

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](#).

NQF #: 1982	NQF Project: Neurology Project
(for Endorsement Maintenance Review)	
Original Endorsement Date:	Most Recent Endorsement Date: Last Updated Date: Oct 21, 2015
BRIEF MEASURE INFORMATION	
De.1 Measure Title: Parkinson's Disease Psychiatric Disorders or Disturbance Assessment	
Co.1.1 Measure Steward: American Academy of Neurology	
De.2 Brief Description of Measure: All patients with a diagnosis of Parkinson's disease who were assessed for psychiatric disorders or disturbances (e.g., psychosis, depression, anxiety disorder, apathy, or impulse control disorder) at least annually.	
2a1.1 Numerator Statement: Patients who were assessed for psychiatric disorders or disturbances (e.g., psychosis, depression, anxiety disorder, apathy, or impulse control disorder) at least annually.	
2a1.4 Denominator Statement: All patients with a diagnosis of Parkinson's disease.	
2a1.8 Denominator Exclusions: None	
1.1 Measure Type: Process	
2a1. 25-26 Data Source: Administrative claims, Electronic Clinical Data : Electronic Health Record	
2a1.33 Level of Analysis: Clinician : Individual	
1.2-1.4 Is this measure paired with another measure? No	
De.3 If included in a composite, please identify the composite measure (title and NQF number if endorsed): N/A	

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

1. IMPACT, OPPORTUNITY, EVIDENCE - IMPORTANCE TO MEASURE AND REPORT
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 : Complications](#), [Safety : Medication Safety](#)

1a.1 Demonstrated High Impact Aspect of Healthcare: [Affects large numbers](#), [A leading cause of morbidity/mortality](#), [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):

[Parkinson's disease is associated with a wide range of psychiatric disorders. Some of these problems are related to the disease itself and some are related to the medications used to treat the disease. These disorders range from anxiety and depression to psychosis and impulse control disorder. It has been demonstrated that depression, in particular, has been often overlooked as a diagnostic possibility in patients with Parkinson's disease. In fact, it has been demonstrated that depression and other psychiatric disorders are often overlooked in the general medical population. This measure will ensure that the clinician remembers to evaluate the patient for the basis of these psychiatric disorders on a yearly basis.](#)

[Depression affects around 40–50% of people with PD. It is usually mild to moderate but can be severe, and symptoms of depression can predate motor manifestations.](#)

[The relationship of depression to the pathology of PD is unclear but the inconsistent relationship between mood changes and the severity of motor symptoms indicates that depression should not simply be considered a reaction to motor disability.](#)

[There are difficulties in diagnosing mild depression in people with PD as the clinical features of depression overlap with the motor features of PD.](#)

[Psychotic symptoms indicate a loss of reality testing; that is, the formation of beliefs and sensations without a basis in reason or external sensory stimulus. Delusions \(false unshakeable beliefs that cannot be understood from the individual's sociocultural context\) and hallucinations \(perceptions in any sensory modality occurring without external sensory stimulus\) are the most common symptoms of psychosis.](#)

[Psychotic symptoms may occur at any stage in PD. Up to 50% of people with the condition may develop psychotic symptoms and 30% may experience hallucinations within the first 5 years. Although visual hallucination is the most frequent psychotic symptom, a degree of auditory hallucination is found in 40%. Delusions may involve themes of persecution, infidelity and jealousy but these are much less common.](#)

[The aetiology of psychotic symptoms in PD is complex. They may arise from the neurotransmitter disturbances of PD but can be caused by any of the drugs used to treat motor symptoms.](#)

[The appearance of psychotic symptoms requires careful evaluation. Psychotic symptoms may also occur as part of delirium \(caused by other physical illness or drug treatments\) or dementia, or may indicate the development of a co-morbid mental illness.](#)

PD is associated with impairment of cognitive function. Compared with people without PD, deficits in visuospatial abilities, category learning, verbal fluency, set switching and executive functions are typically reported.

Particular attention has focused on deficits of executive function that may mediate many of the other impairments. Executive functions include working memory, mental flexibility, and the ability to initiate and suppress responses.

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

Marsh L. Neuropsychiatric aspects of Parkinson's disease. Psychosomatics. 2000 Jan-Feb;41(1):15-23.

