaining participant attention. In order to address these concerns and extend the AANP capacity to meet the training needs of a wide variety of DAS in multiple long-term care settings, this four-hour training was developed, piloted, and ultimately delivered to nearly 1,800 DAS.

- SNAAP (Supervisor Neglect and Adult Abuse Prevention) is an eight-hour training geared toward supervisors and the role that they and the organization play in abuse prevention (Appendix E). Specifically, it:
 - Encourages supervisors to take responsibility for their own behavior.
 - Provides practical strategies for abuse prevention through role-plays, handouts and other tools.
 - Provides direct feedback for supervisors from DAS if the SNAAP is a follow-up to an eight-hour or four-hour DAS training.
- FIMS (Facilitator Instruction Modules) are:
 - Written specifically for staff educators; they can be downloaded as a resource for educating DAS on various elements of abuse and abuse prevention (Appendix F).
 - Designed so that selected aspects of abuse identification, reporting, and prevention can be focused on more fully. Although ideal if taught consecutively, each module can be used individually.
 - Introduces adult learning principles to an otherwise traditional in-service format
 - Has an online design that is easily accessible.

Each of these alternative options honors the learning objectives and underlying principles and values of the initial eight-hour training. However, they each bring a unique strength to the whole AANP portfolio. A timeline for curricula development is provided as an appendix (Appendix G). The FIMS are available in full for supervisors and educators to download and use in any long-term care setting (www.mibeam.org). In addition, a summary of the four- and eight-hour trainings, the Supervisor Training, and contact information for consultations or to schedule on-site trainings are posted on the BEAM website and linked to the OSA website (www.michigan.gov/miseniors). Continuing education credits are being explored for the FIMS¹.

The Foundational Principles

Many adult abuse-training programs have been developed in the past. As stated earlier, there are several principles that frame and distinguish the Michigan AANP training program:

- Person-centered care as the foundational philosophy

¹ As of the date of this document, CEs for all FIMs are approved for nurses.

- Theme: It's About Care – a focus on care, rather than treatment, prevents abuse
- Emphasis on relationship development as a priority in abuse prevention
- Identification of caregiver stress as a factor contributing to abuse and neglect
- Self-awareness and individual empowerment as applicable prevention strategies
- Adult learner-centered training incorporating adult learning principles

Following is a more detailed description of these key principles.

Person-Centered Care

The AANP training is based on principles of person-centered care. Many health care organizations are policy-centered with a high priority placed on paperwork and adherence to rules. Others are more treatment-centered, meeting the medical needs of the clients. While adhering to rules and regulations and meeting clients' medical needs are important, if these are the central driving force behind all decisions, the total needs of individuals are not met. Additionally, it does not create an environment in which either clients or staff can grow and thrive. The Michigan AANP program purports that abuse and neglect are less likely to occur by individuals who are actively practicing person-centered care and in organizations promoting person-centered care. The primary goals of person-centered care include:

- To see the person as a unique individual
- To respect individual skills and abilities
- To support the person to be successful and maintain independence
- To help the person meet needs for attachment, inclusion, occupation, and comfort
- To support the person as a member of a community

In the AANP training, DAS are guided to an understanding of person-centered care and how it can prevent abuse and neglect. For example, in a simple comparison exercise, participants evaluate clients using the lens of the traditional, medical model, e.g., frail, dependent, according to a diagnosis, or as a task to be completed. The person-centered care approach, in contrast, views the client as a unique, wise individual, with strengths and abilities, including the ability to make decisions and contribute to life. Although the two approaches may not be mutually exclusive, this exercise allows participants to distinguish the difference and make a conscious choice about which framework might be preferable. From the discussion generally comes a realization of the extent to which organizations and individuals can frame care and how intentionally adopting a person-centered care philosophy can positively benefit clients.

Theme: It's About Care

The tagline for the Michigan AANP training is "Abuse Prevention: It's About Care." Abuse prevention begins with a commitment to person-centered care by both individuals and organizations. At the individual level, abuse can occur when an individual becomes overstressed by life circumstances, working conditions, and/or challenging client behaviors.

Based on this premise, an effective approach to prevention is to develop person- and relationship-centered individuals and agencies that foster conditions that promote care for self, for co-workers, and for the clients. Quality relationships, where trust has been established, promotes a quick response time to cases of suspected abuse because the involved DAS are more

apt to know the individual needs and personalities of the clients and therefore are better able to ascertain even subtle changes in mood and behavior.

Personal Stress and Empowerment

Although multiple causes can be attributed to elder abuse, one known cause that can be addressed is caregiver stress. A significant portion of the AANP training focuses on understanding stressors that are personally faced, identifying triggers, and learning healthy strategies to cope with or defuse stress as a means of reducing abuse and neglect. Self-awareness is essential to being a competent, effective caregiver. The AANP training empowers DAS with practical techniques for stress management that can reduce the likelihood of being an abuser as well as suggestions for assisting co-workers who are encountering abuse triggers.

Adult Learning Centered Training

The American educator Malcolm Knowles (Donaldson and Scannell, 1986; The Centre for Development and Population Activities, 1995) developed the idea of “andragogy” or the “the art or science of helping adults to learn” into a theory of adult education, which holds that adult learning that can be immediately applied occurs best when it:

- Is self-directed
- Fills an immediate need
- Is participatory
- Is experiential
- Is reflective
- Provides feedback
- Shows respect for the learner
- Provides a safe atmosphere and comfortable environment

Many of these principles are demonstrated in what is referred to as the Adult Learning Cycle. The cycle begins with an experience such as a game or role-play that demonstrates a real-life scenario. The next step involves reflecting on the experience, generalizing about what happened, and then applying the new learning to other situations to see if it holds true outside the learning environment. Table 1 on the following page illustrates this cycle and the role of the trainer.

There is considerable research to support the idea that teaching is least effective through lecture and reading and most effective through techniques such as discussion groups and “practice by doing.” Moreover, adult learning strategies need to take into consideration variations among adults, e.g., different adult learning styles. For example, visual learners learn best through graphic illustrations and demonstrations. Auditory learners may retain more information when it is provided through lecture and discussions. Tactile/Kinesthetic learners learn best when material is presented through written assignments and participation in group activities. A major strength of the AANP is that it incorporates all of these different teaching methods to effectively reach a wide range of adult learning styles.

**Table 1
Adult learning cycle**

Phase	Activities	Trainer's role	Questions to ask
1. Direct experience	<ul style="list-style-type: none"> • Group tasks • Case studies • Role plays • Skills practice • Games 	<ul style="list-style-type: none"> • Structure the experience • Present objectives, instructions, and time frame 	<ul style="list-style-type: none"> • What is the purpose of this activity? • What else do you need to know to carry out this activity? • How much more time do you need?
2. Reflecting on the experience	<ul style="list-style-type: none"> • Small group discussion • Reporting from small groups • Participant presentations • Large group discussions 	<ul style="list-style-type: none"> • Ask questions to keep the learner focused on key points and sharing ideas and reactions with others 	<ul style="list-style-type: none"> • What happened? • How did you feel when...? • What did you notice about...? • How do others feel about...? • Why do you agree/disagree?
3. Generalizing about the experience	<ul style="list-style-type: none"> • Large group discussion • Lectures • Demonstration • Reading 	<ul style="list-style-type: none"> • Ask questions and provide key information to guide the learner to new insights based on experience and discussion 	<ul style="list-style-type: none"> • What did you learn from this? • How does all that we are discussing fit together? • What are some major themes we have seen?
4. Application	<ul style="list-style-type: none"> • Discussion • Action planning • Skills practice • Field visits 	<ul style="list-style-type: none"> • Coach the learner by providing feedback, advice, and encouragement 	<ul style="list-style-type: none"> • How can you apply this information in your own work situation? • What do you think will be most difficult when you use this information? • If you were to use this information in your own situation, how would you do it differently? • How can you overcome barriers to applying what you have learned?

Scope of the AANP Training Programs

The primary training methods to date include the choice between the original eight-hour AANP training and the four-hour PAAN trainings. Detailed statistics on all of the trainings that were scheduled, rescheduled, cancelled and held throughout the eighteen-month project period were collected and included the various participating provider types. A standard list of provider types was developed and included the following:

- | | |
|---------------------------------|---|
| • Adult Foster Care (AFC) | • Hospice |
| • Assisted Living (AL) | • Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) |
| • Developmentally Disabled (DD) | • Long-Term Care (LTC) Hospital |
| • Homes for the Aged (HFA) | • Mental Health (MH) |
| • Home Health Agencies (HHA) | • Nursing Home (NH) |
| • Home Help (HH) | |

- Psychiatric Facility (Psych)

In total, 156 different providers scheduled trainings, 459 trainings were held, and 7,804 DAS were trained across all positions and settings (Table 2). These statistics clearly illustrate the vast scope of the AANP project in terms of number of trainings held and DAS trained. By the end of the project period, both the eight- and four-hour trainings were taking place throughout the entire state of Michigan.

Table 2
All AANP trainings, including both eight- and four-hour trainings

	AL*	DD*	Home health	Home help	Hospice*	LTC hospital	ICF/ MR	MH*	NH	Psych	Other	Total
Number of participants per setting	740	236	146	812	14	458	297	175	4,392	39	495	7,804
Percent of total participants	9.48	3.02	1.87	10.4	.18	5.87	3.81	2.24	56.28	.50	6.34	100
Number of trainings per setting	41	13	9	56	2	26	11	12	257	2	30	459
Percent of total number of trainings	8.93	2.83	1.96	12.2	.44	5.66	2.40	2.61	55.99	.44	6.54	100

* The category of Assisted Living (AL) includes Adult Foster Care homes and Homes for the Aged. The hospice category includes providers of hospice only services whereas many of the Home Care providers include hospice services. The Developmental Disability (DD) and the Mental Health (MH) categories include providers whose DAS serve vulnerable adults in various long-term care settings.

The category of “Other” includes the Alzheimer’s Association, Michigan Career and Technical Institute, the American Red Cross, Michigan Office of Services to the Aging, Senior Centers, and the Gratiot County Commission on Aging.

Table 3 illustrates the number and percentage of participants and trainings across settings in just the eight-hour trainings: 107 different providers scheduled eight-hour trainings and 358 eight-hour trainings were held, representing 6,012 DAS trained across all settings from April 2006 through July 2007.

Table 3
Eight-hour AANP trainings

	AL	DD	Home health	Home help	Hospice	LTC hospital	ICF/ MR	Mental health	Nursing home	Psych	Other	Total
Number of participants per setting	385	217	122	694	14	388	67	139	3,643	0	343	6,012
Percent of total participants	6.40	3.61	2.03	11.54	.23	6.45	1.11	2.31	60.60	0.00	5.71	100.00
Number of trainings per setting	22	11	8	49	2	21	3	9	213	0	20	358
Percent of total number of trainings	6.15	3.07	2.23	13.69	.56	5.87	.84	2.51	59.50	0.00	5.59	100.00

Table 4 illustrates the number and percentage of participants and trainings across settings in just the four-hour trainings that were held from July 2007 through August 2007: 49 different providers scheduled four-hour trainings and 101 four-hour trainings were held, representing 1,792 DAS trained across all settings. A complete list of training locations and number of DAS trained throughout the state is available upon request.

Table 4
Four-hour PAAN trainings

	AL	DD	Home health	Home help	Hospice	LTC hospital	ICF/ MR	Mental health	Nursing home	Psych	Other	Total
Number of participants per setting	355	19	24	118	0	70	230	36	749	39	152	1,792
Percent of total participants	19.81	1.06	1.34	6.58	0.00	3.91	12.83	2.01	41.80	2.18	8.48	100.0
Number of trainings per setting	19	2	1	7	0	5	8	3	44	2	10	101
Percent of total number of trainings	18.81	1.98	.99	6.93	0.00	4.95	7.92	2.97	43.56	1.98	9.90	100.0

The eight-hour AANP training sessions comprised the bulk of the trainings held during the grant period, due in part to the longer time period for the eight-hour training, which was over sixteen months whereas the four-hour trainings were available for the final two months of the project. During these two months, the demand for trainings was not only high, but increasing. Based on the number of inquiries and requests for trainings still being received, there is reason to believe that had the project period been extended, training demand would have continued unabated.

Key Elements of AANP Operations

Achieving such a wide scope, training nearly 8,000 DAS within a three-year pilot project period, required that an organizational infrastructure be developed with the capacity to implement and manage all aspects of a successful operation. The key aspects included the following:

- Oversight of daily operations and staffing.
- Management of resource investments including staff, time, money, materials, and technology.
- Management of organizational activities including recruiting and training trainers, scheduling all trainings, assembling and delivering all training materials, product development and assessments.
- Oversight of the finances including budgets and accounts receivable and payable.
- Ensuring that targeted audiences are reached including learners, trainers, and community partners.
- Ensuring accountability and performance measures are met including completing project reports, responding to requests from project officer, and data collection.

- Monitoring outcomes and impact – working closely with data collection, management and the MSU evaluation team to assess actual impact of the AANP training program on DAS learning, skills, behavior and on systems and environments.
- Product development by working closely with the Curricula Coordinator and Curricula Committee to develop the best curricula and delivery system as possible.
- Overseeing development, execution and upkeep of all marketing efforts including brochures, conference presentations, the website, news releases, and interactions with partners and community.

Effective operational oversight conducted by BEAM was made possible with the assistance of the corporate division of its parent company, MPRO. A solid AANP infrastructure has now been established and can be used to sustain the AANP as well as to launch new projects.

Evaluation

The AANP pilot project involved multiple products and methods of evaluation. Levels of assessment were focused on the scope of participation, changes in learner knowledge and behavior, program implementation and performance, and product need, dissemination and availability. For the training itself, evaluation included continuing education evaluations, a trainer survey, a provider survey, and the formal MSU evaluation all of which will be described separately.

Continuing Education (CE) Evaluation

The core AANP team made a commitment early on to provide CE credit to as many provider disciplines as possible as an added incentive to participate. Through collaboration with MPRO (formerly the Michigan Peer Review Organization), the parent company of BEAM, and the AANP Advisory Committee members, application was successfully made for two disciplines: Nurses and Administrators/Licensees of Adult Foster Care homes. As a requirement of the nursing CE process, an evaluation was created and distributed to each training participant (Appendix H). A separate evaluation was designed for each approved product (AANP, PAAN, SNAAP and FIMS). All AANP participants completed the evaluation. Individuals attending trainings from other disciplines were strongly encouraged to apply on their own for CE credit. BEAM staff facilitated this application process. Consequently, individuals sought and were approved for credit from numerous disciplines including a nursing home administrator, social worker, registered dietitian, emergency medical technician, and activities personnel.

CE evaluation responses indicate that participants in both the eight- and four-hour trainings overwhelmingly agreed on the applicability and relevance of the AANP training to their work. More than 98 percent responded that they “agreed” or “strongly agreed” that they had reached the AANP training goals and objectives and more than 98 percent “agreed” or “strongly agreed” that the trainer was effective.

Trainer Survey

Trainer feedback was sought throughout the project during training sessions, trainer chats, and ongoing communications. As the project drew to a close, a formal evaluation was conducted for the purpose of collecting qualitative data on their perceptions of the overall program quality

and logistical aspects of its implementation (Appendix I). Trainers were emailed a set of open-ended questions and asked to submit responses anonymously by email, fax or mail. Feedback was specifically requested on the initial train-the-trainer training, scheduling, communication, materials, distribution and response time of BEAM staff. They were also asked to comment on both the content and delivery of the eight-hour and four-hour trainings and compare the two. The Curricula Committee reviewed all responses, shared aggregate findings with the Advisory Committee, and incorporated many of their ideas into program changes and plans for sustainability.

Responses were overwhelming positive regarding all aspects of the AANP training program. Trainers felt the train-the-trainer sessions adequately prepared them to conduct AANP trainings, materials were appropriate, and communication between BEAM and trainers was sufficient and helpful. The following quote typifies the majority of responses:

It was a positive experience. The training was good, I learned a lot about various presentation techniques to involve the participants. I learned so much from the participants, such as their point of view, their frustrations and fears relating to resident abuse and neglect.

Two areas of concern were identified. Trainers indicated that the preparation time for training sessions was excessive when it involved the need to restructure the participant packets. This is addressed again under Lessons Learned. Scheduling was also identified as initially problematic although trainers indicated that this improved with increased communications, as noted in the following quote:

Early in the process, facilities were frustrated about who to contact to schedule the trainings. Later it worked better when the facility was sent a confirmation email that the trainer also received and the trainer made contact with the facility to make the final arrangements (what door to come in, who I should ask for when I get there, etc.). It improved greatly as the system became more organized.

Provider Survey

As the AANP team discussed sustainability of the program, it became clear that additional information was needed from the providers. The team was interested in knowing what factors most contributed to provider decisions to hold an AANP training or not, such as training length, cost, whether or not it was mandatory, or other conditions. A survey was designed and vetted by the Advisory Committee (Appendix J). With their approval, it was sent to a randomly selected subset of the total state lists of all provider types targeted for marketing of the AANP program. A total of 2,774 surveys were sent (1,175 by email and 1,599 by regular mail). Confidentiality was assured. MSU Institutional Review Board (IRB) approval was granted.

Two follow-up emails and a post-card were sent as reminders, resulting in a final response rate of 10 percent (n=277). Responses were received from providers who had registered staff for the training (n=81/29.24 percent of total respondents) as well as those who did not (n=196/70.76 percent of total respondents). Important data were collected on provider training needs and how best to further develop the AANP program so that it is accessible to as many DAS as possible. Key findings include:

- Among respondents who had registered staff for the project trainings, the majority were either “very satisfied” or “satisfied” with the program (94 percent).
- More than half of respondents who registered DAS indicated that they noticed a positive change in staff behavior or performance as a result of the training, particularly related to direct access staff/client relationships.
- 60 percent of those who had some staff trained stated that they did not have all DAS trained due to the need to cover client care.
- 49 percent of those who did not register DAS for an AANP training indicated that they had obtained abuse training from another source.
- Among the entire sample of respondents, provider preferences regarding length of training are for one-hour, two-hours, four-hours and then eight-hours.
- Among the entire sample, provider preferences regarding method of training are for on-site sessions with an outside presenter, video presentations, and then facilitator-guided instructional materials.

