

NATIONAL QUALITY FORUM

TO: Neurology Steering Committee

FR: Suzanne Theberge, Project Manager
Karen Johnson, Senior Director

SU: Neurology Endorsement Maintenance—Post-Comment Call to Discuss Public and Member Comments for Phase II Measures

DA: December 11, 2012

The Neurology Steering Committee will meet via conference call on Thursday, December 13. The purpose of this call is to:

- Review and discuss comments received during the public and member comment period.
- Provide input on responses to comments.
- Determine whether reconsideration of any measures or other courses of action is warranted.

Due to time constraints on the call, we would like for the Committee member who served as the lead discussant for each measure to be prepared to summarize the rationale for the Committee's decision on the measure *and to summarize any new information that was included in the comments*. Please review and consider the full text of all of the comments received prior to the post-comment call.

Discussion Leader	Measure Number	Measure Title
David Hackney	0507	Stenosis measurement in carotid imaging studies AMA-PCPI)
Jocelyn Bautista	1953	Seizure type(s) and current seizure frequency(ies) (AAN)
Ramon Bautista (David Tirschwell)	1954	Documentation of Etiology of Epilepsy or Epilepsy Syndrome (AAN)
Michael Kaplitt	1973	Annual Parkinson's Disease Diagnosis Review (AAN)
Jane Sullivan	1982	Parkinson's Disease Psychiatric Disorders or Disturbance Assessment (AAN)
John Duda* Risha Gidwani*	1983	Parkinson's Disease Cognitive Impairment or Dysfunction Assessment (AAN)
Jack Scariano	1985	Parkinson's Disease: Querying About Sleep Disturbances (AAN)
Mary Van de Kamp	1988	Parkinson's Disease Rehabilitative Therapy Options (AAN)
David Knowlton	2029	Dementia: Counseling regarding Risks of Driving (AMA-PCPI)
Gwendolyn Buhr	2111	Antipsychotic Use in Persons with Dementia (Pharmacy Quality Alliance)

*Co-lead discussants

Please let us know if you have any questions.

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Steering Committee Action:

1. Review this briefing memo
2. Review the comments received and the proposed responses (see Excel and PDF files included with the call materials).
3. Be prepared to provide feedback and input on proposed comment responses.

Please use the following information to access the conference call line and online webinar:

Date/Time: Thursday, December 13, 2012, 1:00-3:00 pm ET

Speaker dial-in #: 888-799-5160

Confirmation Code: 45230548

Webinar: <http://nqf.commpartners.com/se/Rd/Mt.aspx?905766>

All committee and speaker phone lines will be open. Please place your phone on mute when not speaking. Do not put your phone on hold during the call.

NQF received comments on the draft report from 11 NQF member organizations and 20 members of the public. In order to facilitate discussion, the majority of the comments have been categorized into major topic areas. Where possible, NQF staff has proposed draft responses for the Committee to consider. Although all comments and proposed responses are subject to discussion, we will not necessarily discuss each comment and response on the post-comment call. Instead, we will spend the majority of the time considering the major topics and/or those measures with the most significant issues that arose from the comments. Note that the organization of the comments into major topic areas is not an attempt to limit Committee discussion.

We have included all of the comments that we received in the Excel spreadsheet that is included with the call materials. This comment table contains the commenter's name, as well as the comment, associated measure, topic (if applicable), and draft responses for the Committee's consideration. Please refer to this comment table to view the individual comments received and the proposed responses to each.

MAJOR TOPICS

Four major topics were identified in the comments, as follows:

1. Reconsideration of the AAN/AMA-PCPI measures
2. Reconsideration of measure #2111: Antipsychotic use in persons with dementia
3. Discussion of measure #0507: Stenosis measurement in carotid imaging studies

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4. Support for other recommended measures (#1814: Counseling for women with childbearing potential with epilepsy; #2091/#2092: Persistent Indicators of Dementia without a Diagnosis—Long Stay/Short Stay)

Topic 1: Reconsideration of the AAN/AMA-PCPI Measures

The AAN has requested that the Committee reconsider the following eight measures:

- 1953: Seizure type(s) and current seizure frequency(ies)
- 1954: Documentation of etiology of epilepsy or epilepsy syndrome
- 1973: Annual Parkinson’s disease diagnosis review
- 1982: Parkinson’s disease psychiatric disorders or disturbance assessment
- 1983: Parkinson’s disease cognitive impairment or dysfunction assessment
- 1985: Parkinson’s disease querying about sleep disturbances
- 1988: Parkinson’s disease rehabilitative therapy options
- 2029: Dementia: Counseling regarding risks of driving

The formal letter requesting reconsideration is included in **Appendix A** (note that the full text of this letter also is included in the comment table, but is split into 20 comments due to character limitations). We also received 15 comments regarding these and other AAN/AMA-PCPI measures from NQF member organizations and the public (many whom submitted their comments through the Behavioral Neurology & Geriatric Neurology Section of the AAN). Most—but not all—of these comments were supportive of some or all of the 18 measures submitted by AAN/AMA-PCPI.

The Committee is not obligated to formally re-vote these measures unless so desired. If re-voting is desired, we will collect your votes via an online survey after the call.

The majority of the Committee’s discussion of these measures during the in-person meeting centered around the evidence criterion. The following NQF criteria and guidance was considered by the Committee at that time:

- Process measures should measure those aspects of care with the most direct evidence of a strong relationship to the desired outcome; such evidence is most often about the relationship between some intervention and a desired health outcome, and, therefore, interventions are the preferred focus of process measures.
- Empirical evidence and specific information on the quantity, quality, and consistency from a systematic review of a body of evidence is required. Such evidence should support that the measured healthcare process leads to desired health outcomes in the target population with benefits that outweigh harms to patients.
- Expert opinion is not considered empirical evidence; if a measure is based only on expert consensus, it does not meet the NQF evidence criterion. An exception to the evidence criterion should only be considered if no empirical evidence exists, the expert opinion is systematically assessed, and there is a strong rationale for why the specific structure or process should be the focus of a quality performance measure. Use of this evidence exception should not be a routine occurrence.

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- Clinical practice guidelines alone do not meet NQF criteria for evidence. If a guideline does not provide the necessary information on quantity, quality, and consistency, developers should seek other sources such as the Cochrane Collaboration, AHRQ evidence reports, USPSTF, or systematic reviews published in the literature, which often are cited in the guidelines.
- Guidance provided by the CSAC on measure construction practices recommends avoiding specifying measures so that they can be met primarily through documentation without an evaluation of the quality of the activity (examples of documentation measures: assessment completed; care plan created; or instruction or advice given).

For your convenience, for each of these measures, we have provided the measure description, the voting results from the in-person meeting, and the rationale underlying the Committee's decision during the in-person meeting. We have also briefly summarized the overall and measure-specific rationale(s) for reconsideration that was provided by the AAN and/or other commenters. Committee members *should thoroughly review and consider the full text of all of the comments received for these measures prior to the post-comment call.*

Staff summary of overall rationale for reconsideration, based on comments received

- These measures were developed prior to the updates of the NQF measure evaluation criteria.
- NQF expects empirical data that supports the relationship between the measure and desired outcome; however, this type of evidence currently rarely exists for most neurological conditions.
- Relatively few members of the Steering Committee have expertise (or related experience) in Parkinson's disease, epilepsy, or dementia; this may have negatively affected the Committee's overall understanding of the key issues and intricacies related to the management of patients with these conditions.
- These measures address patient and family engagement, which is a critical part of the National Priorities Partnership and few endorsement measures exist that address this area.
- Querying and counseling of patients has been associated with improving the patients' positive perceptions of care and is associated with better recovery from discomfort and concerns, better emotional health, improved health status, and fewer diagnostic tests and referrals (references cited).
- Epilepsy is a common and widely recognized neurologic condition, but it is often poorly understood, misdiagnosed, and improperly treated.
- Parkinson's disease significantly affects health related quality of life (HRQOL), a measurable patient-reported outcome.
- Dementia is a chronic condition that poses a major and growing threat to the public's health, yet studies have shown low and/or variable adherence to recommended practices for the assessment, management, and treatment of patients with dementia.
- The development of reliable outcome measures for dementia proved impracticable. The AAN/AMA-PCPI dementia measures were developed in the context of care management, where the goals are to improve the quality of life for patients and caregivers, maintain optimal function, and provide maximum comfort. The dementia measures target

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underemphasized, yet vital, aspects of the evaluation and management of dementia patients.

- Steering Committees are given minimal guidance around the exception to the evidence criterion, and therefore, invoking the exception is a subjective process.
- These measures are currently in use in the PQRS program; the AAN/AMA-PCPI will urge continued use of these measures in this and other programs regardless of NQF endorsement status.
- NQF endorsement of these measures would support performance of assessment more uniformly (anecdotal evidence of beneficial effects of counseling on quality of life was provided).

1953: Seizure type(s) and current seizure frequency(ies)

Measure description	All visits for patients with a diagnosis of epilepsy who had the type(s) of seizure(s) and current seizure frequency for each seizure type documented in the medical record.
SC votes (10/3/12)	The measure did not meet the Importance criteria. 1a. Impact: NA ; 1b. Performance Gap: NA ; 1c. Evidence: Y-11; N-9; I-4
Rationale (from the 10/3/12 in-person meeting)	<ul style="list-style-type: none"> • While the Committee acknowledged that seizure frequency is the key outcome in epilepsy care, members agreed that there is no evidence that documentation (of seizure type/frequency alone) leads to better outcomes. • Committee members noted that although the classification systems (for epilepsy type and seizure type) are currently under review by experts in the field, describing the types and frequency of seizures should be a minimal standard of care, particularly in a neurology clinic.

