National Collaboratory to Address
Elder Mistreatment

Elder Mistreatment
Emergency Department Toolkit

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The National Collaboratory to Address Elder Mistreatment is supported by grants to EDC from:

The John A. Hartford Foundation

GORDON AND BETTY MOORE FOUNDATION

Health Foundation for Western & Central New York

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National Collaboratory to Address
Elder Mistreatment

Elder Mistreatment
Emergency Department Toolkit

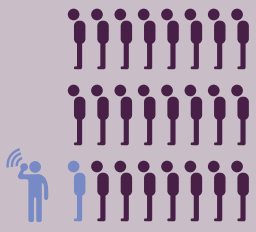
1 in 10

people ages 60 and older experience some form of mistreatment

"I think [the Elder Mistreatment Emergency Department Toolkit] enhances our current practice. And it provides a service to patients that may otherwise fall through the cracks. And so, it's good for our patients. It's good for our community."

— Hospital Emergency Center Manager

1 in 24



cases of elder mistreatment are reported to the authorities

THE CHALLENGE:

Elder mistreatment is a prevalent public health problem in the US that has devastating consequences. It can be defined as the abuse or neglect of an older adult by a person they trust, including physical, sexual, or emotional abuse, neglect, and exploitation. Even as we enter an era of increasing "age-friendliness," the estimated one in ten older adults who experience elder mistreatment remain largely uncared for and unrecognized.

To respond to this challenge, The National Collaboratory to Address Elder Mistreatment has developed a toolkit for use by health systems and communities to improve the safety and wellbeing of older adults. Focused on screening and referral in Emergency Departments, the toolkit also offers resources for clinicians and health systems to strengthen relationships with community resources that can support older adults after discharge.

"You can't have an Age-Friendly Health Care System if you don't address elder mistreatment."

–Terry Fulmer, PhD, RN, FAAN, President of The John A. Hartford Foundation

If these numbers stay the same, it is estimated that:

7.3 million

older adults in the U.S. will be mistreated in 2030

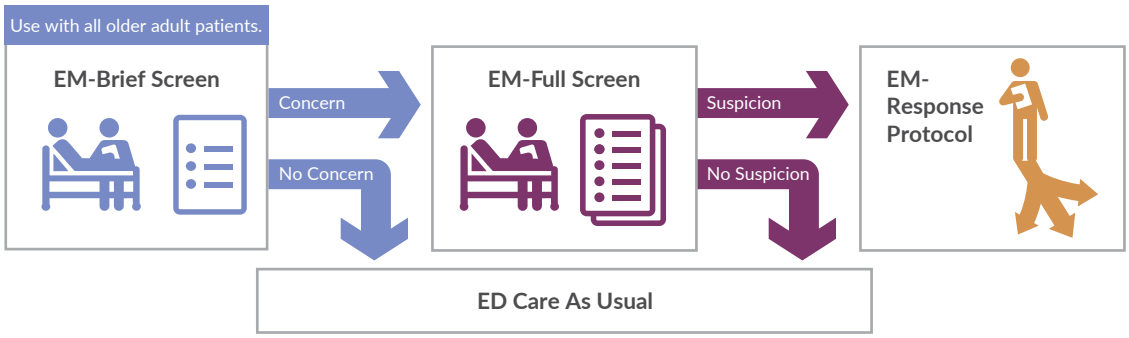
**more than 7 million cases will go unreported.*

WHAT'S IN THE TOOLKIT?

The toolkit has four key elements.

ED Staff Survey	Online Training Modules	Screening and Response Tool	Community Connections Roadmap
20 question/10 minute online tool for ED staff assesses current practices and defines priorities for practice and systems change.	Interactive online training in how to identify and respond to elder mistreatment.	Brief screening and response tools to identify at-risk patients and develop safety and discharge plans.	A guide for identifying and connecting with community partners that can support patient safety and follow up.

HOW DOES IT WORK?



WHY USE THE TOOLKIT?

The Toolkit is available, free of charge, to any institution interested in improving elder mistreatment identification and response. It has been tested in a range of health care settings—urban and rural, private and safety-net, academic and religiously affiliated—and found to be feasible to use and to improve rates of screening for elder mistreatment in every case.

The Toolkit aligns with related national initiatives including Age-Friendly Health Systems (AFHS) and Geriatric Emergency Department Accreditation (GED-A). The Toolkit is a resource that helps address each of the 4Ms Framework of AFHS: know what Matters to older adults, including safety and access to needed Medications; treat and manage Mentation challenges, including depression and dementia (which are risk factors for mistreatment); and ensure that older adults are not prevented from Mobility.

ABOUT THE NATIONAL COLLABORATORY TO ADDRESS ELDER MISTREATMENT AND EDC

With funding from The John A. Hartford Foundation and the Gordon and Betty Moore Foundation, the **National Collaboratory to Address Elder Mistreatment** was founded in 2016 with a charge to develop a scalable response to the prevalence of elder mistreatment. This group comprises national experts in elder mistreatment from the University of Southern California Keck School of Medicine, the University of Massachusetts Medical School, the University of Texas, and Weill-Cornell College of Medicine, with **Education Development Center (EDC)** serving as the Collaboratory convener. EDC is a global nonprofit with more than 60 years of experience designing, testing, and implementing innovative programs addressing critical challenges in health, education, and economic inequality.

Contact:
The National Collaboratory to Address Elder Mistreatment, ncaem@edc.org

Scan this code to learn more.

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Staff Survey: Emergency Department Assessment Profile (EDAP)

The Emergency Department Assessment Profile (EDAP) is a web-based staff survey designed for use in the emergency department setting, but it can be adapted for other settings as well. To access the online version of the EDAP, please email ncaem@edc.org.

EDAP can be used to identify the gaps and opportunities in preparing staff for screening and responding to elder mistreatment. To learn about the development of EDAP, please access our publication here: https://www.tandfonline.com/doi/full/10.1080/08946566.2021.1965930

Sites have used the results of EDAP to improve staff education, referral processes, and relationships with community partners. To learn how EDAP was used in different sites, access the Elder Mistreatment Emergency Department (EMED) Toolkit feasibility case studies here: https://gedcollaborative.com/toolkit/elder-mistreatment-emergency-department-toolkit/

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National Collaboratory to Address Elder Mistreatment

Staff Survey: Emergency Department Assessment Profile (EDAP)

Consent

You are invited to participate in a web-based online questionnaire that [SITE] is conducting to better understand emergency department practices to address elder mistreatment. It should take only 10 minutes to complete.

Completing the questionnaire is voluntary. You may refuse to take part or exit the questionnaire at any time without penalty. You are free to decline to answer any particular question you do not wish to answer for any reason.

Should you choose to participate, your responses will help us learn how we can improve care for older adults who have been or are at risk of being mistreated by others. However, you will receive no direct benefits from participating in this research study. Risks to participation are minimal, with the main foreseeable risk being breach of confidentiality. However, measures are in place to minimize that risk. Although this questionnaire does ask you to indicate your position (e.g., physician, nurse, social worker), it does not collect information on your name, email address, or IP address. Responses will be stored in a password protected, electronic format on the Qualtrics survey system. A research team at Education Development Center (EDC) will download and store data in password-protected and encrypted files. EDC will report all results in aggregate rather than by position. No one at [SITE] will be able to identify you or your answers based on your position, and no one will know whether or not you participated in the study.

If you have questions at any time about this assessment, you may contact [SITE CONTACT]; or the National Collaboratory to Address Elder Mistreatment at ncaem@edc.org.

