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The forensic lens: Bringing elder neglect into focus in the emergency department

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Abstract

We present two case studies of older patients who were brought to the emergency department (ED) in severely debilitated states. Both presented with severe malnutrition, contractures, decubiti, and

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Honoraria		X	X		X		X	
Speaker Forum		X	X		X		X	
Consultant		X	X		X		X	
Stocks		X	X		X		X	
Royalties		X	X		X		X	
Expert Testimony		X	X		X		X	
Board Member		X	X		X		X	
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were nonverbal with histories of dementia and end-stage disease. Their primary caregivers, adult children, were uncooperative with Adult Protective Services (APS) and disregarded treatment recommendations. Although both elders had signs suspicious of neglect, a comprehensive review revealed many layers of complexity. We use these cases to illustrate an approach to the assessment of possible elder neglect in ED settings and how to intervene to ensure patient safety. We begin with a discussion of the differences between *willful*, *unintentional*, and *unsubstantiated* neglect by a caregiver, and then describe when to suspect neglect by evaluating the elder, interviewing the caregiver and first responders, assessing the caregiver's ability to meet the elder's needs, and, if possible, obtaining past medical history and information about the home care environment. These cases illustrate the importance of careful documentation in cases of suspected neglect in order to assist investigative agencies, reduce the risk of further harm, and improve patient outcomes.

Keywords

forensic center; caregiver neglect; elder abuse; emergency physician; multidisciplinary team; forensic lens

Introduction

Case 1

Responding to a 9-1-1 call from Adult Protective Services (APS), paramedics found Mr. K., age 73, clothed in only a T-shirt, lying in the fetal position in a dimly lit bedroom in the back of his home. Paramedics observed that he was emaciated, filthy and in pain. At the emergency department, Mr. K was awake but disoriented with generalized weakness, contractures, cachexia, hypoalbuminemia, and a BMI of 15.6, indicative of severe malnutrition. Records showed he had a history of Alzheimer's disease, alcoholism, tobacco use, diabetes, and chronic obstructive pulmonary disease. Early-stage pressure ulcers covered his left side. Test results for leukocytosis and hypercalcemia pointed to a finding that was confirmed by chest X-ray: a right lung mass measuring 12cm × 8.5cm was later determined to be non-small cell lung cancer and had metastasized to bone.

Mr. K's son lived in the home and was intoxicated when the paramedics arrived. He rejected recommendations for moving his father into a skilled nursing facility, insisting that his father's wishes were to live and die at home. Mr. K's inadequate dress, high pain level, malnutrition, multiple decubiti, and his caregiver's lack of response to the gravity of his condition were all red flags for elder neglect.

Case 2

Mr. M., age 85, with end-stage Parkinson's disease, was brought to the emergency department (ED) by his daughter who lived in his home. Mr. M was nonverbal but presented with significantly deteriorated health, impaired physical and cognitive function, and multiple decubiti ranging from Stage I to Stage III. Like Mr. K.'s son, Mr. M's daughter insisted that he be discharged back to her care and challenged the hospital's recommendation to place him in a skilled nursing facility. The physician believed that Mr. M required professional

care and made a report to APS with suspicion of elder neglect. The same red flags were present: poor nutrition, contractures, multiple decubiti, and an uncooperative caregiver.

Elder Neglect—A seminal report by the National Research Council defined elder neglect as “failure by a caregiver to satisfy the elder's basic needs or protect the elder from harm.”¹ Examples include failure to ensure the elder's physical safety, failure to help with personal care, and/or failure to prevent malnutrition or dehydration.² The American College of Emergency Physicians recommends that emergency personnel screen patients for elder mistreatment³ and laws mandate that healthcare providers report suspicions of neglect to APS in 49 states and the District of Columbia.⁴

Elder neglect can be difficult to diagnose. Symptoms are often confounded with end-of-life physiologic states,⁵ and, unlike other forms of elder mistreatment such as physical or sexual abuse, neglect stems from an omission of care as well as actions that inflict harm, like physical restraints and social isolation. As these two cases demonstrate, patients may be unable to report poor quality care due to cognitive impairment, advanced illness, or, ultimately, death.² Others may deny mistreatment for fear of angering and/or losing their caregiver.⁶

There are important distinctions between *willful* neglect, *unintentional* neglect, and sub-acute symptoms caused by an underlying illness that manifest as neglect in spite of a caregiver's best efforts. Examples of willful neglect are intentionally denying food, water, and medication, use of physical restraints, or isolating the elder thereby withholding emotional stimulation and social interaction.⁷ Some caregivers have underlying motives like financial compensation, free housing, desire for power and control, and retaliation for dementia-related problem behaviors by the elder.⁸ Other caregivers may have mental illness⁹ or substance abuse disorders.

