**National Quality Forum—Evidence (subcriterion 1a)**

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

**IF the measure is a component in a composite performance measure, provide the title of the Composite Measure here:** Click here to enter composite measure title

**Date of Submission**: 1/17/2014

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| **Instructions**  *For composite performance measures:*  *A separate evidence form is required for each component measure unless several components were studied together.*  *If a component measure is submitted as an individual performance measure, attach the evidence form to the individual measure submission.*   * Respond to all questions as instructed with answers immediately following the question. All information needed to demonstrate meeting the evidence subcriterion (1a) must be in this form. An appendix of *supplemental* materials may be submitted, but there is no guarantee it will be reviewed. * If you are unable to check a box, please highlight or shade the box for your response. * Maximum of 10 pages (*incudes questions/instructions*; minimum font size 11 pt.; do not change margins). ***Contact NQF staff if more pages are needed.*** * Contact NQF staff regarding questions. Check for resources at [Submitting Standards webpage](http://www.qualityforum.org/Measuring_Performance/Submitting_Standards.aspx). |

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| **Note: The information provided in this form is intended to aid the Steering Committee and other stakeholders in understanding to what degree the evidence for this measure meets NQF’s evaluation criteria.**  **Subcriterion 1a.** **Evidence to Support the Measure Focus**  The measure focus is a health outcome or is evidence-based, demonstrated as follows:   * Health outcome:**[3](#Note3)** a rationale supports the relationship of the health outcome to processes or structures of care. * Intermediate clinical outcome, Process,**[4](#Note4)** or Structure: a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence[**5**](#Note5)that the measure focus leads to a desired health outcome. * Patient experience with care: evidence that the measured aspects of care are those valued by patients and for which the patient is the best and/or only source of information OR that patient experience with care is correlated with desired outcomes. * Efficiency:**[6](#Note6)** evidence for the quality component as noted above.   **Notes**  **3.** Generally, rare event outcomes do not provide adequate information for improvement or discrimination; however, serious reportable events that are compared to zero are appropriate outcomes for public reporting and quality improvement.  **4.** Clinical care processes typically include multiple steps: assess → identify problem/potential problem → choose/plan intervention (with patient input) → provide intervention → evaluate impact on health status. If the measure focus is one step in such a multistep process, the step with the strongest evidence for the link to the desired outcome should be selected as the focus of measurement.  **5.** The preferred systems for grading the evidence are the U.S. Preventive Services Task Force (USPSTF) [grading definitions](http://www.uspreventiveservicestaskforce.org/uspstf/grades.htm) and [methods](http://www.uspreventiveservicestaskforce.org/methods.htm), or Grading of Recommendations, Assessment, Development and Evaluation [(GRADE) guidelines](http://www.gradeworkinggroup.org/publications/index.htm).  **6.** Measures of efficiency combine the concepts of resource use and quality (NQF’s [Measurement Framework: Evaluating Efficiency Across Episodes of Care](http://www.qualityforum.org/Publications/2010/01/Measurement_Framework__Evaluating_Efficiency_Across_Patient-Focused_Episodes_of_Care.aspx); [AQA Principles of Efficiency Measures](http://www.aqaalliance.org/files/PrinciplesofEfficiencyMeasurementApril2006.doc)). |

**1a.1.This is a measure of**:

Outcome

☐ Health outcome: Click here to name the health outcome

*Health outcome includes patient-reported outcomes (PRO, i.e., HRQoL/functional status, symptom/burden, experience with care, health-related behaviors)*

☐ Intermediate clinical outcome: Click here to name the intermediate outcome

☒ Process: Screening for elder maltreatment and documenting a follow up plan

☐ Structure: Click here to name the structure

☐ Other: Click here to name what is being measured

**HEALTH OUTCOME PERFORMANCE MEASURE**  *If not a health outcome, skip to* [*1a.3*](#Section1a3)

**1a.2.** **Briefly state or diagram the linkage between the health outcome (or PRO) and the healthcare structures, processes, interventions, or services that influence it**

**1a.2.1.** **State the rationale supporting the relationship between the health outcome (or PRO) and at least one healthcare structure, process, intervention, or service**.

