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Emergency Department Provider Perspectives on Elder Abuse and Development of a Novel ED-Based Multi-Disciplinary Intervention Team

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Abstract

Background: An emergency department (ED) visit provides a unique opportunity to identify elder abuse, which is common and has serious medical consequences. Despite this, emergency providers rarely recognize or report it. We have begun the design of an ED-based multi-disciplinary consultation service to improve identification and provide comprehensive medical and forensic assessment and treatment for potential victims.

Methods: We qualitatively explored provider perspectives to inform intervention development. We conducted 15 semi-structured focus groups with 101 providers, including: emergency physicians, social workers, nurses, technologists, security, radiologists, and psychiatrists at a large, urban academic medical center. Focus groups were transcribed, and data were analyzed to identify themes.

Results: Providers reported not routinely assessing for elder mistreatment and believed that they commonly missed it. They reported 10 reasons for this, including lack of knowledge or training, no time to conduct an evaluation, concern that identifying elder abuse would lead to additional work, and absence of a standardized response. Providers believed an ED-based consultation service would be frequently utilized and would increase identification, improve care, and help ensure safety. They made 21 recommendations for a multi-disciplinary team, including: the importance of 24/7 availability, the value of a positive attitude in a consulting service, and the

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importance of feedback to referring ED providers. Participants also highlighted that geriatric nurse practitioners may have ideal clinical and personal care training to contribute to the team.

Conclusions: An ED-based multi-disciplinary consultation service has potential to impact care for elder abuse victims. Insights from providers will inform intervention development.

Keywords

violence; domestic; geriatrics; qualitative research; emergency department

INTRODUCTION

Elder mistreatment, which includes physical abuse, sexual abuse, psychological abuse, financial exploitation, and neglect,^{1,2} is common, affecting 5–15% of community-dwelling older adults globally each year.^{1–4} This mistreatment leads to dramatically increased mortality as well as depression and nursing home placement.² Unfortunately, as few as 1 in 24 cases are identified and reported to the authorities,³ with delays in detection increasing the likelihood of poor outcomes.

An Emergency Department (ED) visit for acute injury or illness is an important potential opportunity to identify elder mistreatment and initiate intervention, as this may be the only time a vulnerable, isolated older adult leaves his/her home.^{5,6} The importance of ED-based identification of elder mistreatment has begun to be recognized around the world.⁷ The ED already plays an important role in the identification of and intervention for other types of family violence, including child abuse⁸ and intimate partner violence among younger adults.⁹

Despite the prevalence of elder mistreatment and potential value of identifying it, emergency providers rarely recognize or report abuse.^{6,10,11} Reasons for this are poorly understood but may include time constraints, inadequate training and experience, and concern about involvement in the legal system.^{10,12} Identification of and intervention for social issues including family violence and victimization among ED patients is typically in the purview of social workers, who work closely with medical providers in many EDs. Increasingly, EDs have recognized the value of social workers to the care team,¹³ particularly for older patients,¹⁴ and large EDs often have social workers in the department 24/7. In addition to medical providers and social workers, other members of the ED team observe and interact with a patient during the visit and may contribute to identification.⁶

We have begun the design of an ED-based multi-disciplinary intervention: a novel consultation service to improve identification and to provide comprehensive medical and forensic assessment and treatment for potential victims. This intervention is modeled on child protection teams, which were initially proposed >50 years ago and exist in many large hospitals in the US and worldwide.^{8,15} To inform the development and implementation of this intervention, our goal was to qualitatively explore perspectives of medical providers, social workers, and other ED team members on elder mistreatment and the proposed multi-disciplinary team.

METHODS

Study Design

We conducted a qualitative study utilizing focus groups with practicing ED providers from multiple disciplines to improve understanding of both current practice surrounding elder abuse identification and the potential for a multi-disciplinary team intervention. Qualitative approaches are particularly useful to investigate topics about which little is known and to answer research questions not amenable to quantitative techniques.^{16–18} 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.^{19,20}

To conduct these focus groups, we developed a semi-structured topic guide with two sections. The first, which was based partly on an existing instruments,²¹ included questions such as:

- Do you think that you encounter elder abuse and/or neglect frequently in your practice?
- Do you routinely assess for elder abuse or neglect as part of your evaluation?
- Do you think that you miss elder abuse and/or neglect in your patients?
- What do you think are the barriers to identifying cases of elder abuse?

The second section explored participants' perspective on our proposed multi-disciplinary intervention. Questions included:

- Do you think that a multi-disciplinary elder protection team would be helpful?
- Do you think that you or the providers with whom you work would access this team frequently, infrequently, or never?
- How do you think your discipline can contribute to the detection of elder abuse or neglect?
- How do you think a multi-disciplinary elder protection can contribute most effectively in the ED patient care setting?

