# NATIONAL QUALITY FORUM

**Measure Evaluation 4.1**
**January 2010**

This form contains the measure information submitted by stewards. Blank fields indicate no information was provided. Attachments also may have been submitted and are provided to reviewers. The sub-criteria and most of the footnotes from the evaluation criteria are provided in Word comments and will appear if your cursor is over the highlighted area (or in the margin if your Word program is set to show revisions in balloons). Hyperlinks to the evaluation criteria and ratings are provided in each section.

**TAP/Workgroup** (if utilized): Complete all <mark>yellow highlighted</mark> areas of the form. Evaluate the extent to which each sub-criterion is met. Based on your evaluation, summarize the strengths and weaknesses in each section.

<u>Note</u>: *If there is no TAP or workgroup, the SC also evaluates the* sub-criteria (*<mark>yellow</mark> highlighted areas*).

**Steering Committee**: Complete all <mark>pink</mark> highlighted areas of the form. Review the workgroup/TAP assessment of the sub-criterion, noting any areas of disagreement; then evaluate the extent to which each major criterion is met; and finally, indicate your recommendation for the endorsement. Provide the rationale for your ratings.

<u>Evaluation ratings of the extent to which the criteria are met</u>
C = Completely (unquestionably demonstrated to meet the criterion)
P = Partially (demonstrated to partially meet the criterion)
M = Minimally (addressed BUT demonstrated to only minimally meet the criterion)
N = Not at all (NOT addressed; OR incorrectly addressed; OR demonstrated to NOT meet the criterion)
NA = Not applicable (only an option for a few sub-criteria as indicated)

| (for NQF staff use) **NQF Review #**: PSM-010-10 **NQF Project**: Patient Safety Measures |
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| **MEASURE DESCRIPTIVE INFORMATION** |
| **De.1 Measure Title:** Querying and Counseling about Anti-Epileptic Drug (AED) Side-Effects |
| **De.2 Brief description of measure***:* Percentage of patient visits for patients with a diagnosis of epilepsy where the patients were queried and counseled about Anti-Epileptic Drug (AED) side-effects and the querying and counseling was documented in the medical record |
| **1.1-2 Type of Measure:** process<br>**De.3 If included in a composite or paired with another measure, please identify composite or paired measure** Not applicable |
| **De.4 National Priority Partners Priority Area:** safety<br>**De.5 IOM Quality Domain:** safety<br>**De.6 Consumer Care Need:** Staying Healthy |

| CONDITIONS FOR CONSIDERATION BY NQF | |
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| Four conditions must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards: | **NQF Staff** |
| **A.** The measure is in the public domain or an intellectual property (measure steward agreement) is signed.<br>*Public domain only applies to governmental organizations. All non-government organizations must sign a measure steward agreement even if measures are made publicly and freely available.*<br>**A.1** Do you attest that the measure steward holds intellectual property rights to the measure and the right to use aspects of the measure owned by another entity (e.g., risk model, code set)? Yes<br>**A.2 Indicate if** Proprietary Measure (*as defined in measure steward agreement*): | A<br>Y ☐<br>N ☐ |

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| **A.3** Measure Steward Agreement:  agreement signed and submitted<br>**A.4** Measure Steward Agreement attached:  NQF Steward Agreement.pdf | | |
| B. The measure owner/steward verifies there is an identified responsible entity and process to maintain and update the measure on a schedule that is commensurate with the rate of clinical innovation, but at least every 3 years.  Yes, information provided in contact section | B<br>Y☐<br>N☐ | |
| C. The intended use of the measure includes <u>both</u> public reporting <u>and</u> quality improvement.<br>►**Purpose:**  public reporting, quality improvement Accreditation, Payment Incentive, Accountability | C<br>Y☐<br>N☐ | |
| D. The requested measure submission information is complete.  Generally, measures should be fully developed and tested so that all the evaluation criteria have been addressed and information needed to evaluate the measure is provided.  Measures that have not been tested are only potentially eligible for a time-limited endorsement and in that case, measure owners must verify that testing will be completed within 12 months of endorsement.<br>**D.1** Testing:  No, testing will be completed within 12 months<br>**D.2** Have NQF-endorsed measures been reviewed to identify if there are similar or related measures?  Yes | D<br>Y☐<br>N☐ | |
| (for NQF staff use**)** Have all conditions for consideration been met?<br>Staff Notes to Steward (*if submission returned*): | Met<br>Y☐<br>N☐ | |
| Staff Notes to Reviewers (*issues or questions regarding any criteria*): | | |
| Staff Reviewer Name(s): | | |

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| **TAP/Workgroup Reviewer Name:** | |
| **Steering Committee Reviewer Name:** | |
| **1.  IMPORTANCE TO MEASURE AND REPORT** | |
| Extent to which the specific measure focus is important to making significant gains in health care quality (safety, timeliness, effectiveness, efficiency, equity, patient-centeredness) and improving health outcomes for a specific high impact aspect of healthcare where there is variation in or overall poor performance. *Measures must be judged to be important to measure and report in order to be evaluated against the remaining criteria. (*evaluation criteria*)*<br>**1a. High Impact** | **Eval Rating** |
| (for NQF staff use) <u>**Specific NPP goal**</u>: | |
| **1a.1** Demonstrated High Impact Aspect of Healthcare:  a leading cause of morbidity/mortality, severity of illness, patient/societal consequences of poor quality, affects large numbers<br>**1a.2**<br><br>**1a.3** Summary of Evidence of High Impact:  There are over 20 medications used for the treatment of epilepsy, each with specific side effect profiles.  Since antiepileptic drug trials rarely compare one drug against another, it is unclear which medication should be tried first based on efficacy or toxicity.  Thus, it can be hard to predict drug effects in a specific patient, though assessing co-morbidities and picking a medication based on seizure and epilepsy classification may guide therapy.  Patients often fail to report side effects unless this information is specifically requested.  Some patients become noncompliant with medications when these drugs cause side effects, and this can result in breakthrough seizures and their consequences.  Drug side effects may be acute or chronic.  They may be dose related, e.g. sedation, in which case a dose reduction is needed or these side effects may be idiosyncratic, e.g. rash, unrelated to dose, but requiring discontinuation of the drug.  Some side effects are related to pharmacokinetic or pharmacodynamic drug interactions.  In addition, querying patients about cognitive or neuropsychological impairments may be useful in detecting somatic or psychiatric AED side-effects.   Any or all of these factors may result in side effects appearing between visits so it is important to discuss side effects at each visit.<br><br>**1a.4** Citations for Evidence of High Impact:  Efficacy and tolerability of the new antiepileptic drugs I: | 1a<br>C☐<br>P☐<br>M☐<br>N☐ |

