

Detecting Elder Abuse and Neglect: Assessment and Intervention

ROBERT M. HOOVER, MD, *University of Tennessee Health Science Center College of Medicine, Memphis, Tennessee*
MICHOL POLSON, PhD, *Cascades East Family Medicine Residency Program, Klamath Falls, Oregon*

Elder mistreatment includes intentional or neglectful acts by a caregiver or trusted person that harm a vulnerable older person. It can occur in a variety of settings. One out of 10 older adults experiences some form of abuse or neglect by a caregiver each year, and the incidence is expected to increase. Although the U.S. Preventive Services Task Force found insufficient evidence that screening for elder abuse reduces harm, physicians in most states have professional and legal obligations to appropriately diagnose, report, and refer persons who have been abused. Screening or systematic inquiry can detect abuse. A detailed medical evaluation of patients suspected of being abused is necessary because medical and psychiatric conditions can mimic abuse. Signs of abuse may include specific patterns of injury. Interviewing patients and caregivers separately is helpful. Evaluation for possible abuse should include assessment of cognitive function. The Elder Abuse Suspicion Index is validated to screen for abuse in cognitively intact patients. A more detailed two-step process is used to screen patients with cognitive impairment. The National Center on Elder Abuse website provides detailed, state-specific reporting and resource information for family physicians. (*Am Fam Physician*. 2014;89(6):453-460. Copyright © 2014 American Academy of Family Physicians.)

CME This clinical content conforms to AAFP criteria for continuing medical education (CME). See CME Quiz Questions on page 428.

Author disclosure: No relevant financial affiliations.

The National Center on Elder Abuse defines elder abuse as “intentional or neglectful acts by a caregiver or ‘trusted’ individual that lead to, or may lead to, harm of a vulnerable elder.”¹ Although some authors draw distinctions among mistreatment, abuse, and neglect, this article uses the terms inclusively and interchangeably. The major manifestations of elder abuse are described in *Table 1*.²

Abuse appears to occur most often in domestic home situations, and may be perpetrated by adult caregivers, family members, or other persons.³ It may also occur in institutional settings such as long-term care facilities, nursing homes, or hospice.^{4,5} Older patients (older than 75 years) tend to have more risk factors (i.e., shared living arrangements, cognitive impairment with disruptive behaviors, social isolation from family and friends, caregiver mental illness [e.g., major depression], alcohol misuse, and caregiver dependency on the older person [e.g., financial]).⁶ These same risk factors can be barriers to detection of abuse. Not all patients who experience abuse readily demonstrate or express risk factors, and, conversely, many patients with risk factors are not being mistreated.

Prevalence

U.S. estimates indicate that one out of 10 older adults experiences abuse or neglect by a caregiver each year.^{7,8} In addition, it appears that only a fraction of cases are reported to authorities, although reported and investigated cases have increased. A study of state Adult Protective Services (APS) cases found that investigated reports increased by 16.3% and that substantiated reports increased by 15.6% from 2000 to 2004.⁹

A Growing Problem

Over the next 20 years, the geriatric proportion of the U.S. population is projected to increase from 12% to 31%.¹⁰⁻¹² Family physicians can expect more instances of elder abuse because larger numbers of older persons will need medical care.^{12,13} As more states mandate reporting by physicians (most already do), there will be increasing obligations for detection and assessment.¹⁴ Despite this expected increased demand for expertise, physicians generally lack training, experience, education, and adequate guidelines for the assessment and management of abuse. Less than 2% of reports of elder abuse and neglect to state APS agencies come from physicians.¹⁵ A 2005 survey of family physicians

SORT: KEY RECOMMENDATIONS FOR PRACTICE

<i>Clinical recommendation</i>	<i>Evidence rating</i>	<i>References</i>	<i>Comments</i>
Physicians should routinely inquire about risk factors for elder abuse.	C	20-22	Consensus
The Elder Abuse Suspicion Index can be used to assess for risk of and suspected elder abuse.	C	23	—
Screening for cognitive impairment should be performed before screening for abuse in older persons.	C	24, 26, 34	—
Physicians should be aware of medical conditions and medication effects that can mimic abuse in older persons.	C	28, 29	Disease-oriented evidence
Patients and caregivers should be interviewed separately when screening for elder abuse.	C	21	Usual practice
Specific patterns of injury are more suspicious for intentional injury in older persons.	C	28-33	Disease-oriented evidence

A = consistent, good-quality patient-oriented evidence; B = inconsistent or limited-quality patient-oriented evidence; C = consensus, disease-oriented evidence, usual practice, expert opinion, or case series. For information about the SORT evidence rating system, go to <http://www.aafp.org/afpsort>.

