Welcome to the APS Research to Practice Webinar Series!

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“Elder Abuse Screening Tools for Use in Primary Care: Reaching for Solid Ground”

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Note: A copy of today’s presentation slides will be available along with a recording of the webinar on NCCD’s website within two weeks from today’s presentation.
Elder Abuse Screening Tools for Use in Primary Care: Reaching for Solid Ground

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Objectives

At the end of this 75-minute presentation, front-line APS workers, supervisors, program managers & other individuals involved in Elder Abuse identification will be able to:

- Define screening
- Define specificity, sensitivity, positive predictive value & negative predictive value
- State the method of the review
- Describe the 10 studies reviewed to highlight the EA screening tools
- Discuss the developments in EA screening tools from 2004-2011
- Identify relevance of the instruments reviewed to their unique practice setting
Introduction

- Determinants of vulnerability
- Individuals age 65 and older are a vulnerable population
- There is a need to screen for abuse
  - physical, psychological/emotional, sexual, and financial abuse and neglect
Introduction: Profile of older Americans

- Americans age 65 & over was 39.6 million in 2009
- 6 million 85 years or older
- 20% were minority
- 38% of elders reported some type of disability
- 3.7 million elderly persons (9.7%) were below the poverty level in 2008
- At risk for abuse
  - underlying medical conditions
  - decreasing functional abilities
Introduction:
Prevalence of Elder Abuse

- Variations make it difficult to establish
- Acierno et al. (2010) determined an 11.4% prevalence rate (n=5,777) of abuse among community-dwelling, cognitively intact elders.
- A single incident of abuse can initiate a downward trend resulting in loss of autonomy, serious health issues, and even death
Understanding EA

- No universal definition
  - Center for Disease Control (CDC) efforts
- Age for “elder”
- World Health Organization definition
  - “a single, or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person” and excludes random acts of criminal violence against elders
Understanding EA

- Five forms
  - Physical
  - Psychological/Emotional
  - Financial/Material
  - Sexual
  - Neglect
- Excludes self-neglect
- Eldericide
### Screening

- **Definition of screening**
  - “The presumptive identification of unrecognized disease or defect by the application of tests, examinations, or other procedures, which can be applied rapidly to distinguish between apparently well persons who probably have a disease (or its precursor) and those who probably do not” (Wilson & Jungner, 1968, p. 11).

- **Criteria for screening programs & screening tests**

- **Definition of screening for violence by US Preventive Services Task Force (USPSTF, 2004)**
  - “as assessment of current harm or risk of harm from family and intimate partner violence in asymptomatic persons in a health care setting”
Gold Standard?

- Reference standard
  - Best single test (or a combination of tests) that is considered the current preferred method of diagnosing a particular disease
  - All other methods of diagnosing a disease, including any new test, need to be compared against this ‘gold’ standard.
  - Different for different diseases

- USPSTF Diagnostic Accuracy Studies Criteria:
  - Study uses a credible reference standard, performed regardless of test results.
  - Reference standard interpreted independently of screening test.

- Gold standard is EA is difficult to determine

(Parikh et al, 2008)
Screening – Sensitivity & Specificity

- **Sensitivity**
  - Probability that the test says a person has the disease
    - SpIN: a highly Specific test if Positive, rules IN disease.

- **Specificity**
  - Probability that the test says a person does not have the disease when in fact they are disease free
    - SnNOUT: a highly Sensitive test if Negative, rules OUT disease

- **What is ideal?**
  - A test should have high sensitivity and high specificity.
  - Sometimes there are compromises in terms of sensitivity and specificity
  - Even with both high sensitivity and high specificity, it is possible to get false positives and false negatives

(NCSSM, 1999; Parikh et al, 2008)
Screening – Positive & Negative Predictive Values

- **Positive Predictive Value (PPV)**
  - percentage of patients with a positive test who actually have the disease

- **Negative Predictive Value (NPV)**
  - percentage of patients with a positive test who actually have the disease