treatment of new onset epilepsy: report of the Therapeutics and Technology Assessment Subcommittee and Quality Standards Subcommittee of the American Academy of Neurology and the American Epilepsy Society. American Academy of Neurology - Medical Specialty Society.  2004 Apr 27.  9 pages.  NGC:00356

Efficacy and tolerability of the new antiepileptic drugs II: treatment of refractory epilepsy: report of the Therapeutics and Technology Assessment Subcommittee and Quality Standards Subcommittee of the American Academy of Neurology and the American Epilepsy Society. American Academy of Neurology - Medical Specialty Society.  2004 Apr 27.  13 pages.  NGC:003565

ILAE Glauser T, Ben-Menachem E, Bourgeois B, Cnaan A, Chadwick D, Guerreiro C, Kalviainen R, Mattson R, Perucca E, Tomson T. ILAE Treatment Guidelines: Evidence-based Analysis of Antiepileptic Drug Efficacy and Effectiveness as Initial Monotherapy for Epileptic Seizures and Syndromes.  Epilepsia. 2006 Jul;47(7):1094-120

## 1b. Opportunity for Improvement

**1b.1** Benefits (improvements in quality) envisioned by use of this measure: See 1a.3.  Epilepsy is the third most common neurological disorder in the United States after Alzheimer's disease and stroke. It is equal in prevalence to cerebral palsy, multiple sclerosis and Parkinson's disease combined. One in 10 adults will have a seizure
sometime during their life.
Epilepsy is not a single entity but a family of more than 40 syndromes that affects more than 3 million people in the United States and 50,000,000 worldwide. Epilepsy strikes most often among the very young and the very old, although anyone can get it at any age.
In the U.S., it currently affects more than 326,000 children under age fifteen and more than 90,000 of them have severe seizures that cannot be adequately treated. The number of cases in the elderly is beginning to soar as the baby boom generation approaches retirement age. Currently more than 570,000 adults age 65 and above in the U.S. have the condition.
There is an extremely high burden of illness associated with epilepsy. The mortality rate among people with epilepsy is two to three times higher than the general population and the risk of sudden death is 24 times greater. This year another 200,000 people in the U.S. will be diagnosed with epilepsy and an estimated 25,000 to 50,000 will die of seizures and related causes. Thirty to 40 percent of people with epilepsy are severely affected and continue to have seizures despite treatment. Optimal seizure control can reduce the risk of epilepsy related mortality, decrease morbidity, and greatly increase quality of life.
Prevalence/Incidence:
Prevalence of active epilepsy (history of the disorder plus a seizure or use of antiepileptic medicine within the past 5 years) is estimated as approximately 2.7 million in the United States. There is a higher prevalence of epilepsy among racial minorities than among Caucasians.
Cumulative incidence (risk of developing epilepsy): By 20 years of age, one percent of the population can be expected to have developed epilepsy. By 75 years of age, three percent of the population can be expected to have been diagnosed with epilepsy, and ten percent will have experienced some type of seizure.
Burden of illness (cost):
Epilepsy imposes an annual economic burden of $15.5 billion on the nation in associated health care costs and losses in employment, wages and productivit

**1b.2** Summary of data demonstrating performance gap (variation or overall poor performance) across providers:
Diagnosing epilepsy is a multi-step process that can involve multiple different tests and multiple different specialties. Epilepsy is treated by multiple different specialties.
These specialties include neurology, internal medicine, pediatrics, obstetrics and gynecology, psychologists, neurosurgery, and family practice.
There is variability in who has the ability and how to diagnose epilepsy, determine seizure type, determine causation and determine appropriate therapy. A uniform performance measurement set is needed to clarify these roles and how to best establish evidence based standards of care.

**1b.3** Citations for data on performance gap:
http://www.ninds.nih.gov/disorders/epilepsy/detail_epilepsy.htm
How can Epilepsy be Treated?
Accurate diagnosis of the type of epilepsy a person has is crucial for finding an effective treatment. There

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are many different ways to treat epilepsy. Currently available treatments can control seizures at least some of the time in about 80 percent of people with epilepsy. However, another 20 percent -- about 600,000 people with epilepsy in the United States -- have intractable seizures, and another 400,000 feel they get inadequate relief from available treatments. These statistics make it clear that improved treatments are desperately needed.

Doctors who treat epilepsy come from many different fields of medicine. They include neurologists, pediatricians, pediatric neurologists, internists, and family physicians, as well as neurosurgeons and doctors called epileptologists who specialize in treating epilepsy. People who need specialized or intensive care for epilepsy may be treated at large medical centers and neurology clinics at hospitals or by neurologists in private practice. Many epilepsy treatment centers are associated with university hospitals that perform research in addition to providing medical care.