If you have any questions, concerns, or complaints that you wish to address to someone other than [SITE CONTACT] or the National Collaboratory to Address Elder Mistreatment, you may contact the EDC Institutional Review Board at 300 Fifth Avenue, Suite 2010, Waltham, MA, 02451 or humanprotections@edc.org.

Please select your choice below. You may print a copy of this consent form for your records. Clicking on the "Agree" button indicates that:

- **You have read the above information**
- **You voluntarily agree to participate**
- **You are 18 years of age or older**

☐ Agree
☐ Disagree

1. **In what position do you spend the majority of your time?**

- ☐ Attending Emergency Physician
- ☐ Resident Emergency Physician
- ☐ Physician Assistant
- ☐ Nurse Practitioner
- ☐ ED Nurse
- ☐ ED Patient Care Technician
- ☐ Social Worker
- ☐ Case Manager
- ☐ Care Manager
- ☐ Care Coordinator
- ☐ Clerk or Registration
- ☐ Patient Services
- ☐ Patient Escort
- ☐ ED Pharmacist
- ☐ ED Radiology Technician
- ☐ ED Psychiatrist
- ☐ Chaplain
- ☐ Administration [specify discipline]
- ☐ Other [specify here]

2. **How many years of experience do you have in this job role (after completing training)?**

*Please enter a number (e.g., 6 years, 6 months = 6.5)

3. **How many years have you been in this job role at this institution?**

*Please enter a number (e.g., 9 months = 0.75)

4. **How often do you work the overnight shift?**

Never	*Rarely*	*Sometimes*	*Often*	*Always*
0	1	2	3	4

5. **Elder mistreatment may be physical, psychological, or sexual abuse; neglect; or financial exploitation. At your hospital's emergency department:**

	Strongly Disagree	Disagree	Agree	Strongly Agree	No Opinion
a. Medical staff (e.g., physician, nurse practitioner/physician assistant, resident physician) routinely, actively screen older patients for elder mistreatment.	0	1	2	3	N/O
b. Medical staff are trained to recognize suspected cases of elder mistreatment.	0	1	2	3	N/O
c. Medical staff are trained to intervene in suspected cases of elder mistreatment.	0	1	2	3	N/O
d. Nursing staff routinely, actively screen older patients for elder mistreatment.	0	1	2	3	N/O
e. Nursing staff are trained to recognize suspected cases of elder mistreatment.	0	1	2	3	N/O
f. Nursing staff are trained to intervene in suspected cases of elder mistreatment.	0	1	2	3	N/O

6. **At your hospital's emergency department, appropriate staff routinely:**

	Strongly Disagree	Disagree	Agree	Strongly Agree	No Opinion
a. Photograph injuries and other physical findings potentially related to elder mistreatment and add the photographs to the medical chart.	0	1	2	3	N/O
b. Engage a multidisciplinary team of experts in assessing suspected elder mistreatment.	0	1	2	3	N/O
c. Develop safety plans with older adults who are at risk of or who have experienced mistreatment.	0	1	2	3	N/O
d. Report suspected cases of elder mistreatment to appropriate authorities.	0	1	2	3	N/O
e. Refer victims of elder mistreatment to appropriate community resources.	0	1	2	3	N/O
f. Refer alleged perpetrators of elder mistreatment to appropriate community resources.	0	1	2	3	N/O
g. Monitor victims of elder mistreatment after discharge for adherence to referral or care plans	0	1	2	3	N/O
h. Admit victims of elder mistreatment for safety or social reasons despite the absence of a medical indication for hospitalization.	0	1	2	3	N/O
i. Hold potential victims of elder mistreatment, who present during the night shift, until morning when a social worker or case manager is on duty.	0	1	2	3	N/O

7. **The following are barriers to identifying and managing care for older adults who have experienced mistreatment. To what extent does each interfere with care at your hospital?**

None = No Interference and **High** = High Interference.

	None	Low	Moderate	High	No Opinion
a. ED team unaware of emergency medical service concerns about home environment	0	1	2	3	N/O
b. Lack of time to conduct a thorough evaluation given competing priorities with other patients	0	1	2	3	N/O
c. Difficulty distinguishing mistreatment from accidental trauma, illness, or quality of care issues.	0	1	2	3	N/O
d. Lack of (or inadequate) protocol for a streamlined response to elder mistreatment	0	1	2	3	N/O
e. Differences of opinion among staff (between disciplines) regarding how to intervene in cases of elder mistreatment	0	1	2	3	N/O
f. Reliance on family members or caregivers for medical and social historical information	0	1	2	3	N/O
g. Communication difficulties with older adults (e.g., due to cognitive or hearing impairment)	0	1	2	3	N/O
h. Lack of specialized community services for older adults vulnerable to mistreatment	0	1	2	3	N/O
i. Limited follow-up by protective services when cases are reported	0	1	2	3	N/O
j. Lack of basic training and knowledge of elder mistreatment	0	1	2	3	N/O

8. **How would you rate the job your hospital has done educating your discipline about handling cases of suspected elder mistreatment?**

Poor		*Adequate*		*Excellent*
0	1	2	3	4

9. **How knowledgeable do you consider yourself to be about best practices for identifying cases of suspected elder mistreatment?**

Not Very Knowledgeable		*Somewhat Knowledgeable*		*Very Knowledgeable*
0	1	2	3	4

10. **How knowledgeable do you consider yourself to be about best practices for managing cases of suspected elder mistreatment?**

Not Very Knowledgeable		*Somewhat Knowledgeable*		*Very Knowledgeable*
0	1	2	3	4

11. **When you suspect elder mistreatment, what do you do next? [please describe below]**

_____

12. **Among potentially vulnerable older adults seen in the emergency department, how often do you think you:**

	Never	Rarely	Sometimes	Often	Always
a. Recognize a case of elder mistreatment?	0	1	2	3	4
b. Miss cases of elder mistreatment?	0	1	2	3	4

13. **Among potentially vulnerable older adults seen in the emergency department, how confident do you feel in your ability to:**

	Not at All Confident	Not Confident	Unsure	Confident	Very Confident
a. Recognize elder mistreatment?	0	1	2	3	4
b. Intervene for victims of elder mistreatment?	0	1	2	3	4
c. Report cases of elder mistreatment?	0	1	2	3	4

14. **Indicate the extent to which you agree or disagree with the following general statements:**

	Strongly Disagree	Disagree	Agree	Strongly Agree
a. Elder mistreatment is a common and serious public health problem.	0	1	2	3
b. All older adults (aged 60 and older) seen in the ED should be screened for elder mistreatment.	0	1	2	3
c. Elder mistreatment assessment cannot take place in hurried contexts like the ED.	0	1	2	3
d. All ED staff should report elder mistreatment to the proper authorities.	0	1	2	3
e. ED staff should monitor victims of elder mistreatment after they are discharged.	0	1	2	3

15. **Indicate the extent to which you agree or disagree with the following statements about your hospital's emergency department:**

	Strongly Disagree	Disagree	Agree	Strongly Agree	No Opinion
a. There are adequate community resources available to respond to older adults at risk of or experiencing mistreatment.	0	1	2	3	N/O
b. There are ample community resources available to prevent elder mistreatment.	0	1	2	3	N/O
c. ED staff work with multidisciplinary teams to assess and manage cases of elder mistreatment.	0	1	2	3	N/O
d. There are programs in my community to support overburdened caregivers who may inadvertently mistreat older adults.	0	1	2	3	N/O
e. Police personnel are receptive and helpful when ED staff report elder mistreatment to them.	0	1	2	3	N/O
f. Adult Protective Services is receptive and helpful when ED staff report elder mistreatment to them.	0	1	2	3	N/O

