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Caring for Unbefriended Older Adults and Adult Orphans: A Clinician Survey

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Abstract

Objectives: Unbefriended older adults are those who lack the capacity to make medical decisions and do not have a completed advance directive that can guide treatment decisions or a surrogate decision maker. Adult orphans are those who retain medical decision-making capacity but are at risk of becoming unbefriended due to lack of a completed advance health care directive and lack of a surrogate decision maker. In a follow-up to the 2016 American Geriatrics Society (AGS) position statement on unbefriended older adults, we examined clinicians' experiences in caring for unbefriended older adults and adult orphans.

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Timothy W. Farrell contributed to concept and design, acquisition of subjects, qualitative data analysis, interpretation of data, and preparation of the manuscript.

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Eric Widera contributed to the acquisition of subjects and preparation of the manuscript.

Jennifer Moye contributed to concept and design, qualitative and quantitative data analysis, interpretation of data, and preparation of the manuscript.

Conflict of Interest

The authors have no financial or personal conflicts of interest to disclose.

Sponsor's Role

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Methods: Clinicians recruited through the AGS (N = 122) completed an online survey about their experiences with unbefriended older adults regarding the perceived frequency of contact, clinical concerns, practice strategies, and terminology; and also with adult orphans regarding the perceived frequency of contact, methods of identification, and terminology.

Results: Almost all inpatient (95.9%) and outpatient (86.4%) clinicians in this sample encounter unbefriended older adults at least quarterly and 92.2% of outpatient clinicians encounter adult orphans at least quarterly. Concerns about safety (95.9%), medication self-management (90.4%), and advance care planning (86.3%) bring unbefriended older adults to outpatient clinicians' attention "sometimes" to "frequently." Prolonged hospital stays (87.7%) and delays in transitioning to end-of-life care (85.7%) bring unbefriended older adults to inpatient clinicians' attention "sometimes" to "frequently." Clinicians apply a wide range of practice strategies to these populations. Participants suggested alternative terminology to replace "unbefriended" and "adult orphan."

Conclusions: This study suggests that unbefriended older adults are frequently encountered in geriatrics practice, both in the inpatient and outpatient settings, and that there is widespread awareness of adult orphans in the outpatient setting. Clinicians' awareness of both groups suggests avenues for intervention and prevention.

Clinical Implications: Health care professionals in geriatric settings will likely encounter older adults in need of advocates. Clinicians, attorneys, and policymakers should collaborate to improve early detection and to meet the needs of this vulnerable population.

Keywords

Aging; social; guardianship; unbefriended; adult orphan; surrogate decision maker

Introduction

Eliciting patients' goals and preferences for medical decisions is critical. The 2016 American Geriatrics Society (AGS) position statement on unbefriended older adults outlined an approach that health care teams should take when caring for highly vulnerable populations (Farrell, Widera, & Rosenberg et al., 2016). Unbefriended older adults and adult orphans are at high risk for having medical decisions made on their behalf that do not align with their goals and preferences. We return to the issue of terminology later in this paper; here, for consistency with the 2016 position statement, we begin with the terms and definitions as provided in the statement. Unbefriended older adults are those who lack the capacity to make medical decisions and do not have a completed advance directive that can guide treatment decisions or a surrogate decision maker. Adult orphans are those who retain medical decision-making capacity but are at risk of becoming unbefriended due to lack of a completed advance health care directive and lack of a surrogate decision maker.

