Improving Identification and Management of Elder Abuse and Neglect

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DISCLOSURE OF COMMERCIAL RELATIONSHIP(S)

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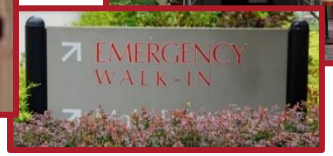
New York State OVS Office of Victim Services



NewYork-Presbyterian
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Improving Identification and Management of Elder Abuse and Neglect:

A Training for Health Care Professionals

Thomas V. Caprio, MD, MPH
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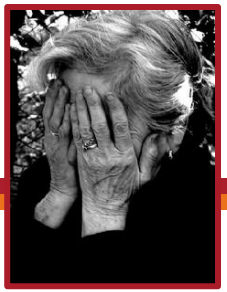
MS. R: 79F FALL VIA EMS



HISTORY

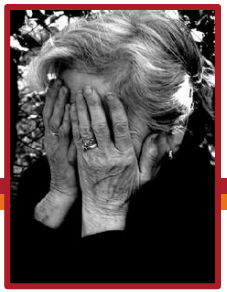
Pt tripped on a wet rug in the bathroom, striking her head and face on the edge of the sink. She did not lose consciousness, and the daughter reports that she was not assisting her mother but witnessed the fall from the hallway. EMS was called, and Ms. R was ambulatory onscene when they arrived.

- pt with recently-diagnosed mild cognitive impairment and lives with her adult daughter, who is primary caregiver

- history provided almost exclusively by daughter, who notably interrupts whenever Ms. R attempts to contribute

Problem	ESI	LOS Total	Status
c\o nausea and vo	3	02:06	03-To Be Se
c/o lt flank pains	3	01:52	03-To Be Se
c/o abd pains sinc	3	01:28	03-To Be Se
sorethroat with sw	3	01:15	03-To Be Se
abdominal pain wi	3	01:09	03-To Be Se

MS. R: 79F FALL VIA EMS



PHYSICAL EXAM

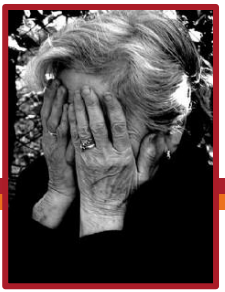
- mildly cachetic-appearing but well-groomed
- ecchymoses/bruising in the peri-orbital areas bi-laterally with the left eye nearly swollen shut
- tenderness in both maxillary sinuses
- bruising on her left cheek and on the external aspects of both upper arms

IMAGING

- acute left zygoma fracture
- acute displaced nasal bone fracture
- age-indeterminate right zygoma fracture
- acute right ulna fracture

NEXT STEPS?

MS. R: 79F FALL VIA EMS



FOLLOW-UP

- On social work evaluation, Ms. R's daughter continues to report that the injuries are due to a fall, and Ms. R agrees when asked directly.

- *When Ms. R is questioned alone in the radiology suite, however, she admits to frequent verbal and infrequent physical abuse by her daughter. Her new story is that her daughter was insisting that she sign papers to allow her to control all of her banking and finances. They argued, as they do frequently, and daughter struck her twice in the face with Ms. R's cane.*

- After the decision is made to admit Ms. R to identify a safe discharge plan, additional testing is done, and she is found to have multiple old rib fractures, to be anemic, and to have low albumin suggesting poor nutrition.

MR. G: 84M NOT HIMSELF VIA EMS

HISTORY

Pt hasn't been acting normally for a few days, hasn't been getting out of bed as he usually does and eating less. No fever, cough, or other complaints. Also hasn't been taking all of his medications.

- grandson, who lives with pt and is at bedside, called EMS
- pt has advanced dementing illness and is unable to contribute to history

Problem	ESI	LOS Total	Status
c\o nausea and vo	3	02:06	03-To Be Se
c/o lt flank pains	3	01:52	03-To Be Se
c/o abd pains sinc	3	01:28	03-To Be Se
sorethroat with sw	3	01:15	03-To Be Se
abdominal pain wi	3	01:09	03-To Be Se
c\o dizziness with	3	00:31	03-To Be Se
Depression and de	3	00:22	03-To Be Se

MR. G: 84M NOT HIMSELF VIA EMS

VITAL SIGNS

HR: 81 RR: 18 SPO2: 93% on room air

Temp (oral): 35.7° C

PHYSICAL EXAM

in the hallway

- ?moaning, AOX0
- dirty clothing
- ?rhonchi at right lung base
- Trace ?edema in ankles b/l

IMAGING & LABS

- CXR: can't rule out RLL pneumonia
- WBC, lactate not elevated
- Cr: 1.4, BUN: 35, Na: 146

NEXT STEPS?

MR. G: 84M NOT HIMSELF VIA EMS

FOLLOW-UP

Medical student brings ACR to team, which documents:

- *apartment very messy, filled with boxes, vermin infestation, foul odor*
- *very cold – heat not on*
- *refrigerator empty*
- *multiple half-filled pill bottles, some prescribed years ago*
- *grandson yelled at pt to "be quiet" while EMS was loading onto stretcher*

MR. G: 84M NOT HIMSELF VIA EMS

FOLLOW-UP

When providing personal care, nurse and tech identify additional physical findings:

Elongated toenails in neglect victim.
Photo courtesy of: D.C. Homeier

Poor dentition in a substantiated case of dependent adult neglect.
Photo courtesy of: L. Gibbs, MD, Orange, CA

Pressure sores in neglected patient
Photo courtesy of D.C Homeier

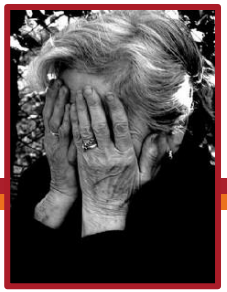
MR. G: 84M NOT HIMSELF VIA EMS

ADDITIONAL LABS

CK: 7,400

Dilantin level: 0
Digoxin level: 0

ELDER ABUSE

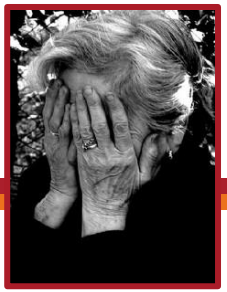


- mistreatment of an older adult (aged ≥60)
  - *by a person in a position with an expectation of trust*

    OR
  - *when an older adult is targeted because of age or disability*

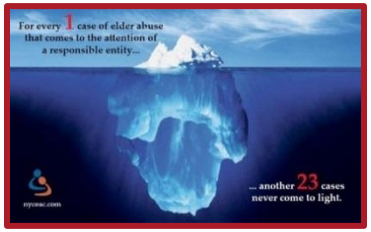
- may include physical abuse, sexual abuse, neglect, psychological abuse, financial exploitation
  - *many victims suffer from multiple types of abuse*

ELDER ABUSE



- common and has serious consequences
  - *10% experience abuse or neglect each year*
  - *victimization increases risk of mortality, nursing home placement, dementia, depression*

- under-recognized and under-reported
  as few as 1 in 24 cases identified



IDENTIFYING ELDER ABUSE

HEALTH CARE AN IMPORTANT OPPORTUNITY

- evaluation by health care provider may be only time abused older adult leaves the home
- many health care providers evaluate patients in their home

BUT

Diagnosis of Elder Abuse in U.S. Emergency Departments

Christopher S. Evans, BS,† Katherine M. Hanold, BSPH,‡ Tony Rosen, MD, MPH,§ and Timothy F. Platts-Mills, MD, MSc‖***

OBJECTIVES: To estimate the proportion of visits to U.S. emergency departments (EDs) in which a diagnosis of elder abuse is reached using two nationally representative datasets.

DESIGN: Retrospective cross-sectional analysis.

SETTING: U.S. ED visits recorded in the 2012 Nation-

and septicemia (OR = 1.92, 95% CI = 1.44–2.55). In the 2011 NHAMCS dataset, no cases of elder abuse were recorded for the 5,965 older adult ED visits.

