

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 **yellow highlighted** 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.

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

Steering Committee: Complete all **pink** 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.

Evaluation ratings of the extent to which the criteria are met

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-011-10	NQF Project: Patient Safety Measures
MEASURE DESCRIPTIVE INFORMATION	
De.1 Measure Title: Counseling about Epilepsy Specific Safety Issues	
De.2 Brief description of measure: Percentage of patients with diagnosis of epilepsy (of their caregiver(s)) counseled about context-specific safety issues, appropriate to the patient's age, seizure type(s) and frequency(ies), occupation and leisure activities, etc. (e.g. injury prevention, burns, appropriate driving restrictions or bathing) at least once a year.	
1.1-2 Type of Measure: process	
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	
De.5 IOM Quality Domain: safety	
De.6 Consumer Care Need: Staying Healthy	

CONDITIONS FOR CONSIDERATION BY NQF	
Four conditions must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards:	NQF Staff
<p>A. The measure is in the public domain or an intellectual property (measure steward agreement) is signed. <i>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.</i></p> <p>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</p> <p>A.2 Indicate if Proprietary Measure (as defined in measure steward agreement):</p> <p>A.3 Measure Steward Agreement: agreement signed and submitted</p>	<p>A</p> <p>Y <input type="checkbox"/></p> <p>N <input type="checkbox"/></p>

A.4 Measure Steward Agreement attached: NQF Steward Agreement-634007234546159353.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 Y <input type="checkbox"/> N <input type="checkbox"/>
C. The intended use of the measure includes <u>both</u> public reporting <u>and</u> quality improvement. ▶ Purpose: public reporting, quality improvement Accreditation, Payment Incentive, Accountability	C Y <input type="checkbox"/> N <input type="checkbox"/>
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. D.1 Testing: No, testing will be completed within 12 months D.2 Have NQF-endorsed measures been reviewed to identify if there are similar or related measures? Yes	D Y <input type="checkbox"/> N <input type="checkbox"/>
(for NQF staff use) Have all conditions for consideration been met? Staff Notes to Steward (<i>if submission returned</i>):	Met Y <input type="checkbox"/> N <input type="checkbox"/>
Staff Notes to Reviewers (<i>issues or questions regarding any criteria</i>):	
Staff Reviewer Name(s):	

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. <i>Measures must be judged to be important to measure and report in order to be evaluated against the remaining criteria. (evaluation criteria)</i>	<u>Eval</u> <u>Rating</u>
1a. High Impact	
(for NQF staff use) Specific NPP goal :	
1a.1 Demonstrated High Impact Aspect of Healthcare: affects large numbers, severity of illness, patient/societal consequences of poor quality, a leading cause of morbidity/mortality 1a.2 1a.3 Summary of Evidence of High Impact: 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	1a C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/>

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 productivity

1a.4 Citations for Evidence of High Impact: Berg AT, Vickrey BG, Sperling MR, et al. Driving in adults with refractory localization-related epilepsy. Multi-Center Study of Epilepsy Surgery. *Neurology*. 54(3):625-30, 2000.

Krauss GL, Ampaw L, Krumholz A. Individual state driving restrictions for people with epilepsy in the US. *Neurology*. 57(10):1780-5, 2001.

Remillard GM, Zifkin BG, Andermann F. Epilepsy and motor vehicle driving--a symposium held in Quebec City, November 1998. *Can J Neurol Sci*. 29(4):315-25, 2002.

Sheth SG, Krauss G, Krumholz A, Li G. Mortality in epilepsy: driving fatalities vs. other causes of death in patients with epilepsy. *Neurology*. 63(6):1002-7, 2004

1b. Opportunity for Improvement

1b.1 Benefits (improvements in quality) envisioned by use of this measure: See 1a.3 Epileptic seizures can pose significant health and safety hazards. All states have laws about driving restrictions and the Federal Government regulates health standards for pilots of aircraft and interstate truck drivers. Businesses have safety regulations for their employees where sudden impairment may cause a dangerous situation for an employee or group of employees. While there are many medical conditions that may cause sudden impairment, seizures can be particularly dangerous and the problem may recur without warning. There are simple safety precautions that any patient with uncontrolled seizures can follow to reduce the risks. In some cases, restrictions are unnecessary since the patient may have only nocturnal seizures or other predictable seizure pattern. Motor vehicle accidents, drowning, burns, falls, fractures, industrial injuries and household injuries can all be prevented or reduced by educating the patient about these risks. Persons with epilepsy may incur legal difficulties if their seizures result in injuries to others. Physicians should discuss driving and other safety concerns. This performance measure could lead to increased patient and public safety.

