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Elder Abuse Screening Protocol for Physicians: Lessons Learned from the Maine Partners for Elder Protection Pilot Project

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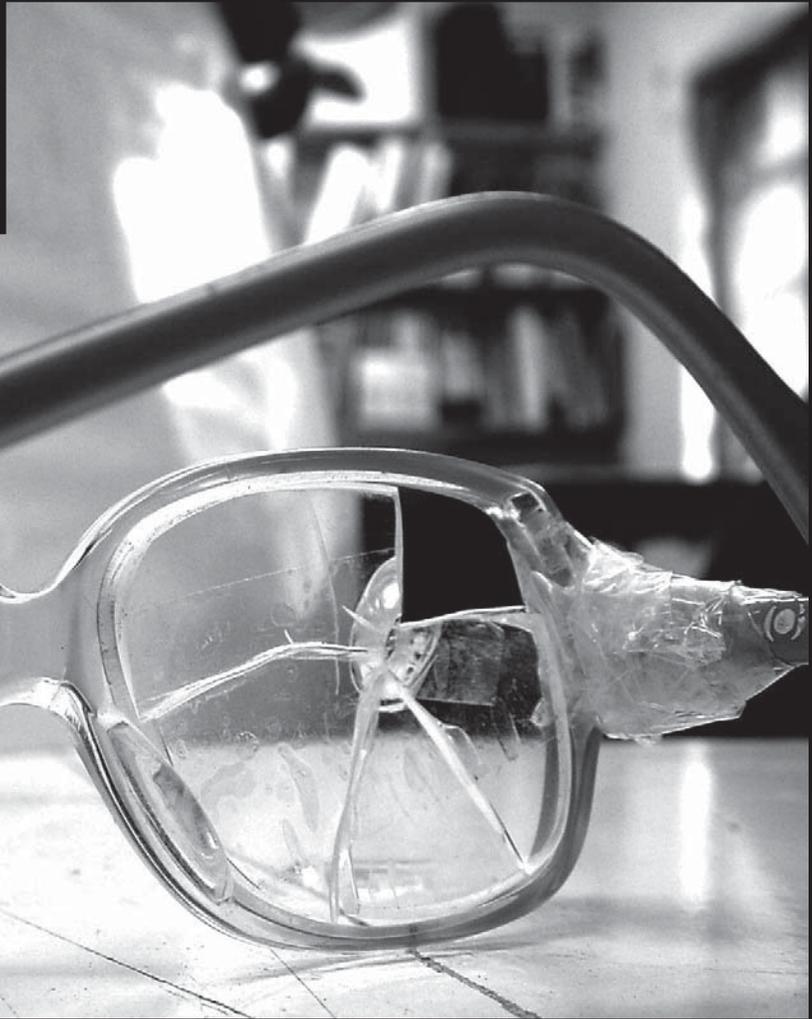
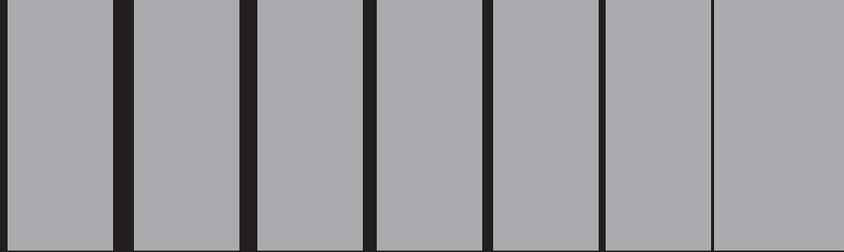
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Elder Abuse Screening Protocol for Physicians: Lessons Learned from the Maine Partners for Elder Protection Pilot Project



University of Maine
Center on Aging

**Elder Abuse Screening Protocol for Physicians: Lessons
Learned from the Maine Partners for Elder Protection Pilot
Project**

May 2, 2007

University of Maine Center on Aging



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To Physicians, Nurses, and Medical Office Managers:

This manual is designed to help you answer the following questions:

- Should I incorporate an interview-format screening process for elder abuse?
- How do I implement this screening process?
- How can I ensure that my screening test actually encourages patients to disclose abuse?
- What will I do if I have a patient at risk of abuse?