CONCLUSION: The proportion of U.S. ED visits by older adults receiving a diagnosis of elder abuse is at least two orders of magnitude lower than the estimated prevalence in the population. Efforts to improve the identifica-

Health care providers seldom identify or report

IDENTIFYING ELDER ABUSE IN THE ED

BARRIERS/DISINCENTIVES

- lack of time to conduct a thorough evaluation
- lack of awareness or inadequate training
- fear and distrust of the legal system
- denial by patient him/herself
- ambiguities surrounding decision-making capacity in victimized older adults
- absence of a protocol for a streamlined response
- difficulty distinguishing abuse from accidental trauma or illness

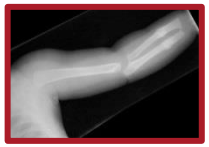
FORENSICS IN CHILD ABUSE DETECTION

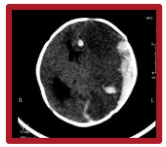
THE BATTERED-CHILD SYNDROME

C. Henry Kempe, M.D., Denver, Frederic N. Silverman, M.D., Cincinnati, Brandt F. Steele, M.D., William Droegemueller, M.D., and Henry K. Silver, M.D., Denver

Professor and Chairman (Dr. Kempe) and Professor of Pediatrics (Dr. Silver), Department of Pediatrics; Associate Professor of Psychiatry (Dr. Steele), and Assistant Resident in Obstetrics and Gynecology (Dr. Droegemueller), University of Colorado School of Medicine; and Director, Division of Roentgenology, Children's Hospital (Dr. Silverman).

Abstract—The battered-child syndrome, a clinical condition in young children who have received serious physical abuse, is a frequent cause of permanent injury or death. The syndrome should be considered in any child exhibiting evidence of fracture of any bone, subdural hematoma, failure to thrive, soft tissue swellings or skin bruising, in any child who dies suddenly, or where the degree and type of injury is at variance with the history given regarding the occurrence of the trauma. Psychiatric factors are probably of prime importance in the pathogenesis of the disorder, but knowledge of these factors is limited. Physicians have a duty and responsibility to the child to require a full evaluation of the problem and to guarantee that no expected repetition of trau





Diagnostic Imaging in Infant Abuse

Paul K. Kleinman[1]

In 1962, C
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ARTICLE

Bruises in Infants and Toddlers

Those Who Don't Cruise Rarely Bruise

Naomi F. Sugar, MD; James A. Taylor, MD; Kenneth W. Feldman, MD; and the Puget Sound Pediatric Research Network

- Bruising of ears, cheeks, buttocks, palms, soles, neck, genitals
- Bruising not over bony prominences
- Bruising in children too young to ambulate
- Metaphyseal fracture
- Multiple posterior rib fractures
- Spinous process fractures
- Burn with immersion pattern
- Subdural hematoma
- Retinal hemorrhages

ELDER ABUSE VS. CHILD ABUSE

CONFIDENTLY IDENTIFYING ELDER ABUSE IS HARDER

- physiologic changes in aging
- common medications
- varied functional status

MUCH LESS EVIDENCE TO ASSIST IN ELDER ABUSE FORENSICS

more than 1000 peer-reviewed articles systematically examining child abuse-related injuries

vs.

distinguishing abuse from accidental trauma or illness

OBJECTIVE

To identify ***injury patterns*** associated with physical elder abuse

OUR RESEARCH

IMPROVING IDENTIFICATION OF PHYSICAL ABUSE

METHODOLOGIC CHALLENGE

Identifying definitive instances of elder abuse to study in detail

SOLUTION

comprehensive analysis of legal files from highly adjudicated physical elder abuse cases in which the presence of abuse is indisputable

focus on photographs of injuries, medical records

Brooklyn District Attorney
Elder Abuse Unit

IMPROVING IDENTIFICATION OF PHYSICAL ABUSE

METHODOLOGIC ADVANCES

- development and evaluation of a standardized protocol for photographing injuries in the acute care setting

Figure: Photos Required for Each Injury

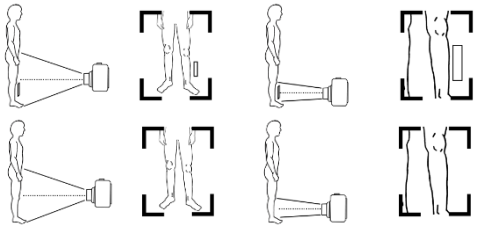
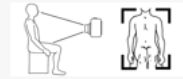
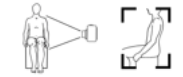
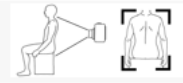
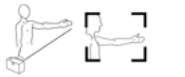
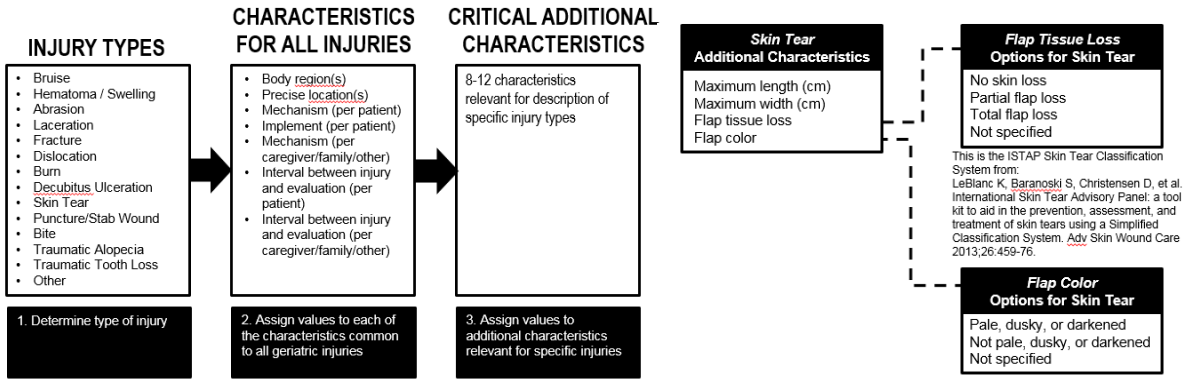


Table: Body Positioning to Photograph Injuries on the Arm

Diagram	Region of the Arm
	Radial / Anterolateral Surface
	Dorsal / Lateral Surface
	Ulnar / Posterolateral Surface
	Volar / Medial Surface
	Elbow

- development of a comprehensive classification system / taxonomy to describe geriatric injuries



IMPROVING IDENTIFICATION OF PHYSICAL ABUSE

COMPARING INJURY PATTERNS

Case-control study comparing injury patterns, physical findings, forensic biomarkers, and photographic evidence from

Physical elder abuse victims

to

Geriatric patients presenting to the Emergency Department after accidental fall

INJURY PATTERNS AND CLINCAL FINDINGS

Physical abuse victims more likely than unintentional fallers to have:

- maxillofacial, dental, or neck injuries combined with no upper and lower extremity injuries (50% vs. 8%)
- injuries to the left cheek or zygoma (22% vs. 3%)
- neck (15% versus 0%) or ear (6% versus 0%)

GERIATRICS/ORIGINAL RESEARCH

Identifying Injury Patterns Associated With Physical Elder Abuse: Analysis of Legally Adjudicated Cases

Tony Rosen, MD, MPH*; Veronica M. LoFaso, MD, MS; Elizabeth M. Bloemen, MPH; Sunday Clark, ScD, MPH; Thomas J. McCarthy, BA; Christopher Reisig, MD; Kriti Gogia, MPH; Alyssa Elman, LMSW; Arlene Markarian, JD; Neal E. Flomenbaum, MD; Rahul Sharma, MD, MBA; Mark S. Lachs, MD, MPH

*Corresponding Author. E-mail: jar2006@med.cornell.edu.

Study objective: Elder abuse is common and has serious health consequences but is underrecognized by health care providers. An important reason for this is difficulty in distinguishing between elder abuse and unintentional trauma. Our goal was to identify injury patterns associated with physical elder abuse in comparison with those of patients presenting to the emergency department (ED) with unintentional falls.