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 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 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. Epileptic seizures can pose significant health and safety hazards. All states have laws about driving restrictions and the Federal Government regulates health standards for pilots of aircraft and interstate truck drivers. Businesses have safety regulations for their employees where sudden impairment may cause a dangerous situation for an employee or group of employees. While there are many medical conditions that may cause sudden impairment, seizures can be particularly dangerous and the problem may recur without warning. There are simple safety precautions that any patient with uncontrolled seizures can follow to reduce the risks. In some cases, restrictions are unnecessary since the patient may have only nocturnal seizures or other predictable seizure pattern. Motor vehicle accidents, drowning, burns, falls, fractures, industrial injuries and household injuries can all be prevented or reduced by educating the patient about these risks. Persons with epilepsy may incur legal difficulties if their seizures result in injuries to others. Physicians should discuss driving and other safety concerns. This performance measure could lead to increased patient and public safety.

1c.5 Rating of strength/quality of evidence (*also provide narrative description of the rating and by whom*):

Not applicable

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<p>1c.6 Method for rating evidence: Not applicable</p> <p>1c.7 Summary of Controversy/Contradictory Evidence: Not applicable</p> <p>1c.8 Citations for Evidence (other than guidelines): Not applicable</p> <p>1c.9 Quote the Specific guideline recommendation (including guideline number and/or page number): At the time of initial seizure evaluation, the patient should receive information on driving restrictions, safety and injury prevention. (Level E 4/ Primary) Pugh (2007)17</p> <p>QI 16. 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</p> <p>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.</p> <p>1c.11 National Guideline Clearinghouse or other URL: Not in NGC</p> <p>1c.12 Rating of strength of recommendation (also provide narrative description of the rating and by whom): Level E; Level D</p> <p>1c.13 Method for rating strength of recommendation (If different from USPSTF system, also describe rating and how it relates to USPSTF): 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.</p> <p>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 (NMC), 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.</p>	
<p>TAP/Workgroup: What are the strengths and weaknesses in relation to the sub-criteria for <i>Importance to Measure and Report</i>?</p>	1
<p>Steering Committee: Was the threshold criterion, <i>Importance to Measure and Report</i>, met? Rationale:</p>	1 Y <input type="checkbox"/> N <input type="checkbox"/>
2. SCIENTIFIC ACCEPTABILITY OF MEASURE PROPERTIES	
<p>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)</p>	Eval Rating

2a. MEASURE SPECIFICATIONS	
<p>S.1 Do you have a web page where current detailed measure specifications can be obtained? S.2 If yes, provide web page URL:</p> <p>2a. Precisely Specified</p> <p>2a.1 Numerator Statement (<i>Brief, text description of the numerator - what is being measured about the target population, e.g. target condition, event, or outcome</i>): Patients (or their caregiver(s)) counseled about context-specific safety issues, appropriate to the patient’s age, seizure type(s) and frequency(ies), occupation and leisure activities, etc. (e.g. injury prevention, burns, appropriate driving restrictions or bathing) at least once a year.</p> <p>2a.2 Numerator Time Window (<i>The time period in which cases are eligible for inclusion in the numerator</i>): Annually (12 month period)</p> <p>2a.3 Numerator Details (<i>All information required to collect/calculate the numerator, including all codes, logic, and definitions</i>): Numerator: Patients (or their caregiver(s)) counseled about context-specific safety issues, appropriate to the patient’s age, seizure type(s) and frequency(ies), occupation and leisure activities, etc. (e.g. injury prevention, burns, appropriate driving restrictions or bathing) at least once a year. • Report the CPT Category II, Counseling about Epilepsy Specific Safety Issues, designated for this numerator 4330F.</p> <p>2a.4 Denominator Statement (<i>Brief, text description of the denominator - target population being measured</i>): All patients with a diagnosis of epilepsy.</p> <p>2a.5 Target population gender: Male, Female 2a.6 Target population age range: No age range specified.</p> <p>2a.7 Denominator Time Window (<i>The time period in which cases are eligible for inclusion in the denominator</i>): Annually (12 month period)</p> <p>2a.8 Denominator Details (<i>All information required to collect/calculate the denominator - the target population being measured - including all codes, logic, and definitions</i>): Denominator (Eligible Population): All 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 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</p>	<p>2a- specs</p> <p>C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>