The focus group guide was piloted for content and comprehension and modified based on suggestions made. The complete topic guide is available as Supplemental Table 1. This study was reviewed and approved by the Weill Cornell Medical College Institutional Review Board, which ensures the ethical conduct of research in our institution. We used the Consolidated Criteria for Reporting Qualitative Research to guide collection, analysis, and reporting.²²

Setting and Participants

We conducted focus groups at a large, urban, university-based academic medical center in the United States that treats over 90,000 patients annually, of whom 30% are 60 years old. It is a Level I trauma center and a regional burn center. The medical center has an Emergency Medicine (EM) residency and is focused on using innovation to optimize ED

care for older adults. A convenience sample of participants from various disciplines was recruited in-person at regular staff meetings.

Data Collection

Focus groups were conducted from January-May, 2016 in ED offices. Each focus group was moderated by one or two of the authors. Moderators included TR (male), MS (male), and MM (female), emergency physicians with additional geriatric emergency medicine fellowship training and an academic interest in elder abuse. The purpose of the research and the members of the research team including their backgrounds were introduced in detailed and standard fashion before the commencement of each focus group. Nobody other than the research team and participants were present. Each focus group was audio-recorded and professionally transcribed. Transcripts weren't subsequently shown to participants. No additional field notes were made. No repeat interviews were conducted.

Data Analysis

Focus group transcripts were reviewed in detail and discussed by the investigative team. Transcripts were analyzed and coded by two authors (TR (male), AE (female)) using content analysis. TR has formal training in qualitative research methods and both have experience. A set of codes was developed a priori and additional codes emerged from the data. Hierarchical codes focused on perspectives on current practice, reasons elder mistreatment is frequently missed, the potential for an ED-based team, and recommendations for a team. Analysis began while focus groups were still ongoing and was conducted iteratively. All discrepancies were resolved by consensus. nVivo 10 (QSR International, Doncaster, Victoria, Australia) software was used for coding. We assessed data saturation as a research team throughout the process by discussing whether any new themes were emerging. Data saturation was achieved before completion of all focus groups. The results of the coding and themes were discussed with the entire investigative team at several meetings. To reduce investigator bias, we also presented the findings to multiple study participants from different disciplines, who provided feedback.

RESULTS

Characteristics of Participants

We conducted 15 semi-structured focus groups with 101 total participants. Focus groups included EM attending and resident physicians, ED physician assistants, ED nurse practitioners, ED social workers, and a wide variety of other disciplines, including: ED nurses, Emergency Medical Services (EMS) providers, ED radiologists, ED psychiatrists, in-patient geriatricians, security officers, ED technologists, ED radiology technologists, ED scribes, and patient escort. All medical and nursing providers (attending and resident physicians, physician assistants, and nurse practitioners) work exclusively in the ED providing acute care to patients. ED social workers are stationed in the ED and provide care to ED patients primarily and assist with in-patient issues in the off hours. EMS providers are affiliated with the medical center and provide emergency transport to the ED. ED radiologists are radiologists who work closely with emergency medical providers and read all images for ED patients. ED psychiatrists are psychiatrists who work in an area of the ED

devoted to acute psychiatric care. In-patient geriatricians provide care for hospitalized older adults. Security officers work in the ED and respond to issues throughout the hospital as necessary. ED technologists are ED staff who assist with personal care, phlebotomy, and electrocardiograms. ED radiology technologists conduct imaging studies in a radiology suite adjacent to the ED. ED scribes work closely with EM attending physicians, assisting in documentation of the medical encounter. Patient escort transport patients throughout the ED and hospital, including to and from imaging studies.

Each focus group was conducted with a single discipline. Characteristics of participants are shown in Table 1.

Focus group duration ranged from 23–68 minutes.

Perspectives of Medical Providers and Social Workers on Current Practice Surrounding Identification of Elder Mistreatment in the ED

ED medical providers reported they did not routinely assess for elder mistreatment and believed they commonly missed it.

ED Physician Assistant #3: I think we're probably missing a lot of [elder abuse]... [Agreement]...Definitely. I just think it may be overlooked or it's coming in as something else, and we're not thinking about it.

ED Physician Assistant #1: I don't have...a structured way to...[assess for elder abuse]...I could not give the coherent points that I go through...[for]...a routine assessment.

