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Improving Quality of Care in Hospitals for Victims of Elder Mistreatment: Development of the Vulnerable Elder Protection Team

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Abstract

Hospitals have an opportunity to dramatically improve the quality of care provided to victims of elder mistreatment, which is common and has serious consequences. An Emergency Department (ED) visit for acute injury or illness may be the only time a victimized older adult leaves their home, and hospitals have a wide range of resources available to respond. EDs already play an important role in the identification of and intervention for other types of family violence, including child abuse and intimate partner violence among younger adults. To date, few interventions to prevent or stop elder abuse, neglect, or exploitation have been described, with none focused in an acute care hospital. Successful hospital-based interventions in child abuse and intimate partner violence may serve as models for approaches to address elder mistreatment. We describe the Vulnerable Elder Protection Team, an innovative, multi-disciplinary ED-based intervention for elder mistreatment victims.

Keywords

elder abuse; emergency department; intervention

Problem Definition

Hospitals have an opportunity to dramatically improve the quality of care provided to a particularly vulnerable population, victims of elder mistreatment. As defined in the 2014 Elder Justice Roadmap, a report prepared by a large, multi-disciplinary team of stakeholders inside and outside the US government, elder mistreatment is: physical, sexual, or

psychological abuse, as well as neglect, abandonment, and financial exploitation of an older person by another person or entity that occurs in any setting (e.g. home, community, or facility) either in a relationship where there is an expectation of trust and/or when an older person is targeted based on age or disability.¹ This mistreatment is surprisingly common, affecting 5–10% of community-dwelling older adults each year.^{1–6} Medical consequences of this abuse are serious, with victims having increased depression,^{6–8} as well as dramatically higher mortality.^{6,9,10} Despite its frequency and severity, elder mistreatment is rarely identified, with as few as 1 in 24 cases reported to the authorities.³ Few programs to prevent or stop elder abuse have been examined in the peer-reviewed literature,^{11–15} with even fewer demonstrating a convincing impact on important outcomes.^{16,17} Notably, these interventions were conducted in various community and institutional settings, with none focused in an acute care hospital.

A hospital emergency department (ED) visit provides a unique potential opportunity to identify elder abuse and to initiate intervention.^{18–21} A visit to the ED for acute injury or illness may be the only time a victimized older adult leaves his or her home.²¹ Mistreatment victims are typically socially isolated and are less likely to seek outpatient medical care.^{18–21} In addition, an ED and hospital have multiple members of the care team who can contribute to identification of mistreatment during an evaluation that is typically prolonged.²¹ The ED also has access to a wide range of resources available 24/7 to respond.²¹ The ED already plays an important role in the identification of and intervention for other types of family violence, including child abuse^{22,23} and intimate partner violence among younger adults.^{24,25} Despite this, ED providers seldom identify or report elder mistreatment.^{26–28} Though not well understood, many reasons likely contribute to this, including time constraints, inadequate training and experience, and concern about involvement with the legal system.^{28,29} Improving detection of and intervention for elder mistreatment are opportunities to provide high-quality impactful care and increase the safety of these vulnerable patients. In this article, we build on ideas initially suggested by Rosen et al.²¹ We examine as models hospital-based interventions for other types of family violence, and we describe in detail an innovative, multi-disciplinary ED-based intervention for elder abuse victims.

Models for Intervention

Models exist to improve intervention for victims of elder mistreatment in the ED/hospital which capitalize on the multi-disciplinary resources already available in many large medical centers. Hospital-based child protection teams were developed more than 50 years ago in response to the recognition that cases of child abuse are often complex, represent high-stakes medical and social care, and frequently require time-consuming forensic evaluation and contact with appropriate authorities.²² Members of these multi-disciplinary teams work together to maximize the quality and coordination of care of the maltreated child, with the aim of improving child health outcomes. By virtue of this coordinated care, these teams allow the ED and hospital clinical providers to return to the care of other emergent patients. Though only limited research has been conducted to rigorously evaluate their effectiveness,²² experts believe that they have a significant impact on care.²² They have been shown to significantly increase the community services obtained by the patient and family.²³

