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

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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.[1–5] Elder abuse is both common and costly. It has an estimated prevalence of 5% to 10%[1–6] and has been linked to major adverse health outcomes, including dementia,[7] depression,[7] and mortality.[6,8,9] Although not easily quantified, elder abuse is estimated to cost many billions of dollars annually.[5,10] 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 is a major public health priority.[17–20] Aging of the baby boom generation makes it likely that the disease burden will increase during the next 2 decades, further increasing the importance of early and reliable victim identification.

An emergency department (ED) visit provides a unique opportunity to identify elder abuse. Medical assessment for injury or illness may be the only time victimized older adults leave their home. Available evidence indicates that victims of elder abuse are less likely to receive routine care from a primary provider than other older adults but receive emergency care more frequently.[21–23] In a recent study, 7% of cognitively intact older ED patients reported a history of physical or psychological mistreatment during the past year.[24] This number likely underestimates the prevalence of elder abuse among ED patients because abuse rates are higher among those with cognitive impairment[25–27] and because this study did not assess neglect or financial 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

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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, uncertainty about the appropriate steps to take after identification, and doubts about the effectiveness of interventions likely all contribute.[30] Although extreme cases may be apparent on a cursory assessment, most cases are subtle and present with nonspecific signs.[31] As with child abuse, victims may be either unable or unwilling to report the problem.[31] Differentiating between unintentional and intentional injuries and between illnesses that occurred despite appropriate care or because of neglect often requires collecting detailed information from multiple sources, which takes time.[32,33] This is particularly challenging for cognitively impaired patients who are unaccompanied in the ED and for whom relevant information cannot be obtained by telephone. In such cases, physical findings and diagnostic results may be the only source of information to determine the presence of abuse or neglect.

One part of the solution to the existing challenges in identifying elder abuse in the ED is to develop a team-based approach, leveraging the unique perspectives of emergency medical services (EMS) providers, triage providers, nurses, radiologists, radiology technicians, social workers, and case managers.

SEEING INSIDE THE HOME

Paramedics and emergency medical technicians typically enter a patient’s home when responding to a 911 call. Examination of the home can provide important information about the overall safety of the environment and may also provide evidence of abuse. Previous research has shown the ability of EMS personnel to use their access to the home to support screening of geriatric patients for mental health, environmental, and social problems, including elder abuse, and refer them to service agencies.[34] Through educational initiatives such as the Geriatrics Emergency Medical Services course,[35] these providers can receive specific training in identifying potential elder abuse.[36] Once abuse is identified, EMS providers should be empowered to communicate with the ED care team about unusual family interactions; cleanliness and upkeep of the home; the availability of food, medications, heat, and sanitation; and other safety issues.[37] The increasing use of electronic data entry by EMS may be a means of encouraging EMS providers to make these observations and communicate them to ED providers.

FIRST IMPRESSIONS

Although some EDs have eliminated the triage process, many large, busy EDs use it to perform a brief, initial patient evaluation. Screening has become an important component of this triage assessment: many US EDs currently screen for conditions including HIV, Ebola, and domestic violence. Although several tools to screen for elder abuse have been described and may be operationalized,[38,39] none of these tools are specifically designed for the ED. A brief, accurate screening protocol to assess all older adults for abuse would be valuable, but whether this can be achieved and whether the best place to conduct the screen is at or after triage is unknown.[23] Research supported by the National Institute of Justice to develop and validate an ED screening tool for elder abuse is ongoing. Because the triage provider may be the only person to see and collect information from EMS, family members, or caregivers, in the absence of a validated ED screening tool it is essential that information obtained at triage be accurately relayed to the ED care team.

TIME AT THE BEDSIDE

In the ED, nurses provide bedside care to patients and typically have significantly more face-to-face contact with patients, caregivers, and other family and friends than do physicians. Close observation by a nurse,[40] with a focus on interactions and discordant information between the patient and caregivers, may identify red fiags requiring further investigation. Furthermore, during a geriatric patient's prolonged ED stay, nurses often provide hygiene care for them, including diaper changes. Careful and complete examination of a patient during this care may uncover otherwise missed physical findings that provide evidence of elder abuse. Literature is emerging describing bruising patterns that may be concerning for elder abuse,[31,41] and additional research in this area is ongoing.

LEVERAGE EXPERTISE IN IDENTIFYING INJURY PATTERNS

Because many older ED patients who present with injuries receive radiographic evaluation, radiologists may be well positioned to raise suspicion for abuse.[16] Findings suggestive of abuse may include injuries inconsistent with the reported mechanism, co-occurrence of old and new injuries, and otherwise uncommon patterns suggestive of nonaccidental trauma. Imaging findings suggestive of child abuse have been described, and radiologists play a critical role in the detection of child abuse in the ED.[42–44] To date, however, little radiology literature exists describing imaging correlates of elder abuse,[16] and training in elder abuse assessment for diagnostic radiologists has not been described, to our knowledge. Future research is needed to define pathognomonic injury patterns and to empower diagnostic radiologists to incorporate detection of elder abuse into their practice. To support radiologists' ability to contribute to detection efforts, emergency physicians should provide them with information about the reported mechanism of injury and communicate any suspicion of abuse.[45]

A PRIVATE MOMENT

When a perpetrator is present in the ED, victims may have difficulty reporting abuse or asking for help from physicians and nurses. Radiology technicians and other employees such as nursing assistants who transport patients are uniquely positioned to receive such reports because they often spend time alone with the patient.[40,46] Patients may also be more comfortable talking to support staff than physicians because they may perceive fewer consequences from such conversations. Training and empowering radiology technicians and patient transporters to contribute to elder abuse detection has the potential to significantly affect early identification.