Table 1. Types of Elder Abuse

<i>Types of abuse</i>	<i>Characteristics</i>	<i>Examples</i>
Financial or material	Illegal or improper use of funds or resources, exploitation	Theft of debit or credit cards, coercion to deprive the older person of assets (e.g., forcible transfer of property or accounts)
Neglect or abandonment	Intentional or unintentional refusal or failure of designated caregiver to meet needs required for an older person's well-being	Failure to provide adequate food, clothing, shelter, medical care, hygiene, or social stimulation/interaction
Physical	Infliction of pain or injury	Slapping, hitting, kicking, force-feeding, restraint, striking with objects
Psychological or emotional	Infliction of mental anguish	Verbal aggression or threat, threats of institutionalization, social isolation, humiliating or degrading statements
Sexual	Nonconsensual genital contact, unwanted sexual talk	Suggestive talk, forced sexual activity, touching, fondling a nonconsenting competent or incompetent person

Adapted with permission from Perel-Levin S. Discussing Screening for Elder Abuse at Primary Health Care Level. Geneva, Switzerland: World Health Organization; 2008:6.

and internists found that more than 80% of them could not recall any medical school or residency training in this area.^{16,17} Another survey showed that 44% of residency program directors report actively screening patients for elder abuse.¹⁸

Screening

The U.S. Preventive Services Task Force found that current evidence is insufficient to assess the balance of harms and benefits of screening all older or vulnerable adults for abuse and neglect. At this time, there does not appear to be supportive evidence that screening and early detection of elder abuse and neglect reduce exposure to abuse, or physical or mental harm from abuse.¹⁹ The Joint Commission, National Center on Elder

Abuse, National Academy of Sciences, and American Academy of Neurology recommend routine screening, and the American Medical Association recommends routine inquiry.²⁰ Identification of and intervention in abuse are considered by many to be a professional responsibility for physicians and are an accreditation requirement for hospitals. The University of Maine Center on Aging, Maine Partners for Elder Protection recommends screening once or twice yearly.²¹

It is not clear if using specific screening protocols decreases the incidence or impact of elder abuse any more than simply having a generally increased threshold of suspicion.⁵ Validated screening instruments are available for physicians to consistently and systematically inquire about abuse. If a family physician

Questions 1 through 5 asked of the patient; question 6 answered by the physician.

Within the past 12 months:

1. Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?	Yes	No	Did not get answer
2. Has anyone prevented you from getting food, clothes, medication, glasses, hearing aids, or medical care, or from being with people you wanted to be with?	Yes	No	Did not get answer
3. Have you been upset because someone talked to you in a way that made you feel shamed or threatened?	Yes	No	Did not get answer
4. Has anyone tried to force you to sign papers or to use your money against your will?	Yes	No	Did not get answer
5. Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?	Yes	No	Did not get answer
6. Physician: Elder abuse may be associated with findings such as poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the past 12 months?	Yes	No	Not sure

NOTE: The EASI was developed to raise a physician's suspicion about elder abuse to a level at which it might be reasonable to propose a referral for further evaluation by social services, Adult Protective Services, or the equivalent. Although all six questions should be asked, a response of "yes" on one or more of questions 2 through 6 may establish concern. The EASI was validated for family physicians to administer to older persons with a Mini-Mental State Examination score of 24 or greater who are seen in ambulatory settings.

Figure 1. The Elder Abuse Suspicion Index (EASI).