Once epilepsy is diagnosed, it is important to begin treatment as soon as possible. Research suggests that medication and other treatments may be less successful in treating epilepsy once seizures and their consequences become established.

**1b.4** Summary of Data on disparities by population group:
Prevalence/Incidence: Prevalence of active epilepsy (history of the disorder plus a seizure or use of antiepileptic medicine within the past 5 years) is estimated as approximately 2.7 million in the United States.  There is a higher prevalence of epilepsy among racial mintorities than among Caucasians.
Cumulative incidence (risk of developing epilepsy): By 20 years of age, one percent of the population can be expected to have developed epilepsy.  By 65 years of age, three percent of the population can be expected to have been diagnosed with epilepsy, and ten percent will have experienced some type of seizure.

**1b.5** Citations for data on Disparities:
http://www.ninds.nih.gov/disorders/epilepsy/epilepsy.htm

**1c. Outcome or Evidence to Support Measure Focus**

**1c.1** Relationship to Outcomes (*For non-outcome measures, briefly describe the relationship to desired outcome. For outcomes, describe why it is relevant to the target population*): Non outcomes measure. Epilepsy and its treatment produce a health-related quality of life – measured in days of activity limitation, pain, depression, anxiety, reduced vitality and insufficient sleep or rest – similar to arthritis, heart problems, diabetes and cancer. A performance measurement set has the potential to increase patient safety, reduce the number of deaths due to epilepsy, and increase the quality of life for those who have epilepsy.

**1c.2-3.** Type of Evidence:  evidence based guideline, expert opinion

**1c.4** Summary of Evidence (*as described in the criteria; for outcomes, summarize any evidence that healthcare services/care processes influence the outcome*):
Non outcomes. See 1c.1. There are over 20 medications used for the treatment of epilepsy, each with specific side effect profiles.  Since antiepileptic drug trials rarely compare one drug against another, it is unclear which medication should be tried first based on efficacy or toxicity.  Thus, it can be hard to predict drug effects in a specific patient, though assessing co-morbidities and picking a medication based on seizure and epilepsy classification may guide therapy.  Patients often fail to report side effects unless this information is specifically requested.  Some patients become noncompliant with medications when these drugs cause side effects, and this can result in breakthrough seizures and their consequences.  Drug side effects may be acute or chronic.  They may be dose related, e.g. sedation, in which case a dose reduction is needed or these side effects may be idiosyncratic, e.g. rash, unrelated to dose, but requiring discontinuation of the drug.  Some side effects are related to pharmacokinetic or pharmacodynamic drug interactions.  In addition, querying patients about cognitive or neuropsychological impairments may be useful in detecting somatic or psychiatric AED side-effects.   Any or all of these factors may result in side effects appearing between visits so it is important to discuss side effects at each visit.

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**1c.5** Rating of strength/quality of evidence (*also provide narrative description of the rating and by whom*):
Not applicable

**1c.6 Method for r**ating evidence:  Not applicable

**1c.7** Summary of Controversy/Contradictory Evidence:  Not applicable

**1c.8** Citations for Evidence (*other than guidelines*):  Not applicable

**1c.9** Quote the Specific guideline recommendation (*including guideline number and/or page number*):
WHEN a patient with epilepsy receives follow-up care, THEN an estimate of the number of seizures since the last visit and an assessment of drug side-effects should be documented. (Level D 1+/Primary)  Pugh (2007)17

IF the patient meets the criteria for epilepsy diagnosis (generally two unprovoked seizures) then AED treatment should be discussed with the patient and caregivers and offered. (Level A 1+/Primary) Pugh (2007)17

If a person newly diagnosed with epilepsy is taking medications for other disorders, then the physician should minimize the risk of interactions between the newly prescribed AED and concomitant medications. (Level A 3/Primary) Pugh (2007)17

The side effect and interaction profiles should direct the choice of drug for the individual patient. (Level A) SIGN(April 2003) 23

Factors to consider when tailoring treatment strategy to the individual: Seizure type, Epilepsy Syndrome, Co-medication, Co-morbidity, Lifestyle, and Preferences of individual (and their family and/or caregivers, as appropriate) (Level A.) NICE (October 2004)22

Antiepileptic drug treatment strategy should be individualized according to the seizure type, epilepsy syndrome, co-medication, co-morbidity and the individuals' lifestyle and preferences (and/or those of their family and/or carers as appropriate).  (Grade A, Level 1++) Singapore (Jan. 2007)25

Patients with epilepsy should receive an annual review of information including topics such as:
- Chronic effects of epilepsy and its treatment including drug side-effects, drug-drug interactions, effect on bone health;- Contraception, family planning, and how pregnancy and menopause may affect seizures (EVIDENCE GRADE C);- Screening for mood disorders;- Triggers and lifestyle issues that may affect seizures;- Impact of epilepsy on other chronic and acute diseases;- Driving and safety issues (Level D/Secondary) Pugh (2007) 17


