

# NATIONAL QUALITY FORUM

## Measure Submission and Evaluation Worksheet 5.0

This form contains the information submitted by measure developers/stewards, organized according to NQF's measure evaluation criteria and process. The evaluation criteria, evaluation guidance documents, and a blank online submission form are available on the [submitting standards web page](#).

<b>NQF #:</b> 1973	<b>NQF Project:</b> <a href="#">Neurology Project</a>
(for Endorsement Maintenance Review)	
<b>Original Endorsement Date:</b>	<b>Most Recent Endorsement Date:</b> Last Updated Date: <a href="#">Oct 21, 2015</a>
<b>BRIEF MEASURE INFORMATION</b>	
<b>De.1 Measure Title:</b> <a href="#">Annual Parkinson's Disease Diagnosis Review</a>	
<b>Co.1.1 Measure Steward:</b> <a href="#">American Academy of Neurology</a>	
<b>De.2 Brief Description of Measure:</b> All patients with a diagnosis of Parkinson's disease who had their Parkinson's disease diagnosis reviewed, including a review of current medications and a review for the presence of atypical features (e.g., falls at presentation and early in the disease course, poor response to levodopa, symmetry at onset, rapid progression [to Hoehn and Yahr stage 3 in 3 years], lack of tremor or dysautonomia) at least annually.	
<b>2a1.1 Numerator Statement:</b> All patients who had an annual assessment including a review of current medications and for the presence of atypical features	
<b>2a1.4 Denominator Statement:</b> All patients with a diagnosis of Parkinson's disease.	
<b>2a1.8 Denominator Exclusions:</b> None	
<b>1.1 Measure Type:</b> <a href="#">Process</a> <b>2a1. 25-26 Data Source:</b> <a href="#">Administrative claims, Electronic Clinical Data : Electronic Health Record</a> <b>2a1.33 Level of Analysis:</b> <a href="#">Clinician : Individual</a>	
<b>1.2-1.4 Is this measure paired with another measure?</b> <a href="#">No</a>	
<b>De.3 If included in a composite, please identify the composite measure (title and NQF number if endorsed):</b>	

<b>STAFF NOTES</b> (issues or questions regarding any criteria)
<b>Comments on Conditions for Consideration:</b>
<b>Is the measure untested?</b> Yes <input checked="" type="radio"/> No <input checked="" type="radio"/> If untested, explain how it meets criteria for consideration for time-limited endorsement:
<b>1a. Specific national health goal/priority identified by DHHS or NPP addressed by the measure (check De.5):</b> <b>5. Similar/related <a href="#">endorsed</a> or submitted measures (check 5.1):</b> <b>Other Criteria:</b>
<b>Staff Reviewer Name(s):</b>

## 1. IMPACT, OPPORTUNITY, EVIDENCE - IMPORTANCE TO MEASURE AND REPORT

See Guidance for Definitions of Rating Scale: H=High; M=Moderate; L=Low; I=Insufficient; NA=Not Applicable  
 Created on: 10/27/2015 at 06:43 AM

Importance to Measure and Report is a threshold criterion that must be met in order to recommend a measure for endorsement. All three subcriteria must be met to pass this criterion. See [guidance on evidence](#).

**Measures must be judged to be important to measure and report in order to be evaluated against the remaining criteria. (evaluation criteria)**

**1a. High Impact: H O M O L O I O**

(The measure directly addresses a specific national health goal/priority identified by DHHS or NPP, or some other high impact aspect of healthcare.)

**De.4 Subject/Topic Areas** (Check all the areas that apply): [Neurology](#)

**De.5 Cross Cutting Areas** (Check all the areas that apply): [Health and Functional Status](#), [Health and Functional Status : Development/Wellness](#), [Health and Functional Status : Functional Status](#), [Prevention](#), [Safety](#), [Safety : Medication Safety](#)

**1a.1 Demonstrated High Impact Aspect of Healthcare:** [Affects large numbers](#), [Patient/societal consequences of poor quality](#), [Severity of illness](#)

**1a.2 If "Other," please describe:**

**1a.3 Summary of Evidence of High Impact** (Provide epidemiologic or resource use data):

According to the Parkinson's Disease Foundation, Parkinson's disease affects about 1 million people in the United States and more than 4 million people worldwide. The disorder occurs in all races, but Parkinson's is somewhat more prevalent among Caucasians.

[Men develop the disease slightly more often than women.](#)<sup>1</sup>

[Parkinson's disease ranks among the most common late-life neurodegenerative diseases, affecting approximately 1.5% to 2.0% of the population older than age 60 years.](#)<sup>2</sup>

[This measure would impact and benefit all patients diagnosed with Parkinson's disease. Parkinson's disease affects both men and women. The average age of onset of Parkinson's disease is 61, but it may begin as early as age 40 or even before. The number of people in the United States with Parkinson's disease is estimated to be between 500,000 and one million, with about 50,000 to 60,000 new diagnoses each year. That number is growing every year as the American population ages.](#)

**1a.4 Citations for Evidence of High Impact cited in 1a.3:** 1.

<http://www.healthcommunities.com/parkinsons-disease/incidence-prevalence.shtml>

2. <http://www.clevelandclinicmeded.com/medicalpubs/diseasemanagement/neurology/parkinsons-disease/>  
[Parkinson's disease Foundation website. www.pdf.org](#)

**1b. Opportunity for Improvement: H O M O L O I O**

(There is a demonstrated performance gap - variability or overall less than optimal performance)

**1b.1 Briefly explain the benefits (improvements in quality) envisioned by use of this measure:**

[Given the error rate in making a diagnosis of PD, even in expert hands, it is apparent that the diagnosis should be kept under regular review.](#)

[In people with early mild symptoms of PD who may not even be on treatment yet, follow-up to check on the diagnosis and the need for treatment may be infrequent \(every 6–12 months\). Once treatment is commenced, follow-up may need to be more frequent \(every 2–3 months\) to assess the response to medication, titrate dosage and re-visit the diagnosis. In later disease, people with PD have more complex problems which require changes in medication. This may require review at frequent intervals \(every 2–3 months\).](#)

Although PD is a common disorder, accurate diagnosis remains a challenge in early stages of the disease. Clinical examination with long term follow-up appears to be the best method for confirmation of diagnosis during the patient's lifetime. Further studies are needed to identify other techniques, such as neuroimaging and levodopa challenge tests, that may improve diagnostic accuracy and adequately address disease progression, and to determine superiority to the clinical exam.

Methods for presymptomatic testing to identify patients who are at risk of developing PD are also critical, particularly for testing of neuroprotective strategies. Similarly, knowledge of disease progression will play a key role, not only in providing useful clinical information, but in assessing the benefit of neuroprotective interventions.