Information from reference 23. Reprinted with permission from Mark Yaffe, MD. © The Elder Abuse Suspicion Index (EASI) was granted copyright by the Canadian Intellectual Property Office (Industry Canada).

chooses, preventive health visits may function as a reasonable occasion for screening.^{20,21}

THE ELDER ABUSE SUSPICION INDEX

Few instruments designed to detect risk of or suspected abuse have been validated in primary care settings.²² The Elder Abuse Suspicion Index (EASI) was validated in a primary care setting and can be used by physicians to screen cognitively intact patients during routine visits (*Figure 1*).²³ It has a sensitivity of 0.47 and a specificity of 0.75. The EASI includes five patient-answered items, plus one physician question that can identify patients who are at risk. At least one "yes" response to questions 2 through 6 indicates a need for further assessment.²³

Screening older patients for mistreatment may follow a one- or two-step process, depending on the patient's level of cognitive function. When the physician has known a normally functioning, cognitively intact patient over time, one-step screening using the EASI is recommended. When the physician does not know the patient or suspects dementia, the two-step process begins with screening for cognitive impairment with the Mini-Cog.²⁴ It can be administered in less than five minutes and has comparable sensitivity and specificity to the well-known Mini-Mental State Examination.^{24,25} If the

Mini-Cog is negative for dementia, the physician may administer the EASI. If the Mini-Cog is positive, further assessment should clarify cognitive impairment before screening for abuse. Cognitive deficits may be limited to specific domains, and a patient may retain memory and capacity in others.

Medical History

Patients who present with injuries or signs of abuse should be evaluated, treated, and appropriately referred. The physician should begin by asking open-ended questions, such as "Can you tell me what happened?" and "What do you remember about how this injury occurred?"

A complete medical and surgical history, as well as a complete medication review, should be obtained, including identification of who is responsible for supplying and managing the patient's medications. Specifically, old trauma, evidence of metabolic bone disease, and use of anticoagulants should be noted. A brief functional assessment should assess activities of daily living (e.g., hygiene, toileting, dressing) and instrumental activities of daily living (e.g., shopping, managing finances, managing medications).^{26,27} Next, the patient should be asked about the safety of the home environment. Lastly, questions such as those in the EASI assess the patient's

Table 2. Diseases and Conditions That Mimic Abuse in Older Persons

<i>Abuse mimicked</i>	<i>Condition</i>	<i>Abuse mimicked</i>	<i>Condition</i>	
Blunt force trauma/contusion	Allergic reactions	Neglect	Constipation from medications or hypercalcemia	
	Bleeding disorder secondary to medications		Dehydration secondary to medications	
	Cushing syndrome		Diabetes mellitus	
	Fixed drug eruption		Fecal impaction	
	Fracture from osteoporosis or Paget disease of bone		Poor wound healing	
	Fragile photo-aged skin		Urinary tract infection (in women)	
	Senile purpura		Vaginitis	
	Steroid purpura		Sexual assault	Cystocele, uterine prolapse
	Subdural hematoma secondary to a fall or coagulopathy			Decreased anal sphincter function
	Thrombocytopenia			Fixed drug eruption
	Burns and scalds		Contact dermatitis	Starvation
Stevens-Johnson syndrome from medications		Perineal excoriation from incontinence or lichen sclerosus		
Toxic epidermal necrolysis		Vaginal bleeding and excoriation from low estrogen		
Chemical restraint	Iatrogenic polypharmacy or drug-drug interactions	Starvation	Vaginitis	
	Increased drug levels secondary to decreased renal clearance		Anorexia caused by mental illness	
				Inflammatory bowel disease
				Malabsorption caused by hypothyroidism
			Weight loss from diabetes mellitus	

Adapted from Collins KA. Elder maltreatment: a review. Arch Pathol Lab Med. 2006;130(9):1294.

experiences and perceptions of personal safety. When abuse or neglect is strongly suspected, referral for complete multidisciplinary functional assessments may include home visits by local social workers, concerned family or friends, or APS authorities.

