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Emergency Medical Services Perspectives on Identifying and Reporting Victims of Elder Abuse, Neglect, and Self-Neglect

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Abstract

Background—Emergency Medical Services (EMS) providers, who perform initial assessments of ill and injured patients, often in a patient's home, are uniquely positioned to identify potential victims of elder abuse, neglect, or self-neglect. Despite this, few organized programs exist to ensure EMS concerns are communicated to or further investigated by other health care providers, social workers, or the authorities.

Objective—To explore attitudes and self-reported practices of EMS providers surrounding identification and reporting of elder mistreatment

Methods—Five semi-structured focus groups with 27 EMS providers

Results—Participants reported believing they frequently encountered and were able to identify potential elder mistreatment victims. Many reported infrequently discussing their concerns with

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DECLARATION OF INTEREST

Conflicts of interest: none.

other health care providers or social workers and not reporting them to the authorities due to barriers: (1) lack of EMS protocols or training specific to vulnerable elders, (2) challenges in communication with emergency department providers, including social workers, who are often unavailable or not receptive, (3) time limitations, and (4) lack of follow-up when EMS providers do report concerns. Many participants reported interest in adopting protocols to assist in elder protection. Additional strategies included photographically documenting the home environment, additional training, improved direct communication with social workers, a dedicated location on existing forms or new form to document concerns, a reporting hotline, a system to provide feedback to EMS, and community paramedicine.

Conclusions—EMS providers frequently identify potential victims of elder abuse, neglect, and self-neglect, but significant barriers to reporting exist. Strategies to empower EMS providers and improve reporting were identified.

Keywords

elder abuse; elder neglect; self-neglect; emergency medical services

INTRODUCTION

Focusing on optimizing care provided to geriatric patients is important for Emergency Medical Services (EMS) providers. Older adults (aged ≥65) are four times more likely than younger patients to utilize EMS services and represent 38% of total EMS responses with transport to the Emergency Department (ED).¹ With anticipated increases in the geriatric population, providing care for older adults will likely become an even larger proportion of EMS practice.^{1,2}

Cases of elder abuse, neglect, and self-neglect are common in geriatric patients and may have serious medical consequences but are rarely identified. An estimated 5–10% of older adults experience elder mistreatment each year.^{3–8} This mistreatment may include: physical abuse, sexual abuse, emotional/psychological abuse, financial exploitation, or neglect.^{3–7} In addition, many older adults self-neglect,^{9,10} threatening their own health and safety by failing to perform or refusing assistance with essential self-care. Elder mistreatment victims have significantly increased mortality^{8,11,12} and are at higher risk for adverse health outcomes including depression,¹³ disability,¹⁴ hospitalization,¹⁵ and nursing home placement.^{16,17} Unfortunately, fewer than 1 in 24 cases of elder mistreatment are identified and reported to the authorities.⁵ Evaluation by health care providers for acute injury or illness represents an important potential opportunity to identify elder mistreatment,¹⁸ as this may be the only time these vulnerable and isolated older adults leave their home.^{19,20}

Emergency Medical Services (EMS) providers, who perform initial assessments of ill and injured patients after activation of the 911 system, often in a patient's home, are uniquely positioned to identify vulnerable older adults who may be mistreatment victims. While providing acute care and transporting, EMS may observe unusual or inappropriate interactions between the caregiver or family and the patient. They may also observe or investigate the safety of the home environment for the older adult, including cleanliness and upkeep as well as the availability of food, medications, and heat. Despite this potential, few

organized programs exist to ensure EMS observations and concerns are communicated to or further investigated by ED and other health care providers, social workers, or authorities, including Adult Protective Services (APS). In addition, little is known regarding EMS providers' attitudes toward their role in elder mistreatment detection and subsequent communication as well as their current practice and need for additional resources or support. Our goal was to qualitatively explore attitudes and self-reported practices of EMS providers surrounding identification and reporting of vulnerable older adults.