*Note: For health outcome performance measures, no further information is required; however, you may provide evidence for any of the structures, processes, interventions, or service identified above.*

**intermediate outcome, PROCESS, or STRUCTURE PERFORMANCE measure**

**1a.3.****Briefly state or diagram the linkages between structure, process, intermediate outcome, and health outcomes**. Include all the steps between the measure focus and the health outcome.

1. Identified suspected risk of current elder maltreatment
2. Report to appropriate local or state Adult Protective Services (or federal agency as appropriate for nursing home residents )for assessment and possible intervention
3. Assessment/Potential intervention to improve the health and well-being of the patient and less use of healthcare resources.

**1a.3.1.** **What is the source of the systematic review of the body of evidence that supports the performance measure?**

☐ Clinical Practice Guideline recommendation – ***complete sections*** [***1a.4***](#Section1a4)***, and*** [***1a.7***](#Section1a7)

☒ US Preventive Services Task Force Recommendation – ***complete sections*** [***1a.5***](#Section1a5) ***and*** [***1a.7***](#Section1a7)

☐ Other systematic review and grading of the body of evidence (*e.g., Cochrane Collaboration, AHRQ Evidence Practice Center*) – ***complete sections*** [***1a.6***](#Section1a6) ***and*** [***1a.7***](#Section1a7)

☒ Other – ***complete section*** [***1a.8***](#Section1a8)

*Please complete the sections indicated above for the source of evidence. You may skip the sections that do not apply.*

**1a.4. CLINICAL PRACTICE GUIDELINE RECOMMENDATION**

**1a.4.1.** **Guideline citation** (*including date*) and **URL for guideline** (*if available online*):

**1a.4.2.** **Identify guideline recommendation number and/or page number** and **quote verbatim, the specific guideline recommendation**.

**1a.4.3.** **Grade assigned to the quoted recommendation with definition of the grade:**

**1a.4.4. Provide all other grades and associated definitions for recommendations in the grading system.** (*Note: If separate grades for the strength of the evidence, report them in section 1a.7.*)

**1a.4.5. Citation and URL for methodology for grading recommendations** (*if different from 1a.4.1*)**:**

**1a.4.6. If guideline is evidence-based (rather than expert opinion), are the details of the quantity, quality, and consistency of the body of evidence available (e.g., evidence tables)?**

☐Yes **→ *complete section*** [***1a.7***](#Section1a7)

☐No **→ *report on another systematic review of the evidence in sections*** [***1a.6***](#Section1a6) ***and*** [***1a.7***](#Section1a7)***; if another review does not exist, provide what is known from the guideline review of evidence in*** [***1a.7***](#Section1a7)

**1a.5.** **UNITED STATES PREVENTIVE SERVICES TASK FORCE RECOMMENDATION**

**1a.5.1.** **Recommendation citation** (*including date*) and **URL for recommendation** (*if available online*):

*Screening for Intimate Partner Violence and Abuse of Elderly and Vulnerable Adults*, Topic Page. U.S. Preventive Services Task Force. Recommendation Statement U.S. Preventive Services Task Force Annals of Internal Medicine, 158(6), 478-487.

URL:<http://www.uspreventiveservicestaskforce.org/uspstf12/ipvelder/ipvelderfinalrs.htm>

**1a.5.2.** **Identify recommendation number and/or page number** and **quote verbatim, the specific recommendation**. No numbering provided; date is January 2013

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

**1a.5.3.** **Grade assigned to the quoted recommendation with definition of the grade**:

I statement - The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.

**1a.5.4. Provide all other grades and associated definitions for recommendations in the grading system.** (*Note: the* *grading system for the evidence should be reported in section 1a.7.*)

**A.**— The USPSTF strongly recommends that clinicians provide [the service] to eligible patients. *The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms*.

**B.**— The USPSTF recommends that clinicians provide [this service] to eligible patients. *The USPSTF found at least fair evidence that [the service] improves important health outcomes and concludes that benefits outweigh harms*.

**C.**— The USPSTF makes no recommendation for or against routine provision of [the service]. *The USPSTF found at least fair evidence that [the service] can improve health outcomes but concludes that the balance of benefits and harms is too close to justify a general recommendation*.