**1b.2 Summary of Data Demonstrating Performance Gap** (*Variation or overall less than optimal performance across providers*): [**For Maintenance** – *Descriptive statistics for performance results for this measure - distribution of scores for measured entities by quartile/decile, mean, median, SD, min, max, etc.*]

Up to 50 percent of Parkinson's patients are seen by primary care physicians or general neurologists, with significant error rates in diagnosis. The areas with the greatest gap in care are: initial diagnosis, and diagnosis and treatment of non-motor aspects of the disease.

What is needed is a systematic approach to improving care for all Parkinson's patients that seeks to leverage and disseminate models of exemplary care practiced by leading movement disorder specialists across the U.S. to help close the gap in care, at a reasonable systemic cost. Such an effort would not only benefit Parkinson's patients, but could serve as a model of the cost-effective elevation of care management of complex chronic condition in an aging population, with applicability to many other conditions.<sup>1</sup>

The diagnosis of PD should be reviewed regularly\*\* and reconsidered if atypical clinical features develop. Acute levodopa and apomorphine challenge tests should not be used in the differential diagnosis of parkinsonian syndromes.<sup>2</sup>

**1b.3 Citations for Data on Performance Gap:** [**For Maintenance** – *Description of the data or sample for measure results reported in 1b.2 including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*]

1. Oberdorf J., Schmidt P.; Improving Care for People with Parkinson's Disease; National Parkinson Foundation; February 2010
2. NICE National Collaborating Centre for Primary Care. National Collaborating Centre for Chronic Conditions. Parkinson's Disease: National Clinical Guideline for Management in Primary and Secondary Care (2006) London: Royal College of Physicians

**1b.4 Summary of Data on Disparities by Population Group:** [**For Maintenance** – *Descriptive statistics for performance results for this measure by population group*]

After controlling for age, sex, and geography, African-Americans were four times less likely than whites to receive any PD treatment (odds ratio, 0.24; 95% confidence interval, 0.09 – 0.64), especially indicated medications. In a group with the same healthcare insurance, disparities in PD treatment exist. Physician and community awareness of these racial differences in PD treatment is the first step in addressing healthcare disparities.<sup>1</sup>

Three hundred and seven newly diagnosed cases of PD were identified. The mean age of diagnosis was 55.1 years (standard deviation, 6.45). Of the sample, 14% were African American and 86% were white. More than half were women (61%) and received care in urban areas (52%). African American and white PD patients did not statistically significantly differ in age, sex, initial visit with neurologist, or reason for Medicaid eligibility (Table 1). African American patients were significantly more likely to receive care in an urban setting than white patients (93 vs 46%).<sup>1</sup>

Overall, 104 patients (34%) were prescribed PD medication or physical therapy, and 124 (40%) had a second visit for PD after initial diagnosis. In unadjusted analysis (Table 2), African American patients were less likely to receive any medication treatment or physical therapy than white patients (12 vs 38%). They were also less likely to receive just medication therapy (12 vs 33%). There was no significant difference in the number of second visits for PD in the 6 months after initial diagnosis. 1

Although disparities of healthcare have been demonstrated in many settings in the United States, some studies have shown reduced disparities in the VA system. Possible explanations for reduced disparities in the VA include: equal access to care among its members and reduced financial incentives for providers. In addition, overall quality of care was quite high in this study and similar to that found in the VA in a large quality indicator project [18]. We detected a 6% racial/ethnic disparity of adherence to PD indicators after controlling for demographic characteristics, clinical characteristics, levels of comorbidity, and healthcare utilization. For perspective, a large study of a population of vulnerable elders found that a 10% increase in adherence to a set of 207 indicators, the vast majority of which addressed chronic disease care, are associated with significant decreases in 3-year mortality rates.2

**1b.5 Citations for Data on Disparities Cited in 1b.4:** *[For Maintenance – Description of the data or sample for measure results reported in 1b.4 including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included]*

1. Dahodwala N., Xie M., Noll E, Siderowf A., Mandell D.; Treatment Disparities in Parkinson's Disease; Ann Neurol.; 2009 August; 66 (2); 142-145

2. Cheng EM, Siderowf AD, Swartztrauber K, Lee M, Vassar S, Jacob E, Eisa MS, Vickrey BG. Disparities of care in veterans with Parkinson's disease. Parkinsonism Relat Disord. 2008;14:8-14

**1c. Evidence** (Measure focus is a health outcome OR meets the criteria for quantity, quality, consistency of the body of evidence.)

Is the measure focus a health outcome? Yes ☐ No ☐ **If not a health outcome, rate the body of evidence.**

Quantity: H ☐ M ☐ L ☐ I ☐ Quality: H ☐ M ☐ L ☐ I ☐ Consistency: H ☐ M ☐ L ☐ I ☐

Quantity	Quality	Consistency	Does the measure pass subcriterion 1c?
M-H	M-H	M-H	Yes <input type="radio"/>
L	M-H	M	Yes <input type="radio"/> IF additional research unlikely to change conclusion that benefits to patients outweigh harms: otherwise No <input type="radio"/>
M-H	L	M-H	Yes <input type="radio"/> IF potential benefits to patients clearly outweigh potential harms: otherwise No <input type="radio"/>
L-M-H	L-M-H	L	No <input type="radio"/>
Health outcome – rationale supports relationship to at least one healthcare structure, process, intervention, or service			Does the measure pass subcriterion 1c? Yes <input type="radio"/> IF rationale supports relationship

**1c.1 Structure-Process-Outcome Relationship** (Briefly state the measure focus, e.g., health outcome, intermediate clinical outcome, process, structure; then identify the appropriate links, e.g., structure-process-health outcome; process-health outcome; intermediate clinical outcome-health outcome):

An annual review of the Parkinson's disease diagnosis is important to ensure that patients have the accurate diagnosis and are being treated appropriately. No tests exist for the diagnosis of Parkinson's disease. The clinician diagnoses Parkinson's disease based on the patient's medical history, a review of your signs and symptoms, and a neurological and physical examination. By reviewing current medications the clinician will be able to identify any medications that may be causing Parkinson-like symptoms and be able to check/modify any Parkinson's disease medications or treatments. It is important to look for atypical

features to substantiate or eliminate the diagnosis of Parkinson's disease. The emergence of atypical features in a patient previously thought to have Parkinson's disease will influence prognosis and medical treatment. This measure will alert the clinician to the emergence of atypical features in Parkinson's disease and suggest alternate diagnostic possibilities. This measure may also have the added benefit of reducing inappropriate treatment and/or improving the patient's quality of life by improving symptom management. It has been demonstrated that in the course of caring for patients with suspected Parkinson's disease, 10-15% will ultimately have a different pathologic diagnosis.

The correct diagnosis of Parkinson's disease is important for prognostic and therapeutic reasons. Investigations of the diagnostic accuracy for the disease and other forms of parkinsonism in community-based samples of patients taking anti-parkinsonian medication confirmed a diagnosis of parkinsonism in only 74% of patients and clinically probable Parkinson's disease in 53% of patients.