MATERIALS AND METHODS

Study Design

We conducted a qualitative study utilizing focus groups with practicing EMS providers to better understand their views on elder mistreatment, as these have not been previously described. Qualitative approaches are particularly useful to investigate topics about which little is known and to answer research questions not amenable to quantitative techniques.^{21–23} Focus groups have become a widely accepted health research methodology and are ideal to closely examine the complexity of a group's perspective on a topic and to identify shared opinions and experiences.^{24,25}

To conduct these focus groups, we developed a semi-structured questionnaire based partly on an existing instrument²⁶ that included questions such as: Do you think that you encounter elder abuse and neglect frequently in your practice? Do you routinely assess for self-neglect as part of your evaluation? Do you think that you are able to identify elder abuse or neglect in your patients when it is occurring? What risks or potential consequences of self-neglect concern you when you encounter a situation of self-neglect? What do you think are the barriers to identifying cases of elder abuse? How about neglect? Do you see any potential solutions to these barriers or changes that might be beneficial? Do you think that more patients should be screened for self-neglect? The interview guide was piloted for content and comprehension and modified based on suggestions made during this preliminary phase. The complete guide is available as an online supplement and on [xxx.com](#). This study was approved by the ____ Institutional Review Board. We used the Consolidated Criteria for Reporting Qualitative Research to guide collection, analysis, and reporting of the data.²⁷

Setting and Participants

We conducted focus groups comprised of EMS providers employed by a single large, private, hospital-based ambulance service in the New York City area. This EMS service employs 350 paramedics and emergency medical technicians (EMTs) and has 44 ambulances. It is part of a large health care network with five campuses and seven affiliated acute care hospitals. Participants were recruited at regular continuing education sessions.

Data Collection

Focus groups were conducted from October, 2014 – February, 2015. Each focus group was moderated by either one or two of the authors. Moderators included TR, MS, and RM, emergency physicians with additional geriatrics training, EB, a public health gerontologist with experience working in elder justice, and CL, an internal medicine physician pursuing

additional fellowship training in geriatrics. Each interview was audio-recorded and professionally transcribed.

Data Analysis

The interview transcripts were coded and analyzed in detail by the lead author (TR) using content analysis. We developed a set of codes a priori and an additional set of codes that emerged from the data. Analysis began while focus groups were still ongoing and was conducted iteratively. Coding was reviewed by the second author (EB) and discrepancies were resolved by consensus. We continued to conduct focus groups until we reached data saturation. The results of the coding were reviewed and themes discussed with the investigative team.

RESULTS

Characteristics of Participants

We conducted five semi-structured focus groups with a total of 27 participants, including 20 paramedics and 7 EMTs. Nineteen percent of participants were female. Paramedics reported median experience of 16.5 years, with a range of 3–30 years. EMTs reported median experience of 11 years, with a range of 6–15 years. Focus groups ranged in duration from 24–69 minutes.

Experience Identifying Victims

EMS providers believed they were able to identify and frequently encountered vulnerable older adults, particularly victims of self-neglect and neglect. Representative dialogue included:

Focus Group #2, Paramedic #4: You walk in, and you see it. The poor hygiene of the house, the hoarding,...[the caregiver and the patient] yelling at each other. It's very frequent.

Focus Group #2, Paramedic #5: Usually, the older patients will just start blabbing..."My son...he tells me not to do this...or he...he takes my money, he took my check." Those are the little comments you hear....There might be some truth to it, but it's not the main purpose we're here for at the moment. So, obviously, when we get to the hospital, I'm like: "Hey, this gentleman's...a little demented but [said these things]...Somebody just check up on it."

Many EMS providers reported that interactions between patients and caregivers raised their suspicion.

Focus Group #3, EMT #5: When I walk into the scene, I try to watch how the patient is interacting with the caregivers...Sometimes, when a certain son or daughter walks in, the patient is very tense...where they don't want to be in the room with them versus with other caregivers they're very relaxed...Once I see that type of reaction from the patient, for me that flag goes up.

Focus Group #5, Paramedic #4: I've noticed at times...a family member who tends to speak for the patient, and, when the patient tries to get their input in there, they

don't allow them to – they'll over talk and say, "I'll handle it" or "I'll speak for you." So...that's...something you notice that doesn't come across as normal.

Focus Group #4, Paramedic #1: You can tell is somebody is being neglected. You can tell if they're mistreated half the time by the way they treat you.

A careful assessment of the home environment also often suggested neglect or self-neglect.

Focus Group #1, Paramedic #2: If things don't look right, if it looks dirty, if the person doesn't look like they're taking care of themselves, [I] look in the refrigerator, look in the kitchen, look in the sink, check the bathroom...Just do a visual inspection. See if there's anything...telling you this person's not being cared for properly. Look at their medications. What are the dates on the medications? Have they been getting their medications? How do their clothes appear? Is their bed clean? You'd be surprised—just little things, looking around, what you could find out.