- The higher the PPV or NPV, the better the test is performing

- PPV & NPV are directly related to the prevalence of the disease in the population
  - PPV will increase with increasing prevalence; and NPV decreases with increase in prevalence
  - In diseases with low prevalence (EA), number of false-positive results will be far higher than the number of true-positive results
Screening Recommendations

- American Medical Association (AMA, 2007)
- National Gerontological Nurses Association (NGNA, 2006)
- The Joint Commission (TJC)
- Mandatory reporting laws
- USPSTF
  - Insufficient evidence to recommend for or against routine screening (Nelson et al., 2004; Nelson et al, 2012).
  - Cites the need for evidence regarding the accuracy of EA screening instruments used in primary care
- Barriers to screening
Literature Review

- Integrative review method described by Whittemore and Knafl (2005)
- Evidence synthesis methodology performed by Nelson, Nygren, and McInerney (2004) for the USPSTF

Aim
- Explore the state of the science related to EA screening tools developed from 2004 to 2011 for use in primary care
Three key questions used by Nelson et al. (2004)

1. How well do the EA screening tools developed since 2004 identify current harm or risk for harm from EA (sensitivity & specificity)?

2. Does screening for EA reduce harm and premature death and disability?

3. What is the quality of the studies conducted from 2004 to 2011 to validate the EA screening tool when compared to USPSTF criteria?
Literature Review

- Three additional descriptive questions

  4. In EA screening tools developed since 2004, who is the EA screening tool designed to screen - the elder (care recipient), the caregiver, or both?

  5. What type of EA is identified in EA screening tools developed since 2004?

  6. Were the potential adverse effects & ethical issues of EA screening addressed?
Methods

• May – August 2011
• Search of:
• Terms:
  – Inclusion criteria
  – Exclusion criteria
  – Determination of Quality of Evidence
Determination of Quality of Evidence

- USPSTF CRITERIA FOR ASSESSING INTERNAL VALIDITY (USPSTF, 2009)

- Good:
  - Evaluate relevant available screening test; uses a credible reference standard; interprets reference standard independently of screening test; reliability of test assessed; has few or handles indeterminate results in a reasonable manner; includes larger number (more than 100) broad-spectrum patients with and without disease.

- Fair:
  - Evaluates relevant available screening test; uses reasonable although not best standard; interprets reference standard independent of screening test; moderate sample size (50 to 100 subjects) and a “medium” spectrum of patients.

- Poor:
  - Has important limitation such as: uses inappropriate reference standard; screening test improperly administered; biased ascertainment of reference standard; very small sample size of very narrow selected spectrum of patients.
Determination of Quality of Evidence

- **USPSTF CRITERIA FOR ASSESSING EXTERNAL VALIDITY (USPSTF, 2009)**

- **Good:**
  - The study differs minimally from the US primary care population/situation/providers and only in ways that are unlikely to affect the outcome; it is highly probable (>90%) that the clinical experience with the intervention observed in the study will be attained in the US primary care setting.

- **Fair:**
  - The study differs from the US primary care population/situation/providers in a few ways that have the potential to affect the outcome in a clinically important way; it is only moderately probable (50%-89%) that the clinical experience with the intervention in the study will be attained in the US primary care setting.

- **Poor:**
  - The study differs from the US primary care population/situation/providers in many ways that have a high likelihood of affecting the clinical outcomes; the probability is low (<50%) that the clinical experience with the intervention observed in the study will be attained in the US primary care setting.
What was found?

- 211 articles
- 10 studies met inclusion criteria
- International scope
  - United States (3), Canada (1), the United Kingdom (2), Australia (1), Taiwan (1); Israel (1), & the Federation of Bosnia and Herzegovina (1)
- In EA screening tools developed since 2004, who is the EA screening tool designed to screen - the elder (care recipient), the caregiver, or both?
  - Caregivers screen (2)
  - Caregivers & elders (2)
  - Elders only (6)
What was found?

- What is the quality of the studies conducted from 2004 to 2011 to validate the EA screening tool when compared to USPSTF criteria?
  - Descriptive (4)
  - Descriptive cross-sectional (1)
  - Descriptive correlational (4)
  - Predictive (1)
  - Part of other longitudinal studies (2)
  - Randomized sampling method (1)
What was found?

