

Prevention of Elder Mistreatment in Our Community

A collaboration between:
UVA Medical School faculty

Albemarle County Department of Social
Services

and

the Community Partnership for Improved
Long-Term Care

Study Investigators:

- Claire E. Curry
UVA School of Law School Advocacy Clinic for the Elderly, Legal Aid Justice Center
- Sue Dwoskin
Adult Division Coordinator, Albemarle County Department of Social Services
- Dr. Jonathan M. Evans
UVA School of Medicine Section of Geriatric and Palliative Medicine
- Dr. James K. Roche
UVA School of Medicine
- Beth Vogel UVA School of Law Class of 2007
- Erika Alonso UVA School of Law Class of 2008

Goal of the Collaborative Research Project

- “To gather information that can be used by the Department of Social Services, the Partnership, and others to maximize the effectiveness of elder abuse prevention efforts in assisted living facilities and nursing homes in Region Ten”

The Community Partnership for Improved Long-term Care

■ **Mission:**

The Community Partnership for Long-term Care brings together concerned individuals and groups to work for improved quality of care in long-term residential facilities in the City of Charlottesville and the counties of Albemarle, Fluvanna, Greene, Louisa and Nelson.

A Study of Elder Mistreatment in Albemarle County, Virginia

Research Results from Two Year Data Analysis Yields Benefits

- Brought together expertise and skills of UVA Physicians, Community Volunteer Advocates, and Albemarle Department of Social Services to understand elder mistreatment and enhance prevention efforts
- $1 + 1 + 1 = >3$
- Created a model approach combining research, analysis and community problem solving
- Research not for research sake but for positive community change
- Establishment of a data base for use by Social Services in continuous improvement of operations

An Increased Understanding of Abuse, Neglect and Financial Exploitation In our Community Supports Efforts to Prevent and Stop Elder Mistreatment

- Enhances Social Service's mission to ensure safe and protected citizens, family well-being, self-sufficiency
- Creates the opportunity to manage and target resources based on fact, supported by data
- Informs advocacy of Community Partnership for Improved LTC
- Enhances project partners' ability to respond to changing demographics and forge new alliances to combat elder mistreatment

Education and Outreach based on the Collaborative Research Project

- Ombudsman for Region Ten-Advocates for Long-Term Care Residents. Joint presentation of study results.
- Increased awareness about what elder mistreatment looks like in Albemarle County, its signs and symptoms, and what to do when abuse/neglect/exploitation is suspected by ombudsmen
- Provided opportunity for volunteer ombudsman to share their experiences and seek clarification about reporting responsibilities
- Raise important question about expectations when

Education and Outreach based on this Research Collaboration

- Arlington Commission on Long-Term Care Residences. Joint presentation of study results.
 - Commission charged with enhancing quality of care and life in LTC residences, and with supporting access, availability, and affordability of LTC in Arlington County;
 - Commission advises public officials of Arlington County on LTC needs;
 - Commission sought to learn from our collaborative research project, both substantively about elder mistreatment and process-wise how such collaborations can be created and sustained.

Education and Outreach based on this Research Collaboration

- Northern Virginia Regional Meeting Presentation to Northern Virginia Ombudsman Program, TLC4LTC, and the Arlington Commission on Long-Term Care Residences
 - Invitation to lead workshop for Northern Virginia family members and advocates seeking to create a regional advocacy voice for L-T Care quality.

Other Opportunities for Education and Outreach based on this Research Collaboration

- 2007 National Aging and Law Conference, The Safety Net for Older Americans: What Can Be Done to Protect It?
- Proposal Submitted for Workshop “Elder Mistreatment in the Community and in Long Term Care Settings: A Multi-Disciplinary Project to Study Mistreatment and Enhance the Safety Net”

Other Positive Uses for Study Results

- Research results used in forging new initiative and Memorandum of Understanding between Albemarle Department of Social Services, the Albemarle Police Department, and Commonwealth's Attorney, to enhance protections and respond to financial exploitation of seniors.
- Research data used by Albemarle County as pilot agency for UVA Institute of Law, Psychiatry and Public Policy study of community members subject to abuse, neglect or exploitation.

