

# Neurology Endorsement Maintenance Phase II

TECHNICAL REPORT

April 2013



NATIONAL  
QUALITY FORUM

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# Neurology Endorsement Maintenance Phase II

## TECHNICAL REPORT

### Introduction

Neurological conditions and injuries affect millions of Americans each year, taking a tremendous toll on patients, families, and caregivers, and costing billions of dollars in treatment, rehabilitation, and lost or reduced earnings. Specifically:

- Strokes were the fourth leading cause of death in the United States in 2009, as well as a leading cause of disability.<sup>1</sup> Each year, approximately 795,000 people suffer a stroke.<sup>2</sup> Health care costs for stroke-related morbidity reached \$73.7 billion in 2010.<sup>3</sup>
- An estimated 5.4 million Americans have Alzheimer’s disease, and an estimated 16 million will have Alzheimer’s by 2050.<sup>4</sup> The disease accounts for 70 percent of the cases of dementia in the country.<sup>5</sup> In 2009, Alzheimer’s disease was the fifth leading cause of death for adults ages 65 and over. Medicare and Medicaid spending on people with Alzheimer’s disease totaled \$130 billion in 2011; this could rise to \$1.1 trillion by 2050.<sup>6</sup>
- Epilepsy affects 2 million Americans and is estimated to cost \$15.5 billion each year in medical costs and lost or reduced earnings and production.<sup>7</sup>
- One million Americans have Parkinson’s disease, and the combined direct and indirect costs are estimated at \$25 billion per year.<sup>8</sup>
- Approximately 400,000 Americans have multiple sclerosis.<sup>9</sup>
- Traumatic brain injury (TBI) is a major health issue affecting all age groups in the United States, causing 52,000 deaths and 275,000 hospitalizations each year.<sup>10</sup>

NQF has endorsed a number of consensus standards to evaluate the quality of care for neurological conditions over the past decade. As quality measurement has matured, better data systems have become available, electronic health records are closer to widespread adoption, and the demand for meaningful performance measures has prompted development of more sophisticated measures of healthcare processes and outcomes for neurological conditions. An evaluation of the NQF-endorsed® neurology measures and consideration of new measures will ensure the currency of NQF’s portfolio of voluntary consensus standards.

This project seeks to identify and endorse new performance measures for accountability and quality improvement that specifically address neurological conditions. In Phase I, the project reviewed measures of quality for stroke. In Phase II, the project reviewed measures related to other neurological conditions, including epilepsy, Parkinson’s disease, and dementia.

### Measure Evaluation

On October 3-4, 2012, the Neurology Steering Committee evaluated 21 new measures and 1 measure undergoing maintenance review against NQF’s standard evaluation criteria. To facilitate the evaluation, the committee and candidate standards were divided into four workgroups for preliminary review of the measures against the evaluation sub-criteria prior to consideration by the entire Steering Committee.

The Committee’s discussion and ratings of the criteria are summarized in the evaluation tables beginning on page 8.

### Neurology Phase II Summary

	Maintenance	New	Total
Measures under consideration	3	21	24
Measures withdrawn from consideration before start of project	2	0	2
Measures recommended	1	4	5
Measures not recommended	0	17	17
Reasons for not recommending		Importance – 15 Scientific Acceptability – 2	

### Overarching Issues

During the Steering Committee’s discussion of the measures, several overarching issues emerged and were factored into the Committee’s ratings and recommendations for multiple measures; these issues are not repeated in detail with each individual measure.

#### *Measure focus not proximal to desired outcomes*

Many measures in this project have a focus that is distal to desired outcomes (e.g., assessment, counseling). While Committee members often acknowledged that such activities are important to perform in clinical practice and that actual performance may be less than optimal, they also agreed that these activities may not be appropriate to measure and report as national voluntary consensus standards for assessing performance on quality.

#### *Insufficient Evidence*

The quantity, quality, and consistency of the body of evidence underlying many of the measures evaluated in this project either does not exist or was not submitted by measure developers.

For a majority of the measures in this project, developers were unable to provide evidence of a link between the actual measure focus and a desired health outcome. Rather, at times they presented evidence related to the impact of the quality problem or evidence about the relationship between particular interventions that were not the focus of the measure and desired outcomes. Committee members agreed that such evidence did not meet subcriterion 1c, Evidence.

Also, for many of the measures in this project, developers relied solely on clinical practice guidelines to support the measure focus. However, the guidelines used for the measures in this project typically did not grade the evidence, used grades that were based on expert opinion, or used grades that did not allow for a distinction between evidence based on empirical evidence and that based on expert opinion. These guidelines did not include information regarding the quantity, quality, or consistency of the evidence, and developers did not supplement the guideline recommendations with additional information to describe the evidence underlying the measure (e.g., references to and summary of systematic literature reviews). In some but not all of these instances, the Committee voiced a belief that such evidence is available.

For each of the measures for which the evidence (as submitted) was insufficient, the Committee had the opportunity to discuss whether or not an exception to the evidence criterion was warranted. However, the Committee opted to vote on the evidence exception only five times and, of these, the Committee invoked the evidence exception only three times.

Because lack of evidence was a key discussion point for many of the measures in this project, the Committee considered the evidence subcriterion (1c) first in their deliberations, and only if the measure passed this subcriterion did they proceed and consider the other subcriteria under Importance to Measure and Report (i.e., impact and opportunity for improvement).

### *Untested measures*

Of the 22 measures under consideration in Phase II, 18 have not yet been tested for reliability or validity. These untested measures were accepted for consideration for potential time-limited (one year) endorsement because they met all three of the following criteria:

- An incumbent measure does not address the specific topic of interest in the proposed measure;
- A critical timeline (e.g., legislative mandate) must be met; and
- The measure is not complex (e.g., not a composite measure or an outcome measure requiring risk adjustment).

Specifically, these 18 measures (for epilepsy, Parkinson’s disease, and dementia) are process measures, are included in the 2012 PQRS program, and fill gap areas in NQF’s measure portfolio. Prior to accepting these measures for evaluation during the project, NQF asked developers to confirm their intent to complete reliability and validity testing within 12 months if granted time-limited endorsement.

When voting on the Scientific Acceptability of these untested measures, the Committee did not use the usual ratings of high, moderate, low, or insufficient. Instead, members considered whether the measures were precisely specified and whether the measure specifications are consistent with the evidence presented for the measure (voting either “yes” or “no”).

## **Recommendations for Future Measure Development**

During their discussions the Committee identified numerous areas where additional measure development is needed:

- Measures that would drive improved diagnosis of Parkinson’s disease
- Measures that include both assessment and referral, or assessment and treatment, for Parkinson’s disease patients (e.g., assessment and referral for rehab services)
- Functional interventions or assessment measures for patients with dementia or Alzheimer’s disease
- Assessment and referral for treatment and interventions for dementia/Alzheimer’s disease
- Measures around support of caregivers of patients with dementia/Alzheimer’s disease
- An outcome measure of getting people with dementia to stop driving
- Other organizations/areas to connect with around measurement (e.g., working with the National Highway Traffic Safety Administration on safety measures around driving)
- Measures that are more focused (e.g., measures focused on depression screening, rather than screening for all neuropsychiatric conditions)
- Advance directives for dementia patients that are written early in the course of illness

- Broader definitions of which providers can meet a measure (e.g., functional assessments/treatments should include physical and occupational therapists, not just physicians)
- Interventions for women with epilepsy who might become pregnant
- A measure about the impact of pregnancy on the epilepsy treatment
- An outcome measure for epilepsy that focuses on seizure frequency
- Epilepsy measures that examine whether the treatment matches the epilepsy type and the seizure type
- Measures for epilepsy patients who are not seizure-free: percent referred to an epilepsy specialist, percent referred for surgical evaluation
- Functional outcome measures for individuals with stroke, TBI, SCI, MS, PD, etc.
- Patient reported measures in the areas of function, self-efficacy, balance/falls, knowledge of care (emergency care, red flags, medication, etc.)
- A process measure of referral for formal driving assessment in patients with dementia/Alzheimer Disease.
- Process measures with strong, demonstrated links to better outcomes for patients with dementia/Alzheimer Disease
- Reduction of psychotic symptoms in patients assessed with psychosis: Clinical trials have shown that psychotic symptoms can be reduced with appropriate management.
- Reduction of depression in patients assessed with depression or reduction of burden of depression in populations at risk for depression (e.g., Parkinson's disease)
- Frequency of falls/hip fracture in patients with a high falls risk (e.g., Parkinson's disease)
- Measures of arterial/venous ulceration and plaque composition that are paired with measure #0507
- Measures of patients with indicators of dementia for other health care settings in addition to nursing homes (measures similar to #2091 and #2092)
- Measures around care plans for epilepsy
- Outcome measures for infants born to women with epilepsy (e.g., infants with congenital birth defects born to mothers who are on epilepsy medications)
- Patient-reported outcome measures to assess the impact of the counseling about contraception and pregnancy for women with epilepsy
- Measures that incorporate screening for Mild Cognitive Impairment and dementia
- Measures around delirium, particularly for patients who have delirium superimposed on dementia.

# Measure Evaluation Summary

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## Endorsed measures

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- 2092: Persistent Indicators of Dementia without a Diagnosis—Short Stay ..... 13
- 1814: Counseling for women of childbearing potential with epilepsy ..... 16
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- 1982: Parkinson's Disease psychiatric disorders or disturbance assessment ..... 28
- 1983: Parkinson's Disease cognitive impairment or dysfunction assessment ..... 31
- 1985: Parkinson's Disease querying about sleep disturbances ..... 33
- 1988: Parkinson's Disease rehabilitative therapy options ..... 35
- 1989: Parkinson's Disease medical and surgical treatment options reviewed ..... 38
- 1953: Seizure type(s) and current seizure frequency(ies) ..... 40
- 1954: Documentation of etiology of epilepsy or epilepsy syndrome..... 42
- 1990: Dementia: Staging of dementia ..... 44
- 2009: Dementia: Neuropsychiatric Symptom Assessment..... 46
- 2011: Dementia: Management of Neuropsychiatric Symptoms ..... 48
- 2016: Dementia: Screening for Depressive Symptoms..... 49
- 2000: Dementia: Cognitive assessment ..... 51
- 2004: Dementia: Functional status assessment ..... 53
- 2028: Dementia: Counseling regarding safety concerns ..... 54
- 2029: Dementia: Counseling regarding risks of driving ..... 56
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Measures withdrawn from consideration

602: Adult(s) with frequent use of acute medications that also received prophylactic medications (Ingenix) ..... 60

644: Patients with a transient ischemic event ER visit that had a follow up office visit (Ingenix) ..... 60



## Endorsed Measures

**Rating Scale:** H=High; M=Moderate; L=Low; I=Insufficient; NA=Not Applicable; Y=Yes; N=No

### 2091: Persistent Indicators of Dementia without a Diagnosis—Long Stay

[Submission](#) | [Specifications](#)

**Status:** New Submission

**Description:** Percentage of nursing home residents age 65+ with persistent indicators of dementia and no diagnosis of dementia.

**Numerator Statement:** Number of adult patients 65 and older who are included in the denominator (i.e., have persistent signs and symptoms of dementia) and who do not have a diagnosis of dementia on any MDS assessment within the last 12 months.

**Denominator Statement:** The denominator is the total of all long-stay residents in the nursing facility who have at least two MDS assessments which may be an admission annual, quarterly, significant change or significant correction assessment during the selected quarter and who do not meet the exclusion criteria.

The denominator includes (i) residents with Section C Brief Interview for Mental Status (BIMS) score <8 on most recent target assessment and a BIMS < 8 on the prior assessment; or (ii) residents with a staff assessment for cognitive status on both the most recent target assessment and the prior assessment that shows severe cognitive impairment.

**Exclusions:** Residents who are hospice or end of life, or who are comatose or with delirium, or with psychotic disorders including hallucinations, anxiety disorder, manic depressive disease, post-traumatic stress disorder, bipolar disorder or schizophrenia will be excluded from the denominator.

**Adjustment/Stratification:** No risk adjustment or risk stratification N/A

**Level of Analysis:** Facility

**Type of Measure:** Process

**Data Source:** Electronic Clinical Data

**Measure Steward:** American Medical Directors Association

#### STEERING COMMITTEE MEETING [10/3/2012]

**Importance to Measure and Report:** The measure meets the Importance criteria

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **H-14; M-9; L-0; I-0**; 1b. Performance Gap: **H-18; M-5; L-0; I-0** 1c. Evidence: **Y-14; N-8; I-1**

Rationale:

- Some Committee members questioned the evidence of a linkage between having a dementia diagnosis and lower healthcare costs. Developers pointed to evidence from the community setting that indicates that when a dementia diagnosis has not been made, inappropriate care is delivered; they maintained that such inappropriate care leads to increased costs.
- Data submitted by the developer suggests that more than half of nursing facility residents have dementia but do not necessarily have a diagnosis of dementia and that older patients may be at higher risk of under-diagnosis.

