

# 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> 2004	<b>NQF Project:</b> <a href="#">Neurology Project</a>
(for Endorsement Maintenance Review)	
<b>Original Endorsement Date:</b>	<b>Most Recent Endorsement Date:</b> Jul 17, 2015
<b>BRIEF MEASURE INFORMATION</b>	
<b>De.1 Measure Title:</b> <a href="#">Dementia: Functional Status Assessment</a>	
<b>Co.1.1 Measure Steward:</b> <a href="#">AMA-convened Physician Consortium for Performance Improvement</a>	
<b>De.2 Brief Description of Measure:</b> <a href="#">Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of functional status is performed and the results reviewed at least once within a 12 month period</a>	
<b>2a1.1 Numerator Statement:</b> <a href="#">Patients for whom an assessment of functional status* is performed and the results reviewed at least once within a 12 month period</a>  * Functional status can be assessed by direct examination of the patient or knowledgeable informant. An assessment of functional status should include, at a minimum, an evaluation of the patient's ability to perform instrumental activities of daily living (IADL) and basic activities of daily living (ADL). Functional status can also be assessed using one of a number of available valid and reliable instruments available from the medical literature. Examples include, but are not limited to: •Lawton IADL Scale •Barthel ADL Index •Katz Index of Independence in ADL	
<b>2a1.4 Denominator Statement:</b> <a href="#">All patients, regardless of age, with a diagnosis of dementia</a>	
<b>2a1.8 Denominator Exclusions:</b> <a href="#">Documentation of medical reason(s) for not assessing functional status (eg, patient is severely impaired and caregiver knowledge is limited, other medical reason)</a>	
<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 Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry</a> <b>2a1.33 Level of Analysis:</b> <a href="#">Clinician : Group/Practice, Clinician : Individual, Clinician : Team</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> <i>(issues or questions regarding any criteria)</i>
<b>Comments on Conditions for Consideration:</b>
<b>Is the measure untested?</b> Yes <input 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 ● M ● L ● I ●**

(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 : Dementia/Delirium**

**De.5 Cross Cutting Areas** (Check all the areas that apply): **Health and Functional Status : Functional Status**

**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):

Dementia is a chronic condition that poses a major and growing threat to the public's health. Improving the effectiveness of care and optimizing patient outcomes will become increasingly important as the population of the United States ages.

- Dementia affects approximately 5%–8% of individuals over age 65 years, 15%–20% of individuals over age 75 years, and 25%–50% of individuals over age 85 years.(1)
- Currently, an estimated 5.4 million Americans of all ages have Alzheimer's disease – the most common form of dementia.(2)
- The estimated annual incidence of Alzheimer's disease increases dramatically with age, from approximately 53 new cases per 1,000 people age 65 to 74 to 231 new cases per 1,000 people over age 85. Because of the increase in the number of people over 65 in the United States, the annual incidence of Alzheimer's and other dementias is projected to double by 2050. (2)
- More than 20 percent of women and approximately 17 percent of men reaching the age of 65 would ultimately develop dementia (estimated lifetime risk). (2)
- Alzheimer's disease was the sixth-leading cause of death across all ages in the United States in 2008. It was the fifth-leading cause of death for those aged 65 and older in 2008. (2)
- People with Alzheimer's disease and other dementias have more than three times as many hospital stays as other older people. (2)
- At any one time, about one-quarter of all hospital patients aged 65 and older are people with Alzheimer's and other dementias.i (1)
- The total estimated worldwide costs of dementia are \$604 billion in 2010, accounting for around 1% of the world's gross domestic product. (3)
- Aggregate payments for health care, long-term care and hospice for people with Alzheimer's disease and other dementias in the United States are projected to increase from \$200 billion in 2012 to \$1.1 trillion in

2050 (in 2012 dollars). Medicare and Medicaid cover about 70 percent of the costs of care. (2)

The identification of high-quality dementia care guidelines and measures across settings has also been identified as a key strategy in HHS's National Plan to Address Alzheimer's Disease. In particular, the plan suggests that measures are needed that can track whether recommended care is being provided. These measures should be based on guidelines tailored to the stages of the disease, addressing the physical, cognitive, emotional, and behavioral symptoms of AD, and covering the myriad care settings in which care is delivered.(4)

**1a.4 Citations for Evidence of High Impact cited in 1a.3:** 1. Alzheimer's Association. 2009 Alzheimer's Disease Facts and Figures. Alzheimer's Association ; 2009.