Conversely, unintentional neglect occurs when a caregiver lacks the necessary resources, strength, psychological stability, maturity, or skills to meet the elder's needs.⁷ Physical or cognitive impairments, inadequate training (e.g., wound care, administering injections), mistrust of the health care system, and limited support can also compromise care. In other situations, elders present with advanced geriatric conditions that are difficult to manage even by skilled professionals, including extreme frailty, loss of skin integrity, weight loss, and poor mental functioning. Even with optimal care, physiological states may develop in dying persons that are not caused by willful or unintentional neglect.¹⁰

This complexity, coupled with lack of training in identifying mistreatment,¹¹⁻¹⁴ make it especially difficult for ED personnel to identify neglect although they are often the first healthcare providers to interact with victims and caregivers. Victims often receive low levels of social support and infrequent primary care,¹⁵ which are risk factors for ED use,¹⁶ and some frail elders arrive to the ED by ambulance due to caregiver inability to transport them. Emergency physicians may feel trapped between doing too little—failing to identify neglect, not reporting, and increasing risk of further harm—and doing too much—accusing a caregiver of neglect, eroding trust, and inhibiting caregivers from providing care consistent with the patient's preferences.^{17,18} Given the aging of the population, emergency physicians

need to be prepared to balance their obligations to the patient by documenting findings, reporting suspicions, and referring to appropriate agencies.

The Forensic Lens

The “forensic lens”¹⁹ involves using medical expertise to answer questions pertaining to criminal justice and the law. The forensic lens is intended to help investigators evaluate the entire clinical, social, and legal scenario when determining the cause of elder mistreatment. Objective documentation of the signs of neglect is helpful to neglect investigators who may subpoena health records if the case is referred for prosecution. While emergency providers are unlikely to be involved in the entire investigation process, viewing patients and their medical presentations through a forensic lens will help providers assess the possibility of neglect and improve patient outcomes.

Evaluating the Elder

All older patients presenting to the ED with signs suspicious of neglect should be interviewed privately at some point during the evaluation. If the patient is unable to answer questions, like Mr. K and Mr. M, individuals who have knowledge of the patient (caregivers, family members, home care workers, primary care physician) may be able to provide information. We recommend starting with general questions about care at home followed by more specific questions regarding neglect.²⁰

Observation of a patient's behavior is critically important at the ED encounter, particularly when the patient cannot communicate. If the patient is alert, nonverbal clues such as changes in demeanor or guarded body language in the presence of the caregiver could indicate fear and anxiety. The physician should note general appearance (cleanliness, hygiene, dress) and state of nutrition and hydration. Specific attention should be paid to dental hygiene, contractures, decubiti, bruises, untreated injuries, and elongated toenails.²⁰ Whenever possible, the provider should take photographs of pressure ulcers and other injuries, and document their locations, color, and size on a body map (a drawing of the injuries on a body diagram). Severe weight loss and pressure ulcers may be signs of neglect, but can also be markers of end-stage disease. The context in which they develop is important.

Some laboratory findings can be useful in determining whether neglect has occurred. Hypernatremia ($\text{Na} > 145$), elevated BUN/Creatinine ratio (>20), and elevated hemoglobin/hematocrit suggest dehydration. Other markers of malnutrition are anemia, low serum albumin (<3.5 g/dL), low prealbumin, and low lymphocyte count ($<1500/\text{mm}$).²¹ Toxicology panels can show inappropriate use of chemical restraints and overuse/underuse of medications.

Evaluating the Caregiver

Caregivers should be interviewed separately from the patient using a nonjudgmental and person-centered approach.²⁰ Questions should focus on the patient's medical conditions, daily care needs, medications and assistance provided. The caregiver's mental/physical health and access to support resources (other family caregivers, in-home care, financial resources, transportation) is important. The physician can look for inconsistencies between

the elder's condition and the caregiver's narrative, and assess the caregiver's attitude toward the elder. Questions should elucidate gaps in the caregiver's understanding of the elder's condition and the extent to which their cultural or religious beliefs, as well as personal coping styles, influenced care choices.