16. **To whom do you report cases of suspected elder mistreatment at your hospital's emergency department? (Check all that apply.)**

- ☐ Nurse Specialist (e.g., Sexual Assault Nurse Examiner, Forensic Nurse)
- ☐ Multidisciplinary Team for Elder Mistreatment
- ☐ Social Worker
- ☐ Police
- ☐ Protective Services Agency
- ☐ Local Council on Aging
- ☐ Local Area Agency on Aging
- ☐ Other [specify here]

17. **Indicate the extent to which you agree or disagree with the following statements about you:**

	Strongly Disagree	Disagree	Agree	Strongly Agree	Not Applicable
a. I know who to contact for reporting elder mistreatment.	0	1	2	3	N/A
b. When I report elder mistreatment, I feel my report is taken seriously.	0	1	2	3	N/A
c. I am aware of the laws surrounding confidentiality, anonymity, and personal liability for reporting cases of suspected elder mistreatment.	0	1	2	3	N/A
d. It is important for me to know the outcome of reported elder mistreatment investigations.	0	1	2	3	N/A
e. I am just as comfortable handling suspected cases of elder mistreatment that present at night as those that present during the day.	0	1	2	3	N/A

18. **Have you received any formal education/training (such as lectures, seminars, simulated cases with debriefing, online educational modules) on elder mistreatment detection, management, or reporting?**

☐ Yes ☐ No

[If YES] What kind of training have you received? [please describe below]

_____

Do you feel that your training was adequate?

☐ Yes ☐ No

19. **Would you like to receive [additional] training in elder mistreatment detection, management, or reporting?**

☐ Yes ☐ No

[If YES] What would you like the training to focus on? [please describe below]

_____

20. **Finally, what are the most pressing issues you currently face in caring for older adults who have been mistreated? [please describe below]**

_____

Online Training Modules

The Online Training Modules are interactive e-learning courses that feature the following topics:

1. *Elder Mistreatment Emergency Department Toolkit Training Program:* This program consists of four modules designed to train emergency department professionals on utilizing the EMED Toolkit. While originally designed for the emergency department environment, the modules can be adapted to suit other settings as well. **Access the Training Program:** https://gedcollaborative.com/course/elder-mistreatment-emergency-department-toolkit-training-program/

2. *Critical Topics in Elder Mistreatment:* This training program contains five short modules that cover topics relevant to the management of cases of elder mistreatment in the emergency department. **Access Critical Topics in Elder Mistreatment:** https://gedcollaborative.com/course/critical-topics-in-elder-mistreatment/

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Elder Mistreatment Screening and Response Tool (EM-SART)

The Elder Mistreatment Screening and Response Tool (EM-SART) is a tool designed for use in the emergency department for identification of suspected elder mistreatment. It consists of two parts: a brief (3-question and observational) screen for use with all older adults in the emergency department, and, for patients whose initial screen indicates the need for further assessment, a more in-depth screening and response protocol.

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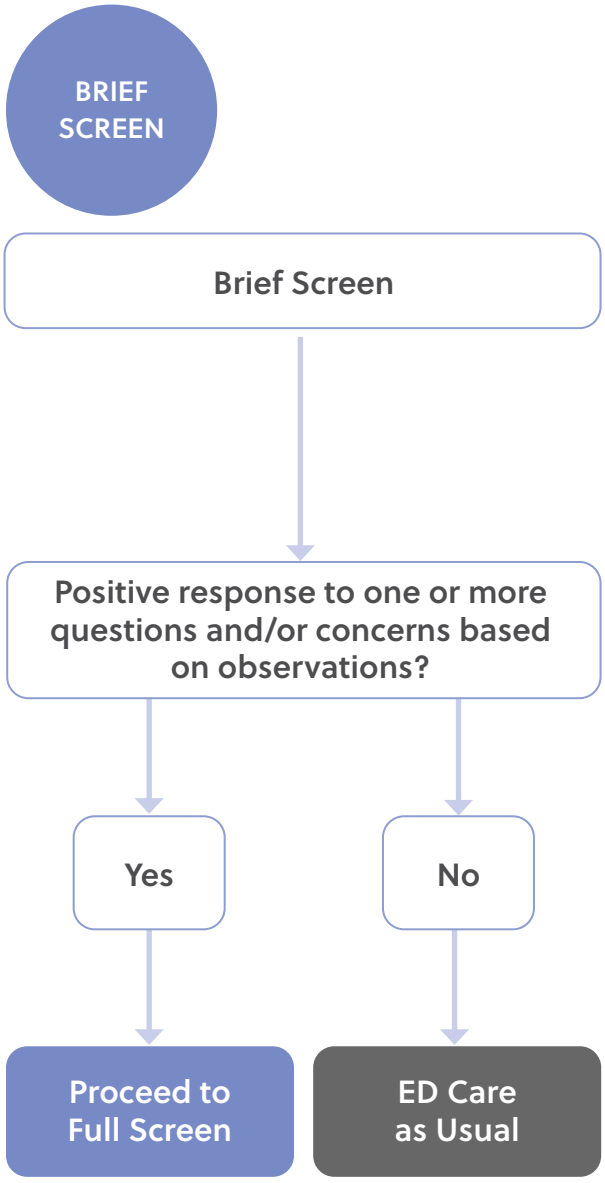
Elder Mistreatment Screening and Response Tool (EM-SART)

The EM-SART is a tool intended for use in the emergency department for identification of suspected elder mistreatment. Users should undergo training regarding the administration of the tool as well as the content areas of elder mistreatment and geriatric medical syndromes. It is important to ask the screening questions privately while the patient is unaccompanied.



Ask the Patient

	YES	NO
Has anyone close to you harmed you?	☐	☐
Has anyone close to you failed to give you the care that you need?	☐	☐
Has anyone tried to force you to sign papers or use your money against your will?	☐	☐

Look for Red Flags

If available, the patient's medical history includes:	YES	NO
Repeated visits to the ED	☐	☐
Frequent or unexplained injuries	☐	☐
History or signs of cognitive impairment	☐	☐
Delayed attention to or unmet health needs	☐	☐

The patient appears to:	YES	NO
Have physical signs of mistreatment (e.g., suspicious wounds, concerning personal hygiene, malnutrition or dehydration)	☐	☐
Have unmet mental health needs or problems with substance use	☐	☐
Lack access to needed resources	☐	☐
Feel uncomfortable with their caregiver(s)	☐	☐

If present, the caregiver appears:	YES	NO
Unengaged, inattentive, or to lack knowledge of the patient's medical needs	☐	☐
Dismissive of, frustrated with, or hostile towards the patient	☐	☐
Overly concerned or anxious about the patient	☐	☐
To have unmet mental health needs or problems with substance use	☐	☐
To lack access to needed resources	☐	☐

Record Additional Notes and Recommendations

☐ *I recommend the EM-Full Screen.*

☐ *I recommend ED care as usual.*

Notes: _____

Adapted from DETECT Screening Tool[1]

The National Collaboratory to Address Elder Mistreatment is supported by grants to Education Development Center from The John A. Hartford Foundation, The Gordon and Betty Moore Foundation, and The Health Foundation for Western and Central New York.

