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INSIDE

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Human Trafficking is a Problem for Case Managers and All HCWs

Most victims see a healthcare provider at some point

About nine in 10 survivors of human trafficking say they had some kind of contact with the healthcare system while they were being exploited. But none of the professionals who admitted, treated, and discharged them picked up on the clues and signs that something was wrong.

This is a problem that a major health system in California has decided to tackle with a long-term project to educate all healthcare professionals, including case managers, about what human trafficking is, how to identify its victims, and how to handle suspected trafficking cases.

A 2014 study about human trafficking shows how unprepared healthcare workers are to respond to the problem, says **Holly Austin Gibbs**, a patient care services program director with San Francisco-based Dignity Health. Gibbs spoke to case managers about human trafficking at the American Case Management Association's 2016 National

EXECUTIVE SUMMARY

There are an estimated 21 million victims of human trafficking worldwide. Numbers have exploded since 2000, which is when the U.S. passed the Victims of Trafficking and Violence Protection Act. Many U.S. healthcare professionals have met or treated a trafficking victim at some point in their careers, but they may not have recognized the signs. A new care services initiative aims to change that trend.

- About 90% of trafficking survivors had some contact with the healthcare system.
- Dignity Health of San Francisco plans to roll out standard education about trafficking to staff at nearly 40 hospitals.
- Abuse and language barriers keep people trapped in trafficking.

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EDITORIAL E-MAIL ADDRESS:
melindagyoung@att.net.

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EDITOR: Melinda Young.
MANAGING EDITOR: Jill Drachenberg (404) 262-5508
EDITORIAL & CONTINUING EDUCATION DIRECTOR: Lee Landenberger

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"I work with survivors across the country — from both sex and labor trafficking — and I know more survivors who had contact with the healthcare system than those who did not," Gibbs says.

A Growing Problem

According to the Victims of Trafficking and Violence Protection Act of 2000, trafficking in 2000 was estimated to affect at least 700,000 people around the world and 50,000 in the United States. Now, the International Labor Organization estimates there are 21 million victims of human trafficking, with most of them exploited for labor. While there are no updated estimates of trafficking victims in the U.S., the National Human Trafficking Resource Center hotline receives more than 35,000 calls for help per year.

Trafficking is a growing problem and there's greater recognition of its existence, says **Dean White**, LCSW, regional director of social work for Dignity Health, St. Joseph's Hospital and Medical Center in Stockton, CA.

"We had an educational meeting with the district attorney, and he said this is growing because they're on the streets and are seeing more and more victims, whether it's from sex trafficking or abuse, because there's money to be made," White says. "Unfortunately, human beings can be taken advantage of again and again, and it doesn't end so long as someone has control over them."

Dignity Health plans to roll out standard education about trafficking to staff at nearly 40 hospitals, White says.

"We're at a pivotal point, and I'm excited to be on a care coordination team with RN case managers and social workers who have been tasked with working with each hospital area and establishing strong relationships with community health, population health, and key stakeholders," White says. "What's unique is that this is a system approach."

Dignity Health began the initiative as a top-down program, Gibbs says.

"It's important to Dignity Health that patients who are victims are identified and that we respond to them effectively," she says. "We are focusing hospital systems right now, implementing the program in maternal-child health, labor and delivery, postpartum, and are rolling out the program systemwide."

The project includes having a community navigator in the ED to identify familiar faces, people who frequent the ED because of mental health issues, poverty, homelessness, or because they are victims of trafficking. It also includes educating all healthcare workers about human trafficking, he says.

Educate, Look for Red Flags

Educational sessions are designed to help healthcare professionals recognize common red flags related to human trafficking. *(See story about trafficking red flags, page 76.)*

The trouble is that healthcare professionals often will see something about a patient that appears unusual or wrong, but they won't know how to ask the patient

questions that might provide clues to what's really going on, White says.

"There are some common themes of when victims of trafficking might have had a lifeline opportunity for someone to save them," he says. "One was being arrested by law enforcement, and the other is hospital emergency rooms."

Traditionally, hospitals have missed this opportunity because healthcare professionals are focused on finding out where the patient hurt and what the medical problem is, White explains.

"We treat the medical problem, and if they're stressed or anxious, we help them calm down," he says. "But we've never taken the time, until recently, to say that as a health system if we can save one life, let's head down that path."