Prevention of Elder Mistreatment in Our Community

- What Does Elder Abuse and Neglect look like in Our Community?
 - What patterns emerge that might suggest preventive strategies?
 - How does elder mistreatment in our community compare to abuse and neglect of younger adults?
 - What is the relative contribution of abuse and neglect in long-term care facilities (nursing homes, assisted living facilities, group homes) to elder mistreatment overall in our community?

A Study of Reported Elder Mistreatment in Albemarle County

- Aim: Identify and describe all reported allegations of elder abuse, neglect and/or financial exploitation in Albemarle County over a 2-year period
- Design: Prospective cohort study
- Population and Sampling Frame: 24 month period from July 1, 2004 through June 30, 2006
- Subjects: Individuals age 18 and older residing in Albemarle County, reported to and investigated by Adult Protective Services as alleged victims of mistreatment during the study period
- Data Source: APS investigative reports, abstracted onto a computerized spreadsheet for data analysis

Definitions

- *Code of Virginia, S 63.2-100*
- **“Abuse”** means the willful infliction of physical pain, injury, or mental anguish or unreasonable confinement of an adult.
- **“Neglect”** means that an adult is living under such circumstances that he is not able to provide for himself or is not being provided services necessary to maintain his physical and mental health and that the failure to receive such necessary services impairs or threatens to impair his wellbeing
- **“Exploitation”** means the illegal use of an incapacitated adult or his resources for another's profit or advantage

Results: Description of Subjects

Number of Reports	N= 746
Number of Subjects	N = 575 18.6% (n=39) were alleged victim in multiple reports (range 2-9) Previous substantiated reports of mistreatment in 24.7% of cases
Age	Median 74 years (Range 18–102) 65% age 65 or older
Gender	Female = 68% Male = 32%
Race	White = 76% Black = 23%
Location where alleged mistreatment occurred	At place of residence in 94%

Results: Living Arrangements

- **Home Settings 57.4% in year 1 and 48.8% in year 2**
 - Home Alone 26.3% and 26.6%
 - Home with family 31.1% and 26.6%
 - spouse 10.6% and 9.8%
 - Other relative 20.4% and 14.7%

- **Institutional Care Settings in year 1 35.9% and 41.1% in year 2**
 - Nursing Home: 25.8% and 27.2%
 - Assisted living: 7.3% and 12.9%
 - Group Home 2.8% and 1.0%

- The remainder (less than 5%) live with persons other than family, or are homeless

Type of Mistreatment Alleged

- Abuse 28.0% in year 1 and 29.6% in year 2
 - Abuse alone 21.6% and 23.9%
 - Abuse plus neglect and/or exploitation 6.4% and 5.7%
- Neglect: 64.4% and 63.8%
 - Neglect alone 54.1% and 56.6%
 - Neglect plus abuse and/or exploitation 10.3% and 7.2%
- Exploitation 20.4% and 15.7%
 - Exploitation alone: 12.9% and 11.3%
 - Exploitation plus neglect and/or abuse 7.6% and 4.4%
- *More than one kind of mistreatment alleged in 9.8% of cases over the two years*

Alleged Source of Mistreatment:

- Spouse/relative = 31.4% in year 1 and 17.2% in year 2
 - Power of attorney = 5.6% and 7.7%
- Self = 32.2% and 31.1%
- Paid Caregiver = 23.2% and 29.0%
 - Institutional caregiver 21.8% and 26.7%
 - Community caregiver 1.4% and 2.3%
- Other = 12.8% and 6.2%

Referral Source/ Complainant

- LTC staff 22.1% and 20.8%
- Relative 17.1% and 13.8%
- Hospital/Clinic 15.1% and 9.8%
- DSS 5.9% and 7.7%
- Mental health/substance abuse services 5.3% and 3.9%
- Anonymous 5.0% and 10.8%
- Friend/neighbor 3.9% and 4.9%
- Self 3.9% and 4.1%
- Law enforcement 3.4% and 5.9%
- Private physician/nurse 3.4% and 1.5%
- Home Health Agency 4.8% and 3.6%
- All others 10.1% and 12.8%
- *Mandatory reporters account for 65.8% of all referrals over the two years*

