USC University of Southern California

Welcome
Interprofessional Education and Collaboration for Geriatrics (IECG) Session # 2

Cognition, Medication, and Elder Mistreatment

Friday, November 10, 2023
1:30 p.m. – 4:30 p.m.

Interprofessional Education and Collaboration for Geriatrics (IECG)

This project is/was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U1QHP28740, Geriatrics Workforce Enhancement Program for $3.5 million. This information or content and conclusions are those of the author and should not be construed as the official position or policy or, nor should any endorsements be inferred by, HRSA, HHS or the U.S. Government.

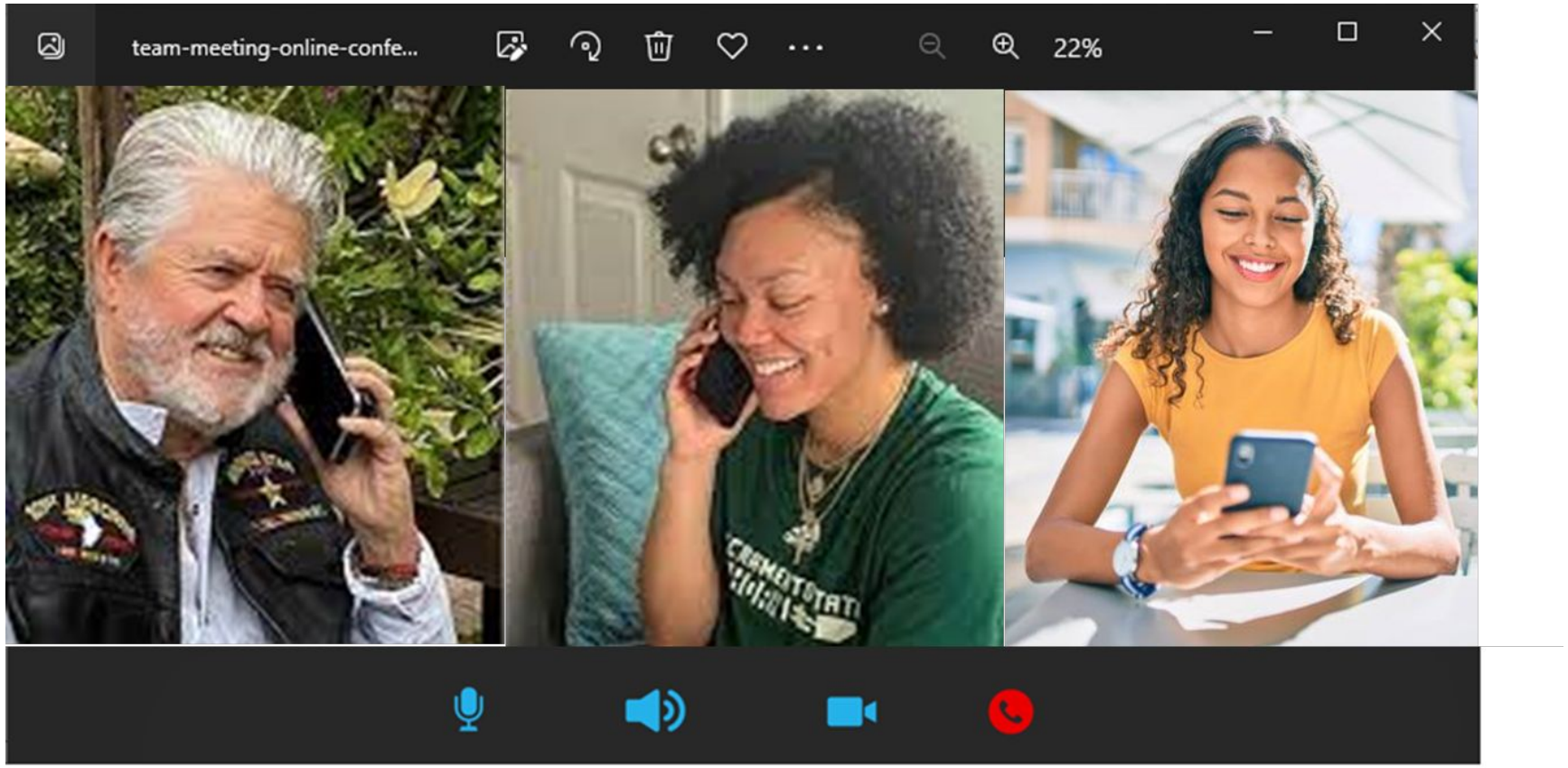
Welcome

Professor Jo Marie Reilly

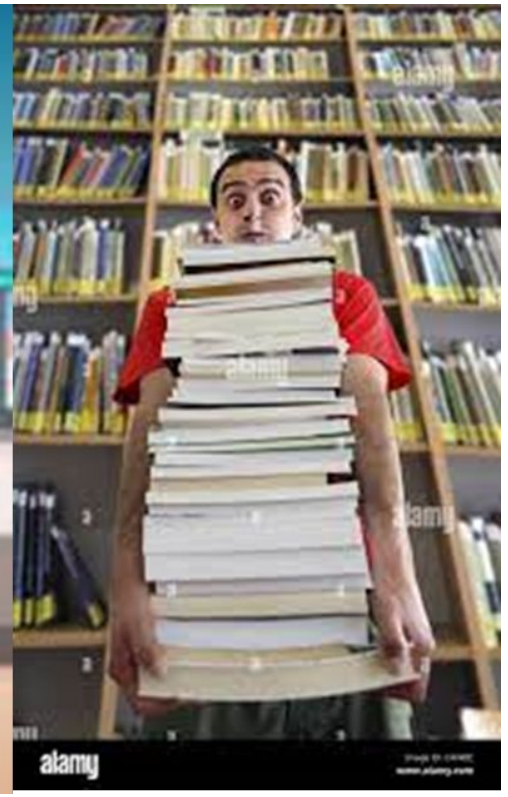
IECG Agenda

1:35 pm – 1:40 pm	Welcome	Jo Marie Reilly
1:40 pm – 1:45 pm	Weekly Communication Strategy with Older Adults ● What has worked well?	Cheryl Resnik
1:45 pm – 1:50 pm	Session # 2 Objectives	Cheryl Resnik
1:50 pm – 2:10 pm	Cognition, Dementia, & Delirium	Christopher Beam
2:10 pm – 2:40 pm	Medication	Tatyana Gurvich
2:40 pm - 2:50 pm	Break	
2:50 pm - 3:10 pm	Elder Mistreatment - National Center on Elder Abuse	Richard Esquivel
3:10 pm 3:20 pm	Model with Older Adult - How to introduce to Older Adults	Christopher Beam Tatyana Gurvich
3:20 pm – 3:30 pm	Team Building & Discussion (practice assessments)	Mitzi D' Aquila
3:30 pm - 4:30 pm	Dismiss into Small Team Breakout Rooms	

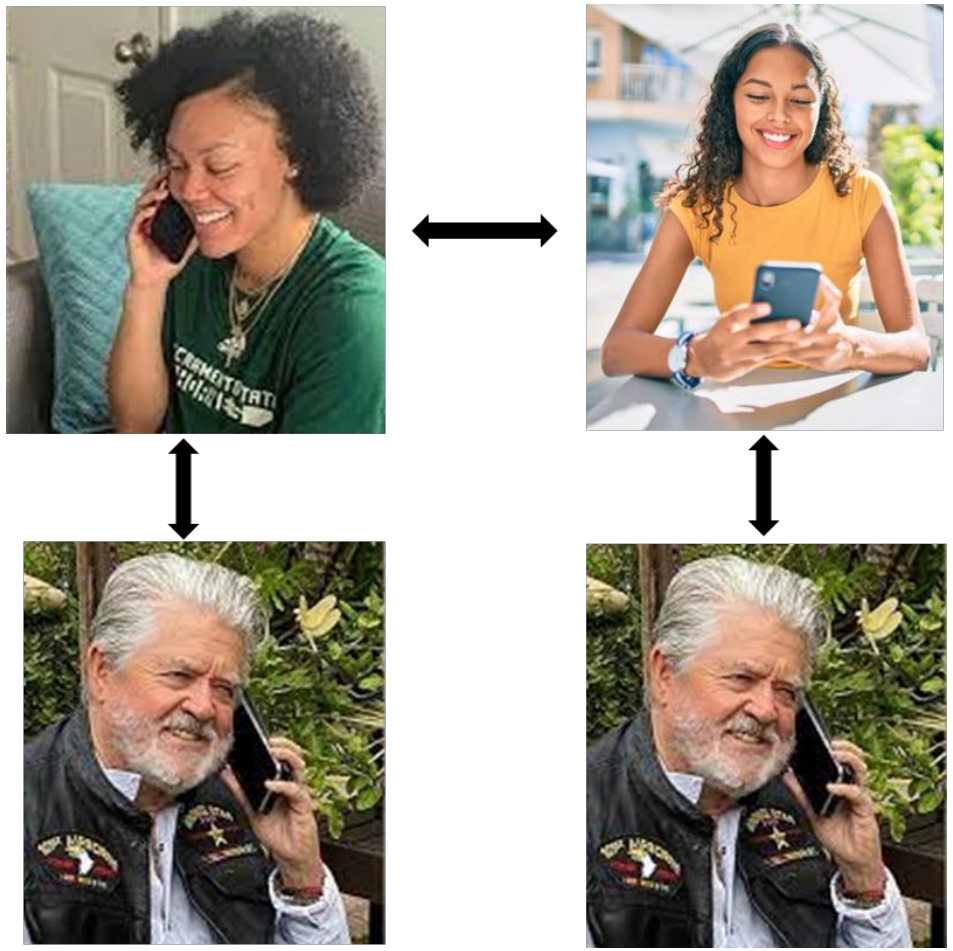
Weekly Communication Strategy - The Dream