Additionally, one study found that institutions with established child protection teams were more likely than others to identify and manage a large number of child abuse or neglect cases and more commonly had complete documentation, were able to track outcomes, and provided follow up care for child abuse and neglect victims.³⁰

Specialized multi-disciplinary programs to intervene for victims of intimate partner violence have also been developed.²⁴ Though interventions have differed in design and scope, and not all have been successful,^{31–33} some have shown decreased re-victimization rates,³⁴ increased use of community and hospital resources, increased use of domestic violence shelters and shelter counseling,³⁵ increased willingness to leave abusive relationships, and improved quality of life.³⁶ Additionally, sexual assault nurse examiner (SANE) programs have been developed in many EDs to provide medical care, forensic evaluation, and counseling 24/7 to victims of sexual assault.^{37–41} SANE nurses are trained to conduct specialized medical evaluations, collect forensic evidence using a legally-sanctioned kit, provide emotional support, and advocate for prosecution of sexual assault.³⁹ These nurses are typically called in from home when a victim presents to the ED. Their evaluation and exam may take multiple hours, and, typically, SANE nurses must remain in the patient's room for the entire forensic portion to preserve chain of custody for evidence collected. SANE programs have reduced the burden on ED providers, who would otherwise be responsible for providing care to these victims, which can be very time-consuming and challenging. Also, though limited research exists, available data suggests that SANE programs have been effective in providing medical care and psychological support for victims of sexual assault while increasing the quality of forensic evidence.³⁹ In many settings, these SANE providers have been integrated into multi-disciplinary sexual assault response teams.⁴²

Approach

Using these models and our own experience, we have developed and launched an innovative, ED-based multi-disciplinary Vulnerable Elder Protection Team (VEPT) at NewYork-Presbyterian/Weill Cornell Medical Center. Our hospital is a large urban, academic medical center that treats over 90,000 patients each year, of whom 30% are 60 years old. Our ED focuses on using innovation to optimize care for older adults. Our ED/hospital is a Level I trauma center, a regional burn center, and has a designated in-patient unit for the Acute Care of the Elderly.

VEPT is a consultation service available 24/7 to improve identification, comprehensive assessment, and treatment for potential victims of elder abuse or neglect. Figures 1 and 2 provide an overview of the current VEPT process and protocol. The design of our intervention takes advantage of the availability of a broad range of resources in a large, urban ED at all times. We are also mindful of the importance to ED providers that a consultation service be available to assist them urgently in the middle of the night.

Activating the VEPT

We have trained all ED providers on how to recognize signs of elder mistreatment. This includes education on identifying high-risk patients using indicators within the medical history, observation of the interactions with caregivers, and physical signs potentially

suspicious for mistreatment. An online version of this training has been incorporated into orientation for all new ED providers. Any provider can activate the VEPT via a single page/telephone call. This allows the ED provider to return to the care of other critically-ill patients while the multi-disciplinary VEPT completes the often time-consuming, complex assessment of the potential mistreatment victim. We anticipate that, by significantly reducing the burden on ED providers, the presence of the VEPT will increase identification and reporting of elder mistreatment.

Social Worker Performs Initial Bedside Assessment

For all cases, when the VEPT is activated, the ED social worker on duty responds initially and assesses the patient. ED social workers are already available in our department 24 hours a day, similar to many large EDs, which have recognized their value to the care team,⁴³ particularly for older patients.⁴⁴ In preparation for the launch of the VEPT, all ED social workers have received additional training in elder mistreatment assessment and intervention. In addition to their routine geriatric evaluation, the VEPT social worker explores in detail the specific concerns expressed by the referring ED provider and will formally screen for mistreatment, including neglect, psychological abuse, financial exploitation, physical abuse, and sexual abuse. If suspicion for mistreatment persists after this initial assessment, the social worker may perform a comprehensive social evaluation, focusing on functional status, living arrangements, financial status, social support/resources, emotional/psychological status, and stressors. A list of questions for this screening and structured interview guide for the comprehensive social evaluation has been developed, and we are currently validating it. A patient with the capacity to make the decision may refuse evaluation by the VEPT or any component of the assessment.