Although the response rate was low, these findings do provide initial insight into the value of the AANP program and provider preferences that can inform decisions related to access and sustainability.

MSU Evaluation Methods

The primary goal of the formal MSU evaluation was to determine the impact of the AANP training program on DAS knowledge and work behavior related to abuse. The research design involved two arms. The first arm consisted of a pre-post knowledge test administered to every DAS that participated in the training (Appendix K). The specific aim of this arm was to assess change in DAS knowledge related to the training. The second arm involved a paid, longitudinal, automated phone survey conducted with a voluntary subset of AANP training program participants (Appendix L). The specific aim of this phone survey was to determine if 1) any DAS knowledge gained during the AANP training was sustained, and 2) the extent to which the AANP had an impact on actual work performance related to abuse. Each of these arms will be discussed separately in terms of their implementation and outcomes.

The Pre-post Test: Implementation

Development of the scannable pre-post instrument was an iterative process. The Curricula Committee was consulted to ensure that questions reflected course content. In addition, the MSU research team included a consultant from the MSU Office of Medical Education and Research Development who is an expert in curricula development and evaluation. The instruments included five sections:

- Demographic data;
- Information on participant employment status such as health care setting in which they worked, position, second job, pay rates, etc.;
- A pre-test consisting of 35 questions that followed the curriculum and reflected the three major curriculum domains: identification, reporting and prevention;
- A post-test consisting of 35 questions that were not identical but mirrored the questions in the pre-test; and

- A course evaluation.

A research technique was used to ensure that trainees did not receive the same items at post-test that they received at pre-test, which could favorably bias their performance on the post-test. Half of the DAS received half the survey items as a pre-test and the other half of the items as a post-test. The other half of the DAS received the items in reverse order. Each instrument included bar codes that identified the training site and individual participant. They were accompanied by a cover letter that explained the purpose of both the pre-post test and the longitudinal phone study, how to complete the forms, and two consent statements – one for each arm. The pre-post was completely anonymous. No identifying information was requested. However, those who consented to participate in the phone survey were asked to sign a second consent and to provide their phone number. Confidentiality of this identifying information was assured. Approval of the MSU IRB for the protection of human subjects was granted for both arms of the study.

Evaluation packets were sent to trainers prior to each training session. The packets included pre-post tests for all participants, instructions for the trainers on how to administer and return them, and a codebook. The train-the-trainer session included a complete explanation of the purpose of the evaluation, the forms that would be used, how to distribute and return them, and how to handle specific situations that might arise such as a participant who did not know how to read. Completed forms were returned to MSU, scanned, responses downloaded into a database, and hard copies stored in a secure location. To date, approximately 6,500 forms have been scanned of which 4,638 participants provided consent to use their data. In addition to the pre-post data, both the MSU and BEAM teams maintained an inventory of all trainings that took place, the on-site trainer and the pre-post bar codes sent to each site.

DAS Demographic and Employment Profile

A total of 4,638 AANP participants provided consent for the research team to use their pre-post test responses in analysis. Table 5 on the following page indicates the demographic profile of these DAS. Several of the characteristics are consistent with what is reported in the literature, e.g., AANP participants were primarily white, middle-aged women. In contrast to DAS profiles reported in the literature, most AANP participants had at least some college education and received higher than average pay rates and annual income. This likely reflects the fact that AANP participants included management and professional staff and represented a wide range of health care settings (Table 6), positions (Table 7), and length of time working in the health care field (Table 8). Several other demographic variables of interest include:

- 73.6 percent of AANP participants had undergone a criminal background check for employment. It would be interesting to evaluate if this statistic changes over time with the introduction of the legislated Michigan Workforce Background Check Program.
- 61.9 percent of AANP participants previously completed some form of adult abuse training. This is worth noting as analysis indicates that even these DAS gained additional knowledge through participation in the AANP program.
- 20.2 percent held a second job, of which 58.3 percent were in health care.

Table 5
Demographic profile of direct access staff participants in AANP training

Variable	Range	Frequency (%)
Age	18–24 years	602 (13.3)
	25–29 years	489 (10.8)
	30–39 years	910 (20.1)
	40–49 years	1,187 (26.2)
	50–59 years	1,036 (22.9)
	60–69 years	286 (5.9)
	70–79 years	37 (0.8)
	Total (n)	4,529 (100.0)
Gender*	Male	479 (10.7)
	Female	4,010 (89.3)
Education	< High school	148 (3.4)
	High school	1,203 (27.4)
	Some college	1,433 (32.7)
	College degree	926 (21.1)
	LPN/RN	674 (15.4)
	Total (n)	4,384 (100.0)
Region	Southwestern MI	601 (13.8)
	South central MI	368 (8.4)
	Southeastern MI	1,157 (26.5)
	Northern lower MI	1,291 (29.6)
	Upper Peninsula MI	946 (21.7)
Pay rate[†]	Minimum Wage	155 (3.6)
	\$7 – \$8	315 (7.4)
	\$8 – \$10	696 (16.2)
	\$10 – \$12	899 (21.0)
	\$12 – \$14	688 (16.1)
	More than \$14	1,531 (35.7)
	Total	4,284 (100.0)

* Missing 149 responses.

[†] Minimum Wage = \$6.65 (Jan 2006) and \$7.15 (Jan 2007).

Table 6
Direct access staff participants and job setting

Job setting	Frequency (%)
Home help/homemaker (DHS)	270 (5.8)
Home health care agency	227 (4.9)
Assisted living facility or retirement home	537 (11.6)
Specialized mental health facility/hospital	442 (9.5)
LTC Hospital	95 (2.0)
Nursing home	2,352 (50.7)
Hospice	25 (0.5)
Total	3,948 (100.0)

Table 7
Direct access staff participants and job position

Job position	Frequency (%)
Homemaker services	85 (2.2)
Home health aide	292 (7.4)
Certified nursing assistant (CNA)	1,105 (28.1)
Housekeeping	148 (3.8)
Food services	175 (4.5)
LPN or RN	621 (15.8)
Social workers or recreation therapist	204 (5.2)
Management, supervisor, or administration	568 (14.5)
Therapist (PT, OT, speech therapist, etc.)	41 (1.0)
Other	687 (17.5)
Total	3,926 (100.0)

Table 8
Direct access staff participants and length of time in health care

Length of time in health care	Frequency (%)
Less than 1 year	499 (11.1)
1–5 years	1,124 (24.9)
6–10 years	844 (18.7)
11–15 years	660 (14.6)
16–20 years	440 (9.8)
More than 20 years	941 (20.9)
Total	4,508 (100.0)

Findings from Pre-post Responses

The key objective of this evaluation was to assess change in DAS knowledge related to the AANP training, primarily by comparing pre- and post-test responses. Particular interest was in examining change, if any, within the three primary curricular areas or domains, e.g. identification, reporting, and prevention. By analyzing across these domains, specific areas in which strengths or needed improvements existed could be isolated. Therefore, for purposes of analysis, each item was coded to one of the three domains and composite scores were determined within these domains. Tables 9 and 10 show the average group scores within each domain. A higher mean score indicates a higher frequency of correct responses. Significant improvements in knowledge occurred across all three domains, comparing pre- and post-test scores.

Table 9
Domain scores per pre-post-test form 1

Domain	Pre		Post		Sig.	Range
	Mean	SD	Mean	SD		
Identification	7.5	1.4	7.7	1.6	***	0-10
Reporting	9.7	1.6	9.8	1.8	*	0-12
Prevention	9.8	1.9	11.07	2.3	***	0-14

*p <.05 and ***p <.001

Table 10
Domain scores per pre-post-test form 2

Domain	Pre		Post		Sig.	Range
	Mean	SD	Mean	SD		
Identification	6.9	1.3	9.9	2.2	***	0-12
Reporting	4.5	1.3	7.5	1.7	***	0-10
Prevention	11.17	2.1	13.03	2.7	***	0-16

*p <.05 and ***p <.001

While significant improvements were clearly indicated, two points need to be taken into consideration. The large sample size results in the ability to detect even slight changes in scores, which statistical tests find to be significant. What is more important is how such change is interpreted and whether or not it is meaningful in terms of actual practice. For example, there were several items in which more DAS responded correctly at post-test yet the number of those who responded incorrectly was still substantial. The desired degree of change, or acceptable frequencies for incorrect responses, has yet to be determined. Further research and discussion is needed on this point.

With this in mind, significant positive change was noted on more than half of the items, many of these by a substantial degree. For example, when asked if not placing a call light in a client's reach when in a hurry is a form of abuse, the correct responses from pre- to post-test jumped from 5.2 percent to 91.8 percent. In response to the statement "hostile and defiant behavior in a client may be a sign of abuse," correct responses increased from 16.5 percent to 93.1 percent. Both of these examples, among others, indicate improved ability to identify abuse. Examples of equally dramatic changes exist in items related to how to respond in a situation in which abuse is suspected, including eventually reporting it if appropriate. For example, when asked about assuring clients confidentiality except for the need to report the abuse, the correct responses increased from 6.8 percent to 86.7 percent.

Four test items in particular provide key benchmarks of program success in terms of workers' confidence in their skills for identifying and recognizing abuse; comfort level with reporting abuse; and knowledge of where to report abuse. Analysis of responses to these items focused on change between pre- and post-test as well as if responses varied by work setting, position or longevity. Scores on all four items showed significant improvement following the training. The most dramatic change was seen in identifying abuse. For example, the percent of DAS who agreed with the statement, "You feel like you understand the different types of abuse and how to identify them" increased from 14.9 percent to 94.3 percent post-training ($\chi^2=2977.09$, $df=6$, $p < .001$). Similarly, the percent of those in agreement with the statement, "You feel like you know what all forms of abuse are and how to recognize them," increased from 43.9 percent at pre-test to 85 percent immediately post-training ($\chi^2=852$, $df=1$, $p < .001$). Changes in scores related to comfort in reporting and understanding of to who abuse should be reported were also significant although not as substantial, partially because the baseline scores were already quite high prior to training. These changes held true across worker settings, positions and longevity although the degree of change varied slightly when considering these factors.

DAS responses to one of the final items reflected their own perceptions of the impact of the AANP training, particularly in the prevention domain. The vast majority (92.7 percent) indicated that they felt they had learned new ways to handle stressful situations. This held true across all settings, DAS positions, and length of time on the job.

A key question of interest to the project team was in knowing if differences exist in impact on knowledge between the eight- and four-hour training. Analysis suggests that the differences are minimal, at least in terms of quantitative measures. The difference in the group mean scores was statistically significant ($t=-2.5$ ($df=4636$), $p <.01$), but very small and lacking real meaning. Again, the statistical significance is likely attributed to the large sample size. However, when comparing by setting, education, position, and work longevity, one significant finding is worth noting. Analysis suggests that individuals with less than a high school education may benefit more from the eight-hour training (F ratio=4.64 ($df=4$), $p <.01$). This is possibly related to evidence suggesting that there is qualitative value added with the eight-hour training as a result of having sufficient time to use more interactive teaching modes and to develop DAS comfort with discussing sensitive topics.

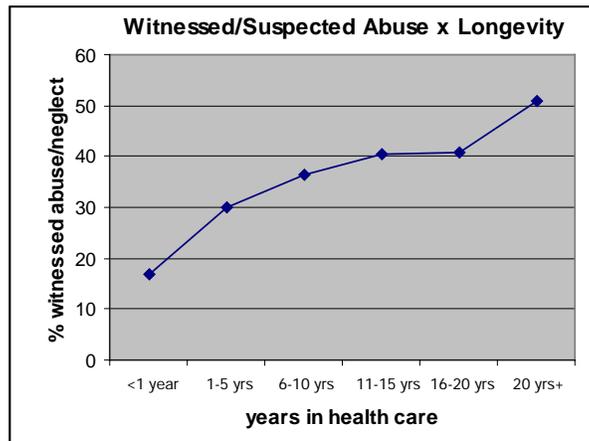
Overall, these findings provide empirical evidence to support the conclusion that the AANP training program successfully met its goal to increase DAS knowledge in all three domains as well as specific markers. Further analysis will continue to determine more targeted areas in which strengths and needed improvements exist. Attention will be given to those items in which the following occurred:

- No significant change in the frequency of correct/incorrect responses with most DAS responding correctly at pre-test and again at post-test suggesting that they already knew the material or an instrument problem existed, e.g., a poorly worded question.
- No significant change with most DAS responding incorrectly at pre-test and again at post-test possibly attributed to a poorly designed question or limitations of the curricula, trainer, or delivery format.
- A significant change in the frequency of correct/incorrect responses with more DAS responding incorrectly at post-test. This is possibly attributed to limits of curricula, trainers, delivery format or poor question design. The few cases in which this occurred, the change was not substantial and therefore likely not meaningful. Nevertheless, these items are worth examining.

In addition to assessing DAS change in knowledge, the pre-post test had a secondary aim to begin to establish baseline data on abuse prevalence that is based on what DAS have actually observed rather than relying only on suspected abuse that has been officially reported to reporting agencies. Questions were asked regarding the frequency and type of abuse that DAS have witnessed or suspected over the course of their career as well as within the past month. Of interest was the degree to which these observations varied by employment longevity, work setting and/or position.

As would be expected, witnessing of abusive situations increased linearly with work longevity (Figure 1). A positive relationship exists between years working in health care and the likelihood that an individual has witnessed an abusive situation in his or her work setting. ($\chi^2=187.97$; $df=5$, $p <.001$).

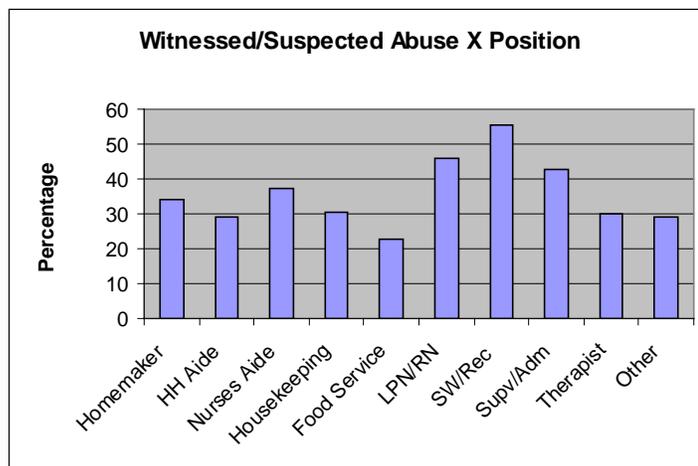
Figure 1
Witnessed/suspected abuse by job longevity



There appeared to be differences in frequency of witnessed abuse across settings with DAS in hospice settings reporting much higher frequencies (66 percent) as compared to DAS in other settings such as Home Help (32 percent), over the course of their careers. However, it cannot be stated that this indicates more frequent abuse occurs in hospice settings. The difference may be attributable to other factors including the low sub-sample size of hospice workers. Additional research is needed with a larger sample size and attention to other contributing factors including the possibility that hospice workers are more attuned to identification of markers of abuse.

The proportion of DAS who witnessed or suspected abuse varied significantly by job position ($\chi^2=100.05$; $df=9$, $p < .001$). Figure 2 illustrates that social workers/recreation therapists, followed by LPN/RNs and administrators were the most likely to have witnessed abuse compared to other positions such as home health aides (56 percent, 46 percent and 43 percent respectively). This is again to be expected and likely due, in part, to work longevity as licensed and professional staff members have typically been working in health care for longer periods of time and have had more opportunity to witness cases of abuse.

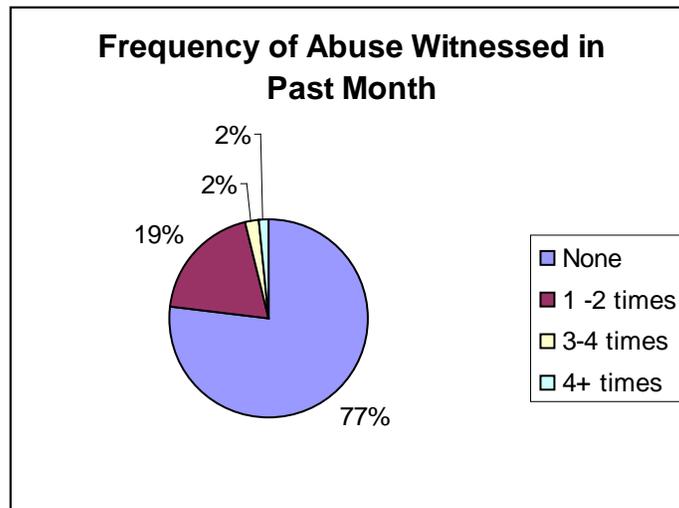
Figure 2
Witnessed/suspected abuse by job position



Similar to having witnessed abuse, participants were more likely to have reported abuse the longer they worked in health care ($\chi^2=267.94$; $df=5$, $p < .001$). DAS from hospice were the most likely to have reported abuse (71 percent) and those in Home Help the least likely (29.2 percent). Again, the experience of hospice needs to be examined more closely as the high frequency noted may be a result of the small sample size in this category ($\chi^2=38.1$; $df=6$, $p < .001$.) or some other explanatory factor. As might be expected, social workers (69.4 percent) and management (52 percent) were more likely to have reported abuse than those with less client/resident contact such as housekeeping or food service (23.5 percent, 18.3 percent respectively). Although the majority of DAS (97.4 percent) indicated that they knew to whom abuse should be reported, confidence in this knowledge appeared to increase with longevity ($\chi^2=1564$; $df=5$, $p < .01$). Further, the vast majority of DAS indicated that they would be comfortable reporting suspected cases of abuse and/or neglect (88 percent).