Clinicopathological studies based on brain bank material from the UK and Canada have shown that clinicians diagnose the disease incorrectly in about 25% of patients. In these studies, the most common reasons for misdiagnosis were presence of essential tremor, vascular parkinsonism, and atypical parkinsonian syndromes.

Population-based studies have shown that at least 15% of patients with a diagnosis of Parkinson's disease in the population do not fulfil strict clinical criteria for the disease, and about 20% of patients with Parkinson's disease who have already come to medical attention have not been diagnosed with the disease.

In clinicopathological studies the most common misdiagnoses relate to other forms of degenerative parkinsonism, such as progressive supranuclear palsy, multisystem atrophy, or corticobasal degeneration. Clinically based studies have shown that other common errors include essential tremor, drug induced parkinsonism, and vascular parkinsonism.

[http://www.anteroperalta.info/contenidos/Movimientos%20involuntarios/The\\_diagnosis\\_of\\_Parkinson\\_disease.pdf](http://www.anteroperalta.info/contenidos/Movimientos%20involuntarios/The_diagnosis_of_Parkinson_disease.pdf)

<http://www.parkinsons-information-exchange-network-online.com/archive/091.html>

The difficulty in accurately distinguishing between neurodegenerative diseases that have parkinsonian extrapyramidal features (multiple system atrophy, progressive supranuclear palsy [PSP], etc.) is reflected in statistics showing a high rate of misdiagnosis among movement-disorder experts when patients are followed throughout the course of their illness to actual autopsy. Both of these series, one from Europe and the other from North America, point out a roughly 24% misdiagnosis rate at autopsy.

The American Academy of Neurology has preliminary data from the implementation of these measures into the Maintenance of Certification Performance in Practice (NeuroPI) Parkinson's disease Modules. There have been 119 physicians to date who have enrolled in Parkinson's disease modules. However, the extrapolation of data from this module is not yet appropriate as the sample size is believed to be too small to be able to provide generalizable data. However, by the time this measure comes back to the NQF for the end of the Temporary Endorsement period (estimated by 1/2014) there will be additional data available to support the link of this measure to the desired patient outcomes. In addition, we will have some data back from the CECity registry database, which just went live in August 2012, by 1/2014 to add additional support to this measure.

[http://www.brainexplorer.org/parkinsons/parkinsons\\_diagnosis.shtml](http://www.brainexplorer.org/parkinsons/parkinsons_diagnosis.shtml)

[http://www.aan.com/professionals/practice/guidelines/pda/Diagnosis\\_PD.pdf](http://www.aan.com/professionals/practice/guidelines/pda/Diagnosis_PD.pdf)

<http://www.clevelandclinicmeded.com/medicalpubs/diseasemanagement/neurology/parkinsons-disease>

**1c.2-3 Type of Evidence** (Check all that apply):

Clinical Practice Guideline, Other, Systematic review of body of evidence (other than within guideline development)  
indicator paper

**1c.4 Directness of Evidence to the Specified Measure** (State the central topic, population, and outcomes addressed in the body of evidence and identify any differences from the measure focus and measure target population):

The diagnosis of PD should be reviewed regularly\*\* and reconsidered if atypical clinical features develop. Acute levodopa and apomorphine challenge tests should not be used in the differential diagnosis of parkinsonian syndromes.

**1c.5 Quantity of Studies in the Body of Evidence** (Total number of studies, not articles): 3  
recommendation statements/indicators were used as the basis for this quality measure.

**1c.6 Quality of Body of Evidence** (Summarize the certainty or confidence in the estimates of benefits and harms to patients across studies in the body of evidence resulting from study factors. Please address: a) study design/flaws; b) directness/indirectness of the evidence to this measure (e.g., interventions, comparisons, outcomes assessed, population included in the evidence); and c) imprecision/wide confidence intervals due to few patients or events): The guideline/indicator authors did not provide an explicit process or documentation of a process like GRADE whereby precision, directness, etc were detailed in a systematic review to demonstrate the quality of the body of evidence for this measure. The available information from the guideline/indicator paper is provided below.

Recommendation:

The diagnosis of PD should be reviewed regularly (6-12 month intervals seen to review diagnosis) and reconsidered if atypical clinical features develop. (Level D (DS)) NICE GL35 (June 2006)

1. NICE National Collaborating Centre for Primary Care. National Collaborating Centre for Chronic Conditions. Parkinson's Disease: National Clinical Guideline for Management in Primary and Secondary Care (2006) London: Royal College of Physicians

Primary Evidence:

Diagnosis is particularly highlighted. This can be difficult, and while swift assessment by someone with appropriate expertise is important when suspicion of Parkinson's disease first arises, so too is it vital to reconsider the diagnosis if atypical features develop later.

People with suspected PD should be referred quickly\* and untreated to a specialist with expertise in the differential diagnosis of this condition.

The diagnosis of PD should be reviewed regularly\*\* and reconsidered if atypical clinical features develop.

People with PD should have regular access to the following:

\_ clinical monitoring and medication adjustment

\_ a continuing point of contact for support, including home visits, when appropriate

-a reliable source of information about clinical and social matters of concern to people with PD and their carers, which may be provided by a Parkinson's disease nurse specialist (PDNS).

Six studies have addressed communication about the diagnosis of PD. Since there were few RCTs in this area, qualitative studies and cross-sectional studies using questionnaire data collection tools were included. The literature search included the area of self-help in relation to communication and education of people with PD. However, no studies were found which specifically addressed this topic. Qualitative studies were



assigned evidence level 3 in accordance with NICE guidance.

A qualitative study<sup>29,30</sup> using an interpretive phenomenological method identified a number of themes, but did not include a clear audit trail demonstrating how these were derived from the original patient data collected.

A cross-sectional self-report questionnaire study<sup>29,30</sup> collected response data from physiotherapists and occupational therapists who observed video records of patients.

It should be noted that:

\_ the PROPATH program<sup>26,27</sup> was a pharmaceutically sponsored educational service only available in the USA

\_ the survey from the Parkinson's Disease Society (PDS)<sup>31</sup> was based on a questionnaire of members in the UK.

The PROPATH program consisted of a disease assessment questionnaire, which was completed by people with PD or their carer. The questionnaire was analysed and computer-generated reports were returned to physicians and individualised recommendation letters returned to people with PD. The questionnaires were analysed by an advisory board of neurologists with broad experience in movement disorders. The reports and recommendation letters were primarily aimed at reducing medication side effects.

Two RCTs<sup>26,27</sup> were found, which assessed the effectiveness of the PROPATH education program, as a novel approach to communication with people with PD.

