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# PQRS Measure # 181

# Elder Maltreatment Screening and Follow-Up Plan

# NQF Endorsement Measure Submission Summary Materials

**Submitted by:**

**Quality insights of Pennsylvania**

**A special project for the Centers for Medicare & Medicaid Services (CMS) and the National Quality Forum**

***Confidential & Proprietary***



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# I. 2010 Physician Quality Reporting System Specification [Tested]

Measure #181 Elder Maltreatment Screening and Follow-Up Plan

# TESTED SPECIFICATION

# 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

**Definition:**

**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.

# TESTED SPECIFICATION

**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

1. 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

# TESTED SPECIFICATION

**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 formof 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 forevery 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.

# TESTED SPECIFICATION

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).

# II. 2014 Physician Quality Reporting System Specification

Measure #181 Elder Maltreatment Screening and Follow-Up Plan

# 2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES: CLAIMS, REGISTRY

# DESCRIPTION:

# Percentage of patients aged 65 years and older with a documented elder maltreatment screen using an Elder Maltreatment Screening Tool on the date of encounter AND a documented follow-up plan on the date of the positive screen

# 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 at the time of the qualifying visit. The documented follow up plan must be related to positive elder maltreatment screening, example: “Patient referred for protective services due to positive elder maltreatment screening.”

# Measure Reporting via Claims:

# CPT or HCPCS 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 or 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 or HCPCS 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): 90791, 90792,90832, 90834, 90837, 96116, 96150, 96151, 97003, 97802, 97803, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0101, G0270, G0402, G0438, G0439

# NUMERATOR:

# Patients with a documented elder maltreatment screen using an Elder Maltreatment Screening Tool on the date of the encounter and follow-up plan documented on the date of the positive screen

# Definitions:

# Screen for Elder Maltreatment – An elder maltreatment screen should include assessment 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 and (7) unwarranted control.

# Physical Abuse – Infliction of physical injury by punching, beating, kicking, biting, burning, shaking, or other actions that result in harm.

# Emotional or Psychological Abuse – Involves psychological abuse, verbal abuse, or mental injury and includes acts 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.

# 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.

# 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.

# Sexual Abuse – The forcing of undesired sexual behavior by one person upon another against their will who are either competent or unable to fully comprehend and/or give consent. This may also be called molestation.

# Elder 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.

# Financial or Material Exploitation – Taking advantage of a person for monetary gain or profit

# Unwarranted Control – Controlling a person’s ability to make choices about living situations, household finances, and medical care.

# Please note: Self neglect is a prevalent form of abuse in the elderly population. Screening for self-neglect and screening tools for self-neglect are not included in this measure. Resources for suspected self-neglect are listed below.

# Follow-Up Plan – Must include a documented report to state or local Adult Protective Services (APS) agency. Note: APS does not have jurisdiction in all states to investigate maltreatment of patients in long-term care facilities. In those states where APS does not have jurisdiction, APS may refer the provider to another state agency -- such as the state facility licensure agency – for appropriate reporting*. Federal reporting: In addition to state requirements, some types of providers are required by federal law to report suspected maltreatment. For example, nursing facilities certified by Medicare and/or Medicaid are required to report suspected maltreatment to the applicable State Survey and Certification Agency*.

# For state-specific information to report suspected elder maltreatment, including self-neglect, the following resources are available:

# 1. National Adult Protective Services Association- http://www.napsa-now.org/get-help/help-in-your-area/

# 2. Eldercare Locater: 1-800-677-1116 www.eldercare.gov

# 3. National Center on Elder Abuse http://www.ncea.aoa.gov/NCEAroot/Main\_Site/Find\_Help/State\_Resources.aspx

# Disclaimer: The follow-up plan recommendations set forth in this quality measure are not intended to supersede any mandatory state, local or federal reporting requirements

# Not Eligible – A patient is not eligible if one or more of the following reasons is documented:

# • 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 NOTE: Documentation of an elder maltreatment screening must include identification of the tool used. Examples of screening tools for elder maltreatment include, but are not limited to: Elder Abuse Suspicion Index (EASI), Vulnerability to Abuse Screening Scale (VASS) and Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST).

