



EFFORT
ELDER ABUSE FATALITY
REVIEW TEAM

BIENNIAL REPORT

2022 - 2024

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INTRODUCTION TO EFFORT AND ITS PURPOSE:

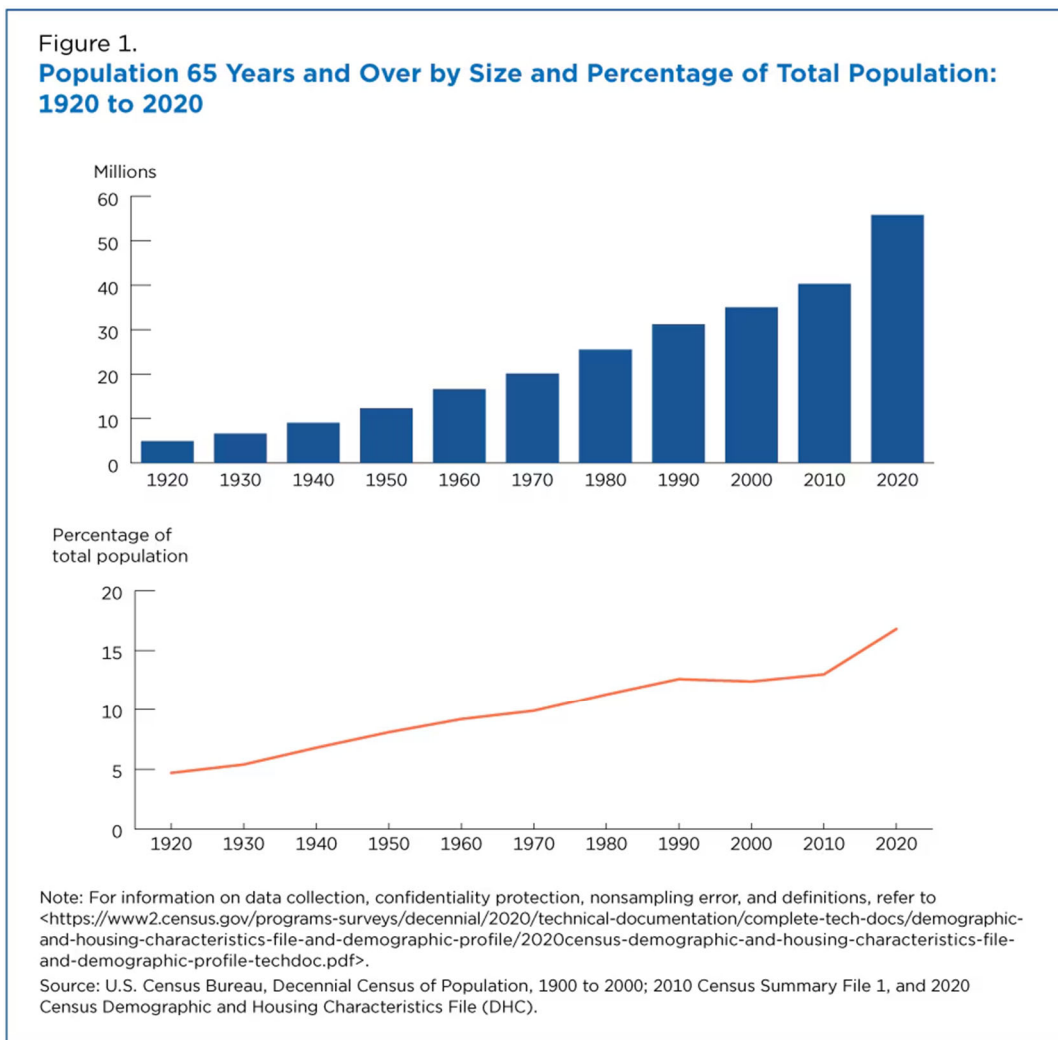
In accordance with Texas Health and Safety Code Title 8, Subtitle A, Chapter 672.002, “A multidisciplinary and multiagency unexpected fatality review team may be established for a county to conduct reviews of unexpected deaths that occur within the county.” Furthermore, Section 672.003 states the purpose of such teams as follows:

The purpose of a review team is to decrease the incidence of preventable adult deaths by:

- (1) promoting cooperation, communication, and coordination among agencies involved in responding to unexpected deaths;
- (2) developing an understanding of the causes and incidence of unexpected deaths in the county or counties in which the review team is located; and
- (3) advising the legislature, appropriate state agencies, and local law enforcement agencies on changes to law, policy, or practice that will reduce the number of unexpected deaths.