Ravina B, Marder K, Fernandez HH, Friedman JH, McDonald W, Murphy D, Aarsland D, Babcock D, Cummings J, Endicott J, Factor S, Galpern W, Lees A, Marsh L, Stacy M, Gwinn-Hardy K, Voon V, Goetz C. Diagnostic criteria for psychosis in Parkinson's disease: report of an NINDS, NIMH work group. Mov Disord. 2007 Jun 15;22(8):1061-8.

Galpern WR, Stacy M. Management of impulse control disorders in Parkinson's disease. Curr Treat Options Neurol. 2007 May;9(3):189-97.

Shulman LM, Taback RL, Rabinstein AA, Weiner WJ. Non-recognition of depression and other non-motor symptoms in Parkinson's disease. Parkinsonism Relat Disord. 2002 Jan;8(3):193-7.

1b. Opportunity for Improvement: H● M● L● I●

(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:

Parkinson's disease is associated with a wide range of psychiatric disorders. Some of these problems are related to the disease itself and some are related to the medications used to treat the disease. These disorders range from anxiety and depression to psychosis and impulse control disorder. It has been demonstrated that depression, in particular, has been often overlooked as a diagnostic possibility in patients with Parkinson's disease. In fact, it has been demonstrated that depression and other psychiatric disorders are often overlooked in the general medical population. This measure will ensure that the clinician remembers to evaluate the patient for the basis of these psychiatric disorders on a yearly basis.

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.]*

Many people with Parkinson's disease experience mental health symptoms. These include: dementia, which affects a third of people with Parkinson's disease; depression, affecting up to half of all people with the condition; and compulsive behaviours, a side-effect of medication affecting an estimated 14% of people taking dopamine agonists, a class of Parkinson's drugs.

Although a number of clinicians identified that there had been a step change in understanding the mental health aspects of Parkinson's disease amongst specialists, evidence to the Inquiry has revealed that many people with the condition are not receiving specialist mental health services. This is of particular concern given the high levels of people with Parkinson's disease experiencing mental health symptoms.

Very few people with Parkinson's disease or carers commented that they were accessing mental health services. The PDS also provided evidence from its Members' survey that less than one in eight people with Parkinson's disease have ever received an assessment or course of treatment in connection with their Parkinson's disease from a mental health professional⁶. Further evidence from a training needs analysis

and members' consultation project conducted by the PDS also revealed that one third of people with Parkinson's disease are not referred to mental health services despite experiencing mental health symptoms.¹

We examined the medical records, from 1998 to 2004, of 401 Los Angeles veterans with Parkinson's disease to determine whether care met key indicators of PD care quality. We compared adherence to each indicator through logistic regression models. Over the study period, 10 indicators of PD care quality were triggered 2,227 times. The 10 PD indicators were triggered 2,227 times during the study period, and patients received recommended care 1,541 times (69%). Gaps in care were particularly large for annual assessment of nonmotor symptoms such as orthostatic hypotension, falls, depression, and hallucinations. Gaps in care were also noted for treatment of wearing off among non-neurologists.²

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. All Parliamentary Group for Parkinson's Disease. Please Mind the Gap: Parkinson's disease services today.

http://www.parkinsons.org.uk/PDF/APPG_Report_Please_Mind_the_Gap.pdf

2. Cheng E, Swarztrauber K, Siderowf A, Eisa M, Lee M, Vassar S, Jacob E, Vickrey B. Association of specialist involvement and quality of care for Parkinson's disease. *Movement disorders*. 2007;22:515

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

These trends in the data suggest that disease rates among Asians appear to be lower than those of Whites, whether they be non-Hispanic or Hispanic Whites. Furthermore, Parkinson's disease rates among Blacks are likely to be lower than those among non-Hispanic Whites, consistent with several past prevalence studies.

Mayeux et al. reported that the highest incidence was among young Black men in a population in northern Manhattan. Their study identified a total of 24 Black cases over the 3-year ascertainment period. Data from the 1990 Census for the Washington Heights' section of northern Manhattan were used to estimate the denominators by race/ethnicity and for age adjustment.¹

Parkinson's disease incidence among Asian/Pacific Islanders (age- and gender-adjusted incidence = 11.3, 95 percent CI: 7.2, 15.3) was similar to that of non-Hispanic Whites. The investigators of the Honolulu Heart Study reported an age-adjusted incidence of 11.1 per 100,000 for the 92 cases of incident Parkinson's disease among a cohort of 8,006 men of Japanese or Okinawan ancestry that have been followed since 1965 (9).