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 these 3 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

2a.9 Denominator Exclusions (Brief text description of exclusions from the target population):

<p>Documentation of system reason for not counseling the patient about context-specific safety issues (i.e. caregiver is not available for the patient who is unable to comprehend counseling about safety issues)</p> <p>2a.10 Denominator Exclusion Details (<i>All information required to collect exclusions to the denominator, including all codes, logic, and definitions</i>): Documentation of system reason for not counseling patient about context-specific safety issues appropriate to the patient's age, seizure type(s) and frequency(ies), occupation and leisure activities, etc. (e.g. injury prevention, burns, appropriate driving restrictions or bathing) at least once a year.</p> <ul style="list-style-type: none"> Append modifier to CPT II code: 44330F-3P
<p>2a.11 Stratification Details/Variables (<i>All information required to stratify the measure including the stratification variables, all codes, logic, and definitions</i>): Not applicable</p>
<p>2a.12-13 Risk Adjustment Type: no risk adjustment necessary</p>
<p>2a.14 Risk Adjustment Methodology/Variables (<i>List risk adjustment variables and describe conceptual models, statistical models, or other aspects of model or method</i>):</p>
<p>2a.15-17 Detailed risk model available Web page URL or attachment:</p>
<p>2a.18-19 Type of Score: Other (specify) Score not calculated. Benchmark care levels to be identified and established based on participants' data</p> <p>2a.20 Interpretation of Score: better quality = higher score</p> <p>2a.21 Calculation Algorithm (<i>Describe the calculation of the measure as a flowchart or series of steps</i>): 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).</p> <p>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.</p> <p>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.</p> <p>See the following URL for the methodology and computation: http://main.uab.edu/show.asp?durki=14508</p>
<p>2a.22 Describe the method for discriminating performance (<i>e.g., significance testing</i>): 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.</p>
<p>2a.23 Sampling (Survey) Methodology <i>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):</i> Chart review sampled at 15 charts and peer reviewed.</p>
<p>2a.24 Data Source (<i>Check the source(s) for which the measure is specified and tested</i>) Documentation of original self-assessment, electronic Health/Medical Record, paper medical record/flowsheet</p>
<p>2a.25 Data source/data collection instrument (<i>Identify the specific data source/data collection instrument, e.g. name of database, clinical registry, collection instrument, etc.</i>): Epilepsy Performance in Practice Data Collection Instrument Parkinson's Disease Performance in Practice Data Collection Instrument</p>

<p>2a.26 The Collection instrument is not yet finalized. Testing is planned for July 1, 2010</p> <p>2a.26-28 Data source/data collection instrument reference web page URL or attachment:</p> <p>2a.29-31 Data dictionary/code table web page URL or attachment:</p> <p>2a.32-35 Level of Measurement/Analysis (<i>Check the level(s) for which the measure is specified and tested</i>) Clinicians: Individual, Can be measured at all levels</p> <p>2a.36-37 Care Settings (<i>Check the setting(s) for which the measure is specified and tested</i>) Ambulatory Care: Office, Ambulatory Care: Clinic, nursing home (NH) /Skilled Nursing Facility (SNF), Ambulatory Care: Hospital Outpatient</p> <p>2a.38-41 Clinical Services (<i>Healthcare services being measured, check all that apply</i>) Clinicians: Physicians (MD/DO)</p>	
TESTING/ANALYSIS	
<p>2b. Reliability testing</p> <p>2b.1 Data/sample (<i>description of data/sample and size</i>): 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.</p> <p>2b.2 Analytic Method (<i>type of reliability & rationale, method for testing</i>): 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.</p> <p>2b.3 Testing Results (<i>reliability statistics, assessment of adequacy in the context of norms for the test conducted</i>): 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.</p>	<p>2b C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>
<p>2c. Validity testing</p> <p>2c.1 Data/sample (<i>description of data/sample and size</i>):</p> <p>2c.2 Analytic Method (<i>type of validity & rationale, method for testing</i>):</p> <p>2c.3 Testing Results (<i>statistical results, assessment of adequacy in the context of norms for the test conducted</i>):</p>	<p>2c C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>
<p>2d. Exclusions Justified</p> <p>2d.1 Summary of Evidence supporting exclusion(s):</p>	<p>2d C <input type="checkbox"/> P <input type="checkbox"/></p>