Unbefriended older adults face adverse health outcomes such as a longer length of stay when hospitalized (Chen, Finn, Homa, St. Onge, & Caller, 2016; Ricotta, Parris, Parris, Sontag, & Mukamal, 2018; White, Curtis, Lo, & Luce, 2006) and are frequently discharged to extended care facilities (Bandy, Helft, Bandy, & Torke, 2010). Studies of unbefriended patients are few but estimate the prevalence to be 16% in the ICU setting (White et al., 2006) and 4% in

the long-term care setting (Karp & Wood, 2003). Unbefriended older adults are more likely to be single, childless, and have fewer siblings and family resources when compared to older adults with a family or friend guardian and more likely to have neurocognitive impairment and multiple chronic diseases (Chamberlain, Baik, & Estabrooks, 2018). Demographic trends in the Baby Boomer generation, which includes 10 million people living alone and 20% who are childless (Redfoot, Feinberg, & Houser, 2013), suggest that geriatrics health care professionals will encounter unbefriended older adults and adult orphans with increasing frequency. However, there have been no studies examining the prevalence of these populations in the outpatient setting.

Despite the expected increase in the prevalence of unbefriended older adults (Kim & Song, 2018) and adult orphans, clinicians' familiarity with and perspectives on caring for these populations across care settings have not been assessed. To the best of our knowledge, there have been no studies regarding outpatient clinicians' experiences with unbefriended older adults or adult orphans. In order to address this gap, we surveyed the American Geriatrics Society (AGS) membership practicing in both the inpatient and outpatient settings.

Methods

Participants

AGS members were eligible to complete the survey. We focused on the AGS because it has nearly 6,000 members, comprised of physicians, nurses, social workers, physician assistants, pharmacists, and other geriatrics health care professionals. We hoped that this group would have awareness of and experience with the unbefriended and adult orphan populations. In addition, we construed this survey as a follow-up to the 2016 AGS position statement, so it made sense to focus on AGS members.

To recruit participants, an announcement describing the survey and requesting AGS members' participation was sent using four methods. We employed various methods over time in an attempt to increase the sample size. First, a general announcement was sent by email through the AGS listserv, reaching 4,658 AGS members of which 81% were physicians at the time of the survey (Mary Jordan Samuel, personal communication, 7/31/18). Second, an announcement was posted on the MyAGSOnline website, available to all AGS members. Third, direct emails were sent to 151 AGS committee members. Fourth, co-authors who serve on AGS committees forwarded the email to AGS member colleagues with a personal request for participation. Therefore, some AGS members received multiple requests to complete the survey. All communications contained a link to an online survey platform. Altogether, we collected data for 8 months between August 2017 and March 2018. A total of 124 individuals (2.7% of the AGS membership) completed the survey.

Prior to beginning the survey, clinicians selected whether they worked *primarily* in an inpatient (including long-term care) setting or an outpatient setting, then clicked an arrow that directed them to a set of setting-specific questions. However, we found some clinicians exited the survey early, so we removed this step in the third and fourth outreach strategies. Therefore, most participants answered questions for the inpatient or outpatient settings only, but two participants answered questions for both settings.

IRB statement

The project was reviewed and approved by the Research and Development Committee of the VA Boston Healthcare System (R&D #10480). Survey responses were anonymous with no identifying information collected. As such, the survey was determined to be human subject exempt.

Measure

This is a survey research study. We developed a survey with three sections, as detailed below with item content based on literature review and team consensus. The first two sections ("unbefriended older adults" and "adult orphans") were based on the two main populations described in the AGS position statement by Farrell et al. (2016). Questions about frequency aimed to fill a gap in the literature, whereas questions about concerns aimed to replicate observations from the literature. We also asked questions about practices that responded to the AGS position statement's recommendation to identify practices. The "key terminology" section was based on feedback from the public received by the authors of the AGS position statement that the terms "unbefriended" and "adult orphan" could be reframed more positively. All co-authors engaged in an iterative process in which the survey questions were edited with attention to alignment with the AGS position statement and also with respect to clarity. Question wording is provided in Table 1–4.

Unbefriended older adults—We asked clinicians three sets of questions about unbefriended older adults. First, clinicians rated their *perceived frequency of encountering* unbefriended adults. Past studies of frequency have determined the proportion of unbefriended adults within an inpatient population. In contrast, here we asked about perceived frequency from the clinicians' perspective – applied to the outpatient and inpatient settings.