**1c.10** Clinical Practice Guideline Citation:  PUGH Pugh MJ, Berlowitz DR, Montouris G, Bokhour B, Cramer JA, Bohm V, Bollinger M, Helmers S, Ettinger A, Meador KJ, Fountain N, Boggs J, Tatum WO 4th, Knoefel J, Harden C, Mattson RH, Kazis L. What constitutes high quality of care for adults with epilepsy?  Neurology. 2007 Nov 20;69(21):2020-7.
SIGN. Scottish Intercollegiate Guidelines Network (SIGN): SIGN 70: (1) Diagnosis and management of epilepsy in adults. A national clinical guideline. (2) Diagnosis and management of epilepsy in adults. Update to printed guideline. Scottish Intercollegiate Guidelines Network - National Government Agency [Non-U.S.]. 2003 Apr (addendum released 2004 Jun 7).  Original guideline: 49 pages; Addendum: 3 pages.  NGC:003832
NICE  National Collaborating Centre for Primary Care.  The diagnosis and management of the epilepsies in adults and children in primary and secondary care.  (Uses information from Reference 20 and 21) London (UK): Royal College of General Practitioners; 2004 Oct.
SINGAPORE Singapore Ministry of Health-National Government Agency Epilepsy in Adults.  2007 Jan. 43 pages. NGC:005532
**1c.11 National Guideline Clearinghouse or other URL:**  NGC: search Epilepsy

**1c.12 R**ating of strength of recommendation (*also provide narrative description of the rating and by whom*):
Level D 1+; Level A 1+; Level A 3/Primary; Level A; Level A; Grade A, Level 1++; Grade C and D

**1c.13 Method for rating strength of recommendation** (*If different from* <u>USPSTF system</u>, *also describe rating and how it relates to USPSTF)*:
PUGH: Pugh Paper: Epilepsy Measures Work Group Grading of Evidence and Indicators
Pugh MJ, Berlowitz DR, Montouris G, Bokhour B, Cramer JA, Bohm V, Bollinger M, Helmers S, Ettinger A, Meador KJ, Fountain N, Boggs J, Tatum WO 4th, Knoefel J, Harden C, Mattson RH, Kazis L. What constitutes high quality of care for adults with epilepsy?  Neurology. 2007 Nov 20;69(21):2020-7.

A: Rated as appropriate
F: Rated as feasible
N: Rated as necessary
N/A: Not Rated

Ratings
1-3     clearly appropriate/ reliable/ necessary
4-6     uncertain or equivocal
7-10   appropriate/ reliable/ necessary
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NICE.
Rating Scheme for Strength of the Evidence
Ia-Systematic review or meta-analysis of randomized controlled trials
Ib-At least one randomized controlled trial
IIa-At least one well-designed controlled stud without randomization
IIb-At least one well-designed quasi-experimental descriptive studies, such as a cohort study
III-Well-designed non-experimental descriptive studies, case-control studies, and case studies
IV-Expert committee reports, opinions and/or clinical experience of respected authorities

Rating Recommendations
A*        Directly based on category I evidence (meta-analysis of randomized controlled trials (RCTs) or at least one RCT)
B*        Directly based on category II evidence (at least one controlled study without randomization or at least one other quasi-experimental study) or extrapolated from category I evidence
C*        Directly based on category III evidence (non-experimental descriptive studies) or extrapolated from category I or II evidence
D*        Directly based on category III evidence (expert committee reports or opinions and/or clinical experience of respected authorities) or extrapolated from category I, II or III evidence
N        Recommendation taken from NICE guideline or technology appraisal guidance
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Scottish Intercollegiate Guidelines Network (SIGN)
SIGN (1): SIGN 70: Diagnosis and Management of Epilepsy in Adults. A National Clinical Guideline. Edinburgh (Scotland) 2003 April p.49.  Under revision as of June 2008. AND
SIGN 81: Diagnosis and management of epilepsies in children and young people.  Edinburgh (Scotland); March 2005 p. 53.
Grading of Recommendations (Note: Only measures graded as A, B, or C were included in the table)
A: At least one meta-analysis, systematic review of randomized controlled trials (RCTs), or randomized controlled trial rated as 1++ and directly applicable to the target population; or A body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results
B: A body of evidence including studies rated as 2++, directly applicable to the target population and demonstrating overall consistency of results; or Extrapolated evidence from studies rated as 1++ or 1+
C: A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results;  or Extrapolated evidence from studies rate as 2++
D: Evidence level 3 or 4; or
Extrapolated evidence from studies rated as 2+

Levels of Evidence
1++: High quality meta-analyses, systematic reviews of randomized controlled trials (RCTs), or RCTs with a very low risk of bias
1+: Well-conducted meta-analyses, systematic reviews of RCTs, or RCTs with a low risk of bias

1-: Meta-analyses, systematic reviews of RCTs, or RCTs with a high risk of bias
2++: High quality systematic reviews of case control or cohort studies. High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal
2+: Well-conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal
2-: Case control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal
3: Non-analytic studies, e.g. case reports, case series
4: Expert opinion
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SINGAPORE (Jan. 2007)
Epilepsy in Adults.  Singapore Ministry of Health-National Government Agency 2007 Jan. 43 pages.
NGC:005532
(Mirrors a lot of the same recommendations as SIGN (1) and NICE)

Levels of Evidence:
Level 1++: High quality meta-analyses, systematic reviews of randomized controlled trials (RCTs), or RCTs with a very low risk of bias. Level 1+: Well conducted meta-analyses, systematic reviews of RCTs, or RCTs with a low risk of bias.
Level 1-: Meta-analyses, systematic reviews of RCTs, or RCTs with a high risk of bias
Level 2++: High quality systematic reviews of case control or cohort studies. High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal
Level 2+: Well conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal
Level 2-: Case control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal
Level 3: Non-analytic studies (e.g. case reports, case series)
Level 4: Expert opinion