Older adults, defined as those 65 years of age and greater, are particularly vulnerable to mistreatment. Statistically, they are more prone to financial exploitation and scams, and they are more likely to experience physical abuse and neglect. Older individuals often experience multiple forms of abuse, neglect and unintentional self-neglect. From financial ruin to hospitalizations and an untimely, undignified death, the effects of abuse, neglect and exploitation (ANE) can be devastating. Even when nothing untoward has happened, successful navigation of the healthcare system and social services can be challenging, especially as businesses and government agencies increasingly interact with the public through the internet and cell phone applications. As demonstrated in the chart below, the older population in America is growing both in sheer number and percentage of the population. With this, so too will the instances of ANE grow.

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The Harris County Elder Fatality Review Team (EFFORT) was formed in 2004 to identify systemic issues and provide recommendations to prevent premature deaths of older or disabled adults caused by elder mistreatment. To accomplish this task, EFFORT members meet monthly to review suspicious deaths of vulnerable adults who were either at least 65 years of age and/or disabled. The goal in reviewing such deaths is to understand how those deaths occurred and thereby to find repetitive systemic problems. In so doing, EFFORT aims to make recommendations to local leaders and policymakers who can implement measures to reduce similar premature deaths.

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AGENCIES INVOLVED IN EFFORT:

- CHI St. Luke's Health - Baylor St. Luke's Medical Center
- City of Galena Park EMS
- Harris County District Attorney's Office
- Harris County Emergency Corps
- Harris County Institute of Forensic Sciences
- Harris County Long-Term Care Ombudsman Program - Cizik School of Nursing at UTHealth Houston
- Harris County Sheriff's Office
- Harris Health System - Ben Taub Hospital
- HCA Healthcare
- Houston Police Department
- Jersey Village Police Department
- Memorial Hermann Health System
- Texas A & M University
- Texas Department of Family and Protective Services Texas Health and Human Services Commission
- Texas Office of the Attorney General – Medicaid Fraud Control Unit
- UTHealth Houston - Forensic Assessment Center Network
- UTHealth Houston - Institute on Aging
- UTHealth Houston - Forensic Assessment Center Network
- UTHealth Houston - McGovern Medical School
- UTHealth Houston - Senior Justice Assessment Center
- UTHealth Houston - Texas Elder Abuse and Mistreatment Institute

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8 Things to Know About the Harris County Elder Fatality Review Team (EFFORT)



1	Legislation Led to the Formation of the Harris County Elder Fatality Review Team (EFFORT) Chapter 672 of the Texas Health and Safety Code describes the purpose and structure of elder fatality review teams in Texas.
2	EFFORT is Largely Modeled on the Harris County Child Fatality Review Team (CFRT) EFFORT and CFRT are county-led. By keeping EFFORT local, the reviews can lead to locally-informed recommendations.
3	The Purpose of EFFORT: • Establish an in-depth understanding of the root causes surrounding preventable deaths • Promote understanding, cooperation, communication, and coordination • Decrease the incidence of preventable deaths among those aged 65 years or older or with disabilities • Reduce unexpected deaths, through advisement on changes to law, policy, or practice to legislature, appropriate state agencies, local law enforcement, and healthcare providers
4	EFFORT Accomplishes Many Goals Through Case Review: • Find missed prevention opportunities by identifying by gaps in the system • Build working relationships between local stakeholders on preventable elderly deaths • Recommend policies, programs, laws, etc. to prevent deaths • Inform local prevention strategies
5	EFFORT Achieves This Purpose Through: • Meeting monthly to review fatality cases • Collecting and maintaining data • Submitting a biennial report • Advising on policy change recommendations to appropriate state agencies, local law enforcement, and healthcare providers
6	EFFORT Engages Many Local Partners From a Variety of Disciplines These team members include representatives from the medical examiner's office, district attorney office, law enforcement, hospitals, emergency medical services, and more. EFFORT members are required to bring relevant reports from their organizations to EFFORT meetings.
7	Agencies Work Together in EFFORT By exploring systemic course of care issues, with an aim to decrease the risk of death of older adults and those with disabilities, new connections are created between the community partners for collaboration.
8	EFFORT is Not Designed to Place Individual Blame EFFORT is not a peer review process or an opportunity to second guess agency policy or practice. It is about coming together as community leaders to determine where there were missed opportunities for prevention/ intervention, and how, across all agencies, practices/procedures can be improved.