A 6-month follow-up PROPATH study<sup>26</sup> (N=155) showed multiple benefits of the PROPATH intervention which are listed in Table 4.1. (1+)

Recommendation:

Determining the presence of the following clinical features in early stages of disease should be considered to distinguish PD from other parkinsonian syndromes: 1) falls at presentation and early in the disease course, 2) poor response to levodopa, 3) symmetry at onset, 4) rapid progression (to Hoehn and Yahr stage 3 in 3 years), 5) lack of tremor, and 6) dysautonomia (urinary urgency/incontinence and fecal incontinence, urinary retention requiring catheterization, persistent erectile failure, or symptomatic orthostatic hypotension) (Level B) AAN QSS PD (April 2006)

2. AAN QSS PD Diag. (April 2006) Suchowersky O, Reich S, Perlmutter J, Zesiewicz T, Gronseth G, Weiner WJ, Quality Standards Subcommittee of the American Academy of Neurology. Practice parameter: diagnosis and prognosis of new onset Parkinson disease (an evidence-based review): report of the Quality Standards Subcommittee of the American Academy of Neurology. Neurology 2006 Apr 11; 66(7):968-75.

Primary Evidence:

We identified four articles that addressed the diagnostic accuracy of clinical features that were helpful in differentiating PD from other forms of parkinsonism (table E-1). A Class II case control study of 77 patients with pathologic diagnoses of different parkinsonian conditions including corticobasal degeneration (CBD), dementia with Lewy bodies (DLB), MSA, PD, and PSP revealed that falling within 1 year of diagnosis was a strong predictor of other forms of parkinsonism. Recurrent falling within the first year was a strong predictor of PSP, whereas time to onset of falling was more delayed in CBD, DLB, and MSA and most prolonged in PD.

A Class II retrospective study of 100 autopsyconfirmed cases of PD and 38 with MSA<sup>10</sup> used a multivariate logistic regression analysis to construct a model of clinical features which help to distinguish PD from MSA. Based on features present until death, and assigning point values to each, the following variables yielded the best prediction: poor response to levodopa (two points); autonomic dysfunction, consisting of symptomatic postural hypotension, urinary urge incontinence, fecal incontinence, urinary retention requiring

catheterization, and persistent erectile dysfunction (two points); speech or bulbar dysfunction (two points); absence of levodopa induced confusion (four points); and falls (four points). A point score of  $\geq 11$  yielded a sensitivity of 90.3% and specificity of 92.6% in predicting patients had MSA rather than PD. It is perhaps more important to make a distinction between PD and MSA earlier in the disease course. In that setting, within the first 5 years, the following variables and point values were most predictive: poor response to levodopa (two points), early motor fluctuations (two points), autonomic dysfunction (two points), and rigidity (two points). A score of  $\geq 4$  had a sensitivity of 87.1% and specificity of 70.5% of predicting MSA.

A Class II retrospective cohort study of 800 patients diagnosed with PD by movement disorder specialists and enrolled in DATATOP found that 65 individuals (8.1%) were ultimately determined to have an alternative diagnosis.<sup>8</sup> Clinical features that distinguished the two groups at baseline included higher Hoehn and Yahr stage, higher Unified PD Rating Scale (UPDRS) scores for bradykinesia, postural instability and gait difficulty, and a lower tremor score in the group with other forms of parkinsonism.

In a Class III case control study of 20 people with PD and 32 with either PSP or MSA identified pathologically, only 5% of patients with PD had orthostatic hypotension and all cases of PD were levodopa responsive.<sup>7</sup> Lack of tremor, symmetry, and rapid progression were more likely to be associated with PSP or MSA, rather than PD.

Levodopa and apomorphine challenge should be considered for confirmation when the diagnosis of PD is in doubt (Level B).

Olfaction testing should be considered to differentiate PD from PSP and CBD, but not PD from MSA (Level B).

There is insufficient evidence to determine whether levodopa and apomorphine challenge or olfaction testing have any advantage over the clinical diagnostic criteria of PD (Level U). Additionally, there is insufficient evidence to determine the optimal combination or sequence of these tests (Level U).

The following may not be useful in differentiating PD from other parkinsonian syndromes: GH stimulation with clonidine, electrooculography, and SPECT scanning (Level C).

There is insufficient evidence to support or refute the following as a means of distinguishing PD from other parkinsonian syndromes: urodynamics, autonomic testing, urethral or anal EMG, MRI, brain parenchyma sonography, and FDG PET (Level U).

#### Recommendation:

All veterans with the suspected diagnosis of PD who are also receiving medications known to cause parkinsonism (e.g. neuroleptics) should have a trial of withdrawal of these medications, a trial of low-potency neuroleptic, or documentation in the medical record that the medication could not be withdrawn before making the diagnosis of PD. Cheng #1 (Assessment of medication-induced PD) 2004  
3. Cheng Eric, Siderowf Andrew, Swaztrauber Kari, Eisa Mahmood, Lee Martin and Vickrey Barbara. Development of Quality of Care Indicators for Parkinson's disease Movement Disorders Vol. 19, No.2, 2004 (P136-150)

#### Primary Evidence:

Of the 38 PD-specific indicators meeting criteria for validity and feasibility, 16 also met criteria for having the highest potential value for subsequent quality improvement interventions (Table 2). Among the highest-rated indicators were ones that dealt with dopaminergic therapy, assessment of functional status, and assessment of depression. At least one indicator from each domain of care was in the highlighted list. Applying our criteria for highlighting indicators of highest potential value for subsequent quality improvement interventions in PD, we identified 13 of the 33 PD-relevant ACOVE indicators (Table 4). Among the highest



rated indicators were ones in the areas of coordination of care, medication use, and recognition and treatment of depression (Table 4).

Pairwise partial correlations that accounted for clustering showed that overall utility rating of an indicator was associated with validity, feasibility, impact on outcomes, and room for improvement ( $P \leq 0.001$ ; Table 5). Clustered multivariable regression modeling showed that validity ( $P \leq 0.003$ ) and impact on outcomes ( $P \leq 0.0001$ ) criteria were uniquely associated with the overall utility rating, while feasibility and room for improvement were not ( $P \geq 0.1$ ).

The ACOVE indicators on coordination of care and medication use were also highly ranked by the panel. Medical information on every VA patient is recorded in a single medical chart, allowing a VA provider to quickly review medical care rendered by another VA provider. The VA's electronic medical record system contains a link to the VA pharmacy record that shows an updated medication list for each patient. By comparing performances of these indicators in the VA with those found in two-managed care plans in which ACOVE has already been implemented, we can examine whether the features of an integrated electronic medical system are linked to better coordination of care and medication use.

**1c.7 Consistency of Results across Studies** (*Summarize the consistency of the magnitude and direction of the effect*): These studies are consistent that all patients with a diagnosis of Parkinson's disease should have a diagnosis review at least annually.