# Numerator Quality-Data Coding Options for Reporting Satisfactorily:

# Elder Maltreatment Screen Documented as Positive AND Follow-Up Plan Documented

# (One G-code [G8733 or G8734] is required on the claim form to submit this numerator option)

# G8733: Elder maltreatment screen documented as positive AND a follow-up is plan is documented

# OR

# Elder Maltreatment Screen Documented as Negative, Follow-Up Plan not Required

# G8734: Elder maltreatment screen documented as negative, follow-up is not required

# OR

# Elder Maltreatment Screen not Documented, Patient not Eligible

# (One G-code [G8535 or G8941] is required on the claim form to submit this numerator option)

# G8535: Elder maltreatment screen not documented; documentation patient is not eligible for the elder maltreatment screen

# OR

# Elder Maltreatment Screen Documented as Positive, Follow-Up Plan not Documented, Patient not Eligible for Follow- up Plan

# G8941: Elder Maltreatment Screen Documented as positive, follow-up plan is not documented. Documentation that the patient is not eligible for follow-up plan

# OR

# Elder Maltreatment Screen not Documented, Reason not Given

# (One G-code [G8536 or G8735] is required on the claim form to submit this numerator option)

# G8536: No documentation of an elder maltreatment screen, reason not given

# OR

# Elder Maltreatment Screen Documented as Positive, Follow-Up Plan not Documented, Reason not Given

# G8735: Elder maltreatment screen documented as positive, follow-up plan not documented, reason not given

# RATIONALE:

“Most cases of elder abuse go unidentified and unreported (Cohen, 2011, p.261). Elder maltreatment is prevalent and occurs predominantly in the community, not in nursing care facilities. One in ten seniors reported being abused, neglected or exploited in the past twelve months; 5.2% for financial abuse, 4.6% for emotional, 1.6% for physical abuse and 0.6% for sexual abuse. Financial exploitation by family members and by strangers was increased among the more physically disabled adults (Aceirno et al., 2010). Elder Abuse and Neglect: In Search of Solutions (2013), reports that every year an estimated 4 million older Americans are victims of physical, psychological, or other forms of abuse and neglect, and for every reported case there may be as many as 23 unreported. Although less prevalent, patients in nursing homes do experience maltreatment. In a 2010 study performed by Natan et al., more than half of nursing facility surveyed staff reported they identified abuse of elderly residents over the past year with approximately two- thirds reporting incidents of neglect.

There are many complex reasons for underreporting; minimal screening, a lack of knowledge and skills for interventions (Cohen, 2011) on the part of health care providers and failure of the abused patient to report due to fear of retaliation by the abuser (APA, 2010), inability of the victim to report due to a cognitive deficit or initiating family discord. This lack of identifying victims of elder abuse leads to increased rates of hospitalization (Dong & Simon, 2013), morbidity (Cohen, 2011), mortality (Dong, et al., 2009) and admission into a nursing home (Lachs et al., 2011). These outcomes are costly. As cited in Dong (2011), the Government Accounting Office reported spending $11.9 million dollars in 2009 for all activities related to elder abuse and this amount was not enough to provide basic protection for older adults from abuse, neglect and exploitation. It is clear that additional screening, education of victims and health care providers and financial support is needed in order to unveil the depth of the problem and provide aid to those who are being abused and neglected.

# CLINICAL RECOMMENDATION STATEMENTS:

The United States Preventive Services Task Force (USPSTF) concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening all elderly or vulnerable adults (physically or mentally dysfunctional) for abuse and neglect (I statement).

Though the USPTFS does not support elder maltreatment screening, it is important to remember that absence of hard evidence supporting screening is not evidence that it is not effective. There have been many qualitative reports that do support the benefits of screening. Expert consensus and public policy for mandatory reporting support the value of screening this vulnerable population.

# III. Beta Testing Results

**Introduction**

The purpose of this document is to demonstrate testing results for *Elder Maltreatment Screen and Follow-up* related to Overall Reliability, Inter-Rater Reliability, Validity, and the Analysis of Claims Data. Performance Data may be derived through analysis of Claims Data and has been stratified by provider, patient age, race, ethnicity, urban/rural, underserved/non-underserved, and CMS Region.