Staff summary of rationale for reconsideration, based on comments received

- Documentation is viewed as the surrogate term for asking about seizure type/frequency and providing appropriate treatment and/or referral.
- Patients whose seizures are controlled have better quality of life: this provides an indirect link between the measure and desired outcomes.
- Poor seizure control is associated with increased risk of death.
- Seizure type and seizure frequency are linked to early treatment costs.
- The potential benefit greatly outweighs harm.

ACTION ITEMS:

- Was any new evidence presented for this measure?
- Has anything made you reconsider your decision not to invoke the evidence exception?
- After review and discussion of the comments on this measure, does the Committee wish to change their evaluation of any of the criteria or overall recommendation for endorsement?

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1954: Documentation of etiology of epilepsy or epilepsy syndrome

Measure description	All visits for patients with a diagnosis of epilepsy who had their etiology of epilepsy or with epilepsy syndrome(s) reviewed and documented if known, or documented as unknown or cryptogenic
SC votes (10/3/12)	The measure did not meet the Importance criteria. 1a. Impact: NA ; 1b. Performance Gap: NA ; 1c. Evidence: Y-0; N-15; I-9
Rationale (from the 10/3/12 in-person meeting)	<ul style="list-style-type: none"> • While Committee members acknowledged the strong evidence base linking treatment options to epilepsy type, evidence was not presented that documenting epilepsy type will improve patient outcomes. • The Committee was concerned that non-specialists or non-neurologists may not be able to make the proper classification of epilepsy syndrome or epilepsy type, especially given the current controversy in the field regarding classification of epilepsy type. • The Committee also expressed some doubt about the utility of documenting epilepsy type at each visit, given that this generally does not progress or change over time.

Staff summary of rationale for reconsideration, based on comments received

- Documentation is viewed as the surrogate for ascertaining the patient’s etiology of epilepsy/syndrome and providing appropriate treatment.
- The measure focus represents the standard of care to ensure that patients receive appropriate treatment.
- The evolving classification system for epilepsy should not affect this measure because as the classification evolves, so must the treatment.

ACTION ITEMS:

- Was any new evidence presented for this measure?
- Has anything made you reconsider your decision not to invoke the evidence exception?
- After review and discussion of the comments on this measure, does the Committee wish to change their evaluation of any of the criteria or overall recommendation for endorsement?

1973: Annual Parkinson’s disease diagnosis review

Measure description	All patients with a diagnosis of Parkinson’s disease who had their Parkinson’s disease diagnosis reviewed, including a review of current medications and a review for the presence of atypical features (e.g., falls at presentation and early in the disease course, poor response to levodopa, symmetry at onset, rapid progression [to Hoehn and Yahr stage 3 in 3 years], lack of tremor or dysautonomia) at least annually.
SC votes	The measure did not meet the Importance criteria.

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(10/3/12)	1a. Impact: NA ; 1b. Performance Gap: NA 1c. Evidence: Y-3; N-8; I-13
Rationale (from the 10/3/12 in-person meeting)	<ul style="list-style-type: none"> • The evidence presented by the developer addressed diagnostic inaccuracies in Parkinson’s disease, but Committee members agreed that no evidence was presented to show that an annual review improves diagnostic accuracy. The developer acknowledged the lack of empirical evidence for the measure but suggested that consensus and expert opinion also were valid types of evidence. However, the Committee agreed that expert opinion was not sufficient to meet NQF criteria for evidence. • Committee members also voiced the concern that this is a “check-box” measure. • Committee members also noted that one of the main studies cited in support of this measure specifically states that there is no evidence regarding the optimal frequency of diagnosis review and that patients should be referred to a specialist for definitive diagnosis.

Staff summary of rationale for reconsideration, based on comments received

- At least one recommendation used to support the measure has Level B strength behind it.
- The potential harm from not regularly reviewing the Parkinson’s disease diagnosis and looking for atypical features is significant.
- The concern that this is a “check box” measure should not have been included in the evaluation of the evidence subcriterion.
- The NICE recommendations regarding optimal frequency of diagnosis review and referral to a specialist for a definitive diagnosis were not used to support this measure.

ACTION ITEMS:

- Was any new evidence presented for this measure?
- Has anything made you reconsider your decision not to invoke the evidence exception?
- After review and discussion of the comments on this measure, does the Committee wish to change their evaluation of any of the criteria or overall recommendation for endorsement?

1982: Parkinson’s disease psychiatric disorders or disturbance assessment

Measure description	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.
SC votes (10/3/12)	<p>The measure met the Importance criteria (the Committee agreed to invoke the evidence exception)</p> <p>1a. Impact: H-19; M-4; L-1; I-0; 1b. Performance Gap: H-9; M-12; L-3; I-0</p> <p>1c. Evidence: Y-1; N-18; I-5; L-0; Evidence exception: Y-14; N-10</p> <p>The measure did not meet the Scientific Acceptability criteria for untested measures.</p>

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	Precise specifications: Y-5; N-19
<p>Rationale (from the 10/3/12 in-person meeting)</p>	<ul style="list-style-type: none"> • The Committee expressed concern that the measure does not specify how assessments should be done (i.e., using specific validated tools). Members suggested modifying the measure so that the assessment be done using validated tools such as, but not limited, to those listed in the guideline recommendations. • Committee members questioned whether the measure as specified suggests that patients should undergo a full round of psychiatric assessments each year (i.e., for depression, psychosis, impulse control disorders, anxiety, etc.) or whether asking about any one of them would suffice to meet the measure. The developer verified that assessment for only one condition would meet the measure, but also explained that while depression is the most prevalent psychiatric disorder in Parkinson’s disease patients, other disorders also impact quality of life. The developer also noted that no single assessment tool can be used to screen for all (or even 2-3) of these disorders. <p>NOTE: The Committee agreed that the non-specificity of the measure (e.g., use of validated instruments not required, potentially addressing only one of many psychiatric disorders) makes it a check-box measure that would not necessarily improve care quality. (Because this was an untested measure, the Committee voted on whether the measure was precisely specified and whether the specifications are consistent with the evidence presented for the measure).</p>

Staff summary of rationale for reconsideration, based on comments received

- Psychiatric symptoms are prevalent among patients with Parkinson’s disease, are a major cause of disability, and are often under-diagnosed and poorly treated (several references cited).
- There is no validated tool that could be used to assess for all psychiatric symptoms.
- No evidence exists to recommend one validated tool over another.
- A minority of SC members thought the measure should focus only on depression; however, Parkinson’s disease is associated with a wide range of psychiatric disorders and disturbances that are often overlooked
- It was infeasible to re-specify the measure to focus on depression only, given in the timeframe allowed (5 days).

ACTION ITEMS:

- Was any new information presented to make you reconsider your decision regarding whether the measure is precisely specified and whether the specifications are consistent with the evidence presented for the measure?
- After review and discussion of the comments on this measure, does the Committee wish to change their evaluation of any of the criteria or overall recommendation for endorsement?

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1983: Parkinson’s disease cognitive impairment or dysfunction assessment

Measure description	All patients with a diagnosis of Parkinson’s disease who were assessed for cognitive impairment or dysfunction at least annually.
SC votes (10/3/12)	The measure did not meet the Importance criteria. 1a. Impact: NA ; 1b. Performance Gap: NA ; 1c. Evidence: Y-3; N-14; I-7; L-0
Rationale (from the 10/3/12 in-person meeting)	<ul style="list-style-type: none"> • The evidence presented by the developer addressed treatment of depression; however, no evidence was presented to show how assessing cognitive impairment annually would result in better patient outcomes. • Committee members also noted that much of the evidence presented actually related to depression and treatment of depression rather than to cognitive impairment. • The Committee did not express interest in invoking the evidence exception for this measure.

Staff summary of rationale for reconsideration, based on comments received

- The onset of cognitive decline/dementia often occurs over a prolonged time period, and although there is limited treatment, it is important to identify.
- Cognitive impairment is prevalent among patients with Parkinson’s disease; assessment will lead to identification of dysfunction, which will then lead to appropriate treatment/referrals, and ultimately, to better quality of life.
- In terms of evidence supporting the measure, depression was only cited in the context of non-motor symptoms of Parkinson’s disease.

ACTION ITEMS:

- Was any new evidence presented for this measure?
- Has anything made you reconsider your decision not to invoke the evidence exception?
- After review and discussion of the comments on this measure, does the Committee wish to change their evaluation of any of the criteria or overall recommendation for endorsement?

1985: Parkinson’s disease querying about sleep disturbances

Measure description	All patients with a diagnosis of Parkinson’s disease (or caregivers, as appropriate) who were queried about sleep disturbances at least annually.
SC votes (10/3/12)	The measure did not meet the Importance criteria. 1a. Impact: NA ; 1b. Performance Gap: NA ; 1c. Evidence: Y-1; N-18; I-5
Rationale (from the 10/3/12 in-	<ul style="list-style-type: none"> • The evidence presented by the developer addressed treatment of sleep disturbances, however, no evidence was presented that querying about sleep disturbances will actually improve patient outcomes.

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person meeting)	<ul style="list-style-type: none"> • One Committee member expressed concern about the use of one of the NICE guidelines as evidence for this measure, noting that it actually recommends that if the patient complains about sleep disturbance, a detailed history should be taken so that a correct diagnosis can be made. Another member noted that this particular guideline is based on expert opinion.
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Staff summary of rationale for reconsideration, based on comments received

- By not querying the patient about sleep disturbances the clinician may miss key factors such as sleep fragmentation (80% of PD patients), restless leg syndrome (20%), REM behavior sleep disorder (>40%), and excessive daytime sleepiness (~50%).

ACTION ITEMS:

- Was any new evidence presented for this measure?
- Has anything made you reconsider your decision not to invoke the evidence exception?
- After review and discussion of the comments on this measure, does the Committee wish to change their evaluation of any of the criteria or overall recommendation for endorsement?

