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Diagnostic and Treatment

Guidelines on

Elder Abuse and Neglect

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These guidelines are not intended to be construed or to serve as a standard of medical care. Standards of medical care are determined on the basis of all the facts and circumstances involved in an individual case and are subject to change as scientific knowledge and technology advance and patterns of practice evolve. These guidelines reflect the views of scientific experts and reports in the scientific literature as of October 1992.

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Introduction

Although elder abuse and neglect has occurred for centuries, it is the most recent form of family violence to come to the attention of modern societies. Rigorous study of the problem only began in the last decade, and fewer empirical data are available on elder mistreatment than on other forms of family violence such as child abuse. The earliest modern reports of elder abuse and neglect emanated from the United Kingdom in the 1970s, when dramatic case reports of the phenomenon, called “Granny battering,” shocked the medical community and public. By the end of the 1970s, small case-control studies in the United States confirmed that the problem was common in this country as well. In the mid-1970s, the US Senate Special Committee on Aging issued a series of reports on abuse and neglect occurring in nursing homes, and in 1981, the US House of Representatives Select Committee on Aging conducted hearings in which victimized elders gave first-hand testimony of their plight.

Since 1981, Congressional and federal agency inquiries have continued to target elder abuse and neglect, especially in institutional care settings, and the media has continued to highlight the problem. In 1986, the Institute of Medicine published recommendations for preventing elder mistreatment in institutions. In 1990, the Secretary of the US Department of Health and Human Services created an Elder Abuse Task Force, which developed an action plan for the identification and prevention of elder mistreatment in homes, communities and nursing facilities. The plan also proposes strategies for national research and data collection, technical assistance, training and public education. In 1991, a National Institute on Elder Abuse was established as part of the Administration on Aging’s Elder Care Campaign. Adult Protective Service organizations now exist in every state to serve vulnerable adults—particularly the elderly in cases involving abuse and neglect.

Other actions have led to increased public and physician awareness of elder abuse and neglect. Since the 1980s, a small group of researchers has been conducting studies to assess the scope and causes of elder mistreatment, and nearly every state has enacted mandatory reporting laws that require physicians and others to report suspected cases. The 1992 standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) for emergency departments and ambulatory care centers call for improved identification and management of elder abuse, as well as spouse or partner abuse and child abuse.

Physicians are ideally situated to play a significant role in the detection, management and prevention of elder abuse and neglect. A physician may be the only person outside the family who sees the older adult on a regular basis, and he or she is uniquely qualified to order confirmatory diagnostic tests such as blood tests or x-rays, to recommend hospital admission, or to authorize services such as home health care. Opportunities for detection and intervention vary with the discipline and the site where the abuse or neglect is encountered. Family physicians, general internists, and psychiatrists may have well-established relationships with older adults and their families that allow them to recognize potential abuse or neglect, and to intervene before a catastrophic event occurs. In contrast,

emergency department physicians routinely witness the effects of elder mistreatment, requiring immediate action to ensure the patient's safety and to prevent further harm. In institutional settings, physician monitoring of patient health is crucial for preventing abuse and neglect and maintaining standards of care.

Since most instances of abuse and neglect are not reported, physicians in all disciplines must be aware of the potential for mistreatment, its signs and symptoms and the appropriate forms of intervention. Whenever possible, physicians should work with multi-disciplinary teams to ensure thorough assessment, intervention, and follow-up of elderly patients.

The purpose of these guidelines is to:

- Sensitize clinicians to the fact that elder abuse and neglect occur commonly and that the problem is likely to be encountered in their medical practices.
- Present what is known about the epidemiology, clinical manifestations, and history of elder mistreatment.
- Describe barriers to the proper identification and management of elder mistreatment.
- Outline an approach that physicians can use to facilitate recognition of elder abuse and neglect in a variety of clinical settings.
- Identify strategies for the management and prevention of elder mistreatment.
- Discuss relevant ethical and medicolegal issues surrounding the detection and reporting of elder abuse and neglect.

Facts About Elder Mistreatment

While the term "elder abuse and neglect" is commonly used to describe acts of commission or omission that result in harm or threatened harm to the health or welfare of an older adult, many authorities prefer to use the term "elder mistreatment." Mistreatment of the elderly person may include physical, psychological, or financial abuse or neglect, and it may be intentional or unintentional. Intentional mistreatment involves a conscious and deliberate attempt to inflict harm or injury, such as verbal abuse or battering; unintentional mistreatment occurs when an inadvertent action results in harm to the elderly person. Unintentional mistreatment is usually due to ignorance, inexperience, or a lack of ability or desire of the caretaker to provide proper care.

Although this document deals with physicians' responses to elder abuse and neglect that is perpetrated by others, self-neglect among the elderly is also a major concern for professionals caring for elderly patients. Many of the same agencies listed in this document also handle reports of self-neglect.

It is difficult to obtain accurate information on the extent of elder abuse and neglect in the United States. Studies often focus on reports of selected populations and many cases are unreported. Victims may be embarrassed, intimidated and overwhelmed by the situation. They may be fearful of reprisals or unaware of the availability of help. In some cases,

victims may be unable to report mistreatment or do not realize that they are being mistreated. Finally, health professionals may ignore signs and symptoms of elder mistreatment because they are unaware of the extent of the problem and uncomfortable with the responsibility of further assessment and action.

A 1991 report from Congress suggests that between 1.5 and 2 million older adults (persons older than 60 years of age) are abused annually in the United States. In one community-based cross-sectional survey, 32 of 1000 older adults reported that they had experienced some form of mistreatment at least once since reaching the age of 65. This same population was asked whether they had been mistreated in the last year—yielding an estimated incidence rate of 26 new cases per 1000 persons aged 65 or older.^o It is estimated that only one in 14 elder mistreatment cases is reported to a public agency. With the elderly segment of the population rapidly increasing, clinicians can be expected to see a steady increase in the number of cases of elder mistreatment.

There have been attempts to elucidate risk factors for elder mistreatment both for older adults and their caretakers. These factors are based on etiologic theories for the occurrence of elder abuse and neglect. Unfortunately, none of these theories has been substantiated with good clinical data. However, awareness of such factors, and the theories underlying them, may help physicians understand, anticipate and prevent situations in which elder mistreatment may occur.

The transgenerational, or family violence, theory asserts that violence is a learned behavior. Individuals who have witnessed or have been victims of family violence may deal with their problems in a like manner. A second theory implicates the psychopathology of the caretaker in some cases of elder mistreatment. Alcoholism, drug addiction, or severe emotional problems on the part of the caretaker may predispose to abusive behavior. A third theory argues that medical, functional, or cognitive disability of elderly persons increases their dependency and vulnerability, and therefore their risk for abuse or neglect. Other authorities point out that the caretaker may be dependent, especially economically, on the older patient. This dependency may lead to resentment and, when combined with other factors, may predispose to mistreatment.

Other theories emphasize stress as an important factor in elder mistreatment. Although the caregiving role is inherently stressful, outside situations such as economic pressures, lack of community support, or increasing care needs may heighten tensions and produce frustrations that lead to abusive behavior. While one theory will not explain all or even a majority of cases of elder mistreatment, it is useful for clinicians to view the interaction of these factors as contributing to the overall behavior pattern.

^oPillemer K., Finkelhor D. The Prevalence of Elder Abuse: A Random Sample Survey. *The Gerontologist*. 1988;28:51-57.

The following factors should be considered when evaluating a potential case of elder mistreatment:

- Elder mistreatment occurs among men and women of all racial, ethnic and socioeconomic groups.
- The perpetrator of neglect is often the spouse or an adult child of the older person, but paid or informal caregivers may also be involved.
- Physical, functional, or cognitive problems in caregivers may prevent them from providing proper care
- Mental illness, alcoholism, or drug abuse in the older person or the caregiver may be associated with abuse and neglect.
- Social isolation and dependence of the elderly person may increase the risk for mistreatment.
- A past history of abusive relationships may predispose the victim to future mistreatment. Financial or other family problems may impair the ability to provide adequate care.
- Inadequate housing or unsafe conditions in the home may increase the likelihood of elder mistreatment.
- Victims often have experienced several forms of elder mistreatment at the same time.

Cases of elder abuse and neglect can be identified by an alert clinician, and realistic interventions exist for management and prevention. However, there are bafflers to the identification of elder mistreatment. Some of these barriers stem from societal attitudes about aging. Ageist views of society include a belief that functional decline and frailty are inevitable results of aging. In fact, many of the typical problems encountered in old age are readily amenable to treatment. Problems such as incontinence, confusion, impaired mobility, falling and “failing to thrive” may be due to treatable underlying organic causes.

Researchers also have noted a general reluctance among primary care physicians to address family violence in all its forms, and elder mistreatment is no exception. Physicians cite the time-consuming nature of the evaluation, as well as their perceived inability to successfully intervene. Proper evaluation of elder abuse and neglect requires a detailed history from the patient, alleged abuser, and other family members, as well as a thorough physical examination. Unfortunately, current reimbursement policies do not favor such cognitively intensive tasks. Whenever possible, a multidisciplinary geriatric team should be used to conduct the evaluation; the issues surrounding elder mistreatment are complex and the patient often needs more than one professional’s knowledge and expertise.