**D.**— The USPSTF recommends against routinely providing [the service] to asymptomatic patients. *The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits*.

**1a.5.5. Citation and URL for methodology for grading recommendations** (*if different from 1a.5.1*)**:**

URL: <http://www.uspreventiveservicestaskforce.org/uspstf/grades.htm>

***Complete section*** [***1a.7***](#Section1a7)

**1a.6. OTHER SYSTEMATIC REVIEW OF THE BODY OF EVIDENCE**

**1a.6.1.** **Citation** (*including date*) and **URL** (*if available online*):

**1a.6.2.** **Citation and** **URL for methodology for evidence review and grading** (*if different from 1a.6.1*)**:**

***Complete section*** [***1a.7***](#Section1a7)

**1a.7. FINDINGS FROM SYSTEMATIC REVIEW OF BODY OF THE EVIDENCE supporting the measure**

**1a.7.1.** **What was the specific structure, treatment, intervention, service, or intermediate outcome addressed in the evidence review?**

The information in the following questions is based on the USPSTF review cited in sections 1a.5 unless otherwise specified.

Screening women of childbearing age and elderly and vulnerable adults for intimate partner violence (IPV) and elderly and vulnerable adults for abuse and neglect was studied for its benefits of detection and early intervention. It also examined the accuracy of screening tools for identifying IPV and elder abuse.

**1a.7.2.** **Grade assigned for the quality of the quoted evidence with definition of the grade**:

The USPSTF concludes that the benefits and harms of screening elderly or vulnerable adults for abuse are uncertain, and that the balance of benefits and harms cannot be determined.

**1a.7.3. Provide all other grades and associated definitions for strength of the evidence in the grading system.**

**Levels of Certainty Regarding Net Benefit**

High**:** The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.

Moderate: The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by such factors as:

• The number, size, or quality of individual studies.

• Inconsistency of findings across individual studies.

• Limited generalizability of findings to routine primary care practice.

• Lack of coherence in the chain of evidence.

As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion Low**:** The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of:

• The limited number or size of studies.

• Important flaws in study design or methods.

• Inconsistency of findings across individual studies.

• Gaps in the chain of evidence.

• Findings not generalizable to routine primary care practice.

• Lack of information on important health outcomes.

More information may allow estimation of effects on health outcomes.

**1a.7.4.** **What is the time period covered by the body of evidence? (*provide the date range, e.g., 1990-2010*). Date range**: 2002- 2012. This includes studies of both childbearing women and vulnerable adults. The date range for evidence related only to abused and vulnerable adults is 2006-2008.

**QUANTITY AND QUALITY OF BODY OF EVIDENCE**

**1a.7.5.****How many and what type of study designs are included in the body of evidence**? (*e.g., 3 randomized controlled trials and 1 observational study*)

The vast majority of the studies in the body of evidence were conducted on women of childbearing age. The USPSTF found no valid, reliable screening tools to identify abuse of elderly or vulnerable adults in the primary care setting. The following studies were conducted on abused and vulnerable adults: (1) descriptive study and (1) screening instrument

**1a.7.6.** **What is the overall quality of evidence across studies in the body of evidence**? (*discuss the certainty or confidence in the estimates of effect particularly in relation to study factors such as design flaws, imprecision due to small numbers, indirectness of studies to the measure focus or target population*).

The information in the following questions is based on Evidence Synthesis Number 92, Screening Women for Intimate Partner Violence and Elderly and Vulnerable Adults for Abuse: Systematic Review to Update the 2004 U.S. Preventive Services Task Force Recommendation (Nelson, Bougatsos, & Blazina, 2012). URL:[*http://www.ncbi.nlm.nih.gov/books/NBK97297/pdf/TOC.pdf*](http://www.ncbi.nlm.nih.gov/books/NBK97297/pdf/TOC.pdf)

Grades for quality of evidence were developed by the USPSTF. The USPSTF grades the quality of the overall evidence for a service on a 3-point scale (good, fair, poor).