The new education focuses on teaching people when to get a social worker to meet with a suspected victim and how to separate victims from their perpetrators, who often will be with them during the healthcare visit. Case managers and others need to be aware of community resources for victims of trafficking, and, just as importantly, they need to know how to get this information to victims. *(See story on how to handle suspected trafficking victims, page 76.)*

For instance, Dignity Health has business cards that case managers and other healthcare professionals can give to patients. These can be split into three pieces and hidden on a person's body. The cards provide a national human trafficking phone number in which the caller can speak to someone in his or her native language and quickly learn where to find help locally, White says.

Trafficking numbers increasing

In the past decade, there has been a significant increase in the number of people being trafficked in the United States for sexual slavery and forced labor, according to the U.S. National Human Trafficking Hotline, which also is called the Polaris Project.

The tragedy of youth, women, immigrants, and others being terrorized and abused by traffickers within the U.S. is personal history, as well as a professional passion, for Gibbs. She often speaks to healthcare professionals and begins by telling them her own story of being forced into prostitution at age 14. At a shopping mall, she met a man who promised her a glamorous modeling career in Los Angeles. Instead, he took her to Atlantic City, NJ.

> TRADITIONALLY, HOSPITALS HAVE MISSED THIS OPPORTUNITY BECAUSE HEALTHCARE PROFESSIONALS ARE FOCUSED ON FINDING OUT WHERE THE PATIENT HURT AND WHAT THE MEDICAL PROBLEM IS.

"He pretended to be a friend and romantic interest," Gibbs says. "But once I was away from home, he forced me into prostitution."

While she was underage and a prisoner of the trafficker, she had numerous interactions with healthcare professionals, but no one recognized the signs of her plight. Finally, she was arrested for solicitation, and that helped her escape, although the experience was traumatizing. Gibbs eventually went to college, majoring in biology, and she began consulting and speaking about human trafficking. Eventually, Gibbs realized she needed to make it a full-time career, and was offered such an opportunity with Dignity Health, she says.

"Human trafficking can be when someone lures a person from another country and then forces them through violence to work against their will," Gibbs says. "Trafficking can involve a young woman, who is in a new relationship, being lured to another state where the man becomes violent and expects her to engage in prostitution."

Runaway teenagers and children often are victims of sexual trafficking, she adds.

"The perpetrators terrorize their victims, so when victims visit a healthcare facility, they might be in fear of reaching out for help because of the consequences," she says. "Perpetrators target vulnerable people, not healthy kids from loving homes."

Labor traffickers target foreign nationals who do not know English. If they're assaulted or injured on the job they'll be brought to a hospital, but they might not know they can reach out for help, Gibbs explains. "This is why it's important healthcare staff is educated on red flags and the ways to engage patients." ■

Red Flags That a Patient is a Victim of Trafficking

Victims of trafficking potentially could meet any healthcare professional, including case managers. They might have injuries that take them to the ED or sexually-transmitted diseases that take them to a clinic or doctor's office, or they might have diabetes, cancer, or another chronic illness for which they end up working with a case manager.

"I know a trafficking survivor who was diagnosed with cancer and went through her entire treatment while she was being exploited," says **Holly Austin Gibbs**, a patient care services program director with San Francisco-based Dignity Health.

"It's a missed opportunity if healthcare systems are not educating their staff and developing protocols to respond," Gibbs adds.

Healthcare professionals typically are trained to look for signs of abuse and domestic violence, but the red flags of human trafficking are signs they may not recognize without some type of training, says **Dean White**, LCSW, regional director of social work for Dignity Health, St. Joseph's Hospital and Medical Center, Stockton, CA.

"This is a whole new frontier," White says.

A first step is to teach healthcare providers how to recognize the more common signs of trafficking, including the following:

• **Pay attention to vulnerable patients.** While trafficking can affect people of any age, ethnic group, and gender, one common trait among victims is vulnerability, Gibbs says.

"The most vulnerable people are at-risk youth and children, homeless people, people addicted to drugs, foreign nationals, and people lacking in resources or support," she says.

• **Look for signs of exploitation.** Traffickers sometimes accompany their victims to the hospital or doctor visits, but that is not always the case. When they are present with the victim, they will come across as a controlling companion, Gibbs says.

They might not let patients speak for themselves. Or, when patients do speak, they will look nervously over at the other person, White says.

"If they answer, they seem jittery and look at the other person for permission," he says. "These are all red flags, and while it doesn't mean the person is a victim, it shows that something is stressing them out."