Interviewing

Physicians should incorporate routine questions related to elder abuse and neglect into their daily practice. Even if the elderly person has a cognitive impairment, it is reasonable to ask about abuse or neglect, since diminished cognitive capacity does not necessarily negate the elderly person’s ability to describe mistreatment. A mini mental status examination can be helpful in evaluating the patient’s cognitive status. If the patient has a

significant dementia and cannot answer questions about abuse, the physician should seek out an appropriate respondent who is not likely to be a perpetrator. The physician should consider how the interview can be conducted to afford the maximum of privacy, and how it can be structured so that the patient and family members are interviewed separately. *The interview and examination of an elderly patient should always be conducted first, away from the caregiver or suspected abuser.*

Every clinical setting should have a protocol for the detection and assessment of elder mistreatment. This may be a narrative, a checklist, or some other type of standardized form that enables all providers in that practice setting to rapidly assess for elder mistreatment and document it in a way that allows physicians to look at patterns over time. *

* Several excellent protocols are available; physicians may wish to consult those produced by Mount Sinai Medical Center and Victim Services Agency Elder Abuse Project in New York, Beth Israel Hospital in Boston or the Harborview Medical Center in Seattle.

The protocol should include basic demographic questions that enable the physician to determine the patient's family composition and socioeconomic status. It should proceed to general questions that give the physician a sense of the overall well-being of the older person, and then screen for the various types of abuse or neglect (physical, psychological and financial). The protocol should target common indicators for each type of mistreatment and should include specific questions for the patient.

Ask the patient direct questions, such as:

- Has anyone at home ever hurt you?
- Has anyone ever touched you without your consent?
- Has anyone ever made you do things you didn't want to do?
- Has anyone taken anything that was yours without asking?
- Has anyone ever scolded or threatened you?
- Have you ever signed any documents that you didn't understand?
- Are you afraid of anyone at home?
- Are you alone a lot?
- Has anyone ever failed to help you take care of yourself when you needed help?*

* Adapted from *Elder Mistreatment Guidelines for Health Care Professionals: Detection, Assessment and Intervention*, Mount Sinai/Victim Services Agency Elder Abuse Project, New York, ©1988.

Any questions answered affirmatively should be followed up to determine how and when the mistreatment occurs, who perpetrates it, and how the patient feels about it and copes with it. Efforts should be made to determine how serious the danger is, and what the older adult thinks can be done to prevent the mistreatment from recurring.

Clinicians do not have to prove that elder mistreatment has occurred; they need only document a reasonable cause to suspect that it has. “Reasonable cause” reporting can be as simple as stating that the patient seems to have health or personal problems and needs assistance, especially if the clinician suspects forms of abuse or neglect that are difficult to quantify.

Effective diagnosis of elder mistreatment depends on both professional and patient education. All personnel who come in contact with older patients, including nurses, nursing assistants, social workers, emergency health workers, and physical therapists, should be familiar with the protocol and should be alert to the various types of mistreatment and possible risk factors. Physicians also should promote patient education on elder mistreatment, including information about the forms of abuse and neglect, the older person’s right to be free from mistreatment, and how to access local resources. Most state departments on aging, adult protective services, and Area Agencies on Aging have materials describing legal rights, prevention strategies, and support services, which physicians can provide to patients in their offices and waiting rooms.

The American Association of Retired Persons (AARP) has published a booklet and pamphlet that are especially useful for this purpose. Write: Criminal Justice Services, AARP, 601 E Street, NW, Washington, DC 20049, or call 202 434-2222 for more information.

Diagnosis and Clinical Findings

The physician should ensure that a comprehensive medical examination is conducted, and that the results of the examination are documented, including the patient’s statements, behavior and appearance. Symptoms of elder mistreatment may result from physical abuse or neglect, psychological abuse or neglect, financial or material abuse or neglect, or any combination of these. In a broad sense, elder mistreatment encompasses violation of any legal or human rights that are accorded members of society. These rights promote concepts of self-respect and dignity, and include the rights to liberty, property, privacy, and free speech.

Physical abuse involves acts of violence that may result in pain, injury, impairment, or disease. Examples include:

- Pushing, striking, slapping, or pinching
- Force-feeding
- Incorrect positioning
- Improper use of physical restraints or medications
- Sexual coercion or assault (sexual contact or exposure without the older person’s consent or when the older person is incapable of giving consent)

The physician has cause to suspect physical abuse when the elderly patient presents with unexplained injuries, when the explanation is not consistent with the medical findings, or when contradictory explanations are given by the patient and the caregiver. Signs of

physical abuse include: bruises, welts, lacerations, fractures, burns, rope marks, (note bilateral injuries and injuries in various stages of healing); laboratory findings indicating medication overdose or undermedication; and unexplained venereal disease or genital infections.

Physical neglect is characterized by a failure of the caregiver to provide the goods or services that are necessary for optimal functioning or to avoid harm. This may include:

- Withholding of health maintenance care, including adequate meals or hydration, physical therapy, or hygiene
- Failure to provide physical aids such as eyeglasses, hearing aids, or false teeth
- Failure to provide safety precautions

Physical neglect may be suspected in the presence of dehydration, malnutrition, decubitus ulcers, poor personal hygiene, or lack of compliance with medical regimens.

Psychological abuse is conduct that causes mental anguish in an older person. This includes:

- Verbal berating, harassment, or intimidation
- Threats of punishment or deprivation
- Treating the older person like an infant
- Isolating the older person from family, friends, or activities

Psychological neglect is the failure to provide a dependent elderly individual with social stimulation. This may involve:

- Leaving the older person alone for long periods of time
- Ignoring the older person or giving him or her the “silent treatment”
- Failing to provide companionship, changes in routine, news, or information

The possibility of psychological abuse or neglect should be investigated if the older person seems extremely withdrawn, depressed, or agitated; shows signs of infantile behavior; or expresses ambivalent feelings toward caregivers or family members.

Financial or material abuse involves misuse of the elderly person’s income or resources for the financial or personal gain of a caretaker or advisor, such as:

- Denying the older person a home
- Stealing money or possessions
- Coercing the older person into signing contracts or assigning durable power of attorney to someone, purchasing goods, or making changes in a will.

Financial or material neglect is failure to use available funds and resources necessary to sustain or restore the health and well-being of the older adult.

Financial abuse or neglect should be considered if the patient is suffering from substandard care in the home despite adequate financial resources, if the patient seems confused about or unaware of his or her financial situation, or has suddenly transferred assets to a family member. Older adults are particularly vulnerable to this type of mistreatment, yet it may be the most difficult to identify.

Violation of personal rights occurs when caretakers or providers ignore the older person's rights and capability to make decisions for himself or herself. This failure to respect the older person's dignity and autonomy may include:

- Denying the older person his or her rights to privacy
- Denying the older person the right to make decisions regarding health care or other personal issues, such as marriage or divorce
- Forcible eviction and/or placement in a nursing home.

This type of abuse may be recognized through reports by the patient or through observation of family or patient-caregiver interactions.

Assessment

The physician should consider the following in assessing for elder mistreatment:

Safety

- Is the patient in immediate danger? If so, consider hospital admission and/or a court protective order.
- Does the patient understand risks and consequences of the decision concerning safety?
- What steps can be taken to increase safety in nonemergency situations?

Access

- Are there barriers limiting or preventing further assessment? If so, the physician may improve access by engaging a trusted family member or friend of the patient, by consulting state adult protective services, and by building a cooperative relationship with local legal advocacy programs.

Cognitive Status

- Does the patient have cognitive impairment on the basis of dementia and/or delirium? Formal, brief instruments such as the mini mental status exam can provide an objective, reliable assessment of this.

- If cognitive impairment is present, is it potentially reversible or remediable (is it due to medications, thyroid disease, depression, or other organic causes)?
- If irreversible cognitive impairment is present, is it severe enough to preclude an accurate history from the older person? Is it severe enough to impair decision-making capacity?

Emotional Status

- Does the patient manifest depression, shame, guilt, anxiety, fear, and/or anger? If yes, explore beliefs associated with these emotions.
- Is the patient reluctant to discuss the possibility of abuse or neglect? If so, attempt to determine the reason.
- Does evidence suggest patient denial? (Does the patient minimize or rationalize family tension or conflict?) If yes, does this denial interfere with patient's recognition or admission of mistreatment?

Health and Functional Status

- What medical problems exist? Could mistreatment have caused or exacerbated them?
- If the patient requires assistance with activities of daily living, who provides it? Does the person have the emotional, financial, and intellectual ability to provide the care?
- Does the patient have physical limitations that impair his or her ability to self-protect?

Social and Financial Resources

- Does the patient have family or friends able and willing to nurture, listen, and assist with care, if needed? If not, why not?
- Does the patient have adequate financial resources for basic substantive needs? If yes, but these needs are not being met, why is this?