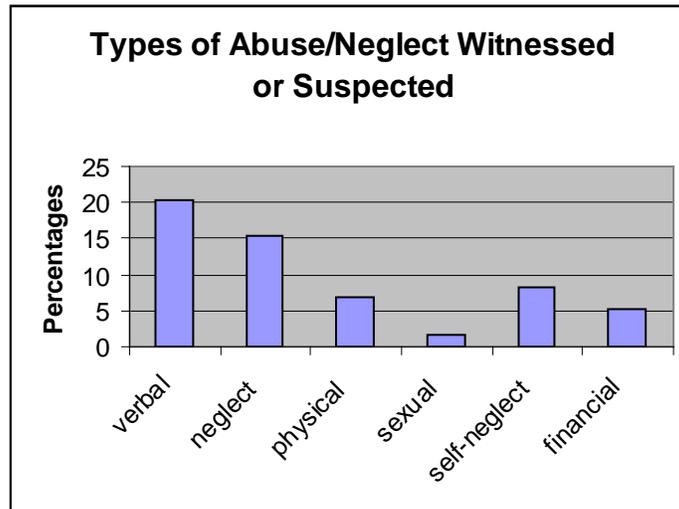
Pre-post test questions were also asked related to the frequency and type of abuse that DAS had witnessed or suspected within the previous month. During this time frame, responses from the total sample indicated that nearly one-quarter (23 percent) of participants had witnessed or suspected some type of abusive situation. Figure 3 indicates the frequency with which these incidents were observed.

Figure 3
Frequency of abuse witnessed/suspected in past month



Verbal or emotional abuse was the most common type of abuse witnessed (20 percent) over the past month. Sexual abuse was the least common, although witnessed or suspected by 2 percent of participants. No notable differences were seen in the types of abuse when compared across work setting, longevity or job position. Exceptions included cases of self-neglect as most likely seen by those working in home health care (13.7 percent) and the least likely by those working in mental health facilities or mental health hospitals (6.1 percent). Figure 4 illustrates types of abuse witnessed or suspected across all settings and positions within the past month.

Figure 4
Types of abuse witnessed/suspected in past month



The Longitudinal Phone Survey: Implementation

As stated, this survey was a paid automated phone survey, using TeleSage software. Respondents were asked to phone a toll-free number one time per month for up to six months to take the survey by entering their responses using the phone keypad. Responses were automatically downloaded into a secure database for analysis. Again, the main goal was to determine if knowledge gained in the AANP training was applied on the job. This is important to examine longitudinally because each abusive situation is potentially very different – perhaps demanding a different response. The intent was to enroll a subset of 1,000 DAS who attended AANP trainings and consented to participation in the phone survey. However, due in part to implementation challenges and delays, 304 DAS were in the final sample, a sufficient number to determine meaningful findings.

Preparing for the implementation of the phone survey involved attention to complex technical programming. For this, the research team included technical expertise and support from the MSU Bioinformatics and Research Center (BRIC), which was responsible for securing and managing the data, creating web interfaces so that the research team could access data using a secure web-based system, and programming the automated phone calling schedule and system. Although TeleSage software was used, it had to undergo significant adaptation to meet the needs of this particular study. For example, TeleSage was not designed to handle open-ended questions or a participant incentive system, both of which this research included.

The call schedule system was designed and programmed entirely by BRIC. Phone numbers collected from the pre-post test consent forms were entered into this system and potential subjects were then first contacted by MSU, with an automated voice message inviting them to participate in the phone survey. Instructions were provided on where to call and how to take the survey. They received up to three calls, on a timed schedule, as well as reminder calls prior to subsequent phone surveys.

Separate phone lines were set up for outgoing automated calls, incoming calls from respondents taking the phone survey, and an information line on which participants could leave a voice mail message. This information line was checked daily. It received little use, mostly requests for clarifying information. None were to report a problem or complaint. Only one caller used it to report suspected abuse. Her call was immediately returned and she was provided with information on the appropriate agency to call.

The phone survey instrument itself went through multiple iterations and was vetted with both the Curricula Committee and the MSU curricula evaluation expert. Further, it had to be refined based on pilot-testing with the automated system. It was pilot tested with both the Trainers and others to determine if the automated voice was legible, skip patterns worked, and other technical aspects of the system were functional. The content included selected items from the AANP training curricula with additional focus on actual incidents of witnessed or suspected abuse and how these incidents were handled. More specifically, respondents were asked about what they had observed since the training or last survey and what steps they took, e.g. if they reported it, to whom, and if they did not report it, why not. A secondary goal was to hear from DAS themselves what changes they believe would reduce abuse. Consequently, several open-ended questions were included, transcribed, and analyzed.

A system for compensating participants while maintaining the highest possible level of confidentiality was developed and involved paying respondents by check, mailed directly to their homes. This required that they leave their name and address by speaking into the phone, thereby creating an audio file that later needed to be transcribed. Participants were paid \$5 per survey and a \$5 bonus if they completed all six surveys.

The Longitudinal Phone Survey: Findings

A total of 2,049 DAS (26.26 percent) who completed the AANP training consented to potentially being contacted by phone and invited to participate in the longitudinal phone survey. They provided their phone numbers on the AANP consent form. An initial introductory automated phone contact was made to all 2,049 DAS as well as follow-up contacts to those who did not respond by calling the toll-free number and taking the survey.

A total of 304 (14.84 percent) of these 2,049 DAS responded by taking the phone survey at least one time. It should be noted that this represents a self-selected, potentially biased subset of DAS, only 6.55 percent of the 4,638 DAS who consented to use of their pre-post test responses, and just 3.9 percent of the 7,804 DAS who completed an AANP training. However, it does provide sufficient initial baseline pilot data to draw conclusions about the impact of the AANP training.

Of the 304 respondents, 59 took the survey 2-5 times with the majority taking it two times (34/57.63 percent) and another 12 (20.34 percent) taking it three times. The remaining respondents took it five times. Analyses of the responses of those who took the survey multiple times support the findings from analyses of Time 1 survey responses. Survey respondents are distributed across long-term care settings (Table 11).

Table 11
Phone survey respondents by job setting (n=304)

	Nursing home	LTC hospital	AL	Home health care	Home help	AFC	Other	Missing	Prefer not to respond	Total
Number	108	12	21	30	15	22	68	20	8	304
Percent	35.53	3.95	6.90	9.87	4.93	7.24	22.39	6.58	2.62	100

The central question the phone survey was intended to answer was to determine if knowledge gained in the AANP training was applied on the job. Two sets of survey items address this question: the perceptions of the DAS themselves and their actual behavior in terms of identifying, reporting, and preventing suspected abuse. The DAS who responded to the survey overwhelmingly perceived that the AANP training improved their ability to do all three. Over 90 percent rated the training as “good” or “excellent.”

Findings related to the impact of the AANP training on DAS perceptions of their ability to effectively deal with potentially abusive situations on-the-job are as follows:

- **Identifying Abuse:** 280 (92.11 percent) respondents indicated that the AANP improved their ability to recognize abuse and more than half (205/67.43 percent) indicated that they recognize abuse more often since the training. The fact that 30.26 percent did not believe that they recognize abuse more often may be due to their perception that abuse does not actually occur more often.
- **Reporting Abuse:** Nearly half of DAS respondents (147/48.36 percent) stated that they actually report suspected abuse more often because of the AANP training. The fact that the other half did not report abuse more often needs closer examination. Again, it may be due in part to the perception that abuse was not actually occurring more frequently. However, it also may be attributed to other reasons. The vast majority of respondents (all but three) indicated that they knew to whom to report abuse. Yet, a DAS who is able to identify abuse and knows how and to whom to report it may still choose not to report it. Potential reasons will be discussed further.
- **Preventing Abuse:** 278 (91.45 percent) of DAS respondents perceived that the AANP training improved their ability to prevent potentially abusive situations from developing; 183 DAS (60.20 percent) indicated that they had actually used prevention techniques learned in the training, since the training; and of these, 95.63 percent indicated that the techniques helped prevent an abusive situation from occurring.

A secondary goal of the phone survey was to begin to establish baseline data on abuse prevalence that is based on what DAS are actually observing rather than relying only on suspected abuse that is officially reported to reporting agencies. Respondents were asked how many times they had witnessed or suspected abuse since the AANP training (1-10 months). Approximately 20 percent of the respondents indicated that they had witnessed abuse. Table 12 illustrates the number of cases of abuse (n=62) that DAS witnessed or suspected since the DAS training. These findings are consistent with what DAS reported in the pre-post test responses.

Table 12
Number of abuse cases

Number of cases	n/%
1	24 (38.71%)
2	19 (30.65%)
3	7 (11.29%)
4	2 (3.23%)
5	3 (4.84%)
6 +	7 (11.29%)
Total	62 (100%)

Further analyses will focus on comparing these frequencies across variations in length of time lapsed between the AANP training and taking the survey. In addition, frequency distributions across long-term care settings will be examined.

Respondents who indicated that they had witnessed or suspected abuse were also asked to consider the most serious case that they could recall and identify the type of abuse it represented. The frequencies/percentages of abuse in each category, ranked in order of prevalence, are illustrated in Table 13. These findings are also consistent with what DAS reported in the pre-post test responses.

Table 13
Types of abuse

Abuse types	n/%
Verbal	40 (64.52%)
Neglect	28 (45.16%)
Physical	14 (22.58%)
Financial	8 (12.9%)
Sexual	3 (4.84%)

The total prevalence of all types of abuse exceeds the number of cases of suspected abuse (62) which suggests that either DAS were referring to more than one case or the most serious cases witnessed involved more than one type of abuse.

Still considering the most serious case of suspected abuse since the AANP training, DAS were asked to identify who they considered to be the primary abuser. Table 14 indicates DAS responses, ranked by prevalence.

Table 14
Primary abuser

Abuser	n/%
Co-worker	26 (41.94%)
Family member	18 (29.03%)
Another client or resident	6 (9.68%)
Supervisor	5 (8.06%)
Friend or neighbor	1 (1.61%)

It is important to note that another five (8.06 percent) preferred not to respond. DAS further indicated their opinions as to why the suspected abuse may have occurred. Table 15 indicates DAS responses, ranked in order of prevalence:

Table 15
Potential reasons for abuse

Potential reasons for abuse	n/%
The abuser was frustrated by the behavior of the older person.	35 (56.45%)
The abuser was frustrated due to short staffing or insufficient help and resources.	27 (43.55%)
The older person was being physically abusive, and the abuser was acting in self-defense.	7 (11.29%)

As the item options may have contributed to prescribed responses, DAS were given the opportunity to answer “other” and then provide additional reasons by speaking into the phone. Very few used this option to indicate reasons other than those already specified although one respondent did suggest that the witnessed abuse was a result of a co-worker’s “laziness.”

Of the 62 respondents who indicated that they had observed suspected abuse since the training, approximately half (33/53.23 percent) reported the abuse to a supervisor or reporting agency. Eight DAS (12.9 percent) said that they had not reported it. The remaining 21 (33.87 percent) preferred not to answer the question so it is difficult to determine if they did or did not report the abuse. However, when asked about reasons for why they did not report the abuse, as many as 24 DAS responded, which suggests that it is likely that the number of DAS who did not report the case of abuse that they had described was about 24 (38.71 percent).

Again, only three of the DAS who stated that they had witnessed abuse but did not report it cited “not knowing to whom to report the abuse” as their reason. This illustrates that there are DAS who state that they are able to identify abuse and know how and to whom to report it, but still choose not to report it. Respondents indicated the following potential reasons for not reporting abuse, ranked by prevalence of responses among those who did not report the abuse (n=24):

- It wouldn’t have made any difference = 13 (54.17 percent)
- It wasn’t serious enough = 10 (41.67 percent)
- It would have had a negative impact on my job = 8 (33.33 percent)
- The older person started it = 7 (29.17 percent)
- Was worried the supervisor might get upset = 3 (12.5 percent)

Although 33 DAS indicated they did report the abuse case that they had described, 42 DAS were willing to comment on whether or not they believed cases of abuse to be handled quickly and appropriately following reporting. Only 12 (28.57 percent) felt very confident that reported cases were handled well; 17 (40.48 percent) felt only somewhat confident; and 13 DAS (30.95 percent) believed that cases were not handled quickly or appropriately.

The phone survey included several open-ended questions including one that asked, “What can be done to prevent abuse in the future?” By far, the most common answer was education followed by increasing the size of the staff. A substantial number of respondents specified that training should be mandatory, repeated on a regular basis, and should include information on stress management, empathy, being watchful, and recognizing abusive situations. Several respondents cited the importance of learning more about dementia and cultural differences. One DAS stated the following:

I think there needs to be more training. People need to have more training on what abuse is and when there have been abuses. I don't think many people know you can verbally abuse patients, especially a lot of young people. And then, we have a racial thing that if people have Alzheimer's they may refer to your race and young people don't understand that they are mentally ill or incompetent. A lot of time people don't understand the disease that people with dementia can have, that they can be very abusive to the people. So many people don't understand when they are being abusive to clients. They just don't know what abuse is.

The widely shared opinion that DAS should have continuing education and training in abuse is reflected in the following quotes:

I think that employees that work in nursing homes, assisted living, hospitals, etc, need to have training, and training needs to be updated at least annually to keep them abreast on how to prevent it and what their job is even when their attention span is low or even when they get angry because a patient is acting out, they still need to know how to handle that so training is very essential.

More training should be done to help keep workers refreshed because they sometimes forget the policies and how to deal with mental conditions as they change.

Respondents cited other important recommendations for reducing the prevalence of adult abuse including providing support services to staff aimed at relieving stress such as anger management counseling; reassuring staff that there would be no retaliation for reporting suspected abuse; more referrals to social workers; and better screening of potential workers including family member caregivers.

The MSU Evaluation: Discussion and Conclusions

For each of the evaluative measures used in this project, significant measures of change were observed. Improvement in knowledge was more pronounced with respect to identifying and recognizing abuse compared to reporting abuse. However, this is likely a result of approaching a "ceiling effect" for reporting given nearly 90 percent of DAS felt comfortable reporting abuse prior to the training. In addition, many DAS, especially those with longer work histories, have already witnessed/suspected and reported some type of abuse. One of the real effects of this project was likely to help DAS understand the more ambiguous areas that constitute abuse, such as not answering call lights right away or whether or not it is considered abuse if the DAS is responding negatively to difficult client initiated behavior. The interactive

format of the AANP trainings provided important discussions and problem-solving strategies related to these types of scenarios.

The findings indicate a lack of substantive differences in knowledge comparing the four-hour and eight-hour trainings across settings and positions, which suggests that the program objectives generally can be met within the shorter time period. This is encouraging particularly as a number of the providers noted that they were unable to release their entire staff for training due to the need for client/resident coverage. Providing the four-hour option can increase accessibility and sustainability of the program. However, it should be noted that evidence suggests there may be positive qualitative differences for DAS who take the eight-hour training in terms of having sufficient time to engage in more interactive learning modes and developing comfort with discussing abusive situations.

Although only representing a small sub-sample of the larger DAS trainees, the longitudinal phone survey revealed a number of key issues that confirm the value of the AANP training, but also speak to the challenges remaining, including DAS who are still not reporting abuse that they witness or suspect. Reasons for not reporting, such as the lack of confidence that it will make a difference, need to be more intensively explored and finding ways to help DAS overcome these barriers is critical.

The phone survey also represented an important step in determining the feasibility of using this method for obtaining sensitive data from DAS. While there were a number of workers who chose not to respond to certain questions, the majority did answer all or most of the survey items. This finding suggests that automated phone surveys may be a promising avenue for collecting data on the prevalence of abuse in the future. As a result of this study, the infrastructure is now in place to successfully implement automated call schedules and surveys, download, track and analyze data using a secure web-based system and provide respondents with incentives. Implemented on a statewide basis, such a system could yield important longitudinal data about abuse prevalence and patterns that could inform state policy and resource allocation.

Lastly, the findings of this study clearly demonstrate that the DAS participants themselves perceived substantial benefit from the training. High rates of satisfaction on a number of levels were reported, even among the most seasoned or highly educated DAS. The degree to which this satisfaction and perceived improvement in knowledge translates to behavior warrants further study. Nonetheless, an initiative such as AANP, that has such a dramatic effect on increasing the confidence of its participants, will likely lead to more vigilant and assertive action in the future. Indeed, the AANP participants themselves asserted that education and training is precisely what caregivers and the public need in order to reduce adult abuse.

Formal Reporting Systems Report

The Formal Reporting Systems Report is the final AANP product to be described herein. It represents a tremendous undertaking; nearly two years of research, analyses, writing, and work with all involved state agencies to document current definitions, data, and processes related to vulnerable adult abuse reporting in Michigan. It was felt by doing so, a more coordinated reporting system could be developed to track abuse, identify patterns, and provide evidence for where and how to target resources, thereby becoming an effective tool for reducing abuse.

The research focused on six organizations that maintain legal jurisdiction over reporting of abuse across a range of settings. Data were collected with the assistance of the MSU research team, the AANP Curricula Committee, and the AANP Advisory Committee. Sixteen descriptive variables of interest were identified such as the organizational function and structure of each agency, the definition of abuse used, and other aspects related to the way in which abuse reports were handled. Detailed, standardized information was collected on each of these variables.

Key findings include the following:

- There is no single, unified, overarching definition of abuse in Michigan from which collective understanding, education, and state policy can emerge.
- There are few standardized or common procedures across agencies, such as use of a common intake form or collection of the same data in comparative formats.
- A central database is not currently available for entering, storing, managing, and analyzing electronic abuse data. As a result, abuse data is not easily shared.

Recommendations resulting from the research paralleled the Governor's Elder Abuse Task Force recommendations and included establishing a unified definition of abuse; one central agency or portal to handle the routing of all adult abuse complaints; one toll-free phone number; and a centralized electronic database. Any statewide abuse reduction program will ultimately rest on making sure that a coordinated system of compatible processes exists for defining and reporting abuse that is understandable and usable. This report was the first step and will now be used to inform state policy and response to elder abuse.

Costs of the Michigan AANP Program

The AANP grant project was made possible through the Michigan Department of Community Health Grant (No. * 11-P-93042/5-01) awarded by the Centers for Medicare & Medicaid Services. MDCH established MSU as the primary subcontractor of the grant funds for the AANP program, with oversight by OSA. For the purposes of curricula development and training coordination, MSU further subcontracted with BEAM. Through a collaborative decision-making process, MSU, BEAM, and OSA reviewed major expenditures, scope of work changes, and other activities impacting the budget. As a result, the AANP staff was able to effectively utilize available funds.