[http://www.alz.org/national/documents/report\\_alzfactsfigures2009.pdf](http://www.alz.org/national/documents/report_alzfactsfigures2009.pdf). Accessed February 24, 2010.

2. Alzheimer's Association. 2012 Alzheimer's Disease Facts and Figures. Alzheimer's Association ; 2012. [http://www.alz.org/downloads/Facts\\_Figures\\_2012.pdf](http://www.alz.org/downloads/Facts_Figures_2012.pdf). Accessed April 19, 2012.

3. Alzheimer's Disease International. World Alzheimer Report 2010: The global economic impact of dementia. [http://www.alz.org/documents/national/World\\_Alzheimer\\_Report\\_2010.pdf](http://www.alz.org/documents/national/World_Alzheimer_Report_2010.pdf). Accessed September 28, 2010.

4. U.S. Department of Health and Human Services. National plan to address alzheimer's disease. Available at: <http://aspe.hhs.gov/daltcp/napa>. Accessed May 16, 2012.

#### **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:**

This measure is intended to encourage the initial and ongoing assessment of functional status to determine a baseline level of functioning, monitor changes over time and to identify strategies to maximize patient's independence.

**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.]*

A 2007 analysis of medical records and caregiver surveys for 378 patients with dementia found that only 9.5% of patients received an assessment of their activities of daily living in the previous 12 months.(1) Similar results were reported in a study analyzing the quality of health care provided to a broader population of vulnerable community-dwelling older patients. Only 18% of vulnerable elders admitted to a hospital or new to a physician practice received an assessment of their functional status.(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. Chodosh J, Mittman BS, Connor KI. Caring for patients with dementia: How good is the quality of care? Results from three health systems. J Am Geriatr Soc. 2007 Aug;55(8):1260-8.

2. Wenger N, Solomon D, Roth C et al. The quality of medical care provided to vulnerable community-dwelling older patients. Ann Intern Med. 2003;139:740–747.

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

We are not aware of any publications/evidence outlining disparities specifically related to assessing functional status. However, a recent systematic review and meta-analysis of the use of dementia treatment, care, and research identified significant racial and ethnic disparities in western countries, particularly the

United States. Overall, the authors found “consistent evidence, mostly from the United States, that [minority ethnic] people accessed diagnostic services later in their illness, and once they received a diagnosis, were less likely to access antidementia medication, research trials, and 24-hour care.”(1)

**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. Cooper C, Tandy AR, Balamurali TB, Livingston G. A systematic review and meta-analysis of ethnic differences in use of dementia treatment, care, and research. *Am J Geriatr Psychiatry*. 2010 Mar;18(3):193-203.

**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):

Dementia is characterized by cognitive deficits that cause functional impairment compromising basic and instrumental activities of daily living. Functional decline for dementia patients is progressive and continuous and typically marked by decline in instrumental activities of daily living followed by a slower decline in basic activities of daily living.(1) Functional impairment is the main factor negatively impacting quality of life in patients with dementia including reported links to the development of apathy and depression.(2,3,4) In addition, decline in basic activities of daily living is an important risk factor for institutionalization and a strong predictor of decreased survival in dementia patients.(5,6) Initial and ongoing assessments of functional status should be conducted to determine baseline level of functioning, monitor changes over time, and to identify strategies to maximize patient’s independence.

#### References:

1. Lechowski L, Van Pradelles S, Le Crane M, et al; and REAL Group. Patterns of loss of basic activities of daily living in Alzheimer patients: A cross-sectional study of the French REAL cohort. *Dement Geriatr Cogn Disord*. 2010;29(1):46-54.
2. Andersen CK, Wittrup-Jensen KU, Lolk A, Andersen K, Kragh-Sørensen P. Ability to perform activities of daily living is the main factor affecting quality of life in patients with dementia. *Health Qual Life Outcomes*. 2004; 2:52.
3. Starkstein SE, Jorge R, Mizrahi R, Robinson RG. The Construct of Minor and Major Depression in Alzheimer’s Disease. *Am J Psychiatry*. 2005;162:2086-2093.