- Self-report measures in the forms of questionnaires and interviews (n= 10)
  - face-to-face interviews conducted by a researcher or expert
  - self-administration of the questionnaire by caregiver and/or elder
  - face-to-face interviews with a healthcare provider
  - telephone interview or mailed questionnaire
  - face-to-face interview combined with direct observation by the researcher
What was found?

- Settings:
  - ranged from the home to primary care clinics inpatient internal medicine and orthopedic units
  - Unclear (2)

- Sample:
  - Community dwelling caregivers & elders (9)
  - Community & institutional care facilities in Taiwan (1)

- Sample Size:
  - ranged from 86 to 10,421
What was found?

- **Language:**
  - English (8)
  - Hebrew (1)
  - Not stated (1)

- **Gender**
  - Men & Women (9)
  - Women only (1)

- **Elder Ages**
  - 65 & over (3)
  - 50 & over (1)
  - Age ranges (3)
  - Mean ages (3)

- **Cognitive Capacity**
  - Cognitively intact (6)
  - Dementia (4)
What was found?

- Scales
  - Nominal & ordinal
  - Multiple-and single-item assessments of concepts
  - Likert scales (5)
  - Dichotomous (5)
  - Items ranged from 6 to 32
  - Period of self-report ranged from 3 previous months to 12 previous months
  - Administration time from 2 minutes to 2 hours
What was found?

What type of EA is identified in EA screening tools developed since 2004?

- Psychological & Physical (MCTS) (2)
- Abuse specific (3)
  - Financial/material (OAFEM)
  - Psychological (EPAS; OAPAM)
- New Tools (4)
  - OAFEM
  - OAPAM
  - EPAS
  - EASI

- Use of Previously Developed Instruments
  - MCTS (5)
  - EAI (2)
  - E-IOA (1)
  - H-S/EAST (2)
What was found?

- How well do the EA screening tools developed since 2004 identify current harm or risk for harm from EA (sensitivity & specificity) (Nelson et al., 2004)?
  - Sensitivity & Specificity
  - Positive predictive values (PPV) & negative predictive values (NPV)
What was found?

- Ongoing issue in EA screening instrument development is lack of “gold standard”
  - observer-rating (1)
  - expert documentation review (1)
  - an in-depth expert interview (1)
  - or a combination of these or other reference standards (3)
  - APS identification of abused & nonabused elders (3)
  - No reference standard (1)
What was found?

- Establishment of reference standard credibility
  - Inter-rater reliability (2)
  - a priori determination of expert consensus guidelines (1)
  - concurrent validity (1)

- Limitations
  - Modified Data Set-A (Cooper et al., 2008)
  - Physician inter-rater reliability (Racic et al., 2006)
  - Failure to conduct screening results & reference standards independently (3)
What was found?

- Were the potential adverse effects & ethical issues of EA screening addressed?
  - Determination of cognitive capacity
    - During informed consent (4)
    - Surrogate consent (2)
    - After enrolled (3)
    - Not stated (4)
  - Mandatory reporting as limitation (2)
What was found?

- Does screening for EA reduce harm and premature death and disability (Nelson et al., 2004)?
  - Similar to the findings of Nelson et al. in 2004, *NONE* of the studies reviewed provided evidence to answer this question.
  - Acceptability addressed by Cooper et al. (2008)
<table>
<thead>
<tr>
<th>Author</th>
<th>Sensitivity</th>
<th>Specificity</th>
<th>PPV</th>
<th>NPV</th>
<th>Comparison</th>
<th>False positive</th>
<th>False negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cooper et al. (2009)</td>
<td>87%</td>
<td>70%</td>
<td>18%</td>
<td>99%</td>
<td>2 geriatric psychiatrists</td>
<td>Not reported (NR)</td>
<td>NR</td>
</tr>
<tr>
<td>MCTS</td>
<td></td>
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<tr>
<td>Cohen et al. (2006)</td>
<td>92%</td>
<td>98%</td>
<td>NR</td>
<td>NR</td>
<td>LESSA &amp; APS identification</td>
<td>2.1%</td>
<td>7.1%</td>
</tr>
<tr>
<td>E-IOA</td>
<td></td>
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<tr>
<td>Wiglesworth et al.</td>
<td>75.4%</td>
<td>70.6%</td>
<td>NR</td>
<td>NR</td>
<td>Expert panel review</td>
<td>NR</td>
<td>NR</td>
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<tr>
<td>(2010) CTS2</td>
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<tr>
<td>Yaffe et al. (2008)</td>
<td>47%</td>
<td>75%</td>
<td>NR</td>
<td>NR</td>
<td>Social worker eval.</td>
<td>NR</td>
<td>NR</td>
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<td>EASI</td>
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<tr>
<td>Racic et al. (2006)</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>2%</td>
<td>3%</td>
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<tr>
<td>EAST</td>
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Study 1: Cooper et al, 2008