The full award for the multi-year grant period is \$1.5 million. Total expenditures are as follows: 2005: \$203,769; 2006: \$401,120; and 2007: \$682,367. Carry forward for 2008 is \$212,744. Table 16 on the following page provides an outline of AANP grant project expenses from 2005–2007.

Multiple budget modifications were made by MSU and AANP staff to accommodate grant project no-cost extensions, changes in the scope of work, and corrections as needed. Modifications of significance included reallocation of funding for training an estimated 2,500 DAS to staffing and contractual expenditures. Funds were utilized to complete the development of a four-hour, supervisory, and facilitator instructional modules as well as complete an employer survey. Work completed by BEAM accounted for 82 percent of expenditures with MSU at 18 percent. In addition, in-kind oversight for AANP was provided by OSA. A summary of yearly expenditures is included in an appendix (Appendix M).

Table 16
AANP grant project expenses: 2005–2007 actual expenses and 2008 carry forward estimate

Expenses	2005 Actual	2006 Actual	2007 Actual	2008 Estimated carry forward*	Total expense
Salaries	\$37,500	\$91,664	\$82,039	\$12,075	\$223,278
Fringe	\$13,125	\$32,083	\$30,765	\$4,528	\$80,501
Travel	\$9,815	\$1,250	\$5,021	\$1,779	\$17,865
Supplies	\$5,750	\$38,238	\$4,671	\$1,874	\$50,533
Contractual	\$77,410	\$34,004	\$169,615	\$50,900	\$331,929
Equipment	\$2,000	\$1,286	\$2,360	\$514	\$6,160
Rent/utilities	\$1,350	\$8,136	\$14,400	\$3,850	\$27,736
Specialist trainers	\$26,400	\$134,864	\$264,498	\$63,408	\$489,170
BEAM annual expense	\$173,350	\$341,525	\$573,369	\$138,929	\$1,227,173
MSU annual expense	\$30,419	\$59,595	\$108,998	\$73,815*	\$272,827
Annual grant project expense	\$203,769	\$401,120	\$682,367	\$212,744	\$1,500,000

* MSU 2008 carry forward includes \$11,000 transferred from BEAM budget.

Implications of Findings and Costs

From the inception of the Michigan AANP Training pilot program, the proposed administrative budget was kept to a minimum to allocate resources to train as many DAS as possible. Cost saving factors included use of contract staff to complete ancillary services such as accounts receivable and payable, human resources and other support services provided by the corporate component of BEAM’s parent company, MPRO. Use of services from BEAM’s parent company limited the need for contracts with outside agencies. In addition, AANP staff members were able to secure contractors committed to providing discounted curricula development, consulting, and training services. For example, BEAM was able to obtain contracts with more than 55 highly qualified long-term care professionals to serve as trainers on a fee-for-service basis throughout the grant period. This reduced the expense typically associated with salaried trainers and/or staff.

Additional measures that could be utilized in the future to improve the efficiency of providing an adult abuse and neglect training program include:

- Materials should be printed on an as needed basis. A significant amount of materials was printed at the beginning of the project. This created a significant one-time expense. Although a discount was received for increasing the volume of printing requested, the number of modifications made to materials later in the project required many materials to be reprinted, which added to the overall cost.
- Efforts should be made to set a realistic goal with regard to the number of individuals trained and the amount of resources needed to complete training. It is essential to hire various individuals with the appropriate skill sets and experiences to complete project activities. AANP initially sought to conduct work with a limited number of staff, but was

able to create a more effective team with additional individuals with the appropriate skill sets and experience to complete each key task.

- Although the administrative manager was budgeted at .2 FTE, the project required a larger percent of dedicated staff time to complete all grant activities. Actual staffing for the administrative manager for the AANP project was .5 FTE. Special consideration should be made for how much supervision of the day-to-day operations by the administrative manager is needed, especially in supervising staff, interacting with partners, and implementing decisions prior to budgeting.
- Budget modifications require a significant amount of time when changes are made to the scope of work or adjustments are requested. Individuals seeking to replicate this project should plan additional time to facilitate budget changes, especially when multiple organizations are involved.
- As staffing changes occur, it is critical to include notes and instructions providing clarification on the budget and completion of forms to ensure a clear understanding of the project's finances. This will help reduce the amount of time needed to complete financial reports and budgets.

In an effort to assess expenditures vital to successful sustainability and/or replication of the AANP training program, AANP staff outlined key expenses. Key expenditures outlined were included as part of a budget assessment requested by ABT Associates in May 2007. These expenditures were also utilized to assess operational costs and make adjustments to the AANP budget as requested.

Individual Training Sessions

Provided below is an estimate of the average cost per training through the Michigan AANP training program (Table 17). Actual costs will vary most significantly based on the total number of participants trained and amount reimbursed per training. For the eight-hour training, trainers were reimbursed \$50 per person trained.

Table 17
Estimate of average cost per training

Individual training direct costs	FTE hours	Expenses	Total
Packet prep staffing	0.5	\$30	\$15
Scheduling staffing	1.0	\$30	\$30
Bulk packet shipping/paperwork return staffing	1.0	\$45	\$45
Payment processing staffing	0.5	\$30	\$15
Typical trainer payment (18 DAS @ \$50/each)	15.0*	\$50	\$900
Evaluation packet—set of 25/staffing/materials		\$25	\$25
DAS folder/misc. handouts (18 DAS @ \$6 each)		\$108	\$108
Trainer materials (supplied by trainer)		\$40	\$40
Total			\$1,178

* Fifteen hours is estimated for average trainer preparation and training implementation. First training will take additional time. Trainer payment is based on per person rate, rather than per hour.

Initial Train-the-Trainer

The initial seven Michigan AANP training program train-the-trainer sessions were conducted over three days in separate locations. Table 18 provides cost estimates for five training sessions. Seventy-six individuals were trained as part of the initial train-the-trainer.

Table 18
Cost estimates for train-the-trainer sessions

Initial train-the-trainer costs (five, 3-day sessions)	FTE hours	expenses	Total
Training prep/event coordination/on-site staffing (curricula coord./proj. coord.)	352	\$40	\$14,080
Curricula development and training (consultants/lead trainers)		\$3,700	\$3,700
Supplies/materials (trainer binders/posters)		\$10,700	\$10,700
Site fees		\$550	\$550
Food/beverages		\$2,450	\$2,450
Trainer/staff lodging		\$4,900	\$4,900
Trainer/staff mileage		\$4,600	\$4,600
Total			\$40,980

Train-the-Trainer Refresher Course (Eight-Hour Curricula Changes)

Modifications were made to the Michigan AANP training curricula in late 2006. As a result, a refresher course was held to update trainers on curricula revisions. Table 19 provides cost estimates for the eight-hour refresher course. Trainer reimbursement for mileage and lodging were not provided during the refresher training. Trainers volunteered to participate for this one refresher course.

Table 19
Cost estimates for the eight-hour trainer refresher course

Eight-hour trainer refresher course activities/supplies (one, 1-day session)	FTE hours	Expenses	Total
Curricula development and training (curricula coordinator./QA manager)/event coordination/on- site staffing (curricula coordinator./QA manager/adm. manager/project assistant)	98	\$40	\$3,920
Curricula development and training (consultants/lead trainers)		\$1,900	\$1,900
Supplies/materials		\$900	\$900
Site fee		\$0	\$0
Food/beverages		\$450	\$450
Lodging		\$0	\$0
Staff mileage		\$300	\$300
Total			\$7,470

Train-the-Trainer Refresher Course (Four-Hour Curricula)

In response to requests for a shorter training session (less than eight hours) and review of the project with CMS, the Michigan AANP staff began developing a four-hour training curricula. Table 20 provides cost estimates for the trainer refresher course held in June 2007.

Table 20
Cost estimates for the trainer refresher course

Four-hour trainer refresher activities/supplies	FTE hours	Expenses	Total
Training development and training (curricula coordinator/QA manager)/event coordination/on-site staffing (curricula coordinator./QA manager/adm. manager/project assistant)	98	\$40	\$3,920
Training development and training (consultants/lead trainers)		\$1,900	\$1,900
Supplies/materials		\$900	\$900
Site fee		\$0	\$0
Food/beverages		\$400	\$400
Lodging		\$0	\$0
Participant \$100 stipend*		\$4,800	\$4,800
Staff mileage		\$300	\$300
Total			\$12,220

* Stipend was included as a reimbursement for trainer's time/expenses for the four-hour train-the-trainer, which was added to the project.

Curricula Development (Eight-Hour Curricula)

A team of multi-disciplinary experts from various aspects of long-term care was utilized along with the AANP staff to develop Michigan's innovative abuse and neglect prevention curricula. In addition to volunteer experts serving on committees, AANP staff also secured contracts with leading experts to achieve the highest quality curricula and ensure successful completion of the curricula. Table 21 provides cost estimates for curricula development.

Table 21
Cost estimates for curricula development

Eight-hour curricula activities/supplies (15 months)	FTE hours	Expenses	Total
Curricula development and testing (curricula coordinator/project coordinator/other staff)	556	\$40	\$22,240
Curricula development and testing (consultants/trainers)		\$38,250	\$38,250
Committee meeting costs (food/supplies)		\$1,200	\$1,200
Food/Beverage (Initial pilots - paid lunch)		\$400	\$400
Staff mileage		\$600	\$600
Total			\$62,690

Modifications were made to the eight-hour curricula following the initial pilot trainings. These changes included the addition of new information and activities as well as reorganization of training protocols to enhance the learning experience. Changes were met with positive response from the AANP trainers who contributed to the recommended changes. Table 22 on the following page provides cost estimates related to modifications of the eight-hour trainings.

Table 22
Cost estimates related to modifications of the eight-hour training

Eight-hour modification activities/supplies	FTE hours	Expenses	Total
Curricula development and testing (curricula coordinator/QA manager)	140	\$40	\$5,600
Curricula development and testing (consultants/lead trainers)		\$5,700	\$5,700
Committee meeting costs (food/supplies)		\$100	\$100
Food/beverage (initial pilots with DAS - paid lunch)		\$350	\$350
Staff mileage		\$400	\$400
Total			\$12,150

Curricula Development (Four-Hour Curricula)

Table 23 provides cost estimates for development of the four-hour training curricula requested by providers and CMS. Curriculum was completed in June 2007.

Table 23
Cost estimates for the development of the four-hour curricula

Four-Hour Modification Activities/Supplies	FTE Hours	Expenses	Total
Curricula development and testing (curricula coordinator/QA manager)	290	\$40	\$11,600
Curricula development and testing (consultants/lead trainers)		\$5,700	\$5,700
Committee meeting costs (food/supplies)		\$100	\$100
Food/beverage (initial pilots with DAS - paid lunch)		\$350	\$350
Staff mileage		\$400	\$400
Total			\$18,150

Continuing Education

As an added benefit of the training program, AANP staff arranged for continuing education (CE) credit for the training sessions. This value-added component aided marketing efforts. Table 24 outlines activities related to the CE staffing process. Table 25 provides cost estimates related to CE per person and Table 26 provides cost estimates per CE type. CE costs per person are difficult to assess as fees vary and cost per person will vary based on the total number of individuals receiving credit. AANP program credits were facilitated through BEAM's parent company, MPRO, which also provides contingent CE staff support. Adult foster care licensee credits were awarded by the Bureau of Children and Adult Licensing/MDHS.

Table 24
Activities related to continuing education process

Continuing education staffing activities	Time required
Initial speaker biography preparation	3 hours
Initial CE setup/application	4 hours
Bio/CV update/follow up on requests	1 hour per week (as needed)
CE credit processing	10 minutes per training
Certificate processing	1.5 hours per 20 certificates

Table 25
Cost estimates related to continuing education per person

Continuing education processing activities per individual	FTE hours	Expense	Total
CE application fee*		\$0.60	\$0.60
CE processing staffing (CE expert/AST/project assist)	5 Min.	\$40	\$3.30
Postage per certificate		\$0.42	\$0.42
Materials (paper/printing/envelopes) per certificate		\$0.16	\$0.16
Total			\$4.48

* Estimate based on three-year fee of \$1,200 for issuing nurse contact hours at a use rate of 2,000 individuals. Fee has been used for multiple training programs (other than AANP), which has significantly reduced the cost per person for the AANP training.

Table 26
Cost estimates related to continuing education per credit type

Continuing education credit type	Eight-hour credits	Four-hour credits	Participant expense
Administrators	8 CEs	4 CEs	\$0
Social workers**	Pending	Pending	\$20
Nurses	6.5 CEs	4 CEs	\$0
Adult foster care	7 CEs	4 CEs	\$0
Other	8 CEs	4 CEs	\$0

** Social worker credits were approved following the completion of the AANP program and are being awarded to participants post training.

Online Marketing

In 2005, BEAM created the initial AANP web pages as an online resource for providers and partners on the grant project, listing trainer and training opportunities. All AANP online resources are now available at www.mibeam.org. The website, which links to the OSA website (www.michigan.gov/miseniors), was completed with oversight of the AANP Project Coordinator at BEAM and technical support of a marketing manager and programmer/web designer provided by BEAM's parent company, MPRO, on an hourly basis. Web updates are provided as needed without dedicated, full, or part-time staff for this service. The development of web pages on the BEAM website, versus a dedicated website, saved project domain, hosting and other general web-related costs. Table 27 provides cost estimates on web development.

Table 27
Cost estimates related to Web development

Web page development	FTE hours	Expenses	Total
Concept/content development	15	\$40	\$600
Initial 6-page development	9	\$45	\$405
Annual maintenance/updates	12	\$45	\$540
Totals			\$1,545

In 2007, BEAM developed an online registration form for use in the training scheduling process. The website listed pre-scheduled trainings for individuals and small groups as well as convenient online resources for providers to send requests for training larger groups. Table 28 provides cost estimates on developing capacity for online registration, based on activity-specific data where available.

Table 28
Cost estimates related to online registration

Online sign-up/registration	FTE hours	Expenses	Total
Content development/securing pre-scheduled dates	10	\$35	\$350
Basic design w/back end database (4 pages)	10	\$45	\$450
Maintenance/updates (7 months)	7	\$45	\$315
Totals			\$1,115

To effectively market to long-term care providers throughout the state, BEAM utilizes in-house and other out-sourced online tools to send email broadcasts. At this time, BEAM has obtained an estimated 3,600 long-term care provider email addresses through the help of the Michigan Background Checks Program. Table 29 provides cost estimates of email broadcasts.

Table 29
Cost estimates of email broadcasts

Email broadcasts	FTE hours	Expenses	Total
Content development (4 months)	4	\$40	\$160
Email broadcast service or IT	4	\$300	\$1,200
Total			\$1,360

Unexpected Outcomes and Lessons Learned

Following are key lessons learned related to the development and implementation of the AANP project and relevant to those who may wish to replicate the program:

- The significance of the state-academic-community partnership has already been noted and cannot be overstated, particularly as the AANP has a strong evaluation component. The core AANP team included key leaders from each area being involved at every stage, even during proposal development. Once funded and the project began to unfold, each key leader's specific role became more evident as did the importance of each leader ensuring that the particular aspect of the project for which they were responsible was being successfully managed. Further, the overall success of the AANP depended on the leadership of these individual key function leaders but also on the ability of everyone involved to work together as a team. While an OSA Project Officer and an MSU Principal Investigator were designated for oversight, the AANP program could not have been executed without the central involvement of the BEAM/AANP Administrative Manager or BEAM/AANP Curricula Coordinator. Good communication and joint decision-making among these key persons was crucial. Together, and with the input of the Advisory and Curricula Committees and the MSU Research Team, the AANP operations were developed and implemented.

- Effective operational oversight conducted by BEAM was made possible with the assistance of the corporate division of its parent company, MPRO. Through this relationship, BEAM was able to access various support services on an as needed basis.
- Complexity of rescheduling: Providers cited numerous reasons for needing to reschedule both eight-hour and four-hour trainings including the arrival of state or federal survey teams, short-staffing, or simply forgetting the scheduled training due to the length of time between scheduling and actual training date. Cancellations and rescheduling were always accommodated. However, each one involved multiple project staff communications with the provider, training site, participants, and trainer.
- Scheduling and equitable distribution of trainings among trainers: Project staff became aware that several trainers were training more often than others despite intentional efforts to distribute trainings equitably. This occurred in part due to trainers scheduling their own trainings. This presented both operational and evaluation challenges. It made it difficult to track training activity for accountability and performance measures. It also made it difficult to plan for availability of training materials. However, this also helped to increase the number of DAS trained. As a result, the AANP team devised several ways to accommodate these additional trainings and ensure that other trainers felt a fair system was in place. For example, Trainers who scheduled their own trainings agreed to contact the BEAM office in advance so that trainings could be logged and resource needs verified.
- Scheduling of small groups and individuals: The AANP eight-hour training was designed to accommodate twenty participants. This was based on a balance between ideal group discussion size, having an adequate number of participants for role-play and small group breakouts, and being too large to have a meaningful, interactive experience. It was also based on efficiency and cost related to trainer and staff time and material resources. However, this design element made accommodating providers with few DAS and individual's requests difficult. This issue was successfully addressed in several ways. In 2007, regional trainings were initiated and designed specifically to bring small groups and individuals together in a central location. In addition, the list of pre-scheduled regional trainings was posted on the BEAM website to ensure easy access for individuals and small groups. AANP staff also assisted in identifying trainings already scheduled at other facilities willing to include additional participants.
- Outreach: Initial marketing was conducted through large group mailings (both traditional mail and email) to providers and organizations. However, as word spread, smaller groups and individuals began to express interest. Feedback from providers indicated that many people who participated in the training heard about it through word-of-mouth. Consequently, marketing efforts were broadened to reach potential users in multiple ways. In addition to scheduled brochure mailings, frequent email reminders were sent to trainers to reinforce the importance of their marketing of the program and reaching out to all of their own contacts. Marketing materials were distributed including newsletter articles and sample emails to provider associations. A presentation was developed and a display poster was created for use by grant managers, project staff and others at various industry conferences and other venues. The Advisory Committee assisted with marketing in multiple ways including publishing articles in association newsletters. Due in large extent to networking with Advisory Committee members, the AANP has been recognized

by state licensing bodies as a valuable program and an important training tool. It has been recommended for facility correction plans and could be used by any type provider.