<p>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</p> <p>2d.2 Citations for Evidence:</p> <p>2d.3 Data/sample <i>(description of data/sample and size)</i>:</p> <p>2d.4 Analytic Method <i>(type analysis & rationale)</i>:</p> <p>2d.5 Testing Results <i>(e.g., frequency, variability, sensitivity analyses)</i>:</p>	<p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p> <p>NA <input type="checkbox"/></p>
<p>2e. Risk Adjustment for Outcomes/ Resource Use Measures</p> <p>2e.1 Data/sample <i>(description of data/sample and size)</i>: Not applicable at this time.</p> <p>2e.2 Analytic Method <i>(type of risk adjustment, analysis, & rationale)</i>:</p> <p>2e.3 Testing Results <i>(risk model performance metrics)</i>:</p> <p>2e.4 If outcome or resource use measure is not risk adjusted, provide rationale:</p>	<p>2e</p> <p>C <input type="checkbox"/></p> <p>P <input type="checkbox"/></p> <p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p> <p>NA <input type="checkbox"/></p>
<p>2f. Identification of Meaningful Differences in Performance</p> <p>2f.1 Data/sample from Testing or Current Use <i>(description of data/sample and size)</i>: Not applicable at this time.</p> <p>2f.2 Methods to identify statistically significant and practically/meaningfully differences in performance <i>(type of analysis & rationale)</i>:</p> <p>2f.3 Provide Measure Scores from Testing or Current Use <i>(description of scores, e.g., distribution by quartile, mean, median, SD, etc.; identification of statistically significant and meaningfully differences in performance)</i>:</p>	<p>2f</p> <p>C <input type="checkbox"/></p> <p>P <input type="checkbox"/></p> <p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p>
<p>2g. Comparability of Multiple Data Sources/Methods</p> <p>2g.1 Data/sample <i>(description of data/sample and size)</i>: Not applicable at this time.</p> <p>2g.2 Analytic Method <i>(type of analysis & rationale)</i>:</p> <p>2g.3 Testing Results <i>(e.g., correlation statistics, comparison of rankings)</i>:</p>	<p>2g</p> <p>C <input type="checkbox"/></p> <p>P <input type="checkbox"/></p> <p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p> <p>NA <input type="checkbox"/></p>
<p>2h. Disparities in Care</p> <p>2h.1 If measure is stratified, provide stratified results <i>(scores by stratified categories/cohorts)</i>: Not applicable at this time.</p> <p>2h.2 If disparities have been reported/identified, but measure is not specified to detect disparities, provide follow-up plans:</p>	<p>2h</p> <p>C <input type="checkbox"/></p> <p>P <input type="checkbox"/></p> <p>M <input type="checkbox"/></p> <p>N <input type="checkbox"/></p> <p>NA <input type="checkbox"/></p>
<p>TAP/Workgroup: What are the strengths and weaknesses in relation to the sub-criteria for <i>Scientific Acceptability of Measure Properties</i>?</p>	<p>2</p>

