Older Adult Death Review Team

OVERVIEW

The Johnson County Older Adult Death Review Team (JCOADRT) is a multi-disciplinary team that seeks to identify and understand the factors associated with the deaths of older adults, particularly those deaths that could be related to caregiver abuse or neglect, as well as self-neglect,and any death that could have been prevented. This process brings together professionals from many disciplines and organizations to share and analyze comprehensive information on the circumstances leading to the death of the older adult. From case reviews, recommendations are developed for preventative public initiatives to reduce older adult fatalities locally and, possibly, at the state level.

The JCOADRT had accomplished many things since it was started in September 2010. Highlighted below are the accomplishments of the JCOADRT thus far:

1. Ensured the Medical Examiner Department developed a policy and procedure that creates a checklist of the "chain of command" for cases where a dependent adult may be left in the home following the death of a partner, caregiver, or other adult living in the home.
2. Ensure the Medical Examiner Department collected comprehensive data detailing the circumstances surrounding the antemortem and perimortem periods for each older adult death case.
3. Provide education on the subject of dementia and dependent adult abuse at the annual training of Johnson County area law enforcement officers.
4. Encouraage the Medical Examiner Department to order autopsies for all medical examiner cases involving older adult's deaths in which the Iowa Administrative Code requires or recommends an autopsy.
5. Provided education to local hospices, VNA, nursing homes, and long-term care facilities regarding the role of the Medical Examiner and their rules and regulations on referring deaths to the Medical Examiner Department.
6. Met with DHS State Supervisors and the DHS Board of Supervisors and discussed issues the JCOADRT is seeing.
7. Ensure the Medical Examiner Department provides bereavement information to families that include grief resources for potential dependent care needs after the loss of a caregiver.

The JCOADRT team facilitator, Sara Sanders, Ph.D., M.S.W., said "in the next year, the JCOADRT plans to continue to engage in community outreach to educate the public on when older adult death cases need to be referred to the JCME. Additionally, we hope to learn from detailed case analysis about how better partnerships between community organizations can occur so that gaps in the system, that may have been associated with the death, can be filled. We also hope that through the cases we will bring greater awareness to the issue of elder abuse and self-neglect. Finally, we will continue to identify opportunities for strengthening the aging service system, such as through advocating for policies and programs that can improve the health and well-being of the older adults and their caregivers."

If you would like to learn more about the team, please see the JCOADRT manual below.

SELF-DETERMINATION vs. SELF-NEGLECT

With older adults, the line can be blurred between what actions are considered self-determination and what constitutes self-neglect.

Self-determination is defined as, “the right of individuals to have full power over their own lives, regardless of presence of illness or disability. It involves free will, civil and human rights, freedom of choice, independence, personal agency, self-direction, and individual responsibility” (UIC National Research and Training Center on Psychiatry and the UIC NRTC Self-Determination Knowledge Development Work Group)

Self-neglect is defined by the National Center on Elder Abuse as, “the behavior of an elderly person that threatens his/her own health and safety. Self-neglect usually manifests itself in an older person as a refusal or failure to provide himself/herself with adequate food, clothing, shelter, personal hygiene, medication (when indicated), and safety precautions.”

Many cases that come before the JCOADRT involve self-neglect. Conversations among team members discussing what constitutes self-determination and what constitutes self-neglect happen frequently. Since the line between self-determination and self-neglect is so faint, it is often difficult for the team to come to a consensus. It is important, though, for the team to have these conversations as well as to raise awareness about the prevalence of self-neglect among older adults in the community.

Johnson County Death Review Teams

OVERVIEW AND PURPOSE

The Johnson County death review teams use a systematic and multidisciplinary process to coordinate case data and resources to improve understanding of many issues relevant to deaths in our community. Johnson County death review teams will examine sudden, unexplained deaths that occur in at-risk populations of older adults and children. Aggregate information from these case reviews will facilitate mapping of trends and risk factors associated with deaths in our jurisdiction. This information will also be used to educate and mobilize community forces to prevent similar deaths in the future.

