

ELDER MALTREATMENT & CARE SYMPOSIUM

Overview of Elder Maltreatment

March 8, 2013

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Quality
Insights
Pennsylvania

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Introduction

Elder maltreatment is a significant public health problem affecting a considerable number of older adults and is associated with increased morbidity and mortality (Mosqueda & Dong, 2011, p. 535). The older population is at risk for neglect and abuse. This is a serious issue that is under recognized and under reported affecting persons over the age of 65, especially those who are vulnerable.

The purpose of this white paper is to offer a brief review of the evidence available, provided by the literature, internet, policy/laws, Federal/State agencies and professional groups that will help determine the best solution to reduce elder maltreatment in the United States. This concise document will furnish the reader with an outline of the current practice of elder maltreatment screening, populations affected, and potential interventions for this group of individuals to improve quality outcomes.

In 2002, the World Health Organization (WHO) defined elder abuse “as a single or repeated act, or lack of appropriate action, occurring in any relationship where there is an expectation of trust, that causes harm or stress to an older person” (as cited in Cohen, 2011, p. 261).

Elder Maltreatment:

The World Health Organization (WHO), in 2002, defined elder abuse “as a single or repeated act, or lack of appropriate action, occurring in any relationship where there is an expectation of trust that causes harm or stress to an older person.”

In 2013, the U.S. Preventative Services Task Force elucidated vulnerable adults as “those age 18 or older who cannot take care of themselves because they have a mental, physical, or developmental disability or they have brain damage.”

Subsequently, in January of 2013, the U.S. Preventative Services Task Force (USPSTF) (2013) clarified abuse of elderly or vulnerable adults as the following: “involves physical, sexual, or psychological harm done to an older person or to an adult who can’t take care of him or herself. This kind of abuse also includes neglecting or abandoning the person or taking advantage of him or her financially” (USPSTF, 2013, p.1) The USPSTF elucidated vulnerable adults as “those age 18 or older who cannot take care of themselves because they have a mental, physical, or developmental disability or they have brain damage” (USPSTF, 2013, p. 3).

Elder maltreatment has received considerable attention in recent years and numerous government, clinical, research, and social agencies have sought screening, assessment, intervention and treatment strategies to increase identification and reduce the impact of abuse for affected individuals and their families. These groups include, but are not limited to, the World Health organization (WHO), the Centers for Medicare & Medicaid

Services (CMS), the Centers for Disease Control (CDC), the National Center on Elder Abuse (NCEA), the National Institute on Aging (NIA), National Guardianship Association, National Research Council, the US Preventative Services Task Force (USPSTF) and many others.

The United States Congress has also influenced the prevention of elder abuse by crafting current and pending legislation and passing into law the Elder Justice Act as part of the Affordable Care Act. Pending bills include the Violence Against Women Act, the Elder Abuse Victims Act, and the Older Americans Act (OAA). These bills will provide services to protect and treat victims of elderly abuse, vulnerable adults, and women (Dong, 2012).

To tackle the concern of elder abuse, the Centers for Medicare & Medicaid Services (CMS) and Quality Insights of Pennsylvania (Quality Insights) are hosting an Elder Maltreatment Symposium on March 8, 2013 in Baltimore, Maryland. This is a four-hour event to solicit input from stakeholders and experts in the field of clinical research, screening tool development, statistics, and other health care professionals. This activity will assist CMS and Quality Insights to further develop Measure #181: Elder Maltreatment Screen and Follow-Up Plan, as part of the Physician Quality Reporting System (PQRS).

Types of Maltreatment:

- *Physical*
- *Sexual*
- *Emotional*
- *Neglect*
- *Abandonment*
- *Financial*

At the symposium, participants will be asked to deliberate the current practice of elder maltreatment screening, including tool selection and use, identifying populations at risk, assessing interventions and evaluating associated care practices for Medicare and Medicaid beneficiaries. The goal will be to address the issue, discuss the challenges and determine the best overall approach to screening, including evaluation of currently available screening tools. (Centers for Medicare & Medicaid Services, 2013a).