Methods: We partnered with a large, urban district attorney's office and examined medical, police, and legal records from successfully prosecuted cases of physical abuse of victims aged 60 years or older from 2001 to 2014.

Results: We prospectively enrolled patients who presented to a large, urban, academic ED after an unintentional fall. We matched 78 cases of elder abuse with visible injuries to 78 unintentional falls. Physical abuse victims were significantly more likely than unintentional fallers to have bruising (78% versus 54%) and injuries on the maxillofacial, dental, and neck area (67% versus 28%). Abuse victims were less likely to have fractures (8% versus 22%) or lower extremity injuries (9% versus 41%). Abuse victims were more likely to have maxillofacial, dental, or neck injuries combined with no upper and lower extremity injuries (50% versus 8%). Examining precise injury locations yielded additional differences, with physical elder abuse victims more likely to have injuries to the left cheek or zygoma (22% versus 3%) or on the neck (15% versus 0%) or ear (6% versus 0%).

Conclusion: Specific, clinically identifiable differences may exist between unintentional injuries and those from physical elder abuse. This includes specific injury patterns that infrequently occur unintentionally. [Ann Emerg Med. 2020;■:1-11.]

Please see page XX for the Editor's Capsule Summary of this article.

Rosen T, LoFaso VM, Bloemen EM, Clark S, McCarthy TJ, Reisig C, Gogia K, Elman A, Markarian A, Flomenbaum NE, Sharma R, Lachs MS. Identifying Injury Patterns Associated With Physical Elder Abuse: Analysis of Legally Adjudicated Cases. Ann Emerg Med. 2020 Sep;763):266-276.

Plan to derive a clinical decision rule to assist health care providers

IDENTIFYING ELDER ABUSE

Physical Signs Suspicious for Potential Elder Abuse

- PHYSICAL ABUSE
- SEXUAL ABUSE
- NEGLECT

POTENTIALLY SUSPICIOUS PHYSICAL SIGNS

PHYSICAL ABUSE

- Bruising in atypical locations
- Patterned injuries
- Wrist or ankle lesions or scars
- Burns
- Multiple fractures or bruises of different ages
- Traumatic alopecia or scalp hematomas
- Subconjunctival, vitreous, or retinal ophthalmic hemorrhages
- Intraoral soft tissue injuries

some "falls" are actually abuse

POTENTIALLY SUSPICIOUS PHYSICAL SIGNS

PHYSICAL ABUSE

- **Bruising in atypical locations**
- Patterned injuries
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- Burns
- Multiple fractures or bruises of different ages
- Traumatic alopecia or scalp hematomas
- Subconjunctival, vitreous, or retinal ophthalmic hemorrhages
- Intraoral soft tissue injuries

- ***not over bony prominences***
- ***on lateral arms, back, face, ears, or neck***

Atypical bruising of the chest in a case of substantiated abuse
Photo courtesy of: Center of Excellence on Elder Abuse and Neglect, University of California, Irvine, CA

Bruising on ear in abused elderly woman
Photo from: Palmer M, Brodell RT, Mostow EN. Elder abuse: dermatologic clues and critical solutions. J Am Acad Dermatol. 2013 Feb;68(2):e37-42.

POTENTIALLY SUSPICIOUS PHYSICAL SIGNS

PHYSICAL ABUSE

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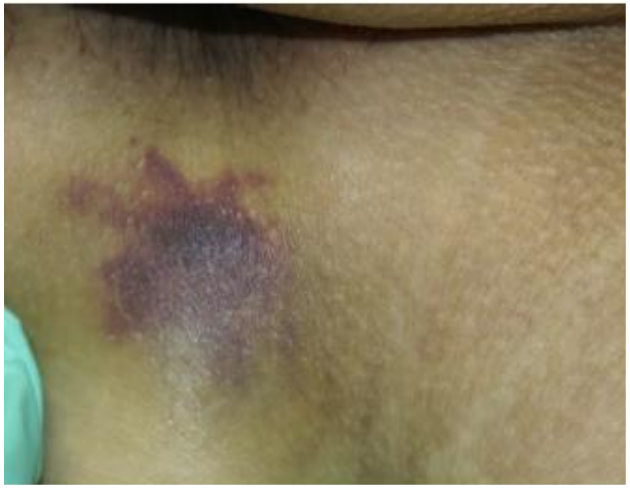
- Intraoral soft tissue injuries

- ***bite marks***
- ***injury consistent with the shape of a belt buckle, fingertip, or other object***

Fingertip-patterned bruising on medial aspect of thigh

Photo from: Palmer M, Brodell RT, Mostow EN. Elder abuse: dermatologic clues and critical solutions. J Am Acad Dermatol. 2013 Feb;68(2):e37-42.



Pattern bruise on the left buttock from unknown object

Photo courtesy of: L. Gibbs, MD, Orange, CA

POTENTIALLY SUSPICIOUS PHYSICAL SIGNS

PHYSICAL ABUSE

- Bruising in atypical locations
- Patterned injuries
- **Wrist or ankle lesions or scars**
- Burns
- Multiple fractures or bruises of different ages
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- Subconjunctival, vitreous, or retinal ophthalmic hemorrhages
- Intraoral soft tissue injuries

Ligature mark created by wire used as restraint

Photo from: Palmer M, Brodell RT, Mostow EN. Elder abuse: dermatologic clues and critical solutions. J Am Acad Dermatol. 2013 Feb;68(2):e37-42.

Pattern bruising on lower leg from a ligature

Photo courtesy of: L. Gibbs, MD, Orange, CA

suggesting restraint

POTENTIALLY SUSPICIOUS PHYSICAL SIGNS

PHYSICAL ABUSE

- Bruising in atypical locations
- Patterned injuries
- Wrist or ankle lesions or scars
- **Burns**
- Multiple fractures or bruises of different ages
- Traumatic alopecia or scalp hematomas
- Subconjunctival, vitreous, or retinal ophthalmic hemorrhages
- Intraoral soft tissue injuries

particularly stocking / glove pattern suggesting forced immersion or cigarette pattern

Burn injuries on the back and buttocks from scalding water
Photo courtesy of: Center of Excellence on Elder Abuse and Neglect, University of California, Irvine, CA

70-year-old burned by cigarette
Photo from: Palmer M, Brodell RT, Mostow EN. Elder abuse: dermatologic clues and critical solutions. J Am Acad Dermatol. 2013 Feb;68(2):e37-42.

POTENTIALLY SUSPICIOUS PHYSICAL SIGNS

PHYSICAL ABUSE

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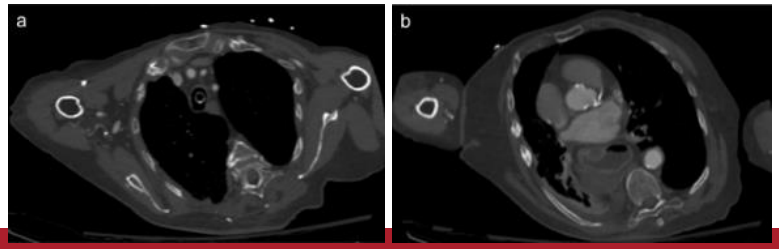
- Intraoral soft tissue injuries

Contusions at varying stages of healing on his chest and arms as well as a linear patterned injury across left anterior chest
Photo courtesy of: D. C. Homeier



POTENTIALLY SUSPICIOUS PHYSICAL SIGNS

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POTENTIALLY SUSPICIOUS PHYSICAL SIGNS

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POTENTIALLY SUSPICIOUS PHYSICAL SIGNS

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- **Intraoral soft tissue injuries**

POTENTIALLY SUSPICIOUS PHYSICAL SIGNS

SEXUAL ABUSE

- Genital, rectal, or oral trauma
- Evidence of sexually-transmitted disease

POTENTIALLY SUSPICIOUS PHYSICAL SIGNS

SEXUAL ABUSE

- **Genital, rectal, or oral trauma**
- Evidence of sexually-transmitted disease

Bruises on bilateral inner thighs of nursing home resident suggestive of sexual abuse