GUIDING PRINCIPLE

Sudden, unexplained, or questionable deaths are a community responsibility. Each death represents an event that should move communities to identify other individuals at risk for similar illnesses or injuries that may end in death. Reviews require multidisciplinary participation from the local area to recognize lessons of events leading to the death of a child or older adult. Understanding the risk factors associated with these fatalities can help the teams translate these lessons into actions that may prevent similar deaths in the future.

GOALS AND OBJECTIVES

There are two goals for the Johnson County death review teams:

1) Enhance interagency/organization collaboration in all activities associated with the death investigations of children and older adults

2) End preventable child and older adult deaths in Johnson County

To accomplish these goals, the following objectives will be met:

1. Ensure the accurate identification and uniform, consistent reporting of the cause and manner of every death under our jurisdiction

2. Develop strategies for increased communication and coordination of agencies response to child and older adult deaths in the investigation and delivery of services to remaining family members

3. Identify specific barriers and system issues involved in these deaths

4. Identify significant risk factors and trends in child and older adult deaths for the future education and prevention efforts

5. Identify needed changes in legislation, policy, and practice in order to enhance public health and safety

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Johnson County Older Adult Death Review Team

OVERVIEW AND PURPOSE

The Older Adult Death Review Team is a multi-disciplinary team that seeks to identify and understand the factors associated with the deaths of older adults, particularly those deaths that could be related to caregiver abuse or neglect, as well as self-neglect and any death that could have been prevented. This process brings together professionals from many disciplines and organizations to share and analyze comprehensive information on the circumstances leading to the death of the older adult. From these case reviews, recommendations will be developed for preventative public initiatives to reduce older adult fatalities locally and, possibly, at the state level.

The Johnson County Older Adult Death Review Team (JCOADRT) is being initiated by the Johnson County Medical Examiner Department in response to the deaths of older adults that appear to have been caused by some form of neglect, either purposeful or inadvertent, as well as suicides among older adults. A community-based older adult death review team is uniquely suited to assess the effectiveness of services provided to families and to enhance coordination and communication among professionals involved with families before and after the death of an older adult.

GUIDING PRINCIPLE

The death of an older adult that is questionable or involves preventable factors requires a community response. It is an event that should mobilize communities to identify other older adults at risk for similar illnesses or injuries that could result in death. Reviews require multidisciplinary participation from the local area to study the lessons contained in the events leading to the death of older adults. Understanding risk factors of questionable older adult fatalities can help the team translate these lessons into actions that may prevent similar deaths in the future.

GOALS AND OBJECTIVES

There are two goals for the Johnson County Older Adult Death Review Team:

1) Enhance interagency/organization collaboration in all activities associated with the investigation of an older adult under our jurisdiction

2) End preventable older adult deaths in Johnson County

To accomplish these goals, the following objectives will be met:

1) Ensure the accurate identification and uniform, consistent reporting of the cause and manner of every older adult death under our jurisdiction

2) Develop strategies for increased communication and coordination of agencies response to older adult deaths in the investigation and delivery of services to remaining family members

3) Identify specific barriers and system issues involved in the deaths of older adults

4) Identify significant risk factors and trends in older adults' deaths for future education and prevention efforts

5) Identify needed changes in legislation, policy, and practice in order to enhance older adult health and safety

TEAM MEMBERS

Core members of an older adult death review team are responsible for responding to the deaths of older adults. They are charged with initiating preventative action plans aimed at protecting older adults' health and safety, in order to avoid future preventable fatalities. The Johnson County Older Adult Death Review team members are:

Community-Based Nurse:	Joyce Eland, BSN, RN *Quality Assurance* *VNA of Johnson County*
Community-Based Social Work:	Steve Siglin, LMSW, ACHP-SW *Social Worker* *Iowa City Hospice*
	Caitlin Learnan, BSW *Elder Rights Specailist* *Elder Services, Inc.*
	Susan Wehr *Executive Director* *Elder Services, Inc.*
County Attorney:	Janet Lyness, JD *Johnson County Attorney*
	Anne Lahey, JD *Assistant Johnson County Attorney*
Department of Human Services:	Karen Evans, BSW *Social Worker Supervisor*
Forensic Pathology:	Marcus Nashelsky, MD *Professor and Director of Autopsy Services;* *Director of Anatomic Pathology* *University of Iowa Hospitals and Clinics* *Johnson County Medical Examiner*
	Dennis Firchau, MD *Clinical Assistant Professor* *Anatomic Pathology* *University of Iowa Hospitals and Clinics* *Johnson County Deputy Medical Examiner*