They reported 10 reasons for this, described in detail with representative quotations in Table 2. These included lack of knowledge or training, reliance on history from family or caregivers or distrust of history from older adults, sympathy with caregivers, lack of time to conduct an evaluation, concern that identifying elder abuse would lead to additional work, and absence of a standardized response

ED social workers reported that, while they tried to assess for elder mistreatment, they did not use any standard screening or assessment tool.

ED Social Worker #5: There's no question about abuse or neglect in our assessment tool....

Moderator: And the tool that you use...[is] a geriatric tool?

ED Social Worker #5: Actually, it's not just geriatric...The assessment [tool]...is... the same for middle-aged person vs. an older adult...It's part of the EMR [electronic medical record]...After an assessment, if we feel based on our gut feeling or the answers that the patient is giving...that there's some issue, then we... go into more depth.

Additionally, social workers were concerned that elder mistreatment was commonly missed during an ED visit because social work involvement in care was not requested by the ED medical team.

ED Social Worker #1: I hear frequently that social workers will sort of stumble upon those cases...but not that [medical] staff are...making a referral to social work...I think there are times there are so many patients, and everybody is really strapped for time...I think that people are also unaware of what kinds of cases are...referrals to ED social work...I think because of the different rotations that people are doing, the different shifts, the constant turnover is that...this is not being messaged to people.

Other Emergency Care Team Members Perspectives on Elder Mistreatment

Other disciplines reported interest in contributing to identification of elder mistreatment and unique opportunities to potentially do so. ED psychiatrists reported that they were often able to identify subtle issues missed by the medical team because of their ability to spend significant time with a patient and caregivers and to develop a therapeutic alliance.

ED Psychiatrist #1: I think we're uniquely suited to detect [elder mistreatment] because we are usually the clinicians who spend time with the patients and...with patients' family members...trying to get to know them and more than just...their list of medical problems...I think we are trained to...look out for when something is amiss.

ED radiologists felt that they could contribute by comparing current to prior images and by examining images for previous injuries.

ED Radiologist #4: What I really think we don't do today which could be a real win in this type of case because I think it's probably more apparent to us than it is to anyone else is: we could interpret it longitudinally. I never comment, I never even look for other recent fractures that the patient's had. You know, there's...20 other body parts that were fractured in the past month. I don't even think to look at it...when I interpret the hip...But it's right there in front of my face.

ED Radiologist #3: Yeah, that's a good point.

ED Radiologist #4: ...That's value add that the radiologist could do because...that's something that's right in our face.

ED technologists reported that clues to potential elder mistreatment occur when staff is providing personal care to a patient, including by observing the behavior of family members or paid caregivers.

ED Tech #2: I think you guys are missing [elder abuse]...I've come across...situations where we're changing them and they will apologize for their...bowel movements and just keep apologizing and asking what they can do to make things better. And I can...sense that it's not...they're just apologizing for that. Something happened to them.

ED Tech #7: They come...with an aide. Sometimes, the aide will just sit there and doesn't really do anything for the patient...Sometimes, they're rough with the patient. They talk back to the patient, and that is part of abuse...and they have a lot of scratches like black-and-blue marks....

ED Tech #8: Sometimes they don't even engage the patient in a conversation. They could be there for the whole 12 hours that I'm working, and they're on the phone... looking away... They're not even engaging.

ED radiology technologists reported that imaging areas are a potentially useful location to separate potential victims from perpetrators and assess the patient alone.

ED Radiology Tech #3: [The radiology suite is a] safe space without anybody there... We could ask... questions... [about whether] they feel safe at home... That's a good time to ask it, and we should.

Moderator: We otherwise ask in triage, where [family, caregivers, potential abusers] are standing next to them. The likelihood that you get the true answer [in the radiology suite]... is much higher...

ED Radiology Tech #3: I think if we make it a part of our everyday practice, I think that would be good...

ED Radiology Tech #3: There's nobody there [in the radiology suite] but us.

ED Radiology Tech #2: Yeah, they're not hiding it from anyone.

ED Radiology Tech #3: And that would be an opportunity to say something.

Perspectives on Potential ED-Based Multi-Disciplinary Response / Intervention Team

ED medical providers and social workers both reported believing strongly that an ED-based multi-disciplinary response / intervention team would assist in assessing and caring for these patients, while helping ensure their safety.

ED Physician Assistant #14: Somebody who can step in and say: "Okay, we're going to take over this now."... That would be... really good... because a lot of times these cases are going to be extremely time-consuming in identifying the problem, trying to solve the problem, trying to figure out how long it's been going on, and what the deeper effects of the abuse are. So if there was somebody who could lead it...

