



## Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to subcriterion 1b).

### Brief Measure Information

**NQF #:** 2426

**De.2. Measure Title:** Elder Maltreatment Screening and Follow-Up Plan

**Co.1.1. Measure Steward:** Centers for Medicare & Medicaid Services

**De.3. Brief Description of Measure:** 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

**1b.1. Developer Rationale:** The aim of this quality measure is to assist eligible providers to identify suspected cases of elder maltreatment and refer these cases to the appropriate agency(s) for assessment and/or intervention for those who are being abused will receive services to stop the abuse. Elder maltreatment is prevalent and underreported. As a result of this, there is an increased rate of hospitalization and use of healthcare resources. 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. Ultimately, halting abuse will improve the quality of life for these individuals and reduce the cost and use of healthcare resources.

**S.4. Numerator Statement:** 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

**S.7. Denominator Statement:** All patients aged 65 years and older

**S.10. Denominator Exclusions:** 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

**De.1. Measure Type:** Process

**S.23. Data Source:** Administrative claims, Paper Medical Records

**S.26. Level of Analysis:** Clinician : Group/Practice, Clinician : Individual

**IF Endorsement Maintenance – Original Endorsement Date: Most Recent Endorsement Date:**

**IF this measure is included in a composite, NQF Composite#/title:**

**IF this measure is paired/grouped, NQF#/title:**

**De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results?** Not paired

### 1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. **Measures must be judged to meet all subcriteria to pass this criterion and be evaluated against the remaining criteria.**

**1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form**  
Elder\_Maltreatment\_MeasSubm\_Evidence.docx

## 1b. Performance Gap

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- disparities in care across population groups.

### 1b.1. Briefly explain the rationale for this measure (e.g., the benefits or improvements in quality envisioned by use of this measure)

The aim of this quality measure is to assist eligible providers to identify suspected cases of elder maltreatment and refer these cases to the appropriate agency(s) for assessment and/or intervention for those who are being abused will receive services to stop the abuse. Elder maltreatment is prevalent and underreported. As a result of this, there is an increased rate of hospitalization and use of healthcare resources. 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. Ultimately, halting abuse will improve the quality of life for these individuals and reduce the cost and use of healthcare resources.

**1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis.** (This is required for endorsement maintenance. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included). This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.

N/A

**1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.**

N/A

**1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability.** (This is required for endorsement maintenance. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.

N/A

**1b.5. If no or limited data on disparities from the measure as specified is reported in 1b4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations.**

N/A

## 1c. High Priority (previously referred to as High Impact)

The measure addresses:

- a specific national health goal/priority identified by DHHS or the National Priorities Partnership convened by NQF; OR
- a demonstrated high-priority (high-impact) aspect of healthcare (e.g., affects large numbers of patients and/or has a substantial impact for a smaller population; leading cause of morbidity/mortality; high resource use (current and/or future); severity of illness; and severity of patient/societal consequences of poor quality).

### 1c.1. Demonstrated high priority aspect of healthcare

Affects large numbers, High resource use

### 1c.2. If Other:

**1c.3. Provide epidemiologic or resource use data that demonstrates the measure addresses a high priority aspect of healthcare. List citations in 1c.4.**

"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.

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 those who are being abused and neglected.

#### 1c.4. Citations for data demonstrating high priority provided in 1a.3

Acierno, R., Hernandez, M.A., Amstadter, A.B., Resnick, H.S., Steve, K., Muzzy, W. & Kilpatrick, D.G. (2010). Prevalence and correlates of emotional, physical, sexual, and financial abuse and potential neglect in the United States: The national elder mistreatment study. *American Journal of Public Health*, 100, 292–297. doi:10.2105/AJPH.2009.163089

American Psychological Association (2013). Elder Abuse and Neglect: In Search of Solutions. Retrieved from <http://www.apa.org/pi/aging/resources/guides/elder-abuse.aspx>

American Psychological Association (2010). Elder Abuse and Neglect: In Search of Solutions. Retrieved from <http://www.apa.org/pi/aging/resources/guides/elder-abuse.aspx>

Cohen, M. (2011). Screening tools for the identification of elder abuse. *Journal of Clinical Outcomes Management*. 18(6), 261-270

Dong, X., & Simon, M. A. (2011). Enhancing national policy and programs to address elder abuse. *JAMA: The Journal of the American Medical Association*, 305(23), 2460-2461. doi: 10.1001/jama.2011.835.

