

Screening for Elder Maltreatment: An Environmental Scan of the Evidence

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Jefferson School of Population Health

- The Jefferson School of Population Health (JSPH) has an established track record in quality measure development, implementation and evaluation
- JSPH is subcontracted by Quality Insights of Pennsylvania to support measure development for the Centers for Medicare and Medicaid (CMS) Physician Quality Reporting System (PQRS)
- *JSPH was asked to conduct an environmental scan of the evidence to support screening for elder maltreatment*

Current 2013 PQRS Measure (#181) on Screening for Elder Maltreatment

- All patients age 65 and above should be screened for elder maltreatment at least once in the reporting period (6 or 12 months)
- A follow-up plan should be documented
- Challenges:
 - Measure seldom reported by EPs
 - Intention to improve feasibility of reporting this measure

U.S. Preventive Services Task Force Recommendation Statement, 2013

ONLINE FIRST: This version will differ from the print version

Annals of Internal Medicine

CLINICAL GUIDELINE

Screening for Intimate Partner Violence and Abuse of Elderly and Vulnerable Adults: A U.S. Preventive Services Task Force Recommendation Statement

Virginia A. Moyer, MD, MPH, on behalf of the U.S. Preventive Services Task Force*

Description: Update of the 2004 U.S. Preventive Services Task Force (USPSTF) recommendation statement on screening for family and intimate partner violence (IPV).

Methods: The USPSTF commissioned a systematic evidence review on screening women for IPV and elderly and vulnerable adults for abuse and neglect. This review examined the accuracy of screening tools for identifying IPV and the benefits and harms of screening women of childbearing age and elderly and vulnerable adults.

Population: These recommendations apply to asymptomatic women (women who do not have signs or symptoms of abuse) of reproductive age and elderly and vulnerable adults.

Recommendation: The USPSTF recommends that clinicians screen women of childbearing age for IPV, such as domestic violence, and provide or refer women who screen positive to intervention services (B recommendation).

The 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).

Ann Intern Med.

www.annals.org

For author affiliation, see end of text.

*For a list of USPSTF members, see the Appendix.

This article was published at www.annals.org on 22 January 2013.

Source: Moyer VA, on behalf of the USPSTF. Available at <https://annals.org>

U.S. Preventive Services Task Force

Recommendation Statement, 2013

- “The evidence for screening elderly and vulnerable adults remains insufficient [since 2004 guideline]; therefore the USPSTF was unable to make a recommendation in favor of or against screening”
- “The USPSTF found no valid, reliable screening tools to identify abuse of elderly or vulnerable adults in the primary care setting”
- “The USPSTF found no evidence on appropriate intervals for screening”
- “The USPSTF found no evidence about the costs of screening for or interventions to reduce elder abuse”

U.S. Preventive Services Task Force Recommendation Statement, 2013

- Benefit vs. Harm
 - “The USPSTF was not able to estimate the magnitude of net benefit for screening all elderly or vulnerable adults for abuse and neglect because 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 intimate partner violence (IPV) screening suggests that the harms of screening elderly and vulnerable adults might also be small”

No Evidence of Harm from Screening for IPV

- “Both screened and non-screened groups exhibited reductions over time in IPV recurrence”
- “There was no indication that IPV screening was associated with short term harm among either abused or non-abused women”

Screening for Intimate Partner Violence in Health Care Settings A Randomized Trial

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FEW ISSUES IN THE FIELD OF FAMILY violence generate as much controversy as screening women for intimate partner violence (IPV) in health care settings.^{1,2} Herein, we use the term *screening* to refer to universal routine inquiry: “a standardized assessment of patients, regardless of their reasons for seeking medical attention,”¹ aimed at identifying women who are experiencing or have recently experienced IPV.

Proponents of screening emphasize the following as a rationale for its implementation: the high prevalence of IPV

Context Whether intimate partner violence (IPV) screening reduces violence or improves health outcomes for women is unknown.

Objective To determine the effectiveness of IPV screening and communication of positive results to clinicians.

Design, Setting, and Participants Randomized controlled trial conducted in 11 emergency departments, 12 family practices, and 3 obstetrics/gynecology clinics in Ontario, Canada, among 6743 English-speaking female patients aged 18 to 64 years who presented between July 2005 and December 2006, could be seen individually, and were well enough to participate.

Intervention Women in the screened group (n=3271) self-completed the Woman Abuse Screening Tool (WAST); if a woman screened positive, this information was given to her clinician before the health care visit. Subsequent discussions and/or referrals were at the discretion of the treating clinician. The nonscreened group (n=3472) self-completed the WAST and other measures after their visit.

Main Outcome Measures Women disclosing past-year IPV were interviewed at baseline and every 6 months until 18 months regarding IPV reexposure and quality of life (primary outcomes), as well as several health outcomes and potential harms of screening.