## 2091: Persistent Indicators of Dementia without a Diagnosis—Long Stay

### 2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-9; M-12; L-1; I-1** 2b. Validity: **H-2; M-11; L-9; I-1**

#### Rationale:

- The Committee agreed that the measure, which relies on data from MDS 3.0, is precisely specified. NOTE: Because developers provided data element validity testing results for the relevant MDS 3.0 items, they were not required to show results of additional data element reliability testing.
- Committee members noted that a Brief Interview for Mental Status (BIMS) score (the portion of the MDS 3.0 assessment used to assess cognition) of 7 (indicating severe impairment) has a specificity of 0.92. They questioned why approximately 8 percent of nursing home patients would show severe impairment according to the BIMS but not actually have dementia. Developers suggested that these patients may have other conditions (e.g., delirium, depression) that would cause the low BIMS scores.
- Committee members asked who in the nursing facility conducts the MDS assessment. Developers stated that trained RNs or social workers perform the assessments, noting that they receive on-going training to assure accuracy and consistency in conducting the assessments.
- One Committee member expressed a concern that someone with cognitive impairment but not dementia would be given a diagnosis of dementia, particularly if a staff assessment of cognition was used rather than the BIMS score. Developers explained that the measure denominator requires a BIMS score < 8 on at least two occasions that are at least 90 days apart or a staff assessment of severe impairment. They emphasized that the actual diagnosis of dementia (which is counted in the numerator) must be made by a physician or nurse practitioner.
- Committee members questioned what happens when a patient does have cognitive impairment but a physician has ruled out dementia as the cause of the impairment (e.g., cognitive impairment due to static encephalopathy). Developers noted that they have specified the measure to exclude some conditions that might result in cognitive impairment in the absence of dementia (e.g., schizophrenia, bipolar disorder). However, Committee members mentioned other conditions (e.g., TBI) that might result in not meeting the measure for particular patients. Developers expressed a willingness to include TBI as one of the exclusions for the measure. **NQF note:** *The developers have since modified this measure to exclude TBI (ICD-9-CM 854.0) and encephalopathy (ICD-9-CM 348.30).*
- One Committee member questioned why dementia was the focus of the measure, rather than cognitive impairment, noting that patients with cognitive impairment also require specialized care. Developers explained they must work within the long-term care systems as it currently exists, and noted that a diagnosis of dementia in nursing facilities triggers the use of a comprehensive guideline for dementia.

## 2091: Persistent Indicators of Dementia without a Diagnosis—Long Stay

### 3. Usability: H-6; M-15; L-2; I-0

(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)

#### Rationale:

- One Committee questioned the usability of a measure when the optimal value is unknown (note that developers do not expect this measure to reach zero). Developers explained that facilities would use the measure to see how they compare to other facilities.
- Committee members again expressed concern about the usability of the measure if facilities score poorly because patients have cognitive impairment that is not due to dementia. The Committee voted on the usability criterion contingent on the assumption that developers would add two additional exclusions: 1) patients with TBI and 2) patients for whom a dementia diagnosis has been ruled out by a physician or other practitioner. **NQF note:** *The developers have since modified this measure to exclude TBI (ICD-9-CM 854.0) and encephalopathy (ICD-9-CM 348.30). They also investigated how they might indicate, as part of the MDS assessment, that a provider has ruled out a dementia diagnosis; however, they concluded that this cannot be done.*

### 4. Feasibility: H-14; M-8; L-1; I-0

(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c. Susceptibility to inaccuracies/unintended consequences identified 4d. Data collection strategy can be implemented)

#### Rationale:

- This measure is computed from data collected as part of the MDS 3.0 assessment, which is required for all nursing facility patients on a routine basis.

## Steering Committee Recommendation for Endorsement: Y-20; N-3

### Public & Member Comment

#### Comments included:

- Eight supportive comments.
- A question about why patients with psychiatric disorders are excluded from the measure denominator, noting possible misdiagnosis of psychiatric disorders on admission to a long-term care facility.

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

#### Committee response:

Committee members reviewed the comments and the developer response and did not wish to change their recommendation.

## Consensus Standards Approval Committee (CSAC) Review (February 2013): Y-13; N-0; A-0

- Decision: Approved for endorsement

**2091: Persistent Indicators of Dementia without a Diagnosis—Long Stay**

**Board of Directors (March 4, 2013)**

- Decision: Ratified for endorsement

## 2092: Persistent Indicators of Dementia without a Diagnosis—Short Stay

[Submission](#) | [Specifications](#)

**Status:** New Submission

**Description:** Number of adult patients 65 and older who are included in the denominator (i.e., have persistent signs and symptoms of dementia) and who do not have a diagnosis of dementia on any MDS assessment.

**Numerator Statement:** Number of adult patients 65 and older who are included in the denominator (i.e., have persistent signs and symptoms of dementia) and who do not have a diagnosis of dementia on any MDS assessment.

**Denominator Statement:** The denominator is the total of all short-stay residents in the nursing facility who have at least two MDS PPS assessments (A0310 = 01. 5-day scheduled assessment or 02. 14-day scheduled assessment or 03. 30-day scheduled assessment or 04. 60-day scheduled assessment or 05. 90-day scheduled assessment or 06. Readmission/return assessment), and who do not meet the exclusion criteria.

The denominator includes (i) residents with Section C Brief Interview for Mental Status (BIMS) score <8 on most recent target assessment and a BIMS < 8 on the prior assessment; or (ii) residents with a staff assessment for cognitive status on both the most recent target assessment and the prior assessment that shows severe cognitive impairment.

**Exclusions:** Residents who are hospice or end of life, or who are comatose or with delirium, manic depressive disease, bipolar disorder or schizophrenia will be excluded from the denominator.

**Adjustment/Stratification:** No risk adjustment or risk stratification NA

**Level of Analysis:** Facility

**Type of Measure:** Process

**Data Source:** Electronic Clinical Data

**Measure Steward:** American Medical Directors Association

### STEERING COMMITTEE MEETING [10/3/2012]

**Importance to Measure and Report:** The measure meets the Importance criteria

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

51a. Impact: **H-15; M-7; L-1; I-0**; 1b. Performance Gap: **H-11; M-12; L-0; I-0** 1c. Evidence: **Y-17; N-4; I-2**

Rationale:

- This measure is identical to measure #2091, except that it covers short-stay nursing facility residents (where length of stay < 100 days) and therefore the timing of the MDS assessments are different. The discussion for this measure is the same as for measure #2091, but is repeated here for ease of review.
- Some Committee members questioned the evidence of a linkage between having a dementia diagnosis and lower healthcare costs. Developers pointed to evidence from the community setting that indicates that when a dementia diagnosis has not been made, inappropriate care is delivered; they maintained that such inappropriate care leads to increased costs.
- Data submitted by the developer suggests that more than half of nursing facility residents have dementia but do not necessarily have a diagnosis of dementia and that older patients may be at higher risk of under-diagnosis.

## 2092: Persistent Indicators of Dementia without a Diagnosis—Short Stay

### 2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-4; M-17; L-2; I-0** 2b. Validity: **H-3; M-17; L-3; I-0**

#### Rationale:

- The discussion for this measure is the same as for measure #2091, but is repeated here for ease of review.
- The Committee agreed that the measure, which relies on data from MDS 3.0, is precisely specified. NOTE: Because developers provided data element validity testing results for the relevant MDS 3.0 items, they were not required to show results of additional data element reliability testing.
- Committee members noted that a Brief Interview for Mental Status (BIMS) score (the portion of the MDS 3.0 assessment used to assess cognition) of 7 (indicating severe impairment) has a specificity of 0.92. They questioned why approximately 8 percent of nursing home patients would show severe impairment according to the BIMS yet do not actually have dementia. Developers suggested that these patients may actually have other conditions (e.g., delirium, depression) that would cause the low BIMS scores. Committee members asked who in the nursing facility conducts the MDS assessment. Developers stated that trained RNs or social workers perform the assessments, noting that they receive on-going training to assure accuracy and consistency in conducting the assessments.
- One Committee member expressed a concern that someone with cognitive impairment but not dementia would be given a diagnosis of dementia, particularly if a staff assessment of cognition was used rather than the BIMS score. Developers explained that the measure denominator requires a BIMS score < 8 on at least two occasions that are at least 90 days apart or a staff assessment of severe impairment. They emphasized that the actual diagnosis of dementia (which is counted in the numerator) must be made by a physician or nurse practitioner.
- Committee members questioned what happens when a patient does have cognitive impairment but a physician has ruled out dementia as the cause of the impairment (e.g., cognitive impairment due to static encephalopathy). Developers noted that they have specified the measure to exclude some conditions that might result in cognitive impairment in the absence of dementia (e.g., schizophrenia, bipolar disorder). However, Committee members mentioned other conditions (e.g., TBI) that might result in not meeting the measure for particular patients. Developers expressed a willingness to include TBI as one of the exclusions for the measure. **NQF note:** *The developers have since modified this measure to exclude TBI (ICD-9-CM 854.0) and encephalopathy (ICD-9-CM 348.30).*
- One Committee member questioned why dementia was the focus of the measure, rather than cognitive impairment, noting that patients with cognitive impairment also require specialized care. Developers explained they must work within the long-term care systems as it currently exists, and noted that a diagnosis of dementia in nursing facilities triggers the use of a comprehensive guideline for dementia.

## 2092: Persistent Indicators of Dementia without a Diagnosis—Short Stay

### 3. Usability: H-8; M-13; L-2; I-0

*(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)*

#### Rationale:

- The discussion for this measure is the same as for measure #2091, but is repeated here for ease of review.
- One Committee questioned the usability of a measure when the optimal value is unknown (note that developers do not expect this measure to reach zero). Developers explained that facilities would use the measure to see how they compare to other facilities.
- Committee members again expressed concern about the usability of the measure if facilities score poorly because patients have cognitive impairment that is not due to dementia. The Committee voted on the usability criterion contingent on the assumption that developers would add two additional exclusions: 1) patients with TBI and 2) patients for whom a dementia diagnosis has been ruled out by a physician or other practitioner **NQF note:** *The developers have since modified this measure to exclude TBI (ICD-9-CM 854.0) and encephalopathy (ICD-9-CM 348.30). They also investigated how they might indicate, as part of the MDS assessment, that a provider has ruled out a dementia diagnosis; however, they concluded that this cannot be done.*

### 4. Feasibility: H-10; M-13; L-0; I-0

*(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c. Susceptibility to inaccuracies/unintended consequences identified 4d. Data collection strategy can be implemented)*

#### Rationale:

- The discussion for this measure is the same as for measure #2091, but is repeated here for ease of review.
- This measure is computed from data collected as part of the MDS 3.0 assessment, which is required for all nursing facility patients on a routine basis.

### Steering Committee Recommendation for Endorsement: Y-20; N-3

#### Public & Member Comment

Comments included:

- Seven supportive comments.

**Committee response:** N/A

### Consensus Standards Approval Committee (CSAC) Review (February 2013): Y-13; N-0; A-0

- Decision: Approved for endorsement

### Board of Directors (March 4, 2013)

- Decision: Ratified for endorsement

## 1814: Counseling for women of childbearing potential with epilepsy

[Submission](#) | [Specifications](#)

**Status:** New Submission **Time-limited**

**Description:** All female patients of childbearing potential (12–44 years old) diagnosed with epilepsy who were counseled about epilepsy and how its treatment may affect contraception and pregnancy at least once a year

**Numerator Statement:** Female patients counseled about epilepsy and how its treatment may affect contraception and pregnancy and documented in the medical record at least once a year.

**Denominator Statement:** All females of childbearing potential (12-44 years old) with a diagnosis of epilepsy.

**Exclusions:** Medical reasons (eg, not indicated, contraindicated, other medical reason)

**Adjustment/Stratification:** N/a

**Level of Analysis:** Clinician : Individual

**Type of Measure:** Process

**Data Source:** Administrative claims, Paper Medical Records

**Measure Steward:** American Academy of Neurology **Other organizations:** AMA convened Physician Consortium for Performance Improvement-measurement set was developed through the PCPI Independent Measure Development Process

### STEERING COMMITTEE MEETING [10/3/2012]

**Importance to Measure and Report:** The measure meets the Importance criteria

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **H-23; M-1; L-0; I-0**; 1b. Performance Gap: **H-24; M-0; L-0; I-0** 1c. Evidence: **Y-11; N-0; I-13; L-0**

**Evidence Exception:** **Y-23; N-1**

Rationale:

- The Committee disagreed about the level of evidence supporting this measure. Several noted that the submission did not provide evidence of a direct link between counseling and patient outcomes. Others noted that the submission did provide evidence that epilepsy treatments can affect both contraception and child development during pregnancy, as well as evidence that women with epilepsy feel that they are not getting adequate information about pregnancy. Committee members recommended invoking the evidence exception because the measure impacts a specific population and there is the potential for great harm if such counseling is not done. Upon vote, the Committee almost unanimously agreed to invoke the exception to the evidence subcriterion.
- The Committee overwhelmingly agreed this measure meets the impact criterion because it potentially would affect roughly half of the population of epilepsy patients (i.e., approximately 500,000 women) and because evidence has shown an increased risk for congenital malformations and impaired cognition in children of women treated during pregnancy with one of the common epilepsy medications.
- Data submitted by the developer indicate that only 2-20% of women with epilepsy receive counseling around issues of contraception and pregnancy.



## 1814: Counseling for women of childbearing potential with epilepsy

### 2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria for untested measures

**Precise specifications: Y-21; N-3**

#### Rationale:

- Committee members expressed concern about the lack of an operational definition of “counseling” (e.g., an actual discussion with the patient vs. handing the patient a pamphlet or directing a patient to a website). One member noted that the measure could be a “check-box” measure. Some members preferred a more prescriptive approach (e.g., discussion about medications with the highest fetal anomalies, the impact of pregnancy on seizure control, use of contraceptives, and use of folate); however, other members noted that different patients would require different types of counseling (e.g., the counseling needs for a 12-year old patient might be very different from those for a 30-year old patient).
- Committee members noted that epilepsy treatment can also impact patients’ choices for contraception and that this should be reflected in the measure.
- The Committee also emphasized the need for the measure to explicitly include discussion of the impact of pregnancy on the patient’s epilepsy and on the treatment of epilepsy (i.e., the potential decrease in seizure control).
- Because this is an untested measure, the Committee voted on whether the measure is precisely specified and whether the specifications are consistent with the evidence presented for the measure. **(NQF note: As initially submitted, this measure was specified for clinician offices/clinics, home health, and post-acute care/long-term care facilities. However, the developer has determined that there will be insufficient sample sizes available for testing of the measure in the home health and post-acute/long-term care settings. Accordingly, the developer has modified the measure specifications to include only the clinician office/clinic setting.)**

### 3. Usability: H-10; M-12; L-1; I-1

*(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)*

#### Rationale:

- This measure will be publicly reported through the PQRS program, beginning in 2012; also, it is currently in use in AAN’s Maintenance of Certification Performance in Practice (NeuroPI) Epilepsy Module. Developers indicated that clinicians using this program have found this measure to be extremely helpful in making them aware of the need for counseling regarding contraception and pregnancy.
- Some members questioned how a measure can be considered useful when no data have been provided to show that the measure has been useful in improving quality of care. NQF staff clarified that there is no an expectation that a measure be in use when first endorsed and if data on usefulness for quality improvement is not yet available, Committee members should base their vote on whether—based on the information that has been provided—they believe that the measure can be useful for quality improvement and informative for public reporting or other accountability purposes.