FULL SCREEN

Initial Cognitive Assessment (AMT4)

✔ *Indicate whether the patient answers the following questions correctly.*

	YES	NO
What is your age?	☐	☐
What is your date of birth?	☐	☐
What is this place?	☐	☐
What is the year?	☐	☐

Elder Mistreatment Questions

✔ *Ask questions when patient is alone, and indicate the patient's response. Preface each question with "In the last 6 months..."*

	YES	NO
Have you needed help with bathing, dressing, shopping, banking, or meals?	☐	☐
*If yes, have you had someone who helps you with this?	☐	☐
*If yes, is this person always there when you need them?	☐	☐
Has anyone close to you called you names or put you down?	☐	☐
Has anyone told you that you give them too much trouble?	☐	☐
Has anyone close to you threatened you or made you feel bad?	☐	☐
Has anyone tried to force you to sign papers or use your money against your will?	☐	☐
Has anyone close to you tried to hurt you or harm you?	☐	☐

Observational Screen/Red Flags

✔ *Indicate the proper response.*

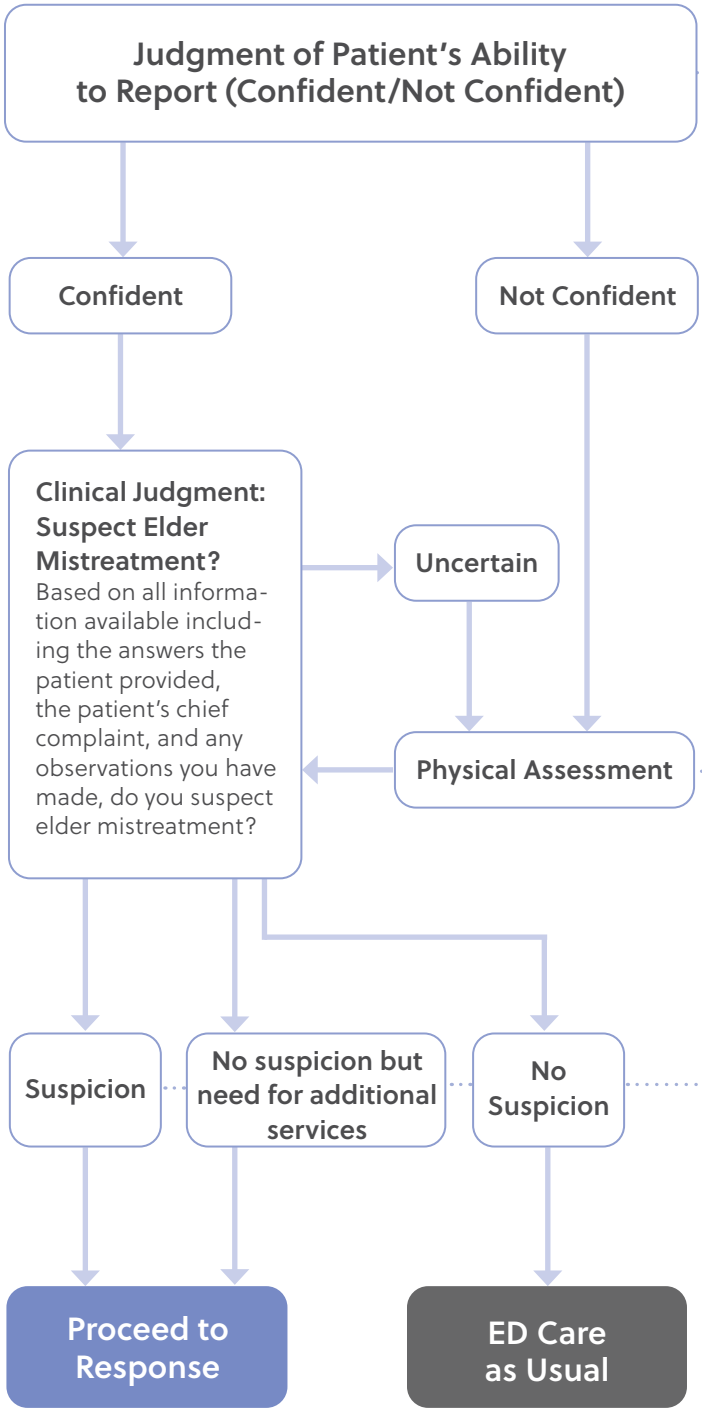
The patient appears to:	YES	NO
Have physical signs of mistreatment (e.g., suspicious wounds, concerning personal hygiene, malnutrition or dehydration)	☐	☐
Have unmet mental health needs or problems with substance use	☐	☐
Lack access to needed resources	☐	☐
Feel uncomfortable with their caregiver(s)	☐	☐

If present, the caregiver appears:	YES	NO
Unengaged, inattentive, or to lack knowledge of the patient's medical needs	☐	☐
Dismissive of, frustrated with, or hostile towards the patient	☐	☐
Overly concerned or anxious about the patient	☐	☐
To have unmet mental health needs or problems with substance use	☐	☐
To lack access to needed resources	☐	☐

Adapted from DETECT Screening Tool[2]

(Full Screen continues on next page)

FULL SCREEN



Judgment of Patient's Ability to Report

Based on the information gathered, do you feel confident that the patient was able to honestly and accurately report mistreatment?

☐ Confident ☐ Not confident

✔ *Indicate the proper response.*

Elements Highly Suggestive of Abuse	YES	NO
Bruising in unusual location, multiple bruises, or large bruises?	☐	☐
Burn patterns suggestive of intentional injury?	☐	☐
Patterned injuries?	☐	☐
Abrasions or lacerations suggestive of intentional injury?	☐	☐
Evidence of neglect?	☐	☐

Elements That May Suggest Abuse	YES	NO
Evidence of malnutrition?	☐	☐
Evidence of dehydration?	☐	☐
Swollen or tender area on palpation?	☐	☐
Evidence of poor control of medical problems?	☐	☐

Specific Circumstances	YES	NO
Genital trauma or infection concerning for sexual abuse?	☐	☐
Fractures concerning for abuse?	☐	☐
Current problem has been present for a long time–unusual delay in seeking medical attention concerning for abuse or neglect?	☐	☐

Clinical Judgment: Suspicion of Elder Mistreatment

☐ Suspicion
☐ No suspicion but need for additional services
☐ No suspicion

Notes:

[1]The Senior Abuse Identification Tool is incorporated into this screening protocol with permission from Tim Platts-Mills, University of North Carolina. Platts-Mills, T.F., Dayaa, J.F., Reeve, B.B., Krajick, K., Mosqueda, L., Haukoos, J.S., Patel, M.D., Mulford, C.F., McLean, S.A., Sloane, P.D., Travers, D., & Zimmerman, S. (2018); Development of the Emergency Department Senior Abuse Identification (ED Senior AID) tool, Journal of Elder Abuse & Neglect.

[2] Detect Screening Tool is incorporated into this screening protocol with permission from Michael Bradley Cannell, University of Texas.

RESPONSE TO POSITIVE SCREEN

Judgment of Situation
Is the patient in immediate danger? STOP

No Suspicion but Need for Additional Services	Suspicion of Elder Mistreatment **No Immediate Danger**	Suspicion of Elder Mistreatment & Immediate Danger
Does not meet APS criteria	Meets APS criteria	Consider: • Contacting hospital security • Notifying law enforcement

Report to APS or Appropriate Authority

Documentation

(Response to Positive Screen continues on next page)

STOP

IMMEDIATE DANGER: STOP

Do not discharge to previous living situation if:

✔ *Check all that apply*

- ☐ **S**exual assault with ongoing risk
- ☐ **T**hreat: concern for or stated threat of physical injury
- ☐ n**O** access: neglect with ongoing risk for insufficient access to shelter, food, medication, or medical care
- ☐ **P**hysical abuse with injury and ongoing risk

Assess decision-making capacity if appropriate:
If a patient wishes to return to an unsafe living situation, assess capacity to make this decision

Report

✔ *Indicate where patient currently lives:*

- ☐ Own residence
- ☐ Residential care community
- ☐ Nursing home
- ☐ Other: _____