1988: Parkinson’s disease rehabilitative therapy options

Measure description	All patients with a diagnosis of Parkinson’s disease (or caregiver(s), as appropriate) who had rehabilitative therapy options (e.g., physical, occupational, or speech therapy) discussed at least annually.
SC votes (10/3/12)	<p>The measure met the Importance criteria (the Committee agreed to invoke the evidence exception)</p> <p>1a. Impact: H-18; M-5; L-0; I-0; 1b. Performance Gap: H-9; M-12; L-2; I-0</p> <p>1c. Evidence: Y-10; N-13; I-1; Evidence Exception: Y-20; N-3</p> <p>The measure does not meet the Scientific Acceptability criteria for untested measures.</p> <p>Precise specifications: Yes-11; No-13</p>
Rationale (from the 10/3/12 in-person meeting)	<ul style="list-style-type: none"> • Several Committee members expressed concerns about the exclusions specified for this measure (i.e., patient has no known physical disability due to Parkinson's disease; patient is unable to respond and no informant is available). The developer explained that these exclusions were added to the measure based on public and physician comments that discussion of rehab options would present undue burden when patients are seen early in the disease course when functional impairments are not yet apparent or later in the disease course when certain patients are incapable of discussing the rehab options. • However, some Committee members disagreed with the exclusion for patients not yet presenting with functional impairment symptoms, noting that early intervention may be beneficial. Other members noted a lack of evidence for early

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	<p>rehab services, although they acknowledged the benefit of physical activity and exercise. Ultimately, the Committee agreed that this issue is still an area of clinical controversy and did not formally recommend removal of this exclusion. The developer noted that the exclusion would not prohibit discussion of rehab options with patients without functional impairment symptoms.</p> <ul style="list-style-type: none"> • Committee members did note that while difficulty with communication is a symptom of Parkinson’s disease, many patients can receive information even if they have trouble conversing; they also noted that a patient’s inability to communicate should be determined via formal assessment, not just assumed by the clinician. <p>NOTE: The Committee encouraged the developer to consider continued work on the measure due to the importance of rehab for Parkinson’s disease patients. (Because this was an untested measure, the Committee voted on whether the measure was precisely specified and whether the specifications are consistent with the evidence presented for the measure).</p>
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Staff summary of rationale for reconsideration, based on comments received

- The argument for including in the measure those patients with no known disability is not evidence-based and should not have been used to argue against this measure.
- Multiple studies cite the link between the discussion of rehabilitation therapy options to an increase in referrals to rehab and/or improved patient outcomes.
- The potential benefit greatly outweighs harm.

ACTION ITEMS:

- Was any new information presented to make you reconsider your decision regarding whether the measure is precisely specified and whether the specifications are consistent with the evidence presented for the measure?
- After review and discussion of the comments on this measure, does the Committee wish to change their evaluation of any of the criteria or overall recommendation for endorsement?

2029: Dementia: Counseling regarding risks of driving

Measure description	Percentage of patients, regardless of age, with a diagnosis of dementia or their caregiver(s) who were counseled regarding the risks of driving and the alternatives to driving at least once within a 12 month period.
SC votes (10/3/12)	The measure did not meet the Importance criteria. 1a. Impact: NA ; 1b. Performance Gap: NA ; 1c. Evidence: Y-0; N-5; I-19
Rationale (from the 10/3/12 in-person)	<ul style="list-style-type: none"> • The evidence underlying this measure includes guideline recommendations from the APA and the AAN. Additional evidence was not provided by the measure developer. • The Committee questioned the need for this measure, noting that counseling regarding risks of driving would also be included under measure #2028

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meeting)	<p>(counseling regarding safety concerns). The developer stated that because driving by dementia patients has potential safety ramifications for others, it warranted a separate performance measure.</p> <ul style="list-style-type: none">• One Committee member noted that if you counsel a patient to stop driving and he/she does, then that patient is thereafter excluded from the denominator; conversely, if you counsel a patient to stop driving and he/she does not comply with this advice, the provider still meets the measure. Committee members noted that there is evidence showing counseling is more effective when done by other caregivers (e.g., social workers, nurses) compared to physicians. The developers clarified that this measure is not applicable to physicians only, but also to other care providers such as social workers and psychologists. Committee members agreed that the submission did not demonstrate evidence to support a link between counseling about risks of driving and improved patient outcomes. Again, several Committee members voiced the belief that such evidence likely is available (e.g., in traffic safety data) and expressed some frustration that such evidence was not included as part of the measure submission.
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Staff summary of rationale for reconsideration, based on comments received

- Everyone with dementia will eventually become an unsafe driver because of impairments in memory, judgment, reasoning, spatial perception, and reaction time.
- Clinicians can influence their patients' decision to modify or stop driving, and help their patients maintain safe driving skills.
- Many groups have tools, position statements, and advisory kits that demonstrate the importance of physician to counsel about driving safety issues.
- Counseling patients with dementia about driving is under-reported in the medical record compared to the caregiver interview (reference cited).

ACTION ITEMS:

- Was any new evidence presented for this measure?
- Has anything made you reconsider your decision not to invoke the evidence exception?
- After review and discussion of the comments on this measure, does the Committee wish to change their evaluation of any of the criteria or overall recommendation for endorsement?

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Topic 2: Reconsideration of measure #2111: Antipsychotic use in persons with dementia

Measure description	The percentage of individuals 65 years of age and older with dementia who are receiving an antipsychotic medication without evidence of a psychotic disorder or related condition.
SC votes (10/3/12)	<p>The measure met the Importance criteria 1a. Impact: H-20; M-2; L-1; I-0; 1b. Performance Gap: H-11; M-11; L-0; I-1 1c. Evidence: Y-16; N-2; I-5</p> <p>The measure did not meet the Scientific Acceptability criteria. 2a. Reliability: H-7; M-12; L-2; I-2 2b. Validity: H-1; M-9; L-12; I-1</p>
Rationale (from the 10/3/12 in-person meeting)	<ul style="list-style-type: none"> • Some committee members voiced discomfort with the measure because there are conditions for which antipsychotic use may be appropriate, even in those with dementia (e.g., “agitated delirium”, dyskinesia in Parkinson’s disease patients). One member suggested that adding a “psychosis not otherwise specified” code (to exclude such patients from the numerator) might be a way to handle this problem. However, other Committee members noted that there are a variety of ways to treat of psychosis in dementia patients and were not in favor of including additional exceptions to the measure. • Another member asked why the specifications do not more closely follow the guideline recommendation to avoid use of antipsychotics among dementia patients “unless non-pharmacological options have failed and patient is a threat to self or others.” The developer was unsure that this level of specification would be possible using claims data. • The developer noted that they specified the measure to count antipsychotic use only if the prescription(s) exceeds a 30-day supply; this was done as a way to differentiate what might be short-term use for an acute psychotic episode. Committee members agreed that 30 days might be a sufficient amount of time for some patients, but not for all. • Committee members questioned why Parkinson’s disease patients were not excluded from the measure, given that antipsychotic medications often are used appropriately for dementia-related psychosis in these patients. However, there was not agreement among Committee members as to whether Parkinson’s disease patients should or should not be excluded. • Committee members acknowledged the effort to try to identify dementia patients by looking at both diagnosis and prescription of medications for dementia (per the assumption that dementia is under-diagnosed). However, they noted that the prevalence of dementia found in the pilot studies was much lower than might be expected. They also questioned whether dementia medications are actually over-prescribed and, if so, if this measure as specified actually captures patients who have dementia. They acknowledged the developer’s assertion that the use of dementia medications for other indications (e.g., TBI) is rare, but noted a lack of evidence to support that assertion. • A Committee member noted this measure uses fewer ICD-9 codes for dementia than do other dementia measures. The developer said they created their list of ICD-9 codes for dementia based on input from their expert panels and relevant studies in the literature, but were open to adding additional codes to their list.

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| | <ul style="list-style-type: none">• Several Committee members suggested that because this is a health-plan level measure, problems with the specifications may be somewhat less concerning, particularly given the importance of the problem of overuse of antipsychotics in dementia patients. |
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Six comments were received regarding this measure, five of which advocate reconsideration of the measure by the Committee. The commenters offered the following reasons for reconsideration:

- Although there are limitations with the use of claims based data (e.g., inability to evaluate appropriateness of regimen), identifying variability in use is important. For example, very high rates might suggest that non-use of non-drug management strategies or inadequate evaluation.
- While claims-based measures cannot capture all possible exclusions, such data are accurate enough for health plan level measures.
- Provider feedback to a large Pharmacy Benefits Manager indicates that providers rarely prescribe the Alzheimer's drugs for a non-dementia reason, suggesting that the false-positive identification of dementia using Alzheimer's drugs as a proxy is remote.

One commenter agreed with the Committee's initial decision not to recommend the measure, noting that "appropriate use (for psychosis and psychosis related agitation and in lowest effective doses) is to be promoted and not discouraged for optimal patient management."

The developer has provided additional information in response to questions raised by the Committee during the in-person meeting; the full text of this material is included in **Appendix B**. Briefly, the developers note the following:

- ***A comparatively narrower list of ICD-9 codes is used to identify patients with dementia compared to what is used in other measures***—Codes that indicate a behavioral disturbance or psychosis are not included because the measure is intended to focus on those dementia patients who do not have a clear indication for an antipsychotic drug.
- ***Variability in performance rates***—Additional analysis at the plan contract level shows that the performance rate varied from 10.2% to 20.3%, with an average of 13.9% and standard deviation of 3.7%. Thus, there is variation in performance across the Medicare contracts with some of the contracts having a rate that is nearly 2 standard deviations above the average.
- ***Use of dementia drugs for conditions other than dementia***—Such drugs may be used for the late effects of traumatic brain injury (ICD-9 code 907.0). Additional analysis show that out of 48,341 patients identified as having dementia, only 46 patients had a claim with this diagnosis (less than 0.1%).
- ***Relatively low prevalence of dementia identified in pilot studies***—Using the combination of medication marker and dementia diagnosis code, there was a fairly consistent rate dementia patients across the numerous Medicare contracts (average of 4.6%; range of 3.4% to 5.9%). The percentage of the population included in the measure is not intended to replicate the overall rate of dementia in the general population, given the focus on a subset of dementia patients who do not have a diagnosis indicating psychoses or behavioral disturbance.