Grades of Recommendation:
Grade A: At least one meta-analysis, systematic review of RCTs, or RCT rated as 1++ and directly applicable to the target population; or A body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results
Grade B: A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results; or Extrapolated evidence from studies rated as 1++ or 1+
Grade C: A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results; or Extrapolated evidence from studies rated as 2++
Grade D: Evidence level 3 or 4; or Extrapolated evidence from studies rated as 2+
GPP (good practice points): Recommended best practice based on the clinical experience of the guideline development group.
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**1c.14 Rationale for using this guideline over others:**
A systematic review of available guidelines, measures and consensus recommendations was carried out using an explicit search strategy devised by AAN staff and a medical librarian. The search was conducted between May 1-October 1, 2008 of all available published data (2008 and earlier.) Databases included the National Guideline Clearinghouse (NGC), National Measures Clearinghouse (NCMC), PubMed, Medline, Embase and the Cochrane Library. Internet searches were carried out on relevant epilepsy websites. The main searches were supplemented by material identified by individual members of the expert panel work group. All selected guidelines, measures and consensus papers were evaluated using PCPI's Framework for Determining Acceptability of Guidelines and other Evidence Review Documents. 160 recommendations were considered for development into measures.

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| **TAP/Workgroup: What are the strengths and weaknesses in relation to the** sub-criteria for *Importance to Measure and Report?* | 1 |
| **Steering Committee: Was the threshold criterion,** *Importance to Measure and Report*, met?<br>**Rationale:** | 1<br>Y☐ |

| | N ☐ |
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| **2. SCIENTIFIC ACCEPTABILITY OF MEASURE PROPERTIES** | |
| Extent to which the measure, <u>as specified</u>, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. (evaluation criteria) | **Eval Rating** |
| **2a. MEASURE SPECIFICATIONS** | |

**S.1** Do you have a web page where current detailed measure specifications can be obtained?
**S.2** If yes, provide web page URL:

2a. Precisely Specified

**2a.1 Numerator Statement** (*Brief, text description of the numerator - what is being measured about the target population, e.g. target condition, event, or outcome*):
Patient visits with patient queried and counseled about Anti-Epileptic Drug (AED) side-effects and the querying and counseling was documented in the medical record.

**2a.2 Numerator Time Window** (*The time period in which cases are eligible for inclusion in the numerator*):
Annually (12 month period)

**2a.3 Numerator Details** (*All information required to collect/calculate the numerator, including all codes, logic, and definitions*):
Numerator: Patient visits with patient queried and counseled about Anti-Epileptic Drug (AED) side effects and the querying and counseling was documented in the medical record
• Report the CPT Category II, Querying and Counseling about Anti-Epileptic Drug (AED) Side-Effects designated for this numerator 6070F.

**2a.4 Denominator Statement** (*Brief, text description of the denominator - target population being measured*):
All visits for patients with a diagnosis of epilepsy.

**2a.5 Target population gender:** Female, Male
**2a.6 Target population age range:** No age range specified.

**2a.7 Denominator Time Window** (*The time period in which cases are eligible for inclusion in the denominator*):
Annually (12 month period)

**2a.8 Denominator Details** (*All information required to collect/calculate the denominator - the target population being measured - including all codes, logic, and definitions*):
Denominator (Eligible Population): All visits for patients with a diagnosis of epilepsy.
99201   Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a problem focused history; a problem focused examination; straightforward medical decision making
99202   Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination; straightforward medical decision making
99203   Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a detailed history; a detailed examination; medical decision making of low complexity
99204   Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of moderate complexity
99205   Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; medical decision

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N ☐

making of high complexity

99212   Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a problem focused history; a problem focused examination; straightforward medical decision making

99213   Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity

99214   Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a detailed history; a detailed examination; medical decision making of moderate complexity

99215   Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity

99241   Office consultation for a new or established patient, which requires these 3 key components: a problem focused history; a problem focused examination; and straightforward medical decision making

99242   Office consultation for a new or established patient, which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making

99243   Office consultation for a new or established patient, which requires these 3 key components: a detailed history; a detailed examination; and medical decision making of low complexity

99244   Office consultation for a new or established patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity

99245   Office consultation for a new or established patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity

99304   Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: a detailed or comprehensive history; a detailed or comprehensive examination; and medical decision making that is straightforward or of low complexity

99305   Initial nursing facility care, per day for the evaluation and management of a patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity

99306   Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these3 key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity

99307   Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a problem focused interval history; a problem focused examination; straightforward medical decision making

99308   Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision making of low complexity

99309   Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a detailed interval history; a detailed examination; medical decision making of moderate complexity

345.00  Generalized nonconvulsive epilepsy; without mention of intractable epilepsy

345.01  Generalized nonconvulsive epilepsy; with intractable epilepsy

345.10  Generalized convulsive epilepsy; without mention of intractable epilepsy

345.11  Generalized convulsive epilepsy; with intractable epilepsy

345.40  Localization-related (focal) (partial) epilepsy and epileptic syndromes with complex partial seizures; without mention of intractable epilepsy

345.41 Localization-related (focal) (partial) epilepsy and epileptic syndromes with complex partial seizures; with intractable epilepsy

345.50  Localization-related (focal) (partial) epilepsy and epileptic syndromes with simple partial seizures; without mention of intractable epilepsy

345.51  Localization-related (focal) (partial) epilepsy and epileptic syndromes with simple partial seizures; with intractable epilepsy

345.60  Infantile spasms; without mention of intractable epilepsy

345.61  Infantile spasms; with intractable epilepsy

345.70  Epilepsia partialis continua; without mention of intractable epilepsy

345.71  Epilepsia partialis continua; with intractable epilepsy
345.90  Epilepsy, unspecified; without mention of intractable epilepsy
345.91  Epilepsy, unspecified; with intractable epilepsy

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**2a.9 Denominator Exclusions** (*Brief text description of exclusions from the target population*): •
Documentation of medical reason for not querying and counseling patient about AED side effects
(e.g. patient is NOT receiving an AED; patient is unable to communicate and no informant is available)

**2a.10 Denominator Exclusion Details** (*All information required to collect exclusions to the denominator, including all codes, logic, and definitions*):
Documentation of medical reason(s) for not documenting patient queried and counseled about Anti-Epileptic Drug (AED) side effects.
•    Append modifier to CPT II code: 6070F-1P.

