♠ Measure #181: Elder Maltreatment Screen and Follow-Up Plan

2010 PQRI REPORTING OPTIONS FOR INDIVIDUAL MEASURES: CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 65 years and older with documentation of a screen for elder maltreatment AND documented follow-up plan

INSTRUCTIONS:
This measure is to be reported for each initial patient evaluation during the reporting period. When reporting CPT service code 96116, 97803, and G0270 the measure is to be reported each time the code is submitted. The not eligible code can be used to report if it is not an initial evaluation with screening for elder maltreatment. This measure may be reported by non-MD/DO clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
CPT codes, G-codes, and patient demographics are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT codes, HCPCS codes, and the appropriate numerator G-code. All measure-specific coding should be reported ON THE SAME CLAIM.

Measure Reporting via Registry:
CPT codes, G-codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions however these codes may be submitted for those registries that utilize claims data.

NUMERATOR:
Patients with a documented screen for elder maltreatment and follow-up plan

Definitions:
Documented – Evidenced in the clinical record. Such evidence can include narrative notes, a formal screen and/or an assessment and treatment plan tool/form, copy of a documented plan or referral request for further evaluation, etc.
Screen for Elder Maltreatment – The screen includes a review of the following components: (1) physical abuse, (2) emotional or psychological abuse, (3) neglect, (4) sexual abuse, (5) abandonment, (6) financial or material exploitation, (7) self-neglect, and (8) unwanted control. (Institute of Medicine 2002)

Physical Abuse – Infliction of physical injury by punching, beating, kicking, biting, burning, shaking or other actions that result in harm. (Institute of Medicine, 2002)

Emotional or Psychological Abuse – Involves psychological abuse, verbal abuse, or mental injury and includes act or omissions by loved ones or caregivers that have caused or could cause serious behavioral, cognitive, emotional, or mental disorders.

Neglect – Involves attitudes of others or actions caused by others-such as family members, friends, or institutional caregivers-that have an extremely detrimental effect upon well-being. (Reyes-Ortiz 2001)

Active – Behavior that is willful, the caregiver intentionally withholds care or necessities. The neglect may be motivated by financial gain or reflect interpersonal conflicts. (NCPEA)

Passive – Situations where the caregiver is unable to fulfill his or her care giving responsibilities as a result of illness, disability, stress, ignorance, lack of maturity, or lack of resources. (NCPEA)

Sexual Abuse – Involves adults who are unable to fully comprehend and/or give informed consent in sexual activities that violate the taboos of society. (Institute of Medicine 2002)

Abandonment – Desertion of an elderly person by an individual who has assumed responsibility for providing care for an elder, or by a person with physical custody of an elder. (NCPEA)

Financial or Material Exploitation – Taking advantage of a person for monetary gain or profit. (Institute of Medicine 2002)

Self-Neglect – Self-imposed attitudes or actions that contribute to decline in the persons overall health and well being, may be associated with an inappropriate or nontraditional lifestyle. Other names used may include Diogenes syndrome (DS), aged reclusion, social breakdown, and squalor syndrome. (Reyes-Ortiz 2001)

Unwarranted Control – Controlling a person's ability to make choices about living situations, household finances, and medical care. (Institute of Medicine 2002)

Follow-Up Plan – May include but is not limited to documentation of a referral or discussion with other providers, on-going monitoring or assessment, and/or a direct intervention.