Results Participant loss to follow-up was high: 43% (148/347) of screened women and 41% (148/360) of nonscreened women. At 18 months (n=411), observed recurrence of IPV among screened vs nonscreened women was 46% vs 53% (modeled odds ratio, 0.82; 95% confidence interval, 0.32-2.12). Screened vs nonscreened women exhibited about a 0.2-SD greater improvement in quality-of-life scores (modeled score difference at 18 months, 3.74; 95% confidence interval, 0.47-7.00). When multiple imputation was used to account for sample loss, differences between groups were reduced and quality-of-life differences were no longer significant. Screened women reported no harms of screening.

Conclusions Although sample attrition urges cautious interpretation, the results of this trial do not provide sufficient evidence to support IPV screening in health care settings. Evaluation of services for women after identification of IPV remains a priority.

Trial Registration clinicaltrials.gov Identifier: NCT00182468

JAMA. 2009;302(5):493-501

www.jama.com

Source: MacMillan HL et al. *JAMA*. 2009;302(5):493-501

American Medical Association Recommendation

American Medical Association National Advisory Council on Violence and Abuse

Policy Compendium
April 2008

American Medical Association

Policy Statement

Opinion 2.02 - Physicians' Obligations in Preventing, Identifying, and Treating Violence and Abuse

“Physicians should routinely inquire about physical, sexual, and psychological abuse as part of the medical history. Physicians should also consider abuse as a factor in the presentation of medical complaints because patients’ experiences with interpersonal violence or abuse may adversely affect their health status or ability to adhere to medical recommendations.”

Issued June 2008 based on the report ["Physicians' Obligations in Preventing, Identifying, and Treating Violence and Abuse,"](http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion202.page) adopted November 2007. Available at: <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion202.page>

American College of Emergency Physicians Recommendation

Recognition and Management of Elder Abuse

This Policy Resource and Education Paper is an explication of the Policy Statement Management of Elder Abuse and Neglect.

January 1999

“Recognition of abuse by health care providers may allow earlier intervention with the eventual elimination of the abuse. Patients should be asked if they are happy at home, or if they have experienced any recent changes in mood, sleeping, or eating patterns.”

Source: <http://www.acep.org/Clinical---Practice-Management/Recognition-and-Management-of-Elder-Abuse/>

American Academy of Neurology Position Statement

SPECIAL ARTICLE



The American Academy of Neurology position statement on abuse and violence

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Neurology® 2012;78:433–435

Neurologists see patients with neurologic disabilities that render them susceptible to abuse or neglect. They also encounter patients with neurologic dysfunction that may be either directly or indirectly related to maltreatment. In 2008, the American Medical Association (AMA) encouraged physicians to “routinely inquire about the family violence histories of their patients, as this knowledge is essential for effective diagnosis and care.”¹ Consensus-based guidelines for identification of intimate partner violence (IPV) have been adopted by numerous medical specialty organizations.^{2–11} The US Department of Health and Human Services has recommended that women be screened and counseled for domestic abuse.¹²

- Sexual abuse: Nonconsensual sexual activity.
- Child abuse: Any type of cruelty inflicted upon a child.
- Elder abuse: Abuse or neglect of an individual 65 years of age or older, and those who are physically or mentally disabled.

ABUSE AND ITS RELATIONSHIP TO NEUROLOGIC DISEASES Abuse can effect the development of neurologic disease. More than 90% of all injuries from IPV occur to the head, face, or neck region^{20,21} and may be associated with traumatic brain injury (TBI). The consequences of lifetime exposure to violence and abuse commonly include neurologic problems.²⁰ The short- and long-term

“The physician should routinely screen all patients for past and ongoing violence, fully integrating the questions into the medical history.”

Source: <http://www.aan.com/globals/axon/assets/9185.pdf>

AHRQ National Guideline Clearinghouse

The screenshot displays the AHRQ National Guideline Clearinghouse website. At the top, the U.S. Department of Health & Human Services logo and the AHRQ logo are visible. The main navigation bar includes links to the National Quality Measures Clearinghouse, Health Care Innovations Exchange, and AHRQ Home. A search bar contains the text "elder abuse". Below the search bar, a sidebar lists navigation options: Home, Guidelines, and a "Browse" section with links to "By Topic", "By Organization", "Guidelines in Progress", "Guideline Index", "Guideline Archive", and "Related NQMC Measures". The main content area shows the "Guideline Summary" for "Elder abuse prevention". It includes the "Guideline Title" and the "Bibliographic Source(s)" which cite a 2010 publication by Daly JM. at the University of Iowa College of Nursing.