• **Identify subtle signs of abuse.** Victims might have signs of being assaulted, or they might simply have a high frequency of urinary tract infections, or a high number of pregnancies that may or may not result in birth, she says.

Also, a person who appears to be under extreme stress and behaves in a guarded, defensive manner could be a trafficking victim, White notes. ■

Tips for Handling Suspected Cases of Trafficking

First step: Create a protocol

Healthcare organizations should have a protocol in place for handling suspected human trafficking cases, says **Holly Austin Gibbs**, a patient care services program director with San Francisco-based Dignity Health.

"I highly recommend that before a potential victim shows up, the healthcare system should be equipped and have everyone educated on the protocol and their role," Gibbs says.

One place to start would be to define human trafficking by referring to the Victims of Trafficking and Violence Protection Act of 2000, which is designed to combat human trafficking especially in the sex trade, slavery, and involuntary servitude.

"The federal trafficking victims act defines what human trafficking means in America," Gibbs says.

The protocol should include information about how healthcare staff could identify victims and handle the cases, says **Dean White**, LCSW, regional director of social work for Dignity Health, St. Joseph's Hospital and Medical Center in Stockton, CA.

Gibbs and White offer the following tips on what to do when a patient is suspected to be a victim of human trafficking:

• **Provide trauma-informed care.** "What's important is that professionals provide victim-centered care or patient-centered care, as well as trauma-informed care," Gibbs says. "These components are important for caring for patients who've been through a trauma such as this."

Trauma-informed care enables healthcare professionals to respond to victims with dignity and respect, and

it will identify the healthcare facility as a place where a victim can return when she is ready to receive help, Gibbs says.

The goal is to prioritize the patient's wishes, safety, and concerns, as a case manager would for any patient. But in the case of patients who are perceived to be victims, healthcare professionals might believe they know which decisions would be best for the person, Gibbs says.

"It needs to be a constant collaborate and ask," she says. "You can say, 'I believe this will be helpful for you; are you okay with contacting this resource?'"

Case managers and other healthcare professionals should keep in mind that the victim they see is someone who might have run away from home at age 13 because of an abusive stepfather and was placed in an abusive foster home situation where she lost trust in the authorities, so she ran away, only to experience violence on the street, Gibbs explains.

"Then she meets a trafficker who says he'll take care of her, but she needs to prostitute for him," she adds. "She might see this as a better option than going home or going into foster care, so trauma-informed care might help people understand why a victim sometimes will refuse help."

• Have a protocol for separating a suspected victim from a controlling companion. A first step is to get the suspected victim to a private place away from the person who might be the perpetrator.

"If they're accompanied by a controlling companion, then that may mean getting creative," Gibbs says. "Keep things friendly and try not to raise any red flags; you could say, 'We need to do some additional diagnostic testing, could you please wait in the waiting room?' Or you could say, 'We're going to take her to get a urinalysis.'"

• Build rapport or call in a social worker. Case managers often are trained to develop rapport with patients, so they can be trained to handle suspected victims with sensitivity. But a healthcare organization might also want to have these cases referred to a trained social worker.

"We ask open-ended questions and the patient will fill in the gap," White says. "Saying, 'So I see you came in for a broken ankle' will shut down conversation."

Instead, the case manager or social worker could ask, "Do you mind if I come in and talk with you for a minute?" White suggests. "This sets the stage so the patient doesn't think you're being overbearing, standing over them, and barraging them with questions; think about everything from the patient's perspective."

Rapport-building also includes keeping a calm and reassuring demeanor, and asking suspected victims if they would like water, or a blanket if they're cold, or a fan if they're hot, White says.

"Meet their basic needs, listen to them, and try to establish rapport so you can say, 'I got called in because the nurse thought there may or may not be any issues at home. Are you safe? What's going on?'"

• Ask questions that might provide clues to the person's status as a victim. One of the first questions to ask is, "Do you feel safe at home?" Another is, "Who is your source of support?" White suggests.

He suggests asking the following additional questions:

- "You seem kind of anxious, what's going on with that?"
- "Is there someone you feel safe with?"
- If the person says she lives with her boyfriend, ask, "Is he always there, or are there any concerns you have with him?"
- "How are you doing?"
- "Do you have any questions or concerns?"

• Offer a safety line. Once a case manager or other healthcare professional has developed rapport with the patient, then it's time to offer the person a safety line, White says.

If the suspected victim is underage or in a life-threatening situation, it might be necessary to contact child protective services or law enforcement, White says.