No overall grade was provided by the USPSTF or Evidence Synthesis Number 92. The quality of evidence was associated with each of 5 key questions and no RCTs or controlled observational studies were identified or met inclusion criteria for any of the key questions. The articles in the body of evidence addressing screening of the elderly for abuse and neglect were limited to two studies. See below

One diagnostic accuracy study with cross-sectional data: The screening tool Elder Abuse Suspicion Index - rated poor quality. There is conflicting information on the quality of evidence of this study. USPSTF source 1a.5 rates the quality as fair, and Nelson, Bougatsos & Blazina (2012) rate the overall quality as poor due to its low applicability and small sample size of a single study.

One descriptive retrospective study: rated poor quality.

**Definitions of Grades**

Fair: Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual studies, generalizability to routine practice, or indirect nature of the evidence on health outcomes

Poor: Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes

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**ESTIMATES OF BENEFIT AND CONSISTENCY ACROSS STUDIES IN BODY OF EVIDENCE**

**1a.7.7.** **What are the estimates of benefit—magnitude and direction of effect on outcome(s) across studies in the body of evidence**? (*e.g., ranges of percentages or odds ratios for improvement/ decline across studies, results of meta-analysis, and statistical significance*)

The USPSTF was not able to estimate the magnitude of net benefit for screening all elderly or vulnerable adults (physically or mentally dysfunctional) for abuse and neglect because there were no studies on the accuracy, effectiveness, or harms of screening.

The following information is based on the review ofEvidence Synthesis Number 92, Screening Women for Intimate Partner Violence and Elderly and Vulnerable Adults for Abuse: Systematic Review to Update the 2004 U.S. Preventive Services Task Force Recommendation (Nelson, Bougatsos, & Blazina, 2012).

URL: <http://www.ncbi.nlm.nih.gov/books/NBK97297/pdf/TOC.pdf>

No quantitative analysis, such as meta-analysis, was conducted. Summary of studies included below:

Outcome: Identified Abuse: A descriptive study of elderly abused veterans who were identified in primary care clinics and referred to case management found that 5.4 percent were reported to Adult Protective Services over a 3-year period. Case Management outcomes were varied, including conservatorship arrangements, nursing home placement, board or assisted living, remaining in the home, refusal of services as well as unknown outcomes. This study is consistent with the direction in favor of increased identification and reporting of abuse.

Outcome: Analysis of Screening Tools: A single instrument, the Elder Abuse Suspicion Index, was evaluated for diagnostic accuracy and had sensitivity and specificity of 9 to 47 percent and 75 to 97 percent, respectively, depending on the number of positive responses to specific questions. This analysis also supports the use of an elder maltreatment screening tool to identify suspected abuse.

**1a.7.8.** **What harms were studied and how do they affect the net benefit (benefits over harms)?**

There were no studies on the accuracy, effectiveness, or harms of screening.

“Although there is no direct evidence, the existing evidence about the lack of harms resulting from IPV screening suggests that the harms of screening elderly and vulnerable adults might also be small. Some potential harms of screening include shame, guilt, self-blame, fear of retaliation or abandonment by perpetrators, and the repercussions of false-positive results” (Moyer, 2013 p. 481).

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**UPDATE TO THE SYSTEMATIC REVIEW(S) OF THE BODY OF EVIDENCE**

**1a.7.9.** **If new studies have been conducted since the systematic review of the body of evidence, provide for each new study: 1) citation, 2) description, 3) results, 4) impact on conclusions of systematic review**.

**1a.8 OTHER SOURCE OF EVIDENCE**

*If source of evidence is NOT from a clinical practice guideline, USPSTF, or systematic review, please describe the evidence on which you are basing the performance measure.*

**1a.8.1** **What process was used to identify the evidence?**

1. AHRQ Guideline summary NGC-9711: *Mistreatment detection*.

Locating the best evidence in the published research is dependent on framing a focused, searchable clinical question. The PICO format—an acronym for population, intervention (or occurrence or risk factor), comparison (or control), and outcome—can frame an effective literature search. The editors enlisted the assistance of the New York University Health Sciences librarian to ensure a standardized and efficient approach to collecting evidence on clinical topics. A literature search was conducted to find the best available evidence for each clinical question addressed. The results were rated for level of evidence and sent to the respective chapter author(s) to provide possible substantiation for the nursing practice protocol being developed.

