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.

Note: *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.

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-012-10 **NQF Project**: Patient Safety Measures
MEASURE DESCRIPTIVE INFORMATION
De.1 Measure Title: Querying about Falls (Parkinson's Disease Patients)
De.2 Brief description of measure*:* Percentage of visits for patients with a diagnosis of Parkinson's disease where the patients (or caregiver(s), as appropriate) were queried about falls.
1.1-2 Type of Measure: patient experience **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**
A. The measure is in the public domain or an intellectual property (measure steward agreement) is signed. *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.* **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 **A.2 Indicate if** Proprietary Measure (*as defined in measure steward agreement*): **A.3 Measure Steward Agreement:** agreement signed and submitted **A.4 Measure Steward Agreement attached:** NQF Steward Agreement-634007228715918076.pdf	A Y☐ N☐

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 ☐ N ☐
C. The intended use of the measure includes both public reporting and quality improvement. ►**Purpose:** public reporting, quality improvement Accreditation, Payment Incentive, Accountability	C Y ☐ 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. **D.1Testing:** 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 ☐ N ☐
(for NQF staff use**)** Have all conditions for consideration been met? Staff Notes to Steward (*if submission returned*):	Met Y ☐ N ☐
Staff Notes to Reviewers (*issues or questions regarding any criteria*):	
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. *Measures must be judged to be important to measure and report in order to be evaluated against the remaining criteria.* (evaluation criteria) **1a. High Impact**	Eval Rating
(for NQF staff use) Specific NPP goal:	
1a.1 Demonstrated High Impact Aspect of Healthcare: a leading cause of morbidity/mortality, high resource use, affects large numbers **1a.2** **1a.3 Summary of Evidence of High Impact:** Parkinson disease (PD) is a chronic neurodegenerative disease. The cardinal signs of PD include rigidity, bradykinesia, tremor, and postural instability. Its impact on mortality is difficult to compute because it is the complications of PD that result in death instead of PD itself. However, PD is well-known to have a wide range of manifestations, including motor, autonomic, cognitive, and psychiatric symptoms. It has a large impact on quality of life. Patients with PD may not only lose their abilities to carry out their normal lives, but in advanced stages, require much attention from family members or caretakers just to carry out basic activities of daily living. Because there is not a pathognomonic test for PD, it may not always be easily identified. In the United States, the incidence is about 60,000 new cases each year, and the prevalence is about 1.5 million. The average age of onset is 62.4 years, but up to 10% of cases begin by age 40. Parkinson's disease is associated with a wide range of psychiatric disorders. Some of these problems are related to the disease itself and some are related to the medications used to treat the disease. These disorders range from anxiety and depression to psychosis and impulse control disorder. It has been demonstrated that depression, in particular, has been often overlooked as a diagnostic possibility in	1a C ☐ P ☐ M ☐ N ☐

patients with Parkinson's disease. In fact, it has been demonstrated that depression and other psychiatric disorders are often overlooked in the general medical population.

According to the National Parkinson's Foundation, each patient spends an average of $2,500 a year for medications. Estimates of costs of medical care, disability payments and lost income exceed $5.6 million annually.

Falls represent a significant risk for injury and can lead to real emergencies (head injury, hip fracture, etc). Eighty percent of falls in Parkinson's disease patients are due to freezing and postural instability. After 8 years of Parkinson's disease, 46% of patients fall at least once and 33% are recurrent fallers. Beyond 8 years of disease, 70% fall at least once and 50% are recurrent fallers. In one study that controlled for age, gender, severity of disease, and number of falls in previous years, 46% fell over a 3-month period and 21% of these were new fallers. Approximately 25% of falls result in injury. The most important risk factor for falling is a prior fall. Assessing patients regularly for falls could allow for preventative measures, including physical therapy, medication adjustments, and use of assistive devices such as canes and walkers.