In some other cases, the best action is to plant the seed that help is available and offer a safe environment for when the person is ready, he notes.

"You can say, 'Here's some information if you ever need to talk with someone outside of the hospital; it's a national hotline,'" he says. "The trafficking hotline number has access to 200 languages and they're not mandated reporters." ■

EXECUTIVE SUMMARY

Every healthcare system should have a protocol and system for handling suspected trafficking victims, according to a speaker and expert on the subject.

- Protocols might include staff education on providing trauma-informed care.
- Healthcare professionals need to know how to separate a victim from the controlling perpetrator.
- Providers should have a mental list of questions to ask of suspected victims.

Avoid These Common Pitfalls in Care Transitions

Focus on top obstacles

As case managers provide the emollient that keeps the healthcare system's care transitions in motion, there are some common pitfalls they need to avoid.

"There are pitfalls that occur during transition of care, and they take place whether patients go from the hospital to a skilled nursing facility [SNF] or SNF to home health, wherever they're transitioning," says **Richard Lasota**, RN, CCM, director of business development for the Southwest division of Life Care Centers of America in Phoenix.

"There are things we take for granted and things we do as care managers that don't work well for patients," Lasota says. "We need to focus on the top four or five things that we run across in our day-to-day lives that cause patients and families a little bit of heartache."

Lasota lists the top care transition pitfalls, as follows:

• Helping patients make informed decisions. Often it's the case manager's role to guide patients and their families into making decisions about the next steps in their healthcare journies. But this moment often is shortchanged, Lasota says.

"So many times in the healthcare industry we talk about freedom of choice and how people need to have choice," he says. "But what happens 90% of the time is the case manager will come up to a patient and family at the last minute and say, 'Hey, you have to go to a skilled nursing facility, so here's a list.'"

The list might have 30-plus facilities, which is no better than handing someone a phone book, Lasota says.

"It doesn't take into consideration that patient's condition, what type of care the patient needs, or what the facility is rated," he says.

Instead, case managers should begin discussions about care transition much sooner, giving people time to visit facilities and to check Medicare star ratings of each site, he suggests.

When case managers give people choices without giving them the kind of information that's necessary to make an informed decision, then it will result in frustrated patients and families, he says.

"You have to figure out a way to provide not just a list, but also some guidance that will help people make a more educated decision," Lasota says. "Have some set of criteria to help guide that person."

Criteria could include Medicare star ratings and information about the types of services the next site could provide. For instance, if the patient needed a specific health service and many providers did not have that service, those sites could be eliminated from consideration, he says.

"If you hand patients a stack of brochures, then all you're doing is having them pick the facility with the best graphic art designer and not the facility that will meet their needs," Lasota says.

• Keep patients' families/ caregivers informed. When case managers are dealing with patients who have involved family members or caregivers, it's important to keep them in the loop with changes and decisions. Poor communication can lead to major problems for the people involved, Lasota notes.

"One woman I worked with had a husband in the hospital for four days, and while she was at work, someone called to tell her that in two hours her husband would need to be picked up and taken to a skilled nursing facility," Lasota recalls. "These are situations that are just wrought with bad choices and having a bunch of people scrambling around, trying to get the patient transferred."

Other situations might include a community case manager assisting a patient in seeing a new provider who orders new therapy, but no one tells the patient's family. When the family visits the patient, they are surprised by seeing strangers in the home.

EXECUTIVE SUMMARY

Transitions of care can be difficult if case managers fail to prepare for some of the more common obstacles and problems.

- Case managers need to guide patients and caregivers when they make decisions about the next step.
- Above all, keep patients and caregivers informed of what's going on and when a care transition will occur.
- Listen, nonjudgmentally, to patients' and caregivers' concerns and goals.

It's always a good idea to let patients' caregivers know what is going on, when changes will occur, and whether there is anything they need to do to facilitate the new healthcare services, Lasota says.

• **Speak with words patients and families can understand.** "When we talk with families and patients about their transition of care, we have to be careful to speak in a language that the patient and family understand," Lasota says.

Avoid abbreviations, medical terms, and jargon, he suggests.

"It can confuse people and, unfortunately, a lot of adults won't ask questions," he adds. "They'll kindly sit there and smile and nod at you, so you have to explain things in a way they can understand."

Case managers also can ask patients and caregivers to repeat back what they've said and then correct any misperceptions.