Second, clinicians indicated their *clinical concerns* for unbefriended adults. This question was phrased differently for outpatient versus inpatient clinicians. For outpatient clinicians, where there are little data in the literature, we asked clinicians about situations that bring a patient's unbefriended status to their attention – with a list of options, developed from our clinical experience. For inpatient clinicians, we asked if they had observed any negative consequences for unbefriended patients as has previously been reported in the literature.

Third, clinicians provided information about useful *mechanisms, practices, strategies, and resources* for unbefriended patients. Clinicians noted whether formal mechanisms to guide decisions for unbefriended patients are available to them (e.g., an ethics committee), and if so, how helpful these mechanisms are. Clinicians also completed an open-ended question about their approaches to this population. These questions respond to a recommendation in the AGS position statement to develop "innovative, efficient and accessible approaches to promote adequate protections and procedural fairness in decision making for unbefriended older adults" (Farrell et al., 2016).

Adult orphans—We asked outpatient clinicians two sets of questions about adult orphans. As above, first, clinicians rated their *perceived frequency of encountering* adult orphans and

how likely they are to know if a patient is an adult orphan. Second, clinicians described practices for identifying adult orphans. This question responds to another recommendation in the AGS position statement "to prevent older adults without surrogates from becoming unbefriended" (Farrell et al., 2016). We were most interested in prevention strategies in the outpatient setting that could occur before inpatient treatment is needed.

Preferred terminology—Clinicians shared their preferences for terminology to describe unbefriended older adults and adult orphans by rank-ordering a list of alternative terms provided in the survey.

Analyses

Quantitative analyses consist of descriptive data summarizing survey responses including percent endorsement for nominal and ordinal data, and mean endorsement for ordinal and interval data. Chi-square analyses examine subsample differences. Analyses were performed using SAS, version 6.0 (SAS Institute, Inc., Cary, NC).

For qualitative analyses, two members of the project team (CC, TF) subjected open-ended responses to thematic analysis. The team assigned responses to coding categories through independent coding and review. Coding discrepancies were resolved through discussion and input from a third team member (JM). After generating specific coding categories, we placed these categories into thematic groups based on discussion by three members of the project team (CC, TF, JM).

Results

Participants

Professional degrees represented by survey respondents (N = 122) include MD or DO (67.2%) followed by NP (18.5%), PhD (5.9%), PharmD (4.2%), and nursing (all degree types, 1.7%); with less than 1% PA, MSW, or other. Participants practice across 38 states in the United States and two countries. A majority of respondents (59.3%) identified their primary practice site as outpatient, while a minority of respondents (39.0%) identified their primary practice setting as inpatient. Two participants (1.6%) identified both inpatient and outpatient settings as primary.

Unbefriended older adults

Frequency of encountering unbefriended older adults—Clinicians in the outpatient setting encounter unbefriended adults at frequencies ranging from weekly (17.6%), monthly (31.1%), to quarterly (37.8%), or annually/never (13.6%). Clinicians in the inpatient setting similarly encounter unbefriended adults at frequencies ranging from weekly (24.5%), monthly (36.7%), to quarterly (34.7%) with only a few meeting unbefriended adults annually or never (4.1%). There were no statistically significant differences in the frequency of encountering unbefriended adults in the two settings (χ^2 = 3.89, p =.273).

Clinical concerns for unbefriended older adults—Concerns about safety, medication self-management, and advance care planning were the three most common clinical situations arising for unbefriended adults in the outpatient setting that are likely to bring their status to the attention of the health care team, with between 60.3% and 71.2% of respondents indicating that these areas frequently brought an unbefriended adult to their attention (see Table 1). Concerns regarding elder abuse, driving, and consent for treatment also triggered awareness of a patient's unbefriended status, but less often, involving between 11.0% and 31.5% of respondents practicing in the outpatient setting.