1a.4 Citations for Evidence of High Impact: Marsh L. Neuropsychiatric aspects of Parkinson's disease. Psychosomatics. 2000 Jan-Feb;41(1):15-23.
Ravina B, Marder K, Fernandez HH, Friedman JH, McDonald W, Murphy D, Aarsland D, Babcock D, Cummings J, Endicott J, Factor S, Galpern W, Lees A, Marsh L, Stacy M, Gwinn-Hardy K, Voon V, Goetz C. Diagnostic criteria for psychosis in Parkinson's disease: report of an NINDS, NIMH work group. Mov Disord. 2007 Jun 15;22(8):1061-8.
Galpern WR, Stacy M. Management of impulse control disorders in Parkinson's disease. Curr Treat Options Neurol. 2007 May;9(3):189-97.
Shulman LM, Taback RL, Rabinstein AA, Weiner WJ. Non-recognition of depression and other non-motor symptoms in Parkinson's disease. Parkinsonism Relat Disord. 2002 Jan;8(3):193-7.
Michalowska M, Fiszer U, Krygowska-Wajs A, Owczarek K. Falls in Parkinson's disease. Causes and impact on patients' quality of life. Funct Neurol 2005;20(4):163-168.
Balash Y, Peretz C, Leibovich G, Herman T, Hausdorff JM, Giladi N. Falls in outpatients with Parkinson's disease: frequency, impact and identifying factors. J Neurol 2005;252(11):1310-1315.
Bloem BR, Hausdorff JM, Visser JE, Giladi N. Falls and freezing of gait in Parkinson's disease: a review of two interconnected, episodic phenomena. Mov Disord 2004;19(8):871-884.
Grimbergen YA, Munneke M, Bloem BR. Falls in Parkinson's disease. Curr Opin Neurol 2004;17(4):405-415.

1b. Opportunity for Improvement

1b.1 Benefits (improvements in quality) envisioned by use of this measure: Prevention of falls could have a large impact on morbidity and mortality as well as decreasing health care costs.

1b.2 Summary of data demonstrating performance gap (variation or overall poor performance) across providers:
 When 10 indicators of Parkinson's disease (PD) care applied to a large healthcare organization, patients received appropriate care 69% of the time. However, there were large variations by process of care, specialist delivering care, and racial/ethnic disparities. Annual assessments of important symptoms of PD including falls, depression, hallucinations, and orthostatic hypotension were conducted only 35-60% of the time. Movement disorder specialist was associated with appropriate care delivered 78% of the time. However, about 2/3 of patients in the study were never seen by a movement disorder specialist during the seven year study period; these patients were significantly less likely to receive appropriate care compared to those with movement disorder specialist involvement. Non-whites were significantly less likely to receive appropriate care compared to white patients with PD in this same study.

1b.3 Citations for data on performance gap:
Parkinsonism & Related Disorders, Volume 14, Issue 1, Pages 8-14
E. Cheng, A. Siderowf, K. Swarztrauber, M. Lee, S. Vassar, E. Jacob, M. Eisa, B. Vickrey

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N☐

1b.4 Summary of Data on disparities by population group:
Parkinson's disease affects both men and women in almost equal numbers. It shows no social, ethnic, economic or geographic boundaries. In the United States, it is estimated that 60,000 new cases are diagnosed each year, joining the 1 million Americans who currently have Parkinson's disease. While the condition usually develops after the age of 65, 15% of those diagnosed are under 50.

1b.5 Citations for data on Disparities:
National Parkinson's Foundation www.parkinson.org Accessed 12.1.2008

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*): Although no cure or neuroprotective agents currently exist for Parkinson's disease (PD), there are considerable number of medications that improve the symptoms of PD and surgery can be used in the most advanced cases. Yet, proper PD management can be complex. Medications that address one symptom (for example, rigidity) can exacerbate other symptoms (hallucinations) or result in the early development of new symptoms (dyskinesias). Guidance to the choice of initial therapy and algorithms for managing advanced stages of PD can lead to clearly better outcomes compared to cases in which PD management is not optimally applied.

Specifically for this measure, prevention of falls could have a large impact on morbidity and mortality as well as health care costs.