"This will cut down on their frustration and anger," Lasota says. "It's a simple thing and takes an extra minute, but that extra minute is well spent."

• **"Listen with our ears and not our mouth."** Patients can tell case managers what they need and want, but someone has to hear them, Lasota says.

"How many times do we have a preconceived idea of what the plan should be for the patient, and we're not even listening to the patient?" he says. "Listen to their concerns, listen to what they're trying to say, and then have a conversation with them."

Case managers will know patients' fears and anxiety after spending time with them, and then they can help them make better decisions, he adds.

The goal is to do what case managers already do best: Think outside the box. Maybe one particular plan would work best for a patient, but if the patient has another idea, then it's time to think of an alternate way to achieve the same positive health outcome. For example, perhaps a patient would do well in a skilled nursing facility, but if the patient wants to go home, then maybe family members or a private duty nurse could care for the patient as well, Lasota says. ■

These Strategies Will Improve Care Transitions for Elderly Patients

"It takes a village" is mantra

"Transitional care" increasingly are buzzwords used to describe the kind of work case managers do, but too often there's a tendency to treat all patients in the care continuum in similar ways despite their different demographics and circumstances.

"There's not one solution out there; it takes a village, and everyone is part of that solution," says **Rani Khetarpal**, CEO of Global Transitional Care in Newport Beach, CA.

"Everyone at the table is trying to solve the problem on their own, and then they realize they can't solve it on their own," she adds. "They have to work collaboratively to keep the patient at the center."

With elderly patients, the care continuum can have hidden obstacles and risks. It takes an experienced case manager to identify and prevent problems. This strategy can include having case managers visit high-risk patients' homes to find answers to personal and environmental barriers to improving their health. Based on more than a year of data and 250 patients seen by Global Transitional Care, this approach works, Khetarpal notes.

"We have had zero preventable readmissions and five unpreventable readmissions on very high acuity-type of patients," she says.

An example of a barrier that might only be discovered with a home visit is this: A patient who has been discharged home from the hospital told providers that she has a wonderful support system of family and friends who will help her get groceries and assist with medications, Khetarpal says.

"But when the patient gets home, something is lost in translation," she says. "The person goes home and the nurse finds out that, yes, the daughter does live in town, but she won't be there to help the patient with medication or to drive the patient to doctors' appointments."

The daughter might be giving the patient some support, but just not the kind the patient needs to keep from going back into the hospital, Khetarpal adds. "We look at all the notes and discharge planning and 100% of the time, we find the reality is very different."

Handling medications is a

problem that can be amplified for older patients who have many different prescriptions.

"What patients might not tell the case manager is they have a fishbowl of medications, and they just throw all of them in there," Khetarpal says. "They don't know how to ask what they should do with their old medications at home."

This is where a case manager's or advanced practice nurse's home visit can be very important: "When we go into the home, we say, 'Please bring out all your medications,'" Khetarpal explains. "They will bring out the fishbowl, and our nurse will go through the medications and find duplicates and things that are not valid."

Deciphering the daily life of elderly patients during care transitions periods can be challenging, and it requires asking the right kind of questions, she says.

"You need to know what kinds of questions to ask that will evoke deeper answers," Khetarpal says. "So when patients tell you their daughter will support them, ask, 'What does that mean to you, and tell me about that support.'"

Not asking the right questions or having a home visit can lead to major problems. For instance, Khetarpal recalls a case where an older patient left the hospital with a walker. "We were in contact with the case manager and the discharge manager," she says. "When we called the patient, he said, 'We have home health, and my wife is here; I have my meds, and all is fine.'"

But it wasn't fine, or anywhere close. It turned out that the man's house was under construction, and his wife worked. So the man was trying to get around with a walker in a house's construction zone, and there was no one around to help him, Khetarpal recalls.

CASE MANAGEMENT TELEPHONIC INTERVENTION IS VERY IMPORTANT, BUT OFTEN IT TAKES A HOME VISIT TO DISCOVER THE ISSUES THAT MIGHT RESULT IN PATIENTS BEING READMITTED.

"He couldn't get into the bathroom when he needed it, and there was no home health," she says. "So he needed home health for medication administration at the very least."

There was an almost certain probability that the man would be readmitted. "You can imagine the mess we saw when we walked in there," Khetarpal says. "It was a high-risk fall situation, and the man was a diabetic; it's so clear when you go into patients' homes why they end up back in the hospital."