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ACTION ITEMS:

- Was any new information presented to make you reconsider your decision regarding whether the measure is precisely specified and whether the specifications are consistent with the evidence presented for the measure?
- After review and discussion of the comments on this measure, does the Committee wish to change their evaluation of any of the criteria or overall recommendation for endorsement?

Topic 3: Measure #0507: Stenosis measurement in carotid imaging studies

(NOTE: Steering Committee Recommendation for Endorsement: Y-24; N-0)

Six comments were received regarding this measure, three of which were supportive. However, two commenters expressed concern that the measure is a documentation measure and therefore of limited (or no) use for accountability purposes. Another commenter expressed the concern that the stenosis is based on the physician's judgment of patient symptoms.

Developer response (regarding physician judgment): Thank you for your comment. The intent of this measure is to quantify stenosis as precisely and reproducibly as possible. Patients with stenoses will benefit from physicians using a standardized method for stenosis calculation. There is wide variation in the use of methods for stenosis calculation, which may also lead to variation in the appropriateness of carotid intervention. Since the degree of stenosis is an important element of the decision for carotid intervention, characterization of the degree of stenosis needs to be standardized. Evidence-based guidelines are cited in support of the measure, along with several individual studies and systematic reviews.

ACTION ITEM: After review and discussion of the comments on this measure, does the Committee wish to change their evaluation of any of the criteria or overall recommendation for endorsement?

Topic 4: Support for other recommended measures

Twenty-two comments were received regarding the remaining three measures that were recommended for endorsement:

- #1814: Counseling for women with childbearing potential with epilepsy
- #2091: Persistent Indicators of Dementia without a Diagnosis—Long Stay
- #2092: Persistent Indicators of Dementia without a Diagnosis—Short Stay

Of these 22 comments, 19 expressed support for the measures. Of the remaining three comments, two suggested additional ideas for measure development and one comment (on measure #2091) questioned why patients with psychiatric disorders are excluded from the measure denominator, noting possible misdiagnosis of psychiatric disorders on admission to a long-term care facility.

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Developer response, measure #2091: While the reviewer is correct that patients with severe psychiatric disease have higher rates of dementia, AMDA needs to be consistent with the Center for Medicare & Medicaid Service (CMS) definition and exclusions for severe dementia as we are using their instrument (The MDS 3.0 and more specifically, the BIMMS). We were requested by the Neurology Measure review committee at the October 3rd NQF meeting in Washington DC to actually broaden the exclusions as a precaution about mislabeling diseases that frequently co-exist with dementia as only dementia (i.e., the quality measure is saying "this is probably undiagnosed dementia"), as we want to be a certain as we can that it is, in fact, undiagnosed dementia and not something else. AMDA also wishes to harmonize with the CMS focus on patients with dementia who are inappropriately prescribed antipsychotics without having a diagnosis of schizophrenia or bipolar disease. As an aside note, Down's syndrome and other "mental retardations" referred to in this reviewer's comment are not exclusions.

Proposed Committee Response: None required.

ADDITIONAL DISCUSSION OF COMMENTS/RESPONSES

No other comments require additional discussion unless specifically desired by the Committee.

ADDITIONAL AREAS FOR MEASURE DEVELOPMENT

Several comments included suggestions for additional measure development, as follows:

- Measures of arterial/venous ulceration and plaque composition that are paired with measure #0507
- Measures of patients with indicators of dementia for other health care settings in addition to nursing homes (measures similar to #2091 and #2092)
- Measures around care plans for epilepsy
- Outcome measures for infants born to women with epilepsy (e.g., infants with congenital birth defects born to mothers who are on epilepsy medications)
- Patient-reported outcome measures to assess the impact of the counseling about contraception and pregnancy for women with epilepsy
- Measures that incorporate screening for Mild Cognitive Impairment and dementia
- Measures around delirium, particularly for patients who have delirium superimposed on dementia.

Proposed Committee Response: The Committee agrees with the suggestions for future measure development and the report was updated to include this suggestion.

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Appendix A: AAN letter requesting reconsideration of measures

November 29, 2012

NQF Neurology Phase II Steering Committee
c/o Helen Burstin, MD, MPH
Senior Vice President, Performance Measures
National Quality Forum
Washington, DC
NQF Neurology Steering Committee

Dear Dr. Burstin,

Thank you for the opportunity to comment on the National Quality Forum (NQF) Neurology Phase II Draft Report. The American Academy of Neurology (AAN) is a national medical specialty society representing more than 25,000 neurologists and neuroscience professionals. The AAN is dedicated to promoting the highest quality patient-centered neurologic care. The AAN is committed to improving care of persons with neurological illness through formal quality improvement programs, has developed over two-hundred sets of evidence-based practice recommendations over the past twenty years, and has developed over fifty quality measures over the past five years. The AAN has participated in the American Medical Association convened Physician Consortium for Performance Improvement® (PCPI) since its inception and has partnered with the PCPI to develop some quality measures and has independently developed other measures. The AAN is a long standing member of the NQF.

On October 3-4, 2012 the NQF Neurology Phase II Steering Committee (SC) reviewed 18 measures that were submitted by the AAN or our partner the PCPI. Only 1 of the 18 measures was approved during the two day meeting, which represents a 6% endorsement pass rate. This is not congruent with the average endorsement pass rate of approximately 58%.

As background, the three measures Parkinson's disease and six measures for epilepsy that were submitted to the NQF for consideration for endorsement were developed well before the current NQF Measure Evaluation Criteria existed. The AAN had been waiting over 3 years for an opportunity to present these measures to the NQF for endorsement. The dementia measures were more recently developed in conjunction with the PCPI.

The AAN would like to request that the SC reconsider the measures we have indicated below. We have provided clarification to the SC concerns and/or presented additional data to support endorsement of the measures.

Overarching concerns with SC review process and SC concerns with measures

Endorsement application and SC composition

The endorsement application was not very user friendly. Specifically, it was unclear what the NQF wanted in the 1c.1 Structure Process Outcome box. NQF requested explicit data from quantitative studies showing that the measure would lead to a proximal outcome. Quite simply, this type of evidence currently rarely exists for most neurological conditions. The AAN is beginning to collect data on documented outcomes from the utilization of these measures in our Maintenance of Certification program, from vendors, in registries, and from practices but the data is still too preliminary to cite.

The AAN notes that the Neurology Phase II project was a continuation of the Phase I project that reviewed only stroke related measures. The majority contingent of the Steering Committee was stroke related experts. The members of the SC that had expertise in Parkinson's disease, epilepsy, dementia or related experience

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were minimal. The AAN believes this may have significantly and negatively affected the SC's overall understanding of the key issues and intricacies related to the management of patients with these conditions.

Linking querying, discussing and counseling to patient outcomes

Patient and family engagement is a critical part of the NQF's National Priorities Partnership and few endorsement measures exist that address this topic. The AAN strongly believes that the SC should reconsider these measures. Several of the measures submitted to the NQF assessed querying and counseling of the patient and the SC was concerned about the link between these actions to the patient's health outcome. In one study, these forms of communication were associated with improving the patients' positive perceptions of care and associated with better recovery from their discomfort and concern, better emotional health two months later and resulted in fewer diagnostic tests and referrals. The study also noted improved health status due to actively engaging the patient (eg querying, discussing, etc.) in patient-centered care. (Stewart M, Brown JB, Donner A, et al. The Impact of Patient-Centered Care on Outcomes 2000; J Family Practice 49(9) www.jfponline.com/pages.asp?aid+2061 accessed 11.20.2012) Another study indicated that patient health outcomes can be improved with good physician-patient communication. (Stewart M. Effective physician-patient communication and health outcomes: a review <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1337906/pdf/cmaj00069-0061.pdf>)

Linking documentation to patient outcomes

The SC rejected measures that were stated as "documentation" measures because they felt that the expected outcome was too distal from the act of documentation. In the field of claims-based reporting, documentation is the only way to evaluate whether the clinician did the best practice. The AAN acknowledges that the act of documenting may not in and of itself change patient outcomes. However, clinician professionalism dictates that if the clinician documented that they did something such as ask the patient about seizure frequencies this would entail that he/she appropriately followed up on appropriate treatment changes, referrals, etc.

Nature of Neurological Disorders or Conditions

The nature of most neurological disorders or conditions is unlike previous disease categories reviewed by the NQF. Parkinson's disease, epilepsy and dementia are all chronic diseases with limited treatments or treatment options. Most neurological diseases are also degenerative in nature with no known cure. Thus, there are rarely any "good clinical outcomes" that could be measured in an outcome specific measure for these neurologic conditions.

Epilepsy

Epilepsy is a common and widely recognized neurologic condition, but it is often poorly understood, misdiagnosed, and improperly treated. Epilepsy is surprisingly common; approximately 3% of the American population will develop epilepsy by age 75. The deficits in quality of life due to epilepsy and its treatment are comparable to conditions such as diabetes, heart disease, and depression. Epilepsy causes considerable medical distress and an enormous economic burden.

The epilepsy treatment gap is defined as the proportion of people with epilepsy who require treatment but do not receive it. There are racial, ethnic, and socioeconomic disparities in access to treatment. A lack of specialty care may lead to delayed recognition of seizures and inadequate treatment. Thus, there is a large disparity between care that should be delivered and the care that is actually delivered.