Focus Group #3, Paramedic #3: I'll tell you one thing that's a red flag...When...you have multiple...[bottles of] the same medicine. They're maybe a couple years old, they're still in containers, different doctor's names. Those are the things that are something to look out for, something that you might want to report back to in the ER. When..they have four of the same medicine with different strengths in their medicine cabinet or their little medicine bag.

Focus Group #5, Paramedic #1: You'll look in the refrigerator, and you'll see evidence of animal infestation. You'll see expired food. When you look at the pill bottles, you'll see really old bottles, maybe the medication is out-of-date. And there doesn't seem to be an appropriate level of clothing that they're wearing...

Paramedic #2: ...The bathroom will be just filled up with stuff, where the tub is literally filled up with clothes, so obviously they're not bathing, they're not showering. The toilet might not work. Things of that nature.

Participants also reported wanting to identify and advocate for these patients. Representative dialogue included:

Focus Group #1, Paramedic #2: Real compassion is being able to...look at that person just like your own grandmother or grandfather...You ask yourself "Would I want them, my own grandmother or grandfather, to live this way?" That's when you take more initiative.

Focus Group #4, Paramedic #3: We worry about...making sure the patient is safe and not in danger.

Focus Group #1, EMT #3: The bottom line is: when we get a place that's really messed up, we care. It doesn't matter how cold you think you are, when you see something that's really bad...if you had a reporting agency, you would [report] to it. You would take the two minutes to do it because that's really all it takes." Hey, 122 Mockingbird Lane is hoarding or...unhealthy, unsafe. I think you should check it out. Any questions, call me back."

Several EMS providers reported screening for elder mistreatment if they suspected it by asking the patient whether he or she felt safe, often privately away from the potential abuser.

Focus Group #1, Paramedic #1: If I suspect it, I ask them...“Do you feel safe at home?”

Focus Group #1, Paramedic #1: I’ve had patients...where I’ve gotten them away from the caretaker, and I’ve asked them: Do you feel safe with this person taking care of you? And I’ve had them say: “No, I don’t feel safe. They don’t feed me, or they won’t give me medicine, or they won’t bathe me.” ...They’re scared.

Focus Group #1, Paramedic #6: If I find the caretaker is very standoffish,...[and] who [doesn’t] know that information [about the patient[...or] where the patient seems skittish or angry...at the caretaker. Those are the ones that I suspect, and...I will kind of dig further in. I’ll actually have the caretaker find another way to the hospital, and I’ll take the patient by myself just so I can talk to the patient without them being there. Because, ultimately, it’s our truck. We make the rules who comes in our truck, so if we don’t want someone in that we feel is going to be detrimental to our patient’s care, then we don’t let them in.

Barriers to Reporting

Many participants reported that, in spite of their desire to advocate for the older patients they encountered, they commonly did not discuss their concerns with other health care providers or social workers or formally report them to authorities. Providers were able to specify four barriers that prevented or discouraged them from doing, including: (1) lack of EMS protocols or training specific to vulnerable elders, (2) challenges in communication with emergency department providers, including social workers, who are often unavailable or not receptive, (3) time limitations, and (4) lack of follow-up when EMS providers do report concerns. These barriers are described in Table 1 with representative dialogue for each.

Solutions

Many participants reported significant interest in adopting protocols to assist in protecting older adults, and suggested several specific strategies to overcome the barriers that prevent EMS providers from effectively reporting their findings. Participants identified seven solutions to improve communication and reporting of vulnerable older adults. These included the opportunity to photographically document the home living situation, additional training for EMS providers, improved direct communication with social workers, a dedicated location on existing forms or a new form to document concerns, a hotline for reporting, a system to provide feedback to EMS providers on outcomes of the cases they identify, and community paramedicine with home visits. These are described in Table 2 with representative dialogue for each.

Additional Opportunities for Detection and Intervention

EMS providers also highlighted additional opportunities for detection of and intervention in elder mistreatment. Participants described the importance of their role in ensuring the safety of older adults who refuse transport to the ED.

Focus Group #4, Paramedic #1: There's a whole other [group]:...the people that we don't take to the hospital...that are in need of help but absolutely refuse to go to the hospital...That is going to go completely unreported to anybody.