Neglect may occur when caregivers can't perform the tasks they claim to do, such as helping administer medications and preparing regular meals. By actively involving caregivers in the history and medical evaluation of the patient, emergency physicians can observe how caregiving duties are performed and whether additional training could help. For example, the physician could ask Mr. K's and Mr. M's caregivers, *"I understand that your father has some pressure ulcers. Can we take a look at them together?"* By focusing on the patient's health, the physician can avoid questions that could be construed as condescending or accusatory. Rather, questions should be task-based: *"How often do you change these dressings? Can you show me how you do it?"*

Obtaining Collateral Information

Although not always readily accessible, when available, health records may provide important clues about the caregiver's commitment to the elder, and patterns such as missed appointments, delay in seeking treatment, and medication noncompliance. Records can also show previous hospitalizations, diagnoses, trajectory of cognitive and physical impairment, failure to follow through with a physician's recommendations, and previous signs/reports of neglect. If available, chart notes from social services agencies and visiting home care workers also offer insights. Busy ED physicians do not typically have patients' medical records on hand, but federal initiatives to develop a nationwide health information network may eventually make them easier to access.^{22,23}

ED personnel should attempt to contact the patient's primary care physician to determine when the elder was last evaluated, for how long s/he has been a patient, and to ask about the caregiver's competency. If the patient has no primary care physician, ED personnel should be attentive to any other signs that the elder is not getting proper care. Emergency responders may also have information about the home environment and the caregiver. If the patient was accompanied to the ED by APS or law enforcement, their observations should be noted along with their motivation for seeking emergency services for the patient. If they are involved, hospice workers, personal care aides, occupational therapists, and other friends/family members can also be contacted for information.

Revisiting Mr. K and Mr. M

Based on the medical examinations, caregiver interviews, and health records, Mr. K and Mr. M were both reported to APS for neglect. APS brought these cases to an elder abuse forensic center for review. The forensic center is a multidisciplinary team that brings together APS, law enforcement, district attorneys, public guardians, health professionals, and forensic neuropsychologists.²⁴ This team used a systematic approach to differentiate between willful neglect, passive neglect, and end-of-life physiologic states not caused by neglect (unsubstantiated neglect).

Health records offered key details in both cases. They showed that Mr. M developed the decubiti during a temporary stay at a skilled nursing facility, which left his daughter with a strong prejudice against nursing homes and a general suspicion of the medical system. Although a caregiver's failure to seek medical treatment is one form of elder neglect,² it became apparent that she sought hospital care for her father in emergency situations, but once his condition stabilized, she believed she could provide better care at home. She was able to demonstrate how she rotated her father to relieve pressure, changed his dressings, and administered medication, proving she routinely did these tasks. Records showed that a home care agency had come weekly until Mr. M's condition became so severe that they refused to accept liability for his care. Mr. M's daughter admitted that she had promised to care for him until his death but had difficulty accepting his prognosis.

In comparison, Mr. K had not seen a doctor in several years and was not receiving any medications or in-home services. Three years prior to the APS report, a chest computerized tomography scan detected a 9mm mass in the upper lobe of his right lung, suspicious for malignancy. Records stated Mr. K was "lost to follow-up" after he missed a subsequent oncology appointment and medications were not refilled. When the APS worker asked Mr. K's son why he did not take him to see a doctor or administer medications, he replied, "*He doesn't need to see a doctor or take medicine because he is dying.*" The son's indifference toward seeking treatment contributed to Mr. K's pain and may have hastened death. Later investigations by the forensic center revealed that the son was compensated through the state's In-Home Supportive Services program and was the representative payee for Mr. K's social security benefits. By keeping Mr. K at home, the son received these benefits and avoided paying for professional care.

These two cases share a number of similar features: Mr. K and Mr. M. were fully dependent on their cohabitating adult children, both were experiencing the end stage of debilitating illnesses and were nonverbal, and both caregivers claimed that the elders' final wishes were to die at home. Despite these similarities, the forensic center arrived at different conclusions about which caregiver intentionally neglected the patient and how to address each situation, underscoring the importance of carefully documenting the entire clinical scenario in the ED.