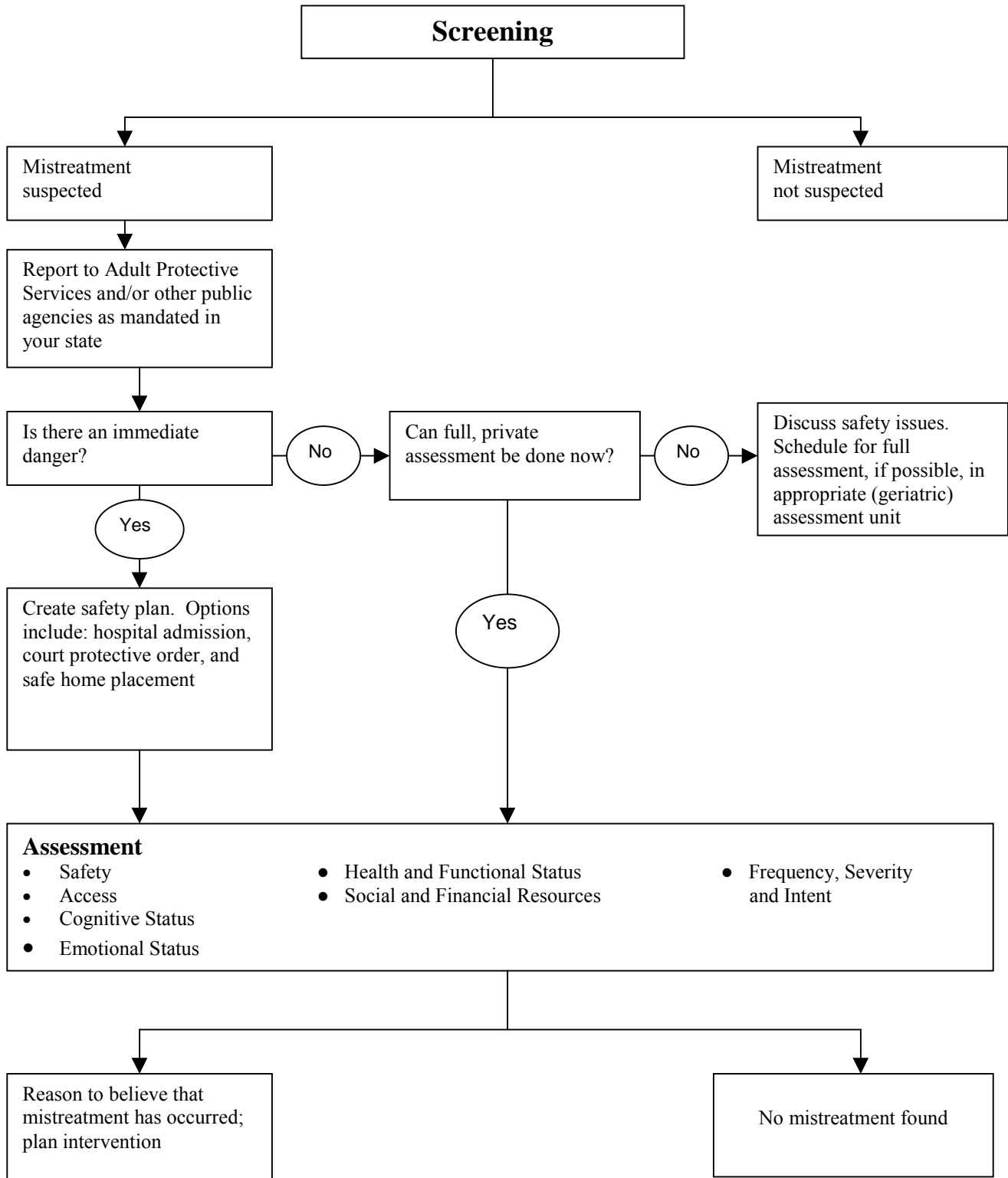
Frequency, Severity and Intent

- Has mistreatment increased in frequency or severity over time?
- Are there motives or remediable causes for the mistreatment? If so, incorporate appropriate services into intervention/treatment plan.

Intervention and Case Management: Part 1

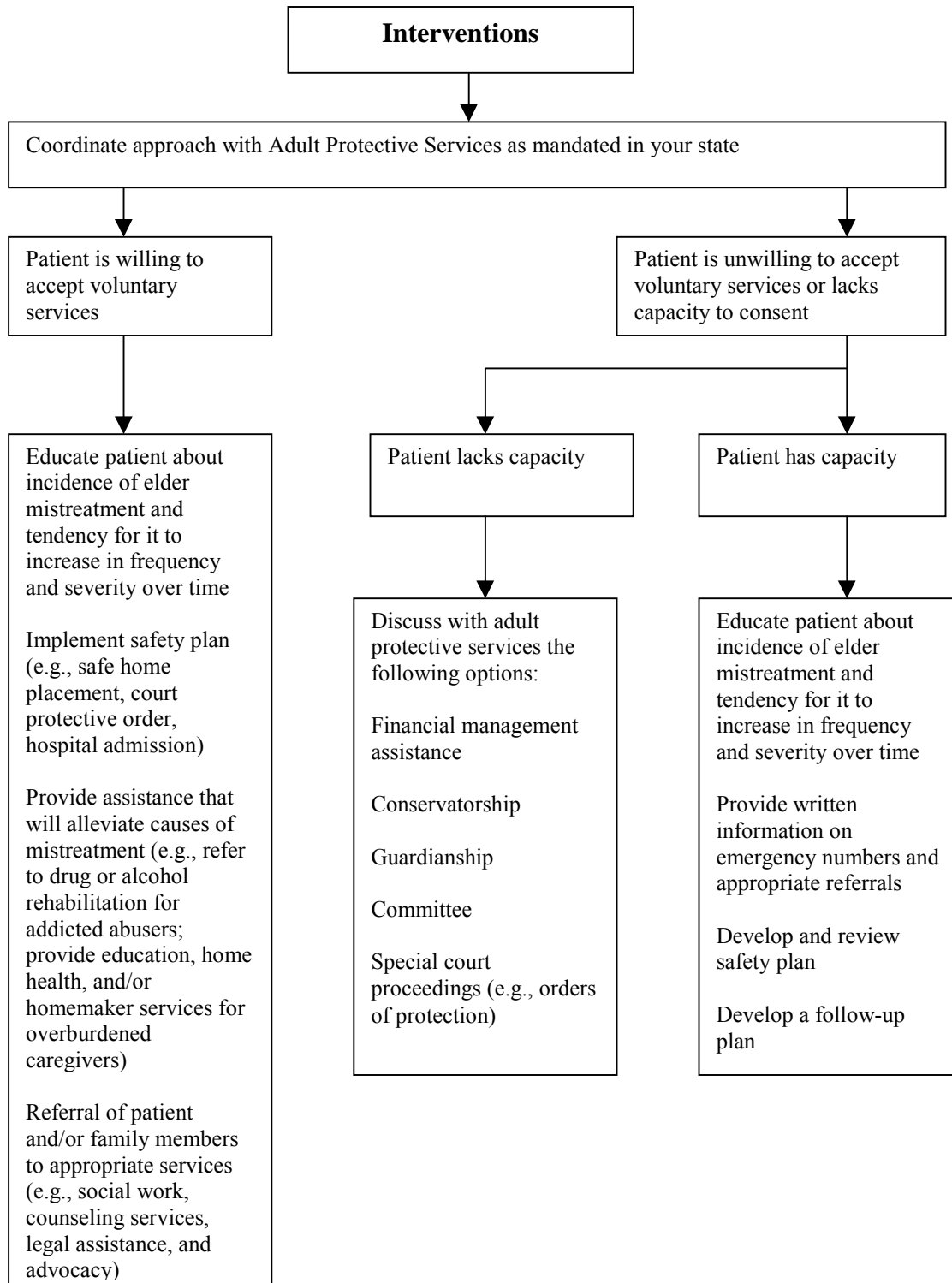
Screening and assessment for elder mistreatment should follow a routine pattern.

Assessment of each case should include the following:



Intervention and Case Management: Part 2

Case management should be guided by choosing the alternatives that least restrict the patient's independence and decision-making responsibilities and fulfill state-mandated reporting requirements. Intervention will depend on the patient's cognitive status and decision-making capability and on whether the mistreatment is intentional or unintentional.



Abuse and Neglect in Institutions

Institutional elder abuse and neglect refers to mistreatment that occurs in nursing homes, board and care homes, and other assisted-living facilities. Nursing home medical directors, as well as private practitioners who see individual residents, play a critical role in identifying, treating, and preventing abuse and neglect in these settings.

In institutions, elder abuse may be perpetrated by a staff member, another patient, an intruder, or a visitor. The forms of abuse and neglect that occur in institutions are virtually the same as those that occur in domestic settings. One form of mistreatment that is of special concern in institutions is the failure to carry out a plan of treatment or care. This may involve unauthorized use of physical or chemical restraints or the use of medication or isolation as punishment, for staff convenience, or as a substitute for treatment and in conflict with a physician's order. Physicians must be aware that substandard care or routine neglect can result in declining health, serious deterioration, pain, and emotional trauma. The plan of care is a critical document, used to determine whether action or inaction by facility staff is abusive or neglectful.

Older persons in institutional care are at risk for mistreatment both because of their extreme vulnerability and because of inadequate training and experience among caregivers. Residents of nursing facilities are typically dependent, extremely frail, and/or chronically ill, and many do not have regular visitors who can monitor their care. Cognitive, vision, and hearing impairments are common; a recent government report states that at least one-half of all nursing home residents—about 600,000 individuals—suffer from dementia. Patients with cognitive impairment may be resistant to care, and difficult to help. In addition, problems such as insufficient resources, staff shortages, high turnover, and inadequate supervision and training increase the risk of mistreatment. Finally, abuse and neglect may be exacerbated by societal ignorance about quality care and by the acceptance of abusive or neglectful behavior as inevitable in institutional life.

Although institutional abuse and neglect has been recognized for more than 40 years, there are no uniform national prevalence data. Sources of information include state licensure and certification agencies, state Medicaid and Medicare fraud and abuse agencies, long term care ombudsman programs established under the *Older Americans Act*, and most state adult protective services programs. Data collection should be improved through planned improvements in the federal Medicare and Medicaid facility survey system, new reporting requirements to state nurse aide registries, and revised ombudsman and adult protective service program reporting requirements.