- Descriptive correlational design
- 86 male & female caregivers of care recipients with dementia in UK; mean age 64
- Instrument: **Modified Conflict Tactics Scale (MCTS)**
  - 5 items psychological abuse; 5 items physical abuse; Likert scale 0=4
  - Period: previous 3 months
  - Score of 2 or greater = significant abuse
- Researchers conducted interviews; setting not stated
- Comparison: Minimum Data Set Abuse screen (MDS-A); 1-hour interview
- Results: Distinguished abuse in 27.9% of caregivers; 83.7% caregivers reported the MCTS scale was acceptable; MCTS abuse score correlated with dysfunctional coping strategy score.
Study 1: Cooper et al, 2008

- **Quality Rating:**
  - **Internal Validity:**
    - Poor: MDSA reasonable although not best standard; narrow selected sample of patients with dementia (mean MMSE 9.3).
  - **External Validity:**
    - Poor: Low probability (<50%) the clinical experience with the MCTS will be attained in the US primary care setting due to unknown administration time & sample from larger longitudinal study.
Study 2: Cooper et al, 2009

- Descriptive design

- 220 family caregiver (CG) of care recipients (CR) with dementia; CG age mean=61.7; CR age mean=86.1 in UK

- Instrument: Modified Conflict Tactics Scale (MCTS)
  - 5 items psychological abuse; 5 items physical abuse; Likert scale 0=4
  - Period: previous 3 months
  - Score of 2 or greater = significant abuse
  - Pillimer criteria for frequency of abuse in previous 12 months

- Self-administered in home with interview assistance available

- Comparison: MCTS & Pillemer criteria to expert opinion of geriatric psychiatrists

- Results: Sensitivity 87%; Specificity 70%; ppv=18%; npv=99%
  - Threshold for EA much higher in geriatric psychiatrists than researchers
Study 2: Cooper et al, 2009

- Quality Rating

- Internal Validity:
  - **Fair:** Expert opinion (reference standard) interpretation made with knowledge of MCTS & Pillemer results instead of independently of screening tests; third expert used to resolve dispute

- External Validity:
  - **Fair:** Moderately probable (50%-89%) clinical experience with weighted scoring & unknown administration time of MCTS would be attained in US primary care.
Study 3: Cohen et al, 2006

- Descriptive correlational design
- 108 caregivers & care recipients age 65 and older during inpatient stay in two hospitals Jerusalem, Israel
- Instrument: **Expanded Indicators of Abuse (E-IOA)**
  - 15 factors; 50 items; 1-4 scale; four factors: caregivers & care recipient personal & interpersonal dimensions; abuse reference time period unknown
- Semi-structured interviews by trained & experienced geriatric social workers
- Added a physiological measure (albumin level)
- Comparison: List of evident signs & symptoms of abuse (LESSA) obtained through interviews & assessments by RNs & SWs
- Results: E-IOA to LESSA -> Sensitivity 92%; Specificity 98%; 7.1% false negative; 2.1% false positive; E-IOA was not able to identify known cases of financial abuse & neglect
Study 3: Cohen et al, 2006

