FEATURE

Recognizing and Managing Elder Abuse in the Emergency Department

Tony Rosen, MD, MPH; Alyssa Elman, LMSW; Mary Mulcare, MD; Michael E. Stern, MD

An ED visit may offer the only opportunity to identify victims of elder abuse. Addressing elder mistreatment may dramatically improve quality of life or save the lives of these vulnerable patients.

Case

An 85-year-old right-handed woman who recently had been diagnosed with mild cognitive impairment arrived at the ED via emergency medical services (EMS) for evaluation of a reported fall. She was accompanied by her daughter, who resided with the patient and was her primary caregiver. The patient stated that she had tripped on a wet rug in the bathroom of her home, striking her head and face on the edge of the sink without losing consciousness. Her daughter reported that she was not assisting her mother when the fall occurred, but had witnessed the fall from the hallway and called EMS. At the patient's home, EMS found the patient to be alert, oriented, and ambulatory with normal vital signs that remained stable throughout prehospital transport.

The remainder of the patient's history was provided almost entirely by her daughter, who constantly interrupted her mother whenever she attempted to directly answer a question or provide information. On physical examination, the patient had bilateral tenderness, edema, and periorbital ecchymoses, and a left eye that was nearly swollen shut. Extraocular movements were normal, visual acuity was intact, and sclerae were noninjected. The patient had tenderness over both maxillary sinuses, and edema and ecchymosis of her left cheek. There was also tenderness, ecchymoses, and edema on the lateral aspects of both forearms, and decreased range of motion of her right lower arm and wrist. With the exception of the patient not knowing the date during the orientation part of the thorough neurological examination, the remainder of the physical examination was unremarkable.

Radiological evaluation found no evidence of traumatic brain injury, but did reveal an acute fracture of the left zygomatic arch, an acute displaced nasal bone fracture, an age-indeterminate fracture of the right zygomatic arch, and an acute right ulnar fracture. Considering all of these findings, particularly the pattern of acute injuries, the emergency physician (EP) considered elder abuse as the possible etiology of the patient's acute and chronic injuries.

Although the patient had initially agreed with her daughter's description of the events—including her claim that she had fallen—when the EP questioned the patient alone, she related a history of frequent verbal and less frequent physical abuse by her

Dr Rosen is an instructor in medicine, division of emergency medicine, Weill Cornell Medical College, New York, New York. He is a former geriatric emergency medicine fellow. **Ms Elman** is the program administrator/social worker, division of emergency medicine, Weill Cornell Medical College, New York, New York. **Dr Mulcare** is an assistant professor of medicine, department of emergency medicine, New York-Presbyterian Hospital/Weill Cornell Medical Center, New York. She is a former geriatric emergency medicine fellow. **Dr Stern** is an assistant professor of medicine and codirector, geriatric emergency medicine fellowship, department of emergency medicine, New York-Presbyterian Hospital/Weill Cornell Medical Center, New York; and an assistant attending physician, department of emergency medicine, New York-Presbyterian Hospital.

Authors' Disclosure Statement: The authors report no actual or potential conflict of interest in relation to this article.

DOI: 10.12788/emed.2017.0028

...elder abuse annually affects 5% to 10% of community-dwelling older adults, and nursing-home residents are at increased risk of abuse.

daughter. The patient further noted that immediately before sustaining the injuries that brought her to the ED, her daughter had been insisting that she sign documents to give her control of her banking and finances. After refusing to sign the papers, the patient said that she and her daughter got into an argument, which she noted "they tended to do frequently." The patient admitted that during this argument, her daughter struck her in the face repeatedly with the cane that the daughter had grabbed with her right hand.

The EP admitted the patient to the hospital for management of her orthopedic injuries and related pain, and to formulate a safe discharge plan. During admission, additional diagnostic testing revealed multiple old rib fractures, anemia, and a low-serum albumin, which suggested poor nutritional status.

Epidemiology

The term elder abuse refers to harm or the risk of harm to an older adult from either action or negligence committed by someone in a relationship of trust, or when a victim has been targeted because of age or disability. Elder abuse encompasses physical, sexual, or psychological abuse, neglect, and financial exploitation.[1-5] Identified victims of elder abuse typically suffer from multiple forms of abuse.[1-5]

At present, elder abuse annually affects 5% to 10% of community-dwelling older adults,[1-6] and nursing-home residents are at increased risk of abuse.[7-10] Poor medical outcomes, including depression and dementia,[11] and much higher mortality[6,12,13] have been linked to victims of elder abuse.