✔ *Indicate whether a report was made to:*

- ☐ Adult Protective Services (APS)
- ☐ Other: _____

Document

✔ *Indicate whether physical assessment findings were documented in health record*

- ☐ Physical assessment findings (e.g., written descriptions, diagrams, photos)

✔ *Indicate the type(s) of mistreatment and whether there is concern for immediate danger in the table below*

- ☐ Level of concern

	Physical Abuse	Sexual Abuse	Emotional Abuse	Financial Abuse	Neglect
Suspicion of EM & Immediate Danger	○	○	○	○	○
Suspicion of EM No Immediate Danger	○	○	○	○	○

Elder Mistreatment (EM)

- ☐ No suspicion of mistreatment but need for additional services

RESPONSE TO POSITIVE SCREEN

Referral

Refer Patient

- ☐ Care/case management services
- ☐ Emergency assistance and material aid services
- ☐ Legal services
- ☐ Housing and relocation services
- ☐ Substance use services
- ☐ Nutrition
- ☐ Mental health services
- ☐ Medical rehabilitation services
- ☐ Medical or dental services
- ☐ Community aging services
- ☐ Other: _____

Safety Planning

Safety Planning

- ☐ Develop safety plan that aligns with patient's values

Discharge

Discharge Patient

STOP

Immediate Danger: Do not discharge to previous living situation. Consider:

- ☐ Hold in ED
- ☐ Inpatient
- ☐ Skilled nursing facility
- ☐ Emergency housing
- ☐ Shelter
- ☐ Other: _____

No Immediate Danger:

- ☐ Inpatient
- ☐ Skilled nursing facility
- ☐ Long-term care facility
- ☐ Emergency housing
- ☐ Home with safety plan
- ☐ Other: _____

Community Connections Roadmap

The Elder Mistreatment Community Connections Roadmap is a set of streamlined tools and resources designed to help emergency department care providers identify and respond to potential cases of elder mistreatment.

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Community Connections Roadmap

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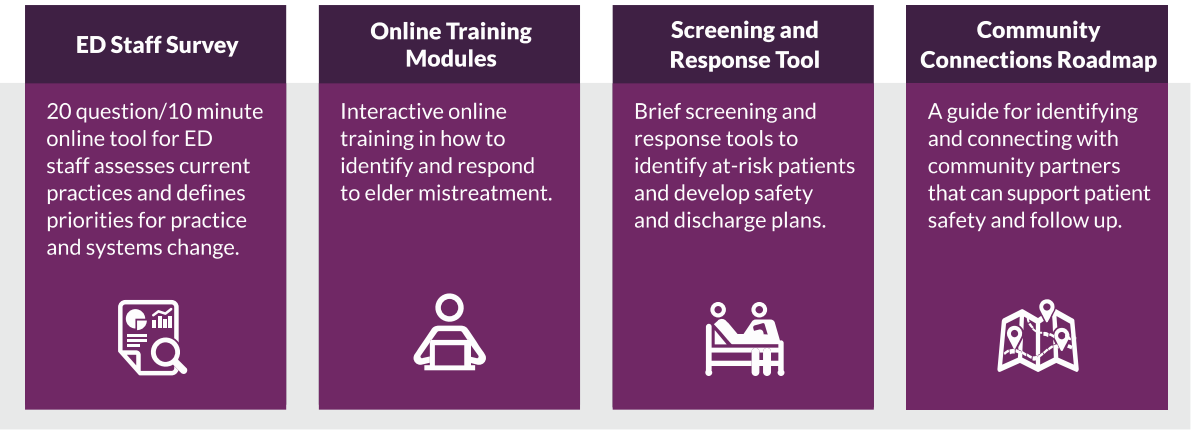
Elder Mistreatment Community Connections Roadmap

Introduction

The Elder Mistreatment Community Connections Roadmap (the Roadmap) is one of four core components of the Elder Mistreatment Emergency Department Toolkit, a set of streamlined tools and resources designed to help emergency department (ED) care providers identify and respond to potential cases of elder mistreatment.



Implementation of the Elder Mistreatment Emergency Department Toolkit includes screening all older adult emergency department patients for potential elder mistreatment, as well as reporting suspected cases and referring to appropriate internal and external services. To implement the Elder Mistreatment Emergency Department Toolkit effectively, ED staff must be aware of the community resources they can refer to in response to concerns about elder mistreatment. The Roadmap is a step-by-step guide to help hospitals connect with relevant community organizations in their area to help mitigate risk for and improve responses to elder mistreatment.

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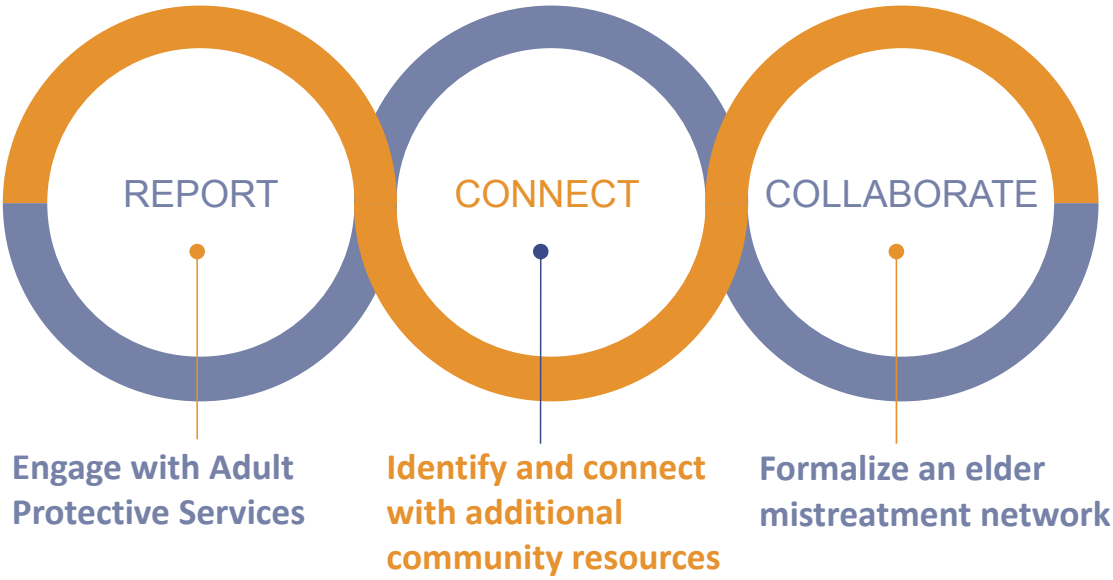
The Roadmap guides users on how to assess their needs and existing resources in order to identify the appropriate starting point in a three-stage continuum that begins with developing a relationship with Adult Protective Services (APS) and ends with engaging a multidisciplinary collaborative team. More specifically, **Stage 1: Report** guides users in developing working relationships with local APS agencies, **Stage 2: Connect** helps users build additional connections with community organizations that serve the older adult population in the hospital service area, and **Stage 3: Collaborate** provides guidance on how to develop or participate in a more formal collaborative team focusing on preventing and addressing elder mistreatment.



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I. Assess Opportunities and Needs

This section includes a tool designed to help you assess available resources. You will be mapping the hospital service area and reviewing existing data collected from community needs assessments and through the Elder Mistreatment Emergency Department (EMED) Toolkit staff survey and resulting EMED Assessment Profile, which summarizes the survey results.

To get started, fill in the worksheet below. Note that some of the questions in the worksheet reference responses to the staff survey. The relevant survey responses are indicated in brackets following the question.