While assessing for suspected elder abuse, physicians must differentiate disease processes or normal aging from signs of injuries (Table 2).²⁸ Underlying conditions that mimic intentional injury or predispose the patient to injury should be noted. Adverse reactions to home remedies and prescription and nonprescription medications can resemble intentional injuries. Some ethnic groups use traditional healing methods, such as cupping, moxibustion, or coin rubbing, which may cause skin lesions resembling intentional injury.²⁹

INTERVIEW PATIENT AND CAREGIVER SEPARATELY

An older patient's neurologic, cognitive, or psychiatric conditions and family dynamics may create barriers to obtaining a reliable history. Fear of retaliation, shame, dependency on the caregiver, and lack of privacy may

hinder disclosure. Using neutral, nonjudgmental questions, family physicians should encourage patients and caregivers to provide detailed information. Interviewing the patient alone, when possible, is paramount.²¹ Some older persons have such high dependency on caregivers for navigating health care systems that they are unable to give a one-on-one interview. A potential red flag for the possibility of elder mistreatment is a caregiver who often interrupts the patient to answer questions for him or her. However, such behavior does not always indicate elder mistreatment, and it could be a compensatory behavior for a patient with cognitive impairment. A hovering and protective caregiver does not imply patient intimidation. Some families may not trust health care professionals based on past experiences. Responding with reassurance and sensitivity overcomes patient and family resistance in many, if not most, cases.

Physical Signs of Abuse

Physical findings specific to abuse are rare. Patterns of injury such as ligature marks; multiple burns; and bruises on the abdomen, neck, posterior legs, or medial arms do

not generally originate from unintentional trauma such as falls. Physicians might not be able to accurately determine the age of bruises or burns; however, particular sizes, patterns, and locations may suggest intentional injury (Table 3).²⁸⁻³⁰ The presence of unusual or unexplained fractures (e.g., spiral long bone fractures, first rib fractures) requires a more thorough skeletal survey and evaluation for metabolic bone disease.

No laboratory tests exist to definitively detect abuse. Undetectable levels of prescribed drugs may indicate medication withholding, which, in the case of a dependent older person with cognitive impairment, constitutes neglect. Caregivers may divert controlled substances for illicit use. Elevated therapeutic drug levels without medical explanation may indicate intentional or unintentional overdose. The presence of drugs or other toxins that are not prescribed may indicate poisoning. Coagulation studies and a platelet count can rule out a medical reason for abnormal or excessive bruising.

Body charts or clinical photographs (obtained with appropriate consent) are useful to document the location and shape of injuries such as bruises, skin tears, burns, and other skin conditions. If a recent sexual assault is reported or suspected, a forensic examination should be performed by a person with appropriate training and expertise.³¹ The central question for differentiating unintentional from intentional injuries is: "Is the explanation provided reasonably consistent with the physical findings?"

Management and Intervention

Depending on the acuity of the presentation, hospitalization may be necessary to provide treatment and protection during further evaluation or pending legal investigation.^{32,33} In the case of positive results on screening tests or other suspicion of abuse, actions are dictated by statutory reporting requirements. Family physicians will need to involve local social services and APS to determine options for disposition.

No consensus exists for a single standard algorithm for the evaluation and management of elder abuse. However, the general

Table 3. Signs and Symptoms of Possible Elder Abuse or Neglect

Bruising in unusual locations (not over bony prominences; on lateral arms, face, or back; larger than 5 cm)	Patterned injuries such as hand slap or bite marks; ligature marks or scars around wrists, ankles, or neck suggesting inappropriate restraint
Burns in patterns inconsistent with unintentional injury or with the explanation provided (e.g., stocking or glove pattern, suggesting forced immersion)	Poor control of medical problems despite a reasonable medical plan and access to medication
Decubitus ulcers, unless the result of unavoidable decline	Subconjunctival or vitreous ophthalmic hemorrhage
Dehydration, fecal impaction	Traumatic alopecia or scalp swelling
Evidence of sexual abuse	Unexplained fractures
Intraoral soft tissue injuries	Unusual delay in seeking medical attention for injuries
Malnutrition, medically unexplained weight loss	Urine burns (similar to severe diaper rash), dirty clothing, or other signs of inattention to hygiene
Missing medications	

Information from references 28 through 30.

algorithm provided in Figure 2 is acceptable for most practice settings.³⁴ Physicians may insert the statutory requirements for their practice location into the appropriate sections. A safety plan (Table 4³⁵) is an important element of the care plan in all situations.