- Quality Rating:
- Internal Validity:
  - Good: LESSA reasonable although not best standard due to lack of establishment of inter-rater reliability for RNs & SWs; interpreted LESSA independent of E-IOA using discriminate functional analysis (DFA).
- External Validity:
  - Poor: Prolonged administration time, experience level of geriatric social workers used to conduct interviews, & semi-structured format of instrument negatively impact the probability (<50%) that the clinical experience with the E-IOA will be attained in the US primary care.
Study 4: Wiglesworth et al, 2010

- Descriptive design
- Convenience sample of 129 English-speaking, community-dwelling caregivers and care recipients diagnosed with dementia/Alzheimer’s age 50 and older in US
- Instrument: Modified version of Conflict Tactics Scale (CTS2)
  - 7-item psychological aggression subscale; 12-item physical assault subscale
- Administered in home by expert researchers
- Comparison: Expert panel (3 geriatricians), dementia researcher, gerontologist with EA research expertise
- Results: Any physical abuse items & four psychological abuse items resulted in Sensitivity 75.4%; Specificity 70.6%; positive response to any one of 6 items (3 items for psych & 3 items from physical) resulted in false positive of 18.6%
Study 4: Wiglesworth et al, 2010

Quality Rating:

Internal Validity:

Fair: Reference standard (expert review) was not interpreted independently of screening test since all research data was provided to LEAD panel and discussed with researchers present although a priori guidelines set threshold for incidences per year for each physical & psychological abuse that would indicate abuse.

External Validity:

Fair: Moderately probable (50%-89%) that the clinical experience with the intervention in the study will be attained in the US primary care setting due to higher education and income of sample between sample and population and unknown administration time of CTS2.
Study 5: Conrad et al, 2010

- Descriptive design
- 227 men & women age 75 to 90 who were verified by APS as having at least one type of EA in US
- Instrument: **Older Adult Financial Exploitation Measure (OAFEM)**
  - 79-, 54- & 30-item version (30-item evaluated)
  - Dichotomous Yes/No
  - Raw score of 12 out of 60 indicative of financial abuse
- Face-to-face interviews conducted by 22 APS personnel
- Comparison: None available.
- Results: Cronbach’s alpha = 0.93 (excellent internal consistency); needs further sensitivity & specificity testing after more firm cut scores are determined
Study 5: Conrad et al, 2010

- **Quality Rating:**
- **Internal Validity:**
  - **Good:** Reference standard (APS confirmation of abuse) used independently of OAFEM screening test; internal reliability (consistency) of test assessed and good; included larger number (more than 100) of patients for instrument field testing.
- **External Validity:**
  - **Fair:** Limited geographic sample, unknown administration time of 30-item instrument & administration by experts rather than clinicians has potential to affect the outcome in a clinically important way; it is only moderately probable (50%-89%) that the clinical experience with the intervention in the study will be attained in the US primary care setting.
Study 6: Conrad et al; 2011

- Descriptive correlational design
- 226 men & women age 75 to 90 who were verified by APS as having at least one type of EA in US
- Instrument: Older Adult Psychological Abuse Measure (OAPAM)
  - 31- & 18-item version (18-item evaluated)
  - Yes/No/suspected/unknown
  - Raw score of 12 or more out of 62 indicating more severe psychological abuse
- Face-to-face interviews conducted by 22 APS personnel in homes
- Comparison: Illinois Dept. of Aging (IDOA) questionnaire & APS staff observations
- Results: Cronbach’s alpha = 0.87 (good internal consistency); needs further sensitivity & specificity testing after more firm cut scores are determined
Study 6: Conrad et al; 2011

- Quality Rating

- Internal Validity:
  - Good: Reference standard (IDOA & APS confirmation of abuse) used independently of OAPAM screening test; internal reliability of test assessed and good; included larger number (more than 100) of patients for instrument field testing.