Dong, X. & Simon, M.A. (2013). Elder abuse as a risk factor for hospitalization in older persons. *JAMA: The Journal of the American Medical Association*. doi:10.1001/jamainternmed.2013.238

Dong, X., Simon, M., Mendes de Leon, C., Fulmer, T., Beck, T., Hebert, L., . . . Evans, D. (2009). Elder self-neglect and abuse and mortality risk in a community-dwelling population. *JAMA : The Journal of the American Medical Association*, 302(5), 517-526. doi: 10.1001/jama.2009.1109.

**1c.5. If a PRO-PM (e.g. HRQoL/functional status, symptom/burden, experience with care, health-related behaviors), provide evidence that the target population values the measured PRO and finds it meaningful. (Describe how and from whom their input was obtained.)**

N/A

## 2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. ***Measures must be judged to meet the subcriteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.***

**2a.1. Specifications** The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

**De.5. Subject/Topic Area** (check all the areas that apply):

Behavioral Health, Behavioral Health : Screening, Mental Health : Domestic Violence

**De.6. Cross Cutting Areas** (check all the areas that apply):

Prevention : Screening, Safety

**S.1. Measure-specific Web Page** (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to

general information.)

Under the subheading “Individual Measures” select the link entitled “2014 PQRS Individual Claims Registry Measure Specification Supporting Document; this link will open a zip file containing the 2014 PQRS measure specifications

**S.2a. If this is an eMeasure**, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

**Attachment:**

**S.2b. Data Dictionary, Code Table, or Value Sets** (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)

**Attachment Attachment:** [Data\\_Dictionary-Code\\_Descriptions-635254597070481973.xlsx](#)

**S.3. For endorsement maintenance**, please briefly describe any changes to the measure specifications since last endorsement date and explain the reasons.

**S.4. Numerator Statement** (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome)

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.

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

**S.5. Time Period for Data** (What is the time period in which data will be aggregated for the measure, e.g., 12 mo, 3 years, look back to August for flu vaccination? Note if there are different time periods for the numerator and denominator.)

This measure is to be reported once during the reporting period for patients seen during the reporting period. The reporting period is 12 months from January 1st to December 31st

**S.6. Numerator Details** (All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.

**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.

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 Locator: 1-800-677-1116 [www.eldercare.gov](http://www.eldercare.gov)
3. National Center on Elder Abuse [http://www.ncea.aoa.gov/NCEARoot/Main\\_Site/Find\\_Help/State\\_Resources.aspx](http://www.ncea.aoa.gov/NCEARoot/Main_Site/Find_Help/State_Resources.aspx)

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

1. Patient refuses to participate
2. 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).

G-codes are defined as Quality Data Codes (QDCs), which are subset of HCPCS II codes. QDCs are non billable codes that providers will use to delineate their clinical quality actions, which are submitted with Medicare Part B Claims. There are 6 G-code options for this measure

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

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

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

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

**S.7. Denominator Statement** (Brief, narrative description of the target population being measured)

All patients aged 65 years and older

**S.8. Target Population Category** (Check all the populations for which the measure is specified and tested if any):

Senior Care

**S.9. Denominator Details** (All information required to identify and calculate the target population/denominator such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

Patients aged = 65 years on date of encounter. 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

**S.10. Denominator Exclusions** *(Brief narrative description of exclusions from the target population)*

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

**S.11. Denominator Exclusion Details** *(All information required to identify and calculate exclusions from the denominator such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)*

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

**S.12. Stratification Details/Variables** *(All information required to stratify the measure results including the stratification variables, definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b)*

Not stratified

**S.13. Risk Adjustment Type** *(Select type. Provide specifications for risk stratification in S.12 and for statistical model in S.14-15)*

No risk adjustment or risk stratification

If other:

**S.14. Identify the statistical risk model method and variables** *(Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development and testing should be addressed with measure testing under Scientific Acceptability)*

No risk model

**S.15. Detailed risk model specifications** *(must be in attached data dictionary/code list Excel or csv file. Also indicate if available at measure-specific URL identified in S.1.)*

Note: Risk model details (including coefficients, equations, codes with descriptors, definitions), should be provided on a separate worksheet in the suggested format in the Excel or csv file with data dictionary/code lists at S.2b.