Table 5 provides a list of resources about elder abuse. The Administration on Aging's National Center on Elder Abuse website (<http://www.ncea.aoa.gov>) is the most comprehensive online resource available on elder abuse. It provides specific information on each state's laws defining elder abuse and mandatory reporting requirements; information on local contact agencies and numbers; links for state or local intervention resources; and information for caregivers and patients. Specific resources for each state are also available weekdays via the Eldercare Locator (telephone: 800-677-1116). Even when APS or law enforcement becomes involved, family physicians still bear significant responsibility for follow-up medical care of patients. Relationship continuity can support the patient and family in the process of healing and recovery.

Data Sources: The search included Agency for Healthcare Research and Quality Evidence Reports, Cochrane Database of Systematic Reviews, Clinical Evidence, National Guidelines Clearinghouse, Institute for Clinical Systems Improvement, U.S. Preventive Services Task Force, PubMed, and Google Professional. We used electronic libraries from the University of Tennessee Health Sciences Center, and the Oregon Health and Sciences

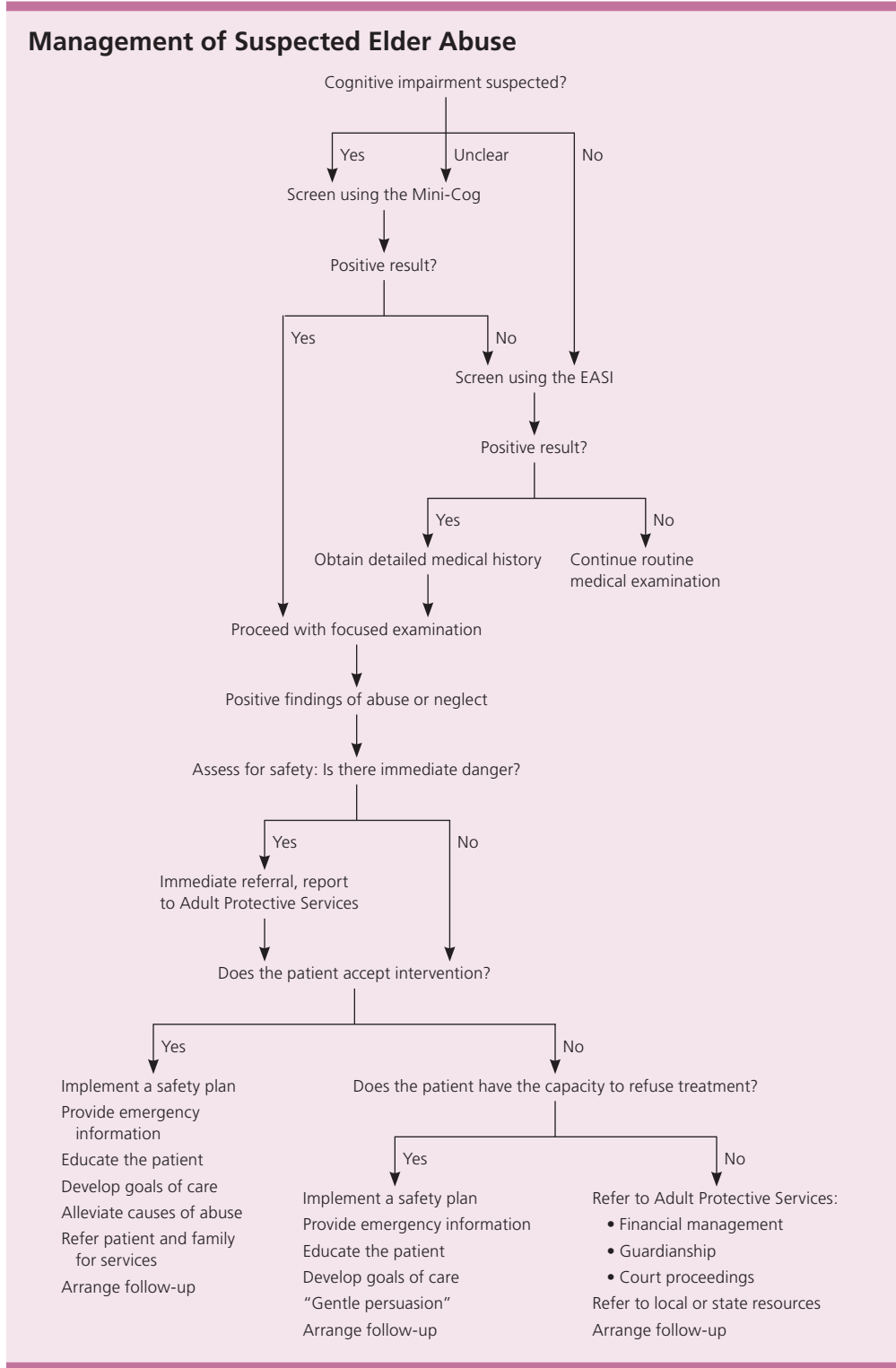


Figure 2. Algorithm for the management of suspected elder abuse. (EASI = Elder Abuse Suspicion Index.)

Information from reference 34.

Table 4. Safety Plan for Older Patients Who Have Been Abused

A safety plan helps identify options for the patient and provides ideas to increase his or her safety. Each plan should be individualized, written down, stored in a safe place, and reviewed regularly by the physician, the patient, and a trusted friend or family member. A safety plan may include:

- Safe places to go, such as the home of a friend or family member, a shelter, or the hospital
- Strategies for reducing harm if the patient is going to continue to have contact with the abuser
- A checklist of essential items to keep together in a safe place (see Table 5 for resources and examples)
- Telephone numbers of family, friends, community organizations, and emergency service providers
- Special considerations, such as transportation needs, if the patient lives in a rural area
- A follow-up appointment with the family physician or referrals to other services

Adapted with permission from Maine Partners for Elder Protection. UMaine Center on Aging. Elder abuse: web module CME. What is a safety plan? <http://www2.umaine.edu/mainecenteronaging/mpep/index.php?page=71> [access restricted]. Accessed May 21, 2012.

University. Key terms: elder abuse and neglect; screening instruments for elder abuse, neglect; injury, wound, bruise patterns for elder abuse; mandatory reporting for elder abuse, neglect; and safety plans for elder abuse, neglect. Search date: May 1, 2010, and October 6, 2013.

The Authors

ROBERT M. HOOVER, MD, FAAFP, is an assistant professor in the Department of Family Medicine at the University of Tennessee Health Science Center College of Medicine in Memphis.

MICHOL POLSON, PhD, is an assistant professor of behavioral medicine in the Cascades East Family Medicine Residency Program at the Oregon Health and Sciences University in Klamath Falls. At the time this article was written, he was an assistant professor in the Department of Family Medicine at the University of Tennessee Health Science Center College of Medicine in Memphis. He was also the director of behavioral science for the Family Medicine Residency Program at the University of Tennessee Health Science Center in Jackson, and in the St. Francis Family Medicine Residency Program in Memphis.