### 4. Feasibility: H-4; M-15; L-2; I-3

*(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c. Susceptibility to inaccuracies/unintended consequences identified 4d. Data collection strategy can be implemented)*

#### Rationale:

- Committee members noted that for claims data, reporting of the measure would be done through CPT-II codes. There was some concern over how data would be collected from paper records; however, the measure has not been specified for paper medical records.

**Steering Committee Recommendation for Endorsement: Y-24; N-0**

**1814: Counseling for women of childbearing potential with epilepsy**

**Public & Member Comment**

Comments included:

- Four supportive comments.
- Several commenters noted the need for outcome measures around issues of contraception and pregnancy for women with epilepsy.

**Committee response:**

- The Committee agreed with the suggestions for future measure development and the report has been updated to include them.

**Consensus Standards Approval Committee (CSAC) Review (February 2013): Y-13; N-0; A-0**

- Decision: Approved for endorsement

**Board Of Directors (March 4, 2013)**

- Decision: Ratified for endorsement

## 0507: Stenosis measurement in carotid imaging studies

### [Submission](#) | [Specifications](#)

**Status:** Maintenance, Original Endorsement: Oct 28, 2008

**Description:** Percentage of final reports for carotid imaging studies (neck MR angiography [MRA], neck CT angiography [CTA], neck duplex ultrasound, carotid angiogram) performed that include direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement

**Numerator Statement:** Final carotid imaging study reports that include direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement

**Denominator Statement:** All final reports for carotid imaging studies (neck MR angiography [MRA], neck CT angiography [CTA], neck duplex ultrasound, carotid angiogram) performed

**Exclusions:** None

**Adjustment/Stratification:** No risk adjustment or risk stratification Not applicable We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

**Level of Analysis:** Clinician : Group/Practice, Clinician : Individual, Clinician : Team

**Type of Measure:** Process

**Data Source:** Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry

**Measure Steward:** American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) **Other organizations:** American Academy of Neurology

American College of Radiology

National Committee for Quality Assurance

### STEERING COMMITTEE MEETING [10/4/2012]

**Importance to Measure and Report:** The measure meets the Importance criteria

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **H-21; M-3; L-0; I-0**; 1b. Performance Gap: **H-21; M-3; L-0; I-0**; 1c. Evidence: **Y-17; N-6; I-1**

#### Rationale:

- The evidence cited as support for this measure includes clinical practice guidelines, systematic reviews, and additional studies. One Committee member noted there is good evidence that stenosis, as measured using the North American Symptomatic Carotid Endarterectomy Trial (NASCET) technique, in symptomatic patients, accurately predicts stroke risk. This member suggested that while it is reasonable to assume that documenting the stenosis measurement would be useful for improving patient outcomes, evidence does not exist to support this process of care.
- The Committee questioned whether results are inaccurate if the NASCET method is not used. Another member clarified that different methods yield different results, so the method must be specified. However, this member noted that most of the data used for stroke risk prediction from carotid stenosis severity uses measures from the NASCET approach.
- Data submitted by the developer stated that stroke is a leading cause of death and disability, that approximately 85% of strokes are ischemic, and that there is evidence of complete occlusion of the internal carotid artery for a large percentage of ischemic stroke patients.

Data provided by the developer from PQRS for 2008 and 2010 indicate there is evidence of non-optimal performance of this measure.

## 0507: Stenosis measurement in carotid imaging studies

### 2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-9; M-15; L-0; I-0**; 2b. Validity: **H-3; M-20; L-1; I-0**

#### Rationale:

- One Committee member cautioned that while this measure focuses only on the reporting of stenosis, there are other important elements that should be included in the report (e.g., ulceration and plaque composition).
- This member also noted that as written, the measure seems to require reporting of stenosis severity for all neck vessel imaging studies, even if the carotid is not the issue of interest (e.g., imaging to detect vessel tears, tumors). This member suggested that the reporting requirement may cause undue burden for clinicians and may also cause harm to patients who are asymptomatic for carotid disease if they are then given additional medical therapy (e.g., endarterectomies or stenting).
- The Committee questioned whether ultrasound should be included as an acceptable methodology for measuring stenosis. One Committee member noted that ultrasound results have been correlated with NASCET results. The developer noted the clarification in the numerator details section of the submission that, for ultrasound results to meet the measure, they must correlate with anatomic measurements that use the distal internal carotid lumen as the denominator for stenosis measurement.

The Committee agreed that this expanded definition addressed their concerns and requested that it also be reflected in the brief numerator statement.

### 3. Usability: **H-3; M-20; L-1; I-0**

*(Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting/Accountability and 3b. Quality Improvement)*

#### Rationale:

- The measure is used in the CMS PQRS program.

One Committee member reiterated a concern that this measure applies to all neck vessel imaging studies (not just carotid imaging studies), stating that this adversely impacts the usefulness of the measure to some extent.

### 4. Feasibility: **H-18; M-5; L-1; I-0**

*(4a. Clinical data generated during care delivery; 4b. Electronic sources; 4c. Susceptibility to inaccuracies/unintended consequences identified 4d. Data collection strategy can be implemented)*

#### Rationale:

The Committee had no questions or comments on the feasibility of this measure, other than noting that it can be met as a part of usual care practices.

**Steering Committee Recommendation for Endorsement: Y-24; N-0**

## 0507: Stenosis measurement in carotid imaging studies

### Public & Member Comment

Comments included:

- Three supportive comments.
- A concern that the measure is a documentation measure and therefore of limited (or no) use for accountability purposes.
- A concern that the stenosis is based on the physician's judgment of patient symptoms.

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

### Committee response:

- The Committee agreed that the concern that stenosis is based on physician's judgment of patient's symptoms reflected a misunderstanding of the intent of the measure.
- Committee members agreed that this measure is a documentation measure, but reiterated their agreement that there is sufficient evidence indicating that the results of the documentation are interpretable and decisions can be made based on those results.

Committee members reviewed the comments and the developer response but did not wish to re-consider their vote on this measure.

### Consensus Standards Approval Committee (CSAC) Review (February 2013): Y-13; N-0; A-0

- Decision: Approved for continued endorsement

### Board of Directors (March 4, 2013)

- Decision: Ratified for continued endorsement

## 2111: Antipsychotic Use in Persons with Dementia

[Submission](#) | [Specifications](#)

**Status:** New Submission

**Description:** The percentage of individuals 65 years of age and older with dementia who are receiving an antipsychotic medication without evidence of a psychotic disorder or related condition.

**Numerator Statement:** The number of patients in the denominator who had at least one prescription and > 30 days supply for any antipsychotic medication during the measurement period and do not have a diagnosis of schizophrenia, bipolar disorder, Huntington's disease or Tourette's Syndrome.

**Denominator Statement:** All patients 65 years of age and older continuously enrolled during the measurement period with a diagnosis of dementia and/or two or more prescription claims and >60 days supply for a cholinesterase inhibitor or an NMDA receptor antagonist.

**Exclusions:** N/A

**Adjustment/Stratification:** No risk adjustment or risk stratification N/A N/A

**Level of Analysis:** Health Plan

**Type of Measure:** Process

**Data Source:** Administrative claims

**Measure Steward:** Pharmacy Quality Alliance

### STEERING COMMITTEE MEETING [10/3/2012]

**Importance to Measure and Report:** The measure does meet the Importance criteria

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **H-20; M-2; L-1; I-0**; 1b. Performance Gap: **H-11; M-11; L-0; I-1** 1c. Evidence: **Y-16; N-2; I-5**

Rationale:

- Approximately 5.2 million people in the U.S. aged 65 and older have dementia.
- According to one study cited by the developer, in 2006, more than 30% of nursing home patients received at least one antipsychotic medication, but there was no clinical indication for the medication for 43% of these patients.
- Pilot testing results reported by the developer found that 14-16% of Medicare Advantage patients with dementia received an antipsychotic medication without evidence of a psychotic disorder. The Committee agreed that although the expected rate would not be zero, these results suggest there likely is room for improvement.
- A study cited by the developer found facility-level variation in the prescription of antipsychotic medications in nursing facilities.
- The evidence base for the measure included two systematic reviews, a meta-analysis, and a clinical practice guideline. The Committee agreed that use of antipsychotic medications in dementia patients may lead to negative outcomes, including cardiovascular problems and death.
- Committee members questioned whether appropriate use of antipsychotics varies based on stage of dementia (i.e., should the rate potentially be lower for those with less cognitive impairment compared to those with greater cognitive impairment?). One member noted that the evidence for the measure is not stratified by stage of dementia; this member also noted that behaviors or psychological symptoms which might instigate a prescription for antipsychotics actually can occur in each stage of the disease, although the actual behaviors/symptoms themselves may vary by stage.
- The Committee agreed the rate of antipsychotic prescription among dementia patients cannot be zero because, for some patients, the risks associated with certain behavioral or psychological symptoms (e.g., becoming a danger to themselves or others) are deemed greater than the risks associated with the use of antipsychotics. However, the Committee expressed discomfort with the lack of evidence to suggest what the appropriate rate should be.

## 2111: Antipsychotic Use in Persons with Dementia

### 2. Scientific Acceptability of Measure Properties: **The measure does not meet the Scientific Acceptability criteria**

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-7; M-12; L-2; I-2** 2b. Validity: **H-1; M-9; L-12; I-1**

#### Rationale:

- Some committee members voiced discomfort with the measure because there are conditions for which antipsychotic use may be appropriate, even in those with dementia (e.g., “agitated delirium”, dyskinesia in Parkinson’s disease patients). One member suggested that adding a “psychosis not otherwise specified” code (to exclude such patients from the numerator) might be a way to handle this problem. However, other Committee members noted that there are a variety of ways to treat of psychosis in dementia patients and were not in favor of including additional exceptions to the measure.
- Another member asked why the specifications do not more closely follow the guideline recommendation to avoid use of antipsychotics among dementia patients “unless non-pharmacological options have failed and patient is a threat to self or others.” The developer was unsure that this level of specification would be possible using claims data.
- The developer noted that they specified the measure to count antipsychotic use only if the prescription(s) exceeds a 30-day supply; this was done as a way to differentiate what might be short-term use for an acute psychotic episode. Committee members agreed that 30 days might be a sufficient amount of time for some patients, but not for all.
- Committee members questioned why Parkinson’s disease patients were not excluded from the measure, given that antipsychotic medications often are used appropriately for dementia-related psychosis in these patients. However, there was not agreement among Committee members as to whether Parkinson’s disease patients should or should not be excluded.
- Committee members acknowledged the effort to try to identify dementia patients by looking at both diagnosis and prescription of medications for dementia (per the assumption that dementia is under-diagnosed). However, they noted that the prevalence of dementia found in the pilot studies was much lower than might be expected. They also questioned whether dementia medications are actually over-prescribed and, if so, if this measure as specified actually captures patients who have dementia. They acknowledged the developer’s assertion that the use of dementia medications for other indications (e.g., TBI) is rare, but noted a lack of evidence to support that assertion.
- A Committee member noted this measure uses fewer ICD-9 codes for dementia than do other dementia measures. The developer stated that they created their list of ICD-9 codes for dementia based on input from their expert panels and relevant studies in the literature, but were open to adding additional codes to their list.
- Several Committee members suggested that because this is a health-plan level measure, problems with the specifications may be somewhat less concerning, particularly given the importance of the problem of overuse of antipsychotics in dementia patients.

#### **Steering Committee Recommendation for Endorsement: No**

- The measure did not pass the criterion of Scientific Acceptability. Although the Committee liked the intent of this measure, many agreed that the validity of the measure as specified was adversely impacted because of the difficulties in identifying dementia patients and the fact that antipsychotic use in dementia patients is sometimes warranted.

#### **Public & Member Comment**

Comments included:

- Five supportive comments that advocated reconsideration of the measure by the Committee; commenters offered the following reasons for reconsideration:
  - Although there are limitations with the use of claims based data (e.g., inability to evaluate appropriateness of regimen), identifying variability in use is important. For example, very high rates might suggest non-use of non-drug management strategies or inadequate evaluation.
  - While claims-based measures cannot capture all possible exclusions, such data are accurate enough for

## 2111: Antipsychotic Use in Persons with Dementia

health plan level measures.

- Provider feedback to a large Pharmacy Benefits Manager indicates that providers rarely prescribe Alzheimer's drugs for a non-dementia reason, suggesting that the false-positive identification of dementia using Alzheimer's drugs as a proxy is remote.
- One comment supporting the Committee's decision not to recommend the measure.

**Developer response:** The developer provided additional information via letter in response to questions raised by the Committee during the in-person meeting. In this letter, which is posted on NQF's public website, the developers note the following:

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

### Committee response:

- After review of the comments, one Committee member expressed the belief that the additional analysis submitted by the developer provided evidence that use of dementia medications as a way to identify dementia patient is a valid proxy, while another member noted that earlier concerns around whether TBI patients would be included in this measure had also been addressed by the developer. These members recommended reconsideration of the measure by the Committee.
- The Committee agreed to re-vote on the measure.