A prolonged hospital stay and a delay in transitioning the patient to end-of-life care were the two most frequently cited adverse consequences involving unbefriended adults in the inpatient setting (Table 2). Respondents practicing in the inpatient setting cited several other adverse consequences pertaining to unbefriended adults, such as inability to improve quality of life, psychological distress for the patient, a delay in treatment, and a loss of rehabilitative potential. In addition, 83.7% of inpatient clinicians reported that they sometimes or frequently experienced distress when caring for unbefriended patients. Delays in charges were reported, although more respondents (20.4%) selected "never" with respect to the frequency of delayed charges in comparison to other clinical consequences.

Mechanisms, practices, strategies, and resources for assisting unbefriended older adults—Clinicians use a variety of mechanisms when they need guidance on decisions for unbefriended older adults, with guardianship, second opinions, and making decisions oneself seen as the most helpful (Table 3). Consultation with an ethics committee or risk management officer is less available in the outpatient versus inpatient setting. For clinicians who say it is available, guidance from a risk management officer or the chief medical officer is least helpful.

Participants named, using open-ended responses, a wide variety of practices, strategies, and resources to meet the needs of unbefriended older adults (Table 4). Some of these strategies echo the more formal mechanisms listed in Table 3 (e.g., guardianship). Most strategies focus on clinical resources ranging from an individual clinician (e.g., case manager, social worker), to teams, to service categories (e.g., home-based services, community resources).

Adult orphans

Frequency of encountering adult orphans—Almost all (90.4%) of outpatient clinicians stated they are "moderately" to "extremely likely" to know when a patient is an adult orphan. Clinicians in the outpatient setting encounter adult orphans quite often and at different frequencies, ranging from weekly (25.5%), monthly (31.4%), to quarterly (35.3%), with few saying they encountered adult orphans annually or never (7.9%; this question was not asked of inpatient clinicians). Clinicians in the outpatient setting reported encountering adult orphans more frequently than unbefriended adults ($\chi^2 = 24.29$, $p = .004$).

Practices for identifying adult orphans—Most (67.6%) outpatient clinicians stated that they do things in their practice to identify adult orphans. When asked what their practice would need to better identify adult orphans, clinicians cited more social workers (59.2%) or care managers (43.7%), or more time in general (53.5%) or in particular for advance care

planning (49.3%). Some (39.4%) expressed a desire for a pathway to community partners or volunteer agencies.

Preferred terminology

Three-quarters (76.2%) of all clinicians surveyed had heard of the term “unbefriended,” and there was no difference between the outpatient and inpatient settings ($\chi^2 = 0.66$, $p = .80$). Participants preferred a descriptive phrase instead of “unbefriended,” with the top option being “incapacitated adult without advocate.” The next most highly ranked option was the single word “unrepresented” (Table 5). The fifth most popular option was to retain the term “unbefriended.”

Only 36.5% of outpatient clinicians had heard of the term “adult orphan.” Regarding participants’ preferences for alternatives to the term “adult orphan,” three terms were ranked equally – “isolated vulnerable adult,” “adult without advocate,” and “isolated adult at risk” (Table 5). The sixth most popular preference was to retain the term “adult orphan.”

Discussion

In a follow-up to the 2016 AGS position statement on unbefriended older adults (Farrell et al., 2016), this study examines both inpatient and outpatient clinicians’ experiences with caring for unbefriended older adults and adult orphans with the goal of further advancing policies and practices regarding these two populations. Our study is novel in that it elicits responses from clinicians who care for unbefriended older adults and adult orphans in the outpatient setting. The inclusion of outpatient clinicians in our study is particularly important from a policy and practice standpoint. This is because outpatient clinicians are well positioned to recognize adult orphans, intervene to help prevent adult orphans from becoming unbefriended, and thereby help prevent the adverse clinical consequences that often accompany the hospitalization of an unbefriended older adult. An important limitation of our study is its low response rate, which should be considered when interpreting the study results.