Table 5. Resources About Elder Abuse

Resource	Description	Website
Administration on Aging	Elder abuse tools and resources with information on how to protect older persons	http://www.aoa.gov/AoARoot/AoA_Programs/Tools_Resources/index.aspx
American Medical Association	Policy regarding family and intimate partner violence	http://134.147.247.42/han/JAMA/https/ssl3.ama-assn.org/apps/ecommm/PolicyFinderForm.pl?site=www.ama-assn.org&uri=/ama1/pub/upload/mm/PolicyFinder/policyfiles/HnE/H-515.965.HTM
Eldercare Locator	Resource for finding local resources by zip code or community	http://www.eldercare.gov/Eldercare.NET/Public/Index.aspx
National Clearinghouse on Abuse in Later Life	Training resources and videos, and links to other resources for health care professionals	http://www.ncall.us
Pocket guide on elder investment fraud and financial exploitation	Information from Baylor College of Medicine's Texas Consortium Geriatric Education Center as part of the Elder Investment Fraud and Financial Exploitation program	http://www.state.nj.us/oag/ca/bos/elder/PocketGuide.pdf
Response to Abuse in Later Life: A Self-Assessment Workbook for Domestic Violence and Sexual Assault Victim Services	Self-assessment tools to assist communities in evaluating practices within and across key intervening agencies and in building a coordinated response to elder abuse	http://www.ncall.us/sites/ncall.us/files/V5%20Tool-June%202011.docx
University of Maine Center on Aging	Steps to develop a safety plan for older persons (from Maine Partners for Elder Protection pilot project)	http://umcoa.siteturbine.com/uploaded_files/mainecenteronaging.umaine.edu/files/elderabusescreeningmanual.pdf

Address correspondence to Michol Polson, PhD, Cascades East Family Medicine, 2801 Daggett Ave., Klamath Falls, OR 97601 (e-mail: polson@ohsu.edu). Reprints are not available from the authors.