4. Boyle PA, Malloy PF, Salloway S, Cahn-Weiner DA, Cohen R, Cummings JL. Executive dysfunction and apathy predict functional impairment in Alzheimer disease. *Am J Geriatr Psychiatry*. 2003 Mar-Apr;11(2):214-21.
5. Steeman E, Abraham IL, Godderis J. Risk profiles for institutionalization in a cohort of elderly people with dementia or depression. *Arch Psychiatr Nurs*. 1997;11, 295-303.
6. Bracco L, Gallato R, Grigoletto F, et al. Factors affecting course and survival in Alzheimer's disease. A 9-year longitudinal study. *Arch Neurol*. 1994 Dec;51(12):1213-9.

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

**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):

Clinical practice guidelines from the APA for the treatment of patients with Alzheimer's disease and other dementias recommend ongoing assessment of functional status to aid the clinician in documenting and tracking changes over time as well as providing guidance to the patient and caregivers. These regular assessments provide a baseline for assessing the effect of any intervention, and they improve the recognition and treatment of acute problems, such as delirium.

Clinical practice guidelines from the California Workgroup on Guidelines for Alzheimer's Disease Management recommend the routine assessment of functional status to determine how best to maximize patients' independence

The measure focus is on the assessment of functional status for all patients with dementia.

**1c.5 Quantity of Studies in the Body of Evidence** (Total number of studies, not articles): The description of the evidence review in the APA guideline did not address the overall quantity of studies in the body of evidence related to performing initial and routine functional assessments. However, 554 articles are cited in the guideline's reference section.

The description of the evidence review in the guidelines from the California Workgroup did not address the overall quantity of studies in the body of evidence related to performing initial and routine functional assessments. However, over 400 articles are cited in the guideline's reference section including 13 citations in the daily functioning section. Four of the citations, in particular, refer to the relationship of the assessments to the outcomes (ie, maximizing patients' independence, providing realistic goal setting and treatment planning information and allowing early supportive interventions to be initiated).

**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 quality of the body of evidence supporting the measure focus was not addressed in either the APA or California Workgroup guidelines.

**1c.7 Consistency of Results across Studies** (Summarize the consistency of the magnitude and direction of the effect): The consistency of results across studies supporting the measure focus was not addressed in either the APA or California Workgroup guidelines. However, one of the relevant APA recommendation statements received a Category I recommendation which indicates that the practice was recommended with substantial clinical confidence.



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

Functional status assessments allow the clinician to determine a baseline level of functioning, monitor changes over time and to identify strategies to maximize patient's independence.

**1c.9 Grading of Strength/Quality of the Body of Evidence.** Has the body of evidence been graded? **No**

**1c.10 If body of evidence graded, identify the entity that graded the evidence including balance of representation and any disclosures regarding bias:** Although the body of evidence was not graded in either the APA or California Workgroup guidelines, the APA guidelines indicate that "each rating of clinical confidence considers the strength of the available evidence and is based on the best available data. When evidence is limited, the level of confidence also incorporates clinical consensus with regard to a particular clinical decision." The California Workgroup indicated that the guideline was developed through a review of scientific evidence supplemented by expert opinion when research has been unavailable or inconsistent.

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

**1c.12 If other, identify and describe the grading scale with definitions:** **None**, the body of evidence was not graded.

**1c.13 Grade Assigned to the Body of Evidence:** **None**

**1c.14 Summary of Controversy/Contradictory Evidence:** **No controversy or contradictory evidence reported.**

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

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

The treatment of patients with dementia should be based on a thorough psychiatric, neurological, and general medical evaluation of the nature and cause of the cognitive deficits and associated noncognitive symptoms, in the context of a solid alliance with the patient and family. (Category I) (1)

Ongoing assessment includes periodic monitoring of the development and evolution of cognitive and noncognitive psychiatric symptoms and their response to intervention. (Category I) (1)

A detailed assessment of functional status may also aid the clinician in documenting and tracking changes over time as well as providing guidance to the patient and caregivers. Functional status is typically described in terms of the patient's ability to perform instrumental activities of daily living such as shopping, writing checks, basic housework, and activities of daily living such as dressing, bathing, feeding, transferring, and maintaining continence. These regular assessments of recent cognitive and functional status provide a baseline for assessing the effect of any intervention, and they improve the recognition and treatment of acute problems, such as delirium. (Recommendation statements not rated) (1)