Regulations and Legal Protection

All but a small number of private nursing facilities are monitored by state and federal regulatory agencies, and other specialized programs, with expectations that public standards of care will be provided. Even so, there is continual concern and increasing information about serious mistreatment in government-licensed and certified facilities. Nonmedical residential facilities, or board and care homes, usually do not employ health

and medical staff. Although most states license such facilities, they do not provide active regulation of the standards of care. Information about abuse and neglect in board and care homes is often obtained by physicians (particularly emergency department staff, family members, investigators and, increasingly, by the state long term care ombudsman program. Most states have legislation that addresses elder mistreatment; such statutes are usually contained in adult protective service or domestic violence legislation. Several states (including Delaware, Georgia, Maryland, Massachusetts, Missouri, and Oregon) have laws specific to the institutional setting. Many state laws identify physicians and other health care providers as key professionals who must report suspected abuse and neglect to state officials.

National standards for care in nursing homes are based on public policy set forth in the *Nursing Home Reform Act of 1987* (Public Law 100-203; Social Security Act, Title C). This law, as part of the Omnibus Budget Reconciliation Act (OBRA), is often referred to as “OBRA 87.” (It became effective October 1990.) The intent of the law and its regulations is to promote high quality care and to prevent substandard care, abuse, and neglect.

The law provides that a set of residents’ rights are ensured for each person. These include: protection against Medicaid discrimination; the right to participate in health care decisions and to give or withhold informed consent for particular interventions; safeguards to reduce inappropriate use of physical and chemical restraints; provisions to ensure proper transfers or discharges; and full access to a personal physician, the long term care ombudsman, and other advocates. Each resident has the right to be free from verbal, sexual, physical, or mental abuse, corporal punishment, and involuntary seclusion. According to the federal guidelines for implementation of the law, “abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish, or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being.”

Residents also have the right to be free from physical restraints or psychoactive drugs administered for purpose of discipline or convenience. The inappropriate use of physical or chemical restraints is of special concern. Federal guidelines specify that “the decision to apply physical restraints should be based on the assessment of each resident’s capabilities, an evaluation of less restrictive alternatives, and the ruling out of their use. The plan of care should also contain a schedule or plan of rehabilitative training to enable the progressive removal of restraints or the progressive use of less restrictive means, as appropriate.”

Despite federal and state laws to protect residents, abuse and neglect continue to occur for a variety of reasons. Some states have lax enforcement of standards. Many residents do not have regular visits from family and friends who can monitor their care. And not all communities have local long term care ombudsman programs to help residents resolve problems and complaints.

The Role of the Physician

Both because of their prescribed roles and because they may be one of the few persons from outside the facility to see the resident on a regular basis, physicians can play a critical role in identifying, treating, and preventing abuse and neglect in institutional settings. State laws require that patients be admitted by physicians to nursing homes (and, in some cases, to other types of residential facilities). After admission, each resident's care must be under the supervision of an attending physician (or a physician assistant, nurse practitioner, or clinical nurse specialist supervised by a physician), and facilities are mandated to provide them immediate access to their patients.

Several of the prescribed roles for personal physicians are likely to permit recognition and prevention of institutional abuse and neglect. These include:

- Participating in the development and monitoring of the resident's plan of care
- Assessing the need for and prescribing physical restraints and antipsychotic drugs only when appropriate for treatment of a resident's particular condition, and not for behavioral modification or control
- Monitoring reports that by law must go to the physician, including any irregularities in drug regime as found by the pharmacist who conducts a monthly drug regimen review of all residents, and findings of substandard care by the state's inspection agency.

New legal requirements under OBRA should help to reduce the inappropriate use of physical and chemical restraints. Physicians should be aware that these regulations will cause their medical prescriptive decisions to be more closely reviewed to ensure that psychotropic drugs are prescribed appropriately, ie, for diagnoses of dementia. Personal physicians can play a crucial role in the identification and prevention of mistreatment by ongoing monitoring of the resident's health through regular physical exams, review of the patient's record, and review of resident assessments.

Assessments must be completed annually, with updates quarterly and whenever there is a significant change in the patient's condition. Other physicians may identify and prevent institutional elder mistreatment while serving as medical directors or as physician members of the facility's Quality Assessment and Assurance Committee. A physician may serve in all three of these capacities at the same time.

Documentation

Thorough, well-documented medical records are essential. They provide concrete evidence and may prove to be crucial to the outcome of any legal case. If the medical record and testimony at trial are in conflict, the medical record may be considered more credible. Records should be kept in a precise, professional manner and should include the following:

- Chief complaint and description of the abusive event or neglectful situation, using the patient's own words whenever possible rather than the physician's assessment
- Complete medical history
- Relevant social history
- A detailed description of injuries, including type, number, size, location, stages of healing, color, resolution, possible causes, and explanations given. Where applicable, the location and nature of the injuries should be recorded on a body chart or drawing.
- An opinion on whether the injuries were adequately explained
- Results of all pertinent laboratory and other diagnostic procedures
- Color photographs and imaging studies, if applicable
- If the police are called, the name of the investigating officer and any actions taken

In addition to complete written records, photographs are particularly valuable as evidence. The physician should ask the patient for permission to take photographs. When the patient is unable to give consent, photographs may be taken and a surrogate decision-maker may need to be consulted after the fact. Imaging studies also may be useful. State laws that apply to the taking of photographs usually apply to x-rays as well.

- When possible, take photographs before medical treatment is given
- Use color film, along with a color standard
- Photograph from different angles, full body and close-up
- Hold up a coin, ruler, or other object to illustrate the size of an injury
- Include the patient's face in at least one picture
- Take at least two pictures of every major trauma area
- Mark photographs precisely and promptly with the patient's name, location of injury, date, time of day, and names of the photographer and others present

For medical records to be admissible in court, the doctor should be prepared to testify:

- That the records were made during the "regular course of business" at the time of the examination or interview
- That the records were made in accordance with routinely followed procedures
- That the records have been properly stored and their access limited to professional staff

Legal Considerations

The first priority of the physician when mistreatment is detected or suspected is to assure the safety of the victim. The second is to report the case to the appropriate state agency, such as adult protective services, in accordance with state laws that govern elder abuse and neglect. The physician's legal obligations may vary depending on whether the patient resides at home or in an institution. In cases of abuse or neglect in the home, the physician simultaneously may request a variety of other services, including respite care, a visiting nurse service, and a social work evaluation. Awareness of some general principles in the initial stages, such as not confronting the perpetrator and not blaming the victim, is likely to result in a better outcome. The patient's safety and well-being is the goal of any intervention, and must be the physician's primary concern.

A competent older adult who is not being coerced may choose to stay in an abusive situation. In such cases, the physician's role in assessment and referral may be more complicated than it would be for an incompetent patient. On the other hand, most patients and their families welcome physician support and referrals for home services and respite care. This is particularly true when mistreatment results from the caregiver being overburdened and there is no malicious intent. It is usually less intrusive and threatening to the family to have these interventions suggested by a physician or other professional who is known to them than by an unfamiliar physician or caseworker.

The primary care physician can participate in ongoing management or at least serve as a monitor who can reactivate assistance if the situation is deteriorating and provide follow-up after a referral has been made. If an abused elderly person is treated by a physician who does not inquire about or make an assessment for elder mistreatment, that physician may be held liable for any subsequent injuries. In some states, failure to report is a misdemeanor, the penalty for which may be a fine or even imprisonment.

Elder mistreatment is a complex problem that requires the assistance of a variety of individuals including social workers, visiting nurses, in-home health aides, and occasionally legal and financial experts. Geriatric assessment programs at large hospitals are ideally equipped to respond in these situations. The alternative is for informal community-based teams to respond on an ad hoc basis. A multidisciplinary approach benefits the victim of mistreatment and also lessens the burden of responsibility shared by the professionals involved in the case.

Reporting Requirements and Ethical Dilemmas

Nearly all states have mandatory reporting laws that require a variety of designated health care professionals and paraprofessionals to report suspected elder abuse and neglect to a designated state authority, usually the Adult Protective Service agency, department of aging, or ombudsman. Some state laws specify that once authorities have been alerted to even the suspicion of elder abuse or neglect, an agent of the state will make an on-site investigation in an attempt to corroborate the report.

There is considerable debate as to whether mandatory reporting laws aid in the identification of elder abuse and neglect. A recent study by the United States General Accounting Office concluded that states with mandatory and nonmandatory reporting laws could not be meaningfully compared because of differences among the states in investigative mechanisms, definitions of abuse and neglect, and who is defined as a mandatory reporter. There also is no consensus among states on the definition of the elderly population by age. An accompanying survey of protective service officials concludes that raising public and professional awareness of the problem of elder abuse and neglect is much more important in uncovering cases than any legislative edict.

While at first glance mandatory reporting laws seem to be an admirable attempt at identifying more cases of elder abuse and neglect, some observers have criticized their advent as an ageist response to the problem. They argue that older adults who are victims of family violence should have the same opportunity as younger adults to endorse or refuse referral to an investigating agency. Mandatory reporting laws for elder abuse and neglect, like child abuse statutes, are based on the state's *parens patriae* power to protect persons who cannot or will not protect themselves.