Weekly Communication Strategy - The Reality



Weekly Communication Strategy - The Fix

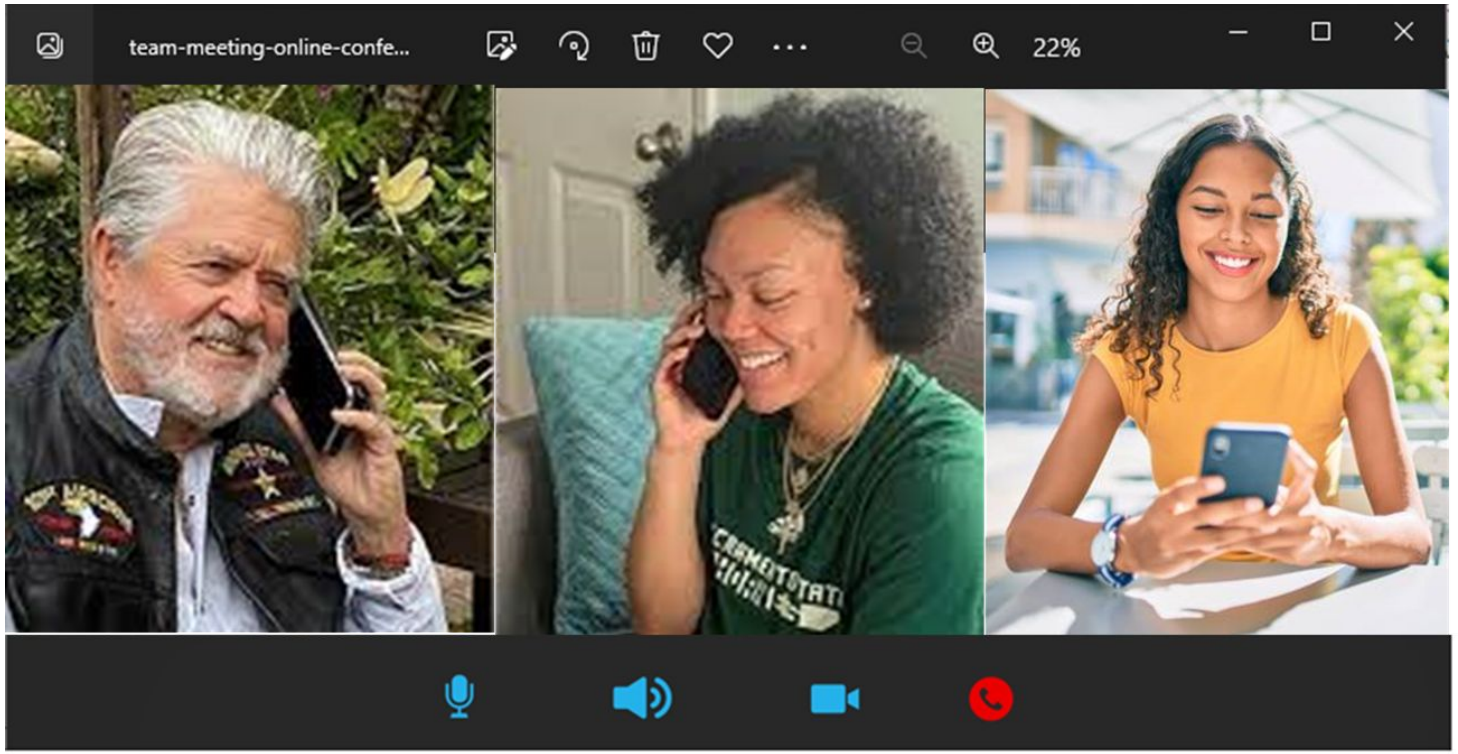


1. You two divide the test to be performed
2. Your partner calls your older adult partner on Tuesday and chats for 30 minutes and performs the nutrition screen
3. You call him on Thursday and assess loneliness and talk for over an hour
4. You two talk on Saturday and go over your meetings.

Weekly Communication Strategy - The Hope

- Calls will occur weekly with your older adult partner, all three together if possible
- Students plan together how to accomplish any tasks that you are to complete, e.g. screens, med rec, along with general conversations to help you build your relationship
- When not to meet
  - Illness, hospitalization, travel
- If issues arise
  - Contact your faculty lead/staff, communicate with your student partner

Weekly Communication Strategy - What has worked for your team?



Session #2 - Overview

Professor: Cheryl Resnik

Keck School of Medicine of USC

Geriatric Healthcare Collective

Session # 2 - Objectives

- Explain the signs of cognitive decline in older adults.
- Describe strategies to help older adults with cognitive and physical deficits and maintain adherence to medications.
- Review the elements of a thorough medication history/reconciliation.
- Discuss the BEERS Criteria for potentially inappropriate use of medications in the elderly.
- Identify common medications that may affect nutrition (appetite, taste, weight, or dry mouth)

Please review the GWEP website and review the list of resources

Link: https://gwep.usc.edu/interprofessional-geriatrics-curriculum-egc-2023-2024/

Cognition, Dementia, & Delirium

Dr. Christopher R. Beam

Keck School of Medicine of USC
Geriatric Healthcare Collective

Cognition Over the Lifespan

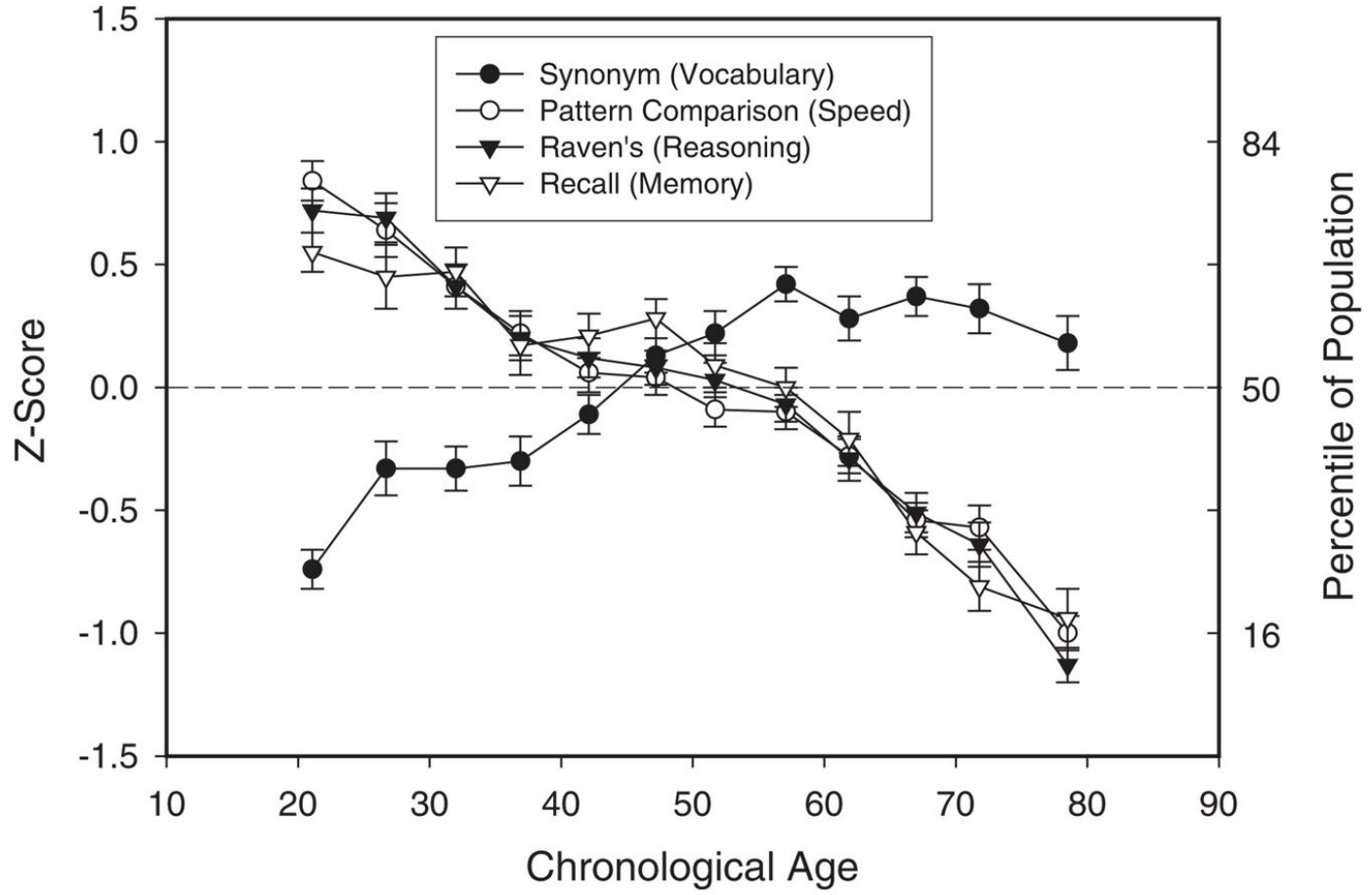


Fig. 1. Means (and standard errors) of performance in four cognitive tests as a function of age. Each data point is based on between 52 and 156 adults.

Salthouse (2004)