The VEPT social worker also separately interviews the potential perpetrator and/or caregiver.^{45,46} The purpose of this interview is to identify important discrepancies from the patient's history, and, for potential perpetrators who are also caregivers, to assess how familiar he/she is with an older adult's routine medications and necessary medical care. The interview is conducted in a nonjudgmental, non-threatening, and supportive manner. It may also explore the perpetrator's risk for mistreatment, including: whether any important changes or recent stresses have occurred in the household, whether caring for the older adult is burdensome, the potential perpetrator's other dependents and responsibilities, and whether any home help services or respite services have been made available. Additionally, the social worker gathers collateral information from other sources when possible.

Collaborative Discussion with the On-Call Medical Provider

After their assessment, the social worker contacts the on-call VEPT medical provider to collaboratively discuss next steps and whether other team members need to become involved. This on-call responsibility is currently shared by three emergency physicians with additional geriatrics and forensic training. The on-call schedule takes into account their other clinical responsibilities. We plan in the future to hire geriatric nurse practitioners to take the on-call responsibilities. The total full-time equivalent devoted to this role at launch is 75% including all participants, but we anticipate that this will change.

Medical Provider Performs Comprehensive Medical and Forensic Assessment

After discussing the case with the ED social worker, the VEPT medical provider is available, when appropriate, to come to the ED to conduct a comprehensive medical and forensic assessment of the patient that the ED medical providers may not have the time and/or the skills to perform. This assessment includes obtaining supplemental history and conducting a head-to-toe physical examination. The VEPT medical provider conducts a comprehensive interview with the patient alone, focusing on the reason for the current ED visit and past medical history/medical status. He/she also performs a formal cognitive assessment. This assessment may include the Montreal Cognitive Assessment (MoCA)⁴⁷ and/or the Mini-Mental State Examination (MMSE).⁴⁸ The MoCA is used if the patient has no history of cognitive impairment and there is low suspicion of significant impairment, as this test is more sensitive for mild impairment.⁴⁹ In other cases, we administer the MMSE. When appropriate, the VEPT medical provider acquires parallel history from family, friends, neighbors, caregivers, and out-patient health care providers. The physical exam includes assessment for trauma inconsistent with purported mechanism and any evidence⁷ of physical abuse, sexual abuse, or neglect, including: atypical bruising, patterned injuries, genital/rectal trauma, cachexia, pressure sores, or poor hygiene. The VEPT medical provider comprehensively documents all findings, which may be critical for future legal processes but is often incomplete and inadequate in current practice, even for child abuse.^{50,51} Additionally, the VEPT medical provider photographs injuries and conducts a sexual assault forensic exam when appropriate. All VEPT providers have received appropriate needed training to perform sexual assault forensic exams. The VEPT medical provider initiates radiographic tests for occult or chronic injuries and collaborate with the ED radiologist to ensure consistency of injuries and reported mechanism as well.^{52,53} He/she may also initiate laboratory testing to evaluate for: dehydration, electrolyte abnormalities, anemia, malnutrition, or rhabdomyolysis.⁵⁴ This initial evaluation by the medical provider typically takes 30–60 minutes, but additional case coordination, with phone calls and follow up/ interpretation of test results may be needed during the next several hours.

Additional Team Members Contribute as Needed

For many potential elder mistreatment victims with complex cases, additional VEPT team members contribute when necessary. For example, a patient may decline VEPT assessment or request discharge into an unsafe environment. If his/her capacity to make these decisions is unclear, as is common among older adults, an ED psychiatrist assesses them and provides guidance. In some cases, hospital security may need to become involved to protect the patient and/or remove a potential perpetrator from the ED or restrict visitation. If a potential perpetrator is the patient's health care proxy or surrogate decision-maker, hospital ethics and legal services may need to become involved to help guide appropriate care decisions and even guardianship. These professionals have received additional training, and the VEPT design takes advantage of the fact that they are all currently available in our hospital 24/7.