Thus, mandatory-reporting laws can engender difficult ethical dilemmas for the physician. He or she has taken an oath to maintain the confidentiality of the doctor-patient relationship, but may have to violate that trust to comply with certain state laws. How then should the physician proceed in cases where clear historical or physical evidence of abuse or neglect is present but a competent patient requests that no report be made? The physician should explain to the patient that he or she is obligated to report suspected mistreatment and should strive to maintain a positive physician-patient relationship, keeping in mind the medical need for intervention. The goal is not to punish the individual or family, but to stop the abuse or neglect and to access help in the form of outside resources. While there is little case law on this area, most experts would agree that a physician's legal duty to report cases of suspected abuse would supersede doctor-patient confidentiality issues.

Another useful strategy is to maintain a good working relationship with local adult protective service personnel. In addition to investigating abuse, these professionals are typically charged with serving as advocates for frail elderly in the community. They often procure a variety of services to which the older person is entitled that may not be related to elder abuse or neglect. Accordingly, a home visit by one of these professionals can be used to gain information about the health and safety of the patient.

Most adults in need of help allow adult protective services to work with them. However, capable adults have the legal right to refuse the provision of ongoing protective services. For the incapacitated older person who insists on remaining in an abusive environment, the court may need to appoint an impartial conservator who can manage his or her finances

and affairs, and/or a guardian who is responsible for health care and other decisions. In such cases, the physician's role includes the documentation of cognitive and other findings to determine a patient's capacity, which may aid the court in a competency hearing.

Testimony

Some physicians are concerned about the time and inconvenience of a court appearance. In some cases, medical records can be admitted without requiring the physician's in-court testimony. However, if testimony is required, it may be possible to place the physician "on call" so that she or he need appear only when it is time to testify.

The physician may testify about general observations of behavior or statements made, a function that is distinct from the use of the doctor as an expert. A physician should never feel insulted if called to give only this type of "layperson" testimony or to testify about a nonmedical issue, because this may be the only way to get such information before the court. When called as an expert witness, the physician may be requested to give an opinion on whether the explanation given is consistent with the injury.

For any testimony, the following guidelines should be followed:

- Insist on pre-trial preparation by the attorney presenting you as a witness
- Determine the legal and factual issues and how your testimony relates to these issues
Determine what demonstrative evidence (ie, photographs) should be part of your testimony
- If testifying as an expert witness, propose questions for the attorney to ask
- Brief the attorney on questions to ask the opposing expert Answer only the questions asked
- If a question is not understood, ask that it be repeated; explain when a one-word answer is not enough
- Do not volunteer information
- Calmly correct an attorney who misstates prior testimony

Risk Management

Duty to the Victim

Most physicians will encounter cases of elder abuse and neglect in their practices. Physicians must be aware of their obligations in these cases, as well as their potential liability for failing to diagnose and/or report cases of suspected mistreatment. In general, doing what is medically best or most appropriate is good risk management. The duty to the victim may arise from the special relationship between doctor and patient or from the courts' interpretations of reporting laws. The argument would be that other physicians, under the same circumstances, would have diagnosed inflicted trauma and taken appropriate management steps that would have prevented the subsequent harm.

Thus, physicians must be willing to ask all elderly patients about mistreatment and should know how to diagnose it. *Failure to conduct the interview and examination apart from the suspected perpetrator may interfere with an accurate diagnosis.* Physicians must be prepared to intervene in situations that are particularly dangerous for the elderly person: repeated, similar injuries, malnutrition or dehydration, under- or overmedication, mental illness in the patient or caregiver; substance abuse by the patient or caregiver; and threatened suicide by the caregiver (there may be increased risk for a murder/suicide).

In states that have enacted mandatory reporting statutes, a physician's failure to report could give rise to liability, but since reporting laws rarely explicitly give victims such a right to sue, courts must determine whether their state's statutes implicitly contain that right. Physicians could be liable, however, under various common law tort actions, including negligence or wrongful death.

Most states provide that reports of suspected mistreatment are kept strictly confidential. Reporters' names may not be released without written consent. In addition, the physician is immune from any civil or criminal liability for making a good faith report of suspected abuse or neglect. To be held liable for reporting, the physician would have to be shown to be acting in a knowingly and intentionally false and malicious manner. Reports made in the context of employment are also generally protected against employer retaliation by "whistleblower" and other public welfare statutes.

Reporters should not be reluctant to report incidents or concerns because they seem "minor" or "not threatening;" physicians should report any reasonable suspicion of abuse or neglect. State reporting agencies will prioritize cases and can provide needed interventions, such as emergency food and care, transportation, medical evaluation, relocation, legal assistance, and other community-based services.

Duty to Warn

Many states recognize a legal duty that physicians have toward third parties who might be harmed by their patients. In those states, if a physician is aware of a patient's intent to harm a third party, such as the patient's spouse or parent, the physician may have a legal duty to breach the patient's confidence and to warn the third party of the impending danger. Physicians, and especially therapists, should know the law where they practice.

Medical Malpractice Lawsuits

- Even after taking all possible measures to handle cases correctly, physicians may still become defendants in medical malpractice suits. These physicians should:
- Not panic
- Not discuss the case with anyone until they have spoken with their attorney
- Contact their malpractice insurance carriers
- Record the circumstances involved in the serving of a summons
- Have thorough documentation

Trends in Treatment and Prevention

State programs such as adult protective services and long term care ombudsman programs have made it easier for physicians to intervene on behalf of patients who have been victims of elder mistreatment. Depending on the state, adult protective statutes may include a statewide system with the capability for immediate investigation and emergency services, including evaluation, counseling, and, if needed, relocation. Physicians may contribute to the success of state services by serving as trainers for adult protective services, explaining how mistreatment is diagnosed, and offering suggestions for improving the effectiveness of interventions. They may also wish to serve on advisory committees in their state or county medical societies. As more research is conducted on elder abuse and neglect, more information will be available to assess protocols and medical and legal interventions.

One of the most important developments in addressing elder mistreatment in recent years has been the use of multidisciplinary teams in hospitals and communities. Specialists in geriatrics, social work, nursing, psychiatry, and other fields offer insight that can help the primary care physician to develop an appropriate intervention plan. These specialists may have important referral information for patients or family members--support groups and other services in the community that focus on aging parents, home care, substance abuse, family violence, and financial and legal planning. Perhaps most important, physicians need to become familiar with long-term care and in-home health service options in their communities. Caring for an elderly parent at home is inherently stressful, and abusive situations can be prevented by providing support to overburdened caregivers.

Resources for Physicians

The following resources are available to assist physicians in their evaluation and interventions on behalf of elderly patients. Physicians should become familiar with their own state resources and state laws that deal with elder abuse and neglect.

- **State Elder Abuse Hot Line:** Most states have instituted a 24-hour toll-free number for receiving reports of abuse and neglect. Calls are confidential.
- **Adult Protective Services:** This is the primary service agency with legal responsibility and authority to investigate reports of abuse and neglect in the home and community, and in institutions (in a majority of states); and to provide services to elderly victims. Adult Protective Services works closely with the medical community to obtain services that will increase the older person's safety and well-being.
- **Law Enforcement:** Local police and sheriffs are being given more power to intervene in cases of family violence, and they may have already been notified of the abuse or neglect by the elderly person or by a friend or advocate. Where state statutes define elder mistreatment as a crime, physicians may be required to report suspected abuse to a law enforcement agency. Some forms of abuse are criminal and must be prosecuted; these may include cases involving sexual abuse or assault.
- **Long Term Care Ombudsman Program:** Every state has a long term care ombudsman program, as established by the *Older Americans Act* in 1978. Each program provides regular visitation of nursing facilities by an ombudsman and trained volunteers; these services may be extended to board and care facilities. Information about the ombudsman program is provided through local Area Agencies on Aging, and such information is required to be posted in nursing facilities.
- **Facility Abuse Investigations:** Every nursing care facility must have a process for investigating reports of abuse, neglect and misappropriation of resident property.
- **State Licensure and Survey Agency:** The state agency responsible for survey and certification of nursing facilities has developed a process for the receipt, timely review, and investigation of allegations of abuse and neglect and misappropriation of resident property by staff or other providers of services to patients at the facility.
- **Medicaid Fraud Control Units:** Each MFCU, located in the state Attorney General's office, is required by federal law to investigate and prosecute Medicaid provider fraud and patient abuse or neglect in health care facilities that participate in Medicaid.
- **Nurse Aide Registry:** A registry maintained by the state lists the names of nurse aides who have been found guilty of mistreatment. Nursing facilities are required to check with the registry before hiring staff.
- **State Boards for Nursing and Medicine:** The state must also notify the appropriate licensure authority about abuse and neglect by other health care professionals.