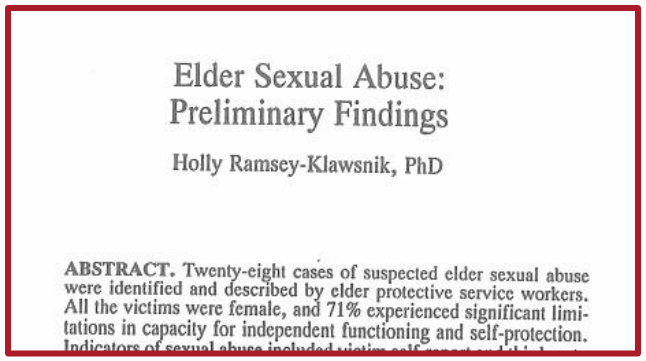
Photo courtesy of D.C. Homeier

including erythema, bruising, lacerations

POTENTIALLY SUSPICIOUS PHYSICAL SIGNS

SEXUAL ABUSE

- Genital, rectal, or oral trauma
- **Evidence of sexually-transmitted disease**



Elder Sexual Abuse:
Preliminary Findings

Holly Ramsey-Klawsnik, PhD

ABSTRACT. Twenty-eight cases of suspected elder sexual abuse were identified and described by elder protective service workers. All the victims were female, and 71% experienced significant limitations in capacity for independent functioning and self-protection.

POTENTIALLY SUSPICIOUS PHYSICAL SIGNS

NEGLECT

- Cachexia / malnutrition
- Dehydration
- Pressure sores / decubitus ulcers
- Poor body hygiene, unchanged diaper
- Dirty, severely worn clothing
- Elongated toenails
- Poor oral hygiene

POTENTIALLY SUSPICIOUS PHYSICAL SIGNS

NEGLECT

- **Cachexia / malnutrition**
- Dehydration
- Pressure sores / decubitus ulcers
- Poor body hygiene, unchanged diaper
- Dirty, severely worn clothing
- Elongated toenails
- Poor oral hygiene

muscle wasting, temporal wasting, sunken eyes

POTENTIALLY SUSPICIOUS PHYSICAL SIGNS

NEGLECT

- Cachexia / malnutrition
- **Dehydration**
- Pressure sores / decubitus ulcers
- Poor body hygiene, unchanged diaper
- Dirty, severely worn clothing
- Elongated toenails
- Poor oral hygiene

dry mucous membranes, sunken eyes, skin tenting, severe constipation / fecal impaction

POTENTIALLY SUSPICIOUS PHYSICAL SIGNS

NEGLECT

- Cachexia / malnutrition
- Dehydration
- **Pressure sores / decubitus ulcers**
- Poor body hygiene, unchanged diaper
- Dirty, severely worn clothing
- Elongated toenails
- Poor oral hygiene

Case of elder abuse neglect showing MASD and ulcers in the sacrum, buttocks, and thighs
Photo courtesy of L. Gibbs, MD, Orange, CA.

Heel pressure ulcer likely due to restraint evidenced by circumferential ankle bruising
Photo courtesy of: D.C. Homeier

Pressure sores in neglected patient
Photo courtesy of D.C Homeier

POTENTIALLY SUSPICIOUS PHYSICAL SIGNS

NEGLECT

- Cachexia / malnutrition
- Dehydration
- Pressure sores / decubitus ulcers
- **Poor body hygiene, unchanged diaper**
- Dirty, severely worn clothing
- Elongated toenails
- Poor oral hygiene

Sacral decubitus ulcer embedded with feces in a case of elder neglect.
Photo courtesy of: Center of Excellence on Elder Abuse and Neglect, University of California, Irvine, CA

POTENTIALLY SUSPICIOUS PHYSICAL SIGNS

NEGLECT

- Cachexia / malnutrition
- Dehydration
- Pressure sores / decubitus ulcers
- Poor body hygiene, unchanged diaper
- **Dirty, severely worn clothing**
- Elongated toenails
- Poor oral hygiene

POTENTIALLY SUSPICIOUS PHYSICAL SIGNS

NEGLECT

- Cachexia / malnutrition
- Dehydration
- Pressure sores / decubitus ulcers
- Poor body hygiene, unchanged diaper
- Dirty, severely worn clothing
- **Elongated toenails**
- Poor oral hygiene

Elongated toenails in neglect victim.
Photo courtesy of: D.C. Homeier

POTENTIALLY SUSPICIOUS PHYSICAL SIGNS

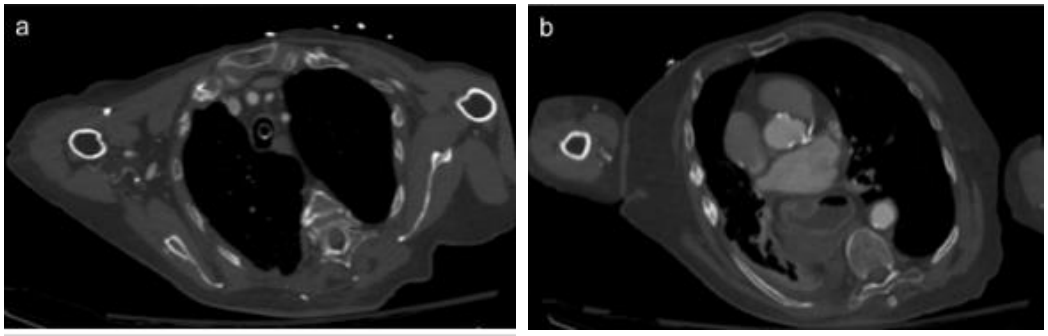
NEGLECT

- Cachexia / malnutrition
- Dehydration
- Pressure sores / decubitus ulcers
- Poor body hygiene, unchanged diaper
- Dirty, severely worn clothing
- Elongated toenails
- **Poor oral hygiene**

Poor dentition in a substantiated case of dependent adult neglect.
Photo courtesy of: L. Gibbs, MD, Orange, CA

IMAGING FINDINGS

- Fractures at different stages of healing or a reported history of injury out of proportion to the observed injury are suspicious for elder abuse
- Provide the radiologist with a description of the clinical scenario to improve the identification of a mismatch between injury severity and the reported mechanism of injury



IMAGING

imaging correlates of elder abuse likely exist

Radiographic Findings Potentially Suggestive of Elder Abuse, Per Radiologists

Upper / posterior / multiple rib fractures
Multiple subdural hematomas (particularly of different ages)
Skull fracture
Small bowel hematomas
Injuries in multiple stages of healing
Injuries inconsistent with mechanism
Multiple fractures and head trauma
Spiral fracture
Brain volume loss secondary to malnutrition
Decubitus ulcers

Health Care Policy and Quality · Original Research

Radiologists' Training, Experience, and Attitudes About Elder Abuse Detection

ELSEVIER

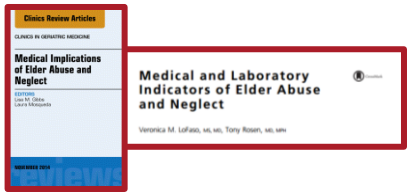
CANADIAN ASSOCIATION OF RADIOLOGISTS JOURNAL

Trauma and Emergency Room Imaging / L'imagerie des urgences et des traumatismes

Imaging Findings in Elder Abuse: A Role for Radiologists in Detection

research ongoing

MEDICAL AND LABORATORY MARKERS



- No laboratory test to definitively detect abuse

BUT

- Lab tests may suggest potential malnutrition, dehydration, anemia, hypothermia/hyperthermia, rhabdomyolysis

- Older adult with suspicious bruising and normal coagulation studies may have abuse-related injuries

- Blood or urine tests for medication levels / drugs / toxins
  - Low or undetectable medication level may suggest intentional or neglectful withholding, diversion
  - Elevated medication level may suggest intentional or unintentional overdose
  - Presence of toxin or medication not prescribed may indicate poisoning