Elder abuse is a serious problem. The United States Senate Special Committee on Aging has reported that as many as 5 million elderly persons are abused each year in the United States. Medical professionals are well-positioned to address elder abuse. You are trusted by older people, and you see them in confidential settings. You are trained to be keen observers and to be sensitive to signs of domestic abuse. You serve as sentinels and mandatory reporters.

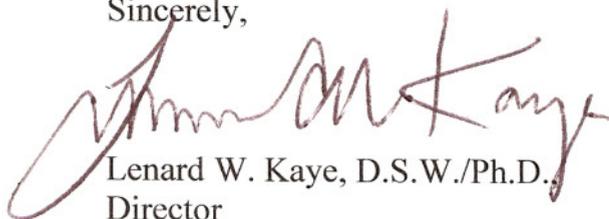
Screening is designed to ensure that your patients have the opportunity to disclose abuse to someone they trust in your office. This tool will enhance your ability to protect your patients from physical or emotional harm.

A number of medical practices have implemented a brief interview-format screening process. We hope that you will join these medical practices.

We encourage you to take advantage of our continuing education module on elder abuse at www.umaine.edu/mainecenteronaging/elderabusemodule/. You will also find a number of state-of-the-art resources on elder abuse at the UMaine Center on Aging's "Publications and Reports" page at www.mainecenteronaging.org/pubandrep.htm.

If you have any comments or questions as you review this manual, please feel free to contact us at info@mainecenteronaging.org or at 207-581-3444. We would like very much to hear from you.

Sincerely,



Lenard W. Kaye, D.S.W./Ph.D.
Director

Acknowledgements

The Center on Aging wishes to acknowledge first and foremost our sponsor for this project, the Maine Health Access Foundation for their generous support and encouragement. We would also like to thank all of the medical practices that have implemented this screen and continue to use it to support patient care.

We also acknowledge the guidance and feedback we have received over the course of the project from our Advisory Board members.

Maine Partners for Elder Protection Project Advisory Board Member Agencies

Dexter Family Medicine
Dover-Foxcroft Family Medicine
Eastern Area Agency on Aging
Homecare for Maine
Legal Services for the Elderly
Maine Adult Protective Services
Maine Coalition to End Domestic Violence
Maine Health Alliance
Milliken Medical Center
Norumbega Medical Evergreen Woods
Penobscot Community Health Center
Penobscot County Sheriff's Office
Rosscare Center for Healthy Aging
Spruce Run
Sunbury Primary Care
University of Maine School of Nursing
University of Maine School of Social Work
WomanCare

Project funding provided by:



**The Maine Health Access Foundation
Augusta, Maine**

*University of Maine Center on Aging Elder Abuse Screening User Manual
Version 5/2/2007*

*An electronic copy of this manual may be obtained at
<http://www.umaine.edu/mainecenteronaging/pubandrep.htm>*

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Project Background

This manual was created as a product of the Maine Partners for Elder Protection Project (MePEP) piloted throughout Maine from 2004-2006 by the University of Maine Center on Aging and its partners. Funding for this project was provided by the Maine Health Access Foundation. The screening protocol described in the following pages has been implemented in medical offices of all sizes as well as hospital settings. The protocol has been designed to facilitate conversation between office staff and older patients regarding risk and safety. The protocol also provides a standard of practice for referral of those patients identified as at-risk for abuse. Our protocol has been tested in 16 healthcare sites with a total of 2082 patients who were administered the screening protocol during the course of the pilot project. Of those who received the screen, approximately 4%-7% of older adults reported risk of abuse.

MePEP Project Goals and Objectives

- Design and implementation of an elder abuse screening protocol in rural primary care offices
- Implementation of a referral protocol to Area Agency on Aging specialist for older adults identified to be at risk for abuse, exploitation, and neglect using the primary care office screening protocol
- Enhancement of the service linkage between primary care physician's offices and Area Agency on Aging network resources
- Facilitation of on-site continuing medical education addressing elder abuse, exploitation, and neglect screening for primary care physician office staff
- Development of an internet-based educational module to expand accessibility to continuing medical education efforts addressing elder abuse, exploitation, and neglect
- Tracking and analysis of services that at-risk elders, who are identified and referred by the screening protocol, are seeking in the Area Agency on Aging resource network

All project products can be found online at the University of Maine Center on Aging website: <http://www.umaine.edu/mainecenteronaging/pubandrep.htm>

Our website also features publications and articles of interest for professionals and healthcare providers on a wide variety of issues such as benzodiazepine use and abuse, caregiving, alcohol abuse and much more.