Overview

The prevalence of elder abuse differs in the literature but has been reported to be somewhere between 5% and 30% (Dong & Simon, 2011). That number was simplified by the National Center of Elder Abuse (NCEA) to stipulate that at least 1 in 10 older adults experience some form of abuse (as cited in Dong & Simon, 2011).

Abuse Sub-Types: Conduct by a Caregiver or Other(s):

- ***Abuse*** – *Such as kicking, punching, slapping, or burning*
- ***Neglect*** – *An act of omission such as withholding food, medication, hygienic assistance, or health care*
- ***Exploitation*** – *The inappropriate use of resources such as use of the person's home or money and withdrawal of care until funds or property are given*
- ***Abandonment*** – *A caregiver's precipitous withdrawal of care, services, or companionship*

In fact, a recent report by the US Government Accountability Office (2011), estimated that 14% of older adults reported some type of physical, psychological, or financial exploitation in the previous year (as cited in Moyer, 2013).

Various strategies have been implemented to identify and treat those at risk including the wide variety of screening tools, innovative clinical education programs, increased availability of local courses, greater awareness of community involvement as well as numerous research initiatives to understand this complex issue. Helplines and hotlines are available to the general public to answer questions and direct callers to learn about services, intervene and potentially remove the individual from a dangerous situation.

Many types of organizations can take action to increase public awareness and education, learn about state reporting requirements for elder abuse, and provide information about services such as their local Adult Protective Services (APS). Community groups and employers have the potential to identify populations at risk and can be instrumental in providing knowledge to their citizens/employees to protect individuals and assist in communicating appropriate options for people to take if a suspicious situation is detected.

Types of Elder Maltreatment

Maltreatment is an all-encompassing word to describe the consequences that transpire when an individual is exploited, abused, neglected or abandoned. It causes harm or the risk of harm to a vulnerable person by a caregiver or another trusted figure. The caregiver may also withhold basic needs such as food, housing, socialization, treatment or medical care.

Victims tend to be older, female, black, and have a lower income and education.

Literature cites different types and subtypes of elder maltreatment. These types have been derived from various screening tools and epidemiological research studies to identify vulnerable individuals.

The CDC asserted six principal types of elder maltreatment:

- **Physical**—this occurs when an elder is injured as a result of hitting, kicking, pushing, slapping, burning, or other show of force.
- **Sexual**—this involves forcing an elder to take part in a sexual act when the elder does not or cannot consent.
- **Emotional**—this refers to behaviors that harm an elder’s self-worth or emotional well-being. Examples include name calling, scaring, embarrassing, destroying property, or not letting the elder see friends and family.
- **Neglect**—this is the failure to meet an elder’s basic needs. These needs include food, housing, clothing, and medical care.
- **Abandonment**—this happens when a caregiver leaves an elder alone and no longer provides care for him or her.
- **Financial**—this is illegally misusing an elder’s money, property, or assets. (CDC, 2012, p. 1)

Fulmer (2008) refers to four subtypes of elder maltreatment. These subtypes illustrate the actions that a caregiver, family member or other individual will carry out toward the person receiving care or management. The subtypes are as follows:

1 in 10 older adults experience some form of maltreatment

- **Abuse** - Conduct by a responsible caregiver or another person that constitutes “abuse” under the applicable federal or state law, such as kicking, punching, slapping, or burning.
- **Neglect** - An act of omission by a responsible caregiver that constitutes “neglect” under the applicable federal or state law, such as withholding food, medication, hygienic assistance, or health care.
- **Exploitation** - The inappropriate use of resources for personal gain, such as use of the person’s home without consent, use of her or his money for personal expenses, and withdrawal of care until funds or property are given.
- **Abandonment** - A caregiver’s precipitous withdrawal of care, services, or companionship (Fulmer, 2008, p. 55).