- The continuity of the Curricula Committee was of critical importance throughout the project. Many of the training improvements meant an alignment of the training materials. Intimate knowledge of the curricula, established relationships with Trainers, and sponsoring of the refresher Train-the-Trainer programs led to smooth transitions whenever revisions were adopted.
- Staffing and trainers: Good communication and relationships with trainers was essential. While Trainers were not considered staff of the AANP project, they were clearly a critical extension of the staff and good communication facilitated the logistics of scheduling statewide, ensuring all training materials were on-site, disseminating information about program changes, trainer refresher sessions, and documentation requirements. In addition, their feedback and input heavily influenced the revision of training materials, compilation and distribution of best practices, improvement of marketing and outreach tools as well as sustainability of the program. Recognizing this, BEAM devised numerous ways in which to facilitate communication with Trainers, both individually and collectively. Use of distance technology, including email, video conferencing, conference calls and other tools were used. Distance technology was particularly useful to engage the Upper Peninsula (U.P.) trainers with the Lower Peninsula trainers (the U.P. is six to ten hours away from the trainer training site in East Lansing, MI and BEAM offices). In addition, a monthly conference call was established, referred to as “Trainer Chats.”
- Start-up and materials: Prior to the start of the training, all materials were printed in an effort to save cost and address issues of distribution from a single source. Training folders were all assembled. These decisions proved difficult in that pre-printed materials could not be revised as training progressed and constructive feedback was received. Consequently, re-printings or addendums were necessary. This also meant that Trainers ended up spending considerable time rearranging training folders.
- Start-up and databases: Particular attention should be paid in advance of start-up to the types of databases needed to track operations and performance adequately. For example, establishing a marketing and training use database proved essential and over time, the various fields that should be included became evident. The AANP core team needed to know who all potential program users were, who was targeted, who responded, who actually trained and so forth. Further, it became important to understand different characteristics of these populations such as provider type, geographic location and number of DAS employed. Establishing a relevant and useful database of this nature has been an iterative process. It is highly recommended to have databases in place from the start, as they are a critical tool for tracking progress, quality improvement, measuring performance, budget justification and sustainability.
- Length of the AANP training and sustainability: Providers with limited staffing found scheduling eight hours of continuous training difficult. Some of the questions asked included: Can the training be split into two days? Can we have just a part of the training? Can we send either more or fewer participants (rather than the 20)? These issues were successfully addressed with the introduction of the alternative AANP programs, e.g. the PAAN (four-hour training), Facilitator Instructional Modules, and potential Regional trainings.

Best/Promising Practices

Through the implementation of the AANP program, several Best Practices were identified including the following:

- **Develop strong state-academic-community partnerships to guide and execute the project from its start to final products.** Identify key staff from state government, universities, and long-term care organizations who can serve on the core planning/steering committee. This should include the Curricula Coordinator who is an expert in both curricula development and the topic. Identify a Curricula Committee that consists of experts in the field and is also widely diverse; representing providers, advocates and others who have strong experience in long-term care education. Identify an Advisory Committee that is equally as diverse and representative of multiple key long-term care stakeholders. These partnerships were essential to the successful completion of this project.
- **Incorporate a strong evaluation component.** The Michigan AANP program included a comprehensive formal evaluation of program outcomes, made possible through a strong relationship with the MSU College of Human Medicine. Evaluation resulted in empirical evidence of the value of the AANP training in terms of DAS knowledge gain and subsequent changes in job performance. This evidence can now be used as a basis for additional research, program development and the sustainability of the AANP. Moreover, it can be used by the state to inform additional abuse reduction initiatives.
- **Provide comprehensive curricula that are focused on prevention, person-centered care, and empowering DAS to take a direct, active role in abuse prevention.** Provide DAS with tools to de-escalate potentially abusive situations that are within their control. The findings from the MSU evaluation provides initial supportive evidence that DAS knowledge gained from participation in the AANP training was then translated into job performance. This suggests that the training may have the potential to ultimately reduce elder abuse.
- **Utilize adult learning principles in all teaching delivery methods.** DAS participants overwhelmingly endorsed the way in which the eight- and four- hour trainings were delivered. The evidence from evaluations suggests that the delivery methods were directly tied to participant satisfaction, knowledge gain and retention, and subsequent application of new knowledge to job practice.
- **Select Specialized Trainers using high standards, provide a quality Train-the-Trainer program and maintain close communication with all Trainers throughout the project.** This is of central importance to training impact and effectiveness, curricula development, and overall DAS participant satisfaction. Although the FIMS modules and other resources are now available online or by request, the AANP emphasis on the utilization of highly trained trainers has been essential to achieving a high level of program quality and consistency throughout the pilot training.

- **Establish a partnership with an organization equipped to execute training operations.** Through the corporate division of its parent company, MPRO/BEAM was able to secure various support services at a reduced rate including accounting, human resources, marketing, and additional operational staffing. These services would have otherwise necessarily been secured through contractors at higher service provision costs as well as additional fees. Moreover, MPRO's comprehensive quality-improvement focus was in direct alignment with the AANP objectives.

Actions to Sustain the Michigan AANP Training Program

The plan to sustain Michigan's AANP training program has been discussed by the AANP team and Curricula and Advisory Committees over several months. The value of the hands-on training with small class sizes emphasizing person-centered care, prevention, communication, and how to report abuse are supported by the MSU evaluation findings. The program sustainability action plans include the following²:

- BEAM has developed and posted twelve Facilitator Individual Modules (FIMS) on the BEAM website for supervisors and educators to download and use in any long-term care setting. A summary of the four- and eight-hour trainings, the Supervisor Training, and information about contacting BEAM for consultation services or scheduling on-site trainings are also posted. Continuing education credits are being explored for use with the FIMS. *As of the date of this document, CEs for all FIMs are approved for nurses.* BEAM will continue to host the website, which is now linked to the OSA website and is in the process of applying for additional funding for web maintenance and ongoing updating. *See footnote below.*
- BEAM is exploring the potential of continuing its oversight of the AANP training. At this time, BEAM plans to utilize its Curricula Coordinator to update materials as needed and develop CE granting criteria and procedures. BEAM also hopes to coordinate scheduling of lead Specialized Trainers using a fee-for-service model. In addition, AANP staff is also planning to utilize other provider organizations to assist in offering AANP training to their members to expand the potential for training. Each of these organizations has Specialized Trainers already on staff. *See footnote below.*
- The Michigan Office of Services to the Aging (OSA) is offering in-kind contributions by the Project Officer to provide oversight of the continuation and integrity of the established program. Due to Michigan's economy, the state currently does not have the resources to fund the program. However, the OSA staff is working with BEAM to seek external grant funding that builds upon existing state-academic-community relationships. *See footnote below.*
- OSA, BEAM and MSU will continue to partner on all initiatives that develop as a result of the Abuse Reporting System research. The findings were mirrored in the Governor's

² Following the completion of the AANP project, PHI accepted administrative oversight of the AANP training, including promotion and expanded use of all of the AANP curricula through regional and national partnerships and fund development. For information on these activities, please contact Hollis Turnham, PHI, Midwest Director, 517- 327-0331, hturnham@phinational.org.

Task Force Report and discussions have already started with state officials on how to move forward with implementing recommendations such as the establishment of a centralized abuse reporting database.

- Michigan’s state licensing bureaus now list the AANP Training as a recommended option for use by facilities seeking abuse training.
- The MSU research team plans to continue with more in-depth data analyses and will share findings with BEAM and OSA as the basis for future research and joint projects.
- AANP training program representatives are approved to present at the NCOA-ASA conference on the state-academic-community partnership experiences of this project and how other states can utilize these “lessons-learned” to create and maximize collaborative relationships for a common goal.
- The Michigan Long Term Care Advisory Commission’s Workforce Workgroup and OSA are actively exploring the potential for adding the AANP training into the current CNA certification curricula.
- BEAM and OSA plan to provide access to the AANP tools at the national level through the partnership with organizations and resources such as the National Center on Elder Abuse, Administration on Aging, and the National Institute for Health – Medline Plus. Partnerships will include such products as conducting presentations potentially via webcasts and providing links to online resources and training tools. *See footnote on previous page.*
- The entire AANP team is willing to work with CMS in coordinating resources, lessons learned and best practices from all states involved in the demonstration projects so as to extend the best information to the widest audience at the national level. There are exciting tools developed in each state that could be coordinated and disseminated to caregivers, state officials and other key groups across all of the states.

Conclusions

The Michigan Adult Abuse and Neglect Prevention pilot training program has been highly successful in terms of meeting and exceeding its stated goals. In the course of the three-year project period, the AANP team has achieved multiple and lasting accomplishments including but not limited to the following:

- Established state-academic-community partnerships that are strong and upon which ongoing projects can be sustained and future projects launched.
- Established an infrastructure that supported the training of nearly 8,000 DAS and with adequate resources has the capacity to train thousands more for years to come.
- Recruited and trained over 76 highly Specialized Trainers of which more than half have expressed desire to continue training DAS using the AANP curricula.
- Developed a model curriculum that has empirical evidence to support its positive impact on DAS knowledge related to identifying, reporting, and preventing abuse.
- Developed multiple methods of delivering this proven curriculum so access is provided to the widest possible audience.
- Collected important data on DAS observations of actual and suspected abuse. If such data collection was sustained, patterns and trends related to abuse prevalence and reporting

could be identified that could inform state policies and resource expenditures directed at reducing abuse of vulnerable adults.

- Conducted extensive research on the formal abuse reporting systems in Michigan that provides an unprecedented understanding of the overall system and underscores the need for coordination. Discussions have already taken place on how to move ahead with implementing the recommendations outlined in this report.

All of these accomplishments now represent potential for making an indelible impact on abuse reduction in Michigan. Indeed, the lessons learned in Michigan can be applied most anywhere. By incorporating methods of staff empowerment, culture change and person-centered care, emphasizing prevention, and using adult learner methods of curriculum delivery, DAS have been given practical tools to prevent abuse. The skills they have gained are applicable not only with the adults they care for in their professional lives, but also in relationships outside of the work environment. Ensuring that all direct access staff receive comparable training is a goal worth championing. Moreover, with an infrastructure already in place, trainers standing ready, and momentum established as a result of this CMS funded pilot project, the window of opportunity is open. The AANP team is committed to working with others to leverage this opportunity while it exists. Every aspect of the training program contributes to a culture change, from recognizing the importance of building relationships with organizational partners, clients and co-workers to raising awareness of individual strengths and needs, both workers and clients. Additional work is needed to continue to advance and measure such culture change at an organizational level.

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To access curricula available online, visit:

www.phinational.org/aanp or www.michigan.gov/miseniors under Elder Rights

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List of Appendixes

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- Appendix B – Eight-Hour Curricula
- Appendix C – Specialized Trainer Train-the-Trainer
- Appendix D – Four-Hour Curricula
- Appendix E – SNAAP Curricula
- Appendix F – FIMS Curricula
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- Appendix H – CE Evaluation Instrument
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- Appendix K – Pre-Post Survey Instrument
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Additional information and documents available upon request:

The Formal Reporting Systems Report - *Vulnerable Adult Abuse in Michigan: The Formal Reporting System—Definitions, Data, and Processes*

A complete list of trainings by date and location

See Appendix A-M for additional details.

Appendix A – Program Contributors

Adult Abuse & Neglect Prevention Training Program State-Academic-Community Partners

The Michigan Adult Abuse and Neglect Prevention (AANP) Training Program was a joint educational grant project conducted by BEAM (formerly Bringing the Eden Alternative to Michigan), Michigan State University (MSU), and the Michigan Office of Services to the Aging (OSA). Following are key contributors:

AANP Team: Marla DeVries, BEAM; Traci Fisher, BEAM; Paula Garland, BEAM/MPRO; Clare Luz, MSU; Catherine Macomber, BEAM; Heather Picotte, BEAM; and Lauren Swanson, OSA; also thanks to Simone Brennan, Karen Peters, and Jack Steiner, formerly of BEAM.

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MPRO (formerly Michigan Peer Review Organization): Kathryn Breznau, Steve Coon, Amy Curry, Lynn DeGrande, Denise Duffy, Jim Grau, Susan Nieminski, Rik Mertens, Carrie Spunar, and Debbie Taylor.

AANP Advisory Committee: Patricia Anderson, Health Care Association of Michigan (HCAM); Diane Baker, Michigan Department of Community Health (MDCH); Renee Beniak, Michigan County Medical Care Facilities Council; Penny Brantley, Citizens for Better Care (CBC); Sally Bruce, Upper Peninsula Area Agency on Aging; Robert Caillier, Michigan Works—Region 7B Consortium; Nick Ciaramitaro, Michigan AFSCME Council 25; Mark Cody, Michigan Protection and Advocacy Services; Norm DeLisle, Michigan Disability Rights Council; Cynthia Farrell, Michigan Department of Human Services (MDHS); Traci Fisher, BEAM; Pamela Gosla, South Central Michigan Works; Frances Grant, CBC; Ellen Hayse, MSU; Helen Hicks, CBC; Catherine Hunter, MDCH; Elizabeth Janks, Wayne State University (WSU); Sandra Kilde, Michigan Association of Homes and Services to the Aging; Linda Lawther, Michigan Center for Assisted Living; Clare Luz, MSU; Janet Martinich, Michigan Home Health Association (MHHA); Catherine Macomber, BEAM; Lynne McCollum, OSA; Tom McWhorter, MDHS; Cherie Mollison, OSA; Susan Oginsky, HCAM; Anita Salustro, AARP; Judy Sivak, Area Agency on Aging-3A; Sarah Slocum, State Long-Term Care Ombudsman Program; Beverly Sobolewski, MDCH; Robert Stein, Michigan Assisted Living Association; Susan Steinke, Michigan Quality Community Care Council; Lauren Swanson, OSA; Jeff Towns, Michigan Hospice & Palliative Care Organization; Hollis Turnham, PHI (formerly Paraprofessional Healthcare Institute); Drew Walker, OSA; Deborah Wood, MDHS; and Harvey Zuckerberg, MHHA.

AANP Lead Curricula Development Team: Marla DeVries, Chair, BEAM; Vickie Burlew, Lebenbom & Rothman, PC; Catherine Macomber, BEAM; and Maureen Sheahan, PHI.

Additional AANP Curricula Committee Members: Simone Brennan, formerly of BEAM; Sarah DeDonatis, CBC; Cynthia Farrell, MDHS; Traci Fisher, BEAM; Dakima Jackson, CBC; Elizabeth Janks, WSU; Clare Luz, MSU; Janet Martinich, MHHA; Maureen Mickus, Western Michigan University (formerly with MSU); Karen Peters, formerly of BEAM; Lauren Swanson, OSA; Jill Tabbutt-Henry, PHI; and Hollis Turnham, PHI.

AANP Specialized Trainers: Amanda Stryker, Barbara Allen, Beverly Sobolewski, Brenda LaVigne, Catherine Macomber, Cathy McRae, Danielle Belman, Dianne Baker, Don Cross, Elaine Archambeau, Ellie Poster, Emily Norton, Fay Flowers, Gail Koeppe-Hall, Gisele Bingham, Grace Tambeau, Gwen Pittman, Janice Osborn, Jimmy Bruce, Joyce McDaniel, Julie Weeks, Karen Currington, Kathy McGeathy, Kim Donlin, Kim Runci, Linda Lawther, Lori Bayer, Lou Hildebrandt, Marilyn Lauscher, Marja Salani, Marla DeVries, Maureen Sheahan, Phyllis Earns, Raymie Postema, Renee Beniak, Richard Johnson, Roxie Sullivan, Sally Arnold, Samira Bond, Sharon Bridges, Sharon O'Rear, Susan Steinke, Stefanie Sinks, Tamara Heaton-Bauer, Teri Aldini, Tracy Hover, and Val Johnson.

Appendix B – Eight-Hour Curricula

Additional information available upon request:

Training Materials (e.g. training protocols, presentations, handouts, posters, forms)



AGENDA

Session 1	Welcome! We Value You!
Session 2	Training Evaluation
Session 3.1	Group Warm-up
Session 3.2	Introduction to Person-Centered Care
Session 3.3	My Ideal Caregiver
Session 3.4	It's About Relationships
Session 4.1	The Picture of Abuse
Session 4.2	Protecting our Vulnerable Adults: The Law and Our Obligations
Session 5.1	Factors that Trigger Abuse: Triggers Stress Test
Session 5.2	Factors that Trigger Abuse: Life Influences, Job Challenges, and Client Behaviors
Session 6.1	Recognizing Triggers in Myself and Others
Session 6.2	Counteracting the Triggers
Session 6.3	Active Listening
Session 6.4	Constructive De-escalation
Session 6.5	When Abuse Happens / I CARE – WE CARE
Session 7	Training Evaluation
Session 8	Learning Circle

BEAM provides these materials in cooperation with the Michigan State University and the Michigan Office of Services to the Aging through the Michigan Department of Community Health Grant No. * 11-P-93042/5-01 awarded by the Centers for Medicare & Medicaid Services.