Assessing Opportunities and Needs Worksheet

1. *Map your hospital service area*

a) In what communities do your older adult patients live?

b) In which states do your older adult patients live?

c) Does your county have an existing multidisciplinary team (MDT) focused on elder mistreatment? (For a partial list of Elder Mistreatment MDTs by state, go here: https://eldermistreatment.usc.edu/elder-abuse-mdt-project/mdt_list/)

2. *Assess your relationship with Adult Protective Services*

	Yes	No
a) Does your organization have an existing relationship with local Adult Protective Services (APS)? **[Refer to responses to EMED staff survey questions 6(d); 15(f); and 17(a), (b), & (c)]**	☐	☐
i. Appropriate staff routinely report suspected cases of elder mistreatment to appropriate authorities.	☐	☐
ii. APS is receptive and helpful when ED staff report elder mistreatment to them.	☐	☐
iii. You, your social worker, case management department, etc. have a named contact at each of the local APS agencies.	☐	☐

iv. When your staff reports suspected elder mistreatment to APS, they feel their reports are taken seriously.	☐	☐
v. You and your staff are aware of the laws surrounding confidentiality, anonymity, and personal liability for reporting cases of suspected elder mistreatment.	☐	☐

3. Review hospital and community needs assessment data

a) Are you connected with organizations in your community that address the following needs?	**Yes**	**No**
i. Primary care, mental health, substance use, and other health services	☐	☐
ii. Memory evaluation and capacity assessment	☐	☐
iii. Legal services	☐	☐
iv. Transportation	☐	☐
v. Emergency housing	☐	☐
vi. Access to food and clothing	☐	☐

b) Are staff aware of community-based resources to support older adults? **[Refer to responses to EMED staff survey question 15(a), (b), & (d)]**	**Yes**	**No**
	☐	☐
i. Does your staff agree that there are adequate community resources available to *respond* to older adults at risk of or experiencing mistreatment?	☐	☐
ii. Does your staff agree that there are ample community resources available to *preven*t elder mistreatment?	☐	☐
iii. Does your staff agree that there are programs in the community to support overburdened caregivers who may mistreat older adults?	☐	☐

c) Did staff indicate a moderate or high level of concern about the following: **[Refer to responses EMED staff survey question 16(h) & (i)]**	**Moderate**	**High**
i. Lack of specialized community services for older adults vulnerable to mistreatment	☐	☐
ii. Limited follow-up by protective services when cases are reported	☐	☐

4. Assess availability of internal resources to manage community connections		
a) Is there someone at your organization (e.g., ED staff person, social work, case management, volunteer) who can be assigned to be responsible for connecting with community resources?	**Yes** ☐	**No** ☐
b) Is there another organization that can manage an elder mistreatment collaborative team over time (e.g., local APS, legal services organization)?	☐	☐

II. Identify a Starting Point

Once you have reviewed existing data and collected relevant information from staff, it is time to identify an appropriate starting point on the community connections continuum.

If you identify connecting with APS as a key barrier to addressing elder mistreatment (see questions 2 and 3C in the Assessing Needs and Opportunities worksheet above) and/or your organization does not have an existing relationship with local APS agencies, begin at **Stage 1: Report**.

If your organization already has a positive working relationship with APS but does not have relationships with each of the types of community organizations listed in question 3a of the worksheet, you should begin at **Stage 2: Connect** to identify relevant community partners.

If your organization is already well connected with the relevant community partners and you have a team member who can devote a substantial amount of time to this work, you may be ready to consider formalizing or joining an elder mistreatment collaborative team. We estimate that a minimum commitment of 4 hours per month will be required if there is an existing team in the community, and more if you will be developing a new team.

The table below lists each stage, their respective goals, and the staff roles required to achieve each goal.

	Engage with Adult Protective Services	Engage additional community resources	Formalize an elder mistreatment team
Goals	Improve communication between hospital and Adult Protective Services (APS)	Engage additional community resources to support follow-up referrals and avoid repeat ED visits or readmits	Develop or join an elder mistreatment community network/team for: • case review/consultation • systems change • education
Hospital Staff Roles:	✓ Assess opportunities and needs ✓ Identify APS agencies in area ✓ Connect with APS agencies	⇢ AND: ✓ Strategically identify community-based resources ✓ Maintain multiple relationships	⇢ AND: ✓ Participate regularly ✓ Provide meeting space ✓ Host meetings ✓ Provide leadership

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III. Build Connections: Report, Connect, Collaborate

Stage 1: Report

Welcome to the first stage in the community connections continuum. In this stage of the continuum, you will identify and engage with local Adult Protective Services (APS). As you learned in the EMED Toolkit Training modules, APS agencies are essential partners in addressing elder mistreatment. Having personal connections with local APS agencies can help hospitals better understand and improve their reporting process. In this section you will find a to-do list that walks you through the process of connecting with the APS agencies in your hospital service area, a set of strategies for connecting with APS, and a worksheet to help you record progress and evaluate next steps.

> *"APS agencies welcome opportunities to work with hospitals because it enhances the reporting process. Hospitals can learn more about how APS agencies work and vice versa.*
>
> *For example, attending hospital grand rounds or working with hospitals to create cross-training of protective services staff and hospital staff. This approach fosters a collaborative, elder-centered approach to tackling complex elder abuse issues. The best way to initiate contact is to reach out to your area protective service agency."*
>
> - Director of Adult Protective Services, MA

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TO DO

- [ ] Identify the local APS agencies for each community that your hospital serves
- [ ] Review your responses to in section 2 of the **Assessing Opportunities and Needs Worksheet** (p.4)
- [ ] Meet with a local contact at each APS agency to introduce your hospital and strategize ways to communicate moving forward
- [ ] Share strategies and contacts with emergency department staff
- [ ] Record progress and evaluate next steps

TIPS AND STRATEGIES FOR IMPROVING COMMUNICATION WITH APS

- To build a connection with local APS agencies, call the local number rather than the centralized intake line that is used for reporting.
- Many APS agencies will have a staff person whose role includes community engagement, training, and outreach. This may be the best person to start with.
- Let the APS representatives know that you are calling from a local hospital because you are preparing to implement/are implementing an elder mistreatment screening and response tool for use with all older adult patients and would like to connect with them to prepare for increased elder mistreatment reports.
- Ask to meet with a representative from APS to brainstorm ways to best work together moving forward. Just like it is useful for the hospital to have a specific contact with someone at APS, APS will likely appreciate having a specific individual they can contact at the hospital.
- Invite APS to participate in grand rounds, deliver trainings, and visit the emergency department.

RECORD PROGRESS AND EVALUATE NEXT STEPS			
Have you or has someone at your organization:	**Yes**	**No**	**In progress**
1. Identified the hospital service area (HSA), particularly for older adults?	☐	☐	☐
2. Identified Adult Protective Services agencies (APS) within the HSA?	☐	☐	☐
3. Identified the point of contact at each APS agency?	☐	☐	☐
4. Communicated with the APS contact person about elder mistreatment screening and options for follow-up on patients reported for elder mistreatment or for being at risk of elder mistreatment?	☐	☐	☐
5. What challenges did you experience engaging with APS?			
6. How did you/do you plan to overcome those challenges?			
7. How has engaging with APS helped or hindered your ability to respond to elder mistreatment?			
8. What are your goals moving forward?			
9. Are you ready to make connections with other community-based resources?			

Stage 2: Connect

Welcome to the second stage of the elder mistreatment community connections continuum. In this stage, you will build on your relationship with Adult Protective Services (APS) and prioritize other types of community-based organizations to connect with. This section includes a series of lists and tools to help you identify, prioritize, and connect with organizations in your community that can follow up with patients after they leave the emergency department.