REFERENCES

- National Center on Elder Abuse. Factsheet: Why should I care about elder abuse? March 2010. http://www.ncea.aoa.gov/Resources/Publication/docs/WhatIsAbuse_2010.pdf. Accessed September 30, 2013.
- Perel-Levin S. *Discussing Screening for Elder Abuse at Primary Health Care Level*. Geneva, Switzerland: World Health Organization; 2008.
- Bond MC, Butler KH. Elder abuse and neglect: definitions, epidemiology, and approaches to emergency department screening. *Clin Geriatr Med*. 2013;29(1):257-273.
- Joshi S, Flaherty JH. Elder abuse and neglect in long-term care. *Clin Geriatr Med*. 2005;21(2):333-354.
- Jayawardena KM, Liao S. Elder abuse at end of life. *J Palliat Med*. 2006;9(1):127-136.
- Lachs MS, Pillemer K. Elder abuse. *Lancet*. 2004;364(9441):1263-1272.
- Acierno R, et al. Prevalence and correlates of emotional, physical, sexual, and financial abuse and potential neglect in the United States: The National Elder Mistreatment Study. *Am J Public Health*. 2010;100(2):292-297.
- Dong X. Elder abuse: research, practice, and health policy. The 2012 GSA Maxwell Pollack Award Lecture [published ahead of print December 2, 2013]. *Gerontologist*. <http://gerontologist.oxfordjournals.org/content/early/2013/11/18/geront.gnt139.full>. Accessed February 5, 2014.
- Teaster PB, et al. *The 2004 Survey of State Adult Protective Services: Abuse of Adults 60 Years of Age and Older*. February 2006. http://vtdigger.org/vtdNewsMachine/wp-content/uploads/2011/08/20110807_surveyStateAPS.pdf. Accessed September 30, 2013.
- Swagerty DL Jr, Takahashi PY, Evans JM. Elder mistreatment. *Am Fam Physician*. 1999;59(10):2804-2808.
- Gibbs LM, Mosqueda L. The importance of reporting mistreatment of the elderly. *Am Fam Physician*. 2007;75(5):628.
- Laumann EO, Leitsch SA, Waite LJ. Elder mistreatment in the United States: prevalence estimates from a nationally representative study. *J Gerontol B Psychol Sci Soc Sci*. 2008;63(4):S248-S254.
- Amstadter AB, et al. Prevalence and correlates of poor self-rated health in the United States: the national elder mistreatment study. *Am J Geriatr Psychiatry*. 2010;18(7):615-623.
- Callahan CM, Weiner M, Counsell SR. Defining the domain of geriatric medicine in an urban public health system affiliated with an academic medical center. *J Am Geriatr Soc*. 2008;56(10):1802-1806.
- Schmeidel AN, Daly JM, Rosenbaum ME, Schmuch GA, Jogerst GJ. Health care professionals' perspectives on barriers to elder abuse detection and reporting in primary care settings. *J Elder Abuse Negl*. 2012;24(1):17-36.
- Kennedy RD. Elder abuse and neglect: the experience, knowledge, and attitudes of primary care physicians. *Fam Med*. 2005;37(7):481-485.
- O'Brien JG. A physician's perspective: elder abuse and neglect over 25 years. *J Elder Abuse Negl*. 2010;22(1-2):94-104.
- Wagenaar DB, Rosenbaum R, Page C, Herman S. Elder abuse education in residency programs: how well are we doing? *Acad Med*. 2009;84(5):611-618.