In another case, a patient who was an orchestra violinist had a broken arm. The woman, in her 70s, returned home in a state of emotional exhaustion since the injury affected her work and passion. On top of that, she was the chief caretaker of a husband who had Parkinson's disease, Khetarpal recalls.

"The woman expected her daughter to take care of her, but the daughter was very busy with a severely autistic son," she says.

The patient had comorbid conditions that qualified her for in-home services, but what she mostly needed were social services, Khetarpal says. "We got her Meals on Wheels because she couldn't cut food, and we found her transportation services because she couldn't drive."

The woman also benefited from home health therapy for her arm and clergy services to help with her emotional distress. Without this help, she likely would have ended up back in the ED within a day or two of discharge, Khetarpal says.

Telephonic case management intervention is very important, but often it takes a home visit to discover the issues that might result in patients being readmitted, she says. "When you walk in the front door, you can see the reality of it." ■

EXECUTIVE SUMMARY

Care transition for elderly patients is fraught with hidden obstacles and risks. Experienced case managers can identify and prevent problems.

- Visiting patients' homes can yield answers to questions about multiple medications and home environment.
- Ask questions about what they mean when they say their loved one can take care of them.
- Sometimes the best help can be from social and emotional services.

Take a Multidisciplinary, Team-based Approach on Elder Abuse

Experts say elder abuse is not only common, it is also linked with adverse outcomes among victims, costing the country billions of dollars every year. Despite the scope of the problem, signs of elder abuse often go unreported and unrecognized. That's understandable, given that it can be difficult to discern between abuse and various disease processes that occur in older adults.

Nonetheless, new research suggests there is ample room for improvement in the way elder abuse is identified and managed, and as with so many other issues, the emergency setting offers perhaps the best opportunity to identify elder abuse and begin to remedy a situation in which an elder person is unsafe at home.

Why do staff often miss signs of elder abuse in the emergency setting? There are multiple contributing factors, according to **Anthony Rosen**, MD, MPH, an emergency physician at New York-Presbyterian Weill Cornell Medical Center.

"There are disincentives to evaluate this. [Emergency providers] are busy, and we realize that if we do identify this, then suddenly we've got a whole set of things that we have to deal with," he explains. "In addition, physicians [often] aren't educated on this, aren't comfortable assessing for it, or aren't comfortable with what they would do if they found something to be positive."

Rosen, who specializes in geriatric emergency medicine, adds that while physicians may feel ethically and morally obligated to report signs of potential elder abuse, they are much less confident in assessing for this issue.

"If you are assessing a patient in a hallway, assessing a patient very briefly, or assessing a patient with the perpetrator standing right next to the patient, you are not likely to find it," he says.

Further complicating the assessment process is the fact that it is often difficult for the at-risk patient to be interviewed alone without the presence of a caregiver, and it can be inconvenient to conduct an exam without a caregiver present, Rosen says.

"In addition, patients themselves may have significant incentives not to tell us the truth," he says. "Particularly for older patients, the caregiver is providing them care; even if [he or she] is also abusing them or neglecting them, this person is also providing them care, and there is a significant concern among many patients ... that this caregiver will abandon them and they might go to a nursing home or there will be another very concerning outcome for them."

Add to these challenges the reality that some of these older patients have dementing illnesses that may make it difficult for them to report neglectful or abusive behavior.

"Even if they do report it, the provider may not be sure that the report is accurate because of the dementing illness, and so the provider will doubt the story," Rosen notes. "The fact the caregiver is more easily able to offer information may incline the physician to trust the perpetrator."

In other instances, the older adult may not suffer from cognitive impairment, but he or she may speak a different language, complicating the reporting process.

"The translator may be the caregiver at the bedside who may also be the perpetrator, and so we may not take the time to use a translator to speak to the patient alone," Rosen explains.

Providing great care to a victim of elder abuse requires time and setting up a circumstance whereby one can actually communicate with the patient reliably and alone, Rosen says.

"In addition, it takes time to then do follow-up, whether that means connecting with a social worker, connecting with adult protective services [APS], or connecting with the police," he explains. "If you find something, you are likely to have created additional work for yourself."

While most states require providers to report suspected cases of elder abuse to APS, there is little evidence that this requirement has incentivized more reports in the same way a similar requirement has prompted providers to report cases of suspected child abuse.

Rosen acknowledges providers may well be concerned about negative consequences if a suspected case turns out not to be elder abuse at all. But he also observes that providers apparently feel very differently about child abuse.