**Reliability Testing**

**Measure Tested**: NQF Measure # N/A

**Type of Test**: Beta

**Areas of Testing**: Outpatient eligible professional office

**Study Objectives**: Test the reliability of G code reporting by eligible professionals

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**Reliability Methods:**

1. Quality Insights of Pennsylvania (Quality Insights) oversees the abstraction of 202 Medicare Part B claims records for 23 unique NPIs/eligible professionals who reported one of the G-codes for the measure. Quality Insights requests the medical record documentation from the NPI/eligible professional for the randomly selected encounter date. The documentation is abstracted and a G-code is assigned by two registered nurse (RN) abstractors, one from Quality Insights and one from ALPS Services, Inc. (ALPS), an independent reviewer contracted with Quality Insights, according to the measure specifications.

Upon completion of the abstraction, Quality Insights’ analytic staff compares the G-code assigned by the Quality Insights RN abstractor to the G-code assigned by the ALPS RN abstractor. Additionally, G-codes assigned by the ALPS RN are compared to the G-codes assigned by the NPI/eligible professional on the Medicare Part B claims record. Crude agreement rates, Prevalence Adjusted Kappa (PAK) and Kappa scores are calculated to assess the reliability of the measure. Records not meeting denominator eligibility are removed.

1. **Data Collection Methods:** Quality Insights completed an ad hoc data request for Medicare Part B claims data for G-codes G8733, G8734, G8536, G8735 and G8535 for the time period of 1/1/2010 – 6/30/2010. Eligible professionals were randomly selected and mailed a letter requesting that they provide the documentation to support the assignment of the numerator/G code submitted on the claim. For each unique case, an RN abstracted the documentation and assigned a G code which was entered into a database for compilation and analysis.
2. **Brief Description of** **Data:**  Time period: 1/1/2010 – 6/30/2010

Claim Type: Medicare Claim Carrier (B)

**Criteria:** Any G-code code in the following string: G8733, G8734, G8535, G8536 or G8735

**Description of test population:** Eligible professionals (EPs) who reported the measure for PQRS were identified through claims data. Twenty-three (23) EPs were identified, reporting a total of 558 claims.

The entire population of 23 EPs was used for reliability testing. A maximum of 15 records from each EP were randomly selected. This limitation was set so that the providers would not see this task as too burdensome and would be more likely to send in their records. The resulting sample was comprised of 216 claims.

Providers were mailed a letter requesting that they provide the documentation to support the assignment of the numerator code that they had submitted on the claim.

Documentation for 202 claims was received and reviewed.

**Number and distribution of test sites:**  A total of 202 records were reviewed for 23 providers.

**Data Sampling Response Rates –** Describes the population sampling methodology.

|  |  |  |
| --- | --- | --- |
|  | **Number** | **Return Rate** |
| **Records Requested/Returned/Reviewed** | 216/202/202 | 93.5% |
| **Providers Requested/Returned/Reviewed** | 23/23/23 | 100% |

1. **Brief Description of Analytic Methods Used:** Crude agreement rates were calculated along with kappa values and corresponding confidence intervals. Cohen’s kappa represents chance-corrected proportional agreement. High prevalence of responses in a small number of cells is known to produce unexpected results known as the “kappa paradox”\*\*. When the prevalence of a rating in the population is very high or low, the value of kappa may indicate poor reliability even with a high observed proportion of agreement. Prevalence Adjusted Kappa (PAK) is shown to provide an additional interpretation of agreement when the prevalence of responses is concentrated in a small number of cells.

Landis and Koch (1977) have proposed the following as standards for strength of agreement for the kappa coefficient: [less than or equal to] 0=poor, .01-.20=slight, .21-.40=fair, .41.-60=moderate, .61-.80=substantial and .81-1=almost perfect (high). These categories are informal.

\*Landis, J.R.; & Koch, G.G. (1977). ["The measurement of observer agreement for categorical data"](http://jstor.org/stable/2529310). *Biometrics* **33** (1): 159–174.

\*\*Feinstein AR, Cicchetti DV. High agreement but low kappa: I. The problems of two paradoxes. J Clin Epidemiol 1990;43:543-9.

\*\*Cicchetti DV, Feinstein AR. High agreement but low kappa: II. Resolving the paradoxes. J Clin Epidemiol 1990;43:551-8.

**Performance Calculation:** For performance purposes, this measure is calculated by creating a fraction with the following components: Numerator, Performance Denominator and Denominator Exclusions.