Emergency Medicine:	Stephen Scheckel, MD *Medical Director* *Mercy Hospital ECU* *Johnson County Deputy Medical Examiner*
Geriatrician:	Gerald Jogerst, MD *Geriatrics Education Professor; Senior Associate Head; Director of Geriatrics* *University of Iowa Hospitals and Clinics*
Law Enforcement:	Lt. Doug Hart *Iowa City Police Department* Lt. Kevin Kinney *Johnson County Sheriff's Office*
Medical Examiner Department:	Michael Hensch, MA, F-ABMDI *Administrator* *Johnson County Medical Examiner Department*
Public Health:	Douglas Beardsley, MPH *Director* *Johnson County Public Health*
Service Providers:	Tracey Robertson, MA *Regional Protective Services Coordinator* *Heritage Area Agency on Aging*
Team Facilitators:	Sara Sanders, PhD, MSW *Associate Professor; specialized academic focus in gerontology, death and dying* *University of Iowa School of Social Work* Kate Bengtson, LMSW *Community Development Specialist* *Iowa Donor Network*

Additional and ad hoc members from other agencies and professions involved in protecting older adults' safety and health will be considered for team membership and certain provisions will be made for their inclusion on a case appropriate basis. Since ad hoc members are not consistently involved in case review, they do not regularly receive team notices. They attend meetings only when they have been directly involved in a case scheduled for review or to provide information on team related activities.

CASE REVIEW CRITERIA AND PROCEDURES

The inclusion criteria for cases to be reviewed include:

- Individuals over age 60

- Deaths considered to be accident, homicide, suicide, undetermined manner of death, or containing questionable characteristics, such as poor living conditions, possible abuse (even if death was deemed natural), and all other factors that would lead someone to consider the death as preventable

Information Needed for Reviews

Prior to each review, team members will be given brief case summaries. Team reviews will be most effective when team members bring their own case-specific information relevant to the circumstances of the death and the resources provided by their agency. This information may be case specific or it may be associated with individual areas of expertise. Each member will individually share this information at the review. Team members who were not involved in the specific case are asked to bring their area of expertise to the review of the case. Beyond case specific details, members should be prepared to speak to the local and national data trends for specific manners of death that relate to the case(s) being presented. Additionally, the team will examine local resources, services, and programs that are relevant to the prevention of similar types of deaths. The following information is needed to conduct a comprehensive review:

- Death investigation reports, including scene reports, interviews, and information on prior criminal activities

- Autopsy report

- Medical and health information concerning the older adult

- Information on the social services provided to the family and/or older adult

- Information from the court proceedings or other legal matters resulting from the death

- Relevant family information, including caregivers, spouses, adult children, extended family, living conditions, neighborhood, etc

- Information on the person/people interacting with the older adult around the time of death

- Other relevant information that could be associated with death

CONFIDENTIALITY

The JCOADRT is a forum for sharing information necessary to improve our community's response to older adult fatalities and for the prevention of questionable older adult deaths. The core function and purpose of the team cannot be met without sharing sensitive and confidential information. The issue of confidentiality involves two different, but related matters: Access to information by the team and access to the team's information by individuals or organizations outside the team. In cases when statistical information, general comments on policy protocols and prevention messages may be of value to alert the public concerning risk factors of older adult fatalities, the JCOADRT Team Coordinator is the primary

spokesperson.

JCOADRT members and attendees must sign a confidentiality agreement before sharing confidential information. The agreement form will briefly state the purpose of the review process and mention the consequences of violating the confidentiality agreement. The agreement will be kept on record at the Johnson County Medical Examiner Department, along with all other confidential information shared at the meetings.