**Vote Following Consideration of Public and Member Comments** (note: because the measure initially failed on validity, the Committee re-vote included only the validity, usability, and feasibility criteria and the overall vote on the suitability of the measure for endorsement):

2. Scientific Acceptability of Measure Properties (based on decision logic): **The measure meets the Scientific Acceptability criteria**

2b. Validity: H-2; M-12; L-1; I- 2

Usability: H-3; M-12; L-2; I-0

Feasibility: H-4; M-11; L-2; I-0

### Steering Committee Recommendation on Overall Suitability for Endorsement: Y-13; N-4

- Upon re-vote, the Committee agreed the additional information provided by the developers was adequate to address their initial concerns about the validity of the measure.



**2111: Antipsychotic Use in Persons with Dementia**

**Consensus Standards Approval Committee (CSAC) Review (February 2013): Y-13; N-0; A-0**

- Decision: Approved for endorsement

**Board of Directors (March 4, 2013)**

- Decision: Ratified for endorsement

## Measures Not Recommended

### 1973: Annual Parkinson's Disease diagnosis review

**Status:** New Submission

**Description:** All patients with a diagnosis of Parkinson's disease who had their Parkinson's disease diagnosis reviewed, including a review of current medications and a review for the presence of atypical features (e.g., falls at presentation and early in the disease course, poor response to levodopa, symmetry at onset, rapid progression [to Hoehn and Yahr stage 3 in 3 years], lack of tremor or dysautonomia) at least annually.

**Numerator Statement:** All patients who had an annual assessment including a review of current medications and for the presence of atypical features

**Denominator Statement:** All patients with a diagnosis of Parkinson's disease.

**Exclusions:** None

**Adjustment/Stratification:** No risk adjustment or risk stratification N/A N/A

**Level of Analysis:** Clinician : Individual

**Type of Measure:** Process

**Data Source:** Administrative claims, Electronic Clinical Data : Electronic Health Record

**Measure Steward:** American Academy of Neurology **Other organizations:** 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 Inc.

Anthem Blue Cross and Blue Shield

Humana Inc.

UnitedHealth Group Inc.

## 1973: Annual Parkinson's Disease diagnosis review

### STEERING COMMITTEE MEETING [10/3/2012]

#### Importance to Measure and Report: The measure does not meet the Importance criteria

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **NA**; 1b. Performance Gap: **NA** 1c. Evidence: **Y-3; N-8; I-13**

#### Rationale:

- The evidence presented by the developer addressed diagnostic inaccuracies in Parkinson's disease, but Committee members agreed that no evidence was presented to show that an annual review improves diagnostic accuracy. The developer acknowledged the lack of empirical evidence for the measure but suggested that consensus and expert opinion also were valid types of evidence. However, the Committee agreed that expert opinion was not sufficient to meet NQF criteria for evidence.
- Committee members voiced the concern that this is a "check-box" measure.
- Committee members noted that one of the main studies cited in support of this measure specifically states that there is no evidence regarding the optimal frequency of diagnosis review and that patients should be referred to a specialist for definitive diagnosis.

#### Steering Committee Recommendation for Endorsement: **No**

- The measure did not pass the criterion of Importance to Measure and Report.

#### Public & Member Comment

Comments included:

- A formal request for reconsideration of the measure by the developer.  
*Staff summary of the rationale for reconsideration articulated by the developer and/or other commenters:*
  - At least one recommendation used to support the measure has Level B strength behind it.
  - The potential harm from not regularly reviewing the Parkinson's disease diagnosis and looking for atypical features is significant.
  - The concern that this is a "check box" measure should not have been included in the evaluation of the evidence subcriterion.
  - The NICE recommendations regarding optimal frequency of diagnosis review and referral to a specialist for a definitive diagnosis were not used to support this measure.

#### Committee response:

The Committee did not dispute the importance of having a correct diagnosis of Parkinson's disease. However, members noted that, as originally submitted, no evidence was presented that reviewing and documenting a diagnosis would result in more accurate diagnosis and/or improved patient outcomes, and they agreed that no additional evidence to support the measure was subsequently provided by the developer. The Committee also verified with NQF staff that, in their evaluation of the evidence for the measure, it was appropriate to discuss their concern that this is a "check-box" measure. After review of the comments submitted and additional discussion, the Committee declined to revote on the measure.

## 1982: Parkinson's Disease psychiatric disorders or disturbance assessment

**Status:** New Submission

**Description:** All patients with a diagnosis of Parkinson's disease who were assessed for psychiatric disorders or disturbances (e.g., psychosis, depression, anxiety disorder, apathy, or impulse control disorder) at least annually.

**Numerator Statement:** Patients who were assessed for psychiatric disorders or disturbances (e.g., psychosis, depression, anxiety disorder, apathy, or impulse control disorder) at least annually.

**Denominator Statement:** All patients with a diagnosis of Parkinson's disease.

**Exclusions:** None

**Adjustment/Stratification:** No risk adjustment or risk stratification N/A N/A

**Level of Analysis:** Clinician : Individual

**Type of Measure:** Process

**Data Source:** Administrative claims, Electronic Clinical Data : Electronic Health Record

**Measure Steward:** American Academy of Neurology **Other organizations:** 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 Inc.

Anthem Blue Cross and Blue Shield

Humana Inc.

UnitedHealth Group Inc.

## 1982: Parkinson's Disease psychiatric disorders or disturbance assessment

### STEERING COMMITTEE MEETING [10/3/2012]

#### Importance to Measure and Report: The measure does meet the Importance criteria

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **H-19; M-4; L-1; I-0**; 1b. Performance Gap: **H-9; M-12; L-3; I-0** 1c. Evidence: **Y-1; N-18; I-5; L-0**

**Evidence exception: Y-14; N-10**

#### Rationale:

- While the Committee acknowledged that psychiatric disorders are relatively prevalent in Parkinson's disease patients, members agreed that evidence linking an annual psychiatric assessment to improved patient outcomes was not provided.
- Data provided by the developer stated that as many as 50% of Parkinson's disease patients may develop psychotic symptoms and 40-50% develop depression.
- Committee members were concerned that this is a "checkbox" measure.
- One member identified this measure as distal to desired health outcomes, noting that one must assume first that an assessment is performed correctly, and second, that appropriate treatment based on that assessment is initiated.
- Because psychiatric disorders are substantially under-diagnosed, one member requested that the Committee consider the exception to the evidence subcriterion. Another member confirmed that depression, particularly, is a key driver of quality of life for Parkinson's patients and that for these patients, assessment would be beneficial.
- In their discussion of whether there were compelling reasons to invoke the exception to the evidence subcriterion, some members suggested that the measure may be harmful if physicians without expertise in Parkinson's make the assessment and asked if the measure could be limited to neurologists. NQF staff clarified that measures should apply to all relevant patients and therefore cannot be limited to certain physician subspecialties. Upon vote, a majority of the Committee agreed to invoke the exception.
- Committee members noted that data regarding opportunity for improvement was not well supported in the submission; however, one member verified for the Committee that psychiatric disorders are under-diagnosed in Parkinson's disease patients.

#### **2. Scientific Acceptability of Measure Properties: The measure does not meet the Scientific Acceptability criteria for untested measures**

**Precise specifications: Y-5; N-19**

#### Rationale:

- The Committee expressed concern that the measure does not specify how assessments should be done (i.e., using specific validated tools). Members suggested modifying the measure so that the assessment be done using validated tools such as, but not limited, to those listed in the guideline recommendations.
- Committee members questioned whether the measure as specified suggests that patients should undergo a full round of psychiatric assessments each year (i.e., for depression, psychosis, impulse control disorders, anxiety, etc.) or whether asking about any one of them would suffice to meet the measure. The developer verified that assessment for only one condition would meet the measure, but also explained that while depression is the most prevalent psychiatric disorder in Parkinson's disease patients, other disorders also impact quality of life. The developer also noted that no single assessment tool can be used to screen for all (or even 2-3) of these disorders.

## 1982: Parkinson's Disease psychiatric disorders or disturbance assessment

### Steering Committee Recommendation for Endorsement: No

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

### Public & Member Comment

Comments included:

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

### Committee response:

Committee members noted that in their original evaluation of the measure, they found the measure specifications unclear (in particular, which tools could be used and how the assessment would be performed). After review of the comments submitted, the Committee agreed that no additional information was provided that would alleviate their concerns with the measure specifications, and members therefore declined to revote on the measure.

### 1983: Parkinson's Disease cognitive impairment or dysfunction assessment

**Status:** New Submission

**Description:** All patients with a diagnosis of Parkinson's disease who were assessed for cognitive impairment or dysfunction at least annually.

**Numerator Statement:** Patients who were assessed for cognitive impairment or dysfunction at least annually.

**Denominator Statement:** All patients with a diagnosis of Parkinson's disease.

**Exclusions:** None

**Adjustment/Stratification:** No risk adjustment or risk stratification N/A N/A

**Level of Analysis:** Clinician : Individual

**Type of Measure:** Process

**Data Source:** Administrative claims, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry

**Measure Steward:** American Academy of Neurology **Other organizations:** 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 Inc.

Anthem Blue Cross and Blue Shield

Humana Inc.

UnitedHealth Group Inc.

#### STEERING COMMITTEE MEETING [10/3/2012]

##### **Importance to Measure and Report: The measure does not meet the Importance criteria**

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **NA**; 1b. Performance Gap: **NA**; 1c. Evidence: **Y-3; N-14; I-7; L-0**

##### Rationale:

- The evidence presented by the developer addressed treatment of depression; however, no evidence was presented to show how assessing cognitive impairment annually would result in better patient outcomes.
- Committee members also noted that much of the evidence presented actually related to depression and treatment of depression rather than to cognitive impairment.
- The Committee did not express interest in invoking the evidence exception for this measure.

##### **Steering Committee Recommendation for Endorsement: No**

- The measure did not pass the criterion of Importance to Measure and Report.

## 1983: Parkinson's Disease cognitive impairment or dysfunction assessment

### Public & Member Comment

Comments included:

- A formal request for reconsideration of the measure by the developer.  
*Staff summary of the rationale for reconsideration articulated by the developer and/or other commenters:*
  - The onset of cognitive decline/dementia often occurs over a prolonged time period, and although there is limited treatment, it is important to identify.
  - Cognitive impairment is prevalent among patients with Parkinson's disease; assessment will lead to identification of dysfunction, which will then lead to appropriate treatment/referrals, and ultimately, to better quality of life.
  - In terms of evidence supporting the measure, depression was only cited in the context of non-motor symptoms of Parkinson's disease.

### Committee response:

One Committee member agreed with the comment that evidence regarding depression was cited only in the context of non-motor symptoms of Parkinson's disease. However, the Committee agreed that no additional evidence was presented to show that assessing cognitive impairment annually would result in better patient outcomes and therefore did not revote on the measure.



## 1985: Parkinson's Disease querying about sleep disturbances

**Status:** New Submission

**Description:** All patients with a diagnosis of Parkinson's disease (or caregivers, as appropriate) who were queried about sleep disturbances at least annually.

**Numerator Statement:** Patients (or caregiver(s), as appropriate) who were queried about sleep disturbances at least annually.

**Denominator Statement:** All patients with a diagnosis of Parkinson's disease.

**Exclusions:** Denominator Exclusion(s): Documentation of medical reason for not querying patient (or caregiver) about sleep disturbances (e.g., patient is unable to respond and no informant is available).

- Append modifier to CPT II code: 4328F-1P

**Adjustment/Stratification:** No risk adjustment or risk stratification N/A N/A

**Level of Analysis:** Clinician : Individual

**Type of Measure:** Process

**Data Source:** Administrative claims, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry

**Measure Steward:** American Academy of Neurology **Other organizations:** 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 Inc.

Anthem Blue Cross and Blue Shield

Humana Inc.

UnitedHealth Group Inc.

### STEERING COMMITTEE MEETING [10/3/2012]

**Importance to Measure and Report:** The measure does not meet the Importance criteria

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **NA**; 1b. Performance Gap: **NA** 1c. Evidence: **Y-1; N-18; I-5**

Rationale:

- The evidence presented by the developer addressed treatment of sleep disturbances; however, no evidence was presented that querying about sleep disturbances will actually improve patient outcomes.
- One Committee member expressed concern about the use of one of the NICE guidelines as evidence for this measure, noting that it actually recommends that if the patient complains about sleep disturbance, a detailed history should be taken so that a correct diagnosis can be made. Another member noted that this particular guideline is based on expert opinion.

**Steering Committee Recommendation for Endorsement: No**

- The measure did not pass the criterion of Importance to Measure and Report.

## 1985: Parkinson's Disease querying about sleep disturbances

### Public & Member Comment

Comments included:

- A formal request for reconsideration of the measure by the developer.  
*Staff summary of the rationale for reconsideration articulated by the developer and/or other commenters:*
  - By not querying the patient about sleep disturbances the clinician may miss key factors such as sleep fragmentation (80% of PD patients), restless leg syndrome (20%), REM behavior sleep disorder (>40%), and excessive daytime sleepiness (~50%).

### Committee response:

The Committee agreed that sleep disturbances are important in Parkinson's disease but noted that no evidence had been presented to link annual query about sleep disturbances with improved outcomes; therefore, Committee members declined to revote on the measure.

## 1988: Parkinson's Disease rehabilitative therapy options

**Status:** New Submission

**Description:** All patients with a diagnosis of Parkinson's disease (or caregiver(s), as appropriate) who had rehabilitative therapy options (e.g., physical, occupational, or speech therapy) discussed at least annually.