In addition to rating each literature citation as to its level of evidence, each citation was given a general classification, coded as "Risks," "Assessment," "Prevention," "Management," "Evaluation/Follow-up," or "Comprehensive." The citations were organized in a searchable database for later retrieval and output to chapter authors. All authors had to review the evidence and decide on its quality and relevance for inclusion in their chapter or protocol. They had the option, of course, to reject or not use the evidence provided as a result of the search or to dispute the applied level of evidence.

2. Elder Maltreatment and Care Symposium sponsored by Centers for Medicare and Medicaid

The Centers for Medicare and Medicaid Services (CMS) developed the Elder Maltreatment Screening Quality Measure in Physician Quality Reporting System as a vehicle to help protect CMS beneficiaries’ well-being and safety as well as demonstrate their deep commitment to their patients. Over the tenure of this measure, the Elder Maltreatment Technical Expert Panel provided Subject Matter Expert (SME) support to continue the use of the screening for Elder Maltreatment quality measure despite the lack of strong clinical evidence to align this quality measure with the NQF National Priority, healthy living and well-being.

In response to the lack of strong evidence in the literature to support screening for elder maltreatment in this NQF National Priority/ Patient Safety Project, the Centers for Medicare and Medicaid Services (CMS) began making plans to convene a national Elder Maltreatment and Care symposium for all relevant stakeholders, held on March 8, 2013.  The aim of this symposium was to assess the value of continuing the implementation and development of PQRS #181 Elder Maltreatment Screening and Follow-up Plan (Beach et al., 2013). The symposium was preceded by months of review of the literature by subject matter experts, stakeholders, researchers and policy makers.  The symposium agenda included the review of prevalence statistics, recommendations and evidence related to screening tools, discussion of controversies surrounding the benefits and harms of screening and the determination of appropriate follow-up steps for suspected elder maltreatment. At the conclusion of this symposium, it was determined there was sufficient expert consensus to support the value of screening this vulnerable population.  Although there are gaps in the science, CMS will move forward to support the further development of the standing PQRS #181 Elder Maltreatment Screening and Follow-Up Plan measure (T. McMullen & K. Schwartz, personal communication, January 17, 2014).

In support of this conclusion, there have been many qualitative reports on the benefits of screening and recommendations by stakeholder organizations for screening for IPV in all patients. Some groups have specific, targeted opinion statements/recommendations on screening for all forms of abuse, including screening all elderly patients for abusive or violent treatment by family, caretakers, or others. The American Medical Association and the American Academy of Neurology both have specific position statements on screening elderly patients for abuse (Moyer, 2012). As a subset to screening all elderly patients for abuse, the Agency for Healthcare Research and Quality (AHRQ), NGC-008596 Elder Abuse Prevention (Daly, 2010), supports screening of potential victims with screening tools, and identifies specific elder maltreatment screening tools. In addition, there are studies reporting elder maltreatment is prevalent and rate of prevalence is underreported.

“It is important to remember that incompleteness of gold standard criteria, does not suggest  there is no evidence at all supporting the screening of  elder abuse” (X. Dong, personal communication, December 20, 2013).

3. Institute of Medicine: Elder Abuse and Its Prevention Workshop Summary, Forum on Global Violence Prevention

The 2-day workshop was dedicated to elder abuse and its prevention to shed light on an underappreciated and frequently overlooked form of violence. The aim was to move beyond what is known and foster discussions on ways to improve prevention, intervention and mitigation of the victims’ needs through collaborative efforts.

4. AHRQ Guideline summary NGC-8569: Elder abuse prevention.

**Description of Methods Used to Collect/Select the Evidence**

To determine the current status and quality of elder abuse research, a comprehensive review of the health sciences literature was performed. An expert reference librarian conducted the electronic search with input from study investigators. Sixteen databases were searched: AgeLine Database; American Theological Library Association (ATLA) Religion Database with AtlaSerials; Cochrane Database of Systematic Reviews; Cumulative Index to Nursing and Allied Health Literature (CINAHL) Plus; Education Resources Information Center (ERIC); Index to Legal Periodicals; LegalTrac; LexisNexis Academic; LexisNexis Government Periodicals Index; National Criminal Justice Reference Service (N CJRS) Abstracts Database; PsycINFO; PubMed, which included MEDLINE; Social Work Abstracts; and the Web of Science three indexes: Social Sciences Citation Index (SSCI), Science Citation Index Expanded (SCI-EXPANDED), and the Arts & Humanities Citation Index (A & HCI). In addition, two other mechanisms were used to retrieve the elder abuse research: a manual search of the reference list of publications dated prior to 1990 and a reference search of elder abuse reviews or annotations.