Different Intelligences

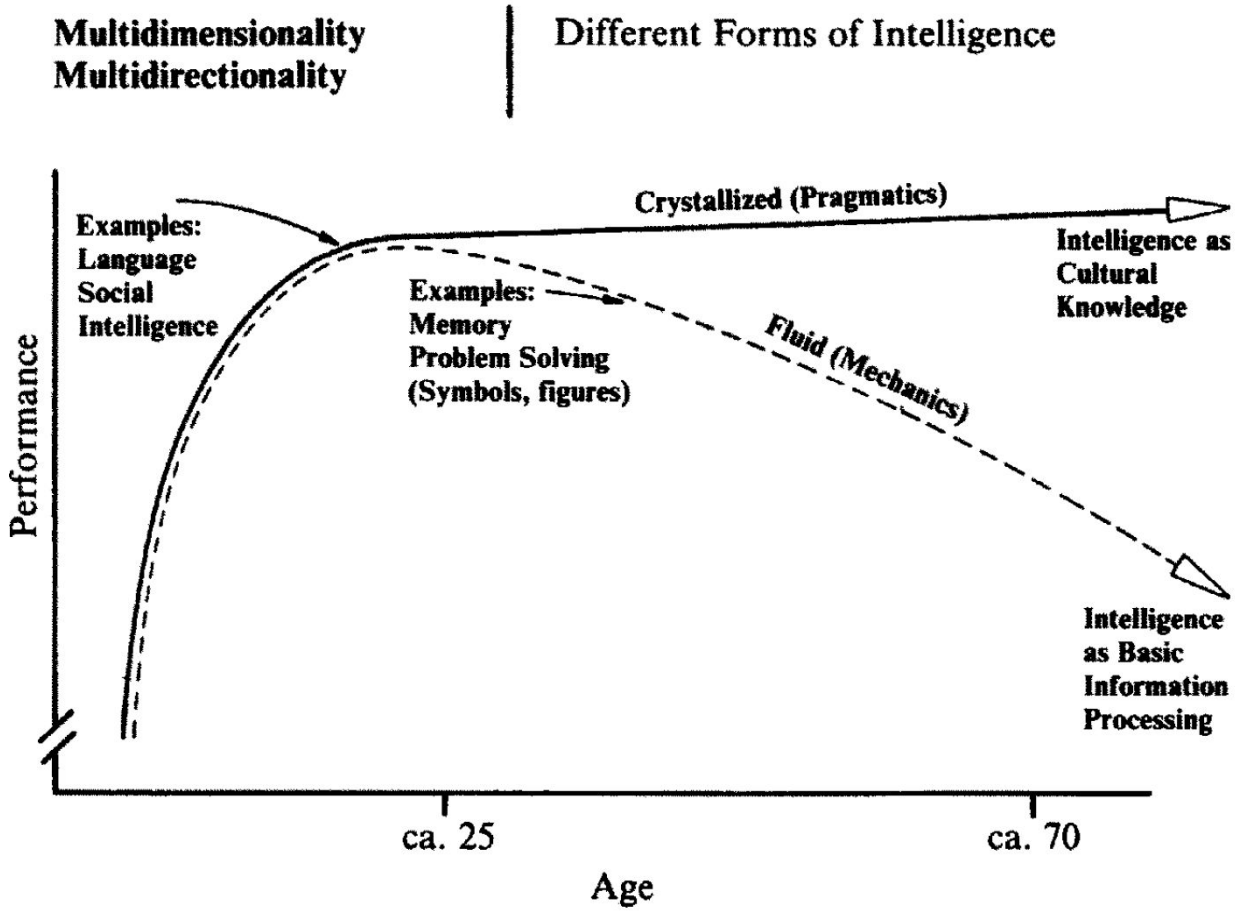


Figure 1. One of the best known psychometric structural theories of intelligence is that of Raymond B. Cattell and John L. Horn. (The two main clusters of that theory, fluid and crystallized intelligence, are postulated to display different life-span developmental trajectories.)

Baltes (1987)

Cognitive Domains

- Not just one score
- Crystallized and fluid intelligence
- Verbal versus nonverbal
  - Verbal Comprehension
  - Nonverbal Reasoning
  - Processing Speed
  - Working Memory
- Memory versus non-memory

Cognitive Aging

- Cognitive aging is best understood using a developmental life span approach that considers cognitive development as a lifelong process that begins with conception and ends with death.

- Cognitive aging occurs within a framework of gains, declines and stability.

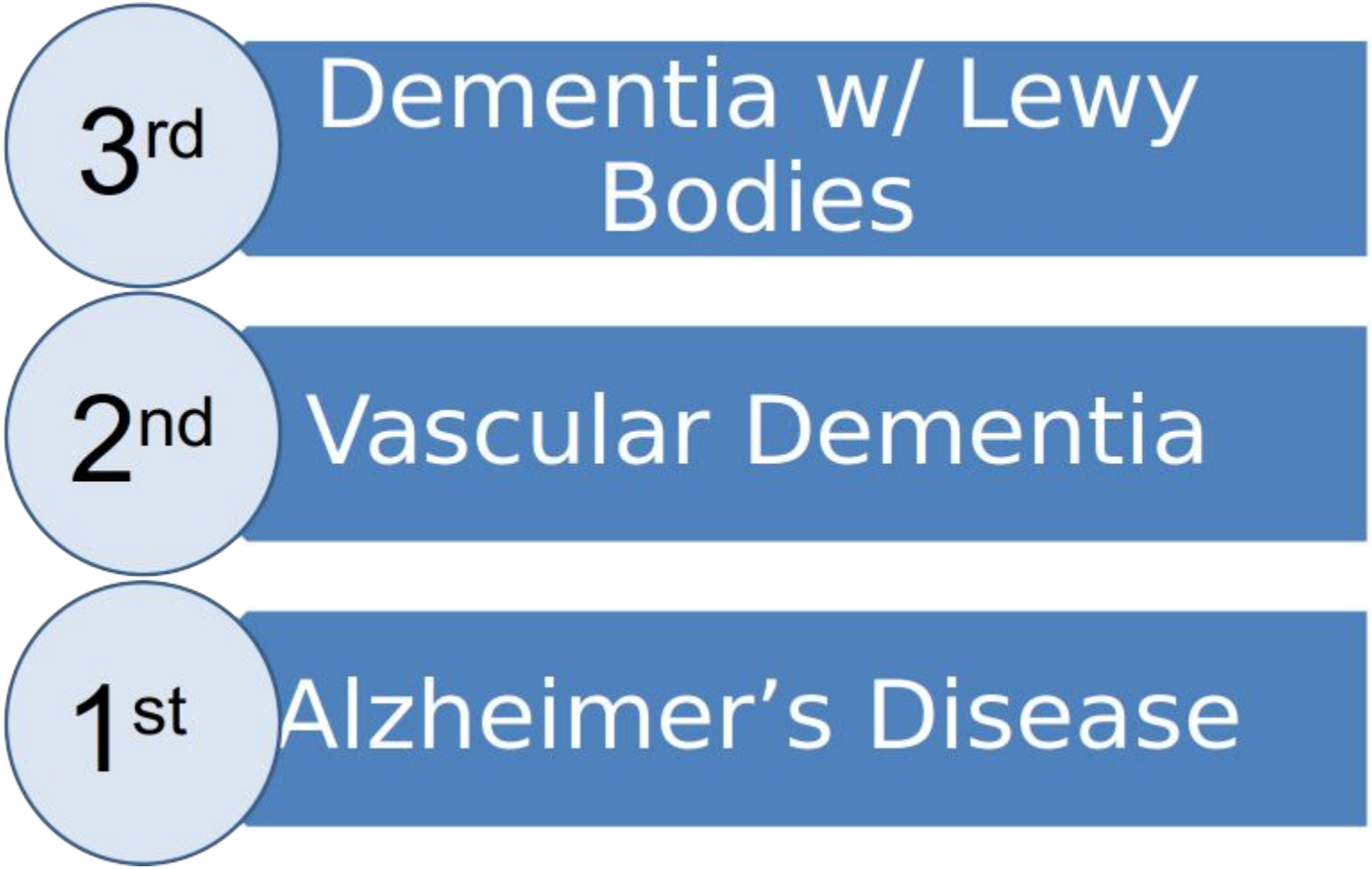
Assessing Cognitive Aging

- Understand the intricate relationship between cognition and everyday function
- Functional impairment is an important outcome
- Be able translate basic research findings into real-world situations and clinical practice

Dementia, Delirium, and Depression

- Neurocognitive Disorder (NCD), i.e., dementia
  - Complex attention
  - Learning and memory
  - Language
  - Executive function
  - Perceptual-motor skill
  - Social cognition
- Severity
  - NCD can be mild or major
  - Major NCD can be mild, moderate, severe too
  - APA (2013) replaced dementia with major NCD

Dementia, Delirium, and Depression



Dementia, Delirium, and Depression

Table 2. Differential Diagnoses for Delirium

Clinical Features	Delirium	Dementia	Depression
Onset	Acute	Insidious	Acute or insidious
Duration	Hours to weeks	Months to years	Weeks to months
Course	Fluctuating	Chronic and progressive	May be chronic
Progress	Usually reversible	Irreversible	Usually reversible
Level of consciousness	Altered	Usually clear	Clear
Orientation	Variable	Disoriented	Oriented
Attention and concentration	Poor	Normal except in late stage	May be impaired
Speech	Incoherent	Coherent until the late stage	Usually normal
Thought process	Disorganized	Limited	Usually organized
Perception	Hallucinations are frequent especially visual	May have hallucinations especially visual	May have hallucinations especially auditory
Psychomotor activity	Variable	Normal	May be slow

(Mittal et al., 2011)

Dementia, Delirium, and Depression

- Delirium
  - Has an acute, dateable onset
  - Treatable or reversible
  - Possible symptoms:
    - Difficulties with attention and concentration
    - Change in alertness
    - Agitation or psychotic symptoms
  - Symptoms can fluctuate dramatically
  - Considered a medical emergency

Dementia, Delirium, and Depression

- Major Depressive Disorder (MDD)
  - Chronic or acute
  - Evident for ≥ 2 weeks on more days than not
  - Five of 9 symptoms endorsed
    - One of 2 cardinal symptoms (sadness or anhedonia) *must* be endorsed
  - Weight change, sleep change, agitation, fatigue, diminished ability to concentrate, feelings of worthlessness, thoughts of death

Cognitive Assessments

- Considerations
  - Avoid making your older adult feeling ”tested”
  - Can complete in multiple visits
  - Do not force older adult to complete if they are uncomfortable or becoming upset
  - Do not diagnose your older adult
  - Make sure you’re not capturing ”something else” (hearing, vision, etc.)
- Short-Form Instruments
  - Mini-Mental Status Exam ($$); Telephone Interview for Cognitive Status (TICS) ($$); **Mini-Cog (FREE!)**
  - Be aware of restrictions for future use
    - Training required? Fees? Permission? (education, clinical or research)

Mini-Cog

- Two-item test
  - Word list recall (3 words, 3 points)
  - Clock Drawing (in person, 2 points)
  - Serial subtraction (telephone) or multi-step performance task (in person)

- Scoring: 5 possible points, with < 3 validated for dementia screening

- No medical or clinical background required

- Available in many languages

Adhikari et al. (2021)

References

Adhikari, S. P., Dev, R., & Borson, S. (2021). Modifying the Mini-Cog to Screen for Cognitive Impairment in Nonliterate Individuals. International Journal of Alzheimer's Disease.

Baltes, P. B. (1987). Theoretical propositions of life-span developmental psychology: On the dynamics between growth and decline. Developmental psychology, 23(5), 611.

Judge, K. S. & Dawson, N. T. (2018). Cognitive function. In B. R. Bonder & V. Dal Bello-Haas (Eds.), Functional performance in older adults: Fourth edition (pp. 93-108). F. A. Davis Company.

Judge, K. S. & Dawson, N. T. (2018). Cognitive and emotional function: Health conditions. In B. R. Bonder & V. Dal Bello-Haas (Eds.), Functional performance in older adults: Fourth edition (pp. 181-200). F. A. Davis Company.

Mittal, V., Muralee, S., Williamson, D., McEnerney, N., Thomas, J., Cash, M., & Tampi, R. R. (2011). Delirium in the elderly: a comprehensive review. American Journal of Alzheimer's Disease & Other Dementias, 26(2), 97-109.

Salthouse, T. A. (2004). What and when of cognitive aging. Current directions in psychological science, 13(4), 140-144.