State Units on Aging and Adult Protective Service Agencies

*The organization and structure of adult protective service programs vary among the states.
Use the numbers in bold to report suspected cases of abuse or neglect.*

Alabama

Elder Abuse Hotline

In-State: 800 458-7214

Martha Murph Beck
Commission on Aging
RSA Plaza, Suite 470
770 Washington Avenue
Montgomery, AL 36130
334 242-5743

J. Christine Kendall, Director
Adult, Child, and Family Services Division
Department of Human Resources
S. Gordon Persons Building
50 Ripley Street
Montgomery, AL 36130
334 242-1350

Alaska

Connie J. Sipe, Director
Division of Senior Services
Alaska Commission on Aging
Department of Administration
3601 C Street, Suite 310
Anchorage, AK 99503-5984
907 563-5654

Dwight Becker, Coordinator
Adult Protective Services Division of Senior Services
Alaska Commission on Aging
Department of Administration
3601 C Street, Suite 310
Anchorage, AK 99503-5984
907 563-5654

Arizona

Art Olin, Director
Aging and Adult Administration
Department of Economic Security
1789 West Jefferson, 950A
Phoenix, AZ 85007
602 542-4446

Tina Dannenfelser, Operations
Manager
Adult Protective Service
Aging and Adult Administration
Department of Economic Security
1789 West Jefferson, 950A
Phoenix, AZ 85007
602 542-4446

Arkansas

Elder Abuse Hotline
In-State: 800 482-8049
or 800 922-5330
Herb Sanderson, Director
Division of Aging and
Adult Services
Department of Human Services
1417 Donaghey Plaza South
P0 Box 1437, Slot 1412
7th and Main Streets
Little Rock, AR 72203-1437
501 682-2441

Arnold Habig, Administrator
Adult Protective Services
Division of Aging and
Adult Services
Department of Human Services
1417 Donaghey Plaza South
P0 Box 1437, Slot 1412
7th and Main Streets
Little Rock, AR 72203-1437
501 682-8491

California

Dixon Arnett, Director
Department of Aging
1600 K Street
Sacramento, CA 95814
916 322-5290

Sherland Jordan, Chief
Adult Services Management Branch
Department of Social Services
744 P Street, M 19-96
Sacramento, CA 95814
916 229-4583

Colorado

Elder Abuse Hotline
In-State: 800 773-1366
or 303 260-4140

Rita Barrera, Director
Aging and Adult Services Division
Department of Human Services
110 16th Street, Suite 200
Denver, CO 80202
303 620-4127

Joanne Marlatt, Administrator
Adult Protection/Elder Rights Program
Aging and Adult Services Division
Department of Human Services
110 16th Street, Suite 200
Denver, CO 80202
303 620-4137

Connecticut

Joyce A. Thomas, Commissioner
Department of Social Services
25 Sigourney Street, 10th Floor
Hartford, CT 06106-5033
860 424-4925

Pamela Giannini, Elder Rights Director
Elderly Services Division
Department of Social Services
25 Sigourney Street, 10th Floor
Hartford, CT 06106-5033
860 424-5241
800 203-1234 (after business hours)

Delaware

Eleanor Cain, Director
Division of Services for the
Aging and Adults with
Physical Disabilities
Department of Health and
Social Services
1901 North DuPont Highway
New Castle, DE 19720
302 577-4791

Vickie Artis, Administrator
Adult Protective Services
Division of Services for the
Aging and Adults with
Physical Disabilities
Department of Health and
Social Services
256 Chapman Road, Suite 200
Newark, DE 19702
302 453-3820

District of Columbia

Jearline Williams, Director
Office on Aging
441 4th Street, NW, Room 950
Washington, DC 20001
202 724-5626

Karel F. Cornwell, Chief
Adult Protective Services
Family Services Administration
Department of Human Services
Randall Building
First and Eye Streets, SW
Washington, DC 20024
202 727-2345

Florida

Elder Abuse Hotline
In-State: 800 96-ABUSE
(800 962-2873)

Bentley Lipscomb, Secretary
Department of Elder Affairs
Building B, Suite 152
4040 Esplanade Way
Tallahassee, FL 32399-7000
904 414-2000

Christopher C. Shoemaker
Program Administrator
Adult Services
Department of Children and
Family Services
Building 3, Room 311
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
904 488-8922

Georgia

Judith E. Hagebak
Division of Aging Services
2 Peachtree Street, NW, Suite 18
Atlanta, GA 30303-3176
404 657-5255

David Hellwig, Unit Chief
for Adult Services
Division of Family and
Children Services
Social Services Section
Department of Human Resources
Suite 12-418
2 Peachtree Street, NW
Atlanta, GA 30303-3180
404 657-3416

Hawaii

Marilyn Seely
Executive Office on Aging
250 South Hotel Street, Suite 107
Honolulu, HI 96813-2831
808 586-0100

Patricia Snyder
Program Administrator
Adult Protective Services
Department of Human Services
420 Waiakamilo Road
Honolulu, HI 96817-4941
808 832-5115

Idaho

Arlene D. Davidson, Director
Commission on Aging
Statehouse, Room 108
PO Box 83720
Boise, ID 83720-0007
208 334-2423
208 334-2221

Omar Valverde, Coordinator
Adult Protection Services
Commission on Aging
Statehouse, Room 108
PO Box 83720
Boise, ID 83720-0007
208 334-2220

Illinois

Elder Abuse Hotline
In-State: 800 252-8966
or 800 279-0400 (after business hours)
Maralee Lindley, Director
Department on Aging
421 East Capitol Avenue, #100
Springfield, IL 62701-1789
217 785-2870

Indiana

Adult Abuse Hotline
In-State: 800 992-6978
Geneva Shedd, Director
Bureau of Aging/In-Home Services
Family and Social Services
Administration
PO Box 7083
402 West Washington Street
South Building, Room W-454
Indianapolis, IN 46207-7083
317 232-7123

Arlene Franklin, Supervisor
Adult Protection Services
Bureau of Aging/In-Home Services
Family and Social Services
Administration
PO Box 7083
402 West Washington Street
South Building, Room W-454
Indianapolis, IN 46207-7083
317 232-1750

Iowa

Elder Abuse Hotline

In-State: 800 362-2178

Betty Grandquist, Director
Department of Elder Affairs
Clemens Building
200 10th Street, 3rd Floor
Des Moines, IA 50309
515 281-4646

Sandi Koll, Program Manager
for Adult Services
Division of Adult, Children,
and Family Resources
Department of Human Services
Hoover Building, 5th Floor
East 13th and Walnut Streets
Des Moines, IA 50319
515 281-6219

Kansas

Elder Abuse Hotline

In-State: 800 432-3535

Thelma Hunter Gordon, Secretary
Department on Aging
Docking State Office Building
915 SW Harrison, Room 150
Topeka, KS 66612-1500
913 296-4986

Rosalie Sacks
Adult Protective Services Program
Commission on Adult and
Medical Services
Department of Social and
Rehabilitation Services
Docking State Office Building
915 SW Harrison, Room 628S
Topeka, KS 66612-1500
913 296-3667
800 922-5330 (in-home abuse)

Kentucky

Jerry Whitley, Director
Division of Aging Services
Cabinet for Families and Children
CHR Building, 5th Floor West
275 East Main Street
Frankfort, KY 40621
502 564-6930

Richard Newman, Branch Manager
Adult Services
Department of Social Services
Cabinet for Families and Children
CHR Building, 6th Floor West
275 East Main Street
Frankfort, KY 40621
502 564-7043

Louisiana

Elder Abuse Hotline

In-State: 800 259-4990

Robert Fontenot, Director
Office of Elderly Affairs
4550 North Boulevard, 2nd Floor
P0 Box 80374
Baton Rouge, LA 70898-0374
504 925-1700

Betty Johnson
Elder Rights Department
Office of Elderly Affairs
4550 North Boulevard, 1st Floor
P0 Box 80374
Baton Rouge, LA 70898-0374
504 925-1730
504 925-1700

Maine

Elder Abuse Hotline

In-State: 800 624-8404

Christine Gianopoulos, Director
Bureau of Elder and Adult Services
Department of Human Services
#11 Station Statehouse
35 Anthony Avenue
Augusta, ME 04333-0011
207 624-5335

Karen Elliott, Regional Operation
Bureau of Elder and Adult Services
Department of Human Services
#11 Station Statehouse
35 Anthony Avenue
Augusta, ME 04333-0011
207 624-5335

Maryland

Elder Abuse Hotline

National: 800 917-7383

Sue F. Ward
Office on Aging
State Office Building
301 West Preston Street, Room 1007
Baltimore, MD 21201
410 767-1100

Susan Seling, Acting Director
Adult Protective Services
Office of Adult and Family Services
Department of Human Resources
311 West Saratoga Street, Room 247
Baltimore, MD 21201
410 767-7384

Massachusetts

Elder Abuse Hotline

In-State: 800 922-2275

Franklin Ollivierre, Secretary
Executive Office of Elder Affairs
1 Ashburton Place, 5th Floor
Boston, MA 02108
617 727-7750, Ext. 258

Donna Reulbach, Director
Protective Services
Executive Office of Elder Affairs
1 Ashburton Place, 5th Floor
Boston, MA 02108
617 727-7750, Ext. 302

Michigan

Carol Parr, Acting Director
Office of Services to the Aging
P0 Box 30026
611 West Ottawa Street
Lansing, MI 48909
517 373-8230

Bill Chaliman
Office of Adult Services
Division of Adult Community
Placement and Adult
Protective Services
Michigan Family
Independence Agency
P0 Box 30037
235 South Grand Ave., Suite 501
Lansing, MI 48909
517 373-9170

Minnesota

James Varpness,
Executive Secretary
Board on Aging
444 Lafayette Road
St. Paul, MN 55155-3843
612 296-2770

Elmer Pierre
Adult Protection Consultant
Aging and Adult Services
444 Lafayette Road
St. Paul, MN 55155-3843
612 296-4019

Mississippi

Elder Abuse Hotline
In-State: 800 222-8000
Eddie Anderson, Director
Division of Aging and
Adult Services
750 N. State Street
Jackson, MS 39202
601 359-4929

Edna Clark, Manager
Adult Protection Services
Department of Human Services
P0 Box 352
Jackson, MS 39205
601 359-4484