Conduct and document an assessment and monitor changes in daily functioning, including feeding, bathing, dressing, mobility, toileting, continence, and ability to manage finances and medications...Functional assessment includes evaluation of physical, psychological, and socioeconomic domains. Physical functioning may focus on basic activities of daily living (ADLs) that include feeding, bathing, dressing, mobility, and toileting. Assessment of instrumental (or intermediate) activities of daily living (IADLs) addresses more advanced self-care activities, such as shopping, cooking, and managing finances and medications. Standardized assessment instruments such as the Barthel or Katz indices can provide information on the patient's capacity for self-care

and independent living. Proxies or patient surrogates can complete a number of these instruments when necessary. The initial assessment of functional abilities is important to determine a baseline to which future functional deficits may be compared.(2)

**1c.17 Clinical Practice Guideline Citation:** 1. American Psychiatric Association (APA). Practice guideline for the treatment of patients with Alzheimer's disease and other dementias. Arlington (VA): American Psychiatric Association (APA); 2007 Oct.

2. California Workgroup on Guidelines for Alzheimer's Disease Management. Guidelines for Alzheimer's disease management. Los Angeles, CA: Alzheimer's Disease and Related Disorders Association, Inc., Los Angeles Chapter. 2008.

**1c.18 National Guideline Clearinghouse or other URL:** <http://guidelines.gov/content.aspx?id=11533>; [http://www.cdph.ca.gov/programs/alzheimers/Documents/professional\\_GuidelineFullReport.pdf](http://www.cdph.ca.gov/programs/alzheimers/Documents/professional_GuidelineFullReport.pdf)

**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:** The APA guidelines were developed by the following members of the work group on alzheimer's disease and other dementias: Peter V. Rabins, M.D., M.P.H., Chair; Deborah Blacker, M.D., Sc.D.; Barry W. Rovner, M.D.; Teresa Rummans, M.D.; Lon S. Schneider, M.D.; Pierre N. Tariot, M.D. and David M. Blass, M.D., Consultant. A number of mechanisms are in place to minimize the potential for producing biased recommendations due to conflicts of interest. Work group members are selected on the basis of their expertise and integrity. Any work group member or reviewer who has a potential conflict of interest that may bias (or appear to bias) his or her work is asked to disclose this to the Steering Committee on Practice Guidelines and the work group. The development of the APA Practice Guidelines is not financially supported by any commercial organization. The California Workgroup guidelines recommendations are not graded.

**1c.21 System Used for Grading the Strength of Guideline Recommendation:** **Other**

**1c.22 If other, identify and describe the grading scale with definitions:** Each APA recommendation is identified as falling into one of three categories of endorsement, indicated by a bracketed Roman numeral following the statement. The three categories represent varying levels of clinical confidence:

[I] Recommended with substantial clinical confidence

[II] Recommended with moderate clinical confidence

[III] May be recommended on the basis of individual circumstances

**1c.23 Grade Assigned to the Recommendation:** APA Guideline: Category I - see the recommendation statement with the corresponding rating in 1c.16.

**1c.24 Rationale for Using this Guideline Over Others:** It is the PCPI policy to use guidelines, which are evidence-based, applicable to physicians and other health-care providers, and developed by a national specialty organization or government agency. In addition, the PCPI has now expanded what is acceptable as the evidence base for measures to include documented quality improvement (QI) initiatives or implementation projects that have demonstrated improvement in quality of care.

**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:** **Moderate** **1c.26 Quality:** **Moderate** **1c.27 Consistency:** **Moderate**

**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:** [www.physicianconsortium.org](http://www.physicianconsortium.org)

**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 for whom an assessment of functional status\\* is performed and the results reviewed at least once within a 12 month period](#)

\* Functional status can be assessed by direct examination of the patient or knowledgeable informant. An assessment of functional status should include, at a minimum, an evaluation of the patient's ability to perform instrumental activities of daily living (IADL) and basic activities of daily living (ADL). Functional status can also be assessed using one of a number of available valid and reliable instruments available from the medical literature. Examples include, but are not limited to:

- Lawton IADL Scale
- Barthel ADL Index
- Katz Index of Independence in ADL

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

[At least once during measurement period](#)

**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*):

[For EHR:](#)

[eMeasure developed—see attached](#)