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**2a.11 Stratification Details/Variables** (*All information required to stratify the measure including the stratification variables, all codes, logic, and definitions*):
Not applicable

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**2a.12-13 Risk Adjustment Type:** no risk adjustment necessary

**2a.14 Risk Adjustment Methodology/Variables** (*List risk adjustment variables and describe conceptual models, statistical models, or other aspects of model or method*):


**2a.15-17 Detailed risk model available Web page URL or attachment:**

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**2a.18-19 Type of Score:** Other (specify) Score not calculated. Benchmark care levels to be identified and established based on participants' data.
**2a.20 Interpretation of Score:** better quality = higher score
**2a.21 Calculation Algorithm** (*Describe the calculation of the measure as a flowchart or series of steps*):
AAN intends to use the University of Alabama (UAB) ABC™ System (Achievable Benchmark Calculation).
(accessed: February 1, 2010 http://main.uab.edu/show.asp?durki=14527).

The ABC method provides an objective, clinically relevant, data-driven, basis for process of care performance improvement by identifying benchmark care levels already achieved by "best-in-class" care givers.

Benchmark performance is measured by the proportion of patients for whom certain clinical processes of care are prescribed or recommended. These processes of care are considered to be indicators (a term used frequently in the ABC method) and their usage indicates differing degrees of excellent care giving. The indicator measure for doctor A or hospital Y is the proportion of clinically appropriate patients to whom this recommendation is actually made. In its benchmark calculation, the ABC system ranks comparable providers and computes statistics that can be used as feedback to individual providers to measure their progress towards health care excellence in relation to that of their "best in class" peers.

See the following URL for the methodology and computation: http://main.uab.edu/show.asp?durki=14508

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**2a.22 Describe the method for discriminating performance** (*e.g., significance testing*):
None. Use will be for practice improvement and what the individual can achieve. A benchmark is provided to help the participant target an achievable benchmark that a participant conducting the same exercise has been able to achieve.

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**2a.23 Sampling (Survey) Methodology** *If measure is based on a sample (or survey), provide instructions for obtaining the sample, conducting the survey and guidance on minimum sample size (response rate)*:
Chart review sampled at 15 charts and peer reviewed.

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**2a.24 Data Source** (*Check the source(s) for which the measure is specified and tested*)
Documentation of original self-assessment, paper medical record/flowsheet, electronic Health/Medical Record

**2a.25 D**ata source/data collection instrument (*Identify the specific data source/data collection

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*instrument, e.g. name of database, clinical registry, collection instrument, etc.*):
Epilepsy Performance in Practice Data Collection Instrument
Parkinson's Disease Performance in Practice Data Collection Instrument
2a.26 The Collection instrument is not yet finalized. Testing is planned for July 1, 2010

**2a.26-28** Data source/data collection instrument reference web page URL or attachment:

**2a.29-31** Data dictionary/code table web page URL or attachment:

**2a.32-35** Level of Measurement/Analysis (*Check the level(s) for which the measure is specified and tested*)
Clinicians: Individual, Can be measured at all levels

**2a.36-37** Care Settings (*Check the setting(s) for which the measure is specified and tested*)
Ambulatory Care: Office, Ambulatory Care: Clinic, nursing home (NH) /Skilled Nursing Facility (SNF), Ambulatory Care: Hospital Outpatient

**2a.38-41** Clinical Services (*Healthcare services being measured, check all that apply*)
Clinicians: Physicians (MD/DO)

## TESTING/ANALYSIS

**2b. Reliability testing**

**2b.1** Data/sample (*description of data/sample and size*):  Five to ten sites will be recruited to conduct feasibility and reliability testing. Each site will be asked to collect data on 30 patients meeting the patient selection criteria for a measure.

**2b.2** Analytic Method (*type of reliability & rationale, method for testing*):
Reliability refers to "the stability of a set of observations generated by an indicator under a fixed set of conditions, regardless of who collects the observations or of when or where they are collected," and is a scientific attribute of measurement instruments. AAN will use peer to peer to assess inter-rater reliability in denominator, numerator, and exclusion case findings as well as the calculation of whole measures in a 'test sample paper chart-based' measurement strategy. This methodology is consistent with the Physician Consortium for Performance Improvement (PCPI) reliability testing protocol. AAN chooses to follow a national framework in both measure development and beta testing.
Inter-rater reliability refers to the extent to which observations from two or more human observers are congruent with each other. AAN is striving for uniformity of observations to the extent possible. Kappa statistics will be used to address agreement rates between peers.

**2b.3** Testing Results (*reliability statistics, assessment of adequacy in the context of norms for the test conducted*):
The standard feasibility and implementation study will enumerate and describe barriers encountered in: implementing/integrating performance measure definitions/specifications within the existing health information system; data abstraction; measure calculation; and performance reporting. Both qualitative methods (asking sites to share observations and assessments) and quantitative methods will be acceptable forms of research for barriers analysis.