Integration with In-Patient, Out-Patient, and Community Resources

For patients admitted to the hospital, the VEPT connects with the in-patient social workers and medical team to ensure appropriate follow-up and care planning. For patients

discharged, the VEPT utilizes out-patient resources including early appointments in our multi-disciplinary geriatrics clinic and, for patients with mental health issues, visits from our hospital's mobile crisis team. We may also consider elder abuse shelter as a discharge option. The VEPT has formed partnerships with other community resources through our participation in the New York City Elder Abuse Center (www.nyceac.com) and refers patients and caregivers, when appropriate, to programs within the New York City Department for the Aging and other agencies. We will also involve Adult Protective Services (APS) and other authorities when necessary. Opportunities exist to use the VEPT itself as a community resource, and we are exploring protocols for APS and emergency medical services to identify and refer to our ED older adults who are in unsafe situation and may benefit from immediate evaluation.

Program Administrator Provides Feedback, Support, and Coordination

A full-time program administrator (PA), who is also a licensed social worker, supports and assists the team. The PA gives and solicits feedback to/from ED providers who have consulted the VEPT, updating them on case status and identifying any issues with the VEPT processes. The PA tracks cases and provide support to in-patient social workers by suggesting intervention strategies, available resources, and disposition options. The PA also coordinates regular multi-disciplinary case review meetings with VEPT program leadership and manages the medical provider on-call schedule. Comprehensive protocols of all aspects of VEPT operations are available as an online supplement and at xxx.com. The presence of a full-time PA also allows for short and long-term patient tracking and program evaluation.

Next Steps/Planned Evaluation

We launched the VEPT program in April 2017 after comprehensive training and plan to use several strategies to evaluate and measure its success. We have already begun to track closely the number of referrals and completed consultations, which types of providers are referring, as well as the characteristics and circumstances of potential victims and perpetrators. This will be critical for quantifying the human resources needed for the program and identifying when and for whom additional training is required. We will hold regular meetings to review individual cases to ensure that the care the VEPT is providing is optimal and standardized. We will also conduct and analyze focus groups and surveys of participating ED providers to improve understanding of their experiences interacting with the VEPT, and the findings will inform changes to our process. The impact of the program will be measured by tracking the short-term and long-term mistreatment-related as well as medical, mental health, functional, psychosocial, and legal outcomes of the vulnerable ED patients for whom we provide care. Selected key outcomes we plan to examine as well as anticipated data sources to track these are described in Table 1. Notably, we have included perpetrator prosecution as a relevant legal outcome. Many victims of elder mistreatment want help/support for the perpetrator and do not want to pursue prosecution.^{16,55,56} Also, however, many elder mistreatment perpetrators are not prosecuted because of insufficient evidence gathered by acute care medical providers,⁵⁷ particularly for patients with cognitive impairment. Therefore, while not relevant for every patient, we think that it is an important outcome to examine overall when evaluating our program. Given the heterogeneity of victim

circumstances and relevant outcomes, we also plan to employ innovative measurement strategies including goal-attainment scaling⁵⁸ to accurately measure the program's impact.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Vulnerable Elder Protection Team Consultation Team and Process