Self-neglect is one of the most common forms of elder mistreatment but difficult to quantify due to the lack of population-based epidemiological studies to isolate the problem and therefore, not always considered part of elder abuse. Evidence suggests that certain individuals are at higher risk for self-neglect such as those with the following characteristics: elderly, over age 75, African American, lower socioeconomic status, and those with a physical disability, cognitive impairment, high levels of

psychological distress, depression, limited social interactions, or limited physical performance (Mosqueda & Dong, 2011).

Population at Risk for Maltreatment

Characteristics of an Elder at Risk:

- *Cognitive impairment*
- *Aggressive behaviors*
- *Psychological distress*
- *Lower levels of social network and social support*
- *Lower household income*
- *Need for activities of daily living assistance*
- *Premorbid relationship to the abuser*
- *A shared living relationship*

Many factors predict which individuals may be victims of maltreatment. Women and vulnerable adults are at increased risk to be targets for violence and abuse.

Unfortunately, many cases are not identified and therefore not reported to health professionals or family members. In addition, a large proportion of people also choose not to report maltreatment due to fear that their family, caregiver or other “trusted” individual will increase the abuse.

Many victims also may feel ashamed or embarrassed, feel guilty, or are in denial that abuse is occurring, and afraid that the perpetrator will get “in trouble.” In addition, persons with certain factors, such as those with depression, alcohol or drug addiction and/or high stress levels, are at greater risk to be abusive toward an elderly or vulnerable person.

Dong et al. reported that cases of elder self-neglect and elder abuse “tended to be older, female, black, and have a lower economic income and education” (Dong et al., 2009, p. 520). In addition, the mortality risk was higher for the same group.

Other researchers described the abused elder as an individual with the following characteristics:

- Cognitive impairment
- Aggressive behaviors
- Psychological distress
- Lower levels of social network and social support
- Lower household income
- Need for activities of daily living assistance
- Premorbid relationship to the abuser
- A shared living relationship (Mosqueda & Dong, 2011, p. 535).

Some Reasons Why Victims Don’t Report:

- *Fear*
- *Embarrassed*
- *Ashamed*
- *Isolation*
- *Cognitive Impairments*
- *Lack of Access to a Professional*

Individual Effects of Maltreatment

Elder maltreatment affects the victim's physical and emotional health. Evidence of physical effects include minor bruises, cuts, abrasions and more serious injuries such as fractures, head injuries, falls, malnutrition, and dehydration. An elder's emotional health is affected and the sufferer may be anxious, fearful, depressed, fear abandonment, and have difficulty trusting others.

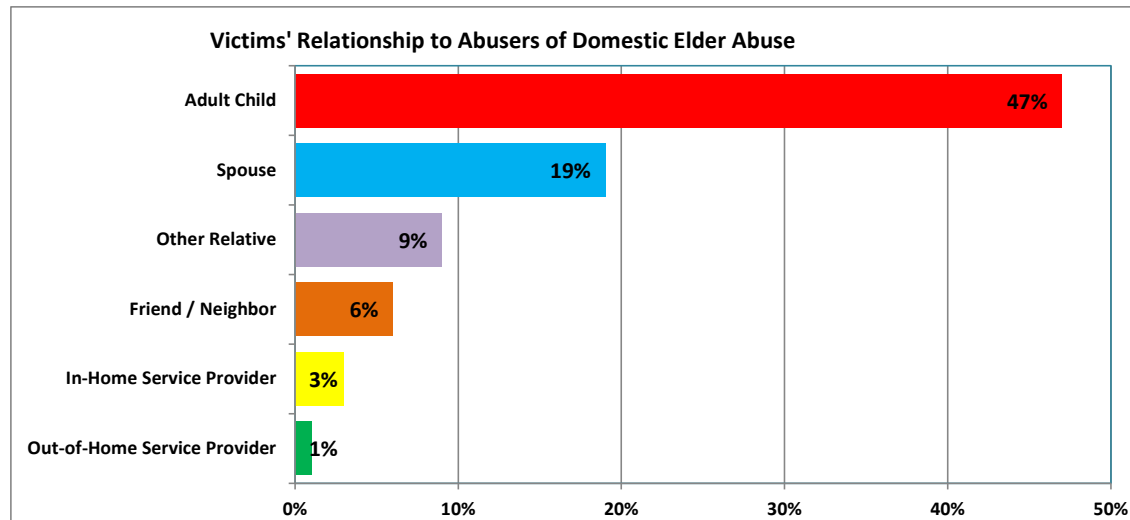
In several national studies, abuse was reported between 10-11% in cognitively intact persons (Mosqueda & Dong, 2011). Cutcher (2012) reported elder financial abuse and stated that seniors lose over \$2.9 billion per year.