Parkinson's disease

A 2006 study examining health related quality of life and economic impact on Parkinson's disease demonstrated that it significantly affects health related quality of life (HRQOL) which is a measurable patient-reported outcome. Please see the information presented below as support for non-motor symptoms affecting outcomes.

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“Parkinson's disease (PD) is associated with significant effects on health utilization economics and health-related quality of life (HRQOL). (Dowding CH, Shenton CL, Salek SS. A review of the health-related quality of life and economic impact of Parkinson's disease. *Drugs Aging*. 2006; 23:693-721) As choices of pharmacologic agents for PD expand, economic and HRQOL outcomes become increasingly relevant for distinguishing between the relative values and roles of new therapies. Increased knowledge and understanding of the potential economic and HRQOL implications associated with PD therapies will enable clinicians to better navigate treatment decisions to provide more favorable outcomes.” (Chrischilles EA, Rubbenstein LM, Voelker MD, Wallace RB, Rodnitzky RL. Linking clinical variables to health related quality of life in Parkinson disease. *Parkinsonism Related Disord* 2002; 8:199 –209.)

Five of these measures pertain to non-motor symptoms, as studies show gaps in assessing non-motor symptoms even though these are often strongly associated with quality of life. Non-motor symptoms are often strongly associated with quality of life. Clinicians who treat PD will recognize that non-motor manifestations are equally important to patient well-being and functioning. These non-motor manifestations include anxiety, depression, cognitive impairment, fatigue, pain, psychosis, and sleep disorders. These non-motor symptoms are readily detectable on clinical interview and specifically measured and captured on HRQOL instruments. Several recent studies confirm the expectation that HRQOL is inversely proportional to PD severity (i.e., reductions in HRQOL measurements parallel increased parkinsonism severity) and a wide range of HRQOL dimensions are affected, including bodily comfort; emotional well-being; self-image; social, cognitive, and sexual function; communication; energy, fatigue, and sleep; and participation in recreational and social activities. (Karlsen KH, Larsen JP, Tandberg E, Maeland JG. Influence of clinical and demographic variables on quality of life in patients with Parkinson's disease. *J Neurol Neurosurg Psychiatry*. 1999; 66:431-435. Karlsen KH, Tandberg E, Arslan P, Larsen JP. Health-related quality of life in Parkinson's disease: a prospective longitudinal study. *J Neurol Neurosurg Psychiatry*. 2000; 69:584-589.)

In particular, the presence of cognitive impairment, depression, fatigue, or sleep difficulties has been shown to have an even greater negative effect on HRQOL dimensions than the motor impairment of PD. Clinicians should routinely assess for the presence of these non-motor features during routine medical care and also consider the potential for PD medications to exacerbate these features (eg, dopamine agonists may exacerbate somnolence, selegiline may exacerbate insomnia, amantadine or anticholinergics may exacerbate cognitive impairment). Additionally, the development of motor fluctuations and dyskinesias is associated with further deteriorations in HRQOL.”

Dementia (from the draft PCPI letter to CMS in regards to the dementia measures currently in use in the PQRS program)

Dementia is a chronic condition that poses a major and growing threat to the public's health, affecting 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 5.3 million Americans of all ages have Alzheimer's disease – the most common form of dementia.² Medicare and Medicaid cover about 70 percent of the costs of care² which are projected to increase from \$200 billion in 2012 to \$1.1 trillion in 2050 (in 2012 dollars).³ The care for individuals with dementia is multidimensional. Clinical practice guidelines indicate the need for a comprehensive approach to management of dementia which can in turn influence quality of life for persons with dementia and that of their caregivers. Unfortunately, a number of studies have indicated a lack of and variability in adherence to recommended practices for the assessment, management and treatment

¹ Alzheimer's Association. 2009 *Alzheimer's Disease Facts and Figures*. Alzheimer's Association ; 2009. 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. Accessed on 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. Accessed September 28, 2010.

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of patients with dementia.^{4,5,6} The identification of high-quality dementia care guidelines and measures across settings was cited as a key strategy in the Department of Health and Human Services' National Plan to Address Alzheimer's Disease. The plan indicates that measures are needed that can track whether recommended care is being provided and suggests that these measures should be based on guidelines tailored to the stages of the disease, addressing the physical, cognitive, emotional, and behavioral symptoms of Alzheimer's Disease, and covering the myriad care settings in which care is delivered.⁸

Defining quality measures for dementia

Given the progressive nature of dementia and the paucity of interventions available to change its course, the development of reliable outcome measures for dementia proved impracticable. The goals of management, particularly for those patients with advanced cognitive impairment, are often focused on improving the quality of life for patients and caregivers, maintaining optimal function and providing maximum comfort.⁹ It is within this context that the nine measures submitted to NQF for consideration for endorsement were conceived by a Dementia Work Group formed by the PCPI in close collaboration with the American Academy of Neurology (AAN), American Geriatrics Society (AGS), American Medical Directors Association (AMDA), and American Psychiatric Association (APA). The measures are based on a number of clinical practice guidelines and primarily target underemphasized aspects of the evaluation and management of dementia patients and address the provision of effective and patient-centered care. The individual measures focus on accurate and appropriate evaluation and monitoring of disease status and associated symptoms to guide treatment, effective therapeutic options in eligible patients, enhancing patient safety and the avoidance of adverse events, and easing patient and caregiver burden by referring them to additional sources for support.

NQF review process

On Thursday, October 4, 2012, NQF's Neurology Endorsement Maintenance Steering Committee met to review measures submitted for Phase 2 of the project and made initial recommendations for endorsement. NQF Steering Committees are charged with reviewing measures and recommending them for endorsement based on whether or not they meet the following four major criteria: importance to measure and report, scientific acceptability of the measure properties, usability, and feasibility. All of the 9 submitted measures failed to pass the importance criterion and were therefore not recommended for endorsement. Specifically, the Steering Committee determined that the body of evidence demonstrating that each individual measure's focus leads to a desired health outcome was insufficient.

The interventions addressed by the measures, namely critical assessments to guide treatment and counseling patients or caregivers on a number of key considerations related to the disease, have not been and are unlikely to be subjected to quantitative studies particularly randomized controlled trials. Requiring the measure focus to have a strong evidence based link to outcome for endorsement is appropriate for many clinical conditions or topic areas where short and long-term clinical outcomes can easily be defined. This requirement, however, fails to give credence to the aforementioned patient-centered outcomes such as improving quality of life and maintaining optimal function that are the focus of dementia care. Furthermore, it fails to acknowledge the

⁴ 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.

⁵ 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.

⁶ Rosen CS, Chow HC, Greenbaum MA, et al. How well are clinicians following dementia practice guidelines? *Alzheimer Dis Assoc Disord.* 2002;16(1): 15-23.

⁷ U.S. Department of Health and Human Services. Second draft: National plan to address Alzheimer's disease. Available at: <http://aspe.hhs.gov/daltcp/napa>. Accessed May 16, 2012.

⁸ U.S. Department of Health and Human Services. Second draft: National plan to address Alzheimer's disease. Available at: <http://aspe.hhs.gov/daltcp/napa>. Accessed May 16, 2012.

⁹ Herrmann N, Gauthier S. Diagnosis and treatment of dementia: 6. Management of severe Alzheimer disease. *CMAJ.* December 2, 2008; 179(12): 1279 - 1287.

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reality of degenerative conditions with no proven intervention to arrest or reverse the prognosis and for which the focus of measure development must narrow in on factors that can be influenced or changed.¹⁰

In revising their evidence criteria, NQF appropriately recognized that much of healthcare has not been subjected to research studies and thus does not have a strong evidence base. As a result, NQF criteria allow for an exception to NQF's empirical body of evidence requirement. In these circumstances, expert judgment must conclude that potential benefits to patients clearly outweigh potential harms to patients from the specific structure or process. The preponderance of benefit over harm for the interventions addressed by the individual measures most certainly was demonstrated by the three or four nationally recognized expert panels who created the guideline recommendation statements upon which the measures were based. To date, steering committees have received minimal guidance on how or when to apply the exception to the evidence requirement. Determining whether to apply the exception is therefore very much a subjective process and governed by the consensus of the particular steering committee. In this review, the focus of the NQF Neurology Endorsement Maintenance Project was quite broad, and the composition of the steering committee similarly broad in expertise. As a result, only 4 of 24 steering committee members noted expertise or interest in dementia or related conditions, representing a small minority who may naturally have been sensitive to the limitations of evidence for dementia and other degenerative neurological disorders. During their deliberations, this Steering Committee entertained the idea of the exception to the evidence requirement briefly and did not vote to invoke the exception for any of the 9 measures discussed. A steering committee comprised of practitioners representing practice settings more familiar with dementia disease management may have assessed the measures more favorably.

MEASURES FOR NQF NEUROLOGY PHASE II COMMITTEE TO RECONSIDER FOR ENDORSEMENT

Measure 1953: Seizure type(s) and current seizure frequency(ies)

• Steering Committee Comment:

While the Committee acknowledged that seizure frequency is the key outcome in epilepsy care, members agreed that there is no evidence that documentation (of seizure type/frequency alone leads to better outcomes. Committee members noted that although the classification systems (for epilepsy type and seizure type) are currently under review by experts in the field, describing the types and frequency of seizures should be a minimal standard of care, particularly in a neurology clinic.

AAN Response: This measure was developed because it is intended to address the problem that many patients and physicians may generalize about seizure control and miss opportunities to intervene to improve seizure control. For example, when patients say they are “doing well,” they may not mean they are seizure-free, but rather that they are continuing to have seizures at the same rate as before. Thus, the only way to assess current seizure control is to ask the patient directly and specify it in the medical record. Documenting frequency for each seizure type is necessary because some seizure types are more disabling than others and may require more or less attention. Documentation was used as the surrogate term for determining that the clinician asked the patient about seizure type and frequency(ies) and then following clinician professionalism standards the clinician followed up as appropriate with any necessary treatment changes or referrals. It is critical that the physician know this information in order to appropriately treat the patient and improve seizure control. This measure also indirectly is linked to better patient quality of life because by controlling the seizures the patient is able to more fully function in activities of daily living, hold down a job and even drive an

¹⁰ National Quality Forum. National Voluntary Consensus Standards for Patient Outcomes Patient Outcomes—Phase 3 Mental Health: A Consensus Report. Available at www.qualityforum.org.