"With suspected child abuse, providers would much rather identify a case and have someone else tell them later that it was not child abuse than let a questionable case go home," Rosen notes. "We have decided as a society that we would rather be sensitive than specific with child abuse."

However, providers have not made the same calculation with respect to elder abuse, Rosen says.

"Because we are only finding one in every 24 cases, the pendulum needs to swing more toward overdetection," he says. "Right now, we are dramatically

underdetecting."

Rosen acknowledges that it is often much more difficult to detect signs of elder abuse than child abuse, for which there is a large base of literature documenting that certain injury patterns are almost unequivocal red flags. He notes older adults are more likely to bruise because of blood thinning medications, and they are more likely to present with fractures due to diseases such as osteoporosis or medications that can cause bone thinning.

To get around some of these issues, Rosen and colleagues are working to identify injury patterns that are consistent with elder abuse so that providers have more tools to work with in identifying a problem that can be very difficult to confirm.

Rosen also advocates for a multidisciplinary, team-based approach to identify elder abuse in the ED, and he is working with colleagues to establish such a team in his own setting.[1]

"Every person can have a role, and every set of eyes is worth training to have focused on this issue because [elder abuse] is worth finding, and it is really hard to find," he explains. "Training every member of the team and empowering every member of the team is important."

For example, Rosen notes that in many EDs the radiology suite is the only area in which a patient is free to discuss sensitive issues without input or influence from others. Consequently, an observant radiology tech could prompt a discussion with the patient about the source of an injury or the patient's safety at home.

"People don't go into the radiology suite with their spouse or their daughter or their mother, so the radiology suite is truly a zone of privacy," Rosen says. "In an emergency practice, it is the only place where you are guaranteed to have the patient alone."

Further, Rosen suggests that EMS providers offer a key perspective, given they have actually seen the patient in his or her home setting, but the other members of the team have to be open to receiving and acting on the information.

"In my own clinical experience, one of the real challenges is making sure that the information that EMS learns — a lot of which is gold, some of which relates to elder abuse, and some of which relates to all kinds of different things that are important to knowing how to care for the patient — does not get lost in the EMS/ED interface," he explains. "That is a ripe area for improvement."

In fact, Rosen notes that he and colleagues working on this issue find EMS workers are often frustrated that their reports about situations in a patient's home are ignored or discounted, he explains. For instance, when EMS providers bring to the ED an elderly patient who has suffered a fracture from a fall, they may inform a social worker and the emergency medical team that there is a fall risk in the home.

"A week later they are called back to the same place for the same patient for the same problem," Rosen explains. "They get a lot of feedback that their information is not getting passed on."

To encourage such reporting, emergency providers need to recognize the critical information that EMS provides, Rosen stresses.

"Make sure to seek it and act on it," he says. "EMS has a critical role here. They can open up the refrigerator, look at the pill bottles ... and notice an unusual interaction in the home."

Marguerite DeLiema, PhD, a postdoctoral researcher at the Stanford University Center on Longevity, agrees that prehospital providers can play a critical role in giving emergency providers a clearer picture of what is actually happening with an older patient. She has reported on how physical signs or symptoms can easily be misinterpreted.[2]

"The real story is in the home and in the interactions between the caregiver and the patient," she explains. "That will give you so much more information on whether a patient is a victim of criminal negligence or whether [the caregivers] are just struggling and can't meet the needs of an older person even though they are doing the best they can."

Paramedics are in a prime position to know where the older person is living in comparison to other family members and whether the environment is clean and safe. Unlike with social workers' planned visits, for example, there is little chance for the environment to be staged by a caregiver or perpetrator of elder abuse, Rosen notes.

Another benefit of the multidisciplinary team approach is that it provides opportunities for clinicians to expand on their command of the issue.

"Physicians can learn a lot by working with a geriatrician who identifies the signs [of elder abuse] or working with a social worker who understands more of the nuanced social side of caregiving and why some people might show up in the ED looking the way they do," DeLiema says. "It brings the issue [of elder abuse] more on their radar screen ... and informs the physician's decision about what is a safe place for the patient moving on."

DeLiema would like to find a way for emergency providers to interact more with APS, but she observes that resources are strained.

"Funding [to APS] has not kept pace with the growth of the older adult population, and there is a lot of turnover in those agencies and a lack of follow-up," she explains.

Another concern is that in cases of suspected elder abuse or neglect in

which older adults have maintained their cognitive capacity, they have the right to refuse APS services.