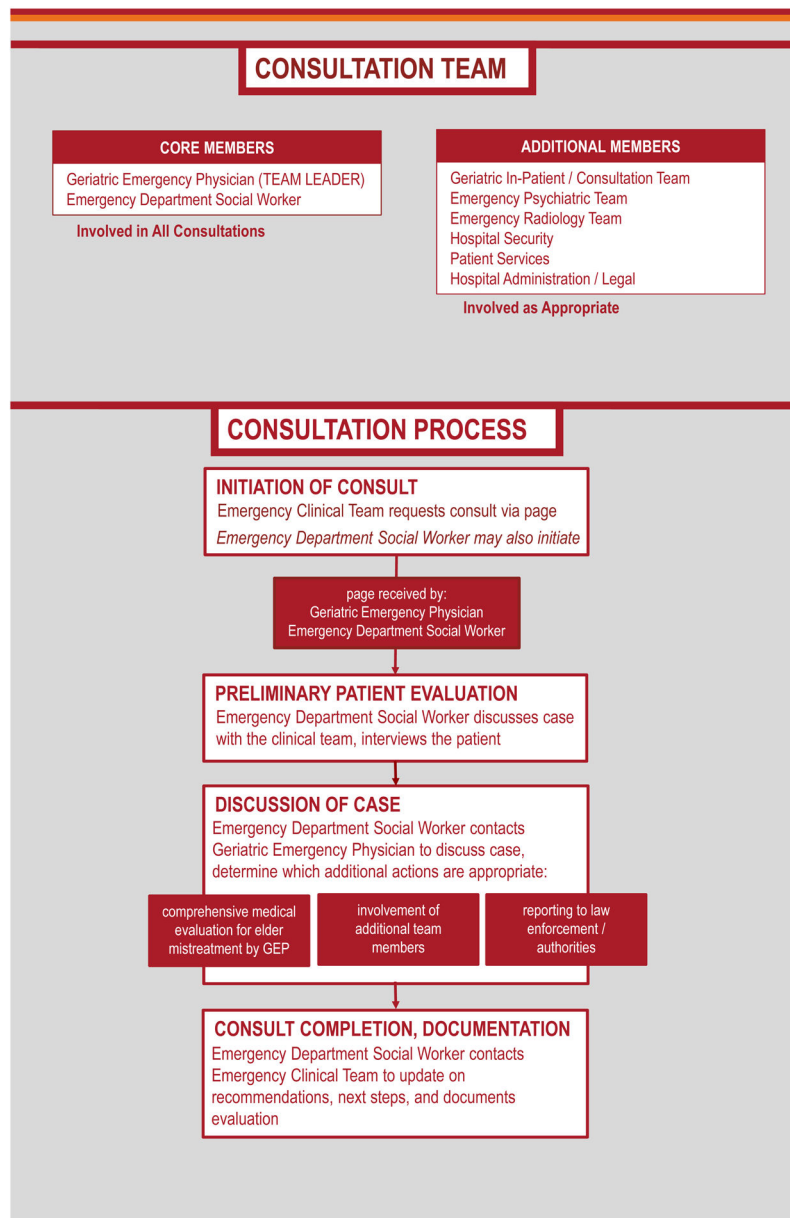


Figure 1.