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SYSTEMIC PROBLEMS AND RECOMMENDATIONS:

A subgroup of the committee reviewed cases referred to the committee and chose to discuss cases that appeared to reflect systemic issues which resulted in an unexpected death due to abuse, neglect, or self-neglect. In the 2023/2024 reporting period the committee reviewed approximately 50 such cases. The following trends were observed:

1. Mistreatment and poor quality of care in unlicensed boarding homes.

Unlicensed boarding home concerns have long been a top focus of EFFORT and have been featured in previous reports as an ongoing opportunity for intervention. Over recent years, advocacy by EFFORT and its members has helped enact legislation allowing counties and municipalities to regulate unlicensed boarding homes by establishing permitting requirements. This has enabled our communities to gain access to unlicensed boarding homes once they are discovered and to subsequently shut them down when the boarding homes fail to meet basic health, safety, and fire requirements. Another benefit to the permitting of boarding homes is that hospitals are able to critically appraise a boarding home for proper permitting prior to discharging a patient there. Although bad actors still operate unlicensed boarding homes, making enforcing the permitting process akin to a game of Whack-A-Mole, the existence of the permitting process is a notable success of EFFORT and a clear step in improving outcomes for our elderly population. **EFFORT recommends: 1) Continued allocation of resources to the boarding home units at law enforcement agencies. 2) Increasing awareness about the importance of ensuring boarding home permitting prior to patient discharge there.**

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2. Nursing home and assisted living facility quality of care issues, largely driven by low staffing levels.

Low levels of staffing in nursing homes and assisted living facilities continue to be implicated in poor outcomes (including death) for individuals residing there. Nursing home regulations currently in effect require only 0.4 nursing hours per resident per day, with no mention of the certified nursing assistants. (For example, a facility with 120 residents is only required to have six eight-hour shifts of licensed nurses,--LVN's or RN's--or two nurses per shift, which equals one nurse per 60 residents on average.) Experts have long recommended that 4.1 total caregiver hours per resident per day be the minimum standard for quality care, which results in more positive outcomes. (For example, a facility with 120 residents would be required to have a little more than twenty direct caregivers per shift on average—including certified nurse aides, certified medication aides and licensed nurses—which equals about one caregiver per six residents per shift on average.) Assisted living facilities that are not certified as Alzheimer's care providers have no specific staffing ratios at all.

EFFORT has reviewed many cases involving deaths of older adults with recurring themes which frequently include falls, inadequate wound care, elopements and other forms of neglect. In each of these, improper staffing and/or inadequate staff training were singled out as a significant contributor to the cause of death. While improved staffing levels will never completely eliminate these occurrences there can be no doubt that the quality of care and outcomes would improve with better staffing levels. Members of EFFORT understand that arguments against improving staffing levels at facilities include the notion that such care is both complicated and expensive. However, given the vast sums of money spent by private citizens and government on care at these facilities, the current shortfalls in staffing must not continue to be ignored. Nearly 200 billion dollars a year is spent on nursing home care and continuing care retirement communities alone, with the bulk of that coming from Medicare and Medicaid (see <https://www.statista.com/statistics/184780/us-nursing-home-expenditures-since-1960/>). All providers should be held accountable for a respectable standard of care. **EFFORT recommends increasing the staffing requirements for nursing homes and assisted living facilities and reinforcing the requirements with solid oversight and enforcement.**

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3. Under-reporting of abuse, neglect and self-neglect to Adult Protective Services.

Caseworkers for Adult Protective Services (APS) are the frontline in the battle to stop elder abuse, neglect, and exploitation. APS caseworkers cannot do their job as effectively if they are not notified of elders in need. Many EFFORT case reviews involve deaths where there are obvious signs of self-neglect, or inadequate care by caregivers who, despite their best intentions, didn't understand the level of care that was required, or who were otherwise unable to provide the needed care.

It is important to note that in many cases, nothing intentionally malicious or criminal was occurring. Rather, caregivers often just need help and support that they do not consistently have in order to function adequately in their caregiving role and responsibilities.

In many such cases, APS has no history of reported neglect or other calls for help. From healthcare professionals and law enforcement to the population at large, too many people think of APS only as a way to report abuse, neglect, and exploitation. While APS does investigate cases of outright elder mistreatment, and it is imperative that these cases be reported, that is far from the full story of APS. Adult Protective Service's focus is on keeping people in their homes and providing them with the proper supports, services, and resources. EFFORT believes that many poor outcomes could be improved if utilizing APS was understood more as calling for help, rather than *only* calling to report harmful actions. Often all an older person or their caregiver or family member needs is help understanding and navigating what resources are available to help them. **EFFORT recommends increased effort at educating the public that APS is not just an avenue to report and stop mistreatment, but also a way for family members, caregivers, and older or disabled adults to get help, resources, and support.**

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Contact INFORMATION

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