ED Social Worker #5: [The team] can be used as a consultant and guide the rest of the staff.

ED Social Worker #4: ..When we're super-busy, where we're dealing with traumas and not able to do all of these geriatric screens. If we do hit upon something, and we can call in this protection team, that's going to help immensely.

ED Social Worker #2: ... Yes, it would be incredibly helpful...

ED Social Worker #3: They're trained and well-versed in asking these questions...

ED Social Worker #1: And the ability to focus... not necessarily juggling simultaneously... many other patients... It just leads to better care, better outcomes

Both believed that this team would be frequently consulted.

EM Attending #8:[We will] probably be accessing them frequently...because it's a gray zone...I'm concerned that there are a lot of subtle clues that I miss or that we just don't have time...to...look at...so I would be using the consult service...hoping that...it's going to have good results.

ED Social Worker #5: I think [the team would be accessed] frequently if it was there. I think so.

[Agreement]

Recommendations for ED-Based Multi-Disciplinary Response / Intervention Team

ED medical providers, social workers, and other disciplines identified 21 key recommendations to consider when developing the ED-based multi-disciplinary team. These are described with representative quotations in Table 3.

DISCUSSION

This research represents, to our knowledge, the first qualitative study to examine perspectives on elder mistreatment evaluation in the ED by a range of disciplines and the potential for an ED-based multi-disciplinary response team to improve care. Our work supports existing research that elder mistreatment is commonly missed in EDs,^{6,11} even when social workers are available. Additional education focused on elder mistreatment for ED medical providers is necessary, including in EM residency curricula. The inclusion of a review article on elder abuse² in the American Board of Emergency Medicine's 2018 Lifelong Learning Self-Assessment Maintenance of Certification Curriculum²³ is encouraging. The development of collaboratively-authored geriatric ED guidelines in the United States, which advocate for additional education and quality improvement focused on elder abuse and neglect,²⁴ are an important step. Progress in recognizing the importance of identifying and managing elder abuse in EDs has occurred internationally also. The British Geriatric Society's multi-disciplinary Silver Book: Quality Care for Older People with Urgent and Emergency Care Needs includes a section on detecting elder abuse.²⁵ Emergency Medicine Australasia's Acute Geriatric Series recently included an article from Hullick et al focused on abuse of older people.⁷

Screening tools, which have been helpful in identifying other types of family violence, are critical to assist EDs in improving elder abuse and neglect detection. Several screening tools exist,^{6,26,27} but none have been validated in an ED setting. Encouragingly, an ED-specific screening tool is currently being developed and tested with the sponsorship of the United States' National Institute of Justice.⁶ Another promising area of ongoing research and specialized training examines forensic patterns of injury in elder abuse.²⁸⁻³² ED providers may eventually be able to use clinical decision support tools based on these patterns to identify abuse in older adults with purportedly accidental injuries. Both screening tools and injury pattern research have the potential to assist busy ED providers, who are primarily focused on medical stabilization of acute critical illness, in detecting elder abuse victims.

Participants' focus on time constraints as a constant challenge in all aspects of ED practice, and concern that identifying elder abuse will lead to additional work and compromise a

provider's ability to appropriately care for other patients strongly suggest the potential value of a dedicated ED-based consultation service. Our findings also suggest that a team-based approach to identification,¹⁰ involving disciplines beyond medicine and social work, is potentially valuable in identifying this often subtle, commonly missed phenomenon.

Encouragingly, ED providers from various disciplines thought that an elder mistreatment consultation service would be valuable and frequently utilized. Participants made a broad range of recommendations for the team. They emphasized the importance of 24/7 availability, with a swift response that does not slow down disposition. Notably, participants highlighted that a positive attitude is crucial to ensuring that an ED-based team is frequently consulted. Training, feedback, and publicity were thought to be important for ED staff members, particularly given the frequency of new staff joining and the large number of ongoing initiatives in the ED. Training should include focus on legal resources and reporting requirements. The importance of standardizing hand-off between EMS and the ED for these patients, which has been noted previously,³³ was highlighted. Strategies for standard protocols to ensure optimal evaluation were emphasized including always examining an older adult patient alone and fully undressing a patient for the physical exam. Radiologists suggested developing a checklist to optimize and standardize their contribution to the team. Participants focused on considering caregivers and families in interventions, including education and respite care when appropriate and having a standard script to explain the activation and team's role. They suggested considering post-discharge home visits as a way to further ensure safety. Participants stressed the importance of buy-in and support from leadership and key stakeholders. They also suggested that periodic case reviews would be helpful for learning and to improve and standardize the team's response.