**1c.8 Net Benefit** (*Provide estimates of effect for benefit/outcome; identify harms addressed and estimates of effect; and net benefit - benefit over harms*):  
See quality of body of evidence question

**1c.9 Grading of Strength/Quality of the Body of Evidence.** Has the body of evidence been graded? **Yes**

**1c.10 If body of evidence graded, identify the entity that graded the evidence including balance of representation and any disclosures regarding bias:** American Academy of Neurology

Classification of evidence for therapeutic articles

Class I: Prospective, randomized, controlled clinical trial with masked outcome assessment, in a representative population. The following are required:

- a) Primary outcome(s) is/are clearly defined.
- b) Exclusion/inclusion criteria are clearly defined.
- c) Adequate accounting for drop-outs and cross-overs with numbers sufficiently low to have minimal potential for bias.
- d) Relevant baseline characteristics are presented and substantially equivalent among treatment groups or there is appropriate statistical adjustment for differences.

Class II: Prospective, matched, group cohort study in a representative population with masked outcome assessment that meets a-d above OR a RCT in a representative population that lacks one criterion a-d.

Class III: All other controlled trials including well-defined natural history controls or patients serving as own controls in a representative population, where outcome assessment is independently assessed or independently derived by objective outcome measurement (an outcome measure that is unlikely to be affected by an observer's [patient, treating physician, investigator] expectation or bias [eg, blood tests, administrative outcome data]).

Class IV: Evidence from uncontrolled studies, case series, case reports, or expert opinion.

Classification of recommendations

A \_ Established as effective, ineffective, or harmful for the given condition in the specified population. (Level A rating requires at least two consistent Class I studies.)

B \_ Probably effective, ineffective, or harmful for the given condition in the specified population. (Level B

rating requires at least one Class I study or at least two consistent Class II studies.)  
 C \_ Possibly effective, ineffective, or harmful for the given condition in the specified population. (Level C rating requires at least one Class II study or two consistent Class III studies.)  
 U \_ Data inadequate or conflicting given current knowledge, treatment is unproven.

**1c.11 System Used for Grading the Body of Evidence:** GRADE

**1c.12 If other, identify and describe the grading scale with definitions:**

**1c.13 Grade Assigned to the Body of Evidence:**

**1c.14 Summary of Controversy/Contradictory Evidence:** N/A

**1c.15 Citations for Evidence other than Guidelines(*Guidelines addressed below*):**

Cheng Eric, Siderowf Andrew, Swaztrauber Kari, Eisa Mahmood, Lee Martin and Vickrey Barbara. Development of Quality of Care Indicators for Parkinson's disease Movement Disorders Vol. 19, No.2, 2004 (P136-150)

All veterans with the suspected diagnosis of PD who are also receiving medications known to cause parkinsonism (e.g. neuroleptics) should have a trial of withdrawal of these medications, a trial of low-potency neuroleptic, or documentation in the medical record that the medication could not be withdrawn before making the diagnosis of PD. Cheng #1 (Assessment of medication-induced PD) 2004

**1c.16 Quote verbatim, the specific guideline recommendation** (*Including guideline # and/or page #*):

The diagnosis of PD should be reviewed regularly (6-12 month intervals seen to review diagnosis) and re-considered if atypical clinical features develop. (Level D (DS)) NICE GL35 (June 2006)

Determining the presence of the following clinical features in early stages of disease should be considered to distinguish PD from other parkinsonian syndromes: 1) falls at presentation and early in the disease course, 2) poor response to levodopa, 3) symmetry at onset, 4) rapid progression (to Hoehn and Yahr stage 3 in 3 years), 5) lack of tremor, and 6) dysautonomia (urinary urgency/incontinence and fecal incontinence, urinary retention requiring catheterization, persistent erectile failure, or symptomatic orthostatic hypotension) (Level B) AAN QSS PD (April 2006)

**1c.17 Clinical Practice Guideline Citation:** NICE National Collaborating Centre for Primary Care.

National Collaborating Centre for Chronic Conditions. Parkinson's Disease: National Clinical Guideline for Management in Primary and Secondary Care (2006) London: Royal College of Physicians

AAN QSS PD Diag. (April 2006) Suchowersky O, Reich S, Perlmutter J, Zesiewicz T, Gronseth G, Weiner WJ, Quality Standards Subcommittee of the American Academy of Neurology. Practice parameter: diagnosis and prognosis of new onset Parkinson disease (an evidence-based review): report of the Quality Standards Subcommittee of the American Academy of Neurology. Neurology 2006 Apr 11; 66(7):968-75.

**1c.18 National Guideline Clearinghouse or other URL:**

<http://www.aan.com/globals/axon/assets/9084.pdf>;

<http://www.guideline.gov/search/search.aspx?term=parkinson+aan>

**1c.19 Grading of Strength of Guideline Recommendation.** Has the recommendation been graded? Yes

**1c.20 If guideline recommendation graded, identify the entity that graded the evidence including balance of representation and any disclosures regarding bias:** American Academy of Neurology guideline development work group, NICE guideline development work group, Cheng quality indicator work group, See the individual guidelines/indicator papers for the list of disclosures

**1c.21 System Used for Grading the Strength of Guideline Recommendation:** [GRADE](#)

**1c.22 If other, identify and describe the grading scale with definitions:**

**1c.23 Grade Assigned to the Recommendation:** [AAN – Level B NICE-level D](#)

**1c.24 Rationale for Using this Guideline Over Others:** [Supports the basis for the measure and demonstrates the gap in current care provided.](#)

**Based on the NQF descriptions for rating the evidence, what was the developer's assessment of the quantity, quality, and consistency of the body of evidence?**

**1c.25 Quantity:** [High](#) **1c.26 Quality:** [Moderate](#) **1c.27 Consistency:** [High](#)

**1c.28 Attach evidence submission form:**

**1c.29 Attach appendix for supplemental materials:**

**Was the threshold criterion, *Importance to Measure and Report*, met?**

**(1a & 1b must be rated moderate or high and 1c yes) Yes ☐ No ☒**

**Provide rationale based on specific subcriteria:**

**For a new measure if the Committee votes NO, then STOP.**

**For a measure undergoing endorsement maintenance, if the Committee votes NO because of 1b. (no opportunity for improvement), it may be considered for continued endorsement and all criteria need to be evaluated.**

## 2. RELIABILITY & 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. (**evaluation criteria**)

Measure testing must demonstrate adequate reliability and validity in order to be recommended for endorsement. Testing may be conducted for data elements and/or the computed measure score. Testing information and results should be entered in the appropriate field. Supplemental materials may be referenced or attached in item 2.1. See [guidance on measure testing](#).

**S.1 Measure Web Page** (*In the future, NQF will require measure stewards to provide a URL link to a web page where current detailed specifications can be obtained*). Do you have a web page where current detailed specifications for this measure can be obtained? [Yes](#)

**S.2 If yes, provide web page URL:** <http://www.aan.com/globals/axon/assets/9084.pdf>

**2a. RELIABILITY. Precise Specifications and Reliability Testing:** **H ☒ M ☒ L ☒ I ☒**

**2a1. Precise Measure Specifications.** (*The measure specifications precise and unambiguous.*)

**2a1.1 Numerator Statement** (*Brief, narrative description of the measure focus or what is being measured about the target population, e.g., cases from the target population with the target process, condition, event, or outcome*):

[All patients who had an annual assessment including a review of current medications and for the presence of atypical features](#)

**2a1.2 Numerator Time Window** (*The time period in which the target process, condition, event, or outcome is eligible for inclusion*):

[At least once annually](#)

**2a1.3 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, codes with descriptors,*

and/or specific data collection items/responses:

Report the CPT Category II, Annual Parkinson's Disease Diagnosis Review 1400F.