After adjustment to the same standard population, our rate for Asian/Pacific Islander men was lower (10.8 per 100,000, 95 percent CI: 6.3, 15.4) than that found in Hawaii (13.1 per 100,000, 95 percent CI: 10.6, 15.6) (table 4). This may be due, in part, to differences in the ancestry of the two groups, as members of the Kaiser

Permanente population included those from or with ancestry from many Asian and Pacific Island areas. No other study has directly reported the incidence of Parkinson's disease among Hispanic/Latino individuals.

However, the "other" category in the northern Manhattan study was stated to be composed of primarily Hispanic individuals. The age-adjusted incidence for men was 11.9 (95 percent CI: 5.6, 18.3) and 23.0 (95 percent CI: 16.8, 29.2) in northern Manhattan and in our study, respectively.¹

For women, the comparable estimates were 12.5 (95 percent CI: 7.7, 17.4) and 11.9 (95 percent CI: 6.8, 17.1). The overall incidence rate for Hispanics was the highest among the race/ethnic groups in our study. The high observed rate and the fact that it was observed among both men and women raise interesting

issues regarding possible explanations that are discussed below.

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]

S. Van Den Eeden, C. Tanner, A. Bernstein, R. Fross, A. Leimpeter, D. Bloch, L. Nelson; Incidence of Parkinson's Disease: Variation by Age, Gender, and Race/Ethnicity; American Journal of Epidemiology; 157:11, 2002

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 subcriterion1c?
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 subcriterion1c?
Yes ☐ 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):

This measure would impact and benefit all patients diagnosed with Parkinson's disease.

This measure is expected to create the following outcomes: improved motor symptom management, improve patient quality of life An assessment for psychiatric disorders or disturbances is expected to lead to better medication management (eg Parkinson's disease drugs may cause psychotic symptoms), appropriate treatment of Parkinson's disease symptoms and related disorders and disturbances, and improved management of co-morbid conditions. These are all known issues for patients with Parkinson's disease and by assessing the patient for these psychiatric disorders or disturbances at least once annual the physician will be able to better assist the patient in managing their treatment, disorder/disturbance symptoms and in turn improve the patient's quality of life.

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 were 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.

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

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

Population: All patients with a diagnosis of Parkinson's disease

Outcomes addressed in the body of evidence: Parkinson's disease is associated with a wide range of psychiatric disorders. Some of these problems are related to the disease itself and some are related to the medications used to treat the disease. These disorders range from anxiety and depression to psychosis and impulse control disorder. It has been demonstrated that depression, in particular, has been often overlooked as a diagnostic possibility in patients with Parkinson's disease. In fact, it has been demonstrated that depression and other psychiatric disorders are often overlooked in the general medical population. This measure will ensure that the clinician remembers to evaluate the patient for the basis of these psychiatric disorders on a yearly basis.

Identify any differences from the measure focus and measure target population: not applicable

1c.5 Quantity of Studies in the Body of Evidence (*Total number of studies, not articles*): 3
recommendation statements and 2 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:

Clinicians should be aware of dopamine dysregulation syndrome, an uncommon disorder in which dopaminergic medication misuse is associated with abnormal behaviors, including hypersexuality, pathological gambling and stereotypic motor acts. This syndrome may be difficult to manage. (Level D)
NICE GL35 (Jun 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:

Although PD is predominantly a movement disorder, other impairments frequently develop, including psychiatric problems such as depression and dementia. Autonomic disturbances and pain may later ensue, and the condition progresses to cause significant disability and handicap with impaired quality of life for the affected person. Family and carers may also be affected indirectly.

This study looked at PDQ-39, patients with high levels of depression, who also had a mini mental status exam of 24 or less, postural instability, and a history of falls or gait difficulties had a significantly worse PDQ-39 score than those patients who did not have these features. These scores were the same regardless of gender. Those patients with akinetic subtype were found to be worse than those with a tremor dominant disease. This difference could not be explained by age or disease duration.