**S.15a. Detailed risk model specifications** *(if not provided in excel or csv file at S.2b)*

**S.16. Type of score:**

Rate/proportion

If other:

**S.17. Interpretation of Score** *(Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)*

Better quality = Higher score

**S.18. Calculation Algorithm/Measure Logic** *(Describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; aggregating data; risk adjustment; etc.)*

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: 1) identify the patients who meet the eligibility criteria for the denominator (PD) which includes patients who are 65 years and older with an appropriate encounter, 2) identify which of those patients meet the numerator criteria (A); and 3) for those patients who do not meet the numerator criteria, determine whether an appropriate exclusion applies (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).



## Denominator Exclusions (B)/ Performance Denominator (PD)

**S.19. Calculation Algorithm/Measure Logic Diagram URL or Attachment** (You also may provide a diagram of the Calculation Algorithm/Measure Logic described above at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)  
No diagram provided

**S.20. Sampling** (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF a PRO-PM, identify whether (and how) proxy responses are allowed.

Based on the entire population of providers reporting this measure with a total of 558 valid claims, it was decided that the entire population of providers would be sampled for the reliability testing. A maximum of 15 records were randomly selected from the population. 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. A simple random sample of records for the 23 NPIs was drawn. From those 23 NPIs, a random sample of approximately 216 claims was identified.

**S.21. Survey/Patient-reported data** (If measure is based on a survey, provide instructions for conducting the survey and guidance on minimum response rate.)

IF a PRO-PM, specify calculation of response rates to be reported with performance measure results.

N/A

**S.22. Missing data** (specify how missing data are handled, e.g., imputation, delete case.)

Required for Composites and PRO-PMs.

N/A

**S.23. Data Source** (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.24.

Administrative claims, Paper Medical Records

**S.24. Data Source or Collection Instrument** (Identify the specific data source/data collection instrument e.g. name of database, clinical registry, collection instrument, etc.)

IF a PRO-PM, identify the specific PROM(s); and standard methods, modes, and languages of administration.

Medicare Part B claims data

**S.25. Data Source or Collection Instrument** (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

No data collection instrument provided

**S.26. Level of Analysis** (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

Clinician : Group/Practice, Clinician : Individual

**S.27. Care Setting** (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient

If other:

**S.28. COMPOSITE Performance Measure** - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

**2a. Reliability** – See attached Measure Testing Submission Form

**2b. Validity** – See attached Measure Testing Submission Form

Elder\_maltreatment\_MeasSubm\_MeasTesting.docx

## 3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without

undue burden and can be implemented for performance measurement.

### 3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

#### 3a.1. Data Elements Generated as Byproduct of Care Processes.

Generated or collected by and used by healthcare personnel during the provision of care (e.g., blood pressure, lab value, diagnosis, depression score), Coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims), Abstracted from a record by someone other than person obtaining original information (e.g., chart abstraction for quality measure or registry)

If other:

### 3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

**3b.1. To what extent are the specified data elements available electronically in defined fields?** (*i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields*)

No data elements are in defined fields in electronic sources

**3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources.**

Some data elements are in electronic sources... For this test in 2010, the majority of providers were still documenting on a paper based product.

**3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL.**

Attachment:

### 3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

**3c.1. Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.**

**IF a PRO-PM, consider implications for both individuals providing PROM data (patients, service recipients, respondents) and those whose performance is being measured.**

Quality Insights of Pennsylvania (Quality Insights obtained data 202 randomly generated Medicare Part B claims records for all 23 unique NPIs/eligible professionals who reported one of the G-codes for the measure during the 1/1/2010 – 6/30/2010 time period. As stated in 2a2.4 reliability testing demonstrated disparate agreement rates observed between IRR vs. Claims. This disparity suggests 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. Modifications have been made to the specifications which are intended to improve claims reliability. These changes are being applied to the 2014 version of the specifications.