The role of a Clinical Pharmacist in the Interdisciplinary Care of an Older Adult

Tatyana Gurvich, Pharm.D., BCGP, APh

Keck School of Medicine of USC
Geriatric Healthcare Collective

Interprofessional Education for Collaboration in Geriatrics 2023-2024

Learning Objectives

Identify

- Identify problems that lead to medication related adverse events in geriatric patients

Define

- Define the term poly-pharmacy

Define

- Define the term medication cascade

Describe

- Describe the 4 pillars of the Age Friendly Health Systems approach to taking care of a geriatric patient

Identify

- Identify “high risk” medications on the Beers Criteria

Develop

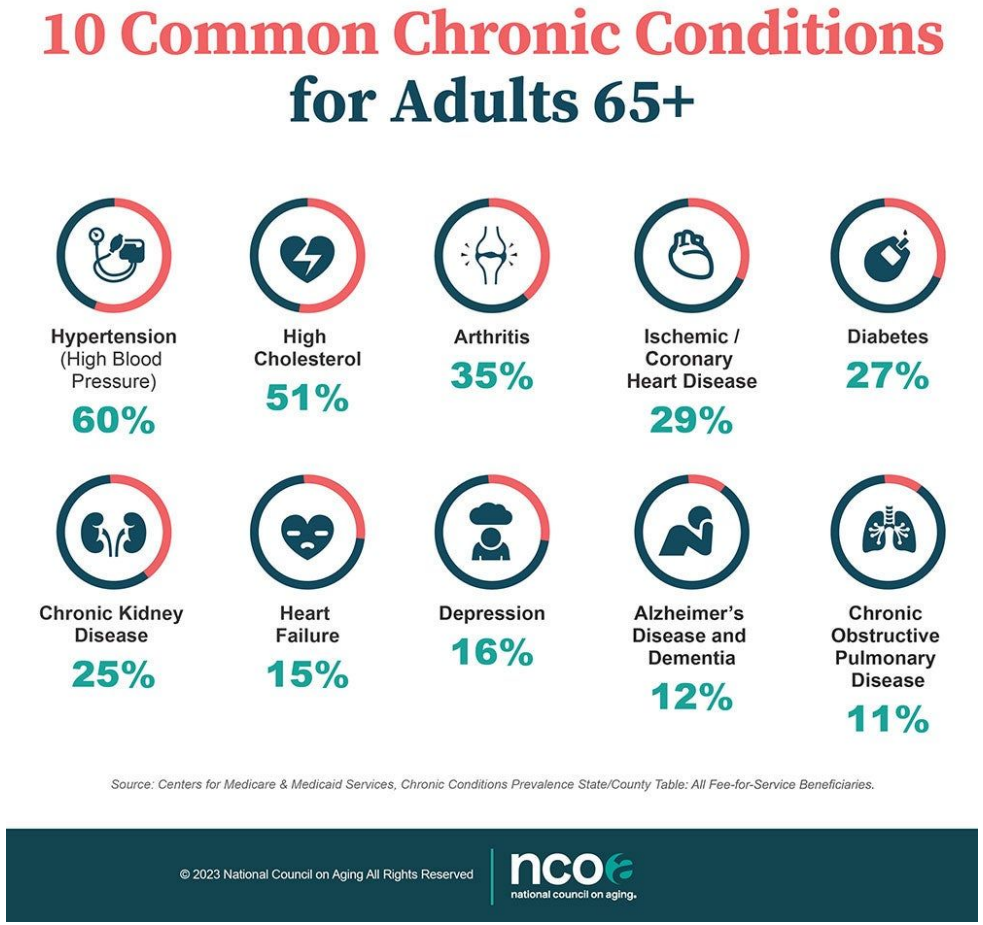
- A model of interdisciplinary care for a geriatric patient with clinical pharmacy interventions

"One of the first duties of the physician is to educate the masses not to take medicine."

Sir William Osler (1849-1919)

- ***"This is the rub. There are many older adults who would be healthier if they threw away half of their medications."***
- Michael A. Steinman, MD. "Polypharmacy: Time to Get Beyond Numbers." JAMA Intern Med. 2016 April;176(4): 482–483.

Typical Chronic Conditions in Older Adults

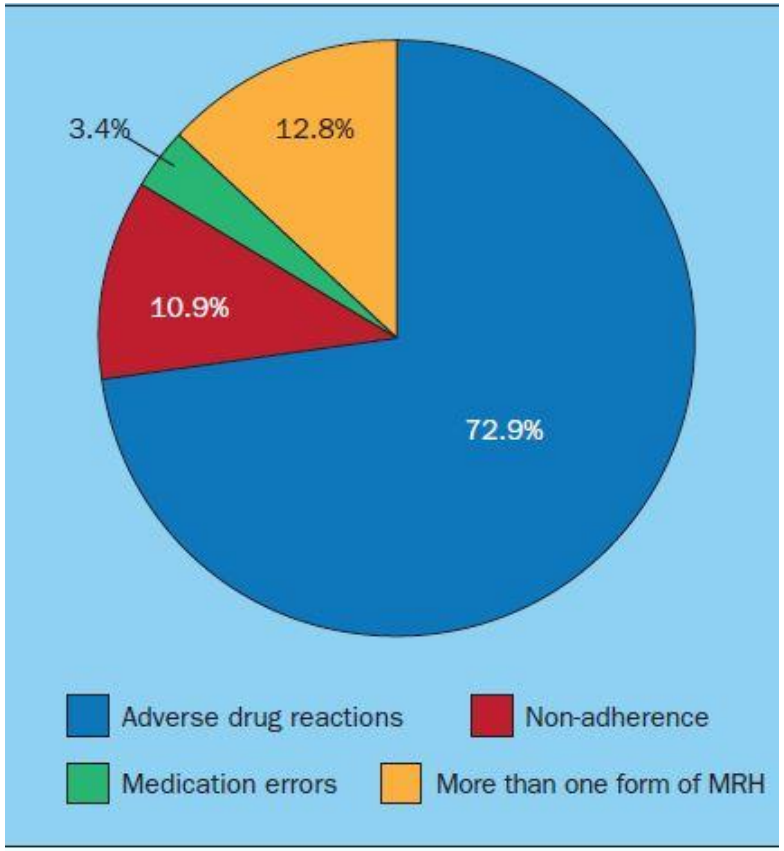


Medication Problems: Common, Costly, Preventable

- Total estimated healthcare expenditure related to potentially inappropriate medications is $7.2 billion
- 27% of adverse events in primary care offices
- 37% of adverse events in nursing homes
- 380,000-450,000 adverse drug events occur annually in hospitals
- JAGS 2012 *Arch Int Med* 2009
- https://www.beckershospitalreview.com/quality/8-statistics-on-adverse-events-at-skilled-nursing-homes.html

Hospitalization-Related Mistakes

•Forms of medicines-related harm (MRH) in older people following hospital discharge, as reported by Parekh *et al*, 2018



Promoting Appropriate Prescribing

Herbal Usage in Older Adults

Rx:

- Wellbutrin 150mg bid
- Clonazepam 0.5mg q day
- Flomax 0.4mg q day
- Proscar 5mg q day

Over the Counter Medications

- **OTC Medications contribute to Polypharmacy**
  - Duplication
  - Adverse side effects and interactions
- High-Risk OTC medications
- 25% of patients don't tell their doctors about OTC use
  - Doctors don't ask
  - Pts think they don't need to know

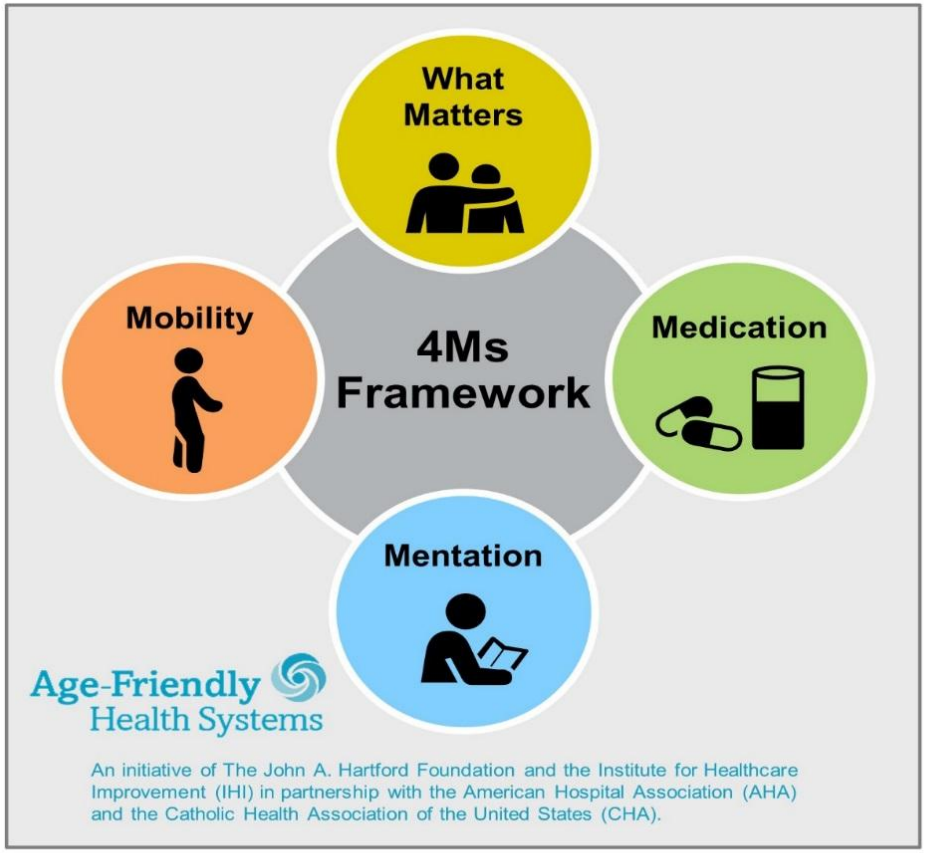
Michael A. Steinman, MD, Polypharmacy: time to get beyond numbers, JAMA Intern Med. 2016 April ; 176(4): 482–483.

Heterogeneity of Older Adults

- The most heterogeneous population of all age groups
- Goals of care vary
  - Level of function
  - Life expectancy
- Treatment goals are more individualized
  - Not always based on Clinical Practice Guidelines
  - What the patient wants is of paramount importance

Age 91

Age-Friendly Health Systems



What Matters

Know and align care with each older adult's specific health outcome goals and care preferences including, but not limited to, end-of-life care, and across settings of care.

Medication

If medication is necessary, use Age-Friendly medication that does not interfere with What Matters to the older adult, Mobility, or Mentation across settings of care.