**2b**
C☐
P☐
M☐
N☐

**2c. Validity testing**

**2c.1** Data/sample (*description of data/sample and size*):

**2c.2** Analytic Method (*type of validity & rationale, method for testing*):

**2c.3** Testing Results (*statistical results, assessment of adequacy in the context of norms for the test conducted*):

**2c**
C☐
P☐
M☐
N☐

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|---|---|
| **2d. <mark>Exclusions Justified</mark>**<br><br>**2d.1 Summary of Evidence supporting exclusion(s):**<br>Testing has not been completed yet. The exclusion is a clinically appropriate exception to eligibility for the measure focus and precisely defined in the measure specifications<br><br>**2d.2 Citations for Evidence:**<br><br><br>**2d.3 Data/sample** *(description of data/sample and size):*<br><br>**2d.4 Analytic Method** *(type analysis & rationale):*<br><br><br>**2d.5 Testing Results** *(e.g., frequency, variability, sensitivity analyses):* | **2d**<br>C☐<br>P☐<br>M☐<br>N☐<br>NA☐ |
| **2e. Risk Adjustment for Outcomes/ Resource Use Measures**<br><br>**2e.1 Data/sample** *(description of data/sample and size):* Not applicable at this time.<br><br>**2e.2 Analytic Method** *(type of risk adjustment, analysis, & rationale):*<br><br><br>**2e.3 Testing Results** *(risk model performance metrics):*<br><br><br>**2e.4 If outcome or resource use measure is not risk adjusted, provide rationale:** | **2e**<br>C☐<br>P☐<br>M☐<br>N☐<br>NA☐ |
| **2f. Identification of Meaningful Differences in Performance**<br><br>**2f.1 Data/sample from Testing or Current Use** *(description of data/sample and size):* Not applicable at this time.<br><br>**2f.2 Methods to identify statistically significant and practically/meaningfully differences in performance** *(type of analysis & rationale):*<br><br><br>**2f.3 Provide Measure Scores from Testing or Current Use** *(description of scores, e.g., distribution by quartile, mean, median, SD, etc.; identification of statistically significant and meaningfully differences in performance):* | **2f**<br>C☐<br>P☐<br>M☐<br>N☐ |
| **2g. Comparability of Multiple Data Sources/Methods**<br><br>**2g.1 Data/sample** *(description of data/sample and size):* Not applicable at this time.<br><br>**2g.2 Analytic Method** *(type of analysis & rationale):*<br><br><br>**2g.3 Testing Results** *(e.g., correlation statistics, comparison of rankings):* | **2g**<br>C☐<br>P☐<br>M☐<br>N☐<br>NA☐ |
| **2h. Disparities in Care**<br><br>**2h.1 If measure is stratified, provide stratified results** *(scores by stratified categories/cohorts):* Not applicable at this time.<br><br>**2h.2 If disparities have been reported/identified, but measure is not specified to detect disparities, provide follow-up plans:** | **2h**<br>C☐<br>P☐<br>M☐<br>N☐<br>NA☐ |

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| **TAP/Workgroup: What are the strengths and weaknesses in relation to the** sub-criteria for *Scientific Acceptability of Measure Properties?* | 2 |
| **Steering Committee: Overall, to what extent was the criterion,** *Scientific Acceptability of Measure Properties*, **met?**<br>**Rationale:** | 2<br>C☐<br>P☐<br>M☐<br>N☐ |

## 3. USABILITY

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|---|---|
| Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making. (evaluation criteria) | Eval Rating |
| **3a. Meaningful, Understandable, and Useful Information**<br><br>**3a.1 Current Use:** testing not yet completed<br><br>**3a.2 Use in a public reporting initiative (disclosure of performance results to the public at large)** (*If used in a public reporting initiative, provide name of initiative(s), locations, Web page URL(s). If not publicly reported, state the plans to achieve public reporting within 3 years*):<br>The measure is not currently in a public reporting intiative. It was submitted for consideration of inclusion in the PQRI 2011 program.<br>We are currently developing a Maintenance of Certification (MOC) Performance in Practice tookit program that will use this measure.<br><br>**3a.3 If used in other programs/initiatives** (*If used in quality improvement or other programs/initiatives, name of initiative(s), locations, Web page URL(s). If not used for QI, state the plans to achieve use for QI within 3 years*):<br>The measure will be used in a Maintenance of Certification Performance In Practice Toolkit that is currently under development.<br><br>**Testing of Interpretability** (*Testing that demonstrates the results are understood by the potential users for public reporting and quality improvement*)<br>**3a.4 Data/sample** (*description of data/sample and size*):<br><br>**3a.5 Methods** (*e.g., focus group, survey, QI project*):<br><br>**3a.6 Results** (*qualitative and/or quantitative results and conclusions*): | 3a<br>C☐<br>P☐<br>M☐<br>N☐ |
| **3b/3c. Relation to other NQF-endorsed measures**<br><br>**3b.1 NQF # and Title of similar or related measures:** | |
| (for NQF staff use) **Notes on similar/related** endorsed **or submitted measures:** | |
| **3b. Harmonization**<br>If this measure is related to measure(s) already endorsed by NQF (e.g., same topic, but different target population/setting/data source or different topic but same target population):<br>**3b.2 Are the measure specifications harmonized? If not, why?** | 3b<br>C☐<br>P☐<br>M☐<br>N☐<br>NA☐ |
| **3c. Distinctive or Additive Value**<br>**3c.1 Describe the distinctive, improved, or additive value this measure provides to existing NQF-endorsed measures:** | 3c<br>C☐<br>P☐<br>M☐<br>N☐ |