Adult Abuse and Neglect Prevention Training

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Appendix C – Specialized Trainer Train-the-Trainer

Additional information available upon request:

Training Materials (e.g. training protocols, presentations, handouts, posters, forms, primary and specialized trainer job descriptions)

Adult Abuse & Neglect Prevention Training Program Train-the-Trainer Manual Table of Contents

Introduction

Synopsis of Program

Acknowledgements

How to Use this Manual

Training-the-Trainers

Timed Agenda

Day 1

Welcome

Group Warm-up

Adult Learner Centered Methods

Protocol Format and Assignments

Two-day Plan and Agenda

Demonstration and Feedback

Day 2

Welcome and Recap

Feedback for Participants

Trainer Tips

Resources

Logistics

The Curriculum

- Session 1 Welcome! We Value you!
- Session 2 Identifying Perceptions of the Audience
- Session 3.1 Group Warm-up
- Session 3.2 Introduction to Person-Centered Care
- Session 3.3 My Ideal Caregiver
- Session 3.4 It's About Relationships
- Session 4.1 The Picture of Abuse
- Session 4.2 Protecting Our Vulnerable Adults: The Law and Our Obligations
- Session 5.1 Factors that Trigger Abuse: Triggers Stress Test
- Session 5.2 Factors that Trigger Abuse: Life Influences, Job Challenges, Client Behaviors
- Session 6.1 Recognizing Triggers in Myself and Others
- Session 6.2 Counteracting the Triggers
- Session 6.3 Active Listening
- Session 6.4 Constructive De-escalation
- Session 6.5 When Abuse Happens / I CARE – WE CARE
- Session 7 Measuring the Change in Perceptions
- Session 8 Learning Circle

Resources

- Vocabulary
- Continuum of Care
- Articles, Websites, Books, and Videos

Logistics

- Supplies
- Room Set-up
- Schedules
- Payment
- Trainer Agreement
- Sign-in Sheet

BEAM provides these materials in cooperation with the Michigan State University and the Michigan Office of Services to the Aging through the Michigan Department of Community Health Grant No. * 11-P-93042/5-01 awarded by the Centers for Medicare & Medicaid Services.

Appendix D – Four-Hour Curricula

Additional information available upon request:

Training Materials (e.g. training protocols, presentations, handouts, posters, forms)



AGENDA

Session 1	Welcome! We Value You!
Session 2	Training Evaluation
Session 3	Reporting
Session 4.1	Introduction to Person-Centered Care
Session 4.2	Understanding Care and Relationships
Session 5.1	Factors that Trigger Abuse
Session 5.2	Trigger Signals
Session 5.3	Trigger Busters
Session 6.1	Active Listening
Session 6.2	Constructive De-escalation
Session 6.3	When Abuse Happens / I CARE – WE CARE
Session 7	Training Evaluation
Session 8	The Real Meaning of Peace

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Appendix E – SNAAP Curricula

Additional information available upon request:

Training Materials (e.g. training protocols, presentations, handouts, posters, forms)



AGENDA

Session 1	Welcome! We Value You!
Session 2	Identifying Perceptions of the Audience
Session 3.1	Mini Wall to Wall
Session 3.2	Introduction to Person-Centered Care
Session 3.3	My Ideal Caregiver
Session 4.1	The Picture of Abuse
Session 4.2	Reporting
Session 5.1	Factors that Trigger Abuse
Session 5.2	Handling Employee Interactions
Session 5.3	Putting It All Together
Session 6.1	Recognizing Triggers in Myself and Others
Session 6.2	Counteracting the Triggers
Session 6.3	Active Listening
Session 6.4	De-escalation
Session 6.5	When Abuse Happens / I CARE – WE CARE
Session 7	Measuring the Change in Perceptions
Session 8	Learning Circle

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Appendix F – FIMS Curricula

Additional information available upon request:

Training Materials (e.g. training protocols, presentations, handouts, posters, forms, guides)



Module Outline

Module	Title	Content
1	Person-Centered Care	<p>This module introduces the concept of person-centered care (PCC) and how abuse can be prevented by instituting the goals of PCC into everyday work and life. The goal of this training is not only to prevent abuse from occurring, but also to transform institutions and organizations from being task-focused and treatment-oriented to being relationship-focused and care-oriented. Person-centered care is a philosophy that puts the client at the center of everything done as caregivers. In the past, many health care organizations have been policy-centered or treatment-centered. This module explores what person-centered care is and how it applies to the work of a direct access staff.</p>
2	Identifying Potential Signs of Abuse and Neglect	<p>Often staff does not see or hear abuse or neglect happening. They are more likely to see the signs of abuse and neglect, including client</p>

Module	Title	Content
		<p>behaviors. This module focuses on the identification of abuse and neglect by exploring the physical signs, emotional responses, and verbal comments an abused person might display. To create an abuse-free environment, all staff must be keen to the potential signs of abuse and neglect.</p>
3	Defining and Reporting	<p>This module will tell participants what to do when facing a situation that may need to be reported as abuse, neglect, or misappropriation. Participants need to leave the session knowing that each and every one of them is mandated by law to report situations that may be abuse or neglect.</p>
4	<p>Understanding Stress Triggers: Life Influences and Practical Steps to Counteract Those Stressors</p>	<p>This module introduces the concept that caregivers (regardless of the specific role they play in a long-term care organization) are often at risk to abuse because of the significant stressors in their lives. These stressors have the potential to impact our overall well-being and ability to cope with difficult situations. The old philosophy of “leave your personal problems at the door” is often unrealistic. It is important to identify how “life influences” impact staff as individuals and then explore healthy means of equipping direct access staff (DAS) to cope with these stressors so they can provide quality care for the clients.</p>

Module	Title	Content
5	Understanding Stress Triggers: Job Challenges and Practical Steps to Counteract Those Stressors	This module introduces the concept that caregivers (regardless of the specific role they play in a long-term care organization) are often at risk to abuse because of the, significant day-to-day stressors in their work environment. These stressors have the potential to impact our overall well-being and ability to cope with difficult situations at work. We often hear people talk about spending more hours with co-workers than with family. If that is the case, it is important to both acknowledge the job stressors that impact staff as well as strategies for equipping direct access staff (DAS) to cope with these stressors so they can provide quality care for the clients.
6	Understanding Stress Triggers: Challenging Client Behaviors and Practical Steps to Counteract Those Stressors	This module introduces the concept that caregivers (regardless of the specific role they play in a long-term care organization) are at risk to abuse because of the challenging behaviors of clients. It is beneficial for caregivers to discuss the client behaviors that are stress inducing and could potentially lead to abuse or neglect if not properly acknowledged and addressed.
7	Signals We Are Getting Near A Trigger Point	This module takes us beyond what factors may trigger abuse as was discussed in modules 4, 5, and 6. Here, we focus on

Module	Title	Content
		<p>the signals that let us know we are nearing a “trigger point”—the point at which abuse may occur. We all respond differently to the triggers; some of our trigger signals are internal, others are not. We need to know ourselves to prevent ourselves from abusing.</p>
8	Active Listening	<p>This session explores the importance of active listening as a basic life skill that benefits all of our relationships. We build quality relationships by practicing active listening skills with co-workers, family, friends, and clients. Abuse prevention happens when we promote person-centered care and quality relationships through active listening. Active listening is a skill we must develop. For many of us, it doesn’t come naturally.</p>
9	Constructive Conflict Resolution	<p>This module offers employees skills and approaches for effective and constructive ways to resolve conflict with supervisors, co-workers, clients and families. Conflict in our lives is inevitable and likely in the workplace. A full-time staff person spends more hours with her co-workers than with her family. Therefore, it is important to arm staff with constructive techniques for managing conflict in a healthy way. Constructively managing conflict can lead to personal</p>

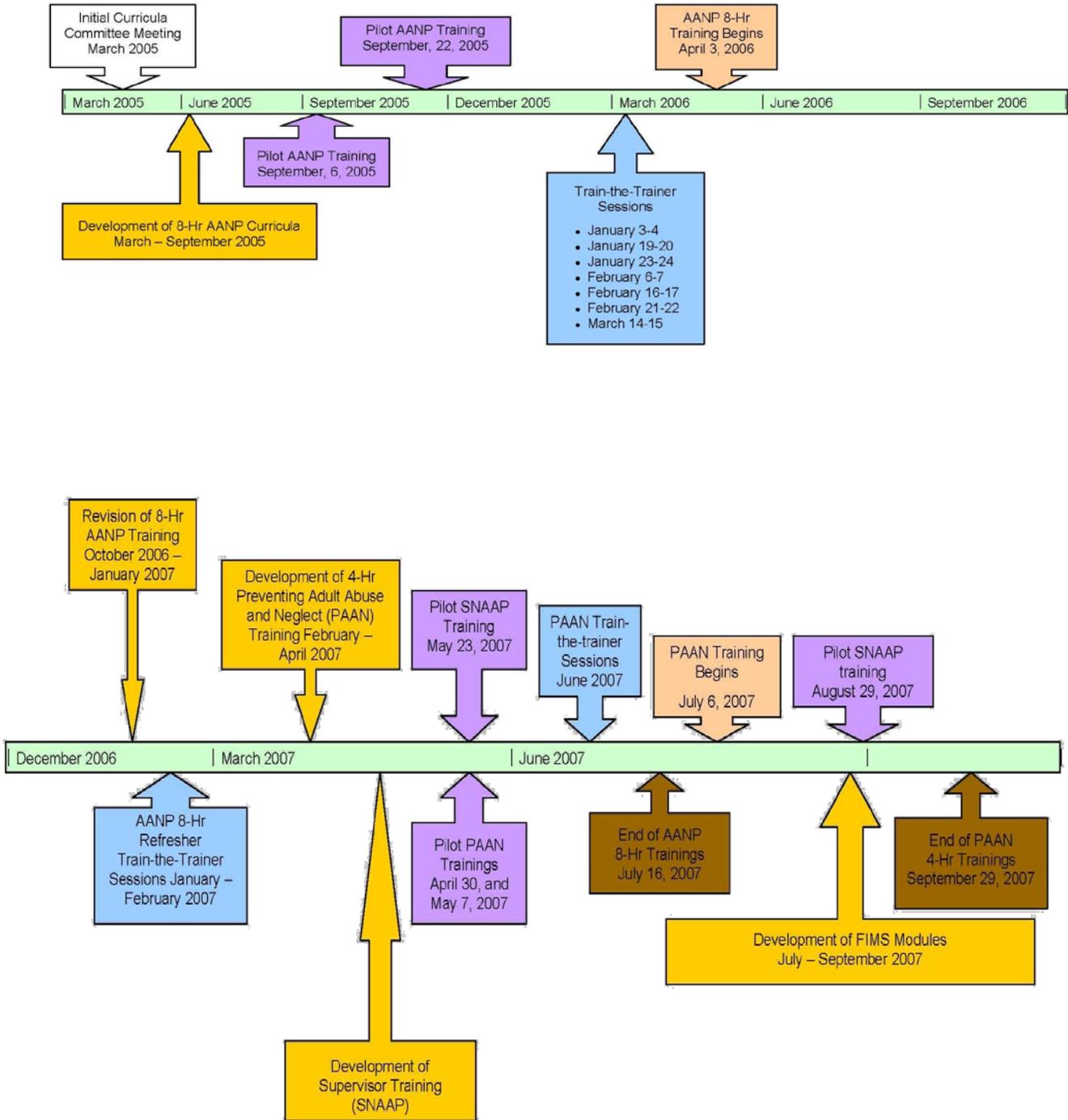
Module	Title	Content
		growth and strengthened relationships.
10	Constructive De-Escalation: Clients with Cognitive Impairments	This module offers strategies to de-escalate conflict situations when caring for clients with cognitive impairments. Participants are introduced to the basics of communication as well as an overview of changes in communication that occur with cognitive impairments. Finally, specific techniques are identified for use with clients with cognitive impairment.
11	When Abuse Happens	Module 11 serves as a wrap-up to modules 1-10, incorporating many of the concepts previously discussed. This module focuses on how to respond when abuse occurs. The reality is that the abuse and neglect of vulnerable adults still happens. Direct Access Staff (DAS) need to know how to appropriately respond in an abusive situation. This module also involves a discussion of the barriers to reporting, exploring the reasons DAS do not report abuse. The barriers are real and each organization must address the issues raised as barriers. Additionally, participants are taught the acronyms I CARE and WE CARE.
12	Learning Circles	This module introduces a group communication technique called a Learning Circle. The Learning Circle

Module	Title	Content
		<p>truly reflects the process by which individuals learn. We observe through our senses, we interpret what we observe, we have feelings, and we think through our intentions before taking action. This happens with all of us every day, all the time, from the day we are born until the day we die. The Learning Circle allows us to share and explore any and all of these elements – observations, interpretations, and feelings intentions. As a result of the process of the circle, we individually can broaden our learning – by considering other's facts (observations); modifying our interpretations, feeling new feelings (via empathy), and shaping new intentions. A Learning Circle also offers a safe place for individuals to share and be heard. It creates an opportunity for quiet, reserved speakers to share alongside their more vocal counterparts.</p>

BEAM provides these materials in cooperation with the Michigan State University and the Michigan Office of Services to the Aging through the Michigan Department of Community Health Grant No. * 11-P-93042/5-01 awarded by the Centers for Medicare & Medicaid Services.

Appendix G – Curricula Development Timeline

Adult Abuse & Neglect Prevention Training Program Curricula Timeline



Appendix H – CE Evaluation Instrument

Additional information available upon request:

Eight-hour AANP continuing education evaluation form follows. Evaluation forms are available for all other curricula upon request.

**AANP - BEAM
Continuing Education Evaluation Form**

Title: Adult Abuse & Neglect Prevention Training Program

Date:

City:

OFFERING OBJECTIVES Following this presentation, I am now able to:	Strongly Agree	Agree	Disagree	Strongly Disagree
1. Identify my own perceptions of abuse and abuse prevention.				
2. Identify the definitions, symptoms, and characteristics of abuse, neglect, and exploitation.				
3. Identify the Michigan laws protecting our vulnerable adults and my obligation to report.				
4. Actively listen and properly respond to a person describing abuse.				
5. Recognize personal, environmental, and cultural factors that may trigger abuse.				
6. Effectively utilize de-escalation, intervention, and resolution skills that are key to preventing abuse.				
7. Participate in the creation of an abuse-free environment and culture.				
8. Measure the change in perceptions of the audience and personal commitment.				
9. Develop an abuse prevention plan – personal and organizational.				
SPEAKER Speaker Name:	Strongly Agree	Agree	Disagree	Strongly Disagree
1. The Speaker(s) was an effective presenter.				
2. The Speaker(s) used appropriate teaching strategies.				
OTHER COMMENTS:				

Appendix I – Trainer Survey Instrument

Additional information available upon request:

Trainer survey response data

Adult Abuse & Neglect Prevention Training Program
Trainer Experience
Survey

Overall, how would you describe your experience with the AANP program? (train-the-trainer, curricula, conducting the trainings, etc.)

What, specifically, did you find the most positive about your experience with AANP?

What, specifically, did you find the most challenging about your experience with AANP?

For the following areas, please describe the most successful and the most challenging aspects:

- Preparation for training (how well prepared did you feel to conduct these trainings):
 - Initial train-the-trainer (Early 2006):
 - Revised eight-hour train-the-trainer:
 - Four-hour train-the-trainer:
 - Preparation for individual trainings (the amount of time/work needed to prepare for a training you were conducting):
 - Trainer manual/resources:

For the following areas, please describe the most successful and the most challenging aspects:

- Communication:
 - Scheduling:
 - Trainings:
 - Train-the-trainer sessions:
- Updates (email):
- Trainer chats:
- Response of AANP staff:

It is our intention to provide you with all final products at the end of this project (eight-hour curriculum, four-hour curriculum, supervisor curriculum and facilitator instructional modules.)
How do you think you will use these products?

- Internal training (training within your organization):
 - Will you use it as it is or will you incorporate parts of it into your own training curricula?
- Training in the community (outside of your organization):
- Other:

General Comments (issues of sustainability, feedback on other aspects of the project, questions, concerns, etc.):

Name (optional): _____

Appendix J – Provider Survey Instrument

Additional information available upon request:

Provider survey response summary



Provider Survey:

Regarding Adult Abuse & Neglect Prevention (AANP) Training Programs

Conducted by BEAM and Michigan State University

As part of a federal three-year, statewide Adult Abuse & Neglect Prevention (AANP) Training Program grant, BEAM and Michigan State University are requesting your assistance in completing the following survey. Information obtained through this survey will assist researchers in understanding providers' needs and preferences with regard to abuse training for future training development and use.

This survey is intended for individuals who make decisions regarding staff training. If you are not the individual primarily responsible for making decisions regarding staff training, please forward this survey to the appropriate person.

Please answer the following questions to the best of your ability and return this survey by October 12, 2007. If you received this survey by email, simply click on the link provided or visit www.mibeam.org/survey/. If you received this survey by regular mail and would like to complete a hard copy, you can return it using the following methods:

- Enclosed, postage-paid envelope
- Fax to (248) 465-7428

Thank you for your assistance.

Direct Access Staff (DAS) – anyone that has direct contact with adults requiring long-term care services. This includes (but is not limited to) nurses, nurse aides, physicians, therapists, housekeepers, maintenance, janitorial, dietary, all levels of home health care, adult foster care residential staff and staff of state operated psychiatric hospitals and intermediate care facilities for persons with mental retardation.

