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

2012 PHYSICIAN QUALITY 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 once during the reporting period for patients seen during the reporting period. This measure may be reported by eligible professionals 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 claim(s) representing the eligible encounter.

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.

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, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350 G0101, G0270, G0402, G0438, G0439
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> *DENOMINATOR NOTE: When reporting CPT code 96116, 97803, and G0270, it is recommended the measure be reported each time the code is submitted.*

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

Definitions:
Documented – Evidence in the clinical record that may appear on 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 and documentation of ***all*** of the following components: (1) physical abuse, (2) emotional or psychological abuse, (3) neglect (active or passive), (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 or when 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.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Elder Maltreatment Screen Documented as Positive and Follow-Up Plan Documented
G8733: Documentation of a positive elder maltreatment screen and documented follow-up plan
OR
Elder Maltreatment Screen Documented as Negative, Follow-Up Plan not Required
G8734: Elder maltreatment screen documented as negative, no follow-up required
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 as Positive, Follow-Up Plan not Documented, Reason not Specified
G8735: Elder maltreatment screen documented as positive, follow-up plan not documented, reason not specified

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 as seen in the American Psychological Association's website (2010), *Elder Abuse and Neglect: In Search of Solutions*, it is reported every year an estimated 2.1 million older Americans are victims of physical, psychological, or other forms of abuse and neglect and for every reported case of elder abuse and neglect 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.

One in nine seniors reported being abused, neglected or exploited in the past twelve months. Elder abuse is vastly under-reported; only one in 23.5 cases are reported to any agency; for financial abuse it is one in 44; and for neglect it is one in 57. Elder abuse victims are four times more likely to go into a nursing home (Lachs et al., 2011). Financial exploitation is extremely high, with 1 in 20 older adults indicating some form of perceived financial mistreatment occurring at least one time in the recent past. Financial exploitation by family members and by strangers was increased among the more physically disabled adults, indicating perhaps a greater need for monitoring for this subgroup of elders (Acierno, et al. 2009).

In a 2010 study performed by Nauan, et al., more than half of nursing facility surveyed staff reported they identified abuse of elderly residents over the past year in one or more than one type of maltreatment with approximately two-thirds reporting incidents of neglect. The study further found 75% of respondents were present at incidents in which another staff member abused an elderly resident in one or more types of maltreatment, and in such situations mental abuse and mental neglect were the most prevalent forms of maltreatment.

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)

CLINICAL RECOMMENDATIONS:

To facilitate health care professionals to assess older persons in domestic and institutional settings who are at risk for elder abuse and recommend interventions to reduce the incidence of mistreatment.

Elder Abuse Prevention Daly JM. Elder abuse prevention. Iowa City (IA): University of Iowa Gerontological Nursing Interventions Research Center Research Dissemination Core; 2004. National Guideline Clearinghouse (NGC). Guideline summary: *Elder abuse prevention*

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