<p>Steering Committee: Overall, to what extent was the criterion, <i>Scientific Acceptability of Measure Properties</i>, met? Rationale:</p>	<p>2 C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>
3. USABILITY	
<p>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)</p>	<p>Eval Rating</p>
<p>3a. Meaningful, Understandable, and Useful Information</p> <p>3a.1 Current Use: testing not yet completed</p> <p>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): The measure is not currently in a public reporting initiative. It was submitted for consideration of inclusion in the PQRI 2011 program. We are currently developing a Maintenance of Certification (MOC) Performance in Practice toolkit program that will use this measure.</p> <p>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): The measure will be used in a Maintenance of Certification Performance In Practice Toolkit that is currently under development.</p> <p>Testing of Interpretability (Testing that demonstrates the results are understood by the potential users for public reporting and quality improvement)</p> <p>3a.4 Data/sample (description of data/sample and size):</p> <p>3a.5 Methods (e.g., focus group, survey, QI project):</p> <p>3a.6 Results (qualitative and/or quantitative results and conclusions):</p>	<p>3a C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>
<p>3b/3c. Relation to other NQF-endorsed measures</p> <p>3b.1 NQF # and Title of similar or related measures:</p>	
<p>(for NQF staff use) Notes on similar/related endorsed or submitted measures:</p>	
<p>3b. Harmonization 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): 3b.2 Are the measure specifications harmonized? If not, why?</p>	<p>3b C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/></p>
<p>3c. Distinctive or Additive Value</p> <p>3c.1 Describe the distinctive, improved, or additive value this measure provides to existing NQF-endorsed measures:</p> <p>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:</p>	<p>3c C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/></p>

TAP/Workgroup: What are the strengths and weaknesses in relation to the sub-criteria for <i>Usability</i> ?	3
Steering Committee: Overall, to what extent was the criterion, <i>Usability</i> , met? Rationale:	3 C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/>
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 4a.1-2 How are the data elements that are needed to compute measure scores generated? coding/abstraction performed by someone other than person obtaining original information,	4a C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/>
4b. Electronic Sources 4b.1 Are all the data elements available electronically? (<i>elements that are needed to compute measure scores are in defined, computer-readable fields, e.g., electronic health record, electronic claims</i>) Yes 4b.2 If not, specify the near-term path to achieve electronic capture by most providers.	4b C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/>
4c. Exclusions 4c.1 Do the specified exclusions require additional data sources beyond what is required for the numerator and denominator specifications? Yes 4c.2 If yes, provide justification. Documentation of medical exception may be required in the medical record.	4c C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/>
4d. Susceptibility to Inaccuracies, Errors, or Unintended Consequences 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.	4d C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/>
4e. Data Collection Strategy/Implementation 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: At this time none of the above items have been identified. 4e.2 Costs to implement the measure (<i>costs of data collection, fees associated with proprietary measures</i>): 4e.3 Evidence for costs: 4e.4 Business case documentation:	4e C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/>

TAP/Workgroup: What are the strengths and weaknesses in relation to the sub-criteria for <i>Feasibility</i>?	4
Steering Committee: Overall, to what extent was the criterion, <i>Feasibility</i>, met? Rationale:	4 C <input type="checkbox"/> P <input type="checkbox"/> M <input type="checkbox"/> N <input type="checkbox"/>
RECOMMENDATION	
(for NQF staff use) Check if measure is untested and only eligible for time-limited endorsement.	Time-limited <input type="checkbox"/>
Steering Committee: Do you recommend for endorsement? Comments:	Y <input type="checkbox"/> N <input type="checkbox"/> A <input type="checkbox"/>
CONTACT INFORMATION	
<p>Co.1 Measure Steward (Intellectual Property Owner) Co.1 Organization American Academy of Neurology 1080 Montreal Avenue Saint Paul Minnesota 55116</p> <p>Co.2 Point of Contact Rebecca Swain-Eng, MS rswaineng@aan.com 651-695-2808</p> <p>Measure Developer If different from Measure Steward Co.3 Organization American Academy of Neurology 1080 Montreal Avenue Saint Paul Minnesota 55116</p> <p>Co.4 Point of Contact Rebecca Swain-Eng, MS rswaineng@aan.com 651-695-2808</p> <p>Co.5 Submitter If different from Measure Steward POC Rebecca Swain-Eng, MS rswaineng@aan.com 651-695-2808- American Academy of Neurology</p> <p>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</p>	
ADDITIONAL INFORMATION	

Workgroup/Expert Panel involved in measure development

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

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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.

American Medical Association Convened-Physician Consortium for Performance

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.

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

Date of Submission (MM/DD/YY): [03/30/2010](#)