Guideline Objective(s)

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

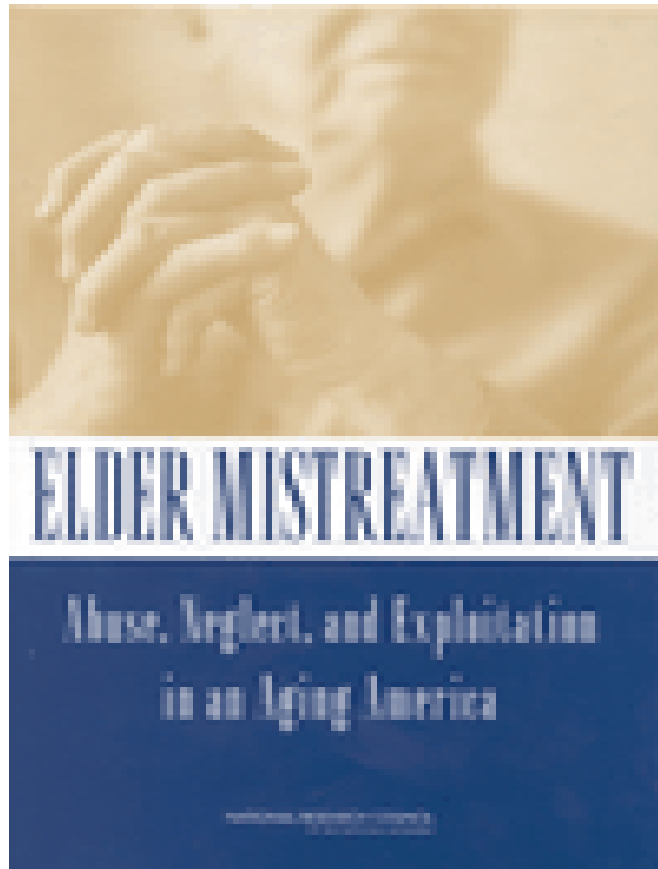
Target Population

Elders in domestic and institutional settings who are at-risk for or victims of elder abuse

Source: <http://guideline.gov/content.aspx?id=34018&search=elder+abuse>

Daly JM. Elder abuse prevention. Iowa City (IA): University of Iowa College of Nursing, John A. Hartford Foundation Center of Geriatric Nursing Excellence; 2010 Oct. 71 p. [136 references]

Research Findings and Recommendations



Chapter 6. Screening and Case Identification in Clinical Settings

“Although little research has been done in most of these areas, several approaches to screening and prescreening are possible.”

Source: Bonnie RJ, Wallace RB. Elder Mistreatment: Abuse, Neglect, and Exploitation in an Aging America. 2002 Available at <http://www.nap.edu/catalog/10406.html>

Research Findings and Recommendations

Elder abuse

Mark S Lachs, Karl Pillemer

Elder abuse has received increasing attention over the past decade as a common problem with serious consequences for the health and wellbeing of old people. Our aim is to assist clinicians by summarising recent international research and clinical findings about elder abuse, and to assess their quality, relevance, and feasibility for health-care providers in clinical practice. This seminar includes issues of definition and frequency of elder abuse and a summary of major known risk factors. The advantages and disadvantages of screening for elder abuse are discussed. We review clinical manifestations and diagnosis of elder abuse, and propose a protocol for medical assessment of a patient with confirmed or suspected abuse. Suggestions for treatment are offered on the basis that elder abuse is multifactorial and needs individual medical and social intervention strategies, preferably in the context of a multidisciplinary team.

Lancet 2004; 364: 1263-72

Division of Geriatric Medicine and Gerontology, Weill Medical College (Prof M Lachs MD), and Department of Human Development and Cornell Gerontology Research Institute (Prof K Pillemer PhD), Cornell University, Ithaca, NY, USA

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In view of the limits of current techniques, should screening for elder abuse be abandoned?

“Without evidence either way at an early stage, we believe that related published work – on self-reported practice by clinicians and educational interventions in elder abuse supports reliance on clinical judgment and raising of awareness in physicians.”

Source: Lachs MS, Pillemer K. Elder abuse. *Lancet* 2004; 364:1263-72

Research Findings and Recommendations

PROGRESS IN GERIATRICS

Progress in Elder Abuse Screening and Assessment Instruments

Terry Fulmer, PhD, RN, FAAN, Lisa Guadagno, BS, MPA,* Carmel Bitondo Dyer, MD,†‡
and Marie Therese Connolly, JD§*

“Elder mistreatment screening and assessment instruments have a valuable potential role in the clinical and research arenas. Screening is important because elder mistreatment, like other forms of domestic mistreatment, is often a hidden problem.”

“All clinicians should be strongly encouraged to develop an approach for incorporating elder mistreatment screening and assessment in their practices, and the use of these instruments may help support decisions regarding the diagnosis of elder mistreatment, especially for those who have less experience with the problem”

Source: Fulmer T et al. Progress in elder abuse screening and assessment instruments. *J Am Geriatr Soc.* 2004; 52: 297-304

Research Findings and Recommendations

- “There are still major limitations to the available screening instruments for elder mistreatment. However, this study shows patients’ willingness to answer extremely sensitive elder mistreatment questions, as well as to use computer technology for interviewing.”

Source: Fulmer T et al. Screening for elder mistreatment in dental and medical clinics. *Gerondotology*. 2012;29(2):96-105

Summary

- Evidence weak for screening
- Consensus among experts that screening is desirable
- How do we reconcile the gap between the recommendations and the evidence?