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-outcome measure. Falls represent a significant risk for injury and can lead to real emergencies (head injury, hip fracture, etc). Eighty percent of falls in Parkinson's disease patients are due to freezing and postural instability. After 8 years of Parkinson's disease, 46% of patients fall at least once and 33% are recurrent fallers. Beyond 8 years of disease, 70% fall at least once and 50% are recurrent fallers. In one study that controlled for age, gender, severity of disease, and number of falls in previous years, 46% fell over a 3-month period and 21% of these were new fallers. Approximately 25% of falls result in injury. The most important risk factor for falling is a prior fall. Assessing patients regularly for falls could allow for preventative measures, including physical therapy, medication adjustments, and use of assistive devices such as canes and walkers. Prevention of falls could have a large impact on morbidity and mortality as well as health care costs.

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

1c.6 Method for rating 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*):
Determining the presence of the following clinical features in early stages of disease should be considered to distinguish PD from other parkinsonian syndromes: 1) falls at presentation and early in the disease course, 2) poor response to levodopa, 3) symmetry at onset, 4) rapid progression (to Hoehn and Yahr stage 3 in 3 years), 5) lack of tremor, and 6) dysautonomia (urinary urgency/incontinence and fecal incontinence, urinary retention requiring catheterization, persistent erectile failure, or symptomatic orthostatic hypotension) (Level B) AAN QSS PD (April 2006)

All veterans with PD should have documentation that they were asked at least annually about the occurrence of falls. (4 impact outcomes; 4 room for improvement; 3 overall utility rating) Cheng #10 2004 (Annual assessment about falls)

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1c.10 Clinical Practice Guideline Citation: AAN QSS PD Diag. (April 2006) Suchowersky O, Reich S, Perlmutter J, Zesiewicz T, Gronseth G, Weiner WJ, Quality Standards Subcommittee of the American Academy of Neurology. Practice parameter: diagnosis and prognosis of new onset Parkinson disease (an evidence-based review): report of the Quality Standards Subcommittee of the American Academy of Neurology. Neurology 2006 Apr 11;66(7):968-75.

Cheng Eric, Siderowf Andrew, Swarztrauber Kari, Eisa Mahmood, Lee Martin and Vickrey Barbara. Development of Quality of Care Indicators for Parkinson's disease Movement Disorders Vol. 19, No.2, 2004; 136-150

1c.11 National Guideline Clearinghouse or other URL: www.aan.com/go/practice; Cheng article not online in NGC

1c.12 Rating of strength of recommendation (*also provide narrative description of the rating and by whom*):
AAN QSS: Level B; Cheng Indicators: 4 impact outcomes, 4 room for improvement, 3 overall utility rating

1c.13 Method for rating strength of recommendation (*If different from* USPSTF system, *also describe rating and how it relates to USPSTF*):
AAN QSS PD Diag. (April 2006) Suchowersky O, Reich S, Perlmutter J, Zesiewicz T, Gronseth G, Weiner WJ, Quality Standards Subcommittee of the American Academy of Neurology. Practice parameter: diagnosis and prognosis of new onset Parkinson disease (an evidence-based review): report of the Quality Standards Subcommittee of the American Academy of Neurology. Neurology 2006 Apr 11;66(7):968-75.
*It is difficult to transfer information from the table into this form. The table can be provided if needed.
Classification of Evidence
Suggested wording
Translation of evidence to recommendations
Rating of Therapeutic Article
(Note: Wording relevant to diagnostic, prognostic and screening questions are indicated in parenthesis.)
Conclusion:
A = Established as effective, ineffective or harmful (or established as useful/predictive or not useful/predictive) for the given condition in the specified population
Recommendation:
Should be done or, should not be done
Level A rating requires at least two consistent Class I studies*
Class I: Randomized, controlled clinical trial with masked or objective outcome assessment, in a representative population. Relevant baseline characteristics are presented and substantially equivalent among treatment groups or there is appropriate statistical adjustment for differences. The following are required:
a)
Concealed allocation
b)
primary outcome(s) clearly defined
c)
exclusion/inclusion criteria clearly defined
d)
adequate accounting for drop-outs (with at least 80% of enrolled subjects completing the study) and cross-overs with numbers sufficiently low to have minimal potential for bias
60
AAN Parkinson's Disease: Full List of Guideline Recommendations
*Evidence classification/rate schemes described at the end of this document.
Conclusion:
B = Probably effective, ineffective or harmful (or probably useful/predictive or not useful/predictive) for the given condition in the specified population
Recommendation:
Should be considered or, should not be considered

Level B rating requires at least one Class I study or two consistent Class II studies

Class II: Prospective matched group cohort study in a representative population with masked outcome assessment that meets b-d above OR a RCT in a representative population that lacks one criteria a-d.