We found that our sample of clinicians who are AGS members, regardless of inpatient or outpatient practice setting, encounter unbefriended adults and adult orphans most typically on a monthly or quarterly basis. This finding was unexpected, as we anticipated that inpatient clinicians would encounter unbefriended adults more often than outpatient clinicians given that the hospital may be a “final common pathway” for this population. While our small sample size limits our ability to generalize our findings, encountering unbefriended adults and adult orphans was not rare in this sample.

The fact that outpatient clinicians reported becoming aware of unbefriended adults with equal frequency compared to inpatient clinicians suggests an opportunity for intervention – such as identifying an appropriate surrogate and documenting values – before a difficult situation occurs (e.g., prolonged hospital stays or delays to appropriate end-of-life care). In addition, the types of situations that outpatient clinicians reported as most likely to bring an unbefriended adult to their attention – concerns for safety, medications, advance care planning, elder abuse, and driving – are commonly encountered by not only by geriatrics

health care professionals but also by family physicians and general internists. As such, our data suggest that the identification of unbefriended older adults and adult orphans should become a health care policy priority. We recommend that health systems and electronic health records alert clinicians to the possibility that a patient may lack an advance directive and/or a surrogate decision maker, and/or may need decisional supports to maximize capacity. We also recommend that outpatient clinicians proactively triage unbefriended adults and adult orphans to advance care planning visits. This is especially important because typical care processes and documentation templates might not prompt clinicians to consider the possibility that a patient may be an unbefriended older adult, or an adult orphan who is at risk for becoming an unbefriended older adult.

Another important finding in this survey is that inpatient clinicians identified prolonged hospitalization, delay in appropriately transitioning patients to hospice or end-of-life care, and inability to promote quality of life as the top three negative consequences for unbefriended adults under their care. These findings are consistent with previous studies reporting that this population may be at high risk for prolonged hospital stays (Ricotta et al., 2018) with associated risks for delirium, pressure ulcers, falls, infections, deconditioning, and other adverse sequelae of hospitalization. Our findings also expand on the existing literature in revealing problems regarding inappropriate delays in providing appropriate palliative or hospice care. Not surprisingly, the top three negative consequences rated by the inpatient survey respondents who care for unbefriended patients were followed closely by moral distress – an inability to act upon the ethically appropriate course of care due to internal or external constraints. This finding is concerning as it relates to patient care, but also because moral distress negatively impacts health care professionals' job satisfaction and quality of care and promotes burnout (de Veer, Francke, Strujis, & Willems, 2013; Lamiani, Borghi, & Argentero, 2017).

In terms of resources and practice strategies to meet the needs of unbefriended older adults, clinicians in the inpatient setting have more access to formal resources (e.g., ethics committees, risk management officers) than do clinicians in the outpatient setting in this sample. Examination of qualitative responses reveals that clinicians often try multiple strategies to address the needs of unbefriended older adults (Courtwright, Abrams, & Robinson, 2017; Moye, Catlin, Kwak, Wood, & Teaster, 2017). Outpatient clinicians are often aware that patients are socially isolated and feel they could do more if granted more social work or case management resources and time. Models of care in which social workers are embedded in outpatient clinics may be particularly valuable in caring for unbefriended older adults.

Although not directly addressed in this survey, complexity and variation in state laws applicable to unbefriended adults may unnecessarily impede clinicians' efforts in caring for this patient population. For example, seven states lack surrogate consent laws, and there is considerable heterogeneity in these laws, with some states adopting a hierarchy of decision-making authority and other states requiring consensus among surrogate decision makers. In addition, the process of identifying and appointing a guardian can be extremely cumbersome and time-consuming. These delays can potentially contribute to harms including clinicians' inability to provide timely palliative care while waiting for a guardian to be identified

(Farrell et al., 2016). Innovations in interprofessional education and practice, as well as transdisciplinary approaches such as collaboratives involving stakeholders including the health professions, legal system, and community advocates, are needed to promote uniformity in legal standards for unbefriended adults and to improve communication across disciplinary silos. An example of a successful approach to unbefriended adults is the Wishard Volunteer Advocates Program in which volunteer guardians are paired with experienced attorneys to provide surrogate medical decision makers for these patients (Bandy, et al., 2014).