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automobile. Seizure type and seizure frequency are also linked to early treatment costs. A multivariate model was estimated to examine how seizure type and seizure frequency affect early treatment cost while controlling for location, age, gender, and ethnicity. Type and frequency were linked to costs. Therefore it is critical to know the appropriate type and frequency of seizures to understand limit associated costs where applicable. (Begley CE, Lairson DR, Reynolds TF et al. Early treatment cost in epilepsy and how it varies with seizure type and frequency *Epilepsy Research* 2001; 47(3): 205-15).

Although there may not be specific studies that explicitly show how this measure will directly affect an outcome, the expected indirect improvements are so substantial and the risk for harm is so minimal that the AAN believes strongly that the NQF should reconsider this measure for endorsement.

Measure 1954: Documentation of etiology of epilepsy or epilepsy syndrome

• Steering Committee Comment:

While Committee members acknowledged the strong evidence base linking treatment options to epilepsy type, evidence was not presented that documenting epilepsy type will improve patient outcomes. This is required for high-quality medical care, because some etiologies, such as tumors, require regular follow-up and others might suggest eventual resolution, such as childhood absence epilepsy.

AAN Response: Documentation is the surrogate linking the evidence-based guideline recommendation to action of the clinician either asking the patient, reviewing medical records or making other appropriate inquiries to ascertain the patient's etiology of epilepsy or epilepsy syndrome to ensure that the patient is being appropriately treated. This will in turn lead to better management of seizures, improved patient reported outcomes such as improved quality of life, and decreased costs associated with inappropriate treatment(s). While again the AAN acknowledges that no studies to date have been conducted to explicitly document this relationship, it is commonly acknowledged that this is a standard of care to ensure that patients are receiving appropriate treatment.

• Steering Committee Comment:

The Committee was concerned that non-specialists or non-neurologists may not be able to make the proper classification of epilepsy syndrome or epilepsy type, especially given the current controversy in the field regarding classification of epilepsy type.

AAN Response: The AAN acknowledges that there is currently some controversy regarding the classification of epilepsy syndrome or type. However, that does not negate the fact that the treating clinician should know the epilepsy syndrome or type in order to appropriately treat the patient. This measure should be able to be used independent of evolving classification of epilepsy because as the classification evolves so must the treatment. The clinician must still know the classification in order to prescribe appropriate treatment options for the patient.

• Steering Committee Comment:

The Committee also expressed some doubt about the utility of documenting epilepsy type at each visit, given that this generally does not progress or change over time.

AAN Response: The utility of documenting epilepsy type at each visit was not that the clinician would re-diagnose the epilepsy type at every visit but rather than clinician documented the seizure type to indicate that he/she reviewed the seizure type and to use that information to guide treatment options as appropriate.

The AAN requests that the SC reconsider this measure for endorsement.

Measure 1973 (Annual Parkinson's disease diagnosis review)

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•Steering Committee Comment:

The evidence presented by the developer addressed diagnostic inaccuracies in Parkinson's disease, but Committee members agreed that no evidence was presented to show that an annual review improves diagnostic accuracy. The developer acknowledged the lack of empirical evidence for the measure but suggested that consensus and expert opinion also were valid types of evidence. However, the Committee agreed that expert opinion was not sufficient to meeting NQF criteria for evidence."

AAN Response. This is incorrect. The evidence used to support this measure is below. You will note that at least one recommendation has Level B strength behind it. There was one recommendation that was Level D and one recommendation that was a Formal Consensus Review process using a rigorous modified delphi approach that were added as supplementary support for the measure.

Determining the presence of the following clinical features in early stages of disease should be considered to distinguish PD from other parkinsonian syndromes: 1) falls at presentation and early in the disease course, 2) poor response to levodopa, 3) symmetry at onset, 4) rapid progression (to Hoehn and Yahr stage 3 in 3 years), 5) lack of tremor, and 6) dysautonomia (urinary urgency/incontinence and fecal incontinence, urinary retention requiring catheterization, persistent erectile failure, or symptomatic orthostatic hypotension) (**Level B**) (Suchowersky O, Reich S, Perlmutter J, et al, Quality Standards Subcommittee of the American Academy of Neurology. Practice parameter: diagnosis and prognosis of new onset Parkinson disease (an evidence-based review): report of the Quality Standards Subcommittee of the American Academy of Neurology. Neurology 2006 Apr 11; 66(7):968-75)

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

All veterans with the suspected diagnosis of PD who are also receiving medications known to cause parkinsonism (e.g. neuroleptics) should have a trial of withdrawal of these medications, a trial of low-potency neuroleptic, or documentation in the medical record that the medication could not be withdrawn before making the diagnosis of PD. (Cheng E, Siderowf A, Swartztrauber K et al. Development of Quality of Care Indicators for Parkinson's disease Movement Disorders 2004; 19(2):136-150) (Formal Consensus Process)

•Steering Committee Comment:

Committee members voiced the concern that this is a "check-box" measure.

AAN response: The "check box" may or may not be a concern, but that discussion belongs under validity not evidence. Therefore this should not have been discussed in the context of evidence in this measure and under the Evidence criteria for several other measures in this draft report.

•Steering Committee Comment:

Committee members also noted that one of the main studies cited in support of this measure specifically states that there is no evidence regarding the optimal frequency of diagnosis review and that patients should be referred to a specialist for a definitive diagnosis.

AAN Response: This was a NICE recommendation that was not chosen to support this measure as the work group felt it was outside the scope of this measure. All patients in this measure must have a current diagnosis of PD and the indicated recommendation refers to patients without a diagnosis of PD. This measure encourages the provider to look for atypical features that would indicate that diagnosis may have been incorrect. Approximately 20% of patients diagnosed with PD do not have

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PD confirmed by an autopsy. Because this measure is in a national reporting program it was not limited to specialists. Given the potential error in making a diagnosis of PD, patients should be followed closely and the diagnosis reconsidered if atypical features emerge. (Tolosa E, Wenning G, Poewe W. *The diagnosis of Parkinson's disease. Lancet Neurol* 2006; **5**:75–86.)

The potential harm from not regularly reviewing the Parkinson's disease diagnosis and looking for atypical features is significant with links to misdiagnosis, inappropriate treatment and unnecessary associated cost expenditures.

The AAN requests that the SC reconsider this measure for endorsement.

Measure 1982: Parkinson's disease psychiatric disorders or disturbance assessment

• Steering Committee Comment:

Committee members noted that data regarding opportunity for improvement was not well supported in the submission; however, one member verified for the Committee that psychiatric disorders are under-diagnosed in Parkinson's disease patients.

AAN Response: "Psychiatric symptoms frequently coexist with idiopathic Parkinson's disease and are often underdiagnosed and poorly treated. Depression and anxiety are the most common psychiatric conditions that accompany Parkinson's disease. A study by Menza et al. found that 12 out of 42 patients with Parkinson's disease met the criteria for an anxiety disorder according to the *Diagnostic and Statistical Manual* and 11 of them had a comorbid depressive disorder. Recent reviews show that depression is a common and potentially debilitating aspect of Parkinson's disease, affecting 40-50% of patients. Non-motor symptoms of PD have been increasingly recognized as a major cause of disability, particularly neuropsychiatric disorders and cognitive impairment. Most PD-related neuropsychiatric symptoms remain under-recognized and undertreated in clinical practice. (Allain H, Schuck S, Maudui N. Depression in Parkinson's disease *BMJ* 2000; **320**: 1287; Miyasaki JM, Shannon K, Voon V, et al. Practice parameter: evaluation and treatment of depression, psychosis, and dementia in Parkinson disease (an evidence-based review): report of the Quality Standards Subcommittee of the American Academy of Neurology. *Neurology*. 2006; **66**:996-1002. Weintraub D, Moberg PJ, Duda JE, et al. Effect of psychiatric and other nonmotor symptoms on disability in Parkinson's disease. *J Am Geriatr Soc*. 2004; **52**:784-788. 11. Ravina B, Camicioli R, Como PG, et al. The impact of depressive symptoms in early Parkinson disease. *Neurology*. 2007;**69**:342-347; Shulman LM, Taback RL, Rabinstein AA, et al. Non-recognition of depression and other non-motor symptoms in Parkinson's disease. *Parkinsonism Relat Disord*. 2002;**8**:193-197; Weintraub D, Moberg PJ, Duda JE, et al. Recognition and treatment of depression in Parkinson's disease. *J Geriatr Psychiatry Neurol*. 2003; **16**:178-183.)

• The Committee expressed concern that the measure does not specify how assessments should be done (i.e., using specific validated tools). Members suggested modifying the measure so that the assessment be done using validated tools such as, but not limited, to those listed in the guideline recommendations.

AAN Response: There is no one specific validated tool that could be used to assess all possible psychiatric disorders or disturbances. Validated tools do exist for specific types or disorders or disturbances but there is no evidence currently available that has compared one tool over another that the work group felt was conclusive and should be used in this measure.

• The measure did not pass the criterion of Scientific Acceptability. The Committee agreed that the non-specificity of the measure (e.g., use of validated instruments not required, potentially addressing only one of many psychiatric disorders) makes it a check-box measure that would not necessarily improve care quality. (NOTE: Because this was an untested measure, the Committee voted on whether the measure was precisely specified and whether the specifications are consistent with the evidence presented for the measure).