BEYOND FORESNICS

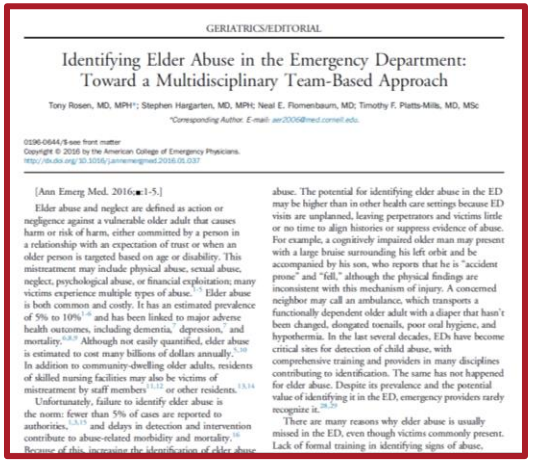
USING DATA MINING TO IDENTIFY PATTERNS

Potential for advanced algorithms using patterns of health care usage to identify potential victims and at-risk older adults

TEAM-BASED APPROACH

TO IDENTIFYING ELDER ABUSE IN CLINICAL SETTING

- EMS
- Triage
- Nursing
- Tech / Radiology Tech / Escort
- Radiologists
- Social Workers
- Care Coordinators / Patient Navigators



GERIATRICS/EDITORIAL

Identifying Elder Abuse in the Emergency Department: Toward a Multidisciplinary Team-Based Approach

Tony Rosen, MD, MPH*; Stephen Hargarten, MD, MPH; Neal E. Flomenbaum, MD; Timothy F. Platts-Mills, MD, MSc

*Corresponding Author. E-mail: ae2006@med.cornell.edu.

0196-0644/$-see front matter
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http://dx.doi.org/10.1016/j.annemergmed.2016.05.037

[Ann Emerg Med. 2016;■:1-5.]

Elder abuse and neglect are defined as action or negligence against a vulnerable older adult that causes harm or risk of harm, either committed by a person in a relationship with an expectation of trust or when an older person is targeted based on age or disability. This mistreatment may include physical abuse, sexual abuse, neglect, psychological abuse, or financial exploitation; many victims experience multiple types of abuse.[1-3] Elder abuse is both common and costly. It has an estimated prevalence of 5% to 10%[1,4] and has been linked to major adverse health outcomes, including dementia,[5] depression,[6] and mortality.[6,8,9] Although not easily quantified, elder abuse is estimated to cost many billions of dollars annually.[3,10] In addition to community-dwelling older adults, residents of skilled nursing facilities may also be victims of mistreatment by staff members[11,12] or other residents.[13,14]

Unfortunately, failure to identify elder abuse is the norm; fewer than 5% of cases are reported to authorities,[1,3,15] and delays in detection and intervention contribute to abuse-related morbidity and mortality.[16] Because of this, increasing the identification of elder abuse

abuse. The potential for identifying elder abuse in the ED may be higher than in other health care settings because ED visits are unplanned, leaving perpetrators and victims little or no time to align histories or suppress evidence of abuse. For example, a cognitively impaired older man may present with a large bruise surrounding his left orbit and be accompanied by his son, who reports that he is "accident prone" and "fell," although the physical findings are inconsistent with this mechanism of injury. A concerned neighbor may call an ambulance, which transports a functionally dependent older adult with a diaper that hasn't been changed, elongated toenails, poor oral hygiene, and hypothermia. In the last several decades, EDs have become critical sites for detection of child abuse, with comprehensive training and providers in many disciplines contributing to identification. The same has not happened for elder abuse. Despite its prevalence and the potential value of identifying it in the ED, emergency providers rarely recognize it.[28,29]

There are many reasons why elder abuse is usually missed in the ED, even though victims commonly present. Lack of formal training in identifying signs of abuse,

it's hard, so everyone needs to be empowered to contribute!

IN MULTI-DISCIPLINARY GERIATRICS CLINIC

Rosen T, Hargarten S, Floemenbaum N, Platts-Mills TF. Identifying elder abuse in the emergency department: Towards a multi-disciplinary team-based approach. Ann Emerg Med 2016 Sep;68(3):378-82.

IDENTIFYING ELDER ABUSE

Concerns about the Home Environment

- utilities not working correctly
  - heating or cooling
  - water
  - electricity
- fecal/urine odor
- empty refrigerator/no evidence of available food
- vermin infestation
- extreme clutter/hoarding
- absence of smoke detector
- presence of fire hazard
- expired or unmarked medication bottles, or multiple bottles of a single medication
- broken window(s)

IDENTIFYING ELDER ABUSE

Concerns about Older Adult / Caregiver Interaction

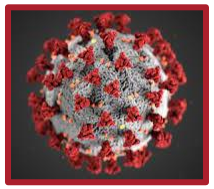
- older adult and caregiver provide conflicting accounts of events
- caregiver interrupts / answers for the older adult
- older adult seems fearful of or hostile towards caregiver
- caregiver appears unengaged / inattentive in caring for the older adult
- caregiver appear frustrated, tired, angry, or burdened by the older adult
- caregiver appears overwhelmed by the older adult
- caregiver appears to lack knowledge of the patient's care needs
- evidence that the caregiver and/or older adult may be abusing alcohol or illicit drugs

IDENTIFYING ELDER ABUSE IN THE ED

Concerns from Medical Hx

- Unexplained injuries
- Past history of frequent injuries
- Elderly patient referred to as “accident prone”
- Delay between onset of medical illness or injury and seeking of medical attention
- Recurrent visits to the emergency department for similar injuries
- Using multiple physicians and emergency departments for care rather than one primary care physician (“doctor hopping or shopping”)
- Noncompliance with medications, appointments, or physician directions

ELDER ABUSE AND COVID-19



- Increased risk factors for older adults and caregivers
- More limited response from community-based resources
- Less visibility into nursing homes

Likely more common but less frequently identified

MANAGEMENT

- Document completely, accurately
- Ensure patient safety
- Report to authorities as appropriate

MANAGEMENT

- **Document completely, accurately**
  - Detailed, specific documentation of all physical findings is important
  - consider using body maps and photographs

Appendix B-4. Geriatric Injury Documentation Tool

Geri-IDT

GERIATRIC-INJURY DOCUMENTATION TOOL
TO DOCUMENT INJURY-RELATED PHYSICAL FINDINGS FOR GERIATRIC PATIENTS

This tool will assist with documentation when an older person has an injury. When one injury is noted, a head-to-toe exam to look for other injuries is warranted. Photograph physical findings if possible. In a case of suspected sexual abuse, follow the appropriate protocols.

For each injury, document:

- Reported mechanism of injury(ies)
- How did it happen/how did the injury(ies) occur?
- Was there pain at the time of the injury(ies) and is there pain now?
- Who is reporting the history? Who else is present while report is given?
- Tenderness to palpation and how it is expressed (e.g., verbal, grimacing, moaning, withdrawal, etc.)
- Precise Location
- Size

Document the following characteristics:

INJURY	CHARACTERISTICS TO DOCUMENT
Abrasion	shape, bleeding, cleanliness, dressings, presence of foreign particles
Bite mark	depth, cleanliness, signs of infection
Bruise	shape, color(s), size, swelling, pattern, elaboration
Burn	burn degree(s), signs of infection, total body surface area
Deformity	bone(s) fractured, whether open or comminuted, healing status, joint(s) dislocated
Laceration	depth, bleeding, cleanliness, linearity/jaggedness, presence of foreign particles, signs of infection
Petechia	location, size, color
Skin Tear	bleeding, dressings, presence of foreign particles, signs of infection
Swelling	size

Document initial physical appearance (including hygiene) on presentation and indications of alcohol or substance abuse.