Adult orphans have decision-making capacity by definition, so the aforementioned legal concerns do not apply to this population. However, health care teams should engage in intensive, proactive efforts to prevent adult orphans from becoming unbefriended. These efforts should include advance care planning to document their preferences, values, and goals of care in the medical record and on an advance directive document such as an advance health care directive or living will. Evidence-based tools (Sudore, 2012) exist to facilitate this advance care planning process, which is reimbursable by Medicare. In addition, adult orphans should be strongly encouraged to identify a surrogate decision maker.

With respect to survey respondents' preferred terminology for unbefriended older adults and adult orphans, it was clear that the survey respondents did not prefer either term, ranking them at or near the bottom of the options we presented to them. Regarding the term "unbefriended," respondents ranked "incapacitated adult without advocate" and "unrepresented" as their top two choices. Regarding the term "adult orphan," respondents ranked "isolated older adult," "adult without advocate," and "isolated adult at risk" equally. We support replacing the term "unbefriended," which carries social stigma and can be misleading (i.e., one can be unbefriended but still have friends, even if these friends are not surrogate decision-makers), with "incapacitated older adult without advocate." We also support replacing the term "adult orphan" with "adult without advocate" given that the latter term best conveys the medical and legal issues with which they are confronted and also suggests a remedy. In addition, other alternative terms for "adult orphan," such as "isolated vulnerable adult" and "isolated adult at risk," may carry social stigma and also be inaccurate (e.g., adult orphans may lack a surrogate decision-maker, but could be very socially active).

Limitations

The low response rate (2.7%) to our survey among AGS members is the most important limitation of our study. We speculate that this low response rate could be due to several factors, including lack of familiarity or interest with the topic, competition for AGS members' attention with other information presented on the AGS listserv, and survey fatigue. Our survey may suffer from response bias, as those AGS members who encounter unbefriended older adults and adult orphans may have been more likely to respond to the survey. As a consequence, the frequency rates described in this study may overestimate the actual prevalence of both vulnerable patient types in the community. Other limitations to our study include that we surveyed only geriatrics health care professionals but not generalists who nonetheless are likely to encounter unbefriended older adults and adult orphans.

Conclusions

Overall, our findings suggest that (1) unbefriended older adults and adult orphans are not infrequently encountered in geriatrics practice and often present with common geriatrics problems; (2) health policy and health systems efforts are needed to identify adult orphans and unbefriended older adults, and to consider guardianship for unbefriended older adults when appropriate; and (3) the terms “unbefriended” and “adult orphan” should be replaced with new terminology.

Additional research and education are needed to raise awareness among health care professionals, health care policymakers, legal professionals, and the public about special considerations for these groups, and to develop new interventions, care processes, and interprofessional education offerings and practice linkages to ensure that health care aligns with the preferences of the highly vulnerable unbefriended older adult and adult orphan populations. Furthermore, additional studies will be needed to determine the impact of a proactive approach to identifying these populations in the outpatient setting on hospital readmissions, length of stay, and health care costs.

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Clinical implications

- Some older adults may become incapacitated and lack family or friends to serve as surrogate decision makers.
- These individuals may face adverse consequences and present care challenges to the health care team.
- A survey of AGS members suggests that unbefriended older adults are frequently encountered in both inpatient and outpatient geriatrics practice, although an important limitation of the survey is its low response rate.
- It is important for older adults without advocates to plan early for their care should they become incapacitated.

Table 1.