Conclusion:

C = Possibly effective, ineffective or harmful (or possibly useful/predictive or not useful/predictive) for the given condition in the specified population

Recommendation:

May be considered or, may not be considered

Level C rating requires at least one Class II study or two consistent Class III studies

Class III: All other controlled trials (including well-defined natural history controls or patients serving as own controls) in a representative population, where outcome is independently assessed, or independently derived by objective outcome measurement.**

Conclusion:

U = Data inadequate or conflicting; given current knowledge, treatment (test, predictor) is unproven

Recommendation:

None

Studies not meeting criteria for Class I – Class III

Class IV: Studies not meeting Class I, II or III criteria including consensus, expert opinion or a case report.

*In exceptional cases, one convincing Class I study may suffice for an "A" recommendation if 1) all criteria are met, 2) the magnitude of effect is large (relative rate improved outcome > 5 and the lower limit of the confidence interval is > 2).

**Objective outcome measurement: an outcome measure that is unlikely to be affected by an observer's (patient, treating physician, investigator) expectation or bias (e.g., blood tests, administrative outcome data). 61

AAN Parkinson's Disease: Full List of Guideline Recommendations

*Evidence classification/rate schemes described at the end of this document.

Rating of Diagnostic Article

Rating of Prognostic Article

Rating of Screening Article

Class I: A cohort study with prospective data collection of a broad spectrum of persons with the suspected condition, using an acceptable reference standard for case definition. The diagnostic test is objective or performed and interpreted without knowledge of the patient's clinical status. Study results allow calculation of measures of diagnostic accuracy.

Class I: A cohort study of a broad spectrum of persons at risk for developing the outcome (e.g. target disease, work status). The outcome is defined by an acceptable reference standard for case definition. The outcome is objective or measured by an observer who is masked to the presence of the risk factor. Study results allow calculation of measures of prognostic accuracy.

Class I. A statistical, population-based sample of patients studied at a uniform point in time (usually early) during the course of the condition. All patients undergo the intervention of interest. The outcome, if not objective, is determined in an evaluation that is masked to the patients' clinical presentations.

Class II: A case control study of a broad spectrum of persons with the condition established by an acceptable reference standard compared to a broad spectrum of controls or a cohort study where a broad spectrum of persons with the suspected condition where the data was collected retrospectively. The diagnostic test is objective or performed and interpreted without knowledge of disease status. Study results allow calculation of measures of diagnostic accuracy.

Class II: A case control study of a broad spectrum of persons with the condition compared to a broad spectrum of controls or a cohort study of a broad spectrum of persons at risk for the outcome (e.g. target disease, work status) where the data was collected retrospectively. The outcome is defined by an acceptable reference standard for case definition. The outcome is objective or measured by an observer who is masked to the presence of the risk factor. Study results allow calculation of measures of prognostic accuracy.

Class II. A statistical, non-referral-clinic-based sample of patients studied at a uniform point in time (usually early) during the course of the condition. Most patients undergo the intervention of interest. The outcome, if not objective, is determined in an evaluation that is masked to the patients' clinical presentations.

Class III: A case control study or cohort study where either persons with the condition or controls are of a narrow spectrum. The condition is established by an acceptable reference standard. The reference standard and diagnostic test are objective or performed and interpreted by different observers. Study

results allow calculation of measures of diagnostic accuracy.

Class III: A case control study or a cohort study where either the persons with the condition or the controls are of a narrow spectrum where the data was collected retrospectively. The outcome is defined by an acceptable reference standard for case definition. The outcome is objective or measured by an observer who did not determine the presence of the risk factor. Study results allow calculation of measures of a prognostic accuracy.