Mentation

Prevent, identify, treat, and manage dementia, depression, and delirium across settings of care.

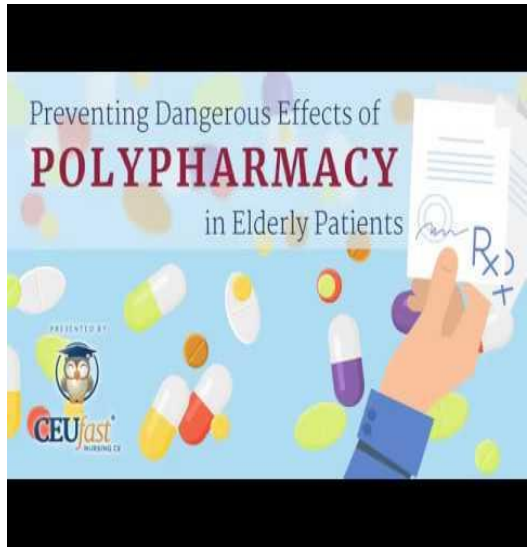
Mobility

Ensure that older adults move safely every day in order to maintain function and do What Matters.

How Medications Impact Each Pillar

What Matters most	Medications	Mentation	Mobility
• Polypharmacy impact on quality of life • Caregiver training in monitoring for medication-related adverse outcomes	• High-risk medications • De-prescribing	• Managing depression effectively • Managing cognitive decline • Medication related cognitive decline and depressive symptoms	• Medication related muscle pain, fatigue • Dizziness and fall risk as a medication side effect

What is Polypharmacy and who is at risk?

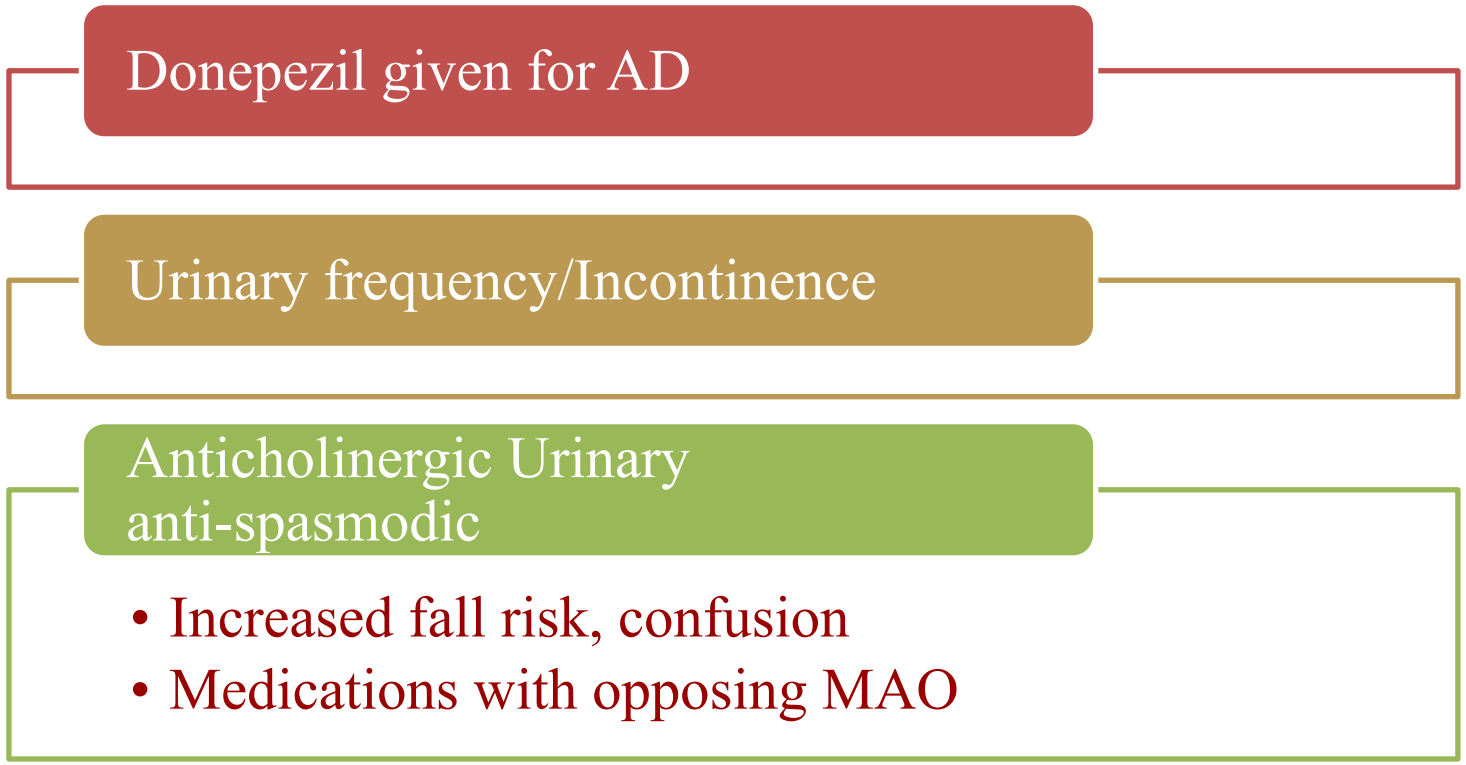


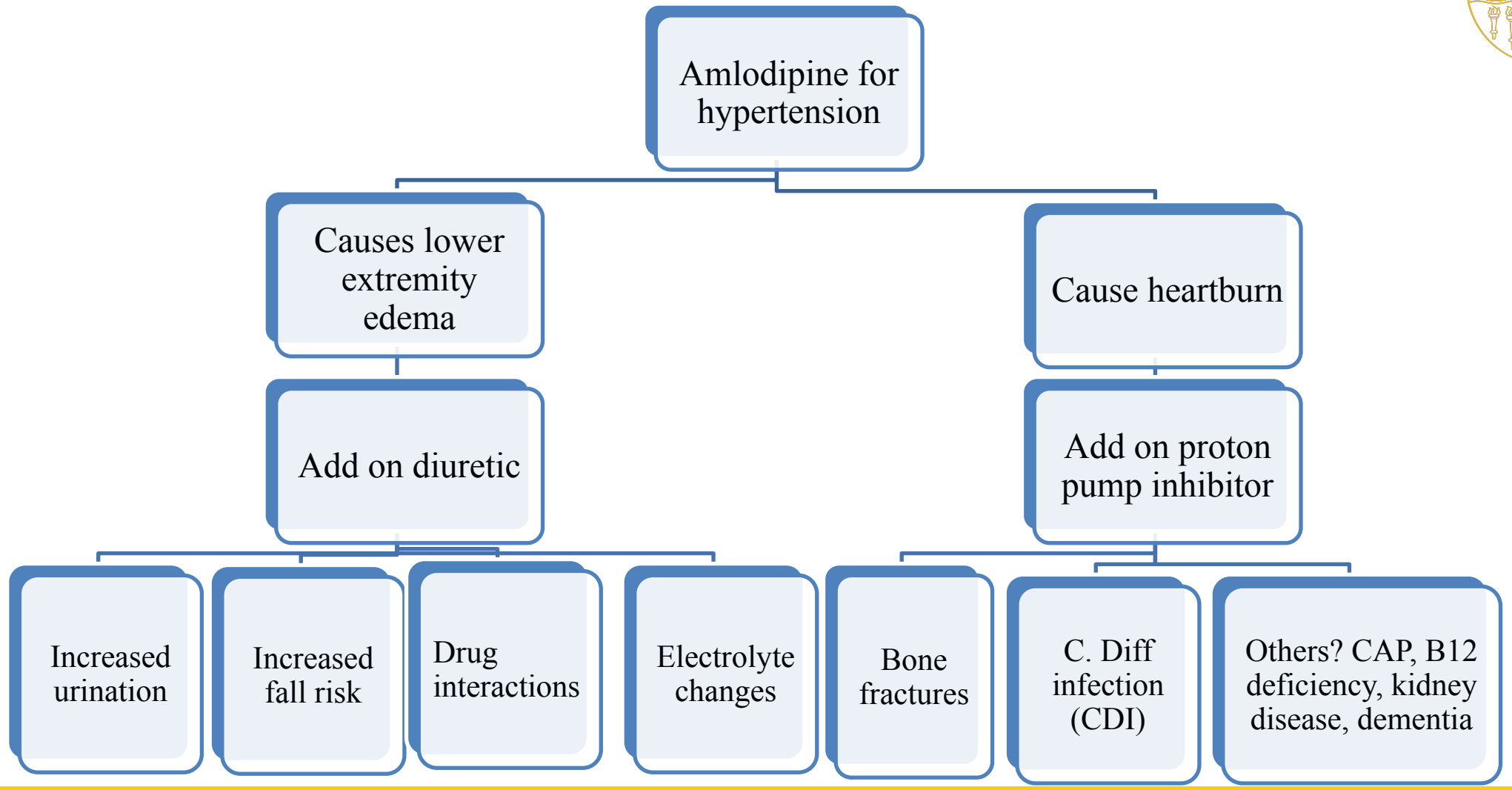
The use of unnecessary medications regardless of the number of medications being taken