ASSESSING THE SOCIAL SUPPORT SYSTEM

Many large EDs have social workers or case managers available, sometimes 24 hours a day. In smaller EDs, social workers may be available from other areas of the hospital or on call. These individuals have a variety of roles, including counseling and assessing patients' financial resources, support system, and social service needs to evaluate the potential for alternatives to hospitalization.[47] This evaluation may reveal risks for or evidence of abuse that may not be apparent to health care providers. The significant value of social workers in EDs has been described,[47] particularly for older adults.[48] Ideally, all dependent geriatric ED patients being considered for discharge would receive a social work evaluation; this is usually not possible because ED social workers are overburdened and understaffed. Therefore, the ED care team should assist social workers in identifying the most vulnerable individuals for assessment.

THE NEXT STEP: TESTING A MULTIDISCIPLINARY INTERVENTION

In most US states, members of the health care team are mandated to file a report if they know or reasonably suspect that elder abuse has occurred.[49] Adult Protective Services are county- or state-based agencies responsible for receiving and investigating these reports. Protocols and systems to facilitate improved communication between ED medical staff and Adult Protective Services are needed. Unfortunately, Adult Protective Services typically cannot become involved in a case investigation while a patient is hospitalized, and in many parts of the country, funding is insufficient to enable them to provide comprehensive services to all older adults identified as experiencing or possibly experiencing elder abuse. Furthermore, an Adult Protective Services response often takes significant time, and, in many programs, the threshold for intervention is high.

The gaps created by limitations in the current activities of Adult Protective Services provide an important opportunity for ED-based teams to help these patients. ED-initiated interventions may be particularly valuable for dependent older adults whose care is suboptimal but doesn't meet Adult Protective Services criteria for their needing protective services. ED-initiated interventions may address immediate safety concerns but also may have the potential to identify pathways for long-term solutions by incorporating input from physicians, social workers, case managers, and mental health professionals. This multidisciplinary approach has worked well for victims of child abuse.[50] Similar

multidisciplinary teams for elder abuse should be developed and their effect evaluated. Such trials are necessary to determine whether busy emergency providers will be more likely to consider and assess for elder abuse when a multidisciplinary team is available, particularly if a single telephone call triggers a careful assessment, identification of resources for both patients and caregivers, contacting of the authorities if appropriate, assistance with disposition, and ensuring patient safety. In addition to contacting Adult Protective Services, when the victim of elder abuse is a resident of a nursing home or other long-term care facility, concerns should be reported to the state's long-term care ombudsman (http://theconsumervoice.org/get_help). For patients living in the community, intervention teams should consider leveraging the expertise of existing community aging services.

FUNDING FOR RESEARCH AND CLINICAL CARE

At present, there are neither validated ED-based screening tools to identify elder abuse nor published studies describing the successful ED-based interventions in this population.[51–53] Funding is critical to develop the evidence base to define the value of and optimal approach to screening and intervention for elder abuse, as well as to disseminate and implement such programs. There are promising signs that this issue is becoming a priority, and significant funding may be available soon. Elder justice was one of the 4 topic areas focused on during the 2015 White House Conference on Aging.[20] The National Institutes of Health recently hosted a workshop of leaders in public policy, medicine, nursing, gerontology, and social work to improve the understanding and prevention of elder abuse.[54] In addition, although not yet funded by Congress, the Elder Justice Act was passed in 2010 and would provide large grants for research and demonstration projects.[55]

For any such programs to be sustainable, payment mechanisms are also needed to support the substantial amount of additional work involved in providing multidisciplinary interventions for all patients at high risk for elder abuse. This funding may come from partnerships with insurance companies, which are likely to be motivated to identify and intervene in cases of elder abuse to reduce health care costs. Analysis of health care use data by health insurance companies may also provide a novel means of identifying abuse. In regions with accountable care organizations, the potential savings in health care costs by being proactive to reduce elder abuse has the potential to motivate health care systems to support screening and interventions.

SUMMARY

As emergency physicians, we take pride in doing our best to identify all critical diagnoses for each patient who comes through our doors. Currently, most victims of elder abuse and neglect pass through our EDs with a life-threatening condition unidentified. A multidisciplinary team-based approach supported by additional research and funding has the potential to improve the identification of elder abuse, as well as the health and safety of our most vulnerable patients.

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