Recommendation:

If a veteran with PD presents with new onset of one of the following symptoms: sad mood, feeling down;

insomnia or difficulties with sleep; apathy or loss of interest in pleasurable activities; complains of memory loss; unexplained weight loss of greater than 5% in the past month or 10% over one year; or unexplained fatigue or low energy, then the patient should be asked about or treated for depression, or referred to a mental health professional within two weeks of presentation. (Outcomes Impact 5; Room for Improvement 4; Overall utility rating 4) Cheng 2004

2. Cheng Eric, Siderowf Andrew, Swartztrauber 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:

Members of the research team reviewed the literature for each PD-specific indicator and created an evidence

summary. Relevant randomized, controlled trials and/or observational studies that were identified in our search strategy but not summarized in existing guidelines or systematic reviews were also included in the evidence summaries. We formally graded the medical evidence using the format issued by the Fifth American College of Chest Physicians Consensus Conference on Antithrombotic Therapy.

Summaries of evidence from the scientific literature for the ACOVE indicators have been published previously. The evidence summaries for the 33 selected ACOVE indicators identified as relevant to PD were reviewed and slightly modified to make them more relevant to PD care, for example, substituting the phrase "a PD patient" for "a vulnerable elder".

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).

Recommendation:

Clinicians should have a low threshold for diagnosing depression in PD. (Level D) NICE GL35 (Jun 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:

The spectrum of PD includes many problems that do not directly affect motor function. These non-motor features are of crucial importance to people since they have a major impact on quality of life. Non-motor features comprise:

- _ mental health problems
- _ depression and dementia
- _ falls and potential fractures
- _ sleep disturbance
- _ autonomic disturbance and pain.

While most people are troubled by these problems in the later stages of their PD, certain nonmotor conditions can develop throughout the course of the condition (eg depression, anxiety, hypersomnolence) or even precede it (eg sleep disturbance, depression, anxiety).

A recent study reported on the non-motor problems experienced by a group of 149 people with PD followed for 15–18 years.²⁸⁷ They found the occurrence rates were: falls 81% (with 23% suffering fractures), cognitive decline 84% (48% fulfilling criteria for dementia), hallucinations 50%, depression 50%, choking 50%, symptomatic postural hypotension 35%, and urinary incontinence 41%.

There have previously been few therapeutic studies examining the effects of treatments for nonmotor disorders. However, there is now a real desire to increase research into the non-motor features of PD as their effect on people's well-being has been recognised.

The non-motor features of PD considered in the scope of this guideline and thus undergoing literature review were:

- _ mental health problems:
 - depression
 - dementia
 - psychosis

Recommendation:

All veterans with PD should be reassessed for complications of PD (including, but not limited to functional status, excessive daytime somnolence, speech and swallowing difficulties, dementia, depression, and psychosis) at least on an annual basis. Cheng #10 (Reassessment for complications for PD) 2004

Primary Evidence:

After reviewing this literature, a set of 46 potential quality indicators were drafted for quality of care issues specific to PD. These indicators were grouped into five "domains" of care: Initial Diagnosis and Treatment; Management of Motor Complications; Management of Non-Motor Complications; Management of Dementia, Depression, and Psychosis; and Education and Reporting. These 46 indicators are listed in Table 1A (Appendix 1).

Quality indicators for the assessment and recognition of depression were highly ranked in their impact on outcomes, room for improvement, and overall utility rating. Depression in PD is quite common. The US Preventive Services Task Force has recommended screening of depression in all adults (not just PD patients) because of its importance in improving clinical outcomes.⁴⁵ A survey of 1,000 PD patients showed that depression had a greater impact than PD severity or use of PD medication in determining health-related quality of life scores.

Recommendation:

All people with PD and psychosis should receive a general medical evaluation and treatment for any precipitating condition. (Level D) NICE GL35 (Jun 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 :

Typical symptoms: delusions, hallucinations Identify non-affective psychotic symptoms General medical evaluation to identify delirium and to treat any precipitating condition

Explain the nature of psychotic symptoms to the patient and carer Consider slowly withdrawing anti-parkinson medication which might have triggered psychosis eg last drug added or May need to reduce anti-parkinson medication to levodopa only or Typical antipsychotic drugs eg phenothiazines, butyrophenones, should not be used In the absence of dementia, clozapine can be used but registration and monitoring are required or Cholinesterase inhibitors have been used with success in some patients but are not licensed for psychosis and require further evaluation

1c.7 Consistency of Results across Studies (*Summarize the consistency of the magnitude and direction of the effect*): The studies are consistent that all patients with a diagnosis of Parkinson's disease should be assessed for psychiatric disorders or disturbances.