Taking more medications than clinically necessary

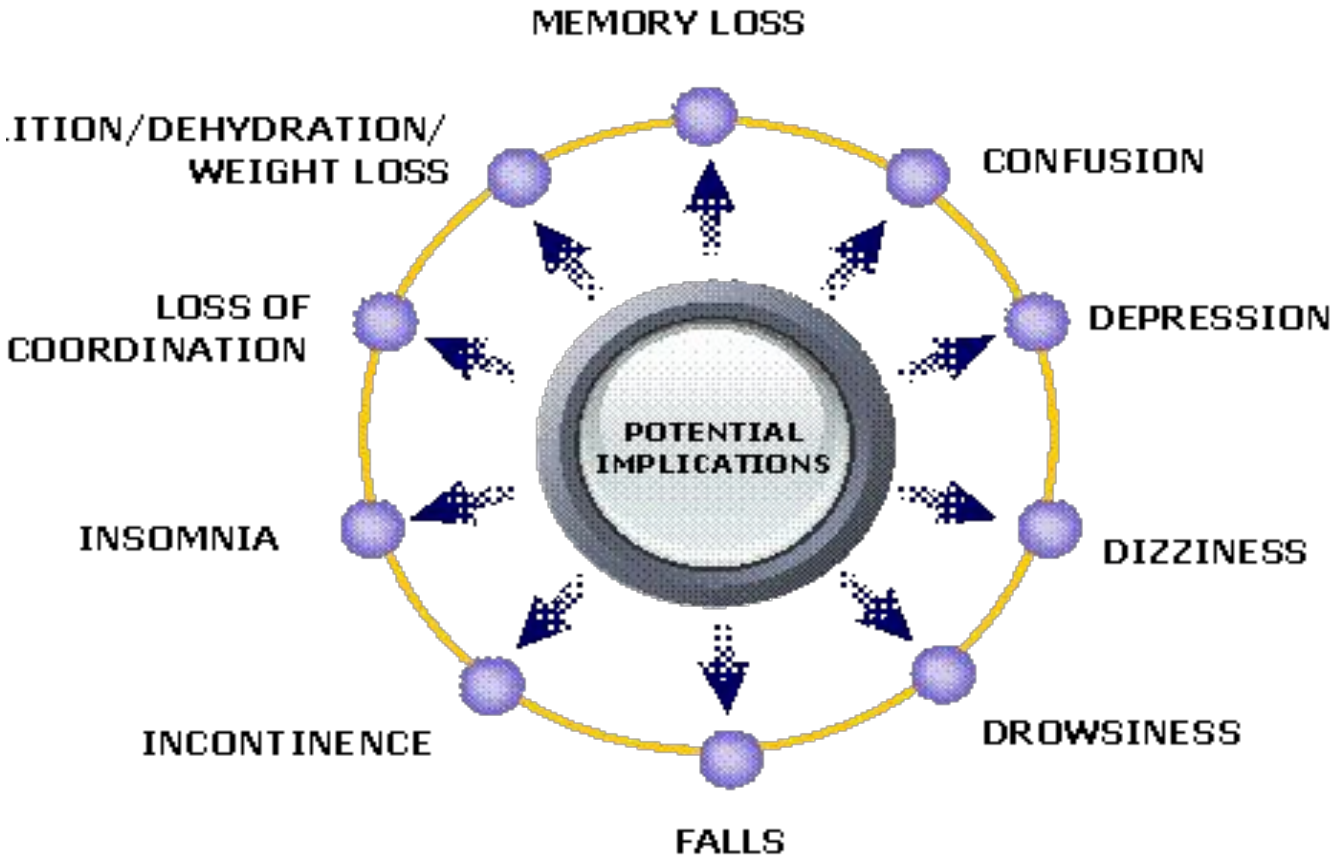
Any Geriatric Patient taking ≥ 5 medications

Prescribing cascade: A drug-induced adverse event which mimics symptoms of another disease which is being treated with more medications




Amlodipine for hypertension
Causes lower extremity edema
Add on diuretic
Increased urination
Increased fall risk
Drug interactions
Electrolyte changes
Cause heartburn
Add on proton pump inhibitor
Bone fractures
C. Diff infection (CDI)
Others? CAP, B12 deficiency, kidney disease, dementia

The Mantra of Geriatric Pharmacology



"Any symptom in an elderly patient should be considered a drug side effect until proven otherwise" ~Jerry Gurwitz MD

How do we know if our older adult patients are on medications that are NOT appropriate?

What is the Beers list?

American Geriatrics Society 2019 Updated AGS Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults

A tool for evaluating care

- Across healthcare settings
  - SNF
  - Ambulatory Care
  - Hospitals

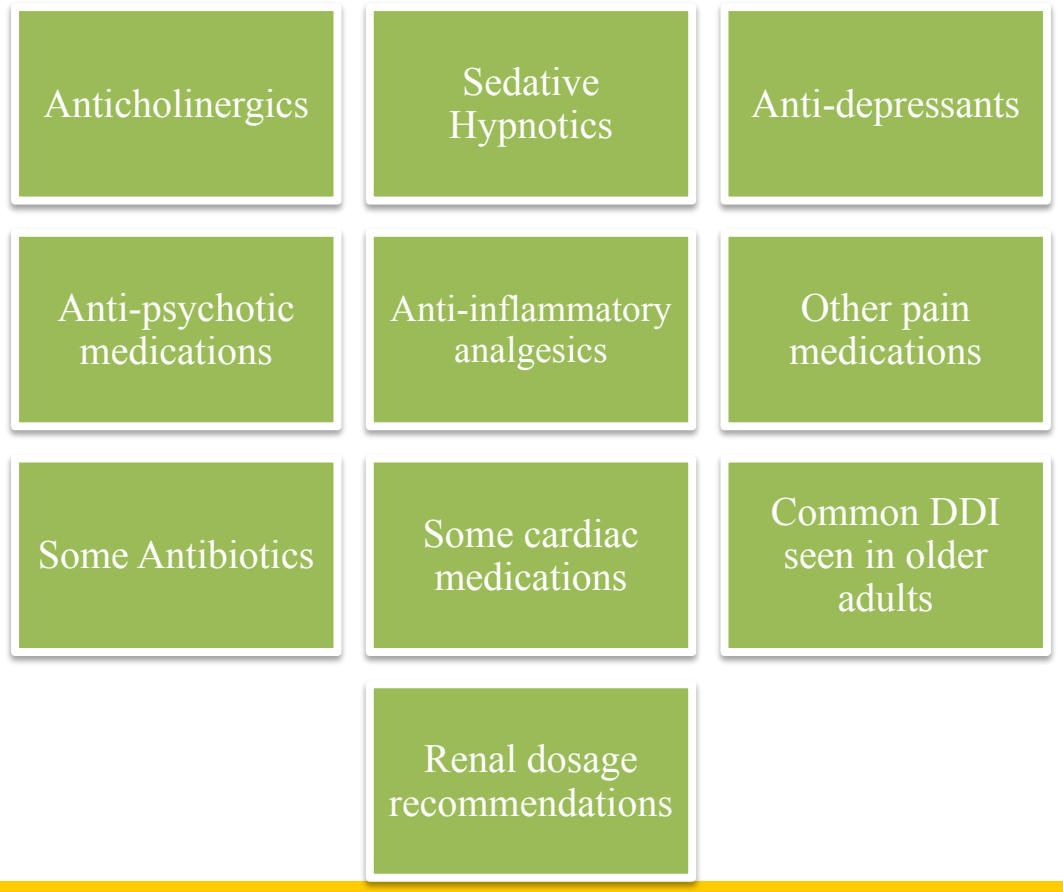
Educate clinicians and patients

- Improve Medication selection
- Reduce the adverse drug events and exposure to PIM's

Risk vs Benefit analysis

- Complexity of prescribing decisions

What is on the Beers criteria?



- Drugs which are likely to make the patient more confused
- Dugs which increase the risk for falling
- Drugs which can cause increased likelihood of side effects or toxicity
- It is OK to use medications on this list as long as the patient is adequately monitored, and benefits outweigh risks

Drugs to Avoid: The Concept of Anticholinergic Load

- Increasing evidence of harm related to cumulative exposure
- Increased dementia in adults younger than 65
- Goal is to keep ACB score to less than 3

Beers Criteria, 2023

Coupland CAC, Hill T, Dening T, Morriss R, Moore M, Hippisley-Cox J. Anticholinergic Drug Exposure and the Risk of Dementia: A Nested Case-Control Study. JAMA Intern Med. 2019;179(8):1084–1093. doi:10.1001/jamainternmed.2019.0677

TABLE 7 Drugs with strong anticholinergic properties.

Antidepressants
Amitriptyline
Amoxapine
Clomipramine
Desipramine
Doxepin (>6 mg/day)
Imipramine
Nortriptyline
Paroxetine
Antiemetics
Prochlorperazine
Promethazine
Antihistamines (first-generation)
Brompheniramine
Chlorpheniramine
Cyproheptadine
Dimenhydrinate
Diphenhydramine
Doxylamine
Hydroxyzine
Meclizine
Promethazine
Triprolidine
Antimuscarinics (urinary incontinence)*
Darifenacin
Fesoterodine
Flavoxate
Oxybutynin
Solifenacin
Tolterodine
Trospium
Antiparkinsonian agents
Benztropine
Trihexyphenidyl
Antipsychotics
Chlorpromazine
Clozapine
Olanzapine
Perphenazine
Antispasmodics
Atropine
Clidinium-chlordiazepoxide
Dicyclomine
Homatropine
Hyoscyamine
Scopolamine
Skeletal muscle relaxants
Cyclobenzaprine
Orphenadrine

Note: This table is not a comprehensive list of all medications with anticholinergic properties.
*Data on whether certain bladder antimuscarinics confer greater adverse cognitive effects than others lack consistent quality. Oxybutynin has the best evidence for adverse cognitive effects. However, caution is warranted for all bladder antimuscarinics given their potential anticholinergic effects.[20]

Definition: Deprescribing

- A systematic approach to dose reduction or discontinuing a medication when existing harm outweighs potential benefit based on:
  - Goals of Care
  - Current Level of Functioning
  - Life Expectancy
  - Values
  - Preferences
- It is a ***patient-centered*** intervention, with inherent uncertainties, and requires shared decision making, informed patient consent, and close monitoring of effects
- It is **NOT** about denying effective treatment to eligible patients.

Five Steps of Deprescribing

Identify potentially inappropriate medications: Rx and OTC

- High risk medication
- Goals of care/comorbidities/cognitive function
- Pill burden/adherence

Dosage reduction vs medication DC

- One drug at a time

Plan for tapering

Monitor (for discontinuation symptoms or the need to restart)

Document outcomes

Scott IA, et al. *JAMA Intern Med.* 2015

AFP Farrel et al Jan 2019

What is Medication Reconciliation?

- **From the Joint Commission:**
  - The process of comparing a patient's medication orders to all of the medications that the patient has been taking.
  - Done to avoid medication errors such as:
    - omissions
    - duplications
    - dosing errors
    - drug interactions
  - Should be done at every transition of care in which new medications are ordered or existing orders are rewritten.
  - Transitions in care include changes in setting, service, practitioner or level of care.

General Guidelines

Remind patients to bring all medications and medication lists to **every** visit

Ask about over the counter medications?

- Sleep? Allergies? Pain? Recent illness?
- Ask about packaging/colors when patient can't remember specific

Ask about vitamins and supplements

Ask about Alcohol, Cannabis, and illicit drug use

Ask follow up questions when discrepancies are noted (Who, What, When, Where, Why, How much?)

Allergies vs. intolerances

Document everything

Search for Answers

- Look at medication bottles, lists, and pillboxes
  - –Last filled
  - –Expiration
  - –Look inside bottles
- Call pharmacy for last fill information
- Ask your team pharmacist

A Multi-Disciplinary Approach to Providing Care to an Older Adult

- Pharmacist
  - Polypharmacy
    - Supplements and OTC
    - Medication cascades
    - DDI and Adverse Events
    - Drug choice
    - Dosing and Titration
    - General Assessment of Pharmacotherapy
    - Patient and caregiver education

QUESTIONS?