In the outpatient setting, which clinical situations brought a patient's unbefriended status to your attention?

Clinical Situation	Never %	Rarely %	Sometimes %	Frequently %	*M*	*SD*
Concern re: safety	2.7	1.4	24.7	71.2	3.65	.65
Concern re: medication self-management	4.1	5.5	30.1	60.3	3.47	.78
Advance care planning process	5.5	8.2	21.9	64.4	3.46	.86
Elder abuse/adult protective issue	4.1	21.9	47.9	26.0	2.95	.81
Concern re: driving	9.6	30.1	28.8	31.5	2.82	.98
Consent for medical procedure	8.2	32.9	47.9	11.0	2.62	.79

Note. *N* = 73 (outpatient clinicians only). Mean was determined based on scoring of never = 1, rarely = 2, sometimes = 3, frequently = 4.

Table 2.

In the inpatient setting, have your unbefriended patients/your team faced any of these problems?

Clinical Situation	Never %	Rarely %	Sometimes %	Frequently %	*M*	*SD*
Prolonged hospital stay, past a medically necessary point	2.0	10.2	26.5	61.2	3.47	0.77
Delay in appropriately transitioning to hospice or end-of-life care	2.0	12.2	24.5	61.2	3.45	0.79
Unable to provide something that may improve quality of life	0.0	16.3	44.9	38.8	3.22	0.72
I experienced personal distress because of an inability to act in my professional role	2.0	14.3	49.0	34.7	3.16	0.75
The patient was in physical or psychological distress	0.0	20.4	53.1	26.5	3.06	0.69
We had to continue with medically non-beneficial care	4.1	20.4	42.9	32.7	3.04	0.84
Delay in treatment or surgery	4.1	20.4	57.1	18.4	2.90	0.74
Loss of rehabilitation ability/potential in patient	6.1	24.5	44.9	24.5	2.88	0.86
Delay in authorizing charges/coverage for care	20.4	18.4	42.9	18.4	2.59	1.02

Note. *N* = 49 (inpatient clinicians only). Mean was determined based on scoring of never = 1, rarely = 2, sometimes = 3, frequently = 4.

Table 3.

Are any of the following mechanisms helpful if you need guidance on decisions for an unbefriended older adult?

Mechanism	Setting	Not Available %	χ^2	If Available %		
				Not helpful	Sometimes helpful	Always helpful
Institutional Program or Position						
Ethics committee	Outpt	26.5	4.49*	18.4	46.9	8.2
	Inpt	8.3		19.4	38.9	33.3
Risk management or legal department	Outpt	28.6	9.50**	26.5	36.7	8.2
	Inpt	2.8		38.9	41.7	16.7
Chief medical officer	Outpt	35.4	2.34	35.4	25.0	4.2
	Inpt	20.0		34.3	42.9	2.9
State Protective Actions						
Guardianship	Outpt	3.8	0.07	9.6	73.1	13.5
	Inpt	2.8		8.3	61.1	27.8
Adult protective services	Outpt	0.0	–	27.5	66.7	5.9
	Inpt	0.0		34.3	57.1	8.6
Clinical Consultation or Action						
Opinion of a second clinician	Outpt	4.0	1.47	12.0	58.0	26.0
	Inpt	0.0		16.7	58.3	25.0
Make decision yourself, abiding by professional ethics/standards	Outpt	6.3	0.51	6.3	68.8	18.8
	Inpt	2.9		11.4	80.0	5.7

Note. $N = 85$ (missing data (question skipped) for $n = 37$). χ^2 analyses compare whether the option was reported as available in each setting. χ^2 was not calculated for adult protective services as 100% rated this option as available.

*$p < .05$

**$p < .01$.

Table 4.

What practices, strategies, or resources have you used to meet the needs of unbefriended older adults in your practice/institution?