Etiology

When treating older adults, it is critically important for EPs and the ED staff to consider and identify elder abuse in the differential diagnosis.[14,15] Presently, only an estimated 1 in 24 cases of abuse is recognized and reported to the authorities,[2] and much of the subsequent morbidity and mortality of elder abuse results from poor detection. A visit to the ED for an acute injury or illness may be the only time socially isolated older adults leave their homes.[15-17] Additionally, the ED setting is uniquely suited to identify mistreatment, as a patient typically may be evaluated for several hours by providers from multiple disciplines who are able to observe, interact with, and examine the patient.[15] The ED already exercises a similar essential role in the identification and initial intervention for both child abuse[18,19] and intimate partner violence among younger adults.[20,21]

Recognition

Unfortunately, at present, ED providers rarely recognize and report elder abuse.[22-24] Though the reasons for this are not entirely understood, inadequate training, lack of time and space to conduct complete evaluations, reluctance to become involved with the legal system, and challenges to distinguishing intentional from unintentional injuries may be contributing factors.[24,25] A focus on improving EP and ED staff approaches to elder abuse is relevant and timely given the growing elderly population.

Risk Factors

When evaluating elderly patients, providers should consider research suggesting that some older adults may be at particularly high risk for abuse.[4,26-29] Notably, individuals who have cognitive impairment are more likely to be victims of abuse.[30-32] Health-related demographic characteristics such as poor physical and mental health, substance abuse, low income/socioeconomic status, and social isolation all may increase the potential for mistreatment.

Family History

Similar to situations resulting in intimate partner violence, a family history of abuse and exposure to traumatic events may increase risk, and those responsible for elder abuse often turn out to be spouses, romantic partners, or an adult child living with the elderly parent—though paid caregivers also can be abusive.

Table 1. Indicators of Possible Elder Abuse or Mistreatment[33-37]

Descriptions of poor living conditions by emergency medical services or others
Unexplained injuries
Past history of frequent injuries
Delay between onset of medical illness or injury and seeking of medical attention
Recurrent visits to the ED for similar injuries
Use of multiple physicians and EDs for care rather than one primary care physician ("doctor hopping" or "doctor shopping")
Noncompliance with medications, appointments, or physician directions
Reluctance of the patient or caregiver to answer questions
Strained patient-caregiver interactions
Inconsistencies between the patient's and caregiver's histories of injury mechanism
An elderly patient who is referred to as "accident-prone"
A caregiver who is not able to provide details of the patient's medical history or routine medications
A caregiver who answers the questions for the patient
Abandonment of the patient in the ED by the caregiver

Suspicion of abuse should be increased when individuals in caregiving roles have a history or show signs of mental illness, substance abuse, financial dependence on the victim, or caregiver stress. Considering that a caregiver may be overwhelmed is particularly relevant when an elderly patient exhibits behavioral issues.

Medical History

Obtaining a clear and thorough medical history from the patient and caregiver, both together and alone, is paramount to assessing the potential for abuse. Many indicators from the history may suggest the possibility of mistreatment (**Table 1**)[33-37] and although challenging in a busy ED, a comprehensive head-to-toe examination is crucial to adequately assess abuse. Suspicious physical findings and injury patterns of physical abuse, sexual abuse, and neglect are listed in **Table 2.**[33-37] Ongoing research is aimed at improving ED providers' ability to differentiate accidental injuries, such as fall injuries, from injuries caused by physical elder abuse.

Injury Patterns

Preliminary studies have indicated that physical abuse injuries most commonly occur on the head, neck, and upper extremities.[38,39] A study comparing abuse victims to accidental injury sufferers found that abuse victims often had large bruises (>5 cm) on the face, lateral right arm, or posterior torso.[40] Preliminary results from a study in progress suggest that injuries to the left periorbital area, neck, and ulnar forearm may be much more common in abuse than in accident.

Imaging Studies

Emergency radiologists are contributing additional concerning findings indicative of elder abuse,[38,41,42] such as the concomitant presence of old and new fractures, high-energy fractures inconsistent with the purported mechanism, and distal ulnar diaphyseal fractures.[41,42] The ultimate goal is to identify pathognomonic injury patterns similar to those found in child abuse cases, to assist ED providers.