Lessons Learned from operational use Underutilization of this measure was thought to be the result of a poorly defined 'follow-up plan' and the requirement that the patient screening included all 8 components of abuse. In addition, no single tool exists no screening tool exists which addresses all 8 types of abuse which adds burden to the implementation of the measure. Also, there was no requirement for the use of an Elder Maltreatment screening tool. As a result of these findings, the following modifications were made to the measure: (1)'self-neglect' was removed as a screening component due to the discordant nature of this form of abuse as compared to the other 7 types of abuse (self abuse vs. abuse by another individual), (2) removed the requirement that all types of abuse must be part of the screening process allowing the practitioner to select from a number of available screening tools (examples of elder abuse screening tools which were vetted by subject matter experts in the Elder Maltreatment Technical Expert Panel (TEP)) and (3) the follow-up plan was modified to include a report to a state or local Adult Protective Services or another appropriate state



or federal agency as guided by law for positive screens. In addition, state specific contact information (organization names, websites, phone numbers) were included to facilitate the reporting process.

**3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (e.g., value/code set, risk model, programming code, algorithm).**

N/A

## 4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

### 4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

#### 4.1. Current and Planned Use

*NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.*

Planned	Current Use (for current use provide URL)
	<a href="http://www.cms.gov/PQRS">Public Reporting Physician Quality Reporting System</a> <a href="http://www.cms.gov/PQRS">http://www.cms.gov/PQRS</a>
	<a href="http://www.cms.gov/PQRS">Payment Program Physician Quality Reporting System</a> <a href="http://www.cms.gov/PQRS">http://www.cms.gov/PQRS</a>

#### 4a.1. For each CURRENT use, checked above, provide:

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included

**Public Use:** [Physician Quality Reporting System](http://www.cms.gov/PQRS) is sponsored by Centers for Medicare and Medicaid Services; PQRS is a national reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals (EPs). The program provides an incentive payment to practices with EPs. EPs satisfactorily report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries.

Refer to the following link for additional information: <http://www.cms.gov/PQRS>

**4a.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)**

N/A

**4a.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)**

N/A

### 4b. Improvement

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

**4b.1. Progress on Improvement. (Not required for initial endorsement unless available.)**

Performance results on this measure (current and over time) should be provided in 1b.2 and 1b.4. Discuss:

- Progress (trends in performance results, number and percentage of people receiving high-quality healthcare)
- Geographic area and number and percentage of accountable entities and patients included

N/A

**4b.2. If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.**

N/A

**4c. Unintended Consequences**

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

**4c.1. Were any unintended negative consequences to individuals or populations identified during testing; OR has evidence of unintended negative consequences to individuals or populations been reported since implementation? If so, identify the negative unintended consequences and describe how benefits outweigh them or actions taken to mitigate them.**

No

## 5. Comparison to Related or Competing Measures

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

**5. Relation to Other NQF-endorsed Measures**

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.

No

**5.1a. List of related or competing measures (selected from NQF-endorsed measures)**

**5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.**

**5a. Harmonization**

The measure specifications are harmonized with related measures;

**OR**

The differences in specifications are justified

**5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):**

**Are the measure specifications completely harmonized?**

**5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.**

**5b. Competing Measures**

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

**OR**

Multiple measures are justified.

**5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):**

**Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)**

## Appendix

**A.1 Supplemental materials may be provided in an appendix.** All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

**Attachment** [Attachment: Elder\\_Maltreatment\\_Summary\\_Materials-635255523288135916.docx](#)

## Contact Information

**Co.1 Measure Steward (Intellectual Property Owner):** Centers for Medicare & Medicaid Services

**Co.2 Point of Contact:** Helen, Dollar-Maples, [Helen.Dollar-Maples@cms.hhs.gov](mailto:Helen.Dollar-Maples@cms.hhs.gov), 410-786-7214-

**Co.3 Measure Developer if different from Measure Steward:** Centers for Medicare & Medicaid

**Co.4 Point of Contact:** Sophia, Autrey, [sophia.autrey@cms.hhs.gov](mailto:sophia.autrey@cms.hhs.gov), 410-786-2004-

## Additional Information

**Ad.1 Workgroup/Expert Panel involved in measure development**

**Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.**

Through a collaborative process, the Technical Expert Panel (TEP) reviewed the current 2013 measure specifications (description, numerator, denominator, definitions, clinical recommendation, and environmental scan); reviewed and considered the Beta Testing results, analysis, finding and recommendations based on testing.

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**Measure Developer/Steward Updates and Ongoing Maintenance**

**Ad.2 Year the measure was first released:** 2009

**Ad.3 Month and Year of most recent revision:** 09, 2013

**Ad.4 What is your frequency for review/update of this measure?** Annually

**Ad.5 When is the next scheduled review/update for this measure?** 08, 2014

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**Ad.8 Additional Information/Comments:**