Strategy	Setting	%	Example
Institutional Program or Position			
Ethics committee	Outpt	9.2	*We have a social worker who can help us with these issues. We also have* ***an ethics committee*** *where we can discuss difficult situations.*
	Inpt	34.1	
Leadership	Outpt	0.0	***Managers/supervisors*** *in hospital to consider 'unusual' ways of funding to allow transition of care to a more appropriate setting than the hospital.*
	Inpt	4.9	
State Protective Actions			
Guardianship	Outpt	16.9	*Social work department working with local authorities seeking* ***court-appointed guardian.***
	Inpt	43.9	
Adult protective services	Outpt	30.8	*Have collaborated with* ***adult protective services*** *to access some local legal groups that will pursue guardianship on behalf of the patient in some cases, but they will only take a few cases per year and the person has to live locally.*
	Inpt	14.6	
Clinical Consultation or Action			
Social worker	Outpt	43.1	*Use of* ***social workers*** *within our practice to connect patients with resources.*
	Inpt	29.3	
Nurse or case manager	Outpt	18.5	*Within the practice we have a* ***nurse manager*** *and social worker and work closely with the county. However, I know we should and can do more.*
	Inpt	7.3	
Neurological or psychiatric specialist	Outpt	1.5	*We have a work group to improve assessments and responses to capacity issues, and social work,* ***psychiatry, neurology, neuropsychology*** *and rehab therapy services (especially speech therapy).*
	Inpt	7.3	
Other clinician or third party	Outpt	6.2	*Our* ***chaplains*** *seem to be the best detectives, better than the social workers, in tracking, identifying and locating relatives. They are also more persuasive in getting distant or alienated relatives to sign consents for custodial care.*
	Inpt	12.2	
Home-based services	Outpt	16.9	*ALL Area on Aging services – Medicaid waiver – meals on wheels – pharmacy delivery – grocery delivery –* ***home health*** *– Adult Protective Services.*
	Inpt	4.9	
Community services	Outpt	26.2	*We call on and call in all our* ***community resource*** *connections, ask for favors, try to advocate for the person.*
	Inpt	19.5	
Care transition	Outpt	3.1	*I had provided services to patient in the outpatient setting until his physical condition precluded his being treated at home. Saw him in hospital and in SNF until he died. Provided psychological interventions.*[a]
	Inpt	19.5	
Team approach	Outpt	6.2	*Advocate for and secure a devoted* ***team of professionals*** *to ensure unbefriended client functions to best of ability independently with supports and free from abuse and exploitation.*
	Inpt	9.8	

Strategy	Setting	%	Example
Procedural approach	Outpt	16.9	*… We always engage the patient as much as is feasible given their deficits. We also always engage community programming and caseworkers. We will typically complete an extensive chart review to try to identify prior patient preferences documented in the record.*[a]
	Inpt	24.4	
Family search	Outpt	12.3	*… Sometimes we can **find family** to get involved who did not know there was a problem, or how bad their family member had deteriorated, as such people are often self-isolating.*
	Inpt	12.2	

Note. *N* = 106. Many responses had more than one strategy; bold is used for text relevant to category. Chi-square was not calculated as percentages were based on qualitative data.

[a]The code does not refer to a specific part of the answer but rather the entire answer.

Table 5.

Mean ranks for terminology.

Top 5 Alternative Terms for "Unbefriended" Preferred by All Clinicians	*M* Rank	Top 5 alternative Terms for "Adult Orphan" Preferred by Outpatient Clinicians	*M* Rank
Incapacitated adult without advocate	2.55	Isolated vulnerable adult	1.09
Unrepresented	2.35	Adult without advocates	1.09
Vulnerable isolated adult	2.03	Isolated adult at risk	1.08
Incapacitated and alone	1.54	Lone elder	0.55
Surrogate-less	0.52	Solitary adult	0.51
No Alternative (Prefer "Unbefriended")	1.47	**No Alternative (Prefer "Adult Orphan")**	0.43