"A lot of times we see these older adults being brought in by a caregiver, and the older adults will defend their caregiver no matter what," DeLiema says. "They would rather live in an acknowledged abusive situation than face the risk of maybe being moved into a nursing home or assisted living facility, or having anything bad like an arrest happen to their caregiver ... so APS has its hands tied in a lot of situations, and providers know that."

Even in cases in which an older adult refuses services, however, it is important for emergency providers to note their concerns.

"Keep really accurate documentation so that if law enforcement or APS needs these records they can subpoena them ... if the case goes to court," DeLiema explains. "It really is the emergency providers who might be the first providers that these patients see. They are on the front lines."

While it's clear that elder abuse is significantly underreported, Rosen believes this is an area that emergency providers can improve. In fact, he likens the state of affairs on this issue to the way things used to be with respect to intimate partner violence (IPV).

"One of my mentors told me that 20 or 30 years ago, emergency providers didn't even ask about intimate partner violence or spousal abuse. They had nothing to offer the victims, so it [apparently] wasn't even worth knowing about," he explains.

While emergency providers generally don't feel this way about IPV anymore, Rosen suspects providers now may be reluctant to identify elder abuse, feeling they don't have the resources, time, or expertise to address it.

Rosen has received feedback on his elder abuse research from emergency providers, telling him that without money or resources, emergency providers should not be expected to address yet another social problem.

"That is a reasonable perspective," Rosen offers. However, he and his research colleagues offer a different perspective. "We make the argument that [elder abuse] is medical, and that the ED is the ideal place to evaluate for it."

There is no question that large, academic medical centers such as New York-Presbyterian Weill Cornell Medical Center often are better equipped to take on the issue than small community hospitals.

"We have a social worker available 24/7 in our ED, but many of my colleagues and former residents don't have that luxury and it changes the dynamics of what you are able to do," Rosen explains.

To get around such barriers, Rosen and colleagues are making a business case for developing incentives that would encourage providers to take on elder abuse.

"You could certainly imagine settings in which payers would be interested in reducing all the associated medical costs, which are thought to be in the billions of dollars," Rosen says. "This is worth finding."

DeLiema agrees, but observes there is too little evidence that medical providers are stepping up to the plate.

"This is a big concern, but only lip service is being paid to detecting elder abuse, and not just in the ED, but for many different providers," she says.

What can providers do to improve their recognition and management of elder abuse? Rosen notes that resources are available nationally and locally. In particular, he suggests emergency providers reach out to the National Center on Elder Abuse (http://www.ncea.aoa.gov/). Further, he encourages EDs to find and connect with groups targeting this issue in their local communities.

"Most of these local task forces or teams are desperate for physician input and physician communication," he says. Another source is Geri-EM, a website (http://geri-em.com/) that offers training and a range of information on caring for the older adult.

Additionally, Rosen and colleagues are preparing some training resources on elder abuse designed specifically for emergency providers. Rosen notes that providers should feel free to reach out to him if they are interested in obtaining these materials or if they have any questions about how to move forward on this issue in their own settings.

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CE QUESTIONS

1. What percentage of human trafficking survivors say they had contact with the healthcare system while they were being exploited?

A. 50%
B. 65%
C. 79%
D. 90%

2. Which of the following is not a sign that a patient is being exploited by a human trafficker?

A. The patient is with a companion who is very controlling and answers questions for the patient.
B. The patient appears to be under extreme stress and behaves in a guarded, defensive manner.
C. The patient reports an addiction to marijuana.
D. The patient has had multiple urinary tract infections or many pregnancies.

3. One way to prevent patients from becoming angry and frustrated during care transition periods, according to Richard Lasota, RN, CCM, is to do what?

A. Speak to patients and their caregivers in clear and simple language, avoiding medical jargon and acronyms.
B. Give patients movie passes or other incentives to adhere to their medication regimens.
C. Apologize to patients for long waits.
D. All of the above

4. Which of the following is a good reason a case manager might want to visit a patient's home rather than rely solely on telephonic support?

A. Patients might report they have adequate support from their family members, but an in-home visit can reveal the family members work full time or are not available when needed.
B. Patients might have a fishbowl of medications and be unable to figure out how to take their new pills or what to do with their old ones.
C. Patients might appear on paper to be able to handle their medical condition without professional in-home care, but when visited, it is clear they have psychological and social issues that could land them back in the emergency room.
D. All of the above.