**Numerator Statement:** Patients (or caregiver(s), as appropriate) who had rehabilitative therapy options (e.g., physical, occupational, or speech therapy) discussed at least annually.

**Denominator Statement:** All patients with a diagnosis of Parkinson's disease.

**Exclusions:** Documentation of medical reason for not discussing rehabilitative therapy options with the patient (or caregiver(s), as appropriate) at least annually (e.g., patient has no known physical disability due to Parkinson's disease; patient is unable to respond and no informant available).

**Adjustment/Stratification:** No risk adjustment or risk stratification N/A N/A

**Level of Analysis:** Clinician : Individual

**Type of Measure:** Process

**Data Source:** Administrative claims, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry

**Measure Steward:** American Academy of Neurology **Other organizations:** 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 Inc.

Anthem Blue Cross and Blue Shield

Humana Inc.

UnitedHealth Group Inc.

## 1988: Parkinson's Disease rehabilitative therapy options

### STEERING COMMITTEE MEETING [10/3/2012]

#### Importance to Measure and Report: The measure does meet the Importance criteria

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **H-18; M-5; L-0; I-0**; 1b. Performance Gap: **H-9; M-12; L-2; I-0** 1c. Evidence: **Y-10; N-13; I-1**

#### Evidence Exception: **Y-20; N-3**

##### Rationale:

- Committee members agreed that no evidence was presented to show that an annual discussion with PD patients (or caregivers) regarding rehabilitation therapy options will increase referrals to rehab and/or improve patient outcomes.
- Committee members also expressed concern that this is another checkbox measure.
- However, one Committee member affirmed that unpublished study results have shown that reminding clinicians about rehab options does result in increased referrals to rehab and there is evidence showing that rehab therapy is helpful for Parkinson's disease patients. .
- Committee members recommended invoking the evidence exception because there is expert opinion regarding the utility of the measure, the potential harm in discussing rehab options likely is low, and there may be harm in not referring patients for rehab (particularly given that medications are not particularly effective for some symptoms including balance and walking problems). Upon vote, a majority of the Committee agreed to invoke the exception.
- Data submitted by developers noted that Parkinson's disease causes progressive reduction in the speed and amplitude of movements, and studies have shown the efficacy of rehabilitation at improving specific impairments and functional limitations in these patients.
- Data submitted by the developer did not directly address the opportunity for improvement in discussing rehab options with Parkinson's disease patients; however, Committee members again referred to the previously mentioned study that found that reminding clinicians about rehab options results in increased referrals to rehab. The Committee agreed that rehabilitation is a critical component of care for Parkinson's patients, and that there is strong evidence that rehab improves patient outcomes.

#### 2. Scientific Acceptability of Measure Properties: The measure does not meet the Scientific Acceptability criteria for untested measures

##### Precise specifications: **Yes-11; No-13**

##### Rationale:

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

## 1988: Parkinson's Disease rehabilitative therapy options

### Steering Committee Recommendation for Endorsement: No

- The measure did not pass the criterion of Scientific Acceptability. However, the Committee encouraged the developer to consider continued work on the measure due to the importance of rehab for Parkinson's disease patients. (NOTE: Because this was an untested measure, the Committee voted on whether the measure was precisely specified and whether the specifications are consistent with the evidence presented for the measure).

### Public & Member Comment

Comments included:

- A formal request for reconsideration of the measure by the developer.  
*Staff summary of the rationale for reconsideration articulated by the developer and/or other commenters:*
  - The argument for including in the measure those patients with no known disability is not evidence-based and should not have been used to argue against this measure.
  - Multiple studies cite the link between the discussion of rehabilitation therapy options to an increase in referrals to rehab and/or improved patient outcomes.
  - The potential benefit greatly outweighs harm.

### Committee response:

The Committee noted the invocation of the evidence exception for this measure and also noted that concerns regarding measure exclusions had not been addressed. The Committee did not re-vote on the measure but encouraged the developer to re-work the measure specifications and re-submit the measure to NQF.

## 1989: Parkinson's Disease medical and surgical treatment options reviewed

**Status:** New Submission

**Description:** All patients with a diagnosis of Parkinson's disease (or caregiver(s), as appropriate who had the Parkinson's disease treatment options (e.g., non-pharmacological treatment, pharmacological treatment, or surgical treatment) reviewed at least once annually.

**Numerator Statement:** Patients (or caregiver(s), as appropriate) who had the Parkinson's disease treatment options (e.g., non-pharmacological treatment, pharmacological treatment, or surgical treatment) reviewed at least once annually.

**Denominator Statement:** All patients with a diagnosis of Parkinson's disease.

**Exclusions:** Documentation of medical reason(s) for not reviewing the Parkinson's disease treatment options (e.g., non-pharmacological treatment, pharmacological treatment, or surgical treatment) at least once annually. (e.g., the patient is unable to respond and no informant is available)

**Adjustment/Stratification:** No risk adjustment or risk stratification N/A N/A

**Level of Analysis:** Clinician : Individual

**Type of Measure:** Process

**Data Source:** Administrative claims, Electronic Clinical Data : Electronic Health Record, Paper Medical Records, Electronic Clinical Data : Registry

**Measure Steward:** American Academy of Neurology **Other organizations:** 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 Inc.

Anthem Blue Cross and Blue Shield

Humana Inc.

UnitedHealth Group Inc.

### STEERING COMMITTEE MEETING [10/3/2012]

**Importance to Measure and Report:** The measure does not meet the Importance criteria

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **NA**; 1b. Performance Gap: **NA**; 1c. Evidence: **Y-2; N-16; I-6**

Rationale:

- Committee members agreed this measure as specified was not well supported by evidence, given that most patients with Parkinson's typically are seen at least every three to four months, and that treatment options (particularly pharmacologic options) are discussed during these visits.
- While technically a point regarding measure specifications, Committee members noted that to meet the measure, clinicians could discuss either pharmacologic, non-pharmacologic, or surgical treatments; they suggested that a focus on non-pharmacologic or surgical options discussion might be more appropriate for a quality measure.

**1989: Parkinson's Disease medical and surgical treatment options reviewed**

**Steering Committee Recommendation for Endorsement: No**

- The measure did not pass the criterion of Importance to Measure and Report.

**Public & Member Comment**

Comments included:

- No comments were received for this measure. The developer did not request reconsideration.

**Committee response:** N/A

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

**Status:** New Submission

**Description:** All visits for patients with a diagnosis of epilepsy who had the type(s) of seizure(s) and current seizure frequency for each seizure type documented in the medical record.

**Numerator Statement:** Patient visits with seizure type(s) specified and current seizure frequency for each seizure type documented in the medical record.

**Denominator Statement:** All visits for patients with a diagnosis of epilepsy.

**Exclusions:** Documentation of medical reason(s) or patient reason(s) for not recording seizure type(s) and seizure frequency for each seizure type (e.g., patient or caregiver unable or unwilling to communicate or provide information) or documentation of patient reason(s)

**Adjustment/Stratification:**

**Level of Analysis:** Clinician : Individual

**Type of Measure:** Process

**Data Source:** Administrative claims

**Measure Steward:** American Academy of Neurology **Other organizations:** See work group members in Ad.1

#### STEERING COMMITTEE MEETING [10/3/2012]

**Importance to Measure and Report:** The measure does not meet the Importance criteria

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **NA**; 1b. Performance Gap: **NA**; 1c. Evidence: **Y-11; N-9; I-4**

Rationale:

- While the Committee acknowledged that seizure frequency is the key outcome in epilepsy care, members agreed that there is no evidence that documentation (of seizure type/frequency) alone leads to better outcomes. Committee members noted that although the classification systems (for epilepsy type and seizure type) are currently under review by experts in the field, describing the types and frequency of seizures should be a minimal standard of care, particularly in a neurology clinic.
- The developer noted that seizure drugs are tested for specific seizure subtypes, and that providers must correctly identify seizure type in order to prescribe the appropriate medication.

**Steering Committee Recommendation for Endorsement: No**

- The measure did not pass the criterion of Importance to Measure and Report.



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

### Public & Member Comment

Comments included:

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

### Committee response:

The Committee agreed that asking about seizure frequency and documenting the result are important steps in the care process. However, members noted that the process of care that is most closely related to improved patient outcomes is how a clinician acts on the information regarding seizure frequency, which is not included in the current measure. Committee members agreed that no additional information was presented to change their evaluation of the measure and therefore declined to revote on the measure.

## 1954: Documentation of etiology of epilepsy or epilepsy syndrome

**Status:** New Submission

**Description:** All visits for patients with a diagnosis of epilepsy who had their etiology of epilepsy or with epilepsy syndrome(s) reviewed and documented if known, or documented as unknown or cryptogenic

**Numerator Statement:** Patient visits with etiology of epilepsy or with epilepsy syndrome(s) reviewed and documented if known, or documented as unknown or cryptogenic.

**Denominator Statement:** All visits for patients with a diagnosis of epilepsy.

**Exclusions:** None

**Adjustment/Stratification:** No risk adjustment or risk stratification None.

**Level of Analysis:** Clinician : Individual

**Type of Measure:** Process

**Data Source:** Administrative claims, Paper Medical Records

**Measure Steward:** American Academy of Neurology **Other organizations:** American Epilepsy Society, Epilepsy Foundation of America, National Association of Epilepsy Centers, American Academy of Family Physicians, American Clinical Neurophysiology Society, American College of Emergency Physicians, American College of Radiology,

### STEERING COMMITTEE MEETING [10/03/2012]

**Importance to Measure and Report:** The measure does not meet the Importance criteria

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **NA**; 1b. Performance Gap: **NA**; 1c. Evidence: **Y-0; N-15; I-9**

Rationale:

- While Committee members acknowledged the strong evidence base linking treatment options to epilepsy type, evidence was not presented that documenting epilepsy type will improve patient outcomes.
- The Committee was concerned that non-specialists or non-neurologists may not be able to make the proper classification of epilepsy syndrome or epilepsy type, especially given the current controversy in the field regarding classification of epilepsy type.
- The Committee also expressed some doubt about the utility of documenting epilepsy type at each visit, given that this generally does not progress or change over time.

**Steering Committee Recommendation for Endorsement: No**

- The measure did not pass the criterion of Importance to Measure and Report.

## 1954: Documentation of etiology of epilepsy or epilepsy syndrome

### Public & Member Comment

Comments included:

- A formal request for reconsideration of the measure by the developer.  
*Staff summary of the rationale for reconsideration articulated by the developer and/or other commenters:*
  - Documentation is viewed as the surrogate for ascertaining the patient's etiology of epilepsy/syndrome and providing appropriate treatment.
  - The measure focus represents the standard of care to ensure that patients receive appropriate treatment.
  - The evolving classification system for epilepsy should not affect this measure because as the classification evolves, so must the treatment.

### Committee response:

The Committee agreed that reviewing and documenting epilepsy etiology are important steps in the care process, but noted that appropriate treatments must then be provided. Members noted that evidence linking the review and documentation of epilepsy etiology to improved patient outcomes had not been initially submitted by the developer; they also agreed that no additional evidence demonstrating that link was subsequently provided and therefore declined to revote on the measure.

## 1990: Dementia: Staging of dementia

**Status:** New Submission

**Description:** Percentage of patients, regardless of age, with a diagnosis of dementia whose severity of dementia was classified as mild, moderate or severe at least once within a 12 month period

**Numerator Statement:** Patients whose severity of dementia was classified\* as mild, moderate or severe\*\* at least once within a 12 month period

\*Dementia severity can be assessed using one of a number of available valid and reliable instruments available from the medical literature. Examples include, but are not limited to:

- Global Deterioration Scale (GDS)
- Functional Assessment Staging Tool (FAST)
- Clinical Dementia Rating (CDR)
- Dementia Severity Rating Scale
- Mini-Mental State Examination (MMSE) [Note: While simple and quick to administer, the MMSE is best suited for screening purposes and is therefore at best a blunt instrument for staging Alzheimer's disease. The MMSE has not been well validated for non-Alzheimer's dementias.]
- Formal Neuropsychological Evaluation

\*\*Mild dementia can be classified quantitatively as MMSE score of >18, GDS or FAST stage 4, CDR of 1; qualitatively as being likely to have difficulty with balancing a checkbook, preparing a complex meal, or managing a complicated medication schedule

Moderate dementia can be classified quantitatively as MMSE score of 10–18, GDS or FAST stages 5 and 6, CDR of 2; qualitatively as experiencing difficulties with simpler food preparation, household cleanup, and yard work and requiring assistance with some aspects of self-care (eg, picking out the proper clothing to wear)

Severe dementia can be classified quantitatively as MMSE score of <10, GDS or FAST stages 6 and 7, CDR of 3; qualitatively as requiring considerable or total assistance with personal care, such as dressing, bathing, and toileting.<sup>21</sup>

Note: The proposed scoring cut-offs listed above are offered only as a guide and are quoted verbatim from the referenced clinical guideline. The scoring and appropriate severity cut-offs for ANY of these instruments must be interpreted in the context of the patient's age, education, and ethnicity.

**Denominator Statement:** All patients, regardless of age, with a diagnosis of dementia

**Exclusions:** None

**Adjustment/Stratification:** No risk adjustment or risk stratification. We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

**Level of Analysis:** Clinician : Group/Practice, Clinician : Individual, Clinician : Team

**Type of Measure:** Process

**Data Source:** Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry

**Measure Steward:** American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) **Other organizations:** This measure set was developed in collaboration with the American Academy of Neurology (AAN), American Geriatrics Society (AGS), American Medical Directors Association (AMDA), and American Psychiatric Association (APA).