Identification of the Abuser

Identification of the abuser is important to reduce the elders' vulnerability, provide a safe environment and reduce their chances of continued issues with their physical and emotional well-being.

In several published research articles, the spouse or an adult child was the abuser in 46% of the cases (Mosqueda & Dong, 2011). Cutcher (2012) reported elder financial abuse and stated that family members account for 55% of the abusers.

The following chart, from the U.S. Department of Health & Human Services Administration on Aging, displays the victims' relationship to the abuser (as Cited in Cutcher (2013)).



The CDC (2012) listed several factors that could increase the risk that someone will hurt an elderly or vulnerable person. These include:

- Using drugs or alcohol
- Heavy drinking
- High stress levels
- High emotional dependence on the elder
- Financial dependence on the elder
- Depression
- Lack of training

Obstacles and Gaps in Identifying Elder Maltreatment

Impediments to identifying which elders are at risk and what signs and symptoms to look for are multifaceted. In the health care setting, clinicians encounter older persons daily yet detection is usually low. McCreadie et al. (2000) noted that “more than 60% of physicians never asked their patients about abuse, and more than half had never identified a case of abuse or had identified a case in the previous 12 months” (as cited in Cohen, 2011, p. 262). Some physicians in specific departments, such as the emergency room and geriatricians had a higher affinity and awareness, yet reporting statistics for these groups remains low.

Professional Gaps:

- *Lack of training*
- *Inexperience identifying abuse*
- *Unclear reporting guidelines*
- *Signs and symptoms similar to other diagnosis*
- *Lack of or inconsistent screening tools*
- *Intervention strategies unclear*
- *Victims do not report*
- *Physicians feel uncomfortable discussing the subject*

Reasons for limited identification include lack of training, limited education about the problem, ambiguity concerning signs and symptoms of abuse, competing diagnosis, and lack of clarity regarding reporting procedures and treatment.

Professionals may feel uncomfortable exploring this delicate topic and it may not be clear if maltreatment is present. In addition, the patient may be reluctant to disclose this to their health care provider.

The elderly may have multiple diseases, diagnoses, medication side effects, and malnutrition not related to abuse and/or normal aging process changes that can coincide with the signs and symptoms of maltreatment. It may be challenging to distinguish between the signs of normal aging and abuse or neglect (Cohen, 2011).

Another obstacle is that the victim is reluctant to report abuse. They may feel ashamed, feel guilty, be in denial or afraid to tell anyone. Many vulnerable adults may not be able to communicate with their physician/nurse due to isolation, cognitive impairments or simply because they do not have access to their health care provider. The victim may be isolated from other people because they are homebound and are only exposed to their family or caregiver who may be the offender.

60% of physicians never asked nor identified a case of abuse in the previous 12 months

Finally, clinicians need standardized tools and implementation strategies to identify and treat the abused or maltreated individuals. Professionals may believe that they need to prove, and not just suspect, elder abuse before reporting it to their local Adult Protective Services agency. Lack of awareness about the process and who to contact is a major gap in identifying elder maltreatment.

Screening for Abuse and Maltreatment

The use of a structured tool(s) to screen for abuse can provide a standardized effective framework to guide providers and lead to higher identification rates. The physician encounter may be the only exposure or chance that the elder has to address and change the abusive situation. Once identified and documented, continued abuse can be

prevented. Treatment can be initiated at the professional visit and a plan developed for follow-up and tracking of the issue.

