The phenomenon of elder abuse, including mistreatment, neglect, and exploitation, is an underreported and growing problem.1,2 Health professionals who come in frequent contact with the elderly represent a strong opportunity for improved recognition and reporting abuse.

OBJECTIVES
1. To understand the barriers to recognition and reporting of elder abuse
2. Determine components of a cost-effective, scalable, interaction tool to address these barriers
3. Identify opportunities to implement such technology among stakeholders

METHODS
We conducted individual key-informant interviews with experts on elder abuse and technology and social media to assess barriers to recognizing and reporting elder abuse, and determine the components of the best possible interactive tool to combat these barriers. We held focus groups with current health professional students to assess clinical knowledge and identify opportunities.

Key Informants (n=4)
Interviews with the following content experts:
1. Practicing geriatrician with an academic teaching appointment at the Yale School of Medicine
2. Adult Protective Services agent
3. Director/managing attorney of an elder abuse prevention center
4. CEO of a health gaming technology company

Focus Groups
Four focus groups with future health professionals studying at the Yale School of Medicine, including:
1. Nursing students (n=5)
2. Physician assistant students (n=4)
3. Medical students (n=10)

KEY INFORMANT INTERVIEW RESULTS
Many of the experts noted the lack of awareness and understanding of the issue of elder abuse, even among health care providers who interact with geriatric patients, with the Director of the elder abuse prevention center noting:

“Injuries in certain ages, you know it’s a child abuse issue. We don’t really understand what findings are diagnostic in the elderly.”

The expert from Adult Protective Services talked about how greater training on the issue could address some of these barriers to recognition. He also mentioned the need for greater training related to the reporting and diagnosis process:

“General demystification. You’ve got to make the reporting mechanisms more useful for people who are provoked in it. You have to give feedback; you have to know what happens with your report. I think it needs to be demystified.

The practicing geriatrician noted the disconnect in the reporting process:

“If physicians report, they don’t know […] If I send a patient to a gynecologist they are going to report back […] I don’t think it really happens in the protective services’ referral. You send something to the black box.

Several of the key informants noted the need for a community response at a level greater than the individual clinician, with the geriatrician saying:

“Through all of that is the development of elder abuse coalitions and community, because no organization can solve the issue on their own. It really needs a community-based response for success.”

The health gaming expert noted that any health technology application must reflect the experience of those using the tool and maintain a level of authenticity in any interactive training tool:

“Users need to recognize themselves in it. They need to hear their voice.

“Keep an eye on where you really need to apply technology and where you’re better off applying psychology.”
FOCUS GROUP DISCUSSION RESULTS
The current students were able to articulate their awareness of the vast array of challenges facing the elderly today:

“Early on I was talking about the elderly losing their autonomy because they have to be with their family when they don’t want to be. On the flip side of that coin, there are many elderly who need support and don’t have it.”

“When I hear of elder abuse, I think more of neglect and a lot of it stems from family members thinking it’s too much of a burden for them, and it’s unfortunate.”

The students gave concrete suggestions on potential ways to integrate this issue into their curriculum

“I think most of it should be covered going into the wards, but I think including it in the class like professional responsibility course is not a bad idea to get students introduced to that matter.

“Because it is such a wide scope that we could be presented with in terms of abuse, that just giving different examples of each, and then how and what, as clinicians do we do next: Do we refer, do we act, when do we call, who do we call.”

CONCLUSION
Educating present and future health professionals provides an opportunity to address the issue of elder abuse and reverse the trends associated with this growing problem. While some awareness of the issue exists among current clinicians and health students, further training and learning is needed. The increasing use of mobile phones, tablet applications, and other technology in medical education and clinical practice, provides a means for implementing effective tools to inform health professionals about the various risks facing elders as they age, and a means of training them to identify and combat elder abuse more effectively. In talking to experts in the field, these new tools need to be developed with input from individuals across the medical field as well as with community members, to effectively close the knowledge gap associated with elder abuse.

LIMITATIONS
In this study one expert from each field of interest pertaining to elder abuse was interviewed and a subset of one potential target population – future health professionals – participated in the focus group discussions. It is important to recognize that those who did not participate in the study may hold different views with regards to the questions we asked. Nevertheless, this particular group of participants offered informative responses and thoughtful suggestions on how education of elder abuse can be integrated into current curricula through use of interactive tools.

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