Hospice Governance Academy®

Creating a Culture of Integrity

HHS OIG Report on Abuse and Neglect (June 2019)

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Summary

The "Identifying Potential Abuse or Neglect" report demonstrates that the OIG's interest in safeguarding vulnerable populations has expanded to all Medicare services. In combination with recommendations from the July 2019 Hospice Safeguards report, home health and hospice agencies may want to proactively assess their policies for abuse reporting and how they might use data from the report.

Figure 1 Photo by Mitchell Griest on Unsplash

While not specifically focused on home health or hospice, the OIG's June 2019 report, "CMS Could Use Medicare Data to Identify Instances of Potential Abuse or Neglect," (A-01-00513) is a report that signals the OIG's intent to address vulnerable populations. In light of the recent Hospice Safeguards report

issued in July (OEI-02-17-00021), home health and hospice agencies should have abuse and neglect on their radar screens.

The "Identifying Potential Abuse or Neglect" report demonstrates that the OIG's interest in safeguarding vulnerable populations has expanded from an initial focus primarily on nursing home residents, that then extended to recipients of personal care, and now, in this report, to all Medicare services.
The report is of interest from two angles:

1. it signals that CMS has the ability to retrospectively identify abuse and neglect based upon diagnostic coding of follow-up treatment, and

2. it provides some insights into the most common scenarios in which abuse and neglect occur.

The study focused on 17 diagnostic codes indicating sexual or physical abuse or maltreatment. From about 35,000 claims with those codes, the OIG reviewed a sample of 100 records which, in 90% of the sample, had records which verified abuse or neglect. It found that 20% of these cases had not been reported to law enforcement.

The report details that the most frequent location of abuse or neglect was at home. The top perpetrators where family members and someone known to the beneficiary. And the frequency by type of issue, in order of highest frequency, was: sexual abuse or rape, physical abuse, neglect or abandonment, and other unspecified maltreatment.

The report recommends the following:

1. That CMS conduct a periodic extract of all claims with at least one code indicating potential abuse or neglect and share that information with States.
2. That CMS review requirements for reporting potential abuse or neglect regardless of where and how the issues arise.

In combination with recommendations from the July 2019 Hospice Safeguards report, home health and hospice agencies may want to proactively assess the following:

1. Are your policies for abuse reporting and patient/family complaints proactive or reactive? What could your organization do to make either process more user-friendly and visible?
2. How might you use the data from this report (and other sources) to help your staff identify potential cases of abuse or neglect?
3. Are your policies and procedures compliant not only with federal standards, but also with state laws that constitute the majority of protections related to abuse and/or neglect?