FORMAT FOR DEATH REVIEW MEETINGS

The following format will be followed at the death review meetings:

1) Share, question, and clarify all case information

Agency representatives will share the information they have on the older adult, family and the circumstances associated with the death. Case reviews are only effective if members attend meetings and bring all pertinent information. Information will be shared in the following order:

- Medical Examiner: review of death scene and circumstances associated with death
- Forensic Pathologist: autopsy report and conclusions of cause and manner of death
- Health Care Providers: information obtained while at hospital or from past medical visits
- Department of Human Services: information on any referrals for elder abuse investigation
- Law Enforcement: criminal investigation
- Community-Based Social Workers and Case Managers: information on elder abuse initiative referrals
- County Attorney: any legal actions occurring
- Additional Members: any perspectives or pertinent information
- Ad hoc member: any perspectives or pertinent information

In order to be the most effective, team members should feel comfortable asking questions of persons presenting the case information. The person sharing the information then has the opportunity to clarify what he/she knows about the older adult, family, or incident. Team meetings are not peer reviews. They are designed to examine system issues, not the performance of individuals. The team review is a professional process aimed at improving system responses to older adult deaths.

2) Discuss the investigation

Questions regarding the investigation include:

What was the lead investigative agency?
Was there a death scene investigation?
Was there a death scene recreation with photos?
Were other investigations conducted?
What were the key findings of the investigation(s)?
Does the team feel the investigation was adequate?
Is the investigation complete?
What more do we need to know?
Does the team have suggestions to improve the investigation system?

All clarification processes are not meant to determine if a person or agency handling the investigation of a death made a mistake in some way. It is used to determine if all the pertinent questions that the team needs to know about the circumstances of death have been answered.

3) Discuss the delivery of services

Questions regarding the delivery of services include:

Were there any services that the family was accessing prior to the death?
Were services provided to the family members as a result of the death?
Were services provided to other members of the family?
Were services provided to responders, witnesses or community members?
Are there additional services that should be provided to anyone?
Who will take the lead in following up on these service provisions?
Does the team have suggestions to improve service delivery systems?

As with the clarification of the investigation process, these questions exist to ensure that those who may be affected by a death receive needed support services. They are not intended to seek errors on the part of specific individuals or agencies.

4) Identify risk factors

Identifying the risk factors involved in an older adult's death during the review process can lead to recommendations that the team believes could reduce or prevent future deaths among older adults who share identified risk factors.

Grouping risk factors into these general categories can help guide this discussion:

Health
Social
Economic
Behavioral

Environmental
Systemic (agency policies and procedures)
Product safety

5) Recommended system improvements

After all the known facts of the case have been shared and discussed, there may be issues involving agency response that need to be addressed. Generally, the team member representing the agency in question will explain their protocol to the team. In this, team members learn more about what the parameters of others' responsibilities are, including legal limitations of the organization that each member represents. The identification of gaps in policy and procedure in response to a death may result in a particular agency representative bringing the review findings back to his/her supervisor. In some situations, a telephone call or an invitation for an agency supervisor to attend the next meeting may be the best way to approach this.

6) Identify and take action to implement prevention recommendations

A review should never be considered complete by the team until the important question is asked:

Was this death preventable?

The team does not necessarily have to be the group that sees the prevention action through from tart to finish. Instead, they can play the important role of being the catalyst for change, the spark that starts a prevention campaign. However, the team should always follow up on their recommendations to ensure accountability for implementing the prevention recommendations.

7) Determine final steps for concluding the current case review

During this time, the team will decide if this case needs to be reviewed in the future when more information about the death and services may be available. During all steps of the review process, detailed notes will be taken so that themes and statistics can be reported at the end of the calendar year on the older adult deaths, common themes of the deaths, and community action taken.

TAKING ACTION TO PREVENT OLDER ADULT DEATHS

The ultimate purpose of reviewing older adult deaths is to improve the health and safety of older adults. By understanding how and why certain older adults die, our community can take action to prevent similar deaths. The team should ensure that every preventable older adult death makes a difference in the lives of other older adults. The JCOADRT should share their findings and information with other people and appropriate agencies, encourage them to utilize our review and act upon the information to help prevent unnecessary older adult fatalities.

The findings of the team may assist in strengthening prevention-focused programs. The key to prevention is leadership at the local level. Review team members can provide this leadership by serving as stimulus

for community action. Prevention efforts can range from changing one agency practice or policy, to more complex interventions, implemented at the community or state-wide level.

1) Determine if the death was preventable

An older adult's death is preventable if the community or an individual could reasonably have done something that would have changed the circumstances that led to the death. While this is not the case for many older adults with a variety of health conditions, it is the case for others.