PRESSURE/WOUND	CHARACTERISTICS TO DOCUMENT
Pressure sore/injury	depth/stage*, size, odor, exudate, evidence of wound care, dressing, signs of infection

*National Pressure Ulcer Advisory Panel stages of pressure injury (2016):

Stage I Non-blanchable erythema of intact skin

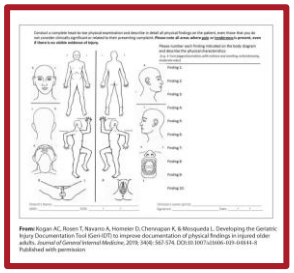
Stage II Partial thickness skin loss with exposed dermis

Stage III Full thickness skin loss

Stage IV Full thickness tissue loss

Unstageable: Obscured full thickness skin and tissue loss such as eschar

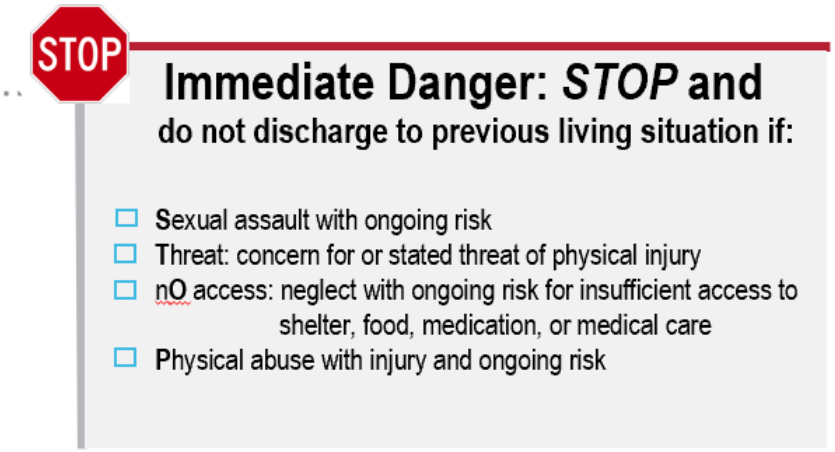
Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration



From: Kogan AC, Rosen T, Navarro A, Homeier D, Chennapan K, & Mosqueda L. Developing the Geriatric Injury Documentation Tool (Geri-IDT) to improve documentation of physical findings in injured older adults. *Journal of General Internal Medicine*, 2019; 34(4): 567-574. DOI:10.1007/s11606-019-04844-8
Published with permission

MANAGEMENT

- **Ensure patient safety**
  - consider transfer to emergency department
  - prevent contact with abuser if immediate danger
  - arrange alternate living arrangements or emergency shelter
  - involve hospital administration / legal if abuser is health care proxy / medical decision-maker



MANAGEMENT

- **Ensure patient safety**

FOR PATIENT THAT REFUSES INTERVENTION

- determine capacity to make this decision (psychiatric consultation may be helpful)

Wishes of older adult with decision-making capacity to return to an abusive situation must be

- Educate about safety planning and potential for escalation
- Provide appropriate referral materials

Aunt Bertha

https://www.findhelp.org

I ♥ Social Work

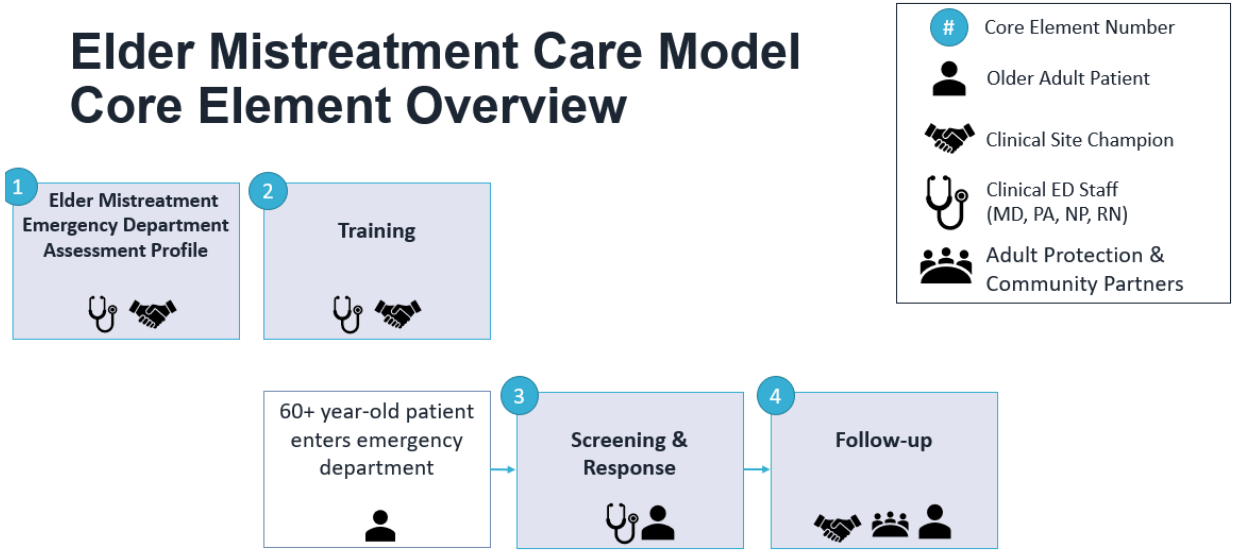
MANAGEMENT

- **Report to authorities as appropriate**
  - call the police
  - report to Adult Protective Services
  - report concerns about a nursing facility to ombudsman / Department of Health

To find out how to report to APS in your community:
http://www.napsa-now.org/get-help/help-in-your-area/

Information on mandatory reporting laws:
http://www.napsa-now.org/wp-content/uploads/2014/11/Mandatory-Reporting-Chart-Updated-FINAL.pdf

COMPREHENSIVE APPROACH



pragmatic trial ongoing in multiple sites

UTHealth The University of Texas Health Science Center at Houston Consortium on Aging

Weill Cornell Medicine

Keck Medicine of USC

EDC Education Development Center

GORDON AND BETTY MOORE FOUNDATION

SCREENING

Has the potential to significantly increase identification

- Single safety question unlikely adequate / appropriate
- Targeted screening is challenging because it is difficult to accurately identify high-risk patients and screening may miss victims
- No evidence yet indicating either improved outcomes or negative consequences with screening

INTERVENTION

Launched the first-of-its-kind, ED-based multi-disciplinary team

Weill Cornell Medicine Vulnerable Elder Protection Team

consultation service available 24/7 to assess, treat, and ensure the safety of elder abuse / neglect victims while also collecting evidence when appropriate and working closely with the authorities

increase identification and reporting and decrease burden on ED providers

similar to existing child protection teams

MEETING A NEED

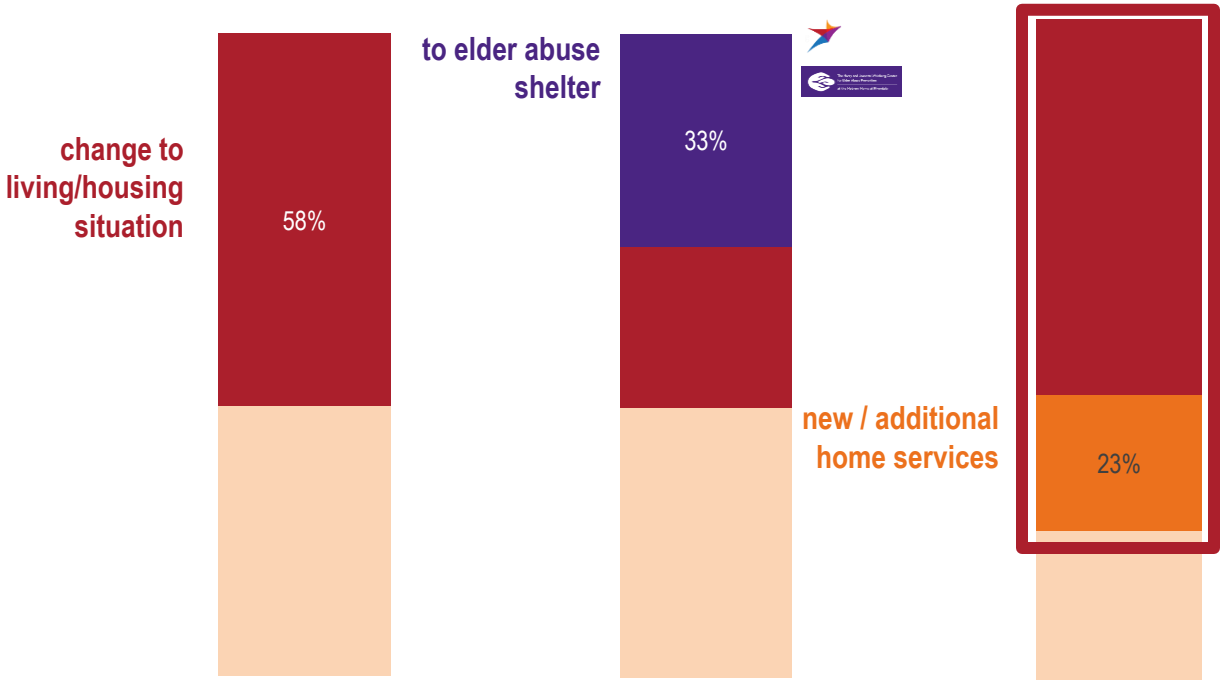
April 1, 2017- March 31, 2019
~24 months / 104 weeks