Focus Group #1, Paramedic #4: [The patient] could refuse, [but if] we had a system where we could just drop a phone call [to a social services provider, saying] "Listen, we did a job at this location It might be worth taking a look at it."

Paramedic #1: ...If we were able to accept the refusal and we noted not good living conditions, that we suspect...[elder abuse, neglect, or self-neglect] is going on, if someone was able to follow up on that...send someone out from social service and check on that patient and determine whether or not [they're] okay...[if they] need help.

Participants also emphasized their ability to informally intervene to improve safety in the home, such as by moving furniture that presents a hazard:

Focus Group #2, Paramedic #1: You try to help out a little bit...

Paramedic #2: There's clearly...physical conditions in the house that are putting this person at risk of falling and injuring themselves so...

Paramedic #1: You separate the couch...

Paramedic #5: Move the bed to one side...Try to clear the...boxes that are behind the door because you want to have a full swing of that door to the bedroom.

Focus Group #4, Paramedic #1: I can clean up stuff, I can kick rugs out of the way. I can get him the right sock so, get his cane and stuff next to him, get him into bed.

DISCUSSION

EMS providers who conduct initial assessments of patients, often in their home environment, may play a critical role in identification, reporting, and intervention for vulnerable victims of elder mistreatment. Our participants reported already frequently identifying potentially vulnerable older adults as part of current practice and wanting to advocate further for their health and safety. EMS may be particularly helpful in the detection of self-neglect, which our participants reported seeing most commonly. An unsafe home environment is often a dangerous part of the self-neglect syndrome, and EMS providers may identify expired pill bottles, an empty refrigerator, hoarding, or vermin infestation, information to which hospital-based providers would not have access. Many self-neglecters have virtually no contact outside the home, making EMS' role critical in identifying these patients. Previous research has demonstrated that EMS personnel can use their access to patients' homes to screen older adults for mental health, environmental, and social problems including elder abuse and refer them to service agencies.²⁸ Other studies have shown that EMS providers can successfully screen for a broad spectrum of health issues, including fall risk,²⁹ depression,³⁰ medication management,³⁰ and immunization status.³¹ We found that EMS providers see themselves as advocates for vulnerable patients, as has been previously reported.³² This suggests that EMS providers would willingly take on additional responsibility for elder mistreatment assessment and reporting.

Despite the opportunity and desire to identify and report patients who may be elder mistreatment victims, EMS providers identified several significant barriers, including lack of existing protocols, communication issues, time constraints, and absence of feedback. Notably, they also identified potential solutions to overcome these barriers. Participants emphasized their reliance on protocols in care provision and the value of protocols in guiding their management of children who may be victims of mistreatment. Analogous protocols should be developed for elder mistreatment and their efficacy should be evaluated. These protocols should include provisions to optimize care and safety for patients who refuse transport and to manage hazards in the home environment, both of which were highlighted by our participants. Dissemination of these protocols also provides an opportunity for additional training of EMS providers, which participants identified as important. Currently, educational initiatives exist such as the Geriatrics Emergency Medical Services (GEMS) course,^{33,34} where EMS providers may receive specific training in recognizing elder mistreatment, and these should be expanded.

Challenges in communication including the loss of critical information during the handoff between EMS and ED personnel were reported by our participants and have been previously described.^{32,35} For elder mistreatment victims, the consequences of this information loss may be grave, as ED providers are unlikely to identify elder mistreatment themselves during their brief medical evaluation. This may result in discharge of these vulnerable older adults back into an unsafe environment or into the care of the abuser. Therefore, ensuring that EMS concerns or suspicions are successfully relayed is particularly important for these patients. Participants suggested improving direct communication with ED social workers who may further evaluate for elder mistreatment while the patient receives care in the ED. In smaller hospitals where social workers may not be available, standardized methods for communicating these concerns should be established. Participants suggested consideration of adding a section within the Ambulance Call Report (ACR) to record concerns about mistreatment or a separate form to report their concerns. The increasing use of electronic data entry by EMS may also offer opportunities to improve this communication.¹⁸ One particularly powerful method of communication highlighted by participants is photography. Photographs of a patient's living environment added to the ACR would allow ED personnel to see inside a patient's home, which may assist with care decisions. Previous research has suggested the potential utility of scene photographs in EMS practice.^{36–38}