The Screening Procedure

All patients age 60 years and older should be routinely screened at least once a year for elder mistreatment.

The screening questionnaire, entitled “Health and Safety Screen,” is attached as Appendix A to this manual. It consists of a brief introduction, followed by six questions:

- Has anyone close to you called you names or put you down recently?
- Are you afraid of anyone in your life?
- Are you able to use the telephone anytime you want to?
- Has anyone forced you to do things you didn’t want to do?
- Has anyone taken things or money that belong to you without your OK?
- Has anyone close to you tried to hurt you or harm you recently?

Patients may also check a box to indicate that they would like to have a local Area Agency on Aging (AAA) contact them to discuss safety issues. AAAs are non-profit organizations that assist older persons with information, support and services. AAAs are funded in part through the federal Older Americans Act.

A flow chart for screening is attached as Appendix B to this user manual.

Confidentiality and Trust

This screening procedure is intended to be brief and quick, but must be performed in a way that encourages patients to disclose abuse. The patient must be given the opportunity to respond to the screening questions in a confidential setting outside the presence of the patient’s family, caregiver, or the person who brings the patient to the appointment.

Patient Comprehension

The patient must be given the opportunity to understand the screening questions. Literate patients may read the form, but patients with literacy problems will need to receive the information through discussion with a staff member.

A medical professional should discuss the screening questions with the patient after the patient has read the form, and should explain why screening is important. This may be done by a physician, a nurse, a nurse practitioner, or a medical social worker.

Some patients may benefit from an explanation that it is routine for your office to ask questions relating to the safety of your older patients, and that help with safety is available for patients who would like to receive such assistance.

How to Implement the Screening in Your Office

The screening procedure has been implemented in various office settings from small rural practices to large urban practices. While each office has its own culture, procedures and practices, they all have one thing in common: concern for the safety of their elderly patients. The decision of how to best implement this screen should be based on the intimate knowledge of your office environment. While there is no “right” way to implement the screen in your office, the scenarios that follow are intended to stimulate thought and discussion regarding how such a screening can be put into place in your own practice.

Before you implement the screening procedure, please call your local Area Agency on Aging to let them know your office is doing interview-format screenings for elder abuse, and to ask them for a contact person or phone number to call if and when you need to refer a patient. You can find the phone number for your local AAA at the website of the National Association of Area Agencies on Aging: www.n4a.org

Scenario One: Implementation in a Small Practice with Paper Records

In a small rural practice with one physician and approximately eight other staff members, and without electronic medical record technology, the following is an example of a workable protocol:

- Screening is done by the physician.
- Screening takes place at least once a year at all routine, non-emergency medical visits.
- Prior to an appointment, the front office staff prepare the paperwork necessary for each patient.
- The staff member checks the chart to see if this particular patient is due for an elder abuse screen.
- If the patient is due for a screen, a blank paper screening form is placed in the chart.
- When the patient arrives, he or she is given the screening form to complete while the patient waits for the physician in the exam room.
- When the physician arrives, he or she reviews the screening results with the patient during the appointment and has a staff member assist with referrals as necessary.
- Tracking of the screening is done through chart stickers that indicate this particular patient has been screened at least once this year, with additional stickers for each screening performed. Sample chart stickers are attached as Appendix C to this user manual.
- The completed screen becomes part of that patient's medical record.

Scenario Two: Implementation in a Large Practice with Electronic Records

In a large urban practice serving over 35,000 patients in a year, with numerous physicians on staff and electronic medical record technology, the following is an example protocol, including a couple of variations based on different types of office management:

- Patients are flagged for screening twice a year through an electronic medical record system based on age and screens completed.
- Screening varies slightly from office to office within this type of practice.
- In one office, a case manager is responsible for administering the screen to patients who are flagged as due for a screening.
- The case manager is also responsible for follow-up referrals as needed.
- In another office, a nursing staff member screens the patient during the initial exam along with the vital signs.
- The physician then reviews the screening responses during the examination.
- Nursing and front office staff handle referrals to services as needed.
- In both situations, screening response is maintained in an electronic database along with all other health information.