Laboratory Studies

Although there are no laboratory tests to definitively identify abuse or neglect, specific findings that may indicate abuse include anemia, dehydration, malnutrition, hypothermia/hyperthermia, and rhabdomyolysis.[43] In addition, inappropriately high- or

Table 2. Signs of Elder Abuse[33-37]

Signs of Physical Abuse
Bruising in atypical locations (not over bony prominences/on lateral arms, back, face, ears, or neck)
Patterned injuries (bite marks, or injuries consistent with the shape of a belt buckle, fingertip, or other object)
Wrist or ankle lesions or scars (suggesting inappropriate restraint)
Burns (particularly stocking/glove pattern suggesting forced immersion or cigarette pattern)
Concomitant fractures or bruises of different ages
Traumatic alopecia or scalp hematomas
Subconjunctival, vitreous, or retinal ophthalmic hemorrhages
Intraoral soft tissue injuries
Signs of Sexual Abuse
Genital, rectal, or oral trauma (including erythema, bruising, lacerations)
Evidence of sexually transmitted disease
Signs of Neglect
Cachexia/malnutrition
Dehydration
Pressure sores/decubitus ulcers
Poor body hygiene, unchanged diaper
Dirty, severely worn clothing
Elongated toenails
Poor oral hygiene

low-medication levels and the presence of illicit drugs, which are not often checked in elderly patients in the ED, may be a sign of abuse.[43]

Laboratory studies that reveal undetectable levels of a patient's prescription medications may indicate a caregiver's intentional or neglectful withholding of such medications—especially diversion of opioid medications prescribed for painful conditions.[43] Likewise, elevated levels of prescribed drugs may point to intentional or unintentional overdose, whereas the presence of nonprescribed drugs or toxins may suggest poisoning.[43]

Screening Tools

To improve identification of elder abuse in the ED, universal or targeted screening tools are under consideration. Though several screening tools for elder abuse are already available, none have been validated in the ED.[15,44,45] Research sponsored by the National Institute of Justice to identify an ED-specific screening tool is ongoing.[15]

Elder Abuse Suspicion Index

The Elder Abuse Suspicion Index (EASI) is a short screening tool that has been validated for cognitively intact patients being treated in family practice and ambulatory care settings, and may be used in EDs.[44] The tool comprises six questions: five for patient response, and a sixth question for clinician response. This tool is available at http://www.nicenet.ca/tools-easi-elder-abuse-suspicion-index.[46]

Interventional Measures

When elder mistreatment is suspected or confirmed, health care providers must first address any acute medical, traumatic, or psychological issues. Bleeding, orthopedic injuries, metabolic abnormalities, infec-

tions, and agitation must be treated and/or stabilized, while neglected or inappropriately managed chronic medical conditions may require treatment.

Hospitalization should be considered for an older adult who needs extended treatment or observation and, in cases of immediate or continued danger of abuse, separation from contact with the suspected abuser. These measures present several challenges, particularly if the suspected abuser is the patient's health care proxy, in which case early involvement of the hospital's legal department, social services, and administration may be necessary—especially in navigating the guardianship process.

Engaging security also may be necessary if the patient requires one-to-one patient watch or when the perpetrator must be removed from the ED. Social workers, patient services representatives, and law enforcement officials should be informed when such intervention is necessary.

In instances when a patient is not at risk of immediate harm, interventions can be more individualized. Coordination with primary care physicians (PCPs) must also be facilitated prior to discharge, to ensure consistent longitudinal follow-up care, and social workers should provide any needed out-of-hospital resources to the patient—and caregiver—such as Meals-on-Wheels, medical transportation services, adult day care/senior center participation, and substance abuse treatment.

Patient Decision-Making Capacity

When a patient experiencing abuse declines interventions or services, the EP must evaluate the patient's decision-making capacity. In unclear cases, a psychiatric evaluation can help to assess decision-making capacity. If the victim is deemed to have capacity with regard to care and/or discharge, the patient's choice of returning to an unsafe environment must be respected, as is true in instances of intimate partner violence among younger adults—but not in child abuse cases. In such situations, the EP should nevertheless discuss safety planning, offer psychoeducation about violence and abuse, suggest appropriate community referrals, and encourage abused patients to return or call a contact person whenever they desire or feel the need to talk further. For a victim who is deemed not to possess capacity, providers should proceed with treatment considered to be in the best interest of the patient.