Missouri

Elder Abuse Hotline
In-State: 800 392-0210
Gregory A. Vadner, Director
Division of Aging
Department of Social Services
P0 Box 1337
615 Howerton Court
Jefferson City, MO 65102-1337
573 751-3082

Montana

Elder Abuse Hotline
In-State: 800 332-2272
Charles Rehbein
Bureau Chief for Aging
Senior and Long Term Care Division
Office on Aging
Department of Health
and Human Services
SRS Building
111 North Sanders, Room 210
Helena, MT 59620-4210
406 444-7788

Nebraska

Elder Abuse Hotline
In-State: 800 652-1999
Mary Jo Iwan, Administrator
Special Services for Children
and Adults Division
Department of Health and
Human Services
P0 Box 95026
301 Centennial Mall South
Lincoln, NE 68509-5026
402 471-9190

Nevada

Jon Thiriot, Deputy Administrator
Division for Aging Services
Department of Human Resources
340 North 11th Street, Suite 203
Las Vegas, NV 89101
702 486-3545

Dale Capurro, Director
Elder Protective Services
Department of Human Resources
Welfare Division-Medicaid
Capitol Complex
2527 North Carson Street
Carson City, NV 89710
702 687-4588

New Hampshire

Elder Abuse Hotline

In-State: 800 852-3345

Richard D. Crocker, Director
Division of Elderly & Adult Services
115 Pleasant Street
Concord, NH 03301-6501
603 271-4680
603 271-4375 (Long Term
Care Abuse)

New Jersey

Elder Abuse Hotline

In-State: 800 792-8820

Ruth M. Reader, Assistant
Commissioner
Division on Senior Affairs
Department of Health
& Senior Services
CN807
Trenton, NJ 08625-0807
609 292-4833

New Mexico

Elder Abuse Hotline

In-State: 800 432-2080

Michelle Lujan Grishan, Director
State Agency on Aging
4th Floor
LaVilla Rivera Building
228 East Palace Avenue
Santa Fe, NM 87501
505 827-7640

Shelley Gallegos, Bureau Chief
Adult Services Bureau
Social Services Division
Human Services Department
228 East Palace Avenue
Santa Fe, NM 87501-2348
505 827-8402

New York

Elder Abuse Hotline

In-State: 800 342-9871

Walter Hoefer, Director
Office for the Aging
Agency Building #2
New York State Plaza
Albany, NY 12223
518 474-4425

Greg Guiliano, Director
Bureau of Community Services
State Department of Social Services
40 North Pearl Street
Albany, NY 12243
518 432-2980

North Carolina

Elder Abuse Hotline

In State: 800 662-7030

Bonnie Cramer, Director
Division of Aging
693 Palmer Drive
Raleigh, NC 27603-2001
919 733-3983

Vicki Kryk
Program Manager, for APS
Adult and Family Services
Division of Social Services
Department of Human Resources
325 North Salisbury Street
Raleigh, NC 27603
919 733-3818
800 662-7030 (Careline)

North Dakota
Linda Wright, Director
Aging Services Division
Department of Human Services
600 S. Second Street, Suite 1C
Bismarck, ND 58504-5729
701 328-8910
800 755-8521

Barbara Kidder,
Program Supervisor
Adult Protective Services
Aging Services Division
Department of Human Services
312 NE 28th Street
Oklahoma City, OK 73105
405 521-3660

Ohio
Elder Abuse Hotline
In-State: 800 686-1581
Judith Brachman, Director
Department of Aging
50 West Broad Street
9th Floor
Columbus, OH 43215-5928
614 466-5500

Oregon
Elder Abuse Hotline
In-State: 800 232-3020
Roger Auerbach, Administrator
Senior & Disabled Services Division
500 Summer Street, NE
Salem, OR 97310
503 945-5811

Erika Taylor, Chief
Bureau of Adult & Senior Services
Office of Child Care
& Family Services
Ohio Department of
Human Services
65 East State
Columbus, OH 43266-0423
614 464-6140

Aileen Kaye, Program Manager
Abuse and Protective Services
Senior Services Division
Department of Human Resources
500 Summer Street, NE, 2nd Floor
Salem, OR 97310-1015
503 945-6399

Oklahoma
Elder Abuse Hotline
In-State: 800 522-3511
Roy Keen
Division Administrator
Aging Services Division
Department of Human Services
P0 Box 25352
Oklahoma City, OK 73125
405 521-2327

Pennsylvania
Fraud and Abuse Hotline
In-State: 800 992-2433
Richard Browdie, Secretary
Department of Aging
400 Market Street, RC 5B
Harrisburg, PA 17101-2301
717 783-1550

James L. Bubb, Jr
Aging Services Specialist
Department of Aging
400 Market Street
Harrisburg, PA 17101-1195
717 772-2934

Puerto Rico
Ruby Rodriguez, MHA
Executive Director
Governor's Office for Elderly Affairs
P0 Box 50063
SanJuan, PR 00902
809 721-5710

Maria I. Soldevila, Program Director
Services to Adults
Department of Social Services
P0 Box 11398
Fernandez Juncos Station
Santruce, PR 00910
809 723-2127
809 724-7474

Rhode Island
Elder Abuse Hotline
In-State: 800 322-2880
Christine Ferguson
Administrator
Department of Human Services
600 New London Avenue
Cranston, RI 02920
401 464-2651

Barbara Ruffino, Director
Department of Elderly Affairs
160 Pine Street
Providence, RI 02903-3708
401 277-2858
401 277-2880

South Carolina
Constance Rinehart, Director
Governor's Office,
Division of Aging
Suite 301
202 Arbor Lake Drive
Columbia, SC 29223
803 737-7500

Tim Cash, Director
Division of Adult Services
Department of Social Services
P0 Box 1520
Columbia, SC 29202-1520
803 734-5670

South Dakota
Gail Ferris, Director
Office of Adult Services & Aging
Kneip Building
700 Governor's Drive
Pierre, SD 57501
605 773-3656

Tennessee
Emily Wiseman, Director
Commission on Aging
500 Deaderick Street
Andrew Jackson Bldg. 9th Floor
Nashville, TN 37243-0860
615 741-2056

Marilyn Whalen, Program Director
Adult Protective Services
Department of Human Services
Citizens Plaza
400 Deaderick Street
Nashville, TN 37219
615 313-4784

Texas
Elder Abuse Hotline
In-Sate: 800 252-5400
Mary Sapp, Executive Director
Department of Aging
P0 Box 12786
4900 N. Lamar
Austin, TX 78751
512 424-6840

Bettye M. Mitchell, Director
Adult Protective Services
Texas Department of Protective
and Regulatory Services
P0 Box 149030- E561
Austin, TX 78714-9030
512 438-5046

Utah

Helen Goddard, Director
Division of Aging &
Adult Services
Department of Human Services
120 North - 200 West
P0 Box 45500
Salt Lake City, UT 84145-0500
801-538-3910

Vermont

Elder Abuse Hotline
In-State: 800 564-1612
David Yacavone
Commissioner
Aging and Disabilities
103 South Main Street
Waterbury, VT 05671-2301
802 241-2400

Dagny Reimondi, Director
Adult Protective Services
Ladd Hall
103 South Main Street
Waterbury, VT 05676
802 241-2345

Virginia

Elder Abuse Hotline
In-State: 800 552-3402
Thelma Bland, Commissioner
Department for the Aging
700 Centre, 10th Floor
700 East Franklin Street
Richmond, VA 23219-2327
804 225-2271

Joy Duke, Program Supervisor
Adult Protective Services
Bureau of Adult & Family Services
Division of Service Programs
Department of Social Services
730 F. Broad Street
Richmond, VA 23219-1849
804 692-1299

Washington

Ralph W. Smith
Assistant Secretary
Aging & Adult Srvcs Administration
Dept of Social & Health Services
P0 Box 45600
Olympia, WA 98504-5600
360 493-2500

Melanie Johnson
APS Program Manager
Adult Protective Services Program
Department of Social & Health Svcs
P0 Box 45600
Olympia, WA 98504-0095
360 407-0354

West Virginia

Elder Abuse Hotline
In-State: 800 352-6513
William Lyntton, Jr
Interim Director
Commission on Aging
Holly Grove-State Capitol
Charleston, WV 25305
304 558-3317

Ronald Nestor, Director
Services to the Aged, Blind
and Disabled
Social Services Bureau
State Capitol Complex
Building 6, Room B850
Charleston, WV 25305
304 558-7980

Wisconsin

Donna McDowell, Director
Bureau on Aging
Division of Supportive Living
Suite 300
217 South Hamilton Street
Madison, WI 53707
608 266-2536

Wyoming

Elder Abuse Hotline

In-State: 800 528-3396

Debbie Fleming, Administrator
Division on Aging
Hathaway Building, #139
Cheyenne, WY 82002-07 10
307 777-7986

Jan Stiles, Program Manager
Family Services
Division of Public Assistance
and Social Services
Department of Hlth & Social Svcs
Hathaway Building
Cheyenne, WY 82002-0710
307 777-6137

**State Long Term Care
Ombudsman Program
Directors**

*The following numbers should be used
for assistance in evaluating potential
abuse and neglect institutions.*

Alabama

Marie Tomlin
Commission on Aging
RSA Plaza, Suite 470
770 Washington Avenue
Montgomery, AL 36130
334 242-5743

Alaska

Frances Purdy
Office of the Long Term Care
Ombudsman
Division of Senior Services
Alaska Commission on Aging
3601 C Street, Suite 260
Anchorage, AK 99503-5209
907 563-6393
800 730-6393