Vulnerable Elder Protection Team Protocol for Consultation and Intervention


CONSULTATION	
<p>REASONS TO CONSULT</p> <ul style="list-style-type: none"> • Patient reports elder abuse or neglect to ED team • Suspicion of mistreatment from any member of ED staff due to: <ul style="list-style-type: none"> • Patient behavior / affect • Unusual / inappropriate interactions between patient and family / caregivers • Trauma inconsistent with purported mechanism, unusual bruising / injury patterns, and/or evidence of inadequate care on exam • EMS notes concerns about elder mistreatment, including issues with home safety / absence of food in home <p style="text-align: right;"><i>please consult if you have any concern</i></p>	<p style="text-align: center;">HOW TO CONSULT ELDER PROTECTION TEAM</p> <p>Page 10838 through Eclipsys</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p style="text-align: center;"><i>page will go to: Geriatric Emergency Physician on call, ED Social Worker</i></p> </div>
EVALUATIONS / INTERVENTIONS	
<i>as appropriate for individual cases</i>	
<p>ADDITIONAL HISTORY</p> <ul style="list-style-type: none"> • Comprehensive interview with the patient alone • Parallel history from family, neighbors, EMS, health care providers <p style="text-align: center;"><small>Including goals-of-care discussion as appropriate</small></p>	<p>PHYSICAL EXAM</p> <ul style="list-style-type: none"> • Assessment for trauma inconsistent with purported mechanism • Head-to-toe exam for evidence of physical abuse, sexual abuse, neglect, including: atypical bruising, patterned injuries, genital / rectal trauma, cachexia, pressure sores, poor hygiene
FORENSIC EVALUATION	
<p style="text-align: center;">EXAM</p> <ul style="list-style-type: none"> • Comprehensive, detailed documentation • Photography of injuries • SAFE exam as appropriate 	<p style="text-align: center;">RADIOLOGIC TESTS</p> <ul style="list-style-type: none"> • Screening exams including chest x-ray, maxillofacial CT scan • Collaboration with ED radiology to ensure: consideration of consistency of injuries and reported mechanism, chronic findings described
<p style="text-align: center;">LABORATORY TESTS</p> <ul style="list-style-type: none"> • To evaluate for: dehydration, electrolyte abnormalities, anemia, malnutrition, rhabdomyolysis 	
<p>CAPACITY EVALUATION</p> <ul style="list-style-type: none"> • To assess whether patient is able to refuse further evaluation / treatment and return to a potentially unsafe home situation 	<p>DETERMINATION OF ACUTE SECURITY NEEDS</p> <ul style="list-style-type: none"> • To identify need for bedside security protection for patient and / or removal from ED or visitation restriction for potential perpetrator
<p>COMPREHENSIVE SOCIAL EVALUATION</p> <ul style="list-style-type: none"> • Extended interview to: <ul style="list-style-type: none"> • Assess social supports, home services, and risk factors for elder mistreatment • Identify potential interventions 	<p>NOTIFICATION OF PATIENT SERVICES</p> <ul style="list-style-type: none"> • To assist with appropriate care decision-making if potential perpetrator is also health care proxy for patient • To provide additional support to the patient as needed
<p>REPORTING TO ADULT PROTECTIVE SERVICES & POLICE / INVOLVING MDTs</p> <ul style="list-style-type: none"> • Collaboration with the authorities to ensure appropriate and timely response • Coordination with New York City Elder Abuse Center multi-disciplinary teams as needed <p style="text-align: right;"><small> NYC ELDER ABUSE CENTER New York City Department of Social Services</small></p>	<p>COORDINATION / CONTINUITY WITH GERIATRIC INPATIENT / OUTPATIENT PROVIDERS</p> <ul style="list-style-type: none"> • Discussion of in-process and additional work-up with admitting / consulting teams • Facilitation of follow-up clinic appointments

Figure 2.

Table 1

Selected Outcomes to Examine and Anticipated Data Sources to Evaluate Impact of Vulnerable Elder Protection Team

Outcomes			Potential Data Sources
Type	Short-Term	Long-Term	
medical	connection to primary care provider, medication adherence, pain control, management of chronic conditions	mortality, ED visits, hospitalizations, skilled nursing facility placement, connection to primary care provider, medication adherence, pain control, management of chronic conditions	hospital and outpatient medical records, collaboration with skilled nursing facilities, follow-up with patient/other reporters
functional	independence in activities of daily living/instrumental activities of daily living, ambulation status	independence in activities of daily living/instrumental activities of daily living, ambulation status	hospital and outpatient medical records, collaboration with skilled nursing facilities, collaboration with community service providers through NYCEAC, follow-up with patient/other reporters
psychosocial	depression, anxiety, social isolation, quality of life	depression, anxiety, social isolation, quality of life	hospital and outpatient medical records, collaboration with skilled nursing facilities, collaboration with community service providers through NYCEAC, follow-up with patient/other reporters
legal	reporting to Adult Protective Services, reporting to police, complaint filing to Department of Health about skilled nursing facility, securing order of protection	case substantiation by Adult Protective Services, perpetrator prosecution	collaboration with police, district attorney's offices through NYCEAC,, follow-up with patient/other reporters