**Numerator (A) Includes:** Number of patients meeting numerator criteria

**Performance Denominator (PD) Includes:** Number of patients meeting criteria for denominator inclusion

**Denominator Exclusions (B) Include:** Number of patients with valid denominator exclusions

The method of performance calculation is determined by the following: identify the patients who meet the eligibility criteria for the denominator **(PD)** which includes patients who are 18 years and older with any of the following CPT© (See page 6 for copyright information) codes during the reporting period: 90801, 90802, 96116, 96150, 97001, 97003, 98940, 98941, 98942, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0101, G0402, G0438, G0439 and identify which of those patients meet the numerator criteria (G8733, G8734) **(A)** and for those patients who do not meet the numerator criteria, determine whether an appropriate exclusion applies (G8535) **(B)** and subtract those patients from the denominator.

**Numerator (A)**

**Performance Denominator (PD) - Denominator Exclusions (B)**

**Exclusion Calculation –** The percentage of Denominator Valid **(PD)** patients with Denominator Exclusions **(B)** as calculated by the following:

**Denominator Exclusions (B)**

**Performance Denominator (PD)**

**E. Description of Reporting G Codes**

|  |  |  |
| --- | --- | --- |
|  | **Code** | **Description** |
| **Meets Numerator Criteria (Numerator) (A)** | G8733 G8734 | **G8733:** Documentation of a positive elder maltreatment screen and documented follow-up plan  **G8734:** Elder maltreatment screen documented as negative, no follow-up required |
| **Does Not Meet Numerator Criteria** | G8536 G8735 | **G8536:** No documentation of an elder maltreatment screen, reason not specified  **G8735:** Elder maltreatment screen documented as positive, follow-up plan not documented, reason not specified |
| **Performance Denominator (PD)** | G8733 G8734  G8736 G8735 |  |
| **Denominator Exclusions (B)** | G8535 | **G8535:** No documentation of an elder maltreatment screen, patient not eligible |

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directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability

for data contained or not contained herein.

# F. Overall Reliability Results: Describes claims versus ALPS abstractor agreement rates, Kappa & applicable Prevalence-Adjusted Kappa (PAK) values, and confidence intervals for the measure.

**Claims vs. ALPS Agreement**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **% Agreement Rate** | **Prevalence Adjusted Kappa (Kappa)** | **95% CI** |
| **Meets Numerator Criteria** | 22.8% | .14  (.05) | .09 - .19  (.03 - .08) |
| **Performance Exclusion** | 95.0% | .90  (.00) | .84 - .96  (-0.0 - 0.0) |

**G. Inter-Rater Reliability Results:** Describes the degree of agreement or concordance among raters.

**Inter-Rater Reliability Methods:** A Quality Insights RN re-abstracts cases abstracted by ALPS to assess inter-rater reliability. Upon completion of re-abstraction, Quality Insights’ analytic staff compares the G codes assigned by the Quality Insights RN to the G codes assigned by the ALPS RN. Crude agreement rates and Kappa scores are calculated to assess the reviewer reliability. Where the prevalence of responses is concentrated in a small number of cells, Prevalence Adjusted Kappa (PAK) is shown. Records not meeting denominator eligibility are excluded.

**Overall Inter-Rater Reliability Results**

Describes overall inter-rater reliability results between ALPS and Quality Insights abstractors.

**ALPS vs. Quality Insights**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **% Agreement Rate** | **Prevalence Adjusted Kappa (Kappa)** | **95% CI** |
| **Meets Numerator Criteria** | 94.3% | .92  (.77) | .82 - 1.00  (.53 - 1.00) |
| **Performance Exclusion** | 100.0% | n/a  (n/a) | n/a  (n/a – n/a) |

**H. Overall Reliability & Inter-Rater Reliability Summary:**  Agreement rates suggest very good reliability based on 2 independent reviews of the submitted documentation.

The disparate agreement rates observed between IRR vs Claims suggest that providers are using a broad interpretation of what needs to be included in the medical record to document the eight components that comprise the screening

**Validity**

Quality Insights of Pennsylvania conducts an Environmental Scan to evaluate the most current research and evidence-based guidelines. The TEP, composed of subject matter specialists and experts with technical measure expertise evaluates the results of the review and provides recommendations based on the scientific merits of the evidence using the Strength of Recommendation Taxonomy (SORT). The TEP also reviews and establishes the measure’s ability to capture what it is designed to capture using a consensus process.