Part I: Background Information

1. Which of the following best describes the services provided by your organization? (please mark all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Adult Foster Care Home | <input type="checkbox"/> Assisted Living (Unlicensed) |
| <input type="checkbox"/> Developmental Disability Organization | <input type="checkbox"/> Home for the Aged |
| <input type="checkbox"/> Home Health Agency | <input type="checkbox"/> Home Help Agency |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Hospital Long Term Care Unit |
| <input type="checkbox"/> Mental Health Facility | <input type="checkbox"/> Mental Health Agency |
| <input type="checkbox"/> Nursing Home | <input type="checkbox"/> Other (please specify): |

2. If you checked more than one type of service provided, please mark in which settings you provide abuse training: (please mark all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Adult Foster Care Home | <input type="checkbox"/> Assisted Living (Unlicensed) |
| <input type="checkbox"/> Developmental Disability Organization | <input type="checkbox"/> Home for the Aged |
| <input type="checkbox"/> Home Health Agency | <input type="checkbox"/> Home Help Agency |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Hospital Long Term Care Unit |
| <input type="checkbox"/> Mental Health Facility | <input type="checkbox"/> Mental Health Agency |
| <input type="checkbox"/> Nursing Home | <input type="checkbox"/> Other (please specify): |

3. Which of the following best describes the ownership structure of your organization? (please mark all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Not-for-profit | <input type="checkbox"/> For-profit |
| <input type="checkbox"/> Corporate owned | <input type="checkbox"/> Private/Family owned |

4. Total number of Direct Access Staff (see definition above) within your organization:

5. Region(s) in which your organization provides care to vulnerable adults: (please mark all that apply)

- Southwest Michigan including Kalamazoo, Grand Rapids and Battle Creek
- South central Michigan including Lansing and Jackson
- Southeastern Michigan including Detroit and Ann Arbor
- Northern Lower Peninsula including Flint
- Upper Peninsula
- Entire State

6. Please indicate your position within the organization:

- | | |
|--|--|
| <input type="checkbox"/> Administrator/Director | <input type="checkbox"/> Director of Nursing |
| <input type="checkbox"/> Education/In-service Director | <input type="checkbox"/> Licensee |
| <input type="checkbox"/> Social Work/Social Service | <input type="checkbox"/> Other: _____ |

7. Please indicate other individual(s) within your organization responsible for making decisions regarding staff training: (please mark all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Administrator/Director | <input type="checkbox"/> Director of Nursing |
| <input type="checkbox"/> Education/In-service Director | <input type="checkbox"/> Licensee |
| <input type="checkbox"/> Social Work/Social Service | <input type="checkbox"/> Other: _____ |

8. Primary county/counties in which you hold training for staff, please rank in the order of greatest number of training sessions per county:

1. _____ 2. _____ 3. _____

Part II: Experience with Abuse Training in General

9. Has your organization provided any abuse training for staff in the last year?

- Yes No

10. Is abuse training required, either by licensure or by your organization, for DAS?

- Yes No

If answer to Question 10 is No, please skip to Question 14

11. If abuse training is required, please mark the source(s) of requirement: (please mark all that apply)

- Licensure (State/Federal)
- Accreditation
- Funding Source
- Provider Organization
- Corporate Office
- Other: _____

12. If abuse training is required, how often is it required? (please mark all that apply)

- Upon Hire/Orientation
- Annually
- Quarterly
- Other: _____

13. If abuse training is required, is it required for all DAS?

- Yes
- No

Part III: Experience with the AANP Training Program

14. How did you hear about the AANP program? (please mark all that apply)

- Email/Internet
- Word of Mouth
- Colleague
- Provider Association
- Never Heard of AANP
- Brochure Mailing
- Conference Presentation
- AANP Trainer
- Corporation
- Other, please specify: _____

If you have participated in AANP training – please skip to Question #16

If you have not heard of AANP training – please skip to Question #24

15. If your organization has heard of AANP but *chose not to sign up*, please indicate reasons why (please mark all that apply *then skip to Question #24*)

- Abuse training is not required
- Abuse training is obtained elsewhere
- Budget constraints
- Location of training
- Time constraints (i.e. training session too long)
- Other, please specify: _____

16. If your organization signed up for AANP training, which method of promotion most prompted this decision? (please mark one)

- | | |
|--|--|
| <input type="checkbox"/> AANP Trainer | <input type="checkbox"/> Brochure |
| <input type="checkbox"/> Colleague | <input type="checkbox"/> Conference Presentation |
| <input type="checkbox"/> Corporation | <input type="checkbox"/> Email/Internet |
| <input type="checkbox"/> Mailing | <input type="checkbox"/> Provider Association |
| <input type="checkbox"/> Word of Mouth | <input type="checkbox"/> Other, please specify:
_____ |

17. Please indicate how important the following factors were in the decision to sign up for AANP training

	Not Important At All					Extremely Important
	1	2	3	4	5	
a. Abuse training is required	1	2	3	4	5	
b. Encouragement from Provider Association	1	2	3	4	5	
c. Training was free	1	2	3	4	5	
d. Curricula emphasized abuse prevention	1	2	3	4	5	
e. Met a need for any type of in-service training	1	2	3	4	5	
f. Other, please specify: _____						

18. What type(s) of AANP training did your DAS (Direct Access Staff) complete? (please mark all that apply)

- a) Eight-hour AANP Training _____
- b) Four-hour PAAN Training _____
- c) Supervisor Training _____

19. What type(s) of AANP training did you personally complete? (please mark all that apply)

- a) Eight-hour AANP Training _____
- b) Four-hour PAAN Training _____
- c) Supervisor Training _____
- d) Did not attend any AANP Training _____

If answer to Question #19 is "Did not attend," please skip to Question #24.

20. Mark one of the following statements regarding AANP training completed:

- _____ Some of the DAS completed AANP training and we would like to train additional DAS
- _____ Some of the DAS completed AANP training and it's not necessary for the rest of our DAS to be trained
- _____ All DAS completed AANP training and we would like continued training
- _____ All DAS completed AANP training and continued training is not necessary

If answer to Question 20 is "All DAS completed training," please skip to Question 22

21. Please indicate the reasons for which your organization did not have all DAS trained: (please mark all that apply)

- _____ Only a portion were trained due to budget limitations
- _____ Only a portion were trained due to time limitations
- _____ Chose to have primarily supervisors trained
- _____ Could only send a portion of our DAS due to need to cover client care
- _____ New DAS on staff after training completed
- _____ Other, please specify: _____

22. How satisfied are you with the AANP training that your DAS participated in?

- Very Satisfied
- Satisfied
- Neutral
- Dissatisfied
- Very Dissatisfied

23. Have you noticed any observable change in DAS attitude, behavior or performance as a result of the AANP training?

Yes No

If yes, please explain

Part IV: Training Preferences

24. If you would like to provide future abuse/AANP training for staff, which method would most fit your staff educational needs? (please mark all that apply)

- Web-based Self-instructional Training
- On-site Presentations Provided by Outside Presenter
- Facilitators Guide for Staff Educators/In-service Directors
- Off-site Presentations
- Video Presentation
- Other, please specify: _____

25. What length of abuse training would most meet your staff training needs (please rank your preference on a scale from 1-4, 1 representing the most preferred):

____ 1 Hour ____ 2 Hour ____ 4 Hour ____ 8 Hour

26. Please mark all of the topics below for which you would like to receive more training as it relates to abuse training:

- | | |
|---|--|
| <input type="checkbox"/> Active Listening | <input type="checkbox"/> Conflict Resolution |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Effective Communication |
| <input type="checkbox"/> Financial Exploitation | <input type="checkbox"/> Mental Health |
| <input type="checkbox"/> Person-centered Care | <input type="checkbox"/> Reporting Requirements |
| <input type="checkbox"/> Stress Management | <input type="checkbox"/> Teambuilding |
| <input type="checkbox"/> Time Management | <input type="checkbox"/> Violent/Aggressive Behavior |
| <input type="checkbox"/> Adult Learning Methods | <input type="checkbox"/> Other: _____ |

27. If AANP training is available after the grant project ends, would you be willing to pay for this training?

_____ Yes _____ No _____ Unsure

If yes, how much would you be willing to pay for AANP training? \$ _____

28. Please provide any other comments or suggestions regarding AANP or abuse training you believe would assist the researchers in understanding your needs:

Thank you for your assistance.

Please return this survey by October 12, 2007. You can return this survey using the following methods:

- Enclosed, postage-paid envelope
- Fax to (248) 465-7428
- If you have access to the Internet, you can complete this survey on-line at: www.mibeam.org/survey/.

Appendix K – Pre-Post Survey Instrument

Adult Abuse & Neglect Prevention (AANP) Training Program Evaluation

Conducted by Michigan State University

This AANP Training evaluation form has five parts. The first three will be completed *before* the AANP Training. The final two parts will be completed *after* the AANP Training. *No part* of this evaluation will be graded. Please **DO NOT** sign your name to this form or provide any contact information unless you choose to also take part in a paid telephone survey that is described below. The AANP Training is being evaluated by Michigan State University. With your permission, your responses will be utilized to assess how effective the Training is in meeting its goals for increasing knowledge of adult abuse and neglect prevention.

You have to complete this form to meet the requirements of the training program but it will NOT be graded and you have the right to say that you do not want your responses used for research purposes. Refusal to participate will not affect your training requirements or employment in any way. You do not have to answer any questions that make you uncomfortable although information and answers recorded on this form are anonymous and will be reported in summary form only. Your responses will not be able to be linked to you in any way. Your privacy will be protected to the maximum extent allowable by law. Participation does not require any additional time and it does not involve any known physical, financial, emotional or legal risk to you. You will not receive financial compensation for participation but your responses will contribute to improved strategies for teaching others about abuse and neglect.

Please indicate if MSU can use your responses to evaluate the AANP Training Program by marking Yes or No. Please fill in the bubble completely.

- Yes, I voluntarily agree to allow my responses on this form to be used for the AANP Training Program evaluation.
- No, I do not want my responses on this form to be used for the AANP Training Program evaluation purposes.

This evaluation instrument is being pilot-tested and validated with the Michigan AANP project. Findings are forthcoming. Contact Clare Luz, Principal Investigator, for more information at 517/432-2208 or luz@msu.edu.

Optional Paid Telephone Survey

The MSU research team is conducting a second evaluation to determine how the information learned in the training program is actually used. You may have the opportunity to participate in this evaluation which involves completing an automated telephone survey (using the phone's keypad) once per month for six months. Each phone survey would take approximately 10-15 minutes of your time and your responses would be kept highly confidential. No one would have access to your responses except the research team. Participation would not result in any cost to you or pose any known financial, employment, legal, physical or emotional risk. Likewise, choosing not to participate would not affect your training requirements or employment in any

Please write your phone number with the area code and enter it in the "bubbles" below:

(_ _ _) _ _ _ - _ _ _ - _ _

- - - - - - - - - -

◀ ◀ ◀ ◀ ◀ ◀ ◀ ◀ ◀ ◀

▶ ▶ ▶ ▶ ▶ ▶ ▶ ▶ ▶ ▶

way. Participation is completely voluntary. The benefits are that you would receive up to \$30 (\$5.00 value for each survey completed) and you would be contributing to increased knowledge of abuse and neglect prevention in Michigan that will affect State policies. More information about this opportunity is on the back of this sheet.

If you are interested in participating in the phone surveys, please provide your phone number in the space provided. Providing this information means that your responses from the first training evaluation will no longer be anonymous but we want to assure you that they will be kept strictly confidential as will your contact information and your responses to the

phone surveys. Only the research team will have access to this information. All findings will be reported in summary form only. No single person will be able to be identified in any reports. Again, your privacy will be protected to the maximum extent allowable by law.

Consent Statement: By providing my phone number in the box above, I am giving my permission for the MSU research team to arrange an automated phone call to me, if my phone number is selected, for the purpose of inviting me to participate in the paid phone surveys. Do NOT provide your Name.

If you have questions about any aspect of the above research, you are encouraged to contact Dr. Clare Luz, Principal Investigator at 517/432-2208, luz@msu.edu. If you have concerns about how the research is being conducted, you can contact Dr. Peter Vasilenko, Chair of the Bio-Medical Research Institutional Review Board at 517/355-2180, ucrihs@msu.edu.

Thank You Very Much for Your Time

Part I: Background Information

1. What is your current age?
 - 18-24
 - 25-29
 - 30-39
 - 40-49
 - 50-59
 - 60-69
 - 70-79

2. Male Female

3. Which of the following describes your racial/ethnic background?
 - African American or Black
 - Asian or Pacific Islander
 - American Indian or Alaska native
 - Caucasian or White
 - Multi-racial or Bi-racial
 - Hispanic, Latino, or Spanish origins
 - Other

4. What is the highest level of education you have completed?
 - Less than High School
 - High School Graduate or GED
 - Some College
 - College/Professional Degree (Other than LPN or RN)
 - LPN or RN

5. Which best describes your annual total household income (from all sources including a second earner)?
 - Less than \$10,000
 - \$10,000 – 19,999
 - \$20,000 - 29,999
 - \$30,000 - 39,999
 - \$40,000 - 59,999

Over \$60,000

6. Have you ever received any previous training in adult abuse and neglect? Yes No

7. What language do you mainly speak?

English

Spanish

Other

Part II: Employment Information

8. In which of the following regions do you ***work***?

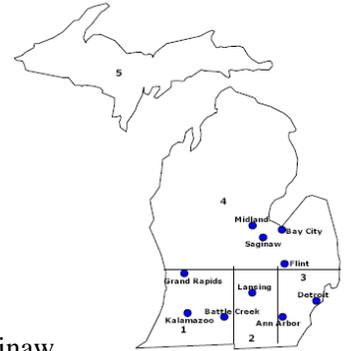
1 = SW Michigan including Kalamazoo, Grand Rapids, and Battle Creek

2 = South central Michigan including Lansing and Jackson

3 = Southeastern Michigan including Detroit and Ann Arbor

4 = Northern Lower Peninsula including Flint, Bay City, Midland, and Saginaw

5 = Upper Peninsula



9. Yes No Have you ever had a criminal background check for employment in health care?

10. Yes No Is your primary job in health care?

11. Yes No Do you have a second paid job?

12. Yes No If you have two jobs, is your second job in health care?

13. How long have you worked in health care?

Less than 1 year

1-5 years

6-10 years

11-15 years

16-20 years

More than 20 years

14. What health care setting(s) do you now work in? Indicate if it is your primary or second job (if you have 2 jobs).

Primary Second Job

- Home Help and/or Homemaker (DHS)
- Home Health Care Agency
- Assisted Living Facility or Retirement Home
- Specialized Mental Health Facility or Mental Health Hospital
- Hospital - general
- Nursing Home
- Hospice

15. What is your position in your healthcare job(s)? Indicate if it is your primary or second job (if you have 2 jobs).

Primary Second Job

- Homemaker Services
- Home Health Aide
- Certified Nursing Assistant
- Housekeeping
- Food Service
- LPN or RN
- Social Worker or Recreation Therapist
- Management, Supervisor, or Administration
- Therapist (PT, OT, Speech Therapist, etc.)
- Other, please specify _____

16. **Yes** **No** Are you related to one or more of your clients?

17. What is your pay rate per hour for your health care job?

- Minimum wage
- \$7 – \$8 per hour
- \$8.10 - \$10 per hour
- \$10.10 - \$12 per hour
- \$12.10 - \$14 per hour
- More than \$14 per hour

Part III: Knowledge of Adult Abuse and Neglect Prevention

Agree Disagree

18. Failure to give adequate or timely care is neglect, even with good reason
19. Yelling at a client is recognized as abuse by law.
20. It's OK to restrain a client in self-defense if they are trying to hurt you
21. Failure to notify the physician of a significant change is an example of neglect
22. Unintentional injury to a client is an example of abuse
23. People who are very ill or disabled are abused more often than others.
24. People who are living with a caregiver or loved one are less vulnerable to abuse.
25. The majority of nursing home residents have some form of dementia or other mental disability
26. Tearfulness, withdrawal or other symptoms of depression may be signs of abuse.
27. You should wait until the client brings it up before reporting suspected abuse.
28. Only physicians, social workers and nurses are required to report suspected abuse.
29. You feel like you know what all the forms of abuse are and how to recognize them?

30. If you witness or suspect abuse, you should first do the following:

Agree Disagree

- Ask probing questions like "What happened? Who did this to you? When? Where?"
- Try to help the client understand that there must be an explanation.
- Explain that you are required to report it even if client doesn't want you to.
- Talk with the client's family or roommate about it to establish facts.
31. Who should you report abuse to at your *primary* health care job setting? (**Mark all that apply**)
- The Administrator
- Adult Protective Services
- The Office of Recipient Rights
- Family member of client
- Co-worker
32. **Yes** **No** Would you feel comfortable reporting abuse if you suspected it?

33. **Yes** **No** Have you ever witnessed or suspected abuse of elders in your work setting?

34. **Yes** **No** Have you ever reported suspected abuse in the past?

Agree **Disagree**

35. If you report abuse directly to an agency, your name will be kept confidential

36. Once a report of abuse is made, the client will not be contacted directly by an agency

Agree **Disagree**

37. Person-Centered Care means respecting each individual's unique needs and abilities

38. Person-Centered Care can prevent abuse because it focuses on building relationships

Agree **Disagree**

39. Being a good listener is essential to Person-Centered Care

40. Encouraging clients to talk about potential abuse is not recommended because it might upset them

41. It's a good idea to take notes while talking to a client to make sure you have heard them correctly

42. It's important to respond to the client's reality so "little white lies" are OK to tell sometimes

43. If a client is potentially abusive, standing back at least six feet is recommended.

44. Conflicts with a co-worker can lead to abuse of clients

45. Avoiding a difficult co-worker is a good way to resolve conflict

46. Closed-ended questions are good to use because they can be answered with one word or yes or no

47. When one or more people are upset and the situation is potentially abusive, it is good to intervene

48. Always remove the client from a potentially abusive situation

49. Whatever triggers stress in a person can lead to abusive behavior if not recognized and defused.

50. Deep breathing is an example of a good stress-buster

51. Involving staff in interviewing new hires can help prevent abuse

52. **Yes** **No** Have you ever felt like you could have become abusive to a client but didn't?

STOP HERE. Do NOT complete Parts IV and V until AFTER the AANP Training

Part IV: Knowledge of Adult Abuse and Neglect Prevention – Complete After AANP Training

Agree Disagree

53. Secluding someone in their room until they cooperate with care is a form of abuse.
54. Telling sexually oriented jokes is not a form of sexual abuse if the client tells them too.
55. Using a client's belongings without their consent is exploitation or theft even if you return them.