Class III. A sample of patients studied during the course of the condition. Some patients undergo the intervention of interest. The outcome, if not objective, is determined in an evaluation by someone other than the treating physician.

Class IV: Studies not meeting Class I, II or III criteria including consensus, expert

Class IV: Studies not meeting Class I, II or III criteria including consensus, expert opinion or a case

Class IV. Studies not meeting Class I, II or III criteria including consensus, expert opinion or a case report. 62

AAN Parkinson's Disease: Full List of Guideline Recommendations

*Evidence classification/rate schemes described at the end of this document.

opinion or a case report.

report.

Retrospective: a case control study. Prospective: a cohort survey. Objective: a measurement unlikely to be affected by expectation bias.

Cheng Eric, Siderowf Andrew, Swarztrauber Kari, Eisa Mahmood, Lee Martin and Vickrey Barbara. Developmnent of Quality of Care Indicators for Parkinson's disease Movement Disorders Vol. 19, No.2, 2004 (P136-150)

*It is difficult to transfer the information from the table into this form. The table can be provided if needed.

Criteria

Definition of criterion supplied to panel

Scale Range

Validity

1. Sufficient evidence to support a link between the performance of that indicator and overall positive outcomes to PD patients, and

2. A provider with higher rates of adherence to that indicator would be considered a higher quality provider

1=Definitely not valid

9=Definitely valid

Feasibility

1. Information on adherence to indicator is available and should be documented in the medical record, and

2. Is available from patient or proxy surveys and is likely to be accurate

1=Definitely not feasible

9=Definitely feasible

Impact on outcomes

Importance of adherence to indicator care process to achieving favorable PD patient outcomes (panelist will compare expected quality of care if indicator is not followed vs. expected quality of care if indicator is followed).

1=No impact on outcomes

9=Substantial room for improvement

Room for improvement

There is "room for improvement" on this indicator in most PD care delivery settings or by most PD care providers in the VA.

1=No room for improvement

5=Substantial room for improvement

Overall Utility

Overall rating of utility of indicator for PD quality of care assessment (panelist should take into account the validity, feasibility, impact on outcomes, and room for improvement in making this assessment).

1=Little reason to do

2=Could do

3=Should do

4=Must do

*The panel rate the PD-relevant ACOVE indicators only on their impact on outcomes, room for improvement

and the overall utility rating. PD, Parkinson's disease; ACOVE, Assessing Care of Vulnerable Elders. **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 October 1-December 30, 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 Parkinson's disease 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. 8 guidelines and 1 consensus paper with approximately 258 recommendations were found to be relevant and thus included in the full list of recommendations.	
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?** **Rationale:**	1 Y☐ N☐

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 (or caregiver(s), as appropriate) queried about falls. **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: Patients (or caregiver(s), as appropriate) queried about falls. • Report the CPT Category II, Querying about Falls in development designated for this numerator XXXXF. The measure has been approved by the Performance Measurement Advisory Group but we have not received the designated CPT II code as of 3.30.10.	
2a.4 Denominator Statement (*Brief, text description of the denominator - target population being measured*): All visits for patients with a diagnosis of Parkinson's disease. **2a.5 Target population gender:** Male, Female **2a.6 Target population age range:** Independent of Age **2a.7 Denominator Time Window** (*The time period in which cases are eligible for inclusion in the denominator*): Annually (12 month period)	2a-specs C☐ P☐ M☐ N☐

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 Parkinson's disease.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 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
99310   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 comprehensive interval history; a comprehensive examination; medical decision making of high complexity
AND
332.0   Paralysis agitans

2a.9 Denominator Exclusions (*Brief text description of exclusions from the target population*):
Documentation of medical reason for not querying patient (or caregiver) about falls (eg patient is unable to respond and no informant is avaiable)

2a.10 Denominator Exclusion Details (*All information required to collect exclusions to the denominator, including all codes, logic, and definitions*):
Append modifer to CPT II Code : XXXXF-1P. See note in 2a.3.