Arizona

Rosalind Webster
Aging and Adult Administration
Department of Economic Security
1789 West Jefferson, 950A
Phoenix, AZ 85007
602 542-4446

Arkansas

Raymond Harvey
Division of Aging and Adult Services
Department of Human Services
1417 Donaghey Plaza South
P0 Box 1437, Slot 1412
7th and Main Streets
Little Rock, AR 72203-1437
501 682-2441

California

Phyllis Heath
Department on Aging
1600 K Street
Sacramento, CA 95814
916 322-5290
800 231-4024

Colorado

Virginia Fraser
The Legal Center
455 Sherman Street, Suite 130
Denver, CO 80203-4403
303 722-0300
800 288-1376

Connecticut

Barbara Frank
Elderly Services Division
Department of Social Services
25 Sigourney Street, 10th Floor
Hartford, CT 06 106-5033
860 424-5200

Delaware

Maxine Nichols
Division of Services for the Aging
and Adults with Physical Disabilities
Department of Health and Social
Services
256 Chapman Road, Suite 200
Newark, DE 19702
302 453-3820
800 223-9074

District of Columbia

Ann Hart
Legal Counsel for the Elderly
601 E Street, NW
Washington, DC 20049
202 662-4933

Florida

Gwen Schaper, Executive Director
Long Term Care
Ombudsman Council
Department of Elder Affairs
Carlton Building, Room 270
501 South Calhoun Street
Tallahassee, FL 32399-0001
904 488-6190

Georgia

Becky Kurtz
Office of Aging
Department of Human Resources
Suite 12-418
2 Peachtree Street, NW
Atlanta, GA 30303-3180
404 657-5327

Hawaii

Executive Office on Aging
250 South Hotel Street, Suite 107
Honolulu, HI 96813-2831
808 586-0100

Idaho

Cathy Hart
Commission on Aging
Statehouse, Room 108
P0 Box 83720
Boise, ID 83720-0007
208 334-4693

Illinois

**Long Term Care/
Nursing Home Hotline**
In-State: 800 252-4343
Neyna Johnson
Department on Aging
421 East Capitol Avenue, #100
Springfield, IL 62701-1789
217 785-3140

Rick Dees, Division Head for
Field Operations
Office of Health Care Regulation
Department of Public Health
525 West Jefferson Street,
5th Floor
Springfield, IL 62761
217 785-2629

Indiana

Robyn Grant
Bureau of Aging/In-Home Services
Family and Social Services
Administration
P0 Box 7083
402 West Washington Street
South Building, Room W-454
Indianapolis, IN 46207-7083
317 232-7134
800 622-4484

Iowa

Carl McPherson
Department of Elder Affairs
Clemens Building
200 10th Street, 3rd Floor
Des Moines, IA 50309
515 281-4656

Kansas

Myron Dunavan
Department on Aging
Docking State Office Building
915 SW Harrison, Room 150
Topeka, KS 66612-1500
913 296-4986
800 432-3535

Mary Jane Kennedy
Bureau of Adult and Child Care
Department of Health and Env
Landon State Office Building
900 SW Jackson, Suite 1001
Topeka, KS 66612
913 296-0131
**(nursing facilities,
home health care, hospice)**

Kentucky
Gary Hammonds
Division of Aging Services
Cabinet for Families and Children
CHR Building, 5th Floor West
275 East Main Street
Frankfort, KY 40621
502 564-6930
800 372-2291

Louisiana
Linda Sadden
Office of Elderly Affairs
4550 North Boulevard, 2nd Floor
P0 Box 80374
Baton Rouge, LA 70898-0374
504 925-1700

Maine
Brenda Gallant, Director
Long Term Care
Ombudsman Program
P0 Box 126
21 Bangor Street
Augusta, ME 04332-0126
207 621-1079

Carter Friend
Legal Services for the Elderly
P0 Box 2723
72 Winthrop Street
Augusta, ME 04338-2723
800 750-5353

Maryland
Patricia Bayliss
Office on Aging
State Office Building
301 West Preston Street
Room 1007
Baltimore, MD 21201
410 767-1074

Massachusetts
Mary McKenna
Ombudsman Program
Executive Office of Elder Affairs
1 Ashburton Place, 5th Floor
Boston, MA 02108
617 727-7750, Ext. 379
800 462-5540 (nursing facilities)

Michigan
Hollis Turnham
Citizens for Better Care
Alpha Building
416 North Homer Street, Suite 101
Lansing, MI 48912
517 336-6753
800 292-7852

Minnesota
Sharon Zoesch
Office of Ombudsman for
Older Minnesotans
Board on Aging
444 Lafayette Road
St. Paul, MN 55155-3843
612 296-0382
800 657-3591

Mississippi
Anniece McLemore
Division of Aging and
Adult Services
750 N. State Street
Jackson, MS 39202
601 359-4929

Missouri

Carol Scott
Division of Aging
Department of Social Services
P0 Box 1337
615 Howerton Court
Jefferson City, MO 65102-1337
573 751-3082

Montana

Doug Blakely
Senior and Long Term Care
Division
Office on Aging
Department of Health
and Human Services
SRS Building
111 North Sanders, Room 210
Helena, MT 59620-4210
406 444-4676
800 332-2272

Nebraska

Geri Tucker
Special Services for
Children and Adults Division
Department of Health and
Human Services
P0 Box 95044
301 Centennial Mall South
Lincoln, NE 68509-5044
402 471-2306
402 471-2307

Nevada

Bruce McAnnany
Community Ombudsman
Division for Aging Services
Department of Human Resources
340 North 11th Street, Suite 203
Las Vegas, NV 89101
702 486-3545

New Hampshire

Doris Beck
Division of Elderly and
Adult Services
6 Hazen Drive
Concord, NH 0330 1-6508
603 271-4375
800 442-5640

New Jersey

Bonnie Kelly
State Ombudsman
Office of the Ombudsman for the
Institutionalized Elderly
Room 305, CN807
Trenton, NJ 08625-0807
609 292-8016
800 792-8820

New Mexico

Tim Covell
State Agency on Aging
LaVilla Rivera Building
228 East Palace Avenue
Santa Fe, NM 87501
505 827-7640

New York

In State: 800 342-9871
Faith Fish
Office for the Aging
Agency Building, #2
Empire State Plaza
Albany, NY 12223
518 474-7329

North Carolina

Michael McCann
Department of Human Resources
Division of Aging
CB-29531
693 Palmer Drive
Raleigh, NC 27603
919 733-3983

North Dakota

Jo Hildebrant
Aging Services Division
Department of Human Services
600 S. Second Street
Bismarck, ND 58507
701 328-8910
800 472-2622

Ohio

Beverly Laubert
Department of Aging
50 West Broad Street, 9th Floor
Columbus, OH 43215-5928
614 466-1221
800 282-1206

Oklahoma

Esther Allgood
Division of Aging Services
Department of Human Services
P0 Box 25352
Oklahoma City, OK 73105
405 521-6734

Oregon

Meredith Cote
Office of LTC Ombudsman
2475 Lancaster Drive, NE
Building B, #9
Salem, OR 97310
503 378-6533
800 522-2602

Pennsylvania

Joyce O'Brien
Department of Aging
400 Market Street
RCSB
Harrisburg, PA 17101-2301
717 783-7247

Puerto Rico

Norma Venegas
Governor's Office for
Elderly Affairs
Corbian Plaza, Stop 23
Ponee De Leon Avenue, #1603
UM Office C
San Ture, PR 00908
809 722-2429

Rhode Island

Cathy McKeon
Department of Elderly Affairs
160 Pine Street
Providence, RI 02903
401 277-2858 ext. 202

South Carolina

Mary B. Fagan
Long Term Care Ombudsman
Office of the Governor
202 Arbor Lake Drive
Suite 301
Columbia, SC 29223
803 737-7500

South Dakota

Jeff Askew
Office of Adult Services & Aging
Department of Social Services
Richard F. Kneip Building
700 Governor's Drive
Pierre, SD 57501-2291
605 773-3656

Tennessee

Adrian Wheeler
Commission on Aging
500 Deaderick Street
Andrew Jackson Building
9th Floor
Nashville, TN 37219-5573
615 741-2056

Texas

John Willis, Director
Division of Elder Rights
P0 Box 12786
4900 N. Lamar
Austin, TX 78751
512 424-6875
800 252-9240

Utah

Carol Blosswick
Division of Aging & Adult Services
Department of Human Services
120 North - 200 West, Room 401
P0 Box 45500
Salt Lake City, UT 84145-0500
801 538-3910

Vermont

Jacqueline Majoras, Director
Vermont Ombudsman Project
264 N. Winooski Avenue
P0 Box 1367
Burlington, VT 05402
802 863-5620 ext 227

Virginia

Mark Miller
530 E. Main Street
Suite 428
Richmond, VA 23219
804 644-2804
800 552-3402

Washington

Kary Hyre
State Ombudsman Program
Multi-Service Center
1200 South 336th Street
Federal Way, WA 98003-7452
206 838-6810

West Virginia

Carolyn Riffle
Commission on Aging
State Capitol Complex
1900 Kanawha Boulevard East
Charleston, WV 25305-0160
304 558-3317

Wisconsin

George Potaracke
Board on Aging and LTC
214 North Hamilton Street
Madison, WI 53703
608-266-8944

Wyoming

Debra Alden
State Ombudsman Program
P0 Box 94
953 Water Street
Wheatland, WY 82201
307 322-5553