Detection of signs of abuse is difficult at times and requires good assessment abilities, relaxed interviewing skills and an unprejudiced, non-threatening approach to beseech the elder person to share their concerns. When the maltreatment is recognized, treatment can begin so it is imperative to determine it as soon as possible.

Types of Screening Tools

Cohen (2011) described different types of screening tools (details are in a table at the end of this paper).

Detection of signs of abuse requires good assessment abilities, relaxed interviewing skills and an unprejudiced, non-threatening approach.

1. Direct Questioning

The direct questioning tools can be self-reports or asked directly by the practitioner to solicit abusive behaviors by family, caregivers or others. These are usually used with cognitively intact adults. These screening tools include the Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST), Vulnerability to Abuse Screening Scale (VASS), Self-Disclosure Tool, the Elder Abuse Suspicion Index (EASI), and the Caregiver Abuse Screen (CASE).

These tools are important in screening because they encourage communication between the professional and the elderly patient but require direct questions. The elder may not start the conversation so discovery may be limited. These tools can only be used for cognitively intact persons.

2. Signs of Abuse

Signs of abuse tools reflect those that list definite physical signs and symptoms, signs of neglect, and/or financial evidence. For example, these tools document questionable bruises, lacerations or burns (physical), dehydration and poor hygiene (neglect), and inquire about any property transfer or bank account irregularities (financial). Screening tools that illustrate this are the Elder Assessment Instrument (EAI) and the Signs of Abuse Inventory.

3. Indications for Risk of Abuse

Since a gap exists between those reporting abuse and those who are suffering from maltreatment, the third type of screening tool can assist with the discovery of people affected. This group of tools selects elders by asking about their risk factors for abuse. Research has identified that strong risk factors can predict actual abuse in many cases. Tools that categorize abuse risk are the following: Indicator of Abuse (IOA) Screen, expanded Indicator of Abuse (E-IOA) Screen, and tools developed by Bass et al and Neale et al (Cohen, 2011).

4. Additional Tools

Additional tools to classify maltreatment include: Brief Abuse Screen for the Elderly (BASE), Screen for Various Types of Abuse or Neglect, Questions to Elicit elder Abuse, Actual Abuse Tool, Suspected Abuse Tool, Risk of Abuse Tool, Health Attitudes Toward Aging, Living Arrangements, and the Finances (HALF) Assessment.

Professional Intervention Algorithms for Identified Cases

Health care professionals are inundated with intervention algorithms for all kinds of clinical options and procedures to solve problems in both the outpatient and inpatient setting. It is understandable that elder abuse processes and procedures can be lost in their busy day. Clinicians will follow systems if available to them. Research is available about the incidence, prevalence and untoward effects of elder maltreatment yet standardized tools and guidelines are limited.

Elder abuse identification and intervention requires the resources from not only physicians, nurses, social workers, home care providers, and Adult Protective Services but also family and caregivers. A team approach is essential to discover, plan and implement strategies to aggressively manage the situation.

An assessment of maltreatment includes various types of information including:

- History from the elderly person or victim
- History from the possible abuser
- History from family or other caregiver