TO DO
☐ Review and update your responses to section 3 of the **Assessing Opportunities and Needs Worksheet**.
☐ Using the information in the **Assessing Opportunities and Needs Worksheet** and the **Types of Community Resources** table (p.23), prioritize the types of community resources that are most needed to help your organization respond to elder mistreatment.
☐ Contact community-based organizations to establish procedures for referral and follow-up for patients identified in the ED as being at risk for elder mistreatment and track progress in the **Community Connections Tracker**.
☐ Communicate contacts and agreed upon referral processes to ED staff for application during the response portion of the Elder Mistreatment Screening and Response Tool.

TIPS AND STRATEGIES FOR CONNECTING WITH COMMUNITY ORGANIZATIONS

- Prioritize connections with organizations that address the most urgent needs for your community (see **Types of Community Resources** table below and the **Appendix on p. 23** for descriptions of each type of community resource).
- Leverage your existing relationship with APS to identify and connect with organizations in your community. It is likely that APS has relationships with these organizations and can make an introduction.
- Meet with representatives from each organization to let them know that you are implementing the Elder Mistreatment Emergency Department Toolkit and would like to partner with organizations in the community that can help to follow up with patients after they leave the ED.
- Strategize with each organization about how the ED can make warm handoffs between the hospital and community-based organization.
- Determine how to stay in regular contact with each other. The cadence and ways in which you communicate with organizations in the community will vary but it is important to establish a shared understanding of the goals and expectations of the relationship.

Example: One strategy for automating communication between organizations

PatientPing is a software program that provides real-time hospital admission and discharge notifications. For example, in central Massachusetts, PatientPing is used by a local hospital to contact case management and APS staff at an Aging Services Access Point when a client is admitted. This tool not only flags high ED utilizers, but also helps strengthen transition of care and post-discharge follow-up to reduce hospital readmissions.

The table below categorizes the services that are useful for responding to elder mistreatment. The **Appendix on pg. 23** includes a more comprehensive list by category and describes their relevance to addressing elder mistreatment.

TYPES OF COMMUNITY RESOURCES Indicate which of the resources listed below are needed to address the needs of your patient population by checking the boxes in the column on the left.	
1. Aging Networks	
☐	Elder Mistreatment Multidisciplinary Teams
☐	Financial Abuse Specialist Teams
☐	Forensic Centers
☐	Aging Service Access Points (ASAP) / Area Agencies on Aging (AAA)
☐	American Association of Retired People (AARP)
2. Health Services	
☐	Primary care providers, geriatricians, physicians, nurses, nurse practitioners, physicians' assistants
☐	Neurology
☐	Psychology
☐	Mental health
☐	Substance use
☐	Pain clinics
3. Public Safety and Legal Services	
☐	Police, fire, emergency medical services
☐	Victim witness advocates
☐	Elder law groups
☐	Guardianship services

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☐	Prosecutors, district attorneys
4. Other	
☐	Housing services
☐	Municipal leaders
☐	Faith-based representatives
☐	Local community organizations and business leaders
☐	Financial institutions
☐	[Add others here as relevant]
☐	[Add others here as relevant]
☐	[Add others here as relevant]

Use the table below to track the contacts you make with community partners. The professions and organizations you list here may be found within your hospital system (e.g., social work department) or in the community, and can be a source for referrals and services for your patients.

Community Connections Tracker

Type of Partner	Organization(s)	Contact Person(s)	Contact Info	Date of Contact	Strength of relationship	Notes/Follow-up
Adult Protective Services (APS)					[0-5 with 0=none, 5=strong working relationship]	
Existing Multidisciplinary Teams					[0-5 with 0=none, 5=strong working relationship]	
[Insert partners, add rows as needed]					[0-5 with 0=none, 5=strong working relationship]	
[Insert partners, add rows as needed]					[0-5 with 0=none, 5=strong working relationship]	
[Insert partners, add rows as needed]					[0-5 with 0=none, 5=strong working relationship]	

Once you have established strong relationships with several organizations and identified someone who is willing to lead the effort, you may be ready to move on to **Stage 3: Collaborate**. Consider the following questions to help you determine whether a formal collaboration is right for you at this time.

RECORD PROGRESS AND EVALUATE NEXT STEPS			
Have you or has someone at your organization:	**Yes**	**No**	**In progress**
1. Identified community-based organizations (CBOs)?	☐	☐	☐
2. Identified the point of contact at each CBO?	☐	☐	☐
3. Communicated with the CBO contact person about implementation of the Elder Mistreatment Emergency Department Toolkit and discussed options for follow-up on patients reported for, or at risk of, elder mistreatment?	☐	☐	☐
4. Shared information with ED staff about the internal and community-based resources and how to refer patients to them?	☐	☐	☐
5. What challenges did you experience engaging with CBOs? How did you overcome those challenges?			
6. How has engaging with CBOs helped or hindered your ability to respond to elder mistreatment?			
7. What are your goals moving forward?			
8. Are you ready to formalize or join an elder mistreatment collaborative team? If not, what would you need to be able to do so?			

Stage 3: Collaborate

Welcome to the third and final stage in the continuum. By the time you begin this stage, you will have already established relationships with Adult Protective Services (APS) and other relevant community-based resources. Now you may be ready to bring these connections together to formalize a collaborative team.

Typically known as Elder Mistreatment Multidisciplinary Teams (MDTs), these teams bring together people from different disciplines to collaboratively address elder mistreatment through shared goals and exchange of information. MDTs can help to coordinate services for victims, develop creative solutions to complex problems, monitor and follow up with patients, and help to break down silos between agencies. There are many different types of teams (e.g., fatality review teams, financial abuse specialist teams, guardianship teams, etc.).

In this section, we point to the Department of Justice's MDT Guide and Toolkit. This guide includes descriptions, tools, examples, and webinars as well as access to an MDT Technical Advisor. The MDT Guide and Toolkit is designed to help communities establish and grow MDTs.

Example: A Multidisciplinary Team in Action

https://www.youtube.com/watch?v=zLrBqJVqu-A

TO DO

- [ ] Review and update your responses to section 3 of the **Assessing Opportunities and Needs Worksheet.**
- [ ] Visit the Department of Justice's MDT Guide and Toolkit website to learn more and determine if have the resources to implement an MDT.
- [ ] Track progress and evaluate next steps.

TIPS AND STRATEGIES FOR ESTABLISHING AN MDT

- **Tailor the team to the community's needs:** MDTs can take many different forms; develop a team that best addresses the needs and goals for your specific community. You can draw on what you learned from working with APS and other community-based organizations thus far to help determine what your team will look like.
- **Don't bite off more than you can chew:** The hospital may or may not be the right organization to lead a collaborative effort in the long term. Other organizations (like APS or a legal services organization) may be best suited to lead the team, with the hospital as an active participant and advocate.
- **Don't recreate the wheel**: Many hospitals are engaged with MDTs that address related issues but are not specific to elder mistreatment (e.g., aging in general, falls, memory). It may be more efficient and feasible to add the topic of elder mistreatment to the scope of one of these teams than to try to develop a whole new team.

RECORD PROGRESS AND EVALUATE NEXT STEPS			
Have you or has someone at your organization:	**Yes**	**No**	**In progress**
1. Identified existing local Elder Mistreatment Multidisciplinary Teams (MDTs)?	☐	☐	☐
2. Participated in local Elder Mistreatment MDTs, coalitions, or taskforces?	☐	☐	☐
3. **If none exist**, invited Adult Protective Services (APS) and/or community-based organizations (CBOs) to create a local Elder Mistreatment MDT, coalition, or taskforce?	☐	☐	☐
→ Identified members?	☐	☐	☐
→ Held meeting(s)?	☐	☐	☐
→ Identified group goals?	☐	☐	☐
→ Identified leadership?	☐	☐	☐
4. What challenges did you experience developing or joining an MDT? How did you overcome those challenges?			
5. What worked well?			
6. How has the MDT helped or hindered your ability to respond to elder mistreatment?			