## 1990: Dementia: Staging of dementia

### STEERING COMMITTEE MEETING [10/4/2012]

#### Importance to Measure and Report: **The measure does not meet the Importance criteria**

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **NA**; 1b. Performance Gap: **NA**; 1c. Evidence: **Y-0; N-10; I-14**

#### Rationale:

- The evidence underlying this measure includes guideline recommendations from the APA, although this evidence was not graded by the guideline developers and additional evidence was not provided by the measure developer. The Committee agreed that evidence showing the link between staging of dementia and improving patient outcomes was not provided and therefore there was insufficient information to rate the quantity, quality, and consistency of the body of evidence.
- One member questioned the evidence supporting a consistent division of dementia into mild, moderate, and severe categories, noting that if guidelines for such classifications are inconsistent, the categorizations would also be inconsistent. Another member noted that staging can help differentiate between mild cognitive impairment and mild Alzheimer's disease and would therefore likely be of some benefit to the patient and their family.

#### **Steering Committee Recommendation for Endorsement: No**

- The measure did not pass the criterion of Importance to Measure and Report.

#### **Public & Member Comment**

Comments included:

- No comments were received for this measure. The developer did not request reconsideration.

**Committee response:** N/A

## 2009: Dementia: Neuropsychiatric Symptom Assessment

**Status:** New Submission

**Description:** Percentage of patients, regardless of age, with a diagnosis of dementia and for whom an assessment of neuropsychiatric symptoms is performed and results reviewed at least once in a 12 month period

**Numerator Statement:** Patients for whom an assessment of neuropsychiatric symptoms\*\* is performed and results reviewed at least once in a 12 month period

\*\* Neuropsychiatric symptoms can be assessed by direct examination of the patient or knowledgeable informant. The following is a non-exhaustive list of dimensions (based on items included in available validated instruments) that may be evaluated during an assessment of neuropsychiatric symptoms:

Activity disturbances:

- o agitation
- o wandering
- o purposeless hyperactivity
- o verbal or physical aggressiveness
- o resistiveness with care
- o apathy
- o impulsiveness
- o socially inappropriate behaviors
- o appetite
- o eating disturbances
- o sleep problems
- o diurnal/sleep-wake cycle disturbances
- o repetitive behavior

Mood disturbances:

- o anxiety
- o dysphoria
- o euphoria
- o irritability
- o mood lability/fluctuations

Thought and perceptual disturbances:

- o having fixed false beliefs (delusions)
- o hearing or seeing non-present entities (hallucinations)
- o paranoia

Examples of reliable and valid instruments that are commonly used in research settings and that can be used to assess behavior include, but are not limited to:

- ? Dementia Signs and Symptoms (DSS) Scale
- ? Neuropsychiatric Inventory (NPI)

The assessment of behavioral status may include the assessment of Behavioral and Psychological Symptoms of Dementia (BPSD). For patients residing in nursing homes, it may include an assessment of the behavioral symptom items from the Minimum Data Set (MDS).

**Denominator Statement:** All patients, regardless of age, with a diagnosis of dementia

**Exclusions:** None

**Adjustment/Stratification:** No risk adjustment or risk stratification. No risk adjustment or risk stratification. We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

**Level of Analysis:** Clinician : Group/Practice, Clinician : Individual, Clinician : Team

**Type of Measure:** Process

**Data Source:** Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry

**Measure Steward:** American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) **Other organizations:** This measure set was developed in collaboration with the American Academy of Neurology, American Geriatrics Society, American Medical Directors Association, and American Psychiatric

## 2009: Dementia: Neuropsychiatric Symptom Assessment

Association.

### STEERING COMMITTEE MEETING [10/3-4/2012]

#### Importance to Measure and Report: **The measure does not meet the Importance criteria**

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **NA**; 1b. Performance Gap: **NA**; 1c. Evidence: **Y-0; N-16; I-8**;

**Evidence Exception: Y-8; N-16; I-0**

#### Rationale:

- The evidence underlying this measure includes guideline recommendations from the American Psychiatric Association (APA), the Third Canadian Consensus Conference on Diagnosis and Treatment of Dementia, and the California Work Group on Guidelines for Alzheimer's Disease and Management. However, the evidence from the APA and California Workgroup guidelines was not graded, and the Canadian guideline was based on expert opinion. The developer did not offer any additional evidence outside of the guideline recommendations. The developer acknowledged the weak evidence base for this measure and asked the Committee consider invoking the exception to the evidence subcriterion.
- Committee members disagreed on the merits of invoking the evidence exception. One member noted that psychiatric symptoms are not subtle and that caregivers typically inform providers if these symptoms are present; this member did not see value in assessing for subtle symptoms, particularly when there is little beyond complicated nonpharmacologic treatments available. However, another member disagreed, noting that patient/caregiver history may not always be adequate, particularly for initial diagnosis. Other members noted that while measuring actual interventions would be preferable, there is strong evidence that assessment is not being done and this measure would be a first step to encourage performance of assessment. The Committee did decide to consider the evidence exception, but ultimately, a majority of the Committee did not agree that the exception was warranted.

#### **Steering Committee Recommendation for Endorsement: No**

- The measure did not pass the criterion of Importance to Measure and Report.

#### **Public & Member Comment**

Comments included:

- No comments were received for this measure. The developer did not request reconsideration.

**Committee response:** N/A

## 2011: Dementia: Management of Neuropsychiatric Symptoms

**Status:** New Submission

**Description:** Percentage of patients, regardless of age, with a diagnosis of dementia who have one or more neuropsychiatric symptoms who received or were recommended to receive an intervention for neuropsychiatric symptoms within a 12 month period

**Numerator Statement:** Patients who received or were recommended to receive an intervention for neuropsychiatric symptoms within a 12 month period

**Denominator Statement:** All patients, regardless of age, with a diagnosis of dementia who have one or more neuropsychiatric symptoms

**Exclusions:** None

**Adjustment/Stratification:** No risk adjustment or risk stratification No risk adjustment or risk stratification. We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

**Level of Analysis:** Clinician : Group/Practice, Clinician : Individual, Clinician : Team

**Type of Measure:** Process

**Data Source:** Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry

**Measure Steward:** American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)

**Other organizations:** This measure set was developed in collaboration with the American Academy of Neurology, American Geriatrics Society, American Medical Directors Association, and American Psychiatric Association.

### STEERING COMMITTEE MEETING [10/3-4/2012]

**Importance to Measure and Report:** The measure does not meet the Importance criteria

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **H-**; **M-**; **L-**; **I-**; 1b. Performance Gap: **H-**; **M-**; **L-**; **I-**; 1c. Evidence: **Y-10**; **N-8**; **I-6**

Rationale:

- The developer used the same guideline recommendations for this measure as with measure #2009; however, the Canadian guideline found Level I evidence (i.e., at least one RCT) for nonpharmacologic interventions. The developer did not offer any additional evidence outside of the guideline recommendations.
- Committee members noted that this measure does move beyond assessment. However, the evidence provided by the developer pertains only to nonpharmacologic treatment, even though measure allows for both pharmacologic and nonpharmacologic treatment. Committee members expressed concern that this measure might cause harm if viewed as fostering pharmacologic treatment over nonpharmacologic treatment.
- One Committee member noted that there actually is strong evidence showing that pharmacologic treatment does improve neuropsychologic symptoms in dementia patients; unfortunately, these treatments (e.g., antipsychotics) are associated with a higher risk of death in dementia patients.

**Steering Committee Recommendation for Endorsement: No**

- The measure did not pass the criterion of Importance to Measure and Report.

**Public & Member Comment**

Comments included:

- No comments were received for this measure. The developer did not request reconsideration.

**Committee response:** N/A



## 2016: Dementia: Screening for Depressive Symptoms

**Status:** New Submission

**Description:** Percentage of patients, regardless of age, with a diagnosis of dementia who were screened for depressive symptoms within a 12 month period

**Numerator Statement:** Patients who were screened for depressive symptoms\* within a 12 month period

\*Depressive symptoms in a patient with dementia can include: anxiety, sadness, lack of reactivity to pleasant events, irritability, agitation, retardation, multiple physical complaints, acute loss of interest, appetite loss, lack of energy, diurnal variation of mood, difficulty falling asleep, multiple awakenings, during sleep, early morning awakenings, suicide, self-depreciation, pessimism, mood congruent delusions. Since patients may be unable to describe their symptoms, caregiver report of depressive symptoms should be reviewed and included in the screen for depressive symptoms.

In addition to clinical qualitative approaches, dementia patients can be screened for depressive symptoms using one of a number of valid, reliable instruments available from the medical literature. Examples include, but are not limited to:

- Cornell Scale for Depression in Dementia
- Geriatric Depression Scale [Note: a short form is also available.]
- PHQ-9

**Denominator Statement:** All patients, regardless of age, with a diagnosis of dementia

**Exclusions:** None

**Adjustment/Stratification:** No risk adjustment or risk stratification. No risk adjustment or risk stratification. We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

**Level of Analysis:** Clinician : Group/Practice, Clinician : Individual, Clinician : Team

**Type of Measure:** Process

**Data Source:** Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry

**Measure Steward:** American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) **Other organizations:** This measure set was developed in collaboration with the American Academy of Neurology, American Geriatrics Society, American Medical Directors Association, and American Psychiatric Association.

## 2016: Dementia: Screening for Depressive Symptoms

### STEERING COMMITTEE MEETING [10/4/2012]

#### Importance to Measure and Report: The measure does not meet the Importance criteria

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **NA**; 1b. Performance Gap: **NA**; 1c. Evidence: **Y-1; N-19; I-4**;

**Evidence Exception: Y-6; N-18; I-0**

#### Rationale:

- The evidence underlying this measure includes guideline recommendations from the APA, the AAN, and the California Work Group on Guidelines for Alzheimer’s Disease and Management. The evidence from the APA was not graded. However, the APA guidelines state that if evidence is limited, the level of confidence assigned to a recommendation also incorporates clinical consensus with regard to a particular clinical decision. According to the developer, AAN guidelines usually require Class II evidence or a strong consensus of Class III evidence. The developer did not offer additional evidence outside of the guideline recommendations.
- One Committee member questioned how the list of depressive symptoms was derived, noting that some are a little vague (e.g., motor? retardation). The developer clarified that the list of symptoms was based on elements from the Cornell scale for depression, noting that the list was provided to serve as guidance about potential symptoms of depression.
- The guidelines cited for the measure described difficulty in administering standardized tools to diagnose depression in patients with Alzheimer’s disease. Also, several studies indicate that using the geriatric depression scale may be less valid when used for patients with dementia.
- Several Committee members requested that exception to the evidence subcriterion be considered for this measure because depression is common in patients with dementia and there are good treatments for depression in this patient population, yet it is often not diagnosed. One member noted that there is evidence that people with dementia and depression who also had agitation or behavioral symptoms improved with treatment.
- The Committee agreed to consider invoking the evidence exception. Some members favored invoking the exception because they saw little chance of harming the patient when asking about depressive symptoms and the potential to help patients if such symptoms are identified. Conversely, other members did not favor the exception because the measure focuses on depressive symptoms rather than depression; these members also expressed concern that this measure might be a “checkbox” measure that would be burdensome to providers, particularly when patients are severely demented and incapable of response.
- Upon vote, a majority of the Committee agreed not to invoke the evidence exception.

#### **Steering Committee Recommendation for Endorsement: No**

- The measure did not pass the criterion of Importance to Measure and Report.

#### **Public & Member Comment**

Comments included:

- No comments were received for this measure. The developer did not request reconsideration.

**Committee response:** N/A

## 2000: Dementia: Cognitive assessment

**Status:** New Submission

**Description:** Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least within a 12 month period

**Numerator Statement:** Patients for whom an assessment of cognition is performed and the results reviewed at least once within a 12 month period

\*Cognition can be assessed by direct examination of the patient using one of a number of instruments, including several originally developed and validated for screening purposes. This can also include, where appropriate, administration to a knowledgeable informant. Examples include, but are not limited to:

- Blessed Orientation-Memory-Concentration Test (BOMC)
- Mini-Cog
- Montreal Cognitive Assessment (MoCA)
- Cognitive Abilities Screening Instrument (CASI)
- St. Louis University Mental Status Examination (SLUMS)
- Mini-Mental State Examination (MMSE) [Note: The MMSE has not been well validated for non-Alzheimer's dementias.
- Short Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE)
- Ascertain Dementia 8 (AD8) Questionnaire
- Minimum Data Set (MDS) Brief Interview of Mental Status (BIMS) [Note: Validated for use with nursing home patients only]
- Formal neuropsychological evaluation

**Denominator Statement:** All patients, regardless of age, with a diagnosis of dementia

**Exclusions:** Documentation of medical reason(s) for not assessing cognition (eg, patient with very advanced stage dementia, other medical reason)

Documentation of patient reason(s) for not assessing cognition

**Adjustment/Stratification:** No risk adjustment or risk stratification. No risk adjustment or risk stratification. We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

**Level of Analysis:** Clinician : Group/Practice, Clinician : Individual, Clinician : Team

**Type of Measure:** Process

**Data Source:** Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry

**Measure Steward:** American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) **Other organizations:** This measure set was developed in collaboration with the American Academy of Neurology (AAN), American Geriatrics Society (AGS), American Medical Directors Association (AMDA), and American Psychiatric Association (APA).

**2000: Dementia: Cognitive assessment**

**STEERING COMMITTEE MEETING [10/4/2012]**

**Importance to Measure and Report: The measure does not meet the Importance criteria**

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **NA**; 1b. Performance Gap: **NA**; 1c. Evidence: **Y-0; N-9; I-15**

**Rationale:**

- The evidence underlying this measure includes guideline recommendations from the APA and the California Work Group on Guidelines for Alzheimer’s Disease and Management. Additional evidence was not provided by the measure developer.
- Committee members agreed that the submission did not demonstrate evidence to support a link between annual cognitive assessments and improved patient outcomes. One member did describe at least one study showing that dementia patients who did not have a cognitive assessment had worse outcomes. Several Committee members expressed some frustration that evidence such as this study was not included in the submission.