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| **5.1 Competing Measures** If this measure is similar to measure(s) already endorsed by NQF (i.e., on the same topic and the same target population), describe why it is a more valid or efficient way to measure quality: | |
| TAP/Workgroup: What are the strengths and weaknesses in relation to the sub-criteria for *Usability?* | 3 |
| Steering Committee: Overall, to what extent was the criterion, *Usability*, met? <br> Rationale: | 3 <br> C☐ <br> P☐ <br> M☐ <br> N☐ |
| **4. FEASIBILITY** | |
| Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement. (evaluation criteria) | Eval Rating |
| 4a. Data Generated as a Byproduct of Care Processes <br><br> **4a.1-2** How are the data elements that are needed to compute measure scores generated? <br> coding/abstraction performed by someone other than person obtaining original information, | 4a <br> C☐ <br> P☐ <br> M☐ <br> N☐ |
| 4b. Electronic Sources <br><br> **4b.1** Are all the data elements available electronically? (*elements that are needed to compute measure scores are in  defined, computer-readable fields, e.g., electronic health record, electronic claims*) <br> Yes <br><br> **4b.2** If not, specify the near-term path to achieve electronic capture by most providers. | 4b <br> C☐ <br> P☐ <br> M☐ <br> N☐ |
| 4c. Exclusions <br><br> **4c.1** Do the specified exclusions require additional data sources beyond what is required for the numerator and denominator specifications? <br> Yes <br><br> **4c.2** If yes, provide justification.  Documentation of medical exception may be required in the medical record. | 4c <br> C☐ <br> P☐ <br> M☐ <br> N☐ <br> NA☐ |
| 4d. Susceptibility to Inaccuracies, Errors, or Unintended Consequences <br><br> **4d.1** Identify susceptibility to inaccuracies, errors, or unintended consequences of the measure and describe how these potential problems could be audited. If audited, provide results. <br> At this time none of the above items have been identified. | 4d <br> C☐ <br> P☐ <br> M☐ <br> N☐ |
| 4e. Data Collection Strategy/Implementation <br><br> **4e.1** Describe what you have learned/modified as a result of testing and/or operational use of the measure regarding data collection, availability of data/missing data, timing/frequency of data collection, patient confidentiality, time/cost of data collection, other feasibility/ implementation issues: <br> Testing has not yet been completed. <br><br> **4e.2** Costs to implement the measure (*costs of data collection, fees associated with proprietary measures*): | 4e <br> C☐ <br> P☐ <br> M☐ <br> N☐ |

| | |
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| **4e.3** Evidence for costs:<br><br>**4e.4** Business case documentation: | |
| **TAP/Workgroup: What are the strengths and weaknesses in relation to the** sub-criteria for *Feasibility?* | **4** |
| Steering Committee: Overall, to what extent was the criterion, *Feasibility*, met?<br>Rationale: | **4**<br>C ☐<br>P ☐<br>M ☐<br>N ☐ |

| RECOMMENDATION | |
|---|---|
| (for NQF staff use)  Check if measure is untested and only eligible for time-limited endorsement. | Time-limited<br>☐ |
| Steering Committee: Do you recommend for endorsement?<br>Comments: | Y ☐<br>N ☐<br>A ☐ |

| CONTACT INFORMATION |
|---|

**Co.1** Measure Steward (Intellectual Property Owner)
**Co.1** Organization
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**Co.2** Point of Contact
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Measure Developer If different from Measure Steward
**Co.3** Organization
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**Co.4** Point of Contact
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**Co.5** Submitter If different from Measure Steward POC
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**Co.6** Additional organizations that sponsored/participated in measure development
American Academy of Neurology
American Epilepsy Society
Epilepsy Foundation of America
National Association of Epilepsy Centers
American Academy of Family Physicians
American Academy of Pediatrics
American Academy of Neurological Surgeons/Congress of Neurological Surgeons
American Clinical Neurophysiology Society
American College of Emergency Physicians
American College of Radiology
American Psychological Association
American Society of Neuroimaging
Child Neurology Society
National Academy of Neuropsychology
National Organization of Rare Disorders
Society of Nuclear Medicine
American Medical Association Convened-Physician Consortium for Performance Improvement
Kresowik Consultants
UnitedHealth Care

Wellpoint
Humana
Aetna

## ADDITIONAL INFORMATION

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

American Academy of Neurology Facilitator
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American Academy of Neurology
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Dennis Dlugos, MD

American Academy of Neurological Surgeons/Congress of Neurological Surgeons
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American Clinical Neurophysiology Society
William Tatum IV, DO

American College of Emergency Physicians
Andrew Jagoda, MD
American College of Radiology
Eric Russell, MD

American Psychological Association
Bruce Hermann, PhD

American Society of Neuroimaging
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Child Neurology Society

Kevin Chapman, MD

National Academy of Neuropsychology
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Thomas James, MD, Humana
Robert Kropp, MD, Aetna

This expert panel held an in-person meeting on October 8, 2008. The expert panel held several conference calls before and after the in-person meeting to discuss the guideline recommendations, discuss the proposed measures, review applicable denominator codes, respond to the comments received in the 30 day public comment period (held in February-April 2009), respond to PMAG coding inquiries and to vote on the measures at all the stages of development.

**Ad.2** If adapted, provide name of original measure:
**Ad.3-5** If adapted, provide original specifications URL or attachment

**Measure Developer/Steward Updates and Ongoing Maintenance**
**Ad.6** Year the measure was first released:  2009
**Ad.7** Month and Year of most recent revision:  2010-01
**Ad.8** What is your frequency for review/update of this measure?  Annually and Triennial Full Review
**Ad.9** When is the next scheduled review/update for this measure?  2010-08

**Ad.10** Copyright statement/disclaimers:  Physician Performance Measures (measures) and related data specifications developed by the American Academy of Neurology (AAN) are intended to facilitate quality improvement activities by physicians.

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

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

**Ad.11 -13** Additional Information web page URL or attachment:

**Date of Submission** (*MM/DD/YY*):  03/30/2010