- Moyer VA; U.S. Preventive Services Task Force. Screening for intimate partner violence and abuse of elderly and vulnerable adults: U.S. Preventive Services Task Force recommendation statement. *Ann Intern Med*. 2013;158(6):478-486.
- American Medical Association. H-515.965: Family and intimate partner violence. <http://134.147.247.42/han/JAMA/https/ssl3.ama-assn.org/apps/ecomm/PolicyFinderForm.pl?site=www.ama-assn.org&uri=/ama1/pub/upload/mm/PolicyFinder/policyfiles/HnE/H-515.965.HTM>. Accessed December 11, 2013.
- University of Maine Center on Aging. Elder abuse screening protocol for physicians: Lessons learned from the Maine Partners for Elder Protection pilot project. May 2, 2007. http://umcoa.siteturbine.com/uploaded_files/mainecenteronaging.umaine.edu/files/elderabuse_screeningmanual.pdf. Accessed December 11, 2013.
- Fulmer T, Guadagno L, Bitondo Dyer C, Connolly MT. Progress in elder abuse screening and assessment instruments. *J Am Geriatr Soc*. 2004;52(2):297-304.
- Yaffe MJ, Tazkarji B. Understanding elder abuse in family practice. *Can Fam Physician*. 2012;58(12):1336-1340.
- Ebell MH. Brief screening instruments for dementia in primary care. *Am Fam Physician*. 2009;79(6):497-498, 500.
- Borson S, Scanlan J, Brush M, Vitaliano P, Dokmak A. The Mini-Cog: a cognitive 'vital signs' measure for dementia screening in multi-lingual elderly. *Int J Geriatr Psychiatry*. 2000;15(11):1021-1027.
- Kreševic DM. Assessment of function. In: Capezuti E, Zwicker D, Mezey M, Fulmer T, eds. *Evidence-Based Geriatric Nursing Protocols For Best Practice*. 3rd ed. New York, NY: Springer Publishing Company; 2008:23-40.
- Elsawy B, Higgins KE. The geriatric assessment. *Am Fam Physician*. 2011;83(1):48-56.
- Collins KA. Elder maltreatment: a review. *Arch Pathol Lab Med*. 2006;130(9):1290-1296.
- Palmer M, Brodell RT, Mostow EN. Elder abuse: Dermatologic clues and critical solutions. *J Am Acad Dermatol*. 2013;68(2):e37-42.
- Chang AL, Wong JW, Endo JO, Norman RA. Geriatric dermatology: Part II. Risk factors and cutaneous signs of elder mistreatment for the dermatologist. *J Am Acad Dermatol*. 2013;68(4):533.e1-10.
- Luce H, Schragger S, Gilchrist V. Sexual assault of women. *Am Fam Physician*. 2010;81(4):489-495.
- Dong X, Simon MA. Elder abuse as a risk factor for hospitalization in older persons. *JAMA Intern Med*. 2013;173(10):911-917.
- Ziminski CE, Phillips LR, Woods DL. Raising the index of suspicion for elder abuse: cognitive impairment, falls, and injury patterns in the emergency department. *Geriatr Nurs*. 2012;33(2):105-112.
- Bomba PA. Use of a single page elder abuse assessment and management tool: a practical clinician's approach to identifying elder mistreatment. *J Gerontol Soc Work*. 2006;46(3-4):103-122.
- Maine Partners for Elder Protection. UMaine Center on Aging. Elder abuse: web module CME. What is a safety plan? <http://www2.umaine.edu/mainecenteronaging/mpep/index.php?page=71> [access restricted]. Accessed May 21, 2012.