Pulling Back the Curtain: A Visit to the Home

In forensic center investigations, team members may recommend a home visit to evaluate the elder and assess the appropriateness of the care setting. Although emergency physicians typically do not examine patients in their homes, first responders—APS, paramedics, and law enforcement—may be able to provide information about safety issues and potential hazards such as extreme temperatures, lack of water or electricity, weapons, aggressive pets, or caregivers or other residents with mental illness or substance abuse problems.²⁵ For example, Mr. K's son was intoxicated the morning paramedics were called, and Mr. M's daughter screamed at investigators to leave, requiring them to involve the police.

When inside the home, emergency responders should note the following: *Where is the elder in relation to other residents? How do the elder's living conditions compare to other parts of the household?* Mr. K's back bedroom was sparsely furnished and unclean, discordant with the elegantly remodeled area where his son resided. He was lying exposed on a filthy

mattress, a half-empty glass of a nutritional supplement collected dust and fruit flies on his bedside table, and medications were untouched. Although Mr. M's home was mildly cluttered, his bedroom was the center of activity. It was furnished with a hospital bed and air mattress to prevent decubiti, a lift to transport him to a wheelchair, an IV pole to administer fluids, and a supply of gauze pads.

To augment any information that first responders can provide, physicians should ask the caregiver about what medical equipment is used, if any, and how the elder's needs are met when the caregiver is away. Other considerations include whether food, medications, and assistive devices are within easy reach, whether the elder has access to clean water and an appropriate place to sleep and eat.

In a busy emergency department setting, an ED physician may not have the time to gather all of this information. If they have concerns that the home is not safe, especially if it appears that the elder will not be admitted or will be taken AMA, physicians can ask the ED or hospital social worker to contact local agencies and/or community partners to conduct welfare checks and home assessments²⁶ and assist in disposition planning.

Reporting

ED providers are not responsible for determining the cause of neglect, but if they have suspicions, and particularly if further harm is possible, they should contact APS immediately in compliance with mandatory reporting laws and emergency department protocol.^{27,28} If there is imminent concern for safety, law enforcement should also be contacted right away.

After receiving a report, APS investigates the allegations and may cross-report to law enforcement. An investigation typically involves meeting face-to-face with the elder to conduct a needs assessment and safety check. APS cannot share details about ongoing investigations, but can share their concerns with the ED physician if they called for emergency services. This information can help inform the disposition decision.

Achieving a Safe Disposition

Emergency medical care is the first priority when neglect is suspected, but situational assessment, reporting suspicions, long-term planning, and preventing further risk are also essential. Proper use of the diagnostic code for Adult Maltreatment (unspecified) can be useful in ensuring care (ICD10: suspected T76.91, confirmed T74.91). If there is immediate danger, contact between the patient and caregiver must be prevented. Hospitalization is one option, however if there is no medical need for hospitalization, safe placement in another care facility is advisable.

Elder abuse interventions differ from child abuse interventions because ED physicians must respect the autonomy of mentally competent adults. If the patient refuses intervention, the ED physician must determine if the elder has the capacity to make decisions. In questionable cases, a psychiatric consultation may be helpful. If the elder lacks capacity, APS, hospital social workers, and the medical team can consider a court ordered guardianship. If the caregiver attempts to take the patient home against medical advice, the ED physician should

determine if the caregiver has a valid power of attorney. Several other options can be considered: medical hold, admission for safety (under alias with restricted visits), risk management, and ethics consultation. An elder who has capacity has the right to refuse intervention, but should be educated about risk and resources. In either case, a report should be made to APS.

When there is less concern for danger, but signs of neglect are present, interventions can be more individualized. If the elder can be safely discharged home, a follow-up plan should be developed with the primary care physician. A hospital social worker can help coordinate community services to assist a well-intentioned caregiver to provide better care. Options include: referral for Medicare, in-home services, Meals on Wheels, transportation services, adult day care, and hospice care.

