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-013-10 **NQF Project:** Patient Safety Measures
MEASURE DESCRIPTIVE INFORMATION
De.1 **Measure Title:** Parkinson's Disease Related Safety Issues Counseling
De.2 **Brief description of measure***:* Percentage of patients with a diagnosis of Parkinson's disease (or caregiver(s), as appropriate) who were counseled about context-specific safety issues appropriate to the patient's stage of disease (eg injury prevention, medication management, or driving) at least annually.
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**: patient-centered, 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-634007228292647662.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.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☐ 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:** affects large numbers, a leading cause of morbidity/mortality, patient/societal consequences of poor quality, severity of illness 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. There are several scenarios where safety issues are important in Parkinson's disease. One relates to balance and the risk of falling. Patients with Parkinson's disease need to be counseled regarding the dangers of climbing on ladders and chairs, climbing and descending stairs, and walking on uneven terrain because of the dangers of falling. Twenty-five percent (25%) of falls result in injury. Medication can cause adverse effects such as orthostasis and excessive daytime sleepiness that result in concerns about safety.	**1a** C☐ P☐ M☐ N☐

Patients need to be counseled on these issues. Patients with Parkinson's disease experience a number of functional difficulties that may affect driving safety. Motor function, visual perceptive activities, reaction time, attention maintenance, sleep disorders, and information processing are all abnormal in patients with Parkinson's disease, which leads to an increase in accidents per mile driven. Dementia is often associated with Parkinson's disease adds another dimension to the problem. In the mild-to-moderate stages of dementia, some patients remain competent whereas others are not. Many continue to drive even in advanced stages because of the issue of independence and the social impact of cessation. The responsibility for determining driving competence in early-to-mid-duration patients with Parkinson's disease is the responsibility of patients, families, and physicians. Driving should be discussed with all patients, and referral for a proper driving assessment by an experienced driver rehabilitation specialist should be considered if necessary. Those who continue to drive should be assessed regularly because the disease and its therapies change with time.

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.
Factor SA, Weiner WJ. Driving. In: Parkinson's Disease: Diagnosis and Clinical Management. Second Edition. Factor SA, Weiner WJ, eds. Demos Publishing, New York, NY. 2008. pp: 779-790.

1b. Opportunity for Improvement

1b.1 Benefits (improvements in quality) envisioned by use of this measure: See 1a.3. The benefits of counseling patients about safety issues specific to the patient's stage of Parkinson's disease include reducing risk of falls, reducing medication adverse effects, reducing driving risks, and reducing other safety related concerns related to motor, autonomic, cogntive and psychiatric symtpoms that directly affect the patient's quality of life.

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

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

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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, counseling about Parkinson's disease safety issues could have a large impact on morbidity and mortality as well as health care costs.

1c.2-3. Type of Evidence: 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 measure. Please see 1b.1 There are several scenarios where safety issues are important in Parkinson's disease. One relates to balance and the risk of falling. Patients with Parkinson's disease need to be counseled regarding the dangers of climbing on ladders and chairs, climbing and descending stairs, and walking on uneven terrain because of the dangers of falling. Twenty-five percent (25%) of falls result in injury. Medication can cause adverse effects such as orthostasis and excessive daytime sleepiness that result in concerns about safety. Patients need to be counseled on these issues. Patients with Parkinson's disease experience a number of functional difficulties that may affect driving safety. Motor function, visual perceptive activities, reaction time, attention maintenance, sleep disorders, and information processing are all abnormal in patients with Parkinson's disease, which leads to an increase in accidents per mile driven. Dementia is often associated with Parkinson's disease adds another dimension to the problem. In the mild-to-moderate stages of dementia, some patients remain competent whereas others are not. Many continue to drive even in advanced stages because of the issue of independence and the social impact of cessation. The responsibility for determining driving competence in early-to-mid-duration patients with Parkinson's disease is the responsibility of patients, families, and physicians. Driving should be discussed with all patients, and referral for a proper driving assessment by an experienced driver rehabilitation specialist should be considered if necessary. Those who continue to drive should be assessed regularly because the disease and its therapies change with time.