10 Minute Break

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Elder Abuse and Elder Financial Exploitation

Ricky Esquivel, MAMG - NCEA Research Assistant

National Center on Elder Abuse

The NCEA provides the latest information regarding research, training, best practices, news and resources on elder abuse, neglect and exploitation to professionals and the public.

NCEA National Center on Elder Abuse

Keck School of Medicine of USC

ACL Administration for Community Living

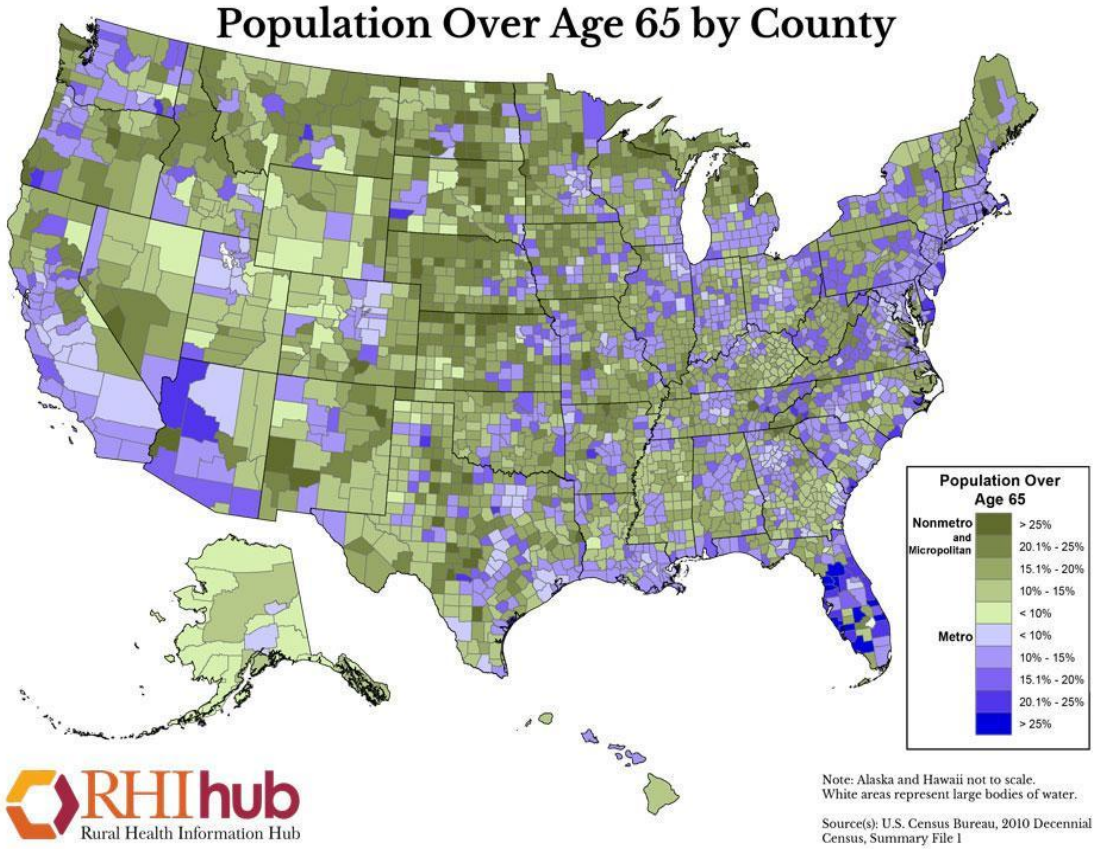
Practice

Education

Policy

Research

The Older Adult Population

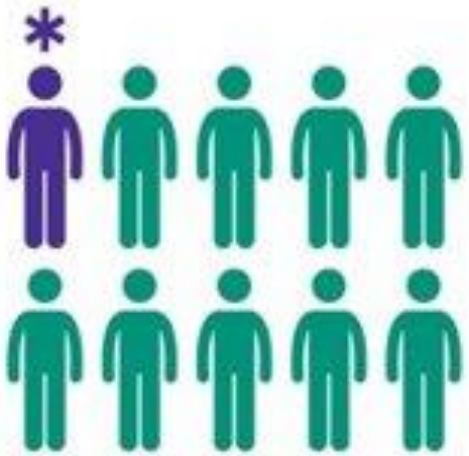


- In 2019, there were over 54.1 million older people in the US.
- By 2050, the population aged 65 and over is projected increase to 90 million.
- By 2050, the percentage of people aged 65+ will represent over 21.6% of the population in the US.

Elder Mistreatment – Definition

According to the **Centers for Disease Control and Prevention**, "Elder abuse is an **intentional act** or **failure to act** that **causes or creates** a **risk of harm** to an **older adult**. An older adult is **someone age 60 or older**. The abuse occurs at the hands of a caregiver or a person the elder **trusts**."

Elder Mistreatment – Incidence



1 in 10 community-dwelling older adults experience abuse every year.

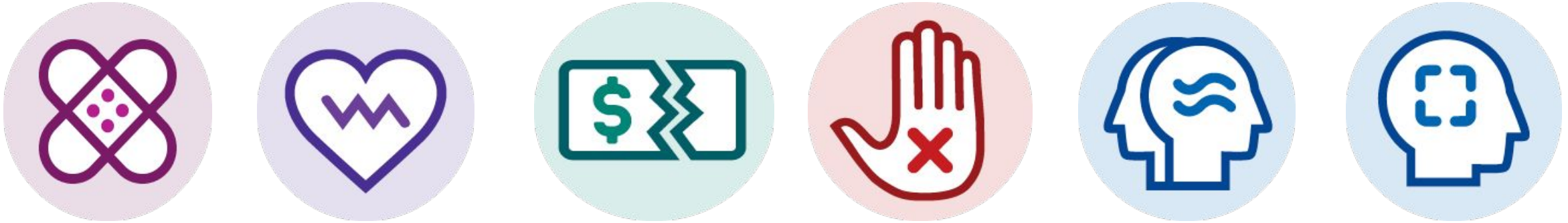
1 in 2 older adults with cognitive impairment experience abuse.

Only **1 in 24** cases of elder abuse are reported.

Note: Heightened incidence of abuse during COVID-19

Elder Abuse Takes Many Forms

Elder Abuse occurs in both **community and institutional settings** and takes many forms, including:



Physical | **Psychological & Emotional** | **Financial** | **Sexual** | **Neglect** | **Self-Neglect**

Multiple forms of abuse can occur at once.

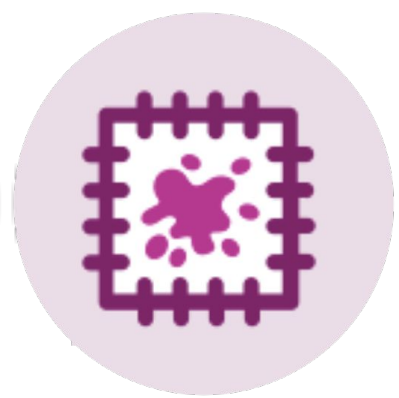
Physical Signs of Abuse

Dehydration or unusual weight loss

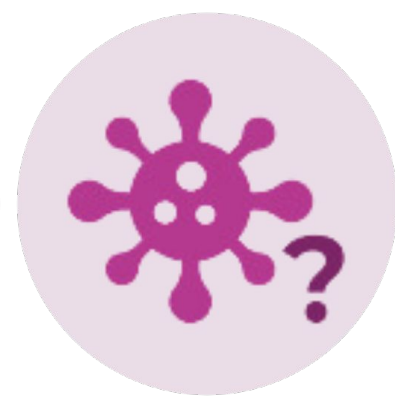
Missing daily living aids

Unexplained injuries, bruises, cuts, or sores

Unattended medical needs



Torn, stained, or bloody underclothing



Unexplained sexually transmitted diseases

Emotional/ Behavioral Signs of Abuse

Increased fear or anxiety

Isolation from friends and families

Unusual changes in behavior or sleep

Withdrawal from normal activities

Financial Signs of Abuse

Fraudulent signatures on financial documents

Unusual or sudden changes in spending pattern

Unpaid bills

Elder Mistreatment – Impact

- Medical and mental health consequences
- Increased cognitive decline
- Social isolation and disconnection
- Poverty and homelessness
- 3x Higher mortality rate
- Billions of dollars in losses

Elder abuse has significant **medical, mental health, financial, and social impacts**.

Reporting Suspected Elder Abuse

Report Suspected Abuse As Soon As Possible

Law Enforcement

Adult Protective Services

Long-Term Care Ombudsman

To connect to a local or state reporting number, contact the Eldercare Locator at eldercare.acl.gov or at 1-800-677-1116 M-F 9AM – 8PM ET.

Financial Fraud & Types of Scams

Elder Financial Fraud – Definition

"Deception carried out for the purpose of achieving personal gain while causing injury to another party. An intentional distortion of truth initiated to convince another to part with something of value or to surrender a legal right."

-The Centers for Disease Control and Prevention

Trusted vs. Stranger

Offenders fabricate a trusted presence through:

- Misrepresenting facts
- Asserting putative authority
- Instilling fear/threats or flattery/charm
- Extracting immediate time-sensitive responses
- Inducing heightened emotions
- Securing confidence and reliance
- Fostering secrecy
- Appealing to identified or acknowledged insecurities

Who is Targeted?

Everyone, regardless of age, gender, or health and economic status, is susceptible

Certain vulnerabilities may render older people more susceptible than others:

1. Social isolation and loneliness
2. Mild cognitive impairment is associated with poor financial decision-making, reduced financial literacy, and greater susceptibility to scams
3. Older adults are more likely to have financial resources than are their younger counterparts
4. Negative life events (never married, divorced, widowed)

'Fraudulent Five'

According to the FTC, the types of fraud older Americans are most likely to fall victim to are:

- #1 Imposter Scams
- #2 Online Shopping Scams
- #3 Prizes, Sweepstakes, and Lottery Scams
- #4 Investment Scams
- #5 Business and Job Opportunities

Imposter Scams

Imposter scammers try to convince you to send money pretending to be someone you know or trust like a sheriff; state, or federal government employee; or charity organiza

What to do: Remember, caller ID can be faked. You can always call the organization or government agency and ask if the person works for them before giving any money.