Outcomes

Mr. K's and Mr. M's cases demonstrate the complexity of elder neglect and how two cases with similar features in the initial assessment have different underlying dynamics that lead to different interventions. If the case is referred for prosecution there must be clear evidence of criminal negligence, like the behavior demonstrated by Mr. K's son. This means that the caregiver acted in a reckless way that created a high risk of death or great bodily injury, and he knew that acting that way would create such a risk.²⁹ In contrast, if the caregiver did not understand the elder's prognosis and needs for end-of-life care, as with Mr. M, the goal of APS and physicians is to support the caregiver through referrals to community-based services.³⁰

In Mr. K's case, law enforcement conducted an investigation and the forensic center geriatrician reviewed all medical records to produce a report documenting the signs of neglect. To ensure that Mr. K was safe, APS involved his daughter who lived out-of-state. She hired a hospice agency to manage Mr. K's care until he passed away. Although the case was filed for prosecution, Mr. K's son was never indicted as is typical of most elder neglect cases. Actions which might have made indictment possible would be bringing in law enforcement as early as possible, more detailed documentation by medical providers on the elder's medical condition and its evolution over time, and systematic examination of the caregiver's attentiveness and approach.

In Mr. M's case, when the forensic center geriatrician conducted a home evaluation, it became apparent that his daughter desperately wanted to care for him at home and stated that this was Mr. M's preference as well. After a lengthy family meeting, APS, law enforcement, and the geriatrician helped her understand her father's prognosis and validated her desire to care for him. A hospice agency was found and she was referred to respite and counseling services. This case was not further investigated by law enforcement.

Conclusion

Using the forensic lens approach that focuses on both the elder and the caregiver, physicians can gather important information that could allow later investigation to differentiate negligent care from situations involving overwhelmed caregivers and/or conditions related to

end-of-life. Ultimately, the definitive determination of whether a patient is being neglected is the responsibility of APS and the criminal justice system. The emergency physician's responsibilities are to initiate the investigation by reporting to APS and law enforcement (if required), provide detailed documentation, and ensure the patient's safety. Emergency physicians can also help prevent misunderstandings about elder neglect by encouraging patients to document care preferences, involve others in care planning, and communicate with their caregivers about how to fulfill their wishes.

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References

1. Bonnie, RJ.; Wallace, RB. Concepts, definitions and guidelines for measurement elder mistreatment: Abuse, neglect, and exploitation in an aging America. Washington, D.C: The National Academies Press; 2002. p. 1
2. Fulmer T, Guadagno L, Dyer CB, et al. Progress in elder abuse screening and assessment instruments. *J Am Geriatr Soc.* 2004; 52(2):297–304. [PubMed: 14728644]
3. American College of Emergency Physicians (ACEP). Domestic family violence. Approved by the ACEP Board of Directors. 2007. [online] <https://www.acep.org/Clinical---Practice-Management/Domestic-Family-Violence/>
4. Lachs MS, Pillemer KA. Elder Abuse. *NEJM.* 2015; 373(20):1947–1956. [PubMed: 26559573]
5. Homeier DC. Aging: Physiology, disease and abuse. *Clin Ger Med.* 2014; 30(4):671–86.
6. Enguidanos SM, DeLiema M, Aguilar I, et al. Multicultural voices: Attitudes of older adults in the United States about elder mistreatment. *Ageing Soc.* 2014; 34(5):877–903. [PubMed: 25364064]
7. Nerenberg L. Communities respond to elder abuse. *J Gerontol Soc Work.* 2006; 46(3–4):5–33. [PubMed: 16803775]
8. Paveza GJ, Cohen D, Eisdorfer C, et al. Severe family violence and Alzheimer's disease: Prevalence and risk factors. *Gerontologist.* 1992; 32(4):493–97. [PubMed: 1427252]
9. Beach SR, Schulz R, Williamson GM, et al. Risk factors for potentially harmful informal caregiver behavior. *J Am Geriatr Soc.* 2005; 53(2):255–61. [PubMed: 15673349]
10. Collins KA, Presnell SE. Elder neglect and the pathophysiology of aging. *Am J Forensic Med Pathol.* 2007; 28(2):157–62. [PubMed: 17525570]
11. Mosqueda L, Xinqi D. Elder abuse and self-neglect: “I don't care anything about going to the doctor, to be honest...”. *JAMA.* 2011; 306(5):532–40. [PubMed: 21813431]
12. Wagenaar DB, Rosenbaum R, Page C, et al. Primary care physicians and elder abuse: Current attitudes and practices. *J Mm Osteopath Assoc.* 2010; 110(12):703–11.
13. Jones JS, Veenstra TR, Seamon JP, Krohmer J. Elder mistreatment: National survey of emergency physicians. *Ann Emerg Med.* 1997; 30:473–79. [PubMed: 9326862]
14. Clark-Daniels CL. Abuse and neglect of the elderly: Are emergency department personnel aware of mandatory reporting laws? *Ann Emerg Med.* 1990; 19(9):970–77. [PubMed: 2393181]
15. Fulmer T, Paveza G, VandeWeerd C, et al. Neglect assessment in urban emergency departments and confirmation by an expert clinical team. *J Gerontol A-Biol.* 2005; 60(8):1002–06.
16. Acierno R, Hernandez MA, Amstadter AB, et al. Prevalence and Correlates of Emotional, Physical, Sexual, and Financial Abuse and Potential Neglect in the United States: The National Elder Mistreatment Study. *Am J Public Health.* 2010; 100(2):292–97. [PubMed: 20019303]
17. Aminzadeh F, Dalziel WB. Older adults in the emergency department: a systematic review of patterns of use, adverse outcomes, and effectiveness of interventions. *Ann Emerg Med.* 2002; 39(3):238–47. [PubMed: 11867975]
17. Faulkner L. Mandating the reporting of suspected cases of elder abuse: An inappropriate, ineffective and ageist response to the abuse of older adults. *Fam Law Quart.* 1982; 16(1):69–91.