[For Claims/Administrative Data:](#)



CPT Category II Code: 1175F: Functional status for dementia assessed and results reviewed

**2a1.4 Denominator Statement** (*Brief, narrative description of the target population being measured*):  
All patients, regardless of age, with a diagnosis of dementia

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

**2a1.6 Denominator Time Window** (*The time period in which cases are eligible for inclusion*):  
12 consecutive months

**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*):

For EHR:

eMeasure developed—see attached

For Claims/Administrative Data:

Denominator Criteria (Eligible Cases):

All patients regardless of age

AND

Diagnosis of dementia

ICD-9-CM Diagnosis codes: 094.1, 290.0, 290.10, 290.11, 290.12, 290.13, 290.20, 290.21, 290.3, 290.40, 290.41, 290.42, 290.43, 290.8, 290.9, 294.10, 294.11, 294.20, 294.21, 294.8, 331.0, 331.11, 331.19, 331.82

ICD-10-CM Diagnosis codes: A52.17, F01.50, F01.51, F02.80, F02.81, F03, F05, F06.0, F06.8, G30.0, G30.1, G30.8, G30.9, G31.01, G31.09, G31.83

AND

CPT Codes: 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90826, 90827, 90828, 90829, 90862, 96116, 96118, 96119, 96120, 97003, 97004, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

**2a1.8 Denominator Exclusions** (*Brief narrative description of exclusions from the target population*):

Documentation of medical reason(s) for not assessing functional status (eg, patient is severely impaired and caregiver knowledge is limited, other medical reason)

**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*):

The PCPI exception methodology uses three categories of reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure, exceptions may include medical reason(s) (eg, eg, patient is severely impaired and caregiver knowledge is limited, other medical reason) for not assessing functional status. Where examples of exceptions are included in the measure language, value sets for these examples are developed and included in the eSpecifications. Although this methodology does not require the external reporting of more detailed

exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. Additional details by data source are as follows:

For EHR:

eMeasure developed—see attached.

For Claims/Administrative Data:

Documentation of medical reason(s) for not assessing functional status (eg, patient is severely impaired and caregiver knowledge is limited, other medical reason)

- Append modifier to CPT II code 1175F-1P

**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 ):*

We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

**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.):*

No risk adjustment or risk stratification.

**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:** Rate/proportion

**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):*

Better quality = Higher 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.):*

To calculate performance rates:

- 1) Find the patients who meet the initial patient population (ie, the general group of patients that a set of performance measures is designed to address).
- 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical.
- 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator

4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for exception when exceptions have been specified [for this measure: medical reason(s) (eg, patient is severely impaired and caregiver knowledge is limited, other medical reason). If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.

Calculation algorithm is included as an attachment (see 2a1.21).

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

Attachment

PCPI\_Measure\_Calculation\_V2.0-634769317338940052.pdf

**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):

Not applicable. The measure does not require sampling or a survey.

**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 Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry

**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.): Not Applicable. Zip file for data dictionary/code table to be sent separately (cannot be attached to 2a1.30).

**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:**

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

Clinician : Group/Practice, Clinician : Individual, Clinician : Team

**2a1.34-35 Care Setting** (Check all the settings for which the measure is specified and tested): Ambulatory Care : Clinician Office/Clinic, Ambulatory Care : Urgent Care, Behavioral Health/Psychiatric : Inpatient, Behavioral Health/Psychiatric : Outpatient, Other:Occupational Therapy Services, 'Domiciliary, Rest Home or Custodial Care Services', 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):*

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

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

**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:*

**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):*

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

**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):*

**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):*

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

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

**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):*

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

**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*):

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

**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*):

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

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

**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*):

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

**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*):

**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*): We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

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

The PCPI advocates that performance measure data should, where possible, be stratified by race, ethnicity, and primary language to assess disparities and initiate subsequent quality improvement activities



addressing identified disparities, consistent with recent national efforts to standardize the collection of race and ethnicity data. A 2008 NQF report endorsed 45 practices including stratification by the aforementioned variables.(1) A 2009 IOM report “recommends collection of the existing Office of Management and Budget (OMB) race and Hispanic ethnicity categories as well as more fine-grained categories of ethnicity(referred to as granular ethnicity and based on one’s ancestry) and language need (a rating of spoken English language proficiency of less than very well and one’s preferred language for health-related encounters).”(2)

#### References:

(1)National Quality Forum Issue Brief (No.10). Closing the Disparities Gap in Healthcare Quality with Performance Measurement and Public Reporting. Washington, DC: NQF, August 2008.