All literature searches were conducted from inception of each index through December 31, 2008. Elder abuse research publication inclusion criteria were: English-language articles reporting completed research on abuse of people aged 55 years and older, from any country.

The databases were searched using combinations of the following keywords: abuse, aged, elder, elder abuse, neglect, and exploitation

**1a.8.2. Provide the citation and summary for each piece of evidence.**

1. Caceres, B. & Fulmer, T. (2012). *Mistreatment detection*. In: Evidence-based geriatric nursing protocols for best practice. 4th ed. Boltz, M., Capezuti, E., Fulmer, T., Zwicker, D. (Eds.). New York (NY): Springer Publishing Company. AHRQ Guideline summary NGC-9711. National Guideline Clearinghouse. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); [cited 2014 Jan 06]. Available:

<http://www.guideline.gov/content.aspx?id=43923&search=elder+mistreatment#Section405>

The following is summary of the guideline: Definitions of levels of evidence will appear at the end of the Major Recommendations

Guideline Objective: To provide a standard of practice protocol to identify best practices in identifying and responding to cases of elder mistreatment

Major Recommendations:

a. Nursing Care Strategies

•Detailed screening to assess for risk factors for elder mistreatment (EM) using a combination of physical assessment, subjective information, and data gathered from screening instruments (Perel-Levin, 2008 [Level I]).

•Strive to develop a trusting relationship with the older adult as well as the caregiver. Set aside time to meet with each individually (Perel-Levin, 2008 [Level I]).

•The use of interdisciplinary teams with a diversity of experience, knowledge, and skills can lead to improvements in the detection and management of cases of EM. Early intervention by interdisciplinary teams can help lower risk for worsening abuse and further deficits in health status (Jayawardena & Liao, 2006 [Level V]; Wiglesworth et al., 2010 [Level IV]).

•Institutions should develop guidelines for responding to cases of EM (Perel-Levin, 2008 [Level I]; Wiglesworth et al., 2010 [Level IV]).

•Educate victims about patterns of EM such that EM tends to worsen in severity over time (Cowen & Cowen, 2002 [Level VI]; Phillips, 2008 [Level II]).

•Provide older adults with emergency contact numbers and community resources (Cowen & Cowen, 2002 [Level VI]).

•Referral to appropriate regulatory agencies

b. Follow-up Monitoring of Condition: Follow-up monitoring in the acute care setting is limited compared to the follow-up that may be performed in the community or long-term care settings

Levels of Evidence

Level I: Systematic reviews (integrative/meta-analyses/clinical practice guidelines based on systematic reviews)

Level II: Single experimental study (randomized controlled trials [RCTs])

Level III: Quasi-experimental studies

Level IV: Non-experimental studies

Level V: Care report/program evaluation/narrative literature reviews

Level VI: Opinions of respected authorities/consensus panels

2**.** Elder Maltreatment and Care Symposium sponsored by Centers for Medicare and Medicaid

Beach, S., McMullen, T., Schwartz, K., & Yaffe, M. (2013*).* II.6 Elder abuse and its prevention: Screening and detection. In *Elder abuse and its prevention: Workshop summary*. Washington, DC: The National Academies Press. Manuscript submitted for publication.

The Centers for Medicare and Medicaid (CMS) explored the current state of elder maltreatment screening and elder care practices across Medicare and Medicaid beneficiary populations and care settings. The aim of this symposium was to develop a framework to build more robust measure specifications for the quality measure PQRS# 181 Elder Maltreatment Screening and Follow-Up Plan. Preliminary findings from the symposium suggest:

* There is consensus for the need to develop a definition of elder maltreatment that can be utilized across Health and Human Services (HHS) agencies
* Crosscutting tools were identified which could be implemented in a variety of care settings and by multiple providers. Among these tools, the EASI, HS-EAST and the VASS scale were identified for increased use in practice, consistency with PQRS #181 measure specification, their ability to assess multiple types of abuse.
* The impact of screening on the provider-patient relationship should be considered
* Cultural diversity should always be taken into account during elder maltreatment measurement; including screening and measurement
* Awareness of feasibility and provider burden should be considered

3. Institute of Medicine and the National Research Council of the National Academies. Elder abuse and its prevention: Workshop summary (2013). Washington, DC: The National Academies Press. Manuscript submitted for publication.