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

2a.12-13 Risk Adjustment Type:

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:

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

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.

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.

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 Data source/data collection instrument (*Identify the specific data source/data collection 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, Ambulatory Care: Hospital Outpatient, nursing home (NH) /Skilled Nursing Facility (SNF)

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
C☐
P☐
M☐
N☐

2c.3 Testing Results *(statistical results, assessment of adequacy in the context of norms for the test conducted)*:	
2d. <mark>Exclusions Justified</mark> **2d.1** Summary of Evidence supporting exclusion(s): 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. **2d.2** Citations for Evidence: **2d.3** Data/sample *(description of data/sample and size)*: **2d.4** Analytic Method *(type analysis & rationale)*: **2d.5** Testing Results *(e.g., frequency, variability, sensitivity analyses)*:	**2d** C☐ P☐ M☐ N☐ NA☐
2e. Risk Adjustment for Outcomes/ Resource Use Measures **2e.1** Data/sample *(description of data/sample and size)*: Not applicable at this time. **2e.2** Analytic Method *(type of risk adjustment, analysis, & rationale)*: **2e.3** Testing Results *(risk model performance metrics)*: **2e.4** If outcome or resource use measure is not risk adjusted, provide rationale:	**2e** C☐ P☐ M☐ N☐ NA☐
2f. Identification of Meaningful Differences in Performance **2f.1** Data/sample from Testing or Current Use *(description of data/sample and size)*: Not applicable at this time. **2f.2** Methods to identify statistically significant and practically/meaningfully differences in performance *(type of analysis & rationale)*: **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** C☐ P☐ M☐ N☐
2g. Comparability of Multiple Data Sources/Methods **2g.1** Data/sample *(description of data/sample and size)*: Not applicable at this time. **2g.2** Analytic Method *(type of analysis & rationale)*: **2g.3** Testing Results *(e.g., correlation statistics, comparison of rankings)*:	**2g** C☐ P☐ M☐ N☐ NA☐
2h. Disparities in Care **2h.1** If measure is stratified, provide stratified results *(scores by stratified categories/cohorts)*: Not applicable at this time.	**2h** C☐ P☐ M☐

2h.2 If disparities have been reported/identified, but measure is not specified to detect disparities, provide follow-up plans:	N ☐ NA ☐
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? Rationale:	*2* C ☐ P ☐ M ☐ N ☐
3. USABILITY	
Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making. (evaluation criteria)	Eval Rating
3a. Meaningful, Understandable, and Useful Information **3a.1** Current Use: testing not yet completed **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 intiative. It was submitted for consideration of inclusion in the PQRI 2011 program. We are currently developing a Maintenance of Certification (MOC) Performance in Practice tookit program that will use this measure. **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. **Testing of Interpretability** (*Testing that demonstrates the results are understood by the potential users for public reporting and quality improvement*) **3a.4** Data/sample (*description of data/sample and size*): **3a.5** Methods (*e.g., focus group, survey, QI project*): **3a.6** Results (*qualitative and/or quantitative results and conclusions*):	3a C ☐ P ☐ M ☐ N ☐
3b/3c. Relation to other NQF-endorsed measures **3b.1** NQF # and Title of similar or related measures: 0035, 0141, 0202, 0101, 0537	
(for NQF staff use) Notes on similar/related endorsed or submitted measures:	
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? This measure does limit individuals based upon age as do most of the currently endorsed NQF falls measures. In addition, this measure is intended to be in used in outpatient visits, clinic visits, and nursing homes. None of the other measures cover all of these care settings. 0035: Limited to individuals 75 years old and older. 0141: Limited to patients in hospitals	3b C ☐ P ☐ M ☐ N ☐ NA ☐