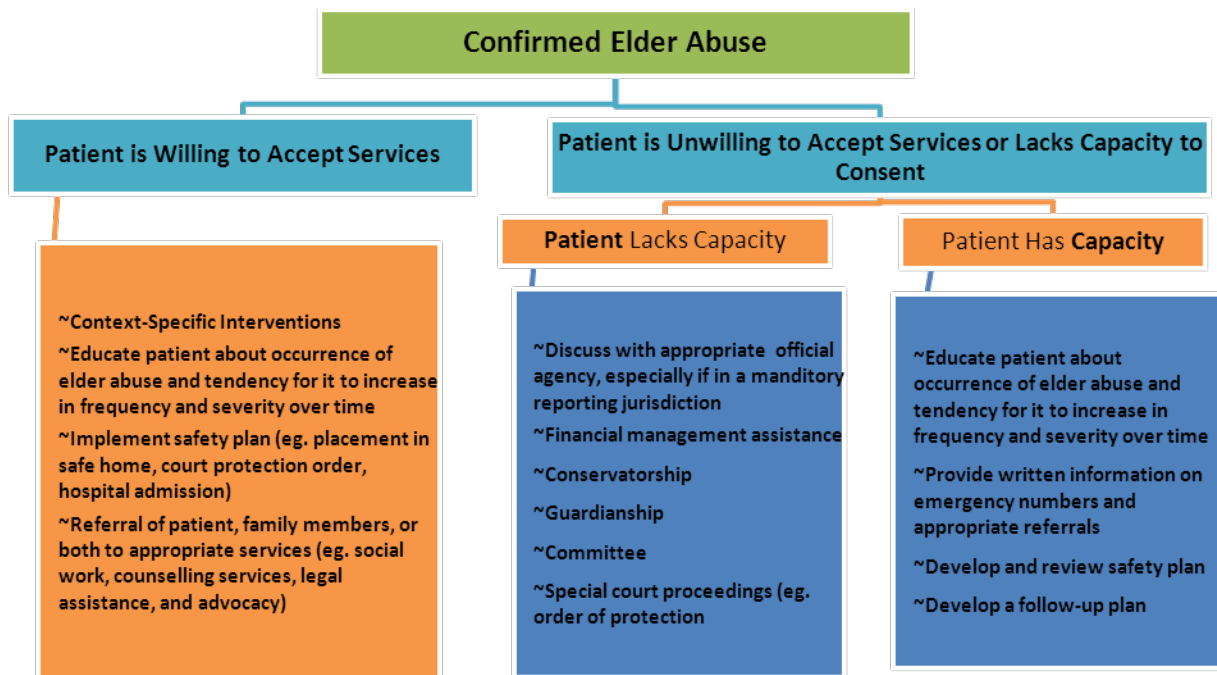
- Data from other sources – neighbors, home care providers
- Behavioral observation
- Mental status
- Physical signs of abuse
- Social and financial resources
- Laboratory results
- Radiological or CT/MRI scan (Modified from Lachs & Pillemer, 2004)

Each member of the interdisciplinary team has a role to manage maltreatment (Modified from Lachs & Pillemer, 2004).

Interdisciplinary Team	Role
Physician	Screen, diagnose, determine medical treatment Make referrals Testify in guardianship or other legal proceedings Report to Adult Protection Services
Nurse	Identify abuse-may know abuser Report findings to physician or other Follow treatment plan Make referrals and report to other team members Report to Adult Protection Services
Social Worker	Coordinate medical and community response to abuse Assist with interventions-adult day care, respite services Identify resources for family
Elder Care Attorney	Advanced care planning and guardianship Identification of decision makers Provide legal counsel
Adult Protection Service	Report to official agencies Identify resources for a comprehensive plan of care
Law Enforcement/Police	Gather and present evidence if necessary in criminal cases
Family or Caregiver	Follow treatment plan Remove victim from harmful situation

Sample Intervention Algorithm for Professionals

The health care professional must deliver interventions to the person at risk. The following decision-support flow chart depicts one approach for clinicians to use when a case of suspected abuse is identified (Lachs & Pillemer, 2004, p. 1270).



It is important to determine what the best approach is for a team of health care professionals. The interdisciplinary team should meet and develop their own flow charts that reflect the best practices for their organization. The processes may need to be adjusted as necessary, and updated at regular intervals.

Summary and Conclusion

Elder maltreatment is a disturbing public issue affecting between 5% and 30% of the older adult population. It is an issue that is under recognized and under reported. Several types of abuse are considered within the scope of the problem. The types include physical, sexual, emotional, neglect, abandonment and financial exploitation. Research is also looking at the abuser as well as the victim to understand how professionals can reduce the impact on the elderly and vulnerable populations.

Gaps and obstacles exist to identify those affected and the most beneficial treatment algorithm within each organization. One of the gaps to identify those at risk and maltreated is the lack of a standardized framework to guide professionals with screening tools that are recommended and validated for most populations. Several organizations are currently addressing this issue and endeavoring to close the gaps to improve the clinical quality outcomes for this conundrum.

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