Time constraints, which can make taking on new assessment protocols challenging,³⁹ and pressures to return to service immediately after delivering a patient to the ED are further barriers identified by participants. Given the potential value of additional in-home assessment while providing care to geriatric patients to evaluate for elder mistreatment as well as other issues, it may be worth considering increasing the anticipated time EMS providers spend responding to those calls. Further, EMS providers should be encouraged to directly communicate with ED personnel if they have concerns about elder mistreatment and should not be penalized for any resulting delays. Notably, despite time pressures, some EMS services report increased time with patients, largely due to delays in offloading.^{40,41} This offloading time offers an additional potential opportunity for an EMS provider to conduct elder abuse or neglect screening.

EMS providers typically provide care for patients for a short time and often do not see the outcome of the interventions they initiate or the information they pass on to ED personnel. Previous research has reported the desire among EMS personnel for patient-related feedback,³² which reinforces for them the importance of the care they provide. Our research supports this finding and also identifies the power of negative feedback in discouraging EMS providers and thereby suppressing reporting. If, after reporting concerns about a patient's home or social situation, an EMS provider responds to a call a week later to find that the hazardous circumstances haven't changed, it perpetuates the perception that their concerns were ignored and undermines their desire to report future cases. Protocols for EMS reporting of elder mistreatment should incorporate feedback about case outcomes, which will empower providers, encourage continued reporting, and provide additional opportunities for education.

Participants also suggested the potential for community paramedicine to intervene and ensure the safety for vulnerable older adults. This is an intriguing way to capitalize on EMS providers' unique skill set and role within the community. Using community paramedicine among older adults to improve health care utilization is already being evaluated,⁴² and expanding these programs to target vulnerable adults may help to provide services to those who need them most.

Limitations

This study has several limitations. As we interviewed paramedics and EMTs from a single urban, private EMS service, our findings may not be generalizable. Our study was conducted in New York State, which does not currently have a law mandating reporting of elder abuse by health care providers. Many other states have these laws, which may impact EMS provider practice. However, similar themes were uncovered in a recent study in the state of Texas,⁴³ which has mandatory reporting. Although the focus of that study was somewhat different, concentrating on the interaction of emergency personnel with APS, comparable issues were raised.⁴³ These included very low reporting rates by EMS and barriers to reporting including limited training and time limitations.⁴³ Other research has also suggested that mandatory reporting laws do not affect health care provider reporting of elder mistreatment.⁴⁴ Another limitation of our study is that participation was voluntary, and there is, therefore, the potential for selection bias, with participant views differing significantly from those of non-participants. Notably, however, of the potential participants we approached, only three did not participate. In all, this was due to scheduling conflicts. In addition, the qualitative nature of the study precludes making quantitative conclusions from findings. Though content analysis is an established research technique, themes and their categorization may be affected by the subjective way in which the transcripts are interpreted by the research team. Despite these limitations, we believe that this study improves understanding of an under-recognized issue in EMS practice and will inform future research.

CONCLUSIONS

EMS providers play a critical role in the care of older adults and are in an ideal position to detect and report elder mistreatment, including self-neglect, which can have a profound

impact on a patient's health. They already commonly identify it and want to advocate for these vulnerable patients. By empowering EMS providers, providing further training, and designing comprehensive protocols for assessment, information transfer, and feedback, it is possible to have a significant impact on care for these vulnerable older adults.

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ARTICLE SUMMARY

1. Why is this topic important?

EMS providers are uniquely positioned to identify potential victims of elder abuse, neglect, or self-neglect. Despite this, few organized programs exist to ensure EMS concerns are communicated to or further investigated by other health care providers, social workers, or the authorities.

2. What does this study attempt to show?

This study explores attitudes and self-reported practices of EMS providers surrounding identification and reporting of elder mistreatment

3. What are the key findings?

Though EMS providers believe they commonly encounter and are able to identify potential elder mistreatment victims, they infrequently discuss their concerns with other health care providers or social workers or report them to the authorities due to barriers including: absence of protocols or training, challenges in communication, time limitations, and lack of follow-up. Strategies for improvement identified included photographically documenting the home environment, additional training, improved direct communication with social workers, a dedicated location on forms to document concerns, a reporting hotline, a system to provide feedback to EMS, and community paramedicine.