Our study focused on abuse and neglect by others. Self-neglect, which occurs when an older adult threatens his/her own health or safety by failing to perform or refusing assistance with essential self-care, is also common with the potential for severe consequences. Emergency providers may also play an important role in identifying self-neglect and initiating intervention. Future research should explore provider perspectives on this phenomenon and potential solutions.

Limitations

This study has several limitations. As we interviewed practitioners from a single urban, academic ED in the United States, our findings may not be generalizable. Small EDs with limited resources and without routine access to social workers may have very different experiences with elder mistreatment assessment. Our goal, however, was to improve understanding of the phenomenon and the potential for a response team in our resource-rich environment, which we hope will be translatable to other clinical settings. Another limitation is that participation was voluntary, suggesting 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 elected not to participate. In all cases, this was due to scheduling conflicts. 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 and offers valuable insights that will inform program development and future research.

Conclusion / Future Directions

Findings from these focus groups will inform the design and implementation of our ED-based, multi-disciplinary elder protection team, ensuring that the diverse perspectives of ED providers are incorporated.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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WHAT THIS PAPER ADDS

Section 1: What is already known on this subject:

An emergency department visit provides a unique opportunity to identify elder abuse, which is common and has serious medical consequences. Despite this, emergency providers rarely recognize or report it.

Section 2: What this study adds:

In this qualitative study at an ED in the US, ED providers reported not routinely assessing for elder abuse and believed that they commonly miss it for many reasons, including lack of knowledge or training, lack of time to conduct an evaluation, concern that identifying elder abuse will lead to additional work, and absence of a standardized response. Providers believe an ED-based consultation service would be frequently utilized and would increase identification, improve care, and help ensure safety.

Table 1:

Characteristics of Focus Group Participants

Discipline	Number of Participants	Median Years of Experience
Emergency Medicine (EM) Attending Physicians	10	13
EM Resident Physicians	7	2
Emergency Department (ED) Physician Assistants	12	2
ED Nurse Practitioners	3	12
ED Social Workers	5	4
ED Nurses	13	9
ED Psychiatrists	5	3
ED Radiologists	5	5
ED Technologists	8	4
Radiology Technologists	3	6
Security	5	2
Patient Escort	3	4
Medical Scribes *	10	0
Emergency Medical Services providers	7	13
Geriatricians	5	18

* Medical scribes are a new role in our institution. All of the medical scribes who were subjects of this study were hired and trained within a year of when the focus group was conducted and had no previous experience in this role.

Table 2:

Reasons Reported by ED Providers for not Routinely Assessing for Elder Mistreatment and for Commonly Missing It