The initial measure development process included alpha-testing in the field with select providers and a public comment period. During the Reliability Testing, Quality Insights again convened a TEP for Environmental Scan review as well as a detailed analysis of beta testing results. Based on the process of multiple stakeholder input, expert panel discussion and public comment, face and content validity of CMS/Quality Insights measures can be assumed to be established.

**Analysis of Claims Data**

Claims data consists of all Medicare Part B claims submitted from 1/1/2010 to 6/30/2010 with one of the numerator G codes for this measure. The G code submissions are voluntary and providers who report may not be representative of all eligible professionals. Performance rates cannot be generalized to the population.

1. **Quality Indicator Performance**

|  |  |  |
| --- | --- | --- |
|  | **1/1/2010-6/30/2010** | |
| **Total Claims Submitted** | 558 |  |
| **Valid Denominator Criteria** | 558 | 100% of total |
| **Performance Exclusion** | 19 | 3.4% of valid |
| **Measure Performance Rate** | 520 / 539 | 96.5% |

1. **Performance Variation by Eligible Professional:** Describes the variation of measure scores by discrete National Provider Identification (NPI).

|  |  |
| --- | --- |
|  | **1/1/2010-6/30/2010** |
| **N (# of NPIs)** | 23 |
| **Mean Measure Score** | 16.8% |
| **Standard Deviation** | .37 |
| **Min/Max** | 0/100% |
| **90th percentile** | 100% |
| **75th percentile** | 100% |
| **50th percentile** | 0.0% |

The reporting providers do not represent all eligible professionals. The true variation in performance could be greater or smaller than what is derived from claims submitted for the Physician Quality Reporting System (formerly PQRI).

1. **Performance Rates by Category:** Describes the number and percentage of claims submitted indicating a pass status in meeting the measure performance criteria as based on the G codes reported between 1/1/2010-6/30/2010.

***Rural/Urban***: The rural/urban category is based on practice location. The practice location was determined using the NPI Registry. Zip codes were matched to the CMS “Zip Code to Carrier Locality File” (<http://www.cms.hhs.gov/ProspMedicareFeeSvcPmtGen/>) to determine urban and rural settings.

***Gender***: The gender category is defined by the patient’s gender designation.

***Non-Underserved/Underserved***: The underserved category is defined by the racial and ethnic designations of African Americans, Asian Americans, Hispanics, and Native Americans. Not all records used in the analysis had race identified.

1. **Performance By Patient Race:** Describes the number and percentage of claims submitted indicating a pass status in meeting the measure performance criteria as based on the G codes reported between 1/1/2010-6/30/2010.

[See Table on next page]

1. **Performance By Patient Age:** Describes the number and percentage of claims submitted indicating a pass status in meeting the measure performance criteria as based on the G Code reported between 1/1/2010-6/30/2010.

**F. Number of Claims Submitted by Classification of Eligible Professional:** Describes the number of claims submitted for the measure by eligible professional Type and Classification, as reported in the NPI registry, between 1/1/2010-6/30/2010.

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **# Claims Submitted** | |
|  |  | **1/1/2010 - 6/3/2010** | |
| **Classification** | **Type** | **#** | **% of total** |
| Psychologist | Behavioral Health & Social Service Providers | 536 | 96.06% |
| Psychiatry & Neurology | Allopathic & Osteopathic Physicians | 20 | 3.58% |
| Internal Medicine | Allopathic & Osteopathic Physicians | 1 | 0.18% |
| Social Worker | Behavioral Health & Social Service Providers | 1 | 0.18% |
| **TOTAL** | | 558 | 100.00% |

**G. Number of Eligible Professionals Reporting by Classification:** Describes the number of eligible professionals (identified by NPI) submitting any claims for the measure by Type and Classification, as reported in the NPI registry, for comparison between 1/1/2010-6/30/2010.

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **# of NPIs** | |
|  |  | **1/1/2010 - 6/30/2010** | |
| **Classification** | **Type** | **#** | **% of total** |
| Psychologist | Behavioral Health & Social Service Providers | 29 | 82.86% |
| Psychiatry & Neurology | Allopathic & Osteopathic Physicians | 4 | 11.43% |
| Internal Medicine | Allopathic & Osteopathic Physicians | 1 | 2.86% |
| Social Worker | Behavioral Health & Social Service Providers | 1 | 2.86% |
| **TOTAL** | | 35 | 100.00% |

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