4. How is patient care impacted?

EMS providers already commonly identify elder mistreatment and want to advocate for these vulnerable patients. Empowering EMS providers, providing further training, and designing comprehensive protocols for assessment, information transfer, and feedback, may have a significant impact on care for these older adult victims.

Table 1

Categories of Barriers to Communication/Reporting of Vulnerable Older Adults Identified by EMS Provider Focus Groups

Lack of protocols or training specific to vulnerable elders	<p><i>Focus Group #4, Paramedic #1: There's a lot of stuff established for reporting child abuse and neglect...but there's not a lot established as far as elder abuse goes.</i></p> <p><i>Focus Group #1, Paramedic #4: There's a...report for the kids [abuse]. There's no real protocol for the elderly.</i></p> <p><i>Focus Group #1, Paramedic #2: With elder abuse, it's provider-dependant...and there's no real reporting system... There's no real set criteria, like bruising, malnutrition, dirty house.</i></p>
Challenges in communication with emergency department providers, including social workers, who are often unavailable or not receptive	<p><i>Focus Group #4, Paramedic #1: In the middle of New York City in the afternoon, I can't even find a doctor...or anybody that's going to give me a moment to be like: "Hey, listen, I think this [elder abuse, neglect, or self-neglect] is going on."</i></p> <p><i>Focus Group #5, Paramedic #2: Most of the time, it's just reported verbally to the [triage] nurse...and then the expectation is that she'll take it from there to the proper chains... We let them know what is going on, which patients we feel need the extra attention.</i></p> <p><i>Paramedic #1: But there's no real way to follow through.</i></p> <p><i>Paramedic #2: Our assumption is...somebody will be able to pick up this ball that we've kind of got rolling.</i></p> <p><i>Focus Group #3, Paramedic #4: I'm going to mention it to the [triage] nurse...I'll say: "Listen, this guy's apartment is destroyed, Maybe they can do some sort of social work." If I'm in line with 400 other patients...400 other ambulances, who knows what really the nurse is going to do...Even if I did put it in the ACR [Ambulance Call Report], where is it going anyway?... With these electronic ACRs, half of them don't get faxed to the hospital. And...I'm pretty sure that nobody's looking.</i></p> <p><i>Focus Group #2, Paramedic #2: What we encounter very often is not really probably a case for law enforcement to intervene...but for social workers...The people I feel really have the tools and the ability to make a meaningful change in these people's lives is social work. And I think that there's a bit of a breakdown in communication between...EMS...and social work. And that's why a lot of these problems continue to persist.</i></p> <p><i>Focus Group #1, Paramedic #4: In our judgment, if we think it's abuse, we'll write it down, but we never see it come back. It gets brushed off... You tell the [triage] nurse they need a social worker, this and that, and that's where it ends...</i></p> <p><i>EMT/Paramedic #1: No matter...how much we push, at some point...it's out of our hands.</i></p>
Time limitations, as EMS providers are only allowed to remain in the emergency department for a short period	<p><i>Focus Group #1, Paramedic #6: Another problem...is the system is in a rush for us to get back into service... They'll say, "Why are you [there] for 50 minutes?... You should only be there for 20 minutes... Why are you in the hospital talking to Social Services? That's not your job."</i></p> <p><i>Focus Group #4, Paramedic #1: I think that one of the reasons that it [elder abuse, neglect, and self-neglect] does get overlooked so much is because of the lack of time that we have...I have people breathing down my neck to get in and out of the hospital as fast as I can... They keep us on a clock... They'll call you on the radio and say... "You've been there too long. You've got to go back to service."</i></p>
Frustration among EMS providers with lack of follow-up when they do report	<p><i>Focus Group #2, Paramedic #4: We mention [our concerns to ED providers]...[But] there's no follow-up after you leave.</i></p> <p><i>Paramedic #2: It's obvious that nothing happened because you return to the same place a week later and the same thing that you said needed to be fixed is still broken. And guess what? Not only is it still broken, but the same problem occurred in the exact same fashion...</i></p> <p><i>Paramedic #1:...Sometimes you have to feel like you're being heard. Because if I'm telling you and telling you, and I don't feel like I'm being heard, I'm going to be like, "I'm not going to tell anybody. I'm just going to do my job and go home."</i></p> <p><i>Focus Group #5, Paramedic #1: There's no real feedback...there's no real interaction.</i></p> <p><i>Paramedic #2: An that just brings about a sense of apathy...If nothing is being done, then why am I bothering?... I'm just wasting my time. And I'm bothering some other person who doesn't want to hear it, because nothing's going on. There could be wonderful things going on, but you have no idea.</i></p>