Total ED Activations: **200** (**1.9** per week)
*also **55** In-patient activations*

Weill Cornell Medicine
Vulnerable Elder
Protection Team

HAVING AN IMPACT: OUTCOMES

among patients with high or moderate concern for mistreatment after VEPT evaluation



81% with change to living/housing situation or with new/additional home services

only 4 of these patients has since returned to the ED for an mistreatment-related issue

Living/Housing Situation after Discharge

EXPANSION

- Grow our ED-based program and team
  - Respond to potential elder abuse cases throughout the hospital
  - Follow patients longitudinally after hospitalization / initial evaluation
  - Add in-patient provider to team
  - Expand partnership with APS
  - Develop service for other NYP EDs via telehealth

Funding from:

New York State Crime Victims Rights Office of Victim Services

REPLICATION

COLORADO
Division of Criminal Justice
Department of Public Safety

Office for Victims Programs

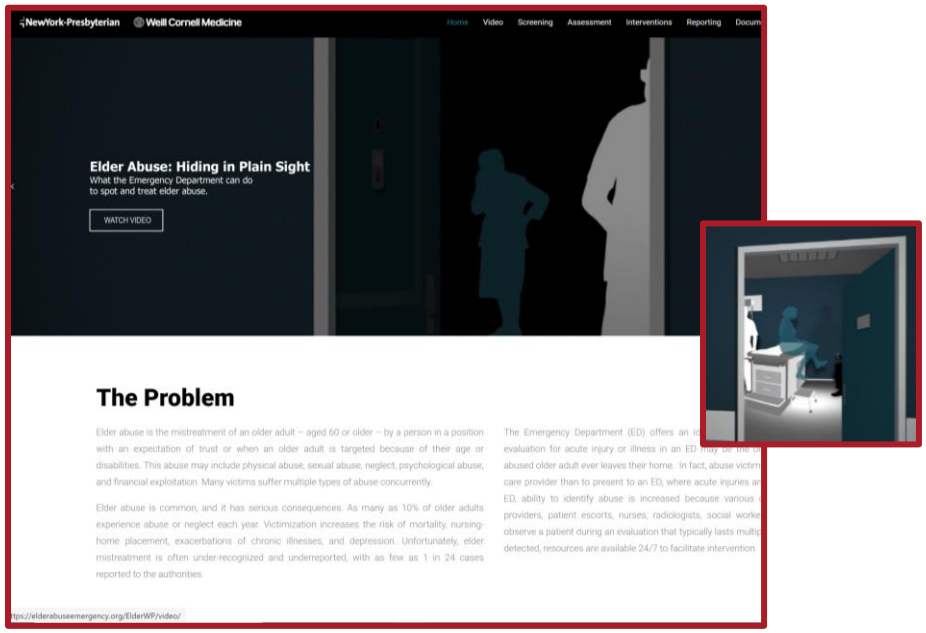
Kempe

THE KEMPE CENTER
FOR THE PREVENTION AND TREATMENT
OF CHILD ABUSE AND NEGLECT

University of Colorado
Anschutz Medical Campus

WWW.ELDERABUSEEMERGENCY.ORG

Check it out if you have a case in clinical setting



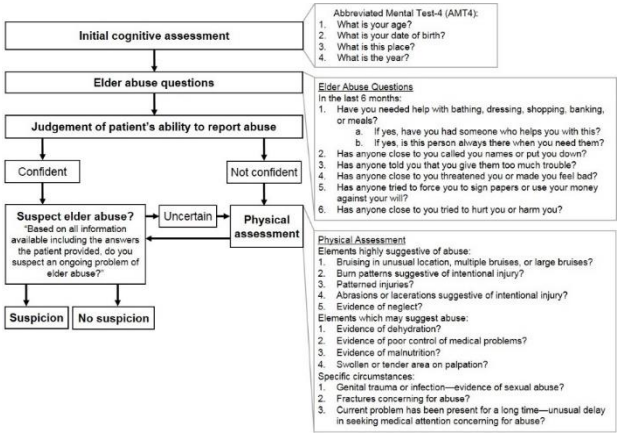
information, protocols, & resources for clinical providers

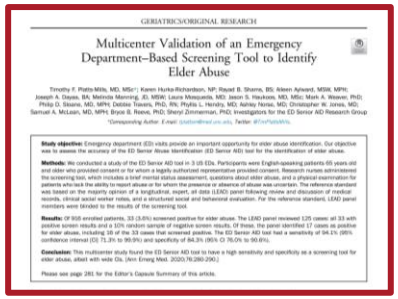
QUESTIONS

Thank you!

SCREENING TOOLS

ED Senior AID





GERIATRICS/ORIGINAL RESEARCH

Multicenter Validation of an Emergency Department–Based Screening Tool to Identify Elder Abuse

Platts-Mills TF, Hurka-Richardson K, Shams RB, Aylward A, Dayaa JA, Manning M, Mosqueda L, Haukoos JS, Weaver MA, Sloane PD, Travers D, Hendry PL, Norse A, Jones CW, McLean SA, Reeve BB, Zimmerman S; Investigators for the ED Senior AID Research Group, Davenport K, Bynum D, Frederick E, Lassiter-Fisher K, Stuckey A, Daley-Placide R, Hoppens M, Betterton J, Owusu S, Flemming C, Colligan A. Multicenter Validation of an Emergency Department-Based Screening Tool to Identify Elder Abuse. Ann Emerg Med. 2020 Sep;76(3):280-290

sensitivity 94.1%, specificity 88.3% in multi-site validation study (experimental conditions)

Elder Abuse Suspicion Index (EASI)

Questions 1 through 5 are answered by the patient. Question 6 is answered by the physician.

1. Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?
2. Has anyone prevented you from getting food, clothes, medication, glasses, hearing aids, or medical care or from being with people you wanted to be with?
3. Have you been upset because some one talked to you in a way that made you feel shamed or threatened?
4. Has anyone tried to force you to sign papers or to use your money against your will?
5. Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?
6. Doctor: Elder abuse may be associated with findings such as poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last 12 months?

The patient can answer "yes," "no," or "unsure." A response of "yes" on one or more of questions 2 through 6 should prompt concern for abuse or neglect.

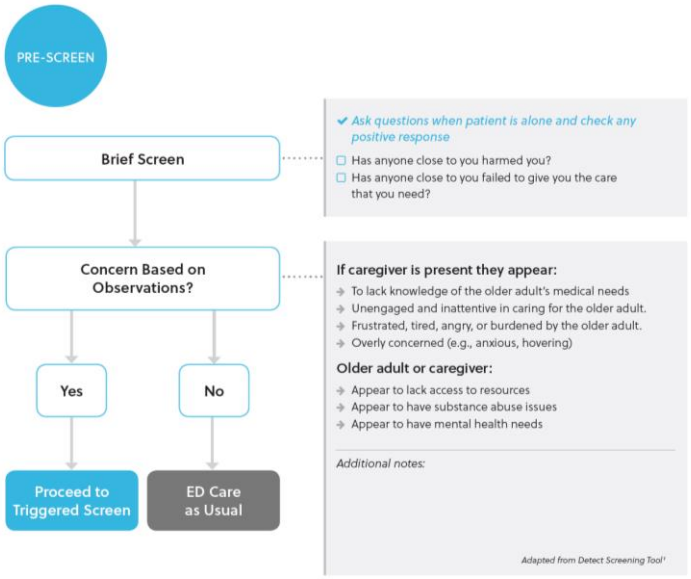
Yaffe MJ1, Wolfson C, Lithwick M, Weiss D. Development and validation of a tool to improve physician identification of elder abuse: the Elder Abuse Suspicion Index (EASI). J Elder Abuse Negl. 2008;20(3):276-300.