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***):**
If a veteran with PD has newly diagnosed dementia, then the diagnosing physician should advise the patient not drive a motor vehicle or request that the Department of Motor Vehicles (or an equivalent agency) retest the patient's ability to drive, or refer the patient to a driver's safety course that includes assessment of driving ability (consistent with state laws). Cheng et al. #24 (Advising against driving in dementia) 2004

All veterans with PD should be asked about their ability to operate a motor vehicle. Cheng et al. 2004. #30 (Assessment of driving ability in PD patients)

All veterans with PD who report excessive daytime sleepiness should be instructed not to drive a motor vehicle. Cheng et al. 2004 #29 (Excessive daytime somnolence and driving restrictions)

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If a veteran with PD or his or her family expresses concern about driving safely, then the clinician should advise the patient not to drive a motor vehicle and/or request the DMV retest the patients' ability to drive, and/or refer the patient to a driver's safety course that includes assessment of driving ability, in accordance with state laws. Cheng #46 (Actions regarding driving safety concerns)

1c.10 Clinical Practice Guideline Citation: Cheng E, Siderowf A, Swarztrauber K, Eisa M, Lee M and Vickrey B. Development of Quality of Care Indicators for Parkinson's disease Movement Disorders Vol. 19, No.2, 2004 (P136-150)

1c.11 National Guideline Clearinghouse or other URL: Not currently in the National Guideline Clearinghouse

1c.12 Rating of strength of recommendation (*also provide narrative description of the rating and by whom***):**

See 1c.13 for explanation. Driving in Dementia (#24) 3, 4, 3; Daytime Somnolence and Driving (#29) 5, 7; Driving Ability in Dementia (#30) 7,8, 3, 4,3; Driving Safety concerns (#46) 9,8,3,4,3

1c.13 Method for rating strength of recommendation (*If different from* USPSTF system*, also describe rating and how it relates to USPSTF)***:**

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 enter the information from the table into this form. The table can be provided if necessary.

Validity

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, as specified, 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***):** Patients (or caregiver(s), as appropriate) who were counseled about context-specific safety issues appropriate to the patient's stage of disease (e.g., injury prevention, medication management, or driving) at least annually. **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 caregivers, as appropriate) who were counseled about context-specific safety issues appropriate to the patient's stage of disease (e.g., injury prevention, medication management, or driving) at least annually. • Report the CPT Category II, Parkinson's Disease Related Safety Issues Counseling 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 patients with a diagnosis of Parkinson's disease. **2a.5 Target population gender:** Male, Female **2a.6 Target population age range:** No age range specified.	**2a-specs** **C☐** **P☐** **M☐** **N☐**

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

2a.8 Denominator Details (*All information required to collect/calculate the denominator - the target population being measured - including all codes, logic, and definitions***):**
Denominator (Eligible Population): All 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***):**
Denominator Exclusion(s): Documentation of medical reason(s) for not counseling the patient (or caregiver, as appropriate) about context-specific safety issues appropriate to the patient's stage of disease (e.g., injury prevention, medication management, or driving) at least annually (e.g., patient is unable to respond and no informant is available).
- Append modifier to CPT II code: XXXX-1P.

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: XXXX-1P for medical reason for exclusion.

2a.11 Stratification Details/Variables (*All information required to stratify the measure including the stratification variables, all codes, logic, and definitions***):**

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, electronic Health/Medical Record, paper medical record/flowsheet

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
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N☐

2c. Validity testing 2c.1 **Data/sample** *(description of data/sample and size)*: 2c.2 **Analytic Method** *(type of validity & rationale, method for testing)*: 2c.3 **Testing Results** *(statistical results, assessment of adequacy in the context of norms for the test conducted)*:	**2c** C☐ P☐ M☐ N☐
2d. Exclusions Justified 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. 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** C☐ P☐ M☐ N☐ NA☐

2g.3 **Testing Results** *(e.g., correlation statistics, comparison of rankings)*:	
2h. Disparities in Care 2h.**1 If measure is stratified, provide stratified results** *(scores by stratified categories/cohorts)*: Not applicable at this time. 2h.2 **If disparities have been reported/identified, but measure is not specified to detect disparities, provide follow-up plans:**	**2h** C☐ P☐ M☐ 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:**	
(for NQF staff use) **Notes on similar/related** endorsed **or submitted measures:**	
3b. Harmonization	**3b**

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?**	**C☐ P☐ M☐ N☐ NA☐**
3c. Distinctive or Additive Value **3c.1 Describe the distinctive, improved, or additive value this measure provides to existing NQF-endorsed measures:** **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:**	**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 medical exception may be required 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** **C☐**

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: Testing has yet to be completed. **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:**	**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 | 651-695-3808	
Measure Developer If different from Measure Steward **Co.3 Organization** American Academy of Neurology | 1080 Montreal Avenue | Saint Paul | Minnesota | 55116 **Co.4 Point of Contact** Rebecca | Swain-Eng, MS | rswaineng@aan.com | 651-695-3808	
Co.5 Submitter If different from Measure Steward POC Rebecca | Swain-Eng, MS | rswaineng@aan.com | 651-695-3808- |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? 2010-01

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