**2a1.4 Denominator Statement** (Brief, narrative description of the target population being measured):  
All patients with a diagnosis of Parkinson's disease.

**2a1.5 Target Population Category** (Check all the populations for which the measure is specified and tested if any): Populations at Risk

**2a1.6 Denominator Time Window** (The time period in which cases are eligible for inclusion):  
At least once annually

**2a1.7 Denominator Details** (All information required to identify and calculate the target population/denominator such as definitions, codes with descriptors, and/or specific data collection items/responses):

All patients with a diagnosis of Parkinson's disease.

CPT @Procedure Codes:

99201 99202 99203 99204 99205 99212 99213 99214 99215 99241 99242 99243 99244 99245 99304 99305 99306 99307 99308 99309 99310 AND

- ICD-9 diagnosis codes: 332.0

**2a1.8 Denominator Exclusions** (Brief narrative description of exclusions from the target population):  
None

**2a1.9 Denominator Exclusion Details** (All information required to identify and calculate exclusions from the denominator such as definitions, codes with descriptors, and/or specific data collection items/responses):

N/A

**2a1.10 Stratification Details/Variables** (All information required to stratify the measure results including the stratification variables, codes with descriptors, definitions, and/or specific data collection items/responses):

N/A

**2a1.11 Risk Adjustment Type** (Select type. Provide specifications for risk stratification in 2a1.10 and for statistical model in 2a1.13): No risk adjustment or risk stratification **2a1.12 If "Other," please describe:**

**2a1.13 Statistical Risk Model and Variables** (Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development should be addressed in 2b4.):

N/A

**2a1.14-16 Detailed Risk Model Available at Web page URL** (or attachment). Include coefficients, equations, codes with descriptors, definitions, and/or specific data collection items/responses. Attach documents only if they are not available on a webpage and keep attached file to 5 MB or less. NQF strongly prefers you make documents available at a Web page URL. Please supply login/password if needed:

**2a1.17-18. Type of Score:**

**2a1.19 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):*

**2a1.20 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.):*

N/A

**2a1.21-23 Calculation Algorithm/Measure Logic Diagram URL or attachment:**

**2a1.24 Sampling (Survey) Methodology.** If measure is based on a sample (or survey), provide instructions for obtaining the sample, conducting the survey and guidance on minimum sample size (response rate):

**2a1.25 Data Source** *(Check all the sources for which the measure is specified and tested).* If other, please describe:

Administrative claims, Electronic Clinical Data : Electronic Health Record

**2a1.26 Data Source/Data Collection Instrument** *(Identify the specific data source/data collection instrument, e.g. name of database, clinical registry, collection instrument, etc.):* The AAN NeuroPI clinical modules are designed to help neurologists meet the American Board of Psychiatry and Neurology (ABPN) Part 4 performance in practice requirement for Maintenance of Certification (MOC). There is a Parkinson disease module that includes this quality measure.

National Parkinson Foundation Registry

CECity PQRI Wizard

Physician Quality Reporting System (2012) program measure

**2a1.27-29 Data Source/data Collection Instrument Reference Web Page URL or Attachment:**

**2a1.30-32 Data Dictionary/Code Table Web Page URL or Attachment:**

URL

<http://www.aan.com/go/practice/quality/measurements>

**2a1.33 Level of Analysis** *(Check the levels of analysis for which the measure is specified and tested):*

Clinician : Individual

**2a1.34-35 Care Setting** *(Check all the settings for which the measure is specified and tested):* Ambulatory Care : Clinician Office/Clinic, Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility

**2a2. Reliability Testing.** *(Reliability testing was conducted with appropriate method, scope, and adequate demonstration of reliability.)*

**2a2.1 Data/Sample** *(Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included):*

N/A

**2a2.2 Analytic Method** *(Describe method of reliability testing & rationale):*

N/A

**2a2.3 Testing Results** (*Reliability statistics, assessment of adequacy in the context of norms for the test conducted*):

N/A

**2b. VALIDITY. Validity, Testing, including all Threats to Validity:** H● M● L● I●

**2b1.1 Describe how the measure specifications** (*measure focus, target population, and exclusions*) **are consistent with the evidence cited in support of the measure focus (criterion 1c) and identify any differences from the evidence:**

N/A

**2b2. Validity Testing.** (*Validity testing was conducted with appropriate method, scope, and adequate demonstration of validity.*)

**2b2.1 Data/Sample** (*Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*):

N/A

**2b2.2 Analytic Method** (*Describe method of validity testing and rationale; if face validity, describe systematic assessment*):

N/A

**2b2.3 Testing Results** (*Statistical results, assessment of adequacy in the context of norms for the test conducted; if face validity, describe results of systematic assessment*):

N/A

**POTENTIAL THREATS TO VALIDITY.** (*All potential threats to validity were appropriately tested with adequate results.*)

**2b3. Measure Exclusions.** (*Exclusions were supported by the clinical evidence in 1c or appropriately tested with results demonstrating the need to specify them.*)

**2b3.1 Data/Sample for analysis of exclusions** (*Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*):

No exclusions

**2b3.2 Analytic Method** (*Describe type of analysis and rationale for examining exclusions, including exclusion related to patient preference*):

N/A

**2b3.3 Results** (*Provide statistical results for analysis of exclusions, e.g., frequency, variability, sensitivity analyses*):

N/A

**2b4. Risk Adjustment Strategy.** (*For outcome measures, adjustment for differences in case mix (severity) across measured entities was appropriately tested with adequate results.*)

**2b4.1 Data/Sample** (*Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*):

N/A

**2b4.2 Analytic Method** (*Describe methods and rationale for development and testing of risk model or risk stratification including selection of factors/variables*):

N/A

**2b4.3 Testing Results** (*Statistical risk model: Provide quantitative assessment of relative contribution of*

See Guidance for Definitions of Rating Scale: H=High; M=Moderate; L=Low; I=Insufficient; NA=Not Applicable

Created on: 10/27/2015 at 06:43 AM



*model risk factors; risk model performance metrics including cross-validation discrimination and calibration statistics, calibration curve and risk decile plot, and assessment of adequacy in the context of norms for risk models. Risk stratification: Provide quantitative assessment of relationship of risk factors to the outcome and differences in outcomes among the strata):*

N/A

**2b4.4 If outcome or resource use measure is not risk adjusted, provide rationale and analyses to justify lack of adjustment:** N/A