Examples of Alleged Mistreatment

■ *Neglect*

– Self-neglect:

- *Elderly person living alone with inadequate food, medication, sanitation*
- *NH resident refuses care, discharges self home*

– Caregiver neglect:

- *Home health aide failed to show up and provide care to bedbound individual*
- *Medications, wound care treatment not provided as ordered to nursing home resident or hospital patient*
- *Poor discharge planning for hospitalized patient sent home unable to meet her own care needs*

Abuse

- CNA allegedly gave a resident a cold shower in retaliation for a complaint made to supervisor*
- Emergency room personnel report unexplained bruising in a patient with Alzheimer's*
- Incontinent man with Alzheimer's slapped by family member after incontinence episode*

■ *Exploitation*

- Nursing home resident unable to pay for continued placement. Family member has misappropriated funds*
- Unauthorized sale of property by Family member leading to Medicaid disqualification and inability to pay for needed nursing home care*

Substantiation of Mistreatment

- **How much mistreatment is substantiated?**
55.9% of all reports of alleged mistreatment were substantiated by APS investigation
- rates of substantiation did not vary significantly by site
- Substantiation rate higher for self neglect
- Inability to substantiate allegation is not the same as proof that it did not occur
- **Primary goal/priority of APS investigation is to ensure individual safety not to prove a crime was committed**

Substantiated Cases:

- Neglect = 46.6% and 45.5%
 - Self neglect = 33.8% and 31.3%
 - Neglect by others = 12.8% and 14.1%
- Abuse by others = 8.7% and 11.1%
 - Physical = 6.4% and 5.0%
 - Mental = 2.2% and 6.1%
- Financial exploitation = 7.8% and 6.1%
- *Over 30% of the cases each year were substantiated with either multiple findings or findings that were not easily classified in the above categories*

Summary of Quantitative Results

- Allegations of elder mistreatment not uncommon in our community
- Rates of reporting, substantiation of allegations in Albemarle County comparable to Statewide rates, rates in Region 10
- Alleged source of mistreatment =
 - 1/3 Self + 1/3 Family + 1/3 Caregivers and others with close contact
- Neglect most common allegation, most common finding.
 - Self-neglect accounts for >2/3 substantiated cases of neglect
- Abuse by others = 1/5 substantiated cases of mistreatment
- Financial exploitation in 1/10 cases

Other Significant Findings

- Rates relatively unchanged over time
- Tension Between Health Care Settings
 - Blame Game (ER vs. LTC, Hospital vs. LTC)
 - A lot of ignorance regarding levels of care, monitoring available/allowable in different community settings
- Inadequate communication between settings, agencies, including medical info

Other Significant Findings, Cont'd

- Methodological, practical problems related to jurisdiction
- Hospitals in Charlottesville but all but one NH in Albemarle County
- *Results in 'Invalid' reports, or no investigation*
 - Staff termination also may have similar effect on investigation or lack thereof

Other Significant Findings, Cont'd

- Uneasy relationship between Nursing Home and Community Agencies
- On the one hand, Nursing Homes seen as the “Problem”, a failure
- On the other hand, for community dwelling victims of neglect, abuse, self neglect, etc. Nursing Homes are the primary “Solution” in many cases, without further efforts at guardianship, etc.
- Nursing Homes fearful of criticism, getting into trouble- creates a barrier to reporting
- Significant underreporting across health care settings, overreporting in some settings as well

What has Happened in 2 Years?

- Concerted training efforts to educate providers, especially in long-term care
- Successful growth and implementation of partnerships to improve care
- Starting to see the beginnings of culture change in local long-term care community
 - Mitigated somewhat by corporate and community culture
- Greater involvement of family councils
- Greater professionalization of LTC
 - Increased physician involvement, NP involvement as Hospital/LTC liaisons
- Widening caregiver shortage
- Hospital volumes increasing without adding beds

Conclusions

- There is a problem
- A lot is being done to deal with that
- There are reasons to be optimistic, even though our numbers haven't changed much yet
- Also reasons to be fearful, given local, regional national changes in health care utilization, financing