Online Shopping Scams

The typical shopping scam starts with a bogus website, mobile app or, increasingly, a social media ad that mimic trusted retailers. Some do deliver merchandise like shady knockoffs, but most will have you waiting for a product that will never arrive. Some even infect devices with malware or harvest personal information.

What to do: use trusted retail sites and search unfamiliar brands and products before purchasing. Verify URLs, contact info, and addresses are genuine. Use credit cards instead of debit cards and don't give away unnecessary information

Prizes, Sweepstakes, and Lottery Scams

In a lottery or prize scam, the scammers may call or email to tell you that you've won a prize through a lottery or sweepstakes and then ask you to pay an upfront payment for fees and taxes.

What to do: Avoid providing any personal or financial information, including credit cards or Social Security numbers, to anyone you don't know. Also, never make an upfront payment for a promised prize, especially if they demand immediate payment.

Investment Scams

You see an infomercial, or an ad online, saying you can learn how to make lots of money. It sounds quick, easy, and low risk — and it might involve investing in financial or real estate markets.

What to do: Stop. Take time to research the offer. Scammers want to rush you into a decision. Slow down. Search online for the name of the company and words like "review," "scam," or "complaint."

Business and Job Opportunity Scams

These scams offer a way to "make money" working from home or offer help starting an online business. They ask you to upload your resume and want your driver's license and bank account numbers. They request money for 'training or special access' but you'll never get the job.

What to do: never pay money to earn money. And don't share personal information until you've done your research.

Other Types of Scams

- **Romance Scams:** a new love interest tricks you into falling for them when they just want your money
- **Grandparent Scams:** a grandchild or relative calls asking you to wire or transfer money or send gift cards to help them out of trouble
- **Health Insurance Scams:** offer big discounts on health insurance or impersonate the government and ask for Medicare number or Social Security information
- **Money Mule Scams:** someone receives and moves money that came from victims of fraud. Don't agree to receive or send money or packages for people you either don't know or haven't me

How Are Scams Perpetrated?

Number of Reports and Amount Lost by Contact Method

Contact Method	# of Reports	Total $ Lost	Median $ Lost
Text	321,374	$326M	$1,000
Phone call	294,659	$798M	$1,400
Email	270,895	$413M	$816
Website or Apps	179,560	$900M	$333
Social Media	162,863	$1,228M	$528
Other	139,236	$1,139M	$800
Mail	36,758	$75M	$800
Online Ad or Pop-up	36,079	$181M	$229

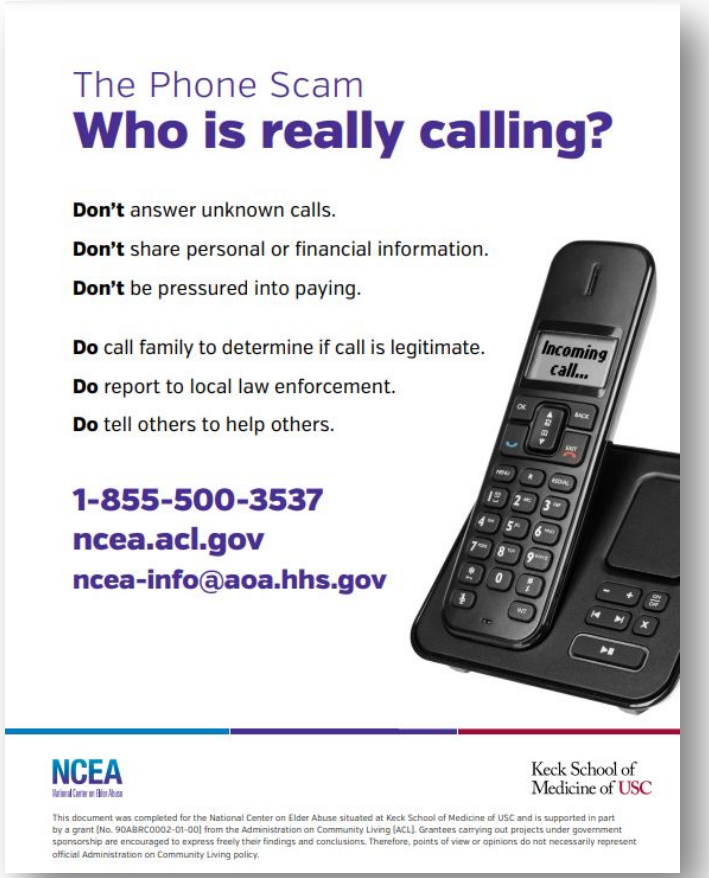
Federal Trade Commission (FTC)- Consumer Sentinel Network Databook for 2022

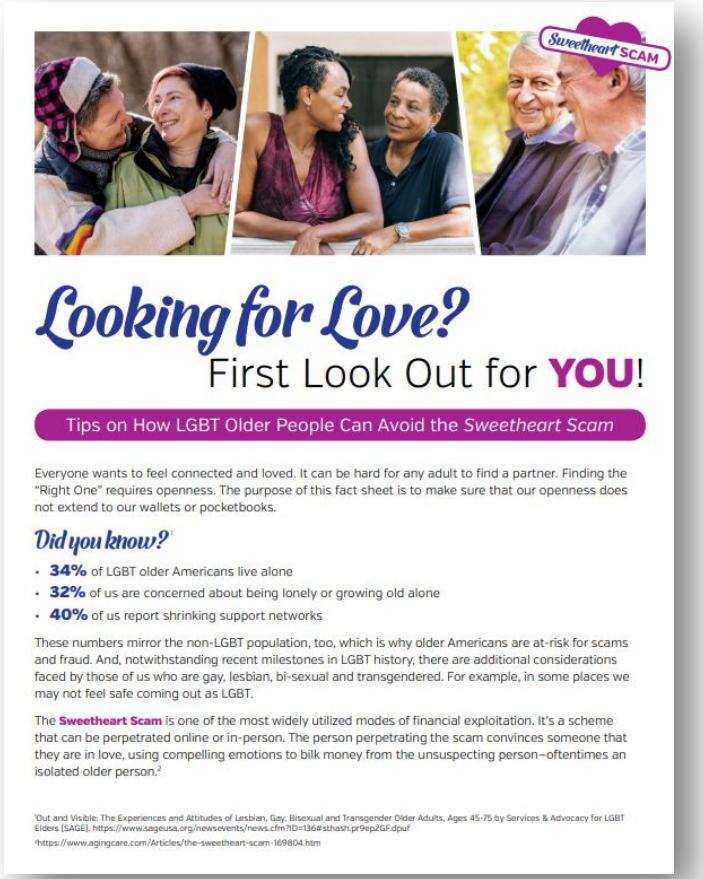
Elder Mistreatment – Interventions

- Federal Trade Commission (FTC)
  - ReportFraud.FTC.gov
- FBI Internet Crime Complaint Center (IC3)
  - https://www.ic3.gov/
- US DOJ Elder Fraud Hotline
  - 833–FRAUD–11 (833–372–831)
- Multidisciplinary Teams (MDTs)

Helpful Resources

NCEA Resources





NCEA Publications Library

Elder Abuse Curriculum

As mandated reporters, healthcare professionals require training to screen, recognize, and respond to elder mistreatment in the clinical setting. This interactive curriculum is available to integrate into training programs.

For more information on the curriculum, please contact Lori.Mars@med.usc.edu

ARCHSTONE FOUNDATION

Keck School of Medicine of USC
Department of Family Medicine

UC San Diego School of Medicine

UC Irvine Health School of Medicine
Division of Geriatric Medicine and Gerontology

UCSF Division of Geriatrics
Department of Medicine

NCEA

Don’t stand by, stand up to elder abuse.
You can make a difference.

Elder Justice Network

Law Enforcement – https://www.usacops.com/

Adult Protective Services (APS) – https://www.napsa-now.org/get-help/

Federal Bureau of Investigation – www.ic3.gov

Federal Trade Commission (FTC) – https://www.ftc.gov/ 877-382-4357

National Elder Fraud Hotline – 833–FRAUD–11 (833–372–8311)

Senior Medicare Patrol (SMP) – https://www.smpresource.org/

State Consumer Protection Offices - https://www.usa.gov/state-consumer

Consumer Financial Protection Bureau – https://www.consumerfinance.gov/ 855- 411-2372

U.S. Securities and Exchange Commission – https://www.sec.gov/

Connect with the NCEA

Visit Us:
ncea.acl.gov

Call Us:
1-855-500-3537

Email Us:
ncea-info@aoa.hhs.gov

NCEA

National Center on Elder Abuse

Team Building and Discussion

Keck School of Medicine of USC

Geriatric Healthcare Collective

Interprofessional Education for Collaboration in Geriatrics 2023-2024

Discussion Questions

1. Has your communication with your older adult transitioned from a telephone call to Facetime, Zoom, Teams.
2. How did you describe the IECG program to your older adult partner? Share helpful hints with the team.
3. What have you learned about "What Matters" to your older adult partner (What is important to them, and What do they value?
4. How will you begin to talk about elder abuse, cognition, and pharmacy with your older adult partner?
5. Tips on how to use the Mini-Cog through the phone, instead, ask the older adult to name (10) 4 legged animal in 30 seconds.
6. Thoughts about elder abuse? Reminder, please contact faculty if you suspect elder abuse.

Reflection Questions

1. What mechanism are teams using to connect with their older adult partner?
2. Discuss how teams experienced the conversation surrounding wellness, mental health, and nutrition?

Please review the full version of the resources which can be located by accessing the GWEP website:

Link: https://gwep.usc.edu/interprofessional-geriatrics-curriculum-egc-2023-2024/

- Mini-Cog
- Clock Drawing
- Wallet Medication Card
- A Pocket Guide to the 2023 AGS BEERS Criteria

Next IECG Sessions

The IECG course will meet in person for six sessions on Friday afternoons over the academic year.

- Friday, September 8, 2023 1:30 pm – 4:30 pm
- Friday, October 20, 2023 1:30 pm – 4:30 pm
- Friday, November 10, 2023 1:30 pm – 4:30 pm
- **Friday, December 1, 2023 1:30 pm – 4:30 pm**
- Friday, January 19, 2023 1:30 pm – 4:30 pm
- Friday, February 23, 2023 1:30 pm – 4:30 pm

Questions

Keck School of Medicine of USC
Geriatric Healthcare Collective

Thank you for attending

Keck School of Medicine of USC

Geriatric Healthcare Collective

Reflection

1. Describe one highlight and one challenge you have learned about caring or communicating with your older adult partner.

2. Describe one highlight and one challenge that you have learned about collaborative health care being part of an interprofessional team.

Debrief: Connectivity with Older Adults