Reason	Representative Quotation(s)
Lack of knowledge, poor understanding of what constitutes elder mistreatment	EM Attending #7: One of the main barriers for me is identifying these cases is...I'm not clear on what the definition is...[Elder mistreatment] doesn't seem to be a black and white issue. What qualifies as neglect? What doesn't?...When you are not even clear on what the definition is, then I think that it's very hard to assess for it and screen for it.
Inadequate training in elder mistreatment identification	EM Resident #3: It just hasn't been drilled into my head enough in terms of academic or clinical curriculum as...pediatric abuse. If you open any pediatric emergency medicine textbook, there is a whole section dedicated to abuse. I feel like there isn't...as much time dedicated to learning about elder abuse....We've gone through airway, breathing, circulation so many times, we do it automatically. Elder abuse...is not one of those things.
Lack of confidence of threshold between minor issues with quality of care and elder mistreatment	EM Resident #7: High threshold for pursuing elder abuse because I feel like every elderly patient that we get into the Emergency Room isn't ideally taken care of....I would probably say like 80 or 90% have some aspect of...neglect or something like that. So it would be really hard to...devote...all those resources...He isn't taking his medications every day but is overall still healthy, so I think we're okay with that. Moderator: ...You're saying that: "If there is a line somewhere, where is that line? Where is that line where we devote the resources...given that we think that...folks might benefit from something, but we don't have unlimited resources." EM Resident #4: We should have...a HEART score [a commonly-used chest pain risk stratification tool] for elderly people [for abuse evaluation], like the "elder score." [Agreement]
Challenges in distinguishing mistreatment from medical issues given lack of standard age-related functional milestones	ED Physician Assistant #1: Every 72-year-old is...at a different stage as far as the ongoing arc of their lifespan... We have milestones established for kids...the norm is well-known, and so deviation from the norm that...might...be...related to abuse...[is] easier to elucidate...The norm in elders is pretty broad...It becomes...very hard. Sometimes you'll see things...that...[are] just medical...but...might seem like abuse... Without clear landmarks, how do...you know...what you're looking for?
Reliance on family members or caregivers for medical and social historical information	ED Physician Assistant #13: A lot of times you take histories from the family members and just assume that whatever information they're providing you is correct... ED Physician Assistant #13: Patients can't provide us with a lot of details, and the family members are like: "This is how they always are. They don't talk." ED Physician Assistant #7: The caregivers put the blame on the patients themselves that they're not taking their meds or whatever. They were not being fed appropriately or being given their meds appropriately by the caregiver, but the caregivers...are saying...that they're not taking care of themselves.
Sympathy with caregivers given difficulties of providing care to dependent older adults	EM Resident #2: I think that it's tough because you look at the caregivers...trying to care for...a demented parent who is living in your house when you have to go to work...Even when people are trying hard to provide care...it's...difficult. If the demented parent...wants to leave the house, this is a difficult problem to solve... There was one patient...we'd put locks on the doors...on the inside, then they climbed out a window...How am I supposed to stop that? Those...are things that may appear like neglect, but I think that makes it hard...Even...people who are trying to do the right thing, it's hard.
Distrust of history provided by older adult patients	ED Nurse Practitioner #3: Sometimes I guess we don't take...[older adults] as seriously because some people become complainers and they complain about everything...I'm sorry to say, but there is some element of truth to that.
Lack of time to conduct a thorough evaluation given competing priorities with other patients	ED Physician Assistant #7: Time: committing yourself to doing a lot of research and investing your attention. To making phone calls and trying to figure out who's taking care of them. Moderator: So, if you...invest...time, it might take you away from other things.
Concern about additional work if elder mistreatment is discovered	ED Nurse Practitioner #3: If I'm going to be honest with myself, I don't want to go in that direction [to assess for elder mistreatment] because I know it's going to be time-consuming and it's going to open up a huge can of worms...It's easier to just look the other way... ED Nurse Practitioner #1: Because once you ask, then you have to follow that route. So I think some of us may not want to ask.
Absence of a clear protocol for streamlined response	EM Resident #2: No clear protocol...EM people like algorithms, like I go through a checklist...There's not a clear process for [elder mistreatment]...I think this is hard... We don't even know how to communicate effectively other than to say: "I have a concern about elder abuse," and the other person is asking, "Well, what does that mean? What am I supposed to do?" So that makes it very...tough.

Table 3:

Recommendations for a Potential ED-Based Multi-Disciplinary Response / Intervention Team Identified by Focus Groups of ED Providers from Various Disciplines