Reporting Abuse

Emergency department providers should notify the appropriate authorities when elder abuse is suspected or identified. A report may be made to the local Adult Protective Services (APS), but this agency operates much differently than Child Protective Services. Case workers with APS will not open a case while a patient is in the ED or hospital, as it is deemed a safe environment and any investigation they undertake will only commence upon discharge. Because of this, contacting the local police department prior to discharge should be considered.

Mandatory elder abuse-reporting laws vary from state to state. Health care providers should therefore contact their respective state or city department of health to obtain local legislation.

Multidisciplinary Approach

Ideally, a multidisciplinary, ED-based intervention team modeled on child abuse teams[18,19] would help to optimize treatment and ensure the safety and treatment of vulnerable older adults. These teams could conduct thorough medical, forensic, and social work assessments, allowing ED providers to attend to other patients. The team could also assist in arranging for appropriate and safe dispositions. An innovative Vulnerable Elder Protection Team was recently launched at New York-Presbyterian Weill Cornell Medical Center to provide these services, and its impact is currently being evaluated.

When elder mistreatment is suspected or confirmed, health care providers must first address any acute medical, traumatic, or psychological issues.

Case Conclusion

The EP who treated the patient realized that blows from a blunt object held by a right-handed person would tend to land on the left side of the victim's face and upper torso, and that a right-handed victim who successfully blocked the blows intended for her face would instead sustain an isolated right ulna or radius midshaft fracture. These findings, together with the concomitant presence of both old and new fractures, led the EP to question the patient alone and, after obtaining a different history of the events that led to the injuries, admit her for further evaluation, treatment, and interventions to prevent continuing abuse.

Summary

Elder abuse has the potential to affect an increasing number of older adults in this growing population, and an ED visit may offer the only opportunity to identify victims and provide intervention, in turn reducing morbidity and mortality. The results of ongoing research will improve the ability of EPs and ED staff to accurately assess the presence or risk of elder abuse and respond more effectively. It is essential that EPs always consider elder abuse and neglect as a possible etiology when evaluating injuries in this population. Moreover, when identified, addressing elder mistreatment may dramatically improve quality of life or save the lives of these vulnerable patients.