56. The following are examples of abuse or neglect:

Agree Disagree

- Failure to carry out a physician's order
- Client failure to tend to personal hygiene to an extreme degree
- Client buying cat food instead of medications
- Not putting a call light in reach when in a hurry

Agree Disagree

57. Clients who are confused or mentally disabled are more vulnerable to abuse.
58. Nursing home residents are more vulnerable to abuse than elders at home with family.
59. Hostile and defiant behavior in a client may be a sign of abuse.
60. Increased confusion, loss of eye contact, and vacant stares may be signs of abuse.
61. Direct access staff are more likely than family to be abusive because of the work they do
62. You feel like you understand the different types of abuse and how to identify them
63. How many times have you witnessed or suspected abuse in a healthcare setting in the past month?
- None
- 1-2 times
- 3-4 times
- More than 4 times
64. What types of abuse have you witnessed or suspected in the past month? (Mark all that apply or leave blank if no abuse suspected)

- Physical
 - Verbal and Emotional
 - Sexual
 - Neglect
 - Self- Neglect
 - Financial or Misappropriation
-

Agree Disagree

65. You should get the client’s permission before reporting suspected abuse.
66. You know who to report abuse to.
67. You should call the state directly if you don’t want to report suspected abuse to your supervisor
68. Whoever reports suspected abuse to an agency has the right to remain anonymous.
69. It’s good to keep asking clients questions about suspected abuse even if they appear to be getting extremely upset because you need to get the facts.
70. You should find out if others suspect abuse before talking with your supervisor
71. **Agree Disagree** If you witness or suspect abuse, you should first do the following:
- Prompt the client to talk with “openers”, i.e. “What happened, when did it happen, etc”
 - Ask “Why did this happen?”
 - Become noticeably alarmed and immediately run to get help
 - Summarize to the client what you heard them say
 - Assure client of confidentiality, except for need to report it
72. Why wouldn’t you report suspected abuse (**Mark all that apply**)
- Don’t think it is serious
 - Don’t want to make trouble for a co-worker
 - Lack of time
 - Concern about what might happen to you
 - The client started it
 - No one would believe you
 - Don’t know who to tell

- Don't know what to say
- It might make the job more difficult because co-workers or a supervisor might not like it
- It wouldn't make any difference
- I would always report suspected abuse and neglect

Agree Disagree

- | | | | |
|-----|-----------------------|-----------------------|--|
| 73. | <input type="radio"/> | <input type="radio"/> | When clients say mean or disrespectful things to staff, it may lead to abuse. |
| 74. | <input type="radio"/> | <input type="radio"/> | Having a heavy caseload and not enough time to complete it well may trigger abusive behavior. |
| 75. | <input type="radio"/> | <input type="radio"/> | You should always intervene when you suspect abuse, even if you suspect a fellow co-worker, your supervisor, or a family member. |
| 76. | <input type="radio"/> | <input type="radio"/> | If you suspect your supervisor of abuse, you are helpless to intervene. |
| 77. | <input type="radio"/> | <input type="radio"/> | If you feel you are reaching a trigger point for abuse, you feel comfortable talking with your supervisor about how to handle the situation. |
| 78. | <input type="radio"/> | <input type="radio"/> | Involving clients, family members and staff in care planning can help prevent abuse |
| 79. | <input type="radio"/> | <input type="radio"/> | It is appropriate to notify the client's family member(s) of suspected abuse. |
| 80. | <input type="radio"/> | <input type="radio"/> | It is appropriate to discuss suspected abuse with a co-worker in order to get more facts or advice. |
| 81. | <input type="radio"/> | <input type="radio"/> | It's rude to ask clients to repeat everything back to you so you know you heard them correctly. |
| 82. | <input type="radio"/> | <input type="radio"/> | It is sometimes good to write down what clients say but only after you have talked with them. |
| 83. | <input type="radio"/> | <input type="radio"/> | It is good to at first stand a few feet away from the client and to the side when abuse is suspected. |
| 84. | <input type="radio"/> | <input type="radio"/> | Removing the client from the room is one de-escalation technique. |
| 85. | <input type="radio"/> | <input type="radio"/> | All de-escalation strategies are appropriate for any potentially abusive situation. |
| 86. | <input type="radio"/> | <input type="radio"/> | Conflicts at home can lead to abuse of clients. |
| 87. | <input type="radio"/> | <input type="radio"/> | Providing child care, money-management, and relaxation classes can prevent abuse. |
| 88. | <input type="radio"/> | <input type="radio"/> | Open-ended questions should be used when trying to gather information about potential abuse. |
| 89. | <input type="radio"/> | <input type="radio"/> | Repeating a mantra or positive statement to yourself is an example of a good stress-buster. |

Part V: Training Evaluation

90. How *satisfied* are you with the following aspects of the training program?

Satisfied	Somewhat Satisfied	Somewhat Unsatisfied	Unsatisfied	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Definitions of abuse provided
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Information on recognizing abuse
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Information on preventing abuse
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Information on who must report abuse
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Information on how to report abuse
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	The written handouts

91. How *satisfied* are you with the following ways in which the information was taught?

Satisfied	Somewhat Satisfied	Somewhat Unsatisfied	Unsatisfied	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Examples/Stories
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Role plays or skits
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Group Discussions and Brainstorming
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Stress Trigger Test
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Lectures

92. **Yes** **No** Do you feel you have learned new ways to handle stressful situations?

93. **Yes** **No** Was the length of the training time adequate?

94. **Yes** **No** Were all your questions about abuse and neglect prevention answered?

96. **Yes** **No** Would you like to have additional training?

Please write any questions, comments or suggestions for improving the training session in the space below. This concludes the evaluation. Thank you for your time.

This evaluation instrument is being pilot-tested and validated with the Michigan AANP project. Findings are forthcoming. Contact Clare Luz, Principal Investigator, for more information at 517/432-2208 or luz@msu.edu.

Appendix L – Phone Survey Instrument

AANP Phone Survey – Time 1 Script-(Sample)

- 1) Thank you for calling the Adult Abuse and Neglect Prevention Training Phone Survey.
- 2) Is this the first time that you have taken this survey? Press 1 for yes or 2 for no
- 3) So that we can accurately match you with each phone survey you complete, we would like to know the last four digits of your Social Security number. Please enter the last four digits of your social security number now, using the number key pad.
- 4) We also need to accurately match your phone surveys with your written survey that you completed at the training session. To do this, please enter the telephone number that we first called to tell you about the phone survey. Using the keypad, please enter the phone number we originally called, including area code, now.
- 5) Is the phone number you just entered, the same number that we should use from now on? For yes – press 1, for no, press 2. **IF they answer YES - skip to #7**
- 6) Please enter the phone number at which you prefer to be contacted if needed, starting with the area code.
- 7) Now we will begin the survey. How would you rate the elder abuse and neglect training program that you attended in terms of increasing your understanding of this topic?
 - If you rate the training program as Excellent, press the number 1
 - If you rate it Good - press 2
 - If you rate it Fair - press 3
 - If you rate it Poor - press 4
 - If you prefer not to respond - press 5
 - To repeat these options - press 6
- 8) Have you changed jobs since the elder abuse and neglect training? If yes, press 1. If no, press 2.

If caller presses 2 for “No” then **skip to Q12**
- 9) Is your new job in health care? If yes, press 1. If no, press 2.

If caller presses 2/No – **skip to Q25**

10) In what type of setting is your main health care job? Please listen to all of the options before making your selection.

- If your main job is in a nursing home – press 1
- If it is a hospital – press 2
- If it is in an assisted living facility – press 3
- If it is with a home health care agency - press 4
- If it is with the Home Help Program – press 5
- If it is an adult foster care home – press 6
- If it is in some other setting – press 7
- If you prefer not to respond - press 8
- To repeat the options – press 9

11) Do you have direct contact with older adults in your current health care job?

- If yes – press 1. If no, press 2.

If caller presses 2/No – skip to **Q25**

12) Does your employer have a clear policy or procedure for handling cases of suspected or actual abuse? If yes, press 1. If no, press 2. If you do not know, press 3. If you prefer not to respond, press 4.

13) Since the training program, about how many times while on the job have you witnessed or suspected any type of abuse of an older adult, including verbal, physical, sexual, or financial abuse or neglect? Enter the number of times on the keypad followed by the pound - # key. If you have not witnessed any abuse since the last call, press 0 followed by the pound - # key

If the respondent enters 0 – then **skip to Q25**

14) Please think about the most serious case of abuse or neglect that you witnessed or suspected since the training. Did the person who was abused have dementia or some other type of mental impairment? If yes, press 1. If no, press 2.

15) Still thinking about the most serious case, did it involve verbal abuse? Press 1 for yes, 2 for no, 3 if you prefer not to respond.

15b) Did the most serious case involve physical abuse? Press 1 for yes, 2 for no, 3 if you prefer not to respond.

15c) Did the most serious case involve sexual abuse? Press 1 for yes, 2 for no, 3 if you prefer not to respond.

15d) Did the most serious case involve financial abuse? Press 1 for yes, 2 for no, 3 if you prefer not to respond.

15e) Did the most serious case involve neglect? Press 1 for yes, 2 for no, 3 if you prefer not to respond.

16) Again, thinking about the most serious case that you witnessed or suspected since the training, who was the primary abuser? Please listen to all of the options before making your selection and then select just one option.

If it was a co-worker – Press 1

If it was a supervisor – Press 2

If it was a family member of the older person– Press 3

If it was another resident, patient or client – Press 4

If it was a friend or neighbor of the resident, patient or client - Press 5

If you prefer to not respond - Press 6.

To repeat the options – Press 7

17) Still thinking about the most serious case....

17a) In your opinion, did the abuse occur because the older person was physically aggressive and the abuser was acting in self-defense? If yes, press 1. If no, press 2, if you prefer not to respond press 3.

17b) In your opinion, did the abuse occur because the older person was verbally aggressive and the abuser felt threatened and acted in self-defense? If yes, press 1. If no, press 2, if you prefer not to respond press 3.

17c) In your opinion, the abuser did ***not*** feel threatened by physical or verbal aggression but was frustrated by some other behavior of the older person. If yes, press 1. If no, press 2, if you prefer not to respond, press 3.

17d) In your opinion, was the abuser upset by his or her own personal problems? If yes, press 1. If no, press 2. If you prefer not to respond, press 3.

17e) In your opinion, was the abuser feeling stressed because there was not enough help to provide all care needs? If yes, press 1. If no, press 2, if you prefer not to respond, press 3.

17f) If you think there was some other reason for why the abuse may have occurred, please speak the reason into the phone after the beep and when you are finished, press the # key.

18) Did you report this particular incident? If yes, press 1. If no, press 2. If you prefer to not respond, press 3.

If the respondent answers 1/Yes then **skip to Q20**

19) Please indicate the reason or reasons why you did not report the suspected abuse. Please respond to each option.

19a) You did not report the abuse because you did not have time. If yes – press 1. If no, press 2. If you prefer not to respond, press 3

19b) You did not report the abuse because you did not think it was serious enough. If yes, press 1. If no, press 2. If you prefer not to respond, press 3.

19c) You did not report the abuse because you did not know who to report it to. If yes – press 1. If no, press 2, if you prefer not to respond, press 3.

19d) You did not report the abuse because the older person started the incident. If yes – press 1. If no, press 2, if you prefer not to respond, press 3.

19e) You did not report the abuse because you were worried that your supervisor might get upset. If yes – press 1. If no, press 2, if you prefer not to respond press 3.

19f) You did not report the abuse because reporting the abuse would have had a negative impact on your job. If yes – press 1. If no, press 2, if you prefer not to respond, press 3.

19g) You did not report the abuse because reporting the abuse would not have made a difference anyway. If yes – press 1. If no, press 2, if you prefer not to respond, press 3.

19h) If you had some other reason NOT to report the abuse, would you please share your reason? If yes – press 1, If no press 2. If 2/No then go to Q19.

19i) Please tell us what your reason for not reporting the suspected abuse by speaking the reason into the phone after the beep and then pressing the “pound - #” key when you are finished.

Then **skip to Q22**

20) Who did you report the suspected or known abuse to?

20a) Did you report it to your supervisor? For yes, press 1 – For no, press 2.

20b) Did you report it to a state agency? For yes, press 1 – For no, press 2.

- 20c) Did you report it to the Administrator? For yes, press 1 – For no, press 2.
- 20d) Did you report it to family member or friend of the abused older person? For yes, press 1. For no, press 2.
- 20e) Did you report it to a co-worker? For yes, press 1. For no, press 2.
- 21) After you reported the abuse - how confident did you feel that it was handled quickly and appropriately? Please listen to all the options before responding and then select just one response.
- You felt very confident – Press 1
 - You felt somewhat confident – press 2
 - You did not feel confident – press 3
 - If you prefer to not respond press 4.
 - To repeat these options – press 5.
- 22) In general, do you feel that the abuse training program that you attended improved your ability to recognize potential abuse when it occurs? Press 1 for yes or 2 for no.
- 23) Since the abuse training, do you actually recognize potential abuse more often? Press 1 for yes or 2 for no.
- 24) Since the abuse training, do you now report suspected abuse more often? Press 1 for yes or 2 for no.
- 25) Do you feel that the abuse training program improved your ability to **prevent** potential abusive situations from developing? Press 1 for yes or 2 for no.
- 26) Since the training, have you actually used any of the abuse prevention techniques that were taught, in order to try and prevent an abusive situation from occurring? Press 1 for yes or 2 for no. **If no – then skip to 28**
- 27) Do you feel that using the technique helped prevent an abusive situation from occurring? Press 1 for yes or 2 for no.
- 28) Thinking about abuse and neglect in general, what in your opinion could be done to prevent adult abuse in the future? Please speak your response after the tone then press the “pound - #” key when you are finished.
- 29) Thank you for completing this month’s survey. In order to mail your payment we need to know your name. Please speak and spell your name after the tone. When you are finished, press the pound key.

30) We also need the address of where to send the payment. Please speak your address, city, state and zip code, after the tone. Spell any difficult words. Press the pound key when you are finished.

That concludes the survey. You may hang up to end this call. Thank you and goodbye.

Clare Luz, PhD, Principal Investigator
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4-23-07 version

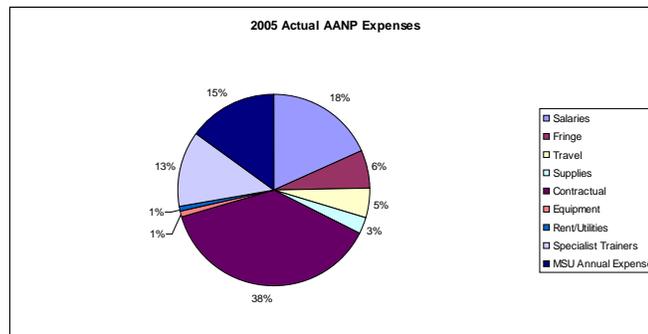
Appendix M – Cost Summary for Yearly Expenditures

AANP Cost Summary for Yearly Expenditures

2005 Expenditures

From January 2005 – September 2005, actual grant expenses incurred by MSU and BEAM were \$203,769. During year one of the project, BEAM contractual costs accounted for 38 percent of total expenses for the majority of the AANP curricula development for the comprehensive eight-hour training and associated tools and resources. In addition, BEAM salaries accounted for 18 percent and MSU expenditures accounted for 15 percent of costs. An additional 13 percent of annual costs were budgeted for train-the-trainer activities and specialist trainer payments. Figure N1 – 2005 Actual AANP Expenses provided below outlines the percent of expenditures.

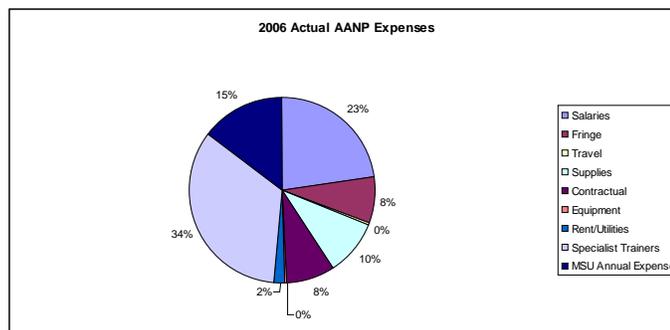
Figure N1
2005 actual AANP expenses



2006 Expenditures

From October 2005 – September 2006, actual grant expenses incurred by MSU and BEAM were \$401,120. Of the significant expenditures for 2006, 35 percent of expenses were specialist trainer payments, 23 percent BEAM salaries, and 15 percent AANP MSU expenditures. In 2006, the percent of funding used for specialist trainer payments increased significantly as the number of trainings began to increase. In addition, the amount of funds used for contractual services decreased as the amount of train-the-trainer and curricula development activities decreased. Figure N2 – 2006 Actual AANP Expenses provided below outlines the percent of expenditures.

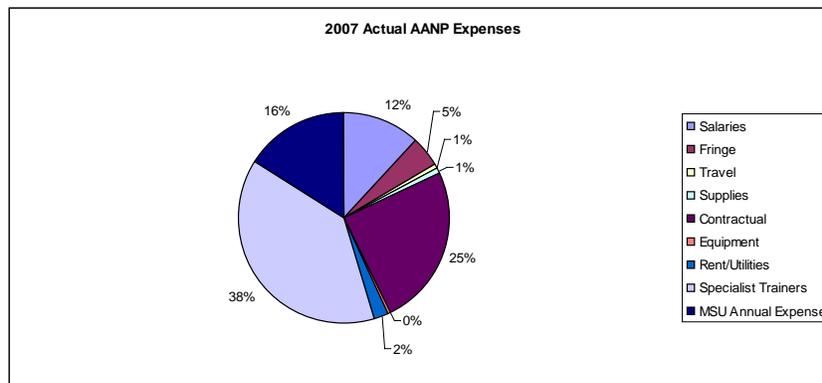
Figure N2
2006 actual AANP expenses



2007 Expenditures

From October 2006 – September 2007, actual grant expenses incurred by MSU and BEAM were \$682,367. In 2007, the percent of funds utilized for specialist trainers continued to increase moderately to accommodate continued training. BEAM staffing activities also continued to increase as more DAS training sessions were scheduled and changes to the scope of work were requested. These changes to the scope of work not only increased staffing needed, but also increased the amount of contractual services with the additional of new curricula products, which included the four-hour, supervisor, and FIMS curricula materials. N3 – 2007 Actual AANP Expenses provided below outlines the percent of expenditures.

Figure N3
2007 actual AANP expenses



2008 Expenditures

From October 2007 – May 2008, the estimated carry-forward budgeted for MSU and BEAM is \$212,744. As part of this no-cost extension, \$11,000 was redirected from the BEAM budget to the MSU budget to cover expenditures. Due to a reduction in the number of individuals trained and project efficiencies, MSU and BEAM anticipate a modest excess of funding. Final project expenses will be determined in late April 2008 following the completion of the project. Carry-forward funding is being utilized to complete activities supporting the completion of the final report.