- External Validity:
  - Fair: Limited geographic sample, unknown administration time of 18-item instrument & administration by experts rather than clinicians has potential to affect the outcome in a clinically important way; it is only moderately probable (50%-89%) that the clinical experience with the intervention in the study will be attained in the US primary care setting.
Study 7: Racic et al, 2006

- Descriptive design
- 185 men and women age 65 and older with mental impairments presenting to four family practice clinics in Bosnia, Herzegovina
- Instrument: **Hwalek-Sengstock Elder Abuse Screening Test (EAST)**
  - 15-items; "No" response to items 1, 6, 12, & 14; a response of “someone else” to item 4; & “yes” response to all other items is scored in the “abused” direction" (Neale et al, 1991)
- Self-administered (RN assist available) as part of larger geriatric assessment
- Comparison: Clinical re-evaluation completed by MD & MD home visit
- Results: False positives = 2%; false negatives = 3%
Study 7: Racic et al, 2006

Quality Rating:

Internal Validity:

- **Fair**: EAST is relevant available screening test but known to have issues with low internal consistency (Cronbach alpha = 0.29) and high false negative rates & this was not discussed (Neale, Hwalek, Scott, Sengstock & Stahl, 1991); physician evaluation as reference standard not completed independently of EAST screening results.

External Validity:

- **Fair**: Lack of information related to administration time, determination of cognitive capacity & difference in prevalence of mental health impairments is US population compared to Bosnian elders has potential to affect the outcome in a clinically important way; it is only moderately probable (50%-89%) that the clinical experience with the intervention in the study will be attained in the US primary care.
Study 8: Schofield et al, 2004

- Multiple time series, descriptive correlational
- 10,421 community-dwelling women age 73-78 in Australia as part of national longitudinal study with oversampling of rural residents
- Instrument: **Vulnerability to Abuse Screening Scale (VASS)**
  - 12-items; four factors; 10-items from H-S/EAST (dichotomous) and 2 items from Conflict Tactics Scale (Likert scale). Self report of abuse in last 12 months.
- Time 1: mailed survey in 1996; Time 2: most received mailed survey with some being telephone surveyed
- Comparison: None
- Results: Cronbach’s alpha by factor - Dependence 0.74 (acceptable); Dejection 0.44; Vulnerability 0.45; Coercion 0.31 (all <0.5 Unacceptable); “good” face validity; dejection confirmed as valid predictor of physical & mental health outcomes over three years; additional sensitivity & specificity testing needed
Study 8: Schofield et al, 2004

- Quality Rating:
- Internal Validity:
  - Fair: Relevant available screening test with demonstrated moderate internal consistency; very large sample from randomized national sample of females; but lacks use of reference standard.
- External Validity:
  - Fair: Longitudinal nature of sample differs from the US primary care population having the potential to affect the outcome in a clinically important way; moderately probable (50%-89%) that the clinical experience with the intervention in the study will be attained in the US primary care setting.
Study 9: Wang et al, 2007

- Descriptive design
- 195 elders age 60 or older who were partially dependent on a caregiver & able to verbally communicate from institutional care setting & private setting in Taiwan
- Instrument: **Elders’ Psychological Abuse Scale (EPAS)**
  - 32-items; detects actual & at risk for psychological abuse;
  - Dichotomous; total score was the sum of all items answered "yes." Score equal to or > than 10 demonstrating larger possibility of psychological abuse; 10 = cut score
- Face-to-face interviews including reports from elder’s caregiver & direct observation by researchers
- Comparison: Short Portable Mental State Questionnaire (SPMQ)
- Results: 26 of 32 items had kappa values Inter-rate agreement) >0.6; remaining 6 items >.4 indicating moderate to substantial strength of agreement. Concurrent validity between EPAS and SPMSQ = -.32 (p<.001); more cognitively impaired elders experienced more psych abuse
Study 9: Wang et al, 2007

- **Quality Rating:**

- **Internal Validity:**
  - *Poor*: EPAS is relevant available screening test; moderate sample size, but EPAS improperly administered in that CGs & interviewer provided some answers on behalf of elder.