Recommendation	Representative Quotation(s)
Importance of 24/7 availability with similar quality and timeliness of response on weekends and overnights	ED Nurse #11: <i>Availability...it has to be consistent, because if it's not 7 days a week, [if] it's only between 8:00 and 5:00 on Monday, Wednesday, and Friday, it becomes lost in the mix of things because of the way we work... Consistency and availability.</i> ED Psychiatrist #5: <i>[During] regular business hours, there's usually...people that can be responsive...but the off-hours is really when we run into things.</i>
Importance of timeliness of team's initial response and final recommendations	EM Resident #2: <i>Are we delaying disposition? Are we...slowing down the system?...That's always what doctors are thinking.</i>
Importance of positive attitude / enthusiasm when receiving consults	PA#3: <i>If you have to call someone and...you get that sense from them—</i> PA#7: <i>The pushback</i> PA#3: <i>...That they don't want to...come in...Over time, that will erode the frequency that people will use [the team]. If you call someone, and they're like: "Yeah, thank you for calling me...I'll be there in 45 minutes...That makes it easier [to consult]. We hesitate to call when the consultants don't want to come in.</i>
Potential for a tiered response based on case severity	EM Resident #6: <i>Having a tiered approach. It's not important to have everybody [from the team] come in all at once, but have it start with one individual. And maybe that's social work. And then have social work call in the appropriate people in conjunction with the physician...Because if it's going to be easy for the [ED] physician to...consult, they still won't want to feel like they're inappropriately using a whole bunch of resources. But they also want to...feel free to just go ahead and do it.</i> EM Resident #2: <i>You can tier your response...If they're going to be admitted, then it's something that could be done over time...[not] this minute right now in the ED. If you have like a really bad case where...the proxy is not able to make decisions, then I think that's its own scenario, but most of the time it's...low level...Unless...the patient wants to go home, [and then] it's a capacity question...That probably involves a different kind of evaluation.</i>
Importance of continuous training and re-training for ED staff	ED Social Worker #2: <i>I think there needs to be ongoing education. [Our support program for assault victims is also] a specialty consult service, and the number of residents who have come up to me and said: "I didn't know this exists. I would use it if I knew."...So I think that is something to consider.</i> ED Nurse #12: <i>Most importantly, it would be nice to have somebody who can reach out to staff...to in-service – especially newcomers, because we have so much turnover in our staff. To engage the staff and help us.</i>
Focus on legal resources and requirements / ramifications surrounding reporting	ED Social Worker #2: <i>I think knowledge about legal resources...a good base of knowledge about...reporting obligations...and...the consequences of what it's going to be like to report would be good. Because it's just not my wheelhouse. And I don't know whose it is.</i>
Value of feedback	ED Radiology Tech #3: <i>A follow-up call to make this a full circle...Not to say "good job," but to bring it full-circle...I usually get e-mails about stroke patients that we treat in CT scan. We...get a little feedback. You know: CT scan, it was ready on time...And that just helps us. It helps everybody in the group move forward.</i> ED Radiology Tech #2: <i>And...if you call for an abuse case, if there's nothing, it's also good to say: "You know, it was nothing, and this is what you can look for in another situation," or they can educate you a little more about why this wasn't an abuse case.</i> EMS #1: <i>I think EMS personnel will be more inclined to...report cases just because they would be able to actually keep track and probably follow up... Sometimes, we fill out these reports, they go to the fire department, and God knows what happens after that</i>
Importance of publicizing program to ensure that staff from all relevant disciplines aware	ED Security #5: <i>A proper roll-out because...we've seen other programs that were in existence for over a year, and nobody still...knew who to call or who the person was...or a pager number; how to get a hold of them...We're that front-line staff...Getting the word out [about] what they do, what they can do for you, and knowing who to...call...that's the big thing...In order to get people to use [a new program], they've got to know it exists, and I know that sometimes we as an organization do not do a good job...[with] the roll-out.</i>
Unique potential for geriatric nurse practitioners to contribute to team given their training	ED Nurse Practitioner #1: <i>I think geriatric nurse practitioners would be very attuned to abuse...it's part of their training...They have quite a bit of [relevant] experience and knowledge...</i> Moderator: <i>Most nurse practitioners have some experience being nurses as well...so they have done both the clinical decision-making but also bedside personal care...a pretty important combination for this [team].</i>