**2b5. Identification of Meaningful Differences in Performance.** *(The performance measure scores were appropriately analyzed and discriminated meaningful differences in quality.)*

**2b5.1 Data/Sample** *(Describe the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included):*

N/A

**2b5.2 Analytic Method** *(Describe methods and rationale to identify statistically significant and practically/meaningfully differences in performance):*

N/A

**2b5.3 Results** *(Provide measure performance results/scores, e.g., distribution by quartile, mean, median, SD, etc.; identification of statistically significant and meaningfully differences in performance):*

N/A

**2b6. Comparability of Multiple Data Sources/Methods.** *(If specified for more than one data source, the various approaches result in comparable scores.)*

**2b6.1 Data/Sample** *(Describe the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included):*

N/A

**2b6.2 Analytic Method** *(Describe methods and rationale for testing comparability of scores produced by the different data sources specified in the measure):*

N/A

**2b6.3 Testing Results** *(Provide statistical results, e.g., correlation statistics, comparison of rankings; assessment of adequacy in the context of norms for the test conducted):*

N/A

**2c. Disparities in Care:** H ☐ M ☐ L ☐ I ☐ NA ☐ *(If applicable, the measure specifications allow identification of disparities.)*

**2c.1 If measure is stratified for disparities, provide stratified results** *(Scores by stratified categories/cohorts):* N/A

**2c.2 If disparities have been reported/identified (e.g., in 1b), but measure is not specified to detect disparities, please explain:**

N/A

**2.1-2.3 Supplemental Testing Methodology Information:**

**Steering Committee: Overall, was the criterion, Scientific Acceptability of Measure Properties, met? (Reliability and Validity must be rated moderate or high) Yes ☐ No ☐**

**Provide rationale based on specific subcriteria:**

**If the Committee votes No, STOP**

### 3. USABILITY

Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making. (**evaluation criteria**)

**C.1 Intended Actual/Planned Use** (*Check all the planned uses for which the measure is intended*):  
Payment Program, Professional Certification or Recognition Program, Public Reporting, Quality Improvement (Internal to the specific organization), Regulatory and Accreditation Programs

**3.1 Current Use** (*Check all that apply; for any that are checked, provide the specific program information in the following questions*): Public Reporting, Payment Program, Professional Certification or Recognition Program, Quality Improvement (Internal to the specific organization)

**3a. Usefulness for Public Reporting: H ☒ M ☒ L ☒ I ☒**

(*The measure is meaningful, understandable and useful for public reporting.*)

**3a.1. Use in Public Reporting - disclosure of performance results to the public at large** (*If used in a public reporting program, provide name of program(s), locations, Web page URL(s)). If not publicly reported in a national or community program, state the reason AND plans to achieve public reporting, potential reporting programs or commitments, and timeline, e.g., within 3 years of endorsement: [For Maintenance – If not publicly reported, describe progress made toward achieving disclosure of performance results to the public at large and expected date for public reporting; provide rationale why continued endorsement should be considered.]*

All of six Parkinson's disease measures are currently in use in the 2012 Physician Quality Reporting System program. They have also been implemented in the CE City Registry, a CMS qualified registry for PQRS, so that physicians can complete the registry and individual claims based measures. In addition, these measures were used as the basis for the American Academy of Neurology's Maintenance of Certification Performance in Practice (NeuroPI) Parkinson's disease Modules. Although we do not have specific data to identify which physicians are using these measures, we do know that many AAN members have told the AAN that they are aware of these measures and are using them in their practices.

**3a.2. Provide a rationale for why the measure performance results are meaningful, understandable, and useful for public reporting.** If usefulness was demonstrated (e.g., focus group, cognitive testing), describe the data, method, and results: The AAN has not yet received any data from CMS regarding the usefulness of the measures in the PQRS program as the measures were only implemented as part of the program in 2012.

**3.2 Use for other Accountability Functions (payment, certification, accreditation).** If used in a public accountability program, provide name of program(s), locations, Web page URL(s): NeuroPI  
<http://www.aan.com/practice/pip/>  
Physician Quality Reporting System/CE City Data Registry  
Parkinson Foundation Registry

**3b. Usefulness for Quality Improvement: H ☒ M ☒ L ☒ I ☒**

(*The measure is meaningful, understandable and useful for quality improvement.*)

**3b.1. Use in QI.** If used in quality improvement program, provide name of program(s), locations, Web page URL(s):

**[For Maintenance – If not used for QI, indicate the reasons and describe progress toward using**

performance results for improvement].

NeuroPI <http://www.aan.com/practice/pip/>

There are currently 119 individuals participating in the AAN's NeuroPI modules on Parkinson's disease.

**3b.2. Provide rationale for why the measure performance results are meaningful, understandable, and useful for quality improvement.** If usefulness was demonstrated (e.g., QI initiative), describe the data, method and results:

The AAN has not yet received any results from the NeuroPI program for Maintenance of Certification. Due to the amount of time it takes to complete a Performance in Practice module the AAN does not yet have data regarding those participating using the Parkinson's disease measures.

**Overall, to what extent was the criterion, Usability, met?** H ☐ M ☐ L ☐ I ☐

**Provide rationale based on specific subcriteria:**

#### 4. FEASIBILITY

Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement. (**evaluation criteria**)

**4a. Data Generated as a Byproduct of Care Processes:** H ☐ M ☐ L ☐ I ☐

**4a.1-2 How are the data elements needed to compute measure scores generated?** (Check all that apply).

Data used in the measure are:

generated by and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition, 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)

**4b. Electronic Sources:** H ☐ M ☐ L ☐ I ☐

**4b.1 Are the data elements needed for the measure as specified available electronically** (Elements that are needed to compute measure scores are in defined, computer-readable fields): Some data elements are in electronic sources

**4b.2 If ALL data elements are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources:** Currently, this measure has been specified for administrative claims. The AAN has contracted with two separate consultants to learn the process to develop eSpecifications, code value sets, logic, and develop eMeasures. The training was complete as of 9/25/12 and the measures will be full specified for eMeasures by December 2012.

**4c. Susceptibility to Inaccuracies, Errors, or Unintended Consequences:** H ☐ M ☐ L ☐ I ☐

**4c.1 Identify susceptibility to inaccuracies, errors, or unintended consequences of the measurement identified during testing and/or operational use and strategies to prevent, minimize, or detect. If audited, provide results:**

Testing has not begun yet but will be completed by January 2014. Strategies to prevent, minimize or detect unintended consequences will be identified during testing in 2013. Operational use of this measure has not identified any inaccuracies, errors or unintended consequences of measurement.

**4d. Data Collection Strategy/Implementation:** H ☐ M ☐ L ☐ I ☐

**A.2 Please check if either of the following apply** (regarding proprietary measures):

**4d.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**

See Guidance for Definitions of Rating Scale: H=High; M=Moderate; L=Low; I=Insufficient; NA=Not Applicable

Created on: 10/27/2015 at 06:43 AM

**collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues** (e.g., fees for use of proprietary measures):

Testing has not begun yet but will be completed by January 2014. Operational use of this measure helped identify the need for a registry to simplify usage of measures (available via the CECity registry as of 8/2012). No other problems or issues have been identified.