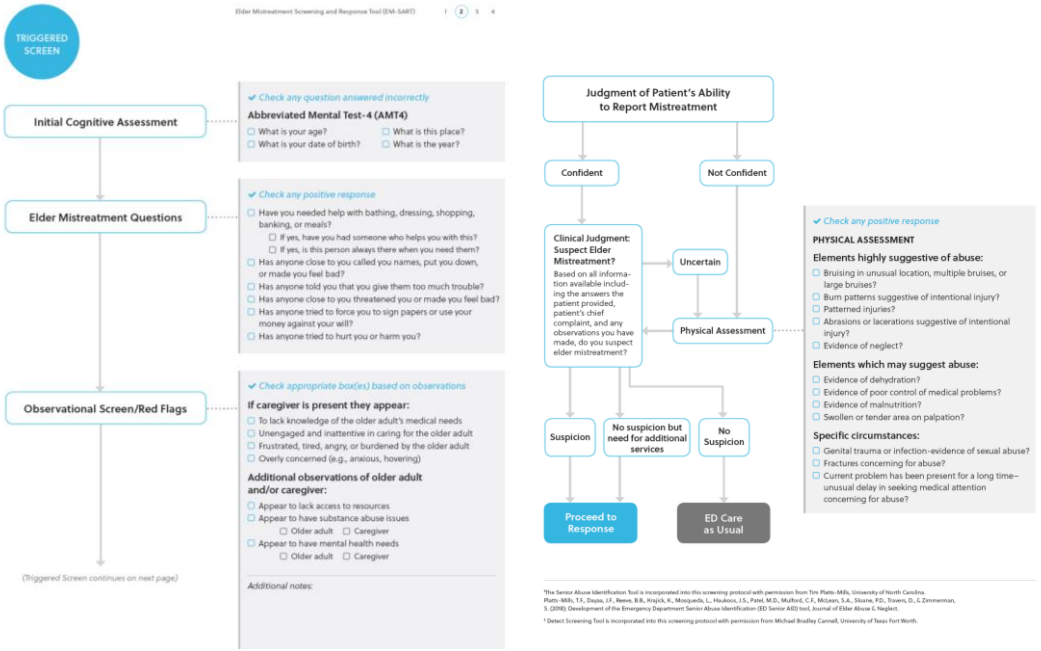
validated for cognitively-intact patients in ambulatory care (sensitivity 47%, specificity 75%)

SCREENING TOOLS

EM-SART

Two-Step Screen Including ED Senior AID Tool

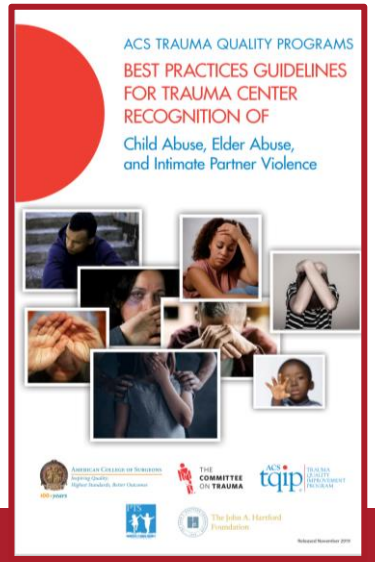




BEST PRACTICES IN TRAUMA

recommendations for elder abuse assessment and management in trauma care

- Overview
- Assessment
- Teamwork
- Documentation
- Intervention
- Performance Improvement



ACS tqip TRAUMA QUALITY IMPROVEMENT PROGRAM

AMERICAN COLLEGE OF SURGEONS FOUNDED IN 1913 OMNIBVS PER ARTEM FIDEMQVE PRODESSE

THE COMMITTEE ON TRAUMA

IDENTIFYING ELDER ABUSE

How can you identify elder abuse or neglect?

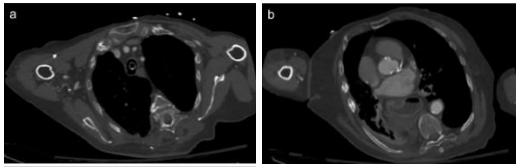
- Risk Factors for Elder Abuse
- Concerns about the Home Environment
- Concerns about Older Adult / Caregiver Interaction
- Concerns from Medical History
- Physical Signs Suspicious for Abuse

IDENTIFYING ELDER ABUSE

Risk Factors for Elder Abuse

FOR BECOMING A VICTIM
Functional dependence or disability
Poor physical health
Cognitive impairment / dementia
Poor mental health
Low income / socio-economic status
Social isolation / low social support
Previous history of family violence
Previous traumatic event exposure
Substance abuse
FOR BECOMING A PERPETRATOR
Mental illness
Substance abuse
Caregiver stress
Previous history of family violence
Financial dependence on older adult

EMPOWERING RADIOLOGISTS

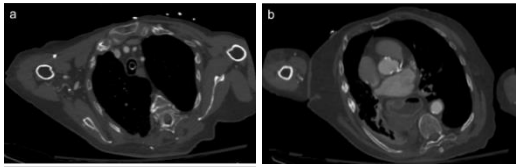


play a critical role in the detection of child abuse in the ED
but imaging correlates of elder abuse have not been described

Qualitative Interview Research: Diagnostic Radiologist Perspectives

- few radiologists reported receiving any formal or informal training in elder abuse detection
- even experienced radiologists reported ***never*** having received a request from a referring physician to assess images for evidence suggestive of elder abuse
- believe imaging correlates exist

Rosen T, Bloemen EM, Harpe J, Sanchez AM, Mennitt KW, McCarthy TJ, Nicola R, Murphy K, LoFaso VM, Flomenbaum N, Lachs MS. Radiologists' training, experience, and attitudes about elder abuse detection. AJR Am J Roentgenol 2016 Dec;207(6):1210-1214.



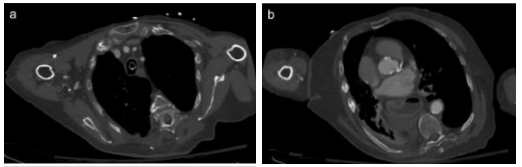
IMAGING

imaging correlates of elder abuse likely exist

Radiographic Findings Potentially Suggestive of Elder Abuse, Per Radiologists

Upper / posterior / multiple rib fractures
Multiple subdural hematomas (particularly of different ages)
Skull fracture
Small bowel hematomas
Injuries in multiple stages of healing
Injuries inconsistent with mechanism
Multiple fractures and head trauma
Spiral fracture
Brain volume loss secondary to malnutrition
Decubitus ulcers

Rosen T, Lien C, Stern ME, Bloemen EM, Mysliwiec R, McCarthy TJ, Clark S, Mulcare MR, Ribaudo DS, Lachs MS, Pillemer K, Flomenbaum NE. Emergency Medical Services Perspectives on Identifying and Reporting Victims of Elder Abuse, Neglect, and Self-Neglect. J Emerg Med. 2017 Oct;53(4):573-582.



EMPOWERING RADIOLOGISTS

reviewing case where victim reported being struck by cane and alleged abuser reported “he fell”

Ulna does not anatomically support the wrist, so you wouldn’t expect distal or mid-shaft ulnar fractures after a FOOSH

Wong NZ, Rosen T, Sanchez AM, Mennitt KW, Hentel K, Nicola R, Murphy K, LoFaso VM, Flomenbaum N, Lachs MS. Imaging findings in elder abuse: A role for radiologists in detection. Can Assoc Radiol J. 2017 Feb;68(1):16-20.