Not Eligible – A patient is not eligible if the following condition(s) exist:

- Patient refuses to participate.
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status.
- Patient elder maltreatment screen was negative and no further follow-up required.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Elder Maltreatment Screen and Follow-Up Plan Documented

G8534: Documentation of an elder maltreatment screen and follow-up plan

OR

Elder Maltreatment Screen Documented, Follow-Up Plan not Documented, Patient not Eligible

G8537: Elder maltreatment screen documented, follow-up plan not documented, patient not eligible

OR

Elder Maltreatment Screen not Documented, Patient not Eligible
G8535: No documentation of an elder maltreatment screen, patient not eligible

OR

Elder Maltreatment Screen not Documented, Reason not Specified
G8536: No documentation of an elder maltreatment screen, reason not specified
OR
Elder Maltreatment Screen Documented, Follow-Up Plan not Documented, Reason not Specified
G8538: Elder maltreatment screen documented, follow-up plan not documented, reason not specified

DENOMINATOR:
All patients aged 65 years and older

Denominator Criteria (Eligible Cases):
Patients aged ≥ 65 years on date of encounter
AND
Patient encounter during the reporting period (CPT or HCPCS): 90801, 90802, 96116*, 96150, 97003, 97802, 97803*, G0270*

Note: **When reporting CPT code 96116, 97803, and G0270, the measure is to be reported* each *time the code is submitted.*

RATIONALE:
Elder abuse is the infliction of physical, emotional, or psychological harm on an older adult, but also can take the form of financial exploitation or intentional or unintentional neglect of an older adult by the caregiver. Over the past ten years there has been an increase in elder abuse, which is not being picked up and reported to appropriate authorities. The reasons for underreporting are two-fold: health care professionals don't ask patients if they are being abused and patients don't tell, for fear of retaliation by their caregivers. In the American Psychological Association's "Elder Abuse and Neglect: In Search of Solutions," found on their website, it is reported that every year an estimated 2.1 million older Americans are victims of physical, psychological, or other forms of abuse and neglect and that for every reported case of elder abuse and neglect, it is estimated that there may be as many as five unreported cases. Recent research suggests that elders who have been abused tend to die earlier than those who are not abused, even in the absence of chronic conditions or life threatening disease.

It is difficult to obtain accurate information on the extent of elder abuse and neglect in the United States. Studies often focus on reports of selected populations and many cases are unreported. Victims may be embarrassed, intimidated and overwhelmed by the situation. They may be fearful of reprisals or unaware of the availability of help. In some cases, victims may be unable to report maltreatment or do not realize that they are being maltreated. Finally, health professionals may ignore the signs and symptoms of elder maltreatment because they are unaware of the extent of the problem and uncomfortable with the responsibility of further assessment and action.

The extent to which elder maltreatment affects the health care system is largely unknown. Common clinical findings associated with maltreatment include bruises, lacerations, abrasions,

head injury, fractures, dehydration, and malnutrition. These injuries commonly result in hospitalization. In one descriptive study that tracked the emergency department utilization of known elderly victims of physical abuse identified through adult protective services, 114 individuals had 628 emergency department visits during a 5-year window surrounding the referral; 30 percent of these visits resulted in hospital admission. (Institute of Medicine 2002)

Studies do indicate that the effects of elder maltreatment increase the medical needs of victims. One longitudinal study of elderly victims of maltreatment documented a threefold increased risk of death in the 3-year period following maltreatment, after adjusting for comorbidity and other factors that predict death in older cohorts (Lachs 1998). In addition, maltreatment may exacerbate or interfere with the treatment of other medical and psychosocial conditions. For example, angina pectoris, emphysema, diabetes mellitus, and arthritis are much more challenging to treat in an abusive environment (Lachs 1997). No studies of the costs associated with these increased medical needs have been published. (Institute of Medicine 2002)

Website searches of the National Quality Measures Database (NQMC) using the keywords Elder Abuse and Elder Neglect resulted in 9 measures. The measures only pertain to intimate partner violence and not the broader topic of elder maltreatment. One measure was focused on preventive counseling on violence and abuse, which is not the measure focus.

CLINICAL RECOMMENDATION STATEMENTS:

Every clinical setting should have a protocol for the detection and assessment of elder maltreatment. This may be a narrative, a checklist, or some other type of standardized form that enables all providers in that practice setting to rapidly assess for elder maltreatment and document it in a way that allows clinicians to look at patterns over time. (Aravanis and Adelman 1993)