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: **NICE:**

Rating Scheme for Strength of the Evidence

Ia-Systematic review or meta-analysis of randomized controlled trials

Ib-At least one randomized controlled trial

Ila-At least one well-designed controlled study without randomization

Ilb-At least one well-designed quasi-experimental descriptive studies, such as a cohort study

III-Well-designed non-experimental descriptive studies, case-control studies, and case studies

IV-Expert committee reports, opinions and/or clinical experience of respected authorities

Rating Recommendations

A* Directly based on category I evidence (meta-analysis of randomized controlled trials (RCTs) or at least one RCT)

B* Directly based on category II evidence (at least one controlled study without randomization or at least one other quasi-experimental study) or extrapolated from category I evidence

C* Directly based on category III evidence (non-experimental descriptive studies) or extrapolated from category I or II evidence

D* Directly based on category III evidence (expert committee reports or opinions and/or clinical experience of respected authorities) or extrapolated from category I, II or III evidence

N Recommendation taken from NICE guideline or technology appraisal guidance

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*):

If a veteran with PD presents with new onset of one of the following symptoms: sad mood, feeling down; insomnia or difficulties with sleep; apathy or loss of interest in pleasurable activities; complains of memory loss; unexplained weight loss of greater than 5% in the past month or 10% over one year; or unexplained fatigue or low energy, then the patient should be asked about or treated for depression, or referred to a mental health professional within two weeks of presentation. (Outcomes Impact 5; Room for Improvement 4; Overall utility rating 4) Cheng 2004

All veterans with PD should be reassessed for complications of PD (including, but not limited to functional status, excessive daytime somnolence, speech and swallowing difficulties, dementia, depression, and psychosis) at least on an annual basis. Cheng #10 (Reassessment for complications for PD) 2004

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)

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

Clinicians should be aware of dopamine dysregulation syndrome, an uncommon disorder in which dopaminergic medication misuse is associated with abnormal behaviors, including hypersexuality, pathological gambling and stereotypic motor acts. This syndrome may be difficult to manage. (Level D) NICE GL35 (Jun 2006)

All people with PD and psychosis should receive a general medical evaluation and treatment for any precipitating condition. (Level D) NICE GL35 (Jun 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

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: NICE guideline development work group

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: 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*):

[Patients who were assessed for psychiatric disorders or disturbances \(e.g., psychosis, depression, anxiety disorder, apathy, or impulse control disorder\) at least annually.](#)

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, Psychiatric Disorders or Disturbances Assessment 3700F.](#)

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*):

[Denominator \(Eligible Population\): 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.):* [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: [URL
http://www.aan.com/practice/pip/](http://www.aan.com/practice/pip/)

2a1.30-32 Data Dictionary/Code Table Web Page URL or Attachment:
[URL
http://www.aan.com/go/practice/quality/measurements](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 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, Regulatory and Accreditation Programs, 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): AAN NeuroPI <http://www.aan.com/practice/pip/>

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 module 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:

Due to the amount of time it takes to complete a Performance in Practice module the AAN does not yet have data from 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 fully 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 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
<p>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?</p> <p>5a.2 If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden:</p>
5b. Competing Measure(s)
<p>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):</p>

CONTACT INFORMATION
<p>Co.1 Measure Steward (Intellectual Property Owner): American Academy of Neurology, 201 Chicago Avenue, Minneapolis, Minnesota, 55415</p>
<p>Co.2 Point of Contact: Amy, Bennett, abennett@aan.com, 612-928-6072-</p>
<p>Co.3 Measure Developer if different from Measure Steward: American Academy of Neurology, 201 Chicago Avenue, Minneapolis, Minnesota, 55415</p>
<p>Co.4 Point of Contact: Amy, Bennett, abennett@aan.com, 612-928-6072-</p>
<p>Co.5 Submitter: Amy, Bennett, abennett@aan.com, 612-928-6072-, American Academy of Neurology</p>
<p>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.</p>
<p>Co.7 Public Contact: Rebecca, Swain-Eng, MS, rswaineng@aan.com, 612-928-6121-, American Academy of Neurology</p>

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 Popadynec, 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 Shield)
 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