What to Do for Patients at Risk

Cognitively Intact Patients

Cognitively intact patients who answer “yes” to any of the questions (or no to the telephone access question) in the screen should be encouraged to speak with someone from their local Area Agency on Aging (AAA) for further assistance. You should consider making a formal referral to the local AAA for such individuals.

Cognitively Impaired Patients

If you believe that your patient may be cognitively impaired, you will need to consider any responsibilities you have under your state’s laws to report elder abuse to adult protective services (APS).

Before you implement the screening procedure, please call your state’s APS agency. You can find a national directory of state Adult Protective Services on the website of the National Center on Elder Abuse: www.elderabusecenter.org.

Privacy Laws and Screening

This manual does not and cannot provide information about the laws and regulations applicable to your medical practice. In general, however, mandatory reporters who report to appropriate authorities or who participate in good faith in an investigation of elder abuse are immune from any civil liability that might otherwise result from these actions. This also includes liability that might otherwise arise under state or local laws or rules regarding privacy and confidentiality of information. Please consult an attorney to determine the laws and rules applicable to your medical practice.

Credits and Research on Screening Instruments

The elder abuse screen presented in this manual has been adapted from the Hwalek-Sengstock Elder Abuse Screening Test. The original screen and subsequent revisions are discussed in the following two articles:

Schofield, M.J., Reynolds, R., Mishra, G. D., Powers, J.R., Dobson, A.J. (2002). Screening for vulnerability to abuse among older women: Women's health Australia study. *The Journal of Applied Gerontology*, 21(1), 24-39.

Neale, A.V., Hwalek, M.A., Scott, R.O., Sengstock, M.C., & Stahl, C. (1991). Validation of the Hwalek-Sengstock Elder Abuse Screening Test. *Journal of Applied Gerontology*, 10(4), 406-418.

If you are interested in learning more about screening instruments, you may want to obtain the following article, which compares several instruments, including the Hwalek-Sengstock instrument:

Fulmer, T., Guadagno, L., Dyer, C.B., & Connolly, M.T. (2004). Progress in elder abuse screening and assessment instruments. *Journal of the American Geriatrics Society*, 52, 297-304.

The American Medical Association recommends screening for all geriatric patients, stating:

Every clinical setting should have a protocol for the detection and assessment of elder mistreatment. This may be a narrative, a checklist, or some other type of standardized form that enables all providers in that practice setting to rapidly assess for elder mistreatment and document it in a way that allows physicians to look at patterns over time.

Several excellent protocols are available; physicians may wish to consult those produced by Mount Sinai Medical Center and Victim Services Agency Elder Abuse Project in New York, Beth Israel Hospital in Boston or the Harborview Medical Center in Seattle.

Source: AMA's Diagnostic and Treatment Guidelines on Elder Abuse and Neglect (1992).

The American Academy of Family Physicians takes a different approach, stating:

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Opinions vary about whether to recommend for or against screening for elder abuse in routine office visits, but various screening protocols have been developed and tested for reliability and validity. The situation often is complicated by the unwillingness or inability of the victim to disclose the abuse. The authors conclude that a generally increased threshold of suspicion by physicians of elder abuse is more likely than formal screening to increase detection in primary care.

Source: AAFP web site: www.aafp.org/afp/20050901/tips/21.html. The AAFP cites to the following article in support of this position:

Lachs, M.S., & Pillemer, K. (2004). Elder abuse. *The Lancet*, 364, 1263-1272.

Complexity of Identifying and Addressing Elder Abuse

As you undoubtedly already know, there is no single, simple way to detect or address a phenomenon as complex as elder abuse. This screening instrument is one tool available to you in the exercise of your clinical judgment.