**Steering Committee Recommendation for Endorsement: No**

- The measure did not pass the criterion of Importance to Measure and Report.

**Public & Member Comment**

Comments included:

- No comments were received for this measure. The developer did not request reconsideration.

**Committee response:** N/A

## 2004: Dementia: Functional status assessment

**Status:** New Submission

**Description:** Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of functional status is performed and the results reviewed at least once within a 12 month period

**Numerator Statement:** Patients for whom an assessment of functional status\* is performed and the results reviewed at least once within a 12 month period

\* Functional status can be assessed by direct examination of the patient or knowledgeable informant. An assessment of functional status should include, at a minimum, an evaluation of the patient's ability to perform instrumental activities of daily living (IADL) and basic activities of daily living (ADL). Functional status can also be assessed using one of a number of available valid and reliable instruments available from the medical literature. Examples include, but are not limited to:

- Lawton IADL Scale
- Barthel ADL Index
- Katz Index of Independence in ADL

**Denominator Statement:** All patients, regardless of age, with a diagnosis of dementia

**Exclusions:** Documentation of medical reason(s) for not assessing functional status (eg, patient is severely impaired and caregiver knowledge is limited, other medical reason)

**Adjustment/Stratification:** No risk adjustment or risk stratification No risk adjustment or risk stratification. We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

**Level of Analysis:** Clinician : Group/Practice, Clinician : Individual, Clinician : Team

**Type of Measure:** Process

**Data Source:** Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry

**Measure Steward:** American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) **Other organizations:** This measure set was developed in collaboration with the American Academy of Neurology, American Geriatrics Society, American Medical Directors Association, and American Psychiatric Association.

### STEERING COMMITTEE MEETING [10/4/2012]

**Importance to Measure and Report:** The measure does not meet the Importance criteria

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **NA**; 1b. Performance Gap: **NA**; 1c. Evidence: **Y-0; N-11; I-13**

Rationale:

- The evidence underlying this measure includes guideline recommendations from the APA and the California Work Group on Guidelines for Alzheimer's Disease and Management. Additional evidence was not provided by the measure developer.
- Again, the Committee agreed that no evidence was presented linking annual functional status assessments with improved patient outcomes.

Steering Committee Recommendation for Endorsement: **No**

- **The measure did not pass the criterion of Importance to Measure and Report.**

### Public & Member Comment

Comments included:

- No comments were received for this measure. The developer did not request reconsideration.

**Committee response:** N/A

## 2028: Dementia: Counseling regarding safety concerns

**Status:** New Submission

**Description:** Percentage of patients, regardless of age, with a diagnosis of dementia or their caregiver(s) who were counseled or referred for counseling regarding safety concerns within a 12 month period

**Numerator Statement:** Patients or their caregiver(s) who were counseled\* or referred for counseling regarding safety concerns within a 12 month period

\*Counseling should include a discussion with the patient and their caregiver(s) regarding one or more of the following common safety concerns and potential risks to the patient. When appropriate, it should also include a recommendation or referral for a home safety evaluation.

Safety concerns include, but are not limited to:

- Fall risk
- Gait/balance
- Medication management
- Financial management
- Home safety risks that could arise from cooking or smoking
- Physical aggression posing threat to self, family caregiver, or others
- Wandering
- Access to firearms or other weapons
- Access to potentially dangerous materials
- Being left alone in home or locked in room
- Inability to respond rapidly to crisis/household emergencies
- Driving
- Operation of hazardous equipment
- Suicidality
- Abuse or neglect

Note: for nursing home patients, different safety concerns might apply.

A number of organizations have developed educational materials that are recommended to aid implementation of the measure. These materials/tools include:

- Alzheimer's Association Safety Topics. Available at: [http://www.alz.org/alzheimers\\_disease\\_publications\\_safety.asp](http://www.alz.org/alzheimers_disease_publications_safety.asp)
- Alzheimer's Disease Education and Referral Center's Home Safety for the Alzheimer's Patient. Available at: <http://www.nia.nih.gov/Alzheimers/>

**Denominator Statement:** All patients, regardless of age, with a diagnosis of dementia

**Exclusions:** Documentation of medical reason(s) for not counseling regarding safety concerns (eg, patient at end of life, other medical reason)

**Adjustment/Stratification:** No risk adjustment or risk stratification. No risk adjustment or risk stratification. We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

**Level of Analysis:** Clinician : Group/Practice, Clinician : Individual, Clinician : Team

**Type of Measure:** Process

**Data Source:** Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry

**Measure Steward:** American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) **Other organizations:** This measure set was developed in collaboration with the American Academy of

**2028: Dementia: Counseling regarding safety concerns**

Neurology (AAN), American Geriatrics Society (AGS), American Medical Directors Association (AMDA), and American Psychiatric Association (APA).

**STEERING COMMITTEE MEETING [10/4/2012]**

**Importance to Measure and Report: The measure does not meet the Importance criteria**

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **NA**; 1b. Performance Gap: **NA**; 1c. Evidence: **Y-1; N-10; I-13**

Rationale:

- The evidence underlying this measure includes guideline recommendations from the APA, the California Work Group on Guidelines for Alzheimer’s Disease and Management, and the Third Canadian Consensus Conference on Diagnosis and Treatment of Dementia. Additional evidence was not provided by the measure developer.
- The Committee agreed that no evidence was presented linking annual counseling about safety concerns with improved patient outcomes.

**Steering Committee Recommendation for Endorsement: No**

- The measure did not pass the criterion of Importance to Measure and Report.

**Public & Member Comment**

Comments included:

- No comments were received for this measure. The developer did not request reconsideration.

**Committee response:** N/A

## 2029: Dementia: Counseling regarding risks of driving

**Status:** New Submission

**Description:** Percentage of patients, regardless of age, with a diagnosis of dementia or their caregiver(s) who were counseled regarding the risks of driving and the alternatives to driving at least once within a 12 month period

**Numerator Statement:** Patients or their caregiver(s) who were counseled regarding the risks of driving and the alternatives to driving at least once within a 12 month period

One resource that includes patient and caregiver educational materials that can be used to aid implementation of the measure is the Physician's Guide to Assessing and Counseling Older Drivers, developed by the American Medical Association in cooperation with the National Highway Traffic Safety Administration,. This document is available at: <http://www.ama-assn.org/ama/pub/physician-resources/public-health/promoting-healthy-lifestyles/geriatric-health/older-driver-safety/assessing-counseling-older-drivers.shtml>

**Denominator Statement:** All patients, regardless of age, with a diagnosis of dementia

**Exclusions:** Documentation of medical reason(s) for not counseling regarding the risks of driving (eg, patient is no longer driving, other medical reason)

**Adjustment/Stratification:** No risk adjustment or risk stratification No risk adjustment or risk stratification. We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

**Level of Analysis:** Clinician : Group/Practice, Clinician : Individual, Clinician : Team

**Type of Measure:** Process

**Data Source:** Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry

**Measure Steward:** American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) **Other organizations:** This measure set was developed in collaboration with the American Academy of Neurology (AAN), American Geriatrics Society (AGS), American Medical Directors Association (AMDA), and American Psychiatric Association (APA).

### STEERING COMMITTEE MEETING [10/4/2012]

**Importance to Measure and Report:** The measure does not meet the Importance criteria

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **NA**; 1b. Performance Gap: **NA**; 1c. Evidence: **Y-0; N-5; I-19**

Rationale:

- The evidence underlying this measure includes guideline recommendations from the APA and the AAN. Additional evidence was not provided by the measure developer.
- The Committee questioned the need for this measure, noting that counseling regarding risks of driving would also be included under measure #2028 (counseling regarding safety concerns). The developer stated that because driving by dementia patients has potential safety ramifications for others, it warranted a separate performance measure.
- One Committee member noted that if you counsel a patient to stop driving and he/she does, then that patient is thereafter excluded from the denominator; conversely, if you counsel a patient to stop driving and he/she does not comply with this advice, the provider still meets the measure.
- Committee members noted that there is evidence showing counseling is more effective when done by other caregivers (e.g., social workers, nurses) compared to physicians. The developers clarified that this measure is not applicable to physicians only, but also to other care providers such as social workers and psychologists.
- Committee members agreed that the submission did not demonstrate evidence to support a link between counseling about risks of driving and improved patient outcomes. Again, several Committee members voiced the belief that such evidence likely is available (e.g., in traffic safety data) and expressed some frustration that such evidence was not included as part of the measure submission.



## 2029: Dementia: Counseling regarding risks of driving

### Steering Committee Recommendation for Endorsement: No

- The measure did not pass the criterion of Importance to Measure and Report.

### Public & Member Comment

Comments included:

- A formal request for reconsideration of the measure by AAN.  
*Staff summary of the rationale for reconsideration articulated by the developer and/or other commenters:*
  - Everyone with dementia will eventually become an unsafe driver because of impairments in memory, judgment, reasoning, spatial perception, and reaction time.
  - Clinicians can influence their patients' decision to modify or stop driving, and help their patients maintain safe driving skills.
  - Many groups have tools, position statements, and advisory kits that demonstrate the importance of physician to counsel about driving safety issues.
  - Counseling patients with dementia about driving is under-reported in the medical record compared to the caregiver interview (reference cited).

### Committee response:

After review of the comments, the Committee agreed that no new evidence was submitted to support the measure; members therefore declined to revote on the measure.

## 2030: Dementia: Caregiver education and support

**Status:** New Submission

**Description:** Percentage of patients, regardless of age, with a diagnosis of dementia whose caregiver(s) were provided with education on dementia disease management and health behavior changes AND referred to additional resources for support within a 12 month period

**Numerator Statement:** Patients whose caregiver(s) were provided with education\* on dementia disease management and health behavior changes AND referred to additional resources for support within a 12 month period

\*Education should also include advising the caregiver that he or she is at “increased risk of serious illness (including circulatory and heart conditions and respiratory disease and hypertension), increased physician visits and use of prescription medications, emotional strain, anxiety, and depression.”(1)

There are a number of assessment tools available for the caregiver. These should be considered as an integral component of comprehensive caregiver education and support. The American Medical Association has developed a Caregiver Health Self-assessment Questionnaire to help caregivers analyze their own health-related behavior and health risks and, with their physician's help, make decisions that will benefit both the caregiver and the patient. This questionnaire is available at: <http://www.ama-assn.org/ama/pub/physician-resources/public-health/promoting-healthy-lifestyles/geriatric-health/caregiver-health/caregiver-self-assessment.shtml>

References:

1. California Workgroup on Guidelines for Alzheimer's Disease Management. Guidelines for Alzheimer's disease management. Los Angeles, CA: Alzheimer's Disease and Related Disorders Association, Inc., Los Angeles Chapter. 2008.

**Denominator Statement:** All patients, regardless of age, with a diagnosis of dementia

**Exclusions:** Documentation of medical reason(s) for not providing the caregiver with education on dementia disease management and health behavior changes or referring to additional sources for support (eg, patient does not have a caregiver, other medical reason)

**Adjustment/Stratification:** No risk adjustment or risk stratification No risk adjustment or risk stratification. We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

**Level of Analysis:** Clinician : Group/Practice, Clinician : Individual, Clinician : Team

**Type of Measure:** Process

**Data Source:** Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry

**Measure Steward:** American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) **Other organizations:** This measure set was developed in collaboration with the American Academy of Neurology (AAN), American Geriatrics Society (AGS), American Medical Directors Association (AMDA), and American Psychiatric Association (APA).

### STEERING COMMITTEE MEETING [10/4/2012]

**Importance to Measure and Report: The measure does not meet the Importance criteria**

(1a. High Impact: 1b. Performance Gap, 1c. Evidence)

1a. Impact: **NA**; 1b. Performance Gap: **NA**; 1c. Evidence: **Y-0; N-6; I-18**

**Rationale:**

- The evidence underlying this measure includes guideline recommendations from the APA and the California Work Group on Guidelines for Alzheimer's Disease and Management. Additional evidence was not provided by the measure developer.
- Committee members agreed that the submission did not demonstrate evidence to support a link between caregiver education and support and improved patient outcomes.

**2030: Dementia: Caregiver education and support**

**Steering Committee Recommendation for Endorsement: No**

- The measure did not pass the criterion of Importance to Measure and Report.

**Public & Member Comment**

Comments included:

- No comments were received for this measure. The developer did not request reconsideration.

**Committee response:** N/A

## Measures Withdrawn from Consideration

Two measures previously endorsed by NQF have been withdrawn from maintenance of endorsement. The following measures are being retired from endorsement:

Measure	Reason for retirement
<b>602: Adult(s) with frequent use of acute medications that also received prophylactic medications (Ingenix)</b>	Developer elected not to pursue maintenance of endorsement.
<b>644: Patients with a transient ischemic event ER visit that had a follow up office visit (Ingenix)</b>	Developer elected not to pursue maintenance of endorsement.

<sup>1</sup>Centers for Disease Control. Available at <http://www.cdc.gov/nchs/fastats/stroke.htm> Last accessed February 2012.