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AAN Response: The SC discussion of this measure was focused a minority of members perception that the measure should only focus on depression rather than all psychiatric disorders or disturbances. The Measure Development work group had considered the development of a depression only measure during the measure development process; however they felt strongly that since PD is associated with a wide range of psychiatric disorders and disturbances that are often overlooked that this measure should not be limited to depression. This measure sets the baseline for best practices for clinicians treating Parkinson's disease patients.

The AAN felt it was inappropriate of the Steering Committee members and NQF staff to ask the AAN to modify this measure to focus only on depression and re-create a measure that has already been through a public comment period and was approved by the Parkinson's disease Measure Development Work Group, the AAN's Quality Measurement and Reporting subcommittee, the AAN's Practice Committee, the AAN's Board of Directors, the AMA's Performance Measurement Advisory Group for CPT II Codes, and implemented in a American Board of Psychiatry and Neurology (ABPN) approved Maintenance of Certification program. Allowing the AAN only 5 business days to work through all the required approvals and public vetting was simply not feasible. It would be more appropriate for the NQF to grant the measure a time limited endorsement and allow the AAN to test the measures and then come back to the NQF by March 2013 with the testing results.

The AAN requests that the SC reconsider this measure for endorsement.

1983: Parkinson's disease cognitive impairment or dysfunction assessment

• Steering Committee Comment:

The evidence presented by the developer addressed treatment of depression; however, no evidence was presented to show how assessing cognitive impairment annually would result in better patient outcomes.

AAN Response: This is incorrect. From the nomination application: Parkinson's disease is associated with cognitive impairment. It is important to assess patients with Parkinson's disease on an annual basis with regard to their cognitive abilities. Clinically significant cognitive difficulties may be present early on in the disease course, but dementia may emerge and be diagnosed later in the course of the disease. However, the insidious onset of cognitive impairment/dementia often occurs over a prolonged period of time. Emerging cognitive impairment has limited treatment, but is important to identify in terms of the patient's care and responsibilities within the home, socially, or in the work place.

Cognitive disorders and dysfunctions are common among individuals affected by Parkinson's disease. An assessment for cognitive impairment or dysfunction will lead to an increase identification of these impairments/dysfunctions, which are regularly associated with PD. The assessment will also in turn help the clinician to assist patients in receiving the appropriate treatment for their cognitive impairment or dysfunction, provide additional resources for the patient and/or caregiver (as necessary), and lead to a better quality of life for the patient.

• Committee members also noted that much of the evidence presented actually related to depression and treatment of depression rather than to cognitive impairment.

AAN Response: Depression was only cited in the context of non-motor symptoms of Parkinson's disease.

The AAN requests that the Steering Committee reconsider this measure for endorsement.

1985: Parkinson's disease querying about sleep disturbances

• Steering Committee Comment:

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The evidence presented by the developer addressed treatment of sleep disturbances, however, no evidence was presented that querying about sleep disturbances will actually improve patient outcomes.

AAN Response: Please see HRQOL information presented on page 3 of this letter. By not querying the patient about sleep disturbances the clinician may miss key factors such as sleep fragmentation (80% of PD patients), restless leg syndrome (20%), REM behavior sleep disorder (>40%), and excessive daytime sleepiness (~50%). This measure is also focused on patient and family and engagement and communication, which are critical parts of the NPP strategy.

The AAN requests that the NQF SC reconsider this measure.

1988: Parkinson's disease rehabilitative therapy options

• Steering Committee Comment:

Several Committee members expressed concerns about the exclusions specified for this measure (i.e., patient has no known physical disability due to Parkinson's disease; patient is unable to respond and no informant is available). The developer explained that these exclusions were added to the measure based on public and physician comments that discussion of rehab options would present undue burden when patients are seen early in the disease course when functional impairments are not yet apparent or later in the disease course when certain patients are incapable of discussing the rehab options. However, some Committee members disagreed with the exclusion for patients not yet presenting with functional impairment symptoms, noting that early intervention may be beneficial. Other members noted a lack of evidence for early rehab services, although they acknowledged the benefit of physical activity and exercise. Ultimately, the Committee agreed that this issue is still an area of clinical controversy and did not formally recommend removal of this exclusion. The developer noted that the exclusion would not prohibit discussion of rehab options with patients without functional impairment symptoms.

AAN Response: One vocal SC member disagreed not with the measure concept but with an exception that may be valid for this measure. The objection was specifically focused on a medical exception for patients who have no known physical disability due to Parkinson's disease. The SC member felt that pre-rehabilitation therapy would be beneficial for patients even though they may have no known physical disability. There is no evidence to support implementing pre-rehabilitation for Parkinson's disease patients. This argument is not evidence based and should not be used to argue against this measure as a whole. There is no harm associated with this measure and there are multiple studies that cite the link between the discussion of rehabilitation therapy options to an increase in referrals to rehab and/or improved patient outcomes.

The AAN asks that the NQF Steering Committee reconsider this measure for endorsement.

2029: Dementia: Counseling regarding risks of driving

• NQF Steering Committee Comment:

One Committee member noted that if you counsel a patient to stop driving and he/she does, then that patient is thereafter excluded from the denominator; conversely, if you counsel a patient to stop driving and he/she does not comply with this advice, the provider still meets the measure. Committee members noted that there is evidence showing counseling is more effective when done by other caregivers (e.g., social workers, nurses) compared to physicians. The developers clarified that this measure is not applicable to physicians only, but also to other care providers such as social workers and psychologists. Committee members agreed that the submission did not demonstrate evidence to support a link between counseling about risks of driving and improved patient outcomes. Again, several Committee members voiced the belief that such evidence likely is available (e.g., in traffic safety data) and expressed some frustration that such evidence was not included as part of the measure submission.

AAN Response: **Everyone with dementia will eventually become an unsafe driver, because of impairments in memory, judgment, reasoning, spatial perception, and reaction time. In a**

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Johns Hopkins University study of drivers diagnosed with Alzheimer's Disease, more than 40% had been in an accident after the diagnosis was made; 44% had gotten lost and 75% continually drove below the speed limit. There is evidence that drivers with Alzheimer's disease and related dementias are at an increased risk for unsafe driving. Crash risk doubles every five years from dementia onset. Clinicians can influence their patients' decision to modify or stop driving. They can also help their patients maintain safe driving skills. A focus group of caregivers of demented drivers stated that physicians should be involved in this important decision making process. (Perkinson M, Berg-Weger, M, Carr D, et al. Driving and dementia of the Alzheimer type: beliefs and cessation strategies among stakeholders. *Gerontologist* 45(5): 676-685.) The Alzheimer's association, the AMA and many other groups have tools, position statements and advisory kits that demonstrate the importance for the physician to counsel demented patients about driving safety issues. Physicians are encouraged to address the issue of driving safety with these patients and their families. (Alzheimer's Association, Alzheimer's Association. Position statement: Driving. Adopted by the Alzheimer's Association Board of Directors, October 2001. Available at: <http://www.alz.org/aboutus/positionstatements/overview.htm>. Accessed 11.27.12; Carr, D.B., Duchek, J., & Morris, J.C. (2000). Characteristics of motor vehicle crashes of drivers with dementia of the Alzheimer type. *Journal of the American Geriatrics Society*, 48(1),18-22; Patterson CJS, Gauthier S, Bergman H, et al. The recognition, assessment and management of dementing disorders: conclusions from the Canadian Consensus Conference on Dementia. *Canadian Medical Association Journal*. 1999; 160(12suppl):S1-S15; AMA Physician's Guide to Assessing and Counseling Older Drivers <http://www.ama-assn.org/ama/pub/physician-resources/public-health/promoting-healthy-lifestyles/geriatric-health/older-driver-safety/assessing-counseling-older-drivers.page>. Accessed 11.20.12) Also in a recent RAND report counseling was under-reported in the medical record compared to the caregiver interview for the 101 patients with dementia and the interview revealed that about half or fewer patients received counseling about safety and accident prevention, caregiver support or managing conflicts. (RAND Corporation Assessment and Management of Patients with Cognitive Impairment and Dementia in Primary Care *J of Nutrition, Health & Aging*, 2012 (16 (5):462-467)

The AAN asks that the NQF SC reconsider this measure for endorsement.

PQRS Usage of Measures

All the neurology measures that were not endorsed by the Neurology Phase II SC were approved by the Centers for Medicaid and Medicare are included in the 2012 and 2013 PQRS program measure lists. The AAN and our partner on the dementia measures, the PCPI, will continue to support the continued use of these measures in future years in PQRS and other CMS programs. We are strongly urging CMS to continue to incorporate these measures in future years independent of the NQF's position to endorse or not endorse these measures. These measures are also all in use in quality initiatives throughout the AAN's NeuroPI Maintenance of Certification (MOC) program that is an ABPN approved program for the MOC Performance in Practice requirement. The implementation of these measures will continue to demonstrate that these measures do improve patient care and outcomes. We strongly urge the NQF to reconsider endorsing these measures.

Thank you for the opportunity to present our comments and concerns regarding the endorsement decisions for these measures. We appreciate your review of these comments and reconsideration of the above measures. Epilepsy, Parkinson's disease and dementia are conditions that cause significant morbidity, mortality and are associated considerable resource use. The AAN feels strongly that the continued implementation of these measures in the CMS Physician Quality Reporting System and in other reporting and quality initiatives will markedly improve care for patients suffering from these debilitating conditions.