You will find fairly detailed medical information about various forms of elder abuse, age-related changes and physiological mimickers of abuse, and the psychosocial dynamics of victims and perpetrators, in the following article by a physician:

Collins, K.A.(2006). Elder maltreatment: A Review. *Archives of Pathology and Laboratory Medicine*, 130, 1290-1296.

We welcome your comments on the complexity, difficulties, and ethical dilemmas presented in the area of elder abuse as you see this issue arise in your practice. The following are a couple of comments offered by MePEP partners and screening sites:

“I think the form is very good. I think it answers a lot of the questions that patients really don’t even realize that they’re being hurt and they’re being abused in any way. You’re there to help patients and that should be the key, protecting the patient is just as important as keeping their health.”

Rose Page
Certified Medical Assistant

“We need to educate physicians more, because [elderly patients] don’t get out and the physician may be the only person that they’re really making an effort to go and see or seeing on a somewhat regular basis. I can’t tell you how many people I’ve evaluated who have a dementia and nobody’s recognized it whatsoever. You need to ask some very basic, simple questions that take all of about two or three minutes in the office that can make you concerned that something might be happening, so that’s why a more comprehensive, assessment of people’s function, emotional status even looking for the abuse, the isolation, is so vital.”

Penny Lamhut, M.D.
Geriatrician

Using Aggregate Screening Data

While patient-level data from screening can help you treat and coordinate care for your patients individually, aggregate can provide insight regarding the risk of elder abuse in your community. Aggregate screening data can hold clues to programming or prevention efforts to be undertaken by your practice or local organizations. Use screening information to help you “connect the dots” among risk and physical ailments and conditions you may be seeing in your patients.

If your practice has a research orientation, data analysis can help you determine roughly the percentage of older adults who are at risk in your community as well as the co-morbid physical ailments that often occur alongside a positive screen. Are there health markers that arise out of your data that can be used to better manage older adults who have been mistreated?

Research indicates that older adults who experience trauma are more likely to have co-morbid diseases and conditions. For more information about the medical consequences of elder abuse, you may want to obtain the article by Kim A. Collins, MD, referred to on page 12¹. It is important to note that older adults who have been mistreated are three times more likely to die (earlier) than older adults who have not experienced mistreatment².

Screening and its resulting data can be used as a starting point for inquiry on elder abuse within your practice.

¹ Collins, K.A. (2006). Elder maltreatment: A Review. *Archives of Pathology and Laboratory Medicine*, 130, 1290-1296.

² Lachs, M. S., Williams, C. S., O'Brien, S., Pillemer, K. A., & Charlson, M. E. (1998). The Mortality of Elder Mistreatment, *JAMA*; 280(5), 428-432.

APPENDIX A: Health and Safety Screen

Office # Screen #	Health and Safety Screen	Date:
<p>Are you someone who is 60 years of age or older and here for your own healthcare (not to bring someone else to an appointment)? If so, this primary care office would like to ask you some questions we ask of all our patients 60 years of age or older.</p> <p>Many people are hurt by or have problems with their family members, loved ones, friends or neighbors. Others may feel pressured by strangers or telephone and door-to-door salespeople.</p> <p>You do not have to complete this screen to see your doctor today, but your doctor is interested in your safety and may want to talk about any concerns you have. This screen is private and will not be shared with anyone without your agreement.</p> <p>Please return finished screen to your doctor Circle one</p>		
Has anyone close to you called you names or put you down recently?		Yes No
Are you afraid of anyone in your life?		Yes No
Are you able to use the telephone anytime you want to?		Yes No
Has anyone forced you to do things you didn't want to do?		Yes No
Has anyone taken things or money that belong to you without your OK?		Yes No
Has anyone close to you tried to hurt you or harm you recently?		Yes No
<p>If you have answered "Yes" to any of these questions or if you are feeling at all under pressure, we would like to have someone from the Agency on Aging call you.</p>		

The Agency on Aging may be able to help by:

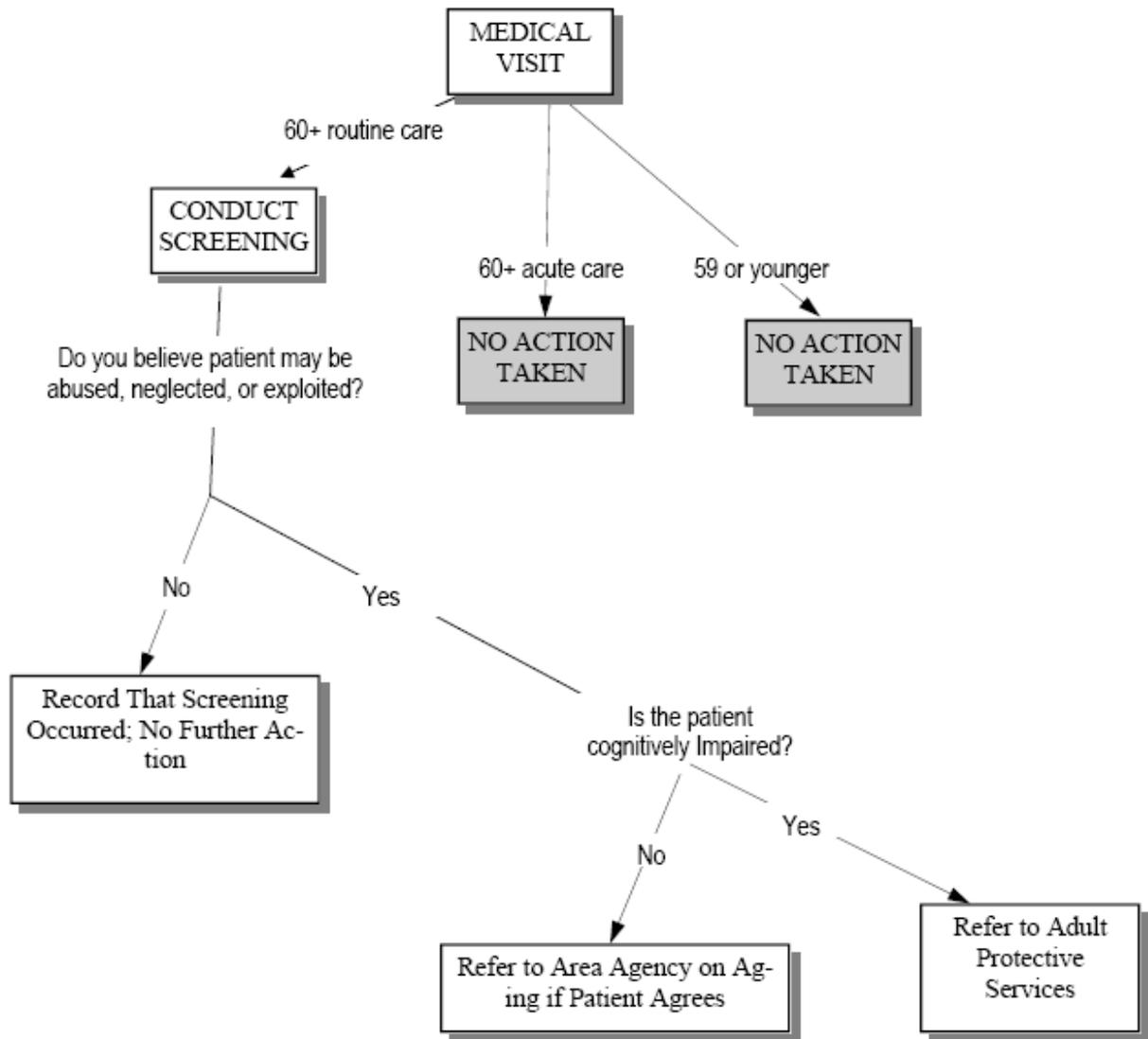
- Listening to your concerns
- Giving information
- Helping you plan ways to feel safer in your life
- Making suggestions for service

Check here to have the Agency on Aging call you. Please provide your name and telephone number. This service is free, private and voluntary.

Name:	Telephone No.:	Best time to call:
<i>Physician Signature:</i>		
<i>Physician Comments:</i>		

APPENDIX B: Screening Flow Chart

Elder Abuse Screening Implementation Flow Chart



APPENDIX C: Screening Stickers for Office Use

Record of Elder Abuse Screening
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Record of Elder Abuse Screening
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