American Stroke Association. Available at [http://www.strokeassociation.org/STROKEORG/AboutStroke/About-Stroke\\_UCM\\_308529\\_SubHomePage.jsp](http://www.strokeassociation.org/STROKEORG/AboutStroke/About-Stroke_UCM_308529_SubHomePage.jsp) Last accessed February 2012

<sup>2</sup>The Internet Stroke Center. Available at <http://www.strokecenter.org/patients/about-stroke/stroke-statistics/> Last accessed February 2012

<sup>3</sup>American Stroke Association. Available at [http://www.strokeassociation.org/STROKEORG/AboutStroke/Impact-of-Stroke\\_UCM\\_310728\\_Article.jsp](http://www.strokeassociation.org/STROKEORG/AboutStroke/Impact-of-Stroke_UCM_310728_Article.jsp) Last accessed February 2012

<sup>4</sup>Centers for Disease Control. Available at [http://www.cdc.gov/mentalhealth/data\\_stats/alzheimers.htm](http://www.cdc.gov/mentalhealth/data_stats/alzheimers.htm)

<sup>5</sup>American Health Assistance Foundation. Available at <http://www.ahaf.org/alzheimers/about/understanding/facts.html> Last accessed February 2012

<sup>6</sup>Centers for Disease Control. Available at [http://www.cdc.gov/mentalhealth/data\\_stats/alzheimers.htm](http://www.cdc.gov/mentalhealth/data_stats/alzheimers.htm) Last accessed February 2012

Alzheimer's Association. Available at [http://www.alz.org/documents\\_custom/2011\\_Facts\\_Figures\\_Fact\\_Sheet.pdf](http://www.alz.org/documents_custom/2011_Facts_Figures_Fact_Sheet.pdf) Last accessed February 2012

<sup>7</sup>Centers for Disease Control. Available at [http://www.cdc.gov/epilepsy/basics/fast\\_facts.htm](http://www.cdc.gov/epilepsy/basics/fast_facts.htm)

<sup>8</sup>Parkinson's Disease Foundation. Available at [http://www.pdf.org/en/parkinson\\_statistics](http://www.pdf.org/en/parkinson_statistics) Last accessed February 2012

<sup>9</sup>National Multiple Sclerosis Society. Available at <http://www.nationalmssociety.org/about-multiple-sclerosis/what-we-know-about-ms/faqs-about-ms/index.aspx#howmany> Last accessed February 2012

<sup>10</sup>Centers for Disease Control. Available at [http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6005a1.htm?s\\_cid=ss6005a1\\_w](http://www.cdc.gov/mmwr/preview/mmwrhtml/ss6005a1.htm?s_cid=ss6005a1_w) Last accessed February 2012

Centers for Disease Control. Available at <http://www.cdc.gov/traumaticbraininjury/statistics.html> Last accessed February 2012

## Appendix A: Measure Specifications

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	<b>0507 Stenosis measurement in carotid imaging studies</b>
<b>Status</b>	Maintenance, Original Endorsement: Oct 28, 2008, Most Recent Endorsement: Oct 28, 2008
<b>Steward</b>	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) <b>Other organizations:</b> American Academy of Neurology American College of Radiology National Committee for Quality Assurance
<b>Description</b>	Percentage of final reports for carotid imaging studies (neck MR angiography [MRA], neck CT angiography [CTA], neck duplex ultrasound, carotid angiogram) performed that include direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement
<b>Type</b>	Process
<b>Data Source</b>	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry Not applicable
<b>Level</b>	Clinician : Group/Practice, Clinician : Individual, Clinician : Team
<b>Setting</b>	Hospital/Acute Care Facility, Imaging Facility
<b>Numerator Statement</b>	Final carotid imaging study reports that include direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement
<b>Numerator Details</b>	<b>Time Window:</b> Each final report for carotid imaging studies performed during a 12 month period.  Definition: “Direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement” – includes direct angiographic stenosis calculation based on the distal lumen as the denominator for stenosis measurement OR an equivalent validated method referenced to the above method (e.g., for duplex ultrasound studies, velocity parameters that correlate with anatomic measurements that use the distal internal carotid lumen as the denominator for stenosis measurement) Numerator Instructions: This measure requires that the estimate of stenosis included in the report of the imaging study employ a method such as the North American Symptomatic Carotid Endarterectomy Trial (NASCET) method for calculating the degree of stenosis. The NASCET method calculates the degree of stenosis with reference to the lumen of the carotid artery distal to the stenosis. EHR Specifications: eMeasure developed – see attached Claims Specifications: CPT II 3100F: Carotid image study report includes direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement
<b>Denominator Statement</b>	All final reports for carotid imaging studies (neck MR angiography [MRA], neck CT angiography [CTA], neck duplex ultrasound, carotid angiogram) performed

<b>0507 Stenosis measurement in carotid imaging studies</b>	
<b>Denominator Details</b>	<p><b>Time Window:</b> Each final report for carotid imaging studies performed during a 12 month period.</p> <p>EHR Specifications: eMeasure developed – see attached</p> <p>Claims Specifications: Patient encounter during the reporting period (CPT): 70498, 70547, 70548, 70549, 75660, 75662, 75665, 75671, 75676, 75680, 93880, 93882</p>
<b>Exclusions</b>	None
<b>Exclusion Details</b>	None
<b>Risk Adjustment</b>	<p>No risk adjustment or risk stratification</p> <p>Not applicable</p>
<b>Stratification</b>	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
<b>Type Score</b>	Rate/proportion    better quality = higher score
<b>Algorithm</b>	<p>To calculate performance rates:</p> <ol style="list-style-type: none"> <li>1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address).</li> <li>2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical.</li> <li>3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator</li> </ol> <p>If the patient does not meet the numerator, this case represents a quality failure.</p> <p>Calculation algorithm is included in data dictionary/code table attachment (2a1.30).</p>
<b>Copyright/Disclaimer</b>	<p>Physician Performance Measures (Measures) and related data specifications have been developed by the American Medical Association (AMA) in collaboration with the Physician Consortium for Performance Improvement (the Consortium) and the National Committee for Quality Assurance (NCQA).</p> <p>These performance Measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications.</p> <p>The Measures, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and the AMA, (on behalf of the Consortium) or NCQA. Neither the AMA, NCQA, Consortium nor its members shall be responsible for any use of the Measures.</p> <p>THE MEASURES AND SPECIFICATIONS ARE PROVIDED “AS IS” WITHOUT WARRANTY OF ANY KIND.</p> <p>© 2007 American Medical Association and National Committee for Quality Assurance. All Rights Reserved.</p> <p>Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA, NCQA, the Consortium and its members disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications.</p> <p>CPT® contained in the Measures specifications is copyright 2006 American Medical Association.</p> <p>© 2007 American Medical Association and National Committee for Quality Assurance. All Rights Reserved.</p> <p>CPT® Copyright 2006 American Medical Association</p> <p>See copyright statement above.</p>

1814 Counseling for Women of Childbearing Potential with Epilepsy	
<b>Status</b>	New Submission <b>Time-limited</b>
<b>Steward</b>	American Academy of Neurology <b>Other organizations:</b> AMA convened Physician Consortium for Performance Improvement-measurement set was developed through the PCPI Independent Measure Development Process
<b>Description</b>	All female patients of childbearing potential (12–44 years old) diagnosed with epilepsy who were counseled about epilepsy and how its treatment may affect contraception and pregnancy at least once a year
<b>Type</b>	Process
<b>Data Source</b>	Administrative claims, Electronic Clinical Data : Electronic Health Record Counseling for Women of Childbearing Potential with Epilepsy Collection Sheet from the AMA PCPI <a href="http://www.physicianconsortium.org">www.physicianconsortium.org</a> NeuroPI Program: for maintenance of certification Performance in Practice module. <a href="http://www.aan.com/practice/pip">www.aan.com/practice/pip</a> CECity PQRS Wizard and registry (in development) Physician Quality Reporting System measurement set Patients Like Me website: patient report of physician use of the quality measure URL <a href="http://www.ama-assn.org/ama1/pub/upload/mm/pqrs/2012-measure268-worksheet.pdf">http://www.ama-assn.org/ama1/pub/upload/mm/pqrs/2012-measure268-worksheet.pdf</a> <a href="http://www.aan.com/globals/axon/assets/9079.pdf">http://www.aan.com/globals/axon/assets/9079.pdf</a> <a href="http://www.aan.com">www.aan.com</a>
<b>Level</b>	Clinician : Individual
<b>Setting</b>	Ambulatory Care : Clinician Office/Clinic,
<b>Numerator Statement</b>	Female patients counseled about epilepsy and how its treatment may affect contraception and pregnancy and documented in the medical record at least once a year.
<b>Numerator Details</b>	<b>Time Window:</b> At least once a year (typically within a 12 month reporting period) CPT II 4340F: Counseling for women of childbearing potential with epilepsy
<b>Denominator Statement</b>	All females of childbearing potential (12-44 years old) with a diagnosis of epilepsy.
<b>Denominator Details</b>	<b>Time Window:</b> At least once a year (typically at least once during a 12 month reporting period)  Epilepsy ICD-9-CM diagnosis codes n 345.00, 345.01, 345.10, 345.11, 345.40. 345.41, 345.50, 345.51, 345.60, 345.61, 345.70, 345.71, 345.90, 345.91 AND CPT codes 99201, 99202, 99203, 99204, 99205 99212, 99213, 99214, 99215 99304, 99305, 99306, 99307, 99308, 99309
<b>Exclusions</b>	Medical reasons (eg, not indicated, contraindicated, other medical reason)
<b>Exclusion Details</b>	CPT II 4340F–1P: Documentation of medical reason(s) why counseling was not performed for women of childbearing potential with epilepsy CPT II 4340F–8P: Counseling about epilepsy specific safety issues provided to patient or caregiver was not performed, reason not otherwise specified
<b>Risk Adjustment</b>	N/a
<b>Stratification</b>	

	<b>1814 Counseling for Women of Childbearing Potential with Epilepsy</b>
<b>Type Score</b>	
<b>Algorithm</b>	
<b>Copyright/Disclaimer</b>	<p>©2009 American Academy of Neurology. All rights reserved.</p> <p>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.</p> <p>Measures are subject to review and may be revised or rescinded at any time by the AAN. The measures may not be altered without prior written approval from the AAN. The measures, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes (e.g. use by health care providers in connection with their practices). Commercial use is defined as the sale, license, or distribution of the measures for commercial gain, or incorporation of the measures into a product or service that is sold, licensed, or distributed for commercial gain. Commercial uses of the measures require a license agreement between the user and the AAN. Neither the AAN nor its members shall be responsible for any use of the measures.</p> <p>THESE MEASURES AND SPECIFICATIONS ARE PROVIDED “AS IS” WITHOUT WARRANTY OF ANY KIND.</p> <p>Limited proprietary coding is contained in the measure specifications for convenience. Users of the proprietary coding sets should obtain all necessary licenses from the owners of these code sets. The AAN and its members disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications.</p>



2091 Persistent Indicators of Dementia without a Diagnosis—Long Stay	
<b>Status</b>	New Submission
<b>Steward</b>	American Medical Directors Association
<b>Description</b>	Percentage of nursing home residents age 65+ with persistent indicators of dementia and no diagnosis of dementia.
<b>Type</b>	Process
<b>Data Source</b>	Electronic Clinical Data MDS 3.0 resident assessment instrument. Section A0310 A Type of Assessment will capture the type of assessment. A0310.A. Federal OBRA Reason for Assessment. 01. Admission assessment (required by day 14). 02. Quarterly review assessment. 03. Annual assessment. 04. Significant change in status assessment. 05. Significant correction to prior comprehensive assessment. 06. Significant correction to prior quarterly assessment. 99. Not OBRA required assessment.
<b>Level</b>	Facility
<b>Setting</b>	Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility
<b>Numerator Statement</b>	Number of adult patients 65 and older who are included in the denominator (i.e., have persistent signs and symptoms of dementia) and who do not have a diagnosis of dementia on any MDS assessment within the last 12 months.
<b>Numerator Details</b>	<p><b>Time Window:</b> Time Window: The numerator is based on the number of long-stay nursing facility residents who are included in the denominator and who do not have a diagnosis of dementia (defined below) on any MDS assessment in the last 12 months which may be an admission, annual, quarterly, significant change, significant correction or discharge assessment. Long stay includes all residents in an episode whose cumulative days in the facility is greater than or equal to 101 days at the end of the target period. Target date -The event date for an MDS record, defined as follows: For an entry record (A0310F = [01]), the target date is equal to the entry date (A1600). For a discharge record (A0310F = [10, 11]) or death-in-facility record (A0310F = [12]), the target date is equal to the discharge date (A2000). For all other records, the target date is equal to the assessment reference date (A2300).</p> <p>Resident is included in the numerator if the resident does not have a diagnosis of dementia on any assessment within one year of the most recent target assessment date coded as:</p> <ol style="list-style-type: none"> <li>Section I on the MDS, under Neurological, I4200 Alzheimer’s Disease = 0 and I4800 Dementia = 0. I4800 includes non-Alzheimer’s dementia such as vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as Pick’s disease; and dementia related to stroke; Parkinson’s or Creutzfeldt-Jakob disease.</li> <li>Section I0800 a-j does not include one of following ICD-9 –CM Diagnosis Code for dementia:  290 Dementias  290.0 Senile dementia, uncomplicated  290.1 Presenile dementia  290.10 Presenile dementia, uncomplicated  290.11 Presenile dementia with delirium  290.12 Presenile dementia with delusional features  290.13 Presenile dementia with depressive features  290.2 Senile dementia with delusional or depressive features  290.20 Senile dementia with delusional features  290.21 Senile dementia with depressive features  290.3 Senile dementia with delirium  290.4 Vascular dementia  290.40 Vascular dementia, uncomplicated  290.41 Vascular dementia with delirium  290.42 Vascular dementia with delusions  290.43 Vascular dementia with depressed mood</li> </ol>

<b>2091 Persistent Indicators of Dementia without a Diagnosis—Long Stay</b>	
	290.8 Other specified senile psychotic conditions 290.9 Unspecified senile psychotic condition 294 Dementia in conditions classified elsewhere 294.10 Dementia in conditions classified elsewhere without behavioral disturbance 294.11 Dementia in conditions classified elsewhere with behavioral disturbance 294.8 