References

1. Elder Mistreatment: Abuse, Neglect, and Exploitation in an Aging America. Bonnie RJ, Wallace RB, eds. Washington, DC: National Academies Press; 2003:1-552. https://www.nap.edu/read/10406/chapter/1. Accessed April 4, 2017.
2. Lifespan of Greater Rochester, Inc; Weill Cornell Medical Center of Cornell University; New York City Department for the Aging. Under the radar: New York state elder abuse prevalence study: self-reported prevalence and documented case surveys 2011. http://ocfs.ny.gov/main/reports/Under%20the%20Radar%2005%2012%2011%20final%20report.pdf. Published May 2011. Accessed April 4, 2017.
3. Connolly MT, Brandl B, Breckman R. The Elder Justice Roadmap: A Stakeholder Initiative to Respond to an Emerging Health, Justice, Financial, and Social Crisis. https://www.justice.gov/elderjustice/file/829266/download. National Center for Elder Abuse. Published January 2014. Accessed April 4, 2017.
4. Acierno R, Hernandez MA, Amstadter AB, 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. doi:10.2105/AJPH.2009.163089.
5. Lachs MS, Pillemer K. Elder abuse. *Lancet*. 2004;364(9441):1263-1272. doi:10.1016/S0140-6736(04)17144-4.
6. Lachs MS, Pillemer KA. Elder abuse. *N Engl J Med*. 2015;373(20):1947-1956. doi:10.1056/NEJMra1404688.
7. Ortmann C, Fechner G, Bajanowski T, Brinkmann B. Fatal neglect of the elderly. *Int J Legal Med*. 2001;114(3):191-193.
8. Schiamberg LB, Oehmke J, Zhang Z, et al. Physical abuse of older adults in nursing homes: a random sample survey of adults with an elderly family member in a nursing home. *J Elder Abuse Negl*. 2012;24(1):65-83. doi:10.1080/08946566.2011.608056.
9. Rosen T, Pillemer K, Lachs M. Resident-to-resident aggression in long-term care facilities: an understudied problem. *Aggress Violent Behav*. 2008;13(2):77-87. doi:10.1016/j.avb.2007.12.001.
10. Shinoda-Tagawa T, Leonard R, Pontikas J, McDonough JE, Allen D, Dreyer PI. Resident-to-resident violent incidents in nursing homes. *JAMA*. 2004;291(5):591-598. doi:10.1001/jama.291.5.591.
11. Dyer CB, Pavlik VN, Murphy KP, Hyman DJ. The high prevalence of depression and dementia in elder abuse or neglect. *J Am Geriatr Soc*. 2000;48(2):205-208.
12. Lachs MS, Williams CS, O'Brien S, Pillemer KA, Charlson ME. The mortality of elder mistreatment. *JAMA*. 1998;280(5):428-432.
13. Dong XQ, Simon MA, Beck TT, et al. Elder abuse and mortality: the role of psychological and social wellbeing. *Gerontology*. 2011;57(6):549-658. doi:10.1159/000321881.
14. Stevens TB, Richmond NL, Pereira GF, Shenvi CL, Platts-Mills TF. Prevalence of nonmedical problems among older adults presenting to the emergency department. *Acad Emerg Med*. 2014;21(6):651-658. doi:10.1111/acem.12395.
15. Rosen T, Hargarten S, Flomenbaum NE, Platts-Mills TF. Identifying elder abuse in the emergency department: toward a multidisciplinary team-based approach. *Ann Emerg Med*. 2016;68(3):378-382. doi:10.1016/j.annemergmed.2016.01.037.
16. Bond MC, Butler KH. Elder abuse and neglect: definitions, epidemiology, and approaches to emergency department screening. *Clin Geriatr Med*. 2013;29(1):257-273. doi:10.1016/j.cger.2012.09.004.
17. Heyborne RD. Elder abuse: keeping the unthinkable in the differential. *Acad Emerg Med*. 2007;14(6):566-567. doi:10.1197/j.aem.2007.01.015.
18. Kistin CJ, Tien I, Bauchner H, Parker V, Leventhal JM. Factors that influence the effectiveness of child protection teams. *Pediatrics*. 2010;126(1):94-100. doi:10.1542/peds.2009-3446.
19. Hochstadt NJ, Harwicke NJ. How effective is the multidisciplinary approach? A follow-up study. *Child Abuse Negl*. 1985;9(3):365-372.
20. Choo EK, Gottlieb AS, DeLuca M, Tape C, Colwell L, Zlotnick C. Systematic review of ED-based intimate partner violence intervention research. *West J Emerg Med*. 2015;16(7):1037-1042. doi:10.5811/westjem.2015.10.27586.
21. Rhodes KV, Rodgers M, Sommers M, et al. Brief motivational intervention for intimate partner violence and heavy drinking in the emergency department:

a randomized clinical trial. *JAMA*. 2015;314(5):466-477. doi:10.1001/jama.2015.8369.
22. Teaster PB, Dugar TA, Mendiondo MS, et al; The National Committee for the Prevention of Elder Abuse; The National Adult Protective Services Association. The 2004 survey of state adult protective services: abuse of adults 60 years of age and older. http://www.napsa-now.org/wp-content/uploads/2012/09/2-14-06-FINAL-60+REPORT.pdf. Published February 2006. Accessed March 10, 2017.
23. Blakely BE, Dolon R. Another look at the helpfulness of occupational groups in the discovery of elder abuse and neglect. *J Elder Abuse Negl*. 2003;13:1-23.
24. Evans CS, Hunold KM, Rosen T, Platts-Mills TF. Diagnosis of elder abuse in U.S. emergency departments. *J Am Geriatr Soc*. 2017;65(1):91-97. doi:10.1111/jgs.14480.
25. Jones JS, Veenstra TR, Seamon JP, Krohmer J. Elder mistreatment: national survey of emergency physicians. *Ann Emerg Med*. 1997;30(4):473-479.
26. Amstadter AB, Zajac K, Strachan M, Hernandez MA, Kilpatrick DG, Acierno R. Prevalence and correlates of elder mistreatment in South Carolina: the South Carolina elder mistreatment study. *J Interpers Violence*. 2011;26(15):2947-2972. doi:10.1177/0886260510390959.
27. Friedman LS, Avila S, Tanouye K, Joseph K. A case-control study of severe physical abuse of older adults. *J Am Geriatr Soc*. 2011;59(3):417-422. doi:10.1111/j.1532-5415.2010.03313.x.
28. Pillemer K, Burnes D, Riffin C, Lachs MS. Elder Abuse: global situation, risk factors, and prevention strategies. *Gerontologist*. 2016;56 Suppl 2:S194-S205. doi:10.1093/geront/gnw004.
29. 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.
30. Cooney C, Howard R, Lawlor B. Abuse of vulnerable people with dementia by their carers: can we identify those most at risk? *Int J Geriatr Psychiatry*. 2006;21(6):564-571. doi:10.1002/gps.1525.
31. Lachs MS, Williams C, O'Brien S, Hurst L, Horwitz R. Risk factors for reported elder abuse and neglect: a nine-year observational cohort study. *Gerontologist*. 1997;37(4):469-474.
32. Wiglesworth A, Mosqueda L, Mulnard R, Liao S, Gibbs L, Fitzgerald W. Screening for abuse and neglect of people with dementia. *J Am Geriatr Soc*. 2010;58(3):493-500. doi:10.1111/j.1532-5415.2010.02737.x.
33. Collins KA. Elder maltreatment: a review. *Arch Pathol Lab Med*. 2006;130(9):1290-1296. doi:10.1043/1543-2165(2006)130[1290:EMAR]2.0.CO;2.
34. Gibbs LM. Understanding the medical markers of elder abuse and neglect: physical examination findings. *Clin Geriatr Med*. 2014 Nov;30(4):687-712. doi:10.1016/j.cger.2014.08.002.
35. Palmer M, Brodell RT, Mostow EN. Elder abuse: dermatologic clues and critical solutions. *J Am Acad Dermatol*. 2013;68(2):e37-e42. doi:10.1016/j.jaad.2011.03.016.
36. Speck PM, Hartig MT, Likes W, et al. Case series of sexual assault in older persons. *Clin Geriatr Med*. 2014;30(4):779-806. doi:10.1016/j.cger.2014.08.007.
37. 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-.e10. doi:10.1016/j.jaad.2013.01.001.
38. Murphy K, Waa S, Jaffer H, Sauter A, Chan A. A literature review of findings in physical elder abuse. *Can Assoc Radiol J*. 2013;64(1):10-14. doi:10.1016/j.carj.2012.12.001.
39. Rosen T, Bloemen EM, LoFaso VM, Clark S, Flomenbaum NE, Lachs MS. Emergency department presentations for injuries in older adults independently known to be victims of elder abuse. *J Emerg Med*. 2016;50(3):518-526. doi:10.1016/j.jemermed.2015.10.037.
40. Wiglesworth A, Austin R, Corona M, et al. Bruising as a marker of physical elder abuse. *J Am Geriatr Soc*. 2009;57(7):1191-1196. doi:10.1111/j.1532-5415.2009.02330.x.
41. Rosen T, Bloemen EM, Harpe J, et al. Radiologists' training, experience, and attitudes about elder abuse detection. *AJR Am J Roentgenol*. 2016;207:1210-1214.
42. Wong NZ, Rosen T, Sanchez AM, et al. Imaging findings in elder abuse: a role for radiologists in detection. *Can Assoc Radiol J*. 2017;68(1):16-20. doi:10.1016/j.carj.2016.06.001.
43. LoFaso VM, Rosen T. Medical and laboratory indicators of elder abuse and neglect. *Clin Geriatr Med*. 2014;30(4):713-28. doi:10.1016/j.cger.2014.08.003.
44. 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.
45. Yaffe MJ, Wolfson C, Lithwick M, Weiss D. Development and validation of a tool to improve physician identification of elder abuse: the Elder Abuse Suspicion Index (EASI). *J Elder Abuse Negl*. 2008;20(3):276-300. doi:10.1080/08946560801973168.
46. National Initiative for the Care of the Elderly. EASI: Elder Abuse Suspicion Index. http://www.nicenet.ca/tools-easi-elder-abuse-suspicion-index. Accessed April 5, 2017.