(2)Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement. March 2010. AHRQ Publication No. 10-0058-EF. Agency for Healthcare Research and Quality, Rockville, MD. Available at: <http://www.ahrq.gov/research/iomracereport>. Accessed May 25, 2010.

#### 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): Professional Certification or Recognition Program, Public Reporting, Quality Improvement (Internal to the specific organization)

**3.1 Current Use** (Check all that apply; for any that are checked, provide the specific program information in the following questions): Public Reporting, 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.]

This measure is currently in use as part of the Dementia Measures Group in the CMS Physician Quality Reporting System program. Information on the PQRS program can be found at: <https://www.cms.gov/PQRS>.

This measure has also been proposed as a clinical Quality Measure for 2014 CMS EHR Incentive Programs for Eligible Professionals.

The PCPI believes that the reporting of participation information is a beneficial first step on a trajectory toward the public reporting of performance results. NQF endorsement will facilitate our ongoing progress toward this public reporting objective.

**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 PCPI believes that the reporting of participation information is a beneficial first step on a trajectory toward the public reporting of performance results. NQF endorsement will facilitate our ongoing progress toward this public reporting objective.

**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's NeuroPI program has been reviewed and approved by the American Board of Psychiatry and Neurology (ABPN) as part of a comprehensive Performance in Practice (PIP) and CME program, which are mandated by the American Board of Medical Specialties (ABMS) as necessary components of maintenance of certification (MOC).

This measure may also be used in additional Maintenance of Certification programs.

### 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].

In the coming months, the American Academy of Neurology is set to launch a NeuroPI clinical module for dementia including this measure and others developed as part of the AAN/AGS/AMDA/APA dementia measure set. NeuroPI is an online program guiding participants step-by-step through a performance improvement project of their choice. 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).

All PCPI measures are suitable for use in quality improvement initiatives and are made freely available on the PCPI website and through the implementation efforts of medical specialty societies and other PCPI members. The PCPI strongly encourages the use of its measures in QI initiatives and seeks to provide information on such initiatives to PCPI members.

**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 PCPI believes that the use of PCPI measures in quality improvement initiatives is a beneficial way to gather scientific data with which to improve physician performance. NQF endorsement will facilitate our ongoing progress toward this quality improvement objective.

**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

**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):* ALL data elements in electronic health records (EHRs)

**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:**

**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:**

We are not aware of any unintended consequences related to this 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):*

This measure was found to be feasible for implementation.

**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:

0112 : Bipolar Disorder: Level-of-function evaluation

#### 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? **No**

**5a.2** If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden:

NQF #0112 is similar in concept to the dementia: functional status assessment measure. However, given the degenerative nature of the dementia, the focus of our measure is the evaluation of a patient's ability to perform IADLS and ADLS including, for example, a variety of tools with this focus. Measure 0112 addresses a very different patient population and requires the use of one monitoring tool but is not specific to the assessment of IADL/ADL functioning. Additionally, the focus of our measure is on initial and routine assessments of functional status whereas the focus of 0112 is on the acute phase of treatment.

#### 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):

No competing measures.

### CONTACT INFORMATION

**Co.1 Measure Steward (Intellectual Property Owner):** [AMA-convened Physician Consortium for Performance Improvement, 330 N. Wabash Ave., Suite 39300, Chicago, Illinois, 60611](#)

**Co.2 Point of Contact:** [Samantha, Tierney, Samantha.Tierney@ama-assn.org, 312-464-5524-](#)

**Co.3 Measure Developer if different from Measure Steward:** [American Medical Association - Physician Consortium for Performance Improvement \(AMA-PCPI\), 515 N. State Street, Chicago, Illinois, 60654](#)

**Co.4 Point of Contact:** [Samantha, Tierney, MPH, samantha.tierney@ama-assn.org, 312-464-5524-](#)

**Co.5 Submitter:** [Samantha, Tierney, MPH, samantha.tierney@ama-assn.org, 312-464-5524-, American Medical Association - Physician Consortium for Performance Improvement \(AMA-PCPI\)](#)

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

This measure set was developed in collaboration with the American Academy of Neurology, American Geriatrics Society, American Medical Directors Association, and American Psychiatric Association.