Table 2

Solutions to Improve Communication/Reporting of Vulnerable Older Adults Identified by EMS Provider Focus Groups

Photographic documentation of the home living situation	<i>Focus Group #2, Paramedic #5: If I tell you the house was in disarray, you're like, "Okay, well there was clothing strewn about, "No, no this" and you show them a photo. Then they're like, "wow, this place is a s***hole"...and that documentation just goes with the ACR.</i>
Protocol/additional training for EMS providers	<i>Focus Group #1, Paramedic #6: Everything in EMS is protocol-driven. If you give us the protocol, we'll follow it thoroughly. You write it down, we'll follow it. Focus Group #5, Paramedic #1: There should be a senior protocol...The protocol, getting the people to realize that there are [age-related] differences, I think is going to be the biggest push. Focus Group #1, Paramedic #4: Follow the same framework...like child abuse. I mean that system works. There's specific criteria: bruising, patterns of abuse. Paramedic #2:...There's very specific criteria. It's a framework that you follow.</i>
Improved direct communication with social workers, in person, via phone, or electronically	<i>Focus Group #1, Paramedic #4: Another great idea would be...more direct relationship between EMS and social services, because all that information trickles down and gets lost... We report to the nurse, nurse reports to the physician...and information gets lost. EMT #3: ...Specific social workers that just deal with EMS and cases like this. Paramedic #4: Right...A number that we could just call, report what our findings are... so [someone] can investigate.</i>
Designated area within the ACR to record concerns about abuse	<i>Focus Group #3, Paramedic #3: On our ACRs, have...a specific section. We have a section for...cardiac arrest. Why not have a section for abuse?...The ACR...it's a legal document that's in the patient's record.</i>
Additional form to report concern about potential elder abuse, neglect, or self-neglect	<i>Focus Group #3, Paramedic #3: If you think something is odd,...[then] you drop it on an actual form and send it to the proper authorities...It's out of our hands, but we did...what we're supposed to do.</i>
Dedicated hotline to allow real-time telephone reporting	<i>Focus Group #4, Paramedic #1: Maybe a hotline... Paramedic #3: A hotline would be perfect. Paramedic #1:... You could notice more trends, especially in the city because that person is not always going to the same hospital...But if you had a central office with a hotline...where you're constantly getting the same reports from...multiple different crews...multiple different hospitals for the same person.</i>
A system to provide feedback to EMS providers on outcomes of the cases they identify	<i>Focus Group #1, Paramedic #1: If we see [elder abuse, neglect, or self-neglect]..., we're going to at least report it to the nurse. What happens after that, we don't really know. Paramedic #6: ...[It would be great for ED providers to give] some positive feedback. Paramedic #1: Yeah. "Oh, what you told us worked out great. We were able to get this person help. This person's n longer caring for them. You, it would be great to hear that —to know that...what we said made a difference. Focus Group #2, Paramedic #4: If I speak to a nurse and mention the case, at least I need...feedback on that case. That will help us to know that what we're doing, it pays off... EMT/Paramedic #4: I want to know follow-up...I want to know what happened. Focus Group #5, Paramedic #1: An e-mail to the [EMS] staff member...would be a way to get feedback, or maybe a supervisor can be a central contact point or administration, and then a follow-up phone call could be made.</i>
Community paramedicine with follow-up home visits as part of a multi-disciplinary team after ED/hospital evaluation or regularly	<i>Focus Group #2, Paramedic #2: I think EMS is in a very unique position to do something about this. And, if we could team up with social workers and make house visits, I think we're in a position to appreciate both the medical and socioeconomic factors that affect these types of issues...and implement some...changes...with community paramedicine...I think it would be very effective. EMT #3: A crisis intervention team... Paramedic #2: To assist with...fall assessments, making changes in the home, evaluating...the medical devices that they have, their medications, how often they're getting their prescriptions filled. Focus Group #3, EMT #5: This would be the perfect opportunity for community paramedicine...to make monthly visits to all these geriatric patients to make sure their well-being is good...and where they're living is fine...The eyes and ears on the street is the medics and EMS, so why not use them to [take] the next step...preventative medicine.</i>