0202: Limited to patients in hospitals 0101: Limited to patients 65 years and older 0537: Limited to home health and patients 65 year old and older	
3c. Distinctive or Additive Value **3c.1** Describe the distinctive, improved, or additive value this measure provides to existing NQF-endorsed measures: This measure covers falls in outpatient visits, clinic visits and nursing homes. No other falls measure covers all these care settings. In addition, this measure does not have age restrictions as Parkinson's disease can develop before the age of 65 and it is important to query patients in any age group with Parkinson's disease about falls. **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: Not applicable.	3c C☐ P☐ M☐ N☐
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? **Rationale:**	3 C☐ P☐ M☐ 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 **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☐ P☐ M☐ N☐
4b. Electronic Sources **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*) Yes **4b.2** If not, specify the near-term path to achieve electronic capture by most providers.	4b C☐ P☐ M☐ N☐
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 patient unable to respond to queries about falls and no informant is available must be made in the medical record.	4c C☐ P☐ M☐ N☐ NA☐
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. At this time none of the above items have been identified.	4d C☐ P☐ M☐ N☐
4e. Data Collection Strategy/Implementation	4e

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: **4e.2** Costs to implement the measure (*costs of data collection, fees associated with proprietary measures*): **4e.3** Evidence for costs: **4e.4** Business case documentation:	C ☐ P ☐ M ☐ N ☐
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? Rationale:	4 C ☐ P ☐ M ☐ N ☐

RECOMMENDATION

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

CONTACT INFORMATION

Co.1 Measure Steward (Intellectual Property Owner)
Co.1 Organization
American Academy of Neurology | 1080 Montreal Avenue | Saint Paul | Minnesota | 55116

Co.2 Point of Contact
Rebecca | Swain-Eng, MS | rswaineng@aan.com | 651-695-2808

Measure Developer If different from Measure Steward
Co.3 Organization
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Co.4 Point of Contact
Rebecca | Swain-Eng, MS | rswaineng@aan.com | 651-695-2808

Co.5 Submitter If different from Measure Steward POC
Rebecca | Swain-Eng, MS | rswaineng@aan.com | 651-695-2808- |American Academy of Neurology

Co.6 Additional organizations that sponsored/participated in measure development
The following groups had representatives on the work group:
American Parkinson's Disease Association, National Parkinson Foundation, Parkinson's Disease Foundation, American Academy of Family Physicians, American Association of Neurosurgeons/Congress of Neurological Surgeons, American Neurological Association, American Psychological Association, American Psychiatric Association, Movement Disorder Society, National Academy of Neuropsychology, Aetna, Anthem Blue Cross Blue Shield, Humana, UnitedHealth Group, Kresowik Consulting (methdodologist)

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: Co-Chairs-William Weiner, MD, FAAN and Stewart Factor, DO, FAAN; Expert Panel Facilitators-Christopher Bever Jr., MD, MBA, FAAN and Eric M. Cheng, MD, MS; Work Group members from Movement Disorder Section of the AAN-Lisa Shulman, MD, FAAN, Sotirios A. Parashos, MD, PhD, Helen Bronte-Stewart, MD, FAAN, Janis Miyasaki, MD, FAAN, and Marian Evatt, MD
American Parkinson's Disease Association- Michele Popadynec, RN
National Parkinson Foundation- Joyce Oberdorf, MA
Parkinson's Disease Foundation-Jim Beck, PhD
American Academy of Family Physicians-H. James Brownlee Jr., MD
American Association of Neurosurgeons/Congress of Neurological Surgeons-Karl Sillay, MD
American Neurological Association-Blair Ford, MD, FAAN
American Psychological Association-Paul MOberg, PhD, ABPP/CN
American Psychiatric Association-Laura Marsh, MD
Movement Disorder Society-Daniel Tarsy, MD, FAAN
National Academy of Neuropsychology-Alexander Troster, PhD
Aetna-Robert M. Kropp,MD, MBA
Anthem Blue Cross Blue Shield-Wesley B. Wong, MD, MMM
Humana-Monte Masten, MD
UnitedHealth Group-David Stumpf, MD
Kresowik Consulting-Rebecca Kresowik
AAN Coding Specialists-Mark Nuwer, MD, PhD, FAAN and Mustafa Saad Siddiqui, MD
AAN Staff-Rebecca Swain-Eng,MS and Sarah Tonn, MPH

This expert panel held an in-person meeting on January 17,2009. 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 September 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: 2009-12
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? 2011-01

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.

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

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