**Co.7 Public Contact:** [Mark S., Antman, DDS, MBA, mark.antman@ama-assn.org, 312-464-5056-, American Medical Association - Physician Consortium for Performance Improvement \(AMA-PCPI\)](#)

### 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.

[Jerry C. Johnson, MD \(Co-Chair\) \(geriatric medicine\)](#)

Germaine Odenheimer, MD (Co-Chair) (neurology)  
 François Boller, MD, PhD, FAAN (neurology)  
 Soo Borson, MD (geriatric psychiatry)  
 Charles A. Cefalu, MD, MS (geriatric medicine)  
 Mirean Coleman, MSW, LICSW, CT (social work)  
 Patricia C. Davis, MD, MBA, FACR (radiology)  
 Mary Ann Forciea, MD (internal/geriatric medicine)  
 Elizabeth M. Galik, PhD, CRNP (nursing)  
 Laura N. Gitlin, PhD (occupational therapy)  
 Helen H. Kyomen, MD, MS (geriatric and adult psychiatry)  
 Katie Maslow, MSW (patient advocacy representative)  
 Haydee Muse, MD (health plan representative)  
 Bruce E. Robinson, MD, MPH (geriatric medicine)  
 Robert Paul Roca, MD, MPH, MBA (geriatric psychiatry)  
 Amy E. Sanders, MD (geriatric neurology)  
 Jason E. Schillerstrom, MD (geriatric psychiatry)  
 Joseph W. Shega, MD (geriatric medicine, hospice and palliative medicine)  
 Eric G. Tangalos, MD, FACP, AGSF, CMD (internal/geriatric medicine)  
 Joan M. Teno, MD, MS (internal medicine)  
 Brian K. Unwin, MD, FAAFP (family medicine)

PCPI measures are developed through cross-specialty, multi-disciplinary work groups. All medical specialties and other health care professional disciplines participating in patient care for the clinical condition or topic under study are invited to participate as equal contributors to the measure development process. In addition, the PCPI strives to include on its work groups individuals representing the perspectives of patients, consumers, private health plans, and employers. This broad-based approach to measure development ensures buy-in on the measures from all stakeholders and minimizes bias toward any individual specialty or stakeholder group. All work groups have at least two co-chairs who have relevant clinical and/or measure development expertise and who are responsible for ensuring that consensus is achieved and that all perspectives are voiced.

**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:**

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

**Ad.3 Year the measure was first released:** 2011

**Ad.4 Month and Year of most recent revision:** 10, 2011

**Ad.5 What is your frequency for review/update of this measure?** Coding/Specifications updates occur annually. See additional information below.

**Ad.6 When is the next scheduled review/update for this measure?** 10, 2012

**Ad.7 Copyright statement:** Physician Performance Measures (Measures) and related data specifications, developed by the Physician Consortium for Performance Improvement® (PCPI™), 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 performance Measures are not clinical guidelines and do not establish a standard of medical care. The PCPI has not tested its Measures for all potential applications. The PCPI encourages the testing and evaluation of its Measures.

Measures are subject to review and may be revised or rescinded at any time by the PCPI. The Measures



may not be altered without the prior written approval of the PCPI. Measures developed by the PCPI, 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 American Medical Association, on behalf of the PCPI. Neither the PCPI nor its members shall be responsible for any use of these Measures.

THE MEASURES AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.

© 2011 American Medical Association. All Rights Reserved

Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA, the Consortium and its members disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications.

CPT® contained in the Measures specifications is copyright 2009 American Medical Association. LOINC® copyright 2004 Regenstrief Institute, Inc. SNOMED CLINICAL TERMS (SNOMED CT®) copyright 2004 College of American Pathologists (CAP). All Rights Reserved. Use of SNOMED CT® is only authorized within the United States.

**Ad.8 Disclaimers:** See copyright statement above.

**Ad.9 Additional Information/Comments:** The PCPI has a formal measurement review process that stipulates regular (usually on a three-year cycle, when feasible) review of the measures. The process can also be activated if there is a major change in scientific evidence, results from testing or other issues are noted that materially affect the integrity of the measure.

**Date of Submission (MM/DD/YY):** 07/09/2012