The Institute of Medicine and the National Research Council of the National Academies sponsored a 2-day workshop dedicated to elder abuse and its prevention in order to shed light on an underappreciated and frequently overlooked form of violence. The aim was to move beyond what is known and foster discussions on ways to improve prevention, intervention and mitigation of the victims’ needs through collaborative efforts. Workshop topics included measuring and conceptualizing elder abuse, risk factors and health outcomes, ethical considerations, screening and prevention and how to move the field of elder abuse research and prevention forward.

4. Daly, J. M. (2010). Elder abuse prevention. AHRQ Guideline summary NGC-8569. National Guideline Clearinghouse. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); [cited 2014 Jan 06]. Available:<http://www.guideline.gov/content.aspx?id=34018&search=elder+abuse+prevention>

The objective of this guideline is to facilitate health care professionals to assess older persons in domestic and institutional settings who are at risk for elder abuse, excluding self-neglect, and to recommend interventions to reduce the incidence of mistreatment. It is intended for use by advanced practice nurses, healthcare providers, nurses and social workers within the clinical specialties of Family Practice, geriatrics, Nursing, Preventive Medicine and Psychology. A systematic review and synthesis of current evidence followed by critique and analysis yielded the following recommendations (evidence grades are defined at the end of this summary):

1. Assessment Criteria were defined for patients most likely to benefit the most from utilizing this practice guideline (*Evidence Grade = C1*): Persons with physical, functional, or cognitive impairment, persons who have mental illness, alcoholism, or drug abuse problems, persons who are socially isolated or have a poor social network. persons who are dependent on others, persons with a past history of abusive relationships, persons with financial or other family problems, persons who reside in inadequate housing or unsafe conditions, persons who are depressed, persons who have delusions, persons who are in poor health, persons whose caregiver is stressed/frustrated with the difficult task of caring for an older person, persons whose caregiver has mental illness, alcoholism, or drug abuse problems, persons whose caregiver has inadequate financial resources, persons whose caregiver has health problems
2. Assessment tools are identified to assess potential victims. The following having an evidence grade = C1: Elder Abuse Suspicion Index©, Elder Assessment Instruments (EAI), Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST), Index of Spouse Abuse, Indicators of Abuse Screen (IOA), Mini-Mental Status Examination (MMSE), Partner Violence Screen (PVS) and Vulnerability to Abuse Screening Scale (VASS)
3. Description of Practice: a definition, defining characteristic, related factors, nursing interventions, nursing outcomes and risk factors are provided for each form of abuse
4. Implementation of the Practice: a step-by-step guideline including assessment and referral protocol is suggested for the health care provider

Potential benefits identified included reduced incidence of elder abuse and mistreatment. No potential harms were stated.

**Rating Scheme for the Strength of the Evidence**

**Evidence Grading**

**A1** = Evidence from well-designed meta-analysis or well-done systematic review with results that consistently support a specific action (e.g., assessment, intervention, or treatment)

**A2** = Evidence from one or more randomized controlled trials with consistent results

**B1** = Evidence from high quality evidence-based practice guideline

**B2** = Evidence from one or more quasi experimental studies with consistent results

**C1** = Evidence from observational studies with consistent results (e.g., correlational, descriptive studies)

**C2** = Inconsistent evidence from observational studies or controlled trials

**D** = Evidence from expert opinion, multiple case reports, or national consensus reports

5. Moyer, V.A. (2013). *Screening for intimate partner violence and abuse of elderly and vulnerable adults*: *A U.S. preventive services task force recommendation statement*. Annals of Internal Medicine, 158(6), 478-487. doi:10.7326/0003-4819-158-6-201303190-00588.

Available: <http://annals.org/article.aspx?articleid=1558517>

This guideline has been summarized within this submission document.