Overall, to what extent was the criterion, *Feasibility*, met? H ☐ M ☐ L ☐ I ☐  
Provide rationale based on specific subcriteria:

### OVERALL SUITABILITY FOR ENDORSEMENT

Does the measure meet all the NQF criteria for endorsement? Yes ☐ No ☐

Rationale:

**If the Committee votes No, STOP.**

**If the Committee votes Yes, the final recommendation is contingent on comparison to related and competing measures.**

### 5. COMPARISON TO RELATED AND 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 before a final recommendation is made.

**5.1 If there are related measures (either same measure focus or target population) or competing measures (both the same measure focus and same target population), list the NQF # and title of all related and/or competing measures:**

#### 5a. Harmonization

**5a.1 If this measure has 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 Measure(s)

**5b.1 If this measure has 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):**

### CONTACT INFORMATION

**Co.1 Measure Steward (Intellectual Property Owner):** [American Academy of Neurology, 201 Chicago Avenue, Minneapolis, Minnesota, 55415](#)

**Co.2 Point of Contact:** [Amy, Bennett, abennett@aan.com, 612-928-6072-](#)

**Co.3 Measure Developer if different from Measure Steward:** [American Academy of Neurology, 201 Chicago Avenue, Minneapolis, Minnesota, 55415](#)

**Co.4 Point of Contact:** [Amy, Bennett, abennett@aan.com, 612-928-6072-](#)

**Co.5 Submitter:** [Amy, Bennett, abennett@aan.com, 612-928-6072-, American Academy of Neurology](#)

**Co.6 Additional organizations that sponsored/participated in measure development:**

[American Parkinson's Disease Association](#)  
[National Parkinson Foundation](#)  
[Parkinson's Disease Foundation](#)  
[American Academy of Family Physicians](#)  
[American Association of Neurosurgeons/Congress of Neurological Surgeons](#)  
[American Neurological Association](#)  
[American Psychological Association](#)  
[American Psychiatric Association](#)  
[Movement Disorder Society](#)  
[National Academy of Neuropsychology](#)  
[Aetna Inc.](#)  
[Anthem Blue Cross and Blue Shield](#)  
[Humana Inc.](#)  
[UnitedHealth Group Inc.](#)

**Co.7 Public Contact:** [Rebecca, Swain-Eng, MS, rswaineng@aan.com, 612-928-6121-, American Academy of Neurology](#)

## ADDITIONAL INFORMATION

**Workgroup/Expert Panel involved in measure development**

**Ad.1 Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.**

[William Weiner, MD \(Co-Chair, American Academy of Neurology\)](#)  
[Stewart Factor, MD \(Co-Chair, American Academy of Neurology\)](#)  
[Christopher Bever Jr., MD, MBA \(Expert Panel Facilitator, American Academy of Neurology\)](#)  
[Eric Cheng, MD \(Expert Panel Facilitator, American Academy of Neurology\)](#)  
[Michele Popadyne, RN \(Panel Member, American Parkinson's Disease Foundation\)](#)  
[Joyce Oberdorf, MA \(Panel Member, National Parkinson Foundation\)](#)  
[Jim Beck, PhD \(Panel Member, Parkinson's Disease Foundation\)](#)  
[H. James Brownlee Jr., MD \(Panel Member, American Academy of Family Physicians\)](#)  
[Lisa Shulman, MD \(Panel Member, American Academy of Neurology\)](#)  
[Sotirios A. Parashos, MD, PhD \(Panel Member, American Academy of Neurology\)](#)  
[Helen Bronte-Stewart, MD \(Panel Member, American Academy of Neurology\)](#)  
[Janis Miyasaki, MD \(Panel Member, American Academy of Neurology\)](#)  
[Marian Evatt, MD \(Panel Member, American Academy of Neurology\)](#)  
[Karl Sillay, MD \(Panel Member, American Association of Neurological Surgeons/Congress of Neurological Surgeons\)](#)  
[Blair Ford, MD \(Panel Member, American Neurological Association\)](#)  
[Paul Moberg, PhD, ABPP/CN \(Panel Member, American Psychological Association\)](#)  
[Laura Marsh, MD \(Panel Member, American Psychiatric Association\)](#)  
[Daniel Tarsy, MD \(Panel Member, Movement Disorder Society\)](#)  
[Alexander Troster, PhD \(Panel Member, National Academy of Neuropsychology\)](#)  
[Marc R. Nuwer, MD, PhD \(Panel Member, American Academy of Neurology Coding Specialist\)](#)  
[Mustafa Saad Siddiqui, MD \(Panel Member, American Academy of Neurology Coding Specialist\)](#)

Robert M. Kropp, MD, MBA (Panel Member, Aetna, Inc.)  
 Wesley B. Wong, MD, MMM (Panel Member, Anthem Blue Cross and Blue Sheild)  
 Monte Masten, MD (Panel Member, Humana, Inc.)  
 David Stumpf, MD (Panel Member, UnitedHealth Group, Inc.)  
 Rebecca Kresowik (Panel Member, Methodologist)  
 Rebecca Swain-Eng, MS (American Academy of Neurology Staff)  
 Sarah Tonn, MPH (American Academy of Neurology Staff)

**Ad.2 If adapted, provide title of original measure, NQF # if endorsed, and measure steward. Briefly describe the reasons for adapting the original measure and any work with the original measure steward:** N/A

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

**Ad.3 Year the measure was first released:** 2010

**Ad.4 Month and Year of most recent revision:** 11, 2010

**Ad.5 What is your frequency for review/update of this measure?** Every 3 years

**Ad.6 When is the next scheduled review/update for this measure?** 01, 2013

**Ad.7 Copyright statement:** ©2009 American Academy of Neurology. All rights reserved. AAN BOD approved 12.21.09.

**Ad.8 Disclaimers:** Physician Performance Measures (measures) and related data specifications developed by the American Academy of Neurology (AAN) are intended to facilitate quality improvement activities by physicians.

These measures are intended to assist physicians in enhancing quality of care. Measures are designed for use by any physician who manages the care of a patient for a specific condition or for prevention. These measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications.

Measures are subject to review and may be revised or rescinded at any time by the AAN. The measures may not be altered without prior written approval from the AAN. The measures, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes (e.g. use by health care providers in connection with their practices). Commercial use is defined as the sale, license, or distribution of the measures for commercial gain, or incorporation of the measures into a product or service that is sold, licensed, or distributed for commercial gain. Commercial uses of the measures require a license agreement between the user and the AAN. Neither the AAN nor its members shall be responsible for any use of the measures.

**Ad.9 Additional Information/Comments:**

**Date of Submission (MM/DD/YY):** 07/13/2012