- **External Validity:**
  - *Poor*: Taiwanese study population differs from the US primary care population in ways that have a high likelihood to affect clinical outcomes; the probability is low (<50%) that the clinical experience with the EPAS will be attained in the US primary care setting.
Study 10: Yaffe et al, 2008)

- Descriptive design
- 858 elders age 65 and older presenting to two university-based family practice clinics & one social service center in Montreal, Canada

- Instrument: **Elder Abuse Suspicion Index (EASI)**
  - 6-items; dichotomous answer choices (5 for elder and 1 two-part question for healthcare provider). Suspicion of EA if one question of 5 questions directed at elder is answered "yes." Reference time period 12 months. Structured interview by healthcare provider

- Comparison: Social Worker Evaluation (SWE) 1.5 to 3-hour interview conducted by trained APS personnel 13 weeks after EASI screening

- Results: Sensitivity 47%; Specificity 75%; 97.2% MDs felt it would be impact practice
Study 10: Yaffe et al, 2008

- Quality Rating

- Internal Validity:
  - **Good**: EASI is relevant available screening test; use of SWE was credible reference standard; SWE interpreted independently of EASI score through blinding APS workers; included larger number (more than 100) broad-spectrum patients with and without disease that was representative of Canadian population.

- External Validity:
  - **Good**: Rapid administration time & positive reception by physicians with successful administered by clinicians in Canadian primary care setting makes it highly probable (>90%) that the clinical experience with the EASI will be attained in the US primary care setting.
Discussion

- Studies reflect lower level evidence to USPSTF
  - USPSTF design code III: Opinions of respected authorities, based on clinical experience; descriptive studies or case reports; reports of expert committees
    - Cross sectional data using descriptive research methods (n=8)
  - USPSTF design code II-3 (2): Multiple time series with or without the intervention; dramatic results from uncontrolled experiments
- Level of evidence has not improved
- Global recognition of EA as problem demonstrated
Discussion

- Four novel EA instruments created:
  - EASI (Yaffe et al., 2008);
  - OAPAM (Conrad, 2010);
  - OAFEM (Conrad et al., 2011);
  - VASS (Schofield and Mishra, 2004)
- Increased recognition of importance of screening for financial/material abuse
- Primary care & inpatient settings
- Increasing number of types of screens
Discussion

- Increase in instrument language availability
  - Need more Spanish
- Inconsistency in sample size ratings
- Inclusion of participants with dementia
- Determination of sensitivity & specificity and ppv & npv testing
- Issues in external validity
- Issues in studies with fair to poor ratings
- Feasibility issues
Limitations

- Studies could have been missed
- Quality ratings not confirmed with another investigator
- More broad than Nelson et al. (2004)
Areas for Future Research

- No studies investigated the possible adverse effects of EA screening
- Future qualitative research could examine the lived experience of elders who screen positive
- Feasibility studies to examine the time requirement, impact on clinic processes, implementation fidelity, and costs of EA screening
Areas for Future Research

- Impact of the instrument delivery method on the self-report of abuse by elders
- Use of technology to deliver EA screening questionnaires
- Validate EA screening instruments with various ethnic and cultural groups.
- Validate instruments in other languages especially Spanish
Conclusions

- More EA screening instruments administered in healthcare environments
- 9 of 10 studies reviewed were & less complicated EA screening instruments
- Increased number of studies with participants with dementia
- Researchers are trying to meet the challenge
Conclusions

- Significant growth seen in nature & number of studies examining EA screening instruments for caregivers, caregivers and elders (care recipients), & elders.
- Knowledge gained in new EA instrument development & ability of EA screening instruments to identify current harm or risk of harm using sensitivity and specificity and positive and negative predictive values.
Relevance to APS practice

- Finding or developing EA screening tools is challenging.
- Be aware of the USPSTF criteria when evaluating in addition to Wilson & Jungner (1968) classic screening recommendations.
  - Watch for that Gold Standard & more serious errors.
- We are making progress!
- Never underestimate the importance of what you do in protecting American elders.
Reaching Solid Ground....

- "People seldom see the halting and painful steps at which the most insignificant success is achieved."
  
  - Anne Sullivan 1866-1936 (instructor of/companion to Helen Keller)

Thank you!

Questions??
References


Save the Date: Wednesday, October 30, 2013

Presenter: Dr. Mark Yaffe

Topic: Seniors’ Self-Administration of the Elder Abuse Suspicion Index (EASI): A Feasibility Study

Thank you!

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www.preventelderabuse.org
www.nccdglobal.org