Author Manuscript	Author Manuscript	Author Manuscript	Author Manuscript
Recommendation	Representative Quotation(s)		
Importance of early involvement of security	<p>ED Security #1: If there are signs that [the clinical staff] might see as far as interaction with family members or possible visitors...giving us more information in a timely fashion just so we could assist...A lot of times, security's eyes are elsewhere, and medical staff can always just give us a quick heads up: "Hey, listen...I see you're taking care of something, but we have a concern here...Maybe you guys can let someone know or call a supervisor or...keep your eyes on this person or just...stick around and help us out."</p> <p>ED Psychiatrist #7: There's always an [administrator] on call...actually on-site, even off-hours, so having them involved would...be helpful...because after 5 [o'clock PM] a lot of people aren't around from legal or ethics or patient services.</p>		
Value of involvement of administrator-on-call to assist with connection to legal and ethics	<p>EMS #5: A failsafe...There's all the questions in triage about where you traveled, are you a victim of domestic violence. In geriatric charts, there could be a...couple of questions that are like a social services assessment for EMS. "Did you observe adequate housing? Did you observe any dangers?...Was somebody screaming at them and belittling them?...Verbal or physical abuse"...That...might catch a lot of things because...sometimes you don't realize you saw something until later on you're talking about it. So if the nurse says: "Did the house look adequate?" I'll go "Geez, you know, well, no it wasn't."</p> <p>EMS #6: The breakdown is...triage. It's really hard to rely to triage, because they get so busy...There's just not the time to spend doing...a social services evaluation on every patient...They just need you to say what's wrong.</p> <p>ED Social Worker #4: It's helpful to talk to EMS to get their perspective...</p> <p>ED Social Worker #1: Getting the collateral information about what somebody's home environment is like. Hearing from a third party like EMS is very different than [family or caregivers], because you assume that...person doesn't have the same vested interest...like the supportive-appearing caregiver at the bedside.</p>		
Standardization of Emergency Medical Services handoff and initial triage process to ensure that concerns relayed to social workers and medical providers	<p>ED Nurse #7: It's to me a red flag when a family is constantly interjecting and trying to take over the person's answers. And that's...made me think that [the patient] should be alone. You will not get a straightforward answer if you're asking them with a family member or the aide...You have to do it completely alone...A lot of times...the family will fight you to go into triage, and we allow that, but you're not going to get your answers...It has to be done alone...</p> <p>ED Nurse #12: Can't be done...in the hallway or the entryway when we're rushing people in...You're in the hallway with the family and all these strangers are present. You're not going to get the straightest answer.</p> <p>ED Social Worker #4: There are times...when the ED is really busy and there might be...three patients in a room. It's really hard to get that rapport where someone feels open to talking because there's a patient separated by a cloth curtain two feet away from them. So you can sense that they're hesitant to answer some questions. So I feel like, when I do those assessments, I'm missing some information...</p> <p>ED Social Worker #2: I feel the same way...Space is always a challenge.</p>		
Importance of evaluating patient alone despite space-related challenges	<p>ED Tech #1: One of the first barriers we can...overcome is making sure that we get [older adult patients] undressed immediately.</p> <p>ED Tech #2: Yes...nurses and doctors come in...and just put in an IV with their clothes...on.</p> <p>[Agreement]</p> <p>ED Tech #7: We need to undress them...It wouldn't take you one minute to undress them.</p>		
Standard script for patients, caregivers, and families beneficial to explain that multi-disciplinary team being activated and what to expect	<p>ED Psychiatrist #2: With children, sometimes it's difficult to actually be the one to introduce that [the child protection team members] are going to come...It's...difficult to tell the parent: "ACS [Administration for Children's Services] is going to come speak with you. You generally have to. They get all upset, and you generally have to give some sort of introduction or reason before the child protection team shows up...It's a little bit difficult to know the words to say that sometimes to a family. They are like: "Why are you calling this team?"</p> <p>ED Psychiatrist #4: So a script or something might be helpful.</p> <p>ED Psychiatrist #2: And when you told them, you could be like... "I just suspect there is something wrong here" or because of the nature of the wounds.</p> <p>ED Psychiatrist #4: ...How do tell them that the elder abuse folks are coming in and still maintain the therapeutic alliance?</p>		
Potential for a checklist for radiologists of specific findings for different imaging types that the report should explicitly mention whether present or absent	<p>ED Radiologist #2: It they have fractures that haven't been treated, it sounds like someone is neglecting them...I think that we might have better insight in that area than specific fracture patterns...that indicate non-accidental trauma. So fractures that are sub-acute and not treated appropriately or are in multiple places or even some abdominal findings...like they have really bad fecal impaction. I think we could make a checklist of things to look for on studies that indicate they're not getting appropriate medical care...</p> <p>ED Radiologist #3: We as radiologists could develop a list of things that...should always be mentioned in the report. For example, fractures in various stages of healing, fecal impaction, cachexia. Stuff that we see in a lot of elderly people but maybe aren't mentioning so often in the report.</p>		
Value of education to caregivers as part of intervention	<p>ED Psychiatrist #1: Sometimes a family really needs to understand how to deal with these patients, and they need education, just basic education...about how to keep somebody with dementia calm...[The team] could serve as an education resource to the whole family.</p>		
Potential for respite care as a solution to assist patients and caregivers	<p>ED Nurse Practitioner #1: Respite care where we could have some sort of help for the caregiver at the same time perhaps...would lead to a better outcome for the whole family.</p>		

Recommendation	Representative Quotation(s)
Potential value of post-discharge home visits	<p><i>ED Nurse Practitioner #3: I think the best thing for the patient would be if the...provider would be able to follow up in their home...a full physical exam, vitals...chronic issues like wound care--</i></p> <p><i>ED Nurse Practitioner #1: Right, exactly, wound care, even diaper rash, anything that they had...and especially someone who has home care experience...I love the [geriatrics clinic] where they actually have nurse practitioners that take care of patients in the home.</i></p> <p><i>EM Resident #3: I feel the most critical time period is immediately after discharge...I remember we had one patient who was questionable whether her caregiver was abusing her...and she was deemed safe to discharge...But she came back 4 days later with multiple rib fractures...she just got completely beat up...in that immediate period. When there is a suspicion...someone should actually go and make sure the patient actually was safely discharged.</i></p>
Importance of ED and institutional leadership and key stakeholder support of program	<p><i>ED Social Worker #1: Institutionally and in the Emergency Room, if this is something that...is going to be an ED initiative, I think it's really important that key stakeholders in the ED leadership and the institution be supporting it in some way.</i></p>
Potential for regular case review by team members to ensure optimization and standardization of response	<p><i>Geriatrician #4: A model where...every Friday...the whole team is hearing every single case that came...in during the week...Let us know where we are with each of these cases. Is the team...supported? Do we have a plan?</i></p>