7. Is there a need to revisit your relationships with APS (Stage 1. Report) or other CBOs (Stage 2. Connect)? Remember, organizations can move back and forth throughout the community connections continuum and it may be a good idea to revisit the previous sections of the Roadmap.

ACKNOWLEDGMENTS

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Appendix: Types of Community Resources

AGING NETWORKS		
Partner	**Definition**	**Contribution to Elder Mistreatment Networks**
Adult Protective Services (APS)	APS agencies collect elder abuse reports, investigate, and make referrals in most communities. In most states, health care professionals are mandated to report suspected mistreatment to APS.	APS can provide information on statutory requirements for reporting and responding to elder abuse and neglect, community resources, and risk factors for mistreatment and profiles of victims and abusers.
Existing Multidisciplinary Teams (MDTs)	An MDT comprises representatives from three or more disciplines who are bound by a commom purpose. They work work collaboratively towards a shared goal, using shared definition of the problem. MDTs are characterized by five elements: Shared Decision-Making, Partnership, Interdependency, Balanced Power, and Process.	If an MDT already exists in your area, you may not want to create redundancy; instead, your focus should be on how your emergency department can become an active member of the team.
Aging service network personnel (AAA, AARP, home care agencies, Councils on Aging, senior centers)	Aging services organizations may be public, private, non-profit, or for-profit. They typically provide information and services to older adults in the community, such as referrals for day programs, meals, and case management.	Aging services representatives can provide information on various methods for accessing services as well as actually delivering services that can reduce dependency, isolation, and vulnerability (e.g., Meals on Wheels).

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HEALTH SERVICES		
Partner	**Definition**	**Contribution to Elder Mistreatment Networks**
Medical practitioners (geriatricians, physicians, physician assistants, nurses, nurse practitioners medical social workers)	Practitioners provide case management, house calls, screening for elder maltreatment, prescriptions, mental capacity assessments, and assistive devices, and can evaluate the victim-offender dynamics.	Practitioners can provide information regarding available medical resources; home health services and their limitations; Medicare and Medicaid; the effects of medications; identification and interpretation of fractures, bruises, wounds, and medical conditions; health risk factors associated with abuse; and instruction on how to conduct investigations in medical facilities, including what to look for on medical charts, chains of command, and staffing patterns.
Neuropsychologists/ clinical psychologists/ geriatric psychiatrists/ outpatient pain clinics	The neuropsychologist/clinical psychologist/geriatric psychiatrist conducts cognitive status evaluations of victims and assesses clients' service needs.	These professionals can provide information to a criminal investigator looking to establish the vulnerability of an alleged victim, or a prosecutor assessing the ability of an alleged victim to serve as a witness to their own mistreatment.
Mental health professionals	Mental health professionals (e.g., psychologists, psychiatrists, therapists, counselors, psychiatric social workers) provide case management, mental health diagnoses, and therapy.	Mental health professionals can provide information on the conditions or illnesses associated with abuse, available mental health interventions, insight into family dynamics, and how best to respond to the victim's particular goals and values.
Substance abuse specialists	Generally speaking, substance abuse specialists help people who have problems with drugs and alcohol by identifying issues and behavior which could be linked to their addiction.	Substance abuse or addiction specialists can contribute valuable insight into the behaviors and dynamics of individuals with substance use disorders (either victims or perpetrators). They often have vast knowledge of treatment options and services available in their area.

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PUBLIC SAFETY AND LEGAL SERVICES		
Partner	**Definition**	**Contribution to Elder Mistreatment Networks**
Public safety (police, fire, emergency medical services)	Under certain circumstances, law enforcement receives and responds to reports of elder abuse. Law enforcement officials are able to make arrests, conduct "well-being checks," initiate or enforce orders of protection, provide standby assistance to other professionals, legally gain entrance into an alleged victim's home, and remove the abuser from the home. Importantly, some older adults will not want law enforcement involved in the case. Other first responders, like fire and emergency medical services providers are trusted members of the community who can observe signs of elder mistreatment in homes, relay information to other providers, and may have ongoing relationships with high-risk patients for whom they are called to help more frequently.	Law enforcement officials can provide expertise and information regarding federal and state laws pertaining to abuse, identify criminal conduct, and identify actions law enforcement officials can take. Law enforcement professionals can include representatives from the Medicaid Fraud Control. Fire and emergency medical services providers can provide unique insights into older adults' home situations and can help teams better understand the case and potential solutions.
Victim Advocates (Victim witness advocates/Victim services providers, elder law groups, guardianship teams [e.g., local YWCA])	These advocates have expertise in victim issues, needs, and services. For example, victim advocates can inform victims about how the criminal justice system works, what they can expect when they come to court, what to do if they are threatened by perpetrators, eligibility for victims' compensation and how to apply for it, and victims' rights and how to exercise them through impact statements or by enforcing restitution orders. Victim advocates provide services such as court accompaniment and transportation, and notification of hearings, trial dates, and other important events.	These individuals know the communities in which they work and can provide the same valuable information to the team that they provide to victims.:

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Prosecutors/District attorneys	State and local prosecutors decide whether to bring criminal charges against perpetrators, and represent the state during a prosecution.	The prosecutor can provide information on judges, how the criminal justice system functions, the benefits and risks of prosecution, theories used to prove elder abuse crimes, what evidence is needed, penalties, and how service providers can help build cases. They can also provide guidance on criminal justice remedies such as restitution or diversion programs, and advice on how to provide evidence and testimony in criminal proceedings.

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OTHER SERVICES		
Partner	**Definition**	**Contribution to Elder Mistreatment Networks**
Housing	Communities may have community- or government-based housing services for low-income individuals and families where advocates assist individuals in locating affordable housing.	Housing services can provide housing information and options for older adults who may need relocation assistance as a result of elder abuse.
Clergy, interfaith efforts, Emergency Medical Service chaplains	Faith-based representatives may provide solace and spiritual guidance to victims of elder abuse.	Faith-based representatives can provide information from a spiritual perspective and may seek services or support from the victim's church.
Financial institution representatives	Financial institution representatives can range from bank tellers to bank presidents, or retired financial institution employees.	Financial institution representatives can describe procedures such as direct deposit of income checks, prevention of fraud through preauthorized charges to bank accounts, verification of transactions through microfilm, trust services, referral to consumer protection agencies, and the risks and benefits of each intervention.
Policymakers, regulators	State securities regulators investigate potentially fraudulent activity and alert the public to the latest scams. The state's housing authority agencies issue a multitude of rules and regulations associated with housing.	These representatives can provide information on relevant regulations and help determine strategies for change.
Municipal leaders (e.g., mayors, aids, chiefs of staff, boards of health)	Local government and public officials are responsible for administering local laws, rules, and regulations. They are generally elected officials who represent the residents of the community and their needs.	It is important to engage local government to keep them abreast of the issue of elder mistreatment in the community. They can be champions and/or gatekeepers to those who will take an active role in addressing elder mistreatment in the community.
Local business leaders and organizations (e.g., chambers of commerce)	These organizations bring the business community together to create networks and lobby for issues related to business.	These organizations and leaders have a stake in a safe and vibrant community and may provide avenues for prevention and intervention efforts.

Additional members and roles can be found in the Department of Justice's MDT Guide and Toolkit.

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