2) Identify modifiable risk factors

Reviewing the circumstances of each death will help the team focus on the specific factors that caused the death or made the older adult more susceptible to harm. Once risk factors are identified, the team needs to decide which factors they can modify or impact. Certain risk factors are easy to impact, and some require long-term, systemic change. Thus, prevention of risk may be easy or it may be a prolonged and complicated process.

Once risk factors are identified, it is important to assess the extent of the problem and who it impacts the most. The JCOADRT may focus prevention strategies on certain populations of older adults to have the most impact. The JCOADRT must collect information to know where and how often these types of deaths occur and obtain data to understand the full extent and frequency of the problem.

3) Determine the best strategy for prevention

There are certain levels at which prevention activities can take place, moving beyond individual services and encouraging the development of creative and effective prevention projects. The members of the team can choose to initiate recommendations under one of the following categories:

a. Strengthening Individual Knowledge and Skills

Assisting individuals to increase their knowledge and capacity to act can lead to behavior change.

b. Promoting Community Education

Reach groups of people with information and resources to build support for healthier behaviors.

c. Training Providers

Providers, such as professionals, community activists or peers, can influence others. It is critical to ensure that those who are providing training, advice or services as role models have the information, skills, capacity and motivation to effectively promote prevention with older adults, caregivers, family members, colleagues and policy members.

d. Fostering Coalitions and Networks

Creating and strengthening the ability of people and organizations to join together to work on a specific problem is useful for accomplishing a broad range of goals that reach beyond the capacity of any individual member or agency.

e. Changing Organization Practices

Looking at the practice of key groups, such as law enforcement, health departments and community based aging services, to determine their potential for affecting the health, safety and satisfaction of the greater community.

f. Mobilizing Neighborhoods and Communities

Engage community members in the process of identifying, prioritizing, planning and making changes. Networking with neighborhoods can act as motivation for communities to be empowered to make a difference.

g. Influence Policy and Legislation

Work to change laws or regulations at the local, state and national levels. Sometimes the greatest improvement in prevention, affecting the largest number of people, can be accomplished by attention to policy issues and regulation.

Given the complexity of many older adult deaths, the best solutions are those that are comprehensively reviewed. Each individual organization may work at one or more level. A coalition throughout Johnson County may assure that all levels are addressed, maximizing potential outcomes.

4) Identify Specific Prevention Activities

After identifying key prevention strategies, the team will then identify the specific activities to be implemented. To determine the specific prevention recommendations, the team should review the prevention literature to ensure that proposals have been proven to be effective and select interventions have demonstrated efficacy and are appropriate to the Johnson County community. When the team is identifying the best prevention campaigns, they should weigh the following:

Effectiveness
Ease of Implementation
Cost
Unintended Consequences
Sustainability
Community Acceptance
Political Reality

The following table can help evaluate the team's recommendations for prevention. The table represents examples of the types of prevention actions the team could consider across four areas: education, agency change, new laws and changes to the environment. Often, the best recommendations will be a combination of these actions.

Education	Media Campaign Community Safety Project Provider Education Caregiver Education Public Forum	Media Campaign: After a rise in elder abuse related deaths, the first step the team will take is to organize a 'Letter to the Editor' writing campaign to raise awareness not only of elder abuse in the community, but of the local resources that are available through county based aging providers.
Agency	New Policy(ies) Revised Policy(ies) New Programs New Services Expanded Services	New Program/Inter-Agency Case Inclusion: The team has noticed a disconnect between agencies involved with elder abuse cases. The team coordinator will initiate a meeting between all involved agencies to examine new policies for investigations and interagency cooperation.
Law	New Law/Ordinance Amended Law/Ordinance Enforcement of Law/ Ordinance	Enforcement of Law/Ordinance: After a series of case reviews involving abuse related deaths that were not reported, the team will partner with local legal authorities to advocate for an expansion of the Mandatory Reporter Law.
Environment	Modify a Consumer Product Recall a Consumer Product Modify a Public/Private Space (s)	Modify a Public Space: After several falls on slick pavement around the community resulted in the deaths of older adults, the team coordinator will meet with the Johnson County Livable Community for Successful Aging Board to present the JCOADRT statistics on these cases.