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Sincerely,

Christopher T. Bever, Jr, MD, MBA, FAAN
Chair, AAN Quality Measurement and Reporting Committee

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Appendix B: Additional material related to measure #2111



6312 Old Keene Mill Court ♦ Springfield, VA 22152
Phone: 703-690-1987 ♦ www.PQAalliance.org ♦ Fax: 703-690-1756

November 30, 2012

To: National Quality Forum

From: David Nau, PhD, RPh, CPHQ, FAPhA
Senior Director, PQA

Re: Response to Concerns of NQF Neurology Steering Committee

We are sharing our perspective on the concerns raised by the Neurology Steering Committee regarding the PQA-developed measure of Antipsychotic Use in Persons with Dementia (#2111). This measure had been developed through PQA's multi-stakeholder, consensus-based, process and was tested within two Medicare Advantage organizations (encompassing a total of 33 Medicare Advantage contracts with CMS) and one employer-sponsored retiree drug benefit plan. The measure was also endorsed by PQA membership in June 2012.

The measure is intended to be used for assessment across Medicare plans and is specified for the data that are available at the plan-level (e.g., medical and drug claims data). We recognize that clinical details on each patient are not available through claims data; however, the diagnosis codes and drug codes are available across all plans and are sufficiently accurate for population-level, or plan-level, assessment. The purpose of measuring safety at the plan-level is to identify plans that may be outliers in that the utilization rate of antipsychotics in the outlier plan is far above the average rate across all plans.

When constructing the measure specifications, the goal was to identify the population of patients that are at high-risk of adverse events from use of antipsychotic medications (i.e., persons with dementia) and to further focus on the sub-population of dementia patients who do NOT have a documented diagnosis that an antipsychotic is clearly indicated (i.e., we exclude persons who have a diagnosis that identifies them as having psychoses or behavioral

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disturbances). Thus, the measure identifies the proportion of patients at high risk of antipsychotic-associated adverse event but without a diagnosis code to indicate that an antipsychotic drug is necessary.

The steering committee expressed concerns with the measure under consideration. Several of the broad concerns are noted below along with our response.

1. The committee asked why the PQA list of ICD-9 codes for dementia was narrower than the list provided for other measures related to dementia. We have attached an Appendix [Appendix C] that compares the list of diagnosis codes used by PQA, AMDA and PCPI for dementia-related measures. It is important to note that the purpose of each measure is different and thus the corresponding list of ICD-9 codes differs according to the purpose of the measure. The PQA list of diagnosis codes is narrowest because our measure is intended to focus on the subset of dementia patients who do not have a clear indication for an antipsychotic drug. Therefore, we did not include ICD-9 codes for dementia-related diagnoses that indicate a behavioral disturbance or psychoses. For example, we did not include ICD-9 = 294.11 “Dementia in conditions classified elsewhere with behavioral disturbance” since patients with this diagnosis have a behavioral disturbance for which an antipsychotic may be warranted.

2. The committee was concerned that there was no clear indication of what “score” on this measure would constitute optimal performance (i.e. it is not expected that plans should have a rate of 0%). As noted earlier, the purpose of this measure is for comparison of Medicare plans to identify those who have a score that is significantly different than the average score. This is based on the premise that there may always be a small percentage of patients who are appropriately receiving an antipsychotic drug but who did not have a diagnosis code listed in the claims data to indicate the purpose of the antipsychotic.

We asked our testing partners to provide us with additional breakdown of the performance rates for each Medicare contract that was included in the original analyses. Previously, we had only reported the rates across the Medicare Advantage organization rather than for each specific contract. By re-analyzing the data at the contract level (which is how CMS performs its analyses), we are better able to assess the variability in performance across Medicare contracts. Since some of the contracts had extremely small sample sizes, we compared only those contracts with enrollment of at least 1,000 beneficiaries. **Across the individual contracts, the performance rate varied from 10.2% to 20.3% with an average of 13.9% and standard deviation of 3.7%. Thus, there is variation in performance across the Medicare contracts with some of the contracts having a rate that is nearly 2 standard deviations above the average.**

3. The committee asked whether the drug markers for dementia were truly specific to dementia. Conversely, could the drug markers be used for conditions other than dementia?

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The drug markers are medications from the following classes: cholinesterase inhibitors and NMDA receptor antagonists. These medications are only indicated for dementia and are unlikely to be used for non-dementia conditions within our older adult population. However, it is possible that older adults could receive these medications for the late effects of traumatic brain injury. Therefore, we asked one of our testing partners to identify the percentage of patients within our analyses who had a claim with the ICD-9 code for the late effects of traumatic brain injury (907.0). Out of 48,341 patients identified as having dementia, only 46 patients had a claim with ICD-9 of 907.0 (less than 0.1%). Some of these patients also had a diagnosis code for dementia so the likelihood of the patient receiving the dementia medication for traumatic brain injury without dementia is nil.

Given that the medication markers for dementia are highly-specific to dementia, it is appropriate to use these markers to supplement the diagnosis codes for dementia for identification of the denominator population. When using the combination of medication marker and dementia diagnosis code, we found a fairly consistent rate dementia patients across the numerous Medicare contracts (average of 4.6% ; range of 3.4% to 5.9%). As noted earlier, the percentage of the population included in our dementia measure is not intended to replicate the overall rate of dementia in the general population since we are focused on a subset of dementia patients who do not have a diagnosis indicating psychoses or behavioral disturbance.

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Appendix C: Diagnosis Codes List Submitted by PQA

A: ADMA Measure	B: PQA Measure	C: PCPI Measures	Rationale
290 Dementias	X	X	Harmonized
290.0 Senile dementia, uncomplicated	X	X	Harmonized
290.1 Presenile dementia	X	X	Harmonized
290.10 Presenile dementia, uncomplicated	X	X	Harmonized
290.11 Presenile dementia with delirium	X	X	Harmonized
290.12 Presenile dementia with delusional features	X	X	Harmonized
290.13 Presenile dementia with depressive features	X	X	Harmonized
290.2 Senile dementia with delusional or depressive features	X	X	Harmonized
290.20 Senile dementia with delusional features	X	X	Harmonized
290.21 Senile dementia with depressive features	X	X	Harmonized
290.3 Senile dementia with delirium	X	X	Harmonized
290.4 Vascular dementia	X	X	Harmonized
290.40 Vascular dementia, uncomplicated	X	X	Harmonized
290.41 Vascular dementia with delirium	X	X	Harmonized
290.42 Vascular dementia with delusions	X	X	Harmonized
290.43 Vascular dementia with depressed mood	X	X	Harmonized
290.8 Other specified senile <i>psychotic</i> conditions		X	This COULD be treated appropriately with antipsychotic because of psychotic condition.
290.9 Unspecified senile <i>psychotic</i> condition		X	This COULD be treated appropriately with antipsychotic because of psychotic condition, especially with a secondary code of 294.11, but should it only be included with the secondary code.

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A: ADMA Measure	B: PQA Measure	C: PCPI Measures	Rationale
294 Dementia in conditions classified elsewhere			Non-specific and includes: Meynert's amentia (nonalcoholic) 294.0 Amnestic (confabulatory) syndrome 294.0 Amnestic post-traumatic 294.0 Korsakoff-Wernicke psychosis (294.0) Korsakoff-Wernicke (nonalcoholic) 294.0, but without mention of psychosis
294.10 Dementia in conditions classified elsewhere without behavioral disturbance	X	X	Harmonized
294.11 Dementia in conditions classified elsewhere with behavioral disturbance		X	This COULD be treated appropriately with antipsychotic because of behavioral disturbance .
	294.20 Dementia in conditions classified elsewhere without behavioral disturbance	X	PCPI also includes 294.21: Dementia in conditions classified elsewhere “with behavioral disturbance” (aggressive, combative, violent).
294.8 Other persistent mental disorders due to conditions classified elsewhere		X	Amnestic syndrome) Also, Organic Brain Syndrome due to chronic brain infection is classified as 294.8. In each case, with or without 294.11 could make a huge difference.
294.9 Unspecified persistent mental disorders due to conditions classified elsewhere			Anergasia (see also Psychosis, organic) 294.9 psychosis, psychotic reaction (see also Psychosis, organic) 294.9. This category also includes Organic brain disorder, not elsewhere classified (NEC), this gives a lot of squishiness that the committee wanted

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A: ADMA Measure	B: PQA Measure	C: PCPI Measures	Rationale
			to avoid, in my humble opinion. Cognitive disorders NOS.
331 Other cerebral degenerations			This code may be too non-specific.
331.0 Alzheimer's disease	X	X	Harmonized
331.1 Frontotemporal dementia			This would be better served with a secondary code for 294.11.
331.11 Pick's disease		X	Pick's disease is more often associated with behavioral disturbances and may be more challenging to effectively treat with standard dementia drugs or non-drug therapy .
331.19 Other frontotemporal dementia		X	Similar issues to Pick's disease.
331.2 Senile degeneration of brain			<p>"correct" coding for this one states, "add modifier 294.11 for dementia with behavioral disturbances and 294.10 without. In this case, a procedure code such as PET could help differentiate. Moreover, this ICD-9 code is not included in the DSM-IV for dementia or for any other reason, include dementia with medical conditions. I can't find any diagnostic criteria for this ICD-9 code.</p> <p>DO use a 294 code as a secondary code for diagnoses other than Alzheimer's disease, or 331.2 can be used for Organic Brain Syndrome when a clear diagnosis has not yet been determined and the patient is still being evaluated...from dementiacoalition.org</p>
331.3 Communicating hydrocephalus			foramen Magendie (acquired) 331.3' these are classified as "diseases of the neurological system" versus dementia. In this case, it is secondary to a medical condition. May still be a dementia, but not organic.

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A: ADMA Measure	B: PQA Measure	C: PCPI Measures	Rationale
331.4 Obstructive hydrocephalus			
331.7 Cerebral degeneration in diseases classified elsewhere			
331.8 Other cerebral degeneration			This would be better if the fifth value was included (e.g., 331.82 includes dementia with Lewy bodies, dementia with Parkinsonism, Lewy body dementia, Lewy body disease).
331.82 Dementia with Lewy bodies	X	X	Harmonized