18. DeLiema M, Navarro AE, Enguidanos SM, et al. Voices from the frontlines: Examining elder abuse from multiple professional perspectives. *Health Soc Work*. 2015; 40(2):15–24.
19. Burgess, AW. *Violence through a forensic lens*. 2nd. King of Prussia, PA: Nursing Spectrum; 2000.
20. Anglin, D.; Schneider, DC. *Rosen's Emergency Medicine: Concepts and Clinical Practice*. 6th. Philadelphia, PA: Mosby; 2006. Elder abuse and neglect; p. 885-892.
21. LoFaso VM, Rosen T. Medical and laboratory indicators of elder abuse and neglect. *Clinics in Geriatric Medicine*. 2014; 30(4):713–28. [PubMed: 25439637]
22. Shapiro JS, Kannry J, Lipton M, et al. Approaches to patient health information exchange and their impact on emergency medicine. *Ann Emerg Med*. 2006; 48(4):426–32. [PubMed: 16997679]
23. DeSalvo KB, Dinkler AN, Stevens L. The US Office of the National Coordinator for Health Information Technology: Progress and promise for the future at the 10-year mark. *Ann Emerg Med*. 2015
24. Navarro AE, Wilber KH, Yonashiro J, et al. Do we really need another meeting? Lessons from the Los Angeles County Elder Abuse Forensic Center. *Gerontologist*. 2010; 50(5):702–11. [PubMed: 20233729]
25. Gerson LW, Schelble DT, Wilson JE. Using paramedics to identify at-risk elderly. *Ann Emerg Med*. 1992; 21(6):688–91. [PubMed: 1590608]
26. Heath JM, Kobylarz FA, Brown M, et al. Interventions from home-based geriatric assessments of adult protective service clients suffering elder mistreatment. *J Am Geriatr Soc*. 2005; 53:1538–42. [PubMed: 16137284]
27. Jones J, Dougherty J, Schelble D, et al. Emergency department protocol for the diagnosis and evaluation of geriatric abuse. *Ann Emerg Med*. 1988; 17(10):1006–15. [PubMed: 3177986]
28. Emergency Department Guidelines. American College of Emergency Physicians and Emergency Nurses Association. *Ann Emerg Med*. 2014; 63(5):e7–e25.
29. CALCRIM. San Francisco: CA: LexusNexus; 2015. Judicial Council of California Jury Instructions, 2015 Edition; p. 749[online] http://www.courts.ca.gov/partners/documents/calcrim_juryins.pdf [Accessed July 19, 2015]
30. Brookoff D, Minniti-Hill M. Emergency department-based home care. *Ann Emerg Med*. 1994; 23(5):1101–06. [PubMed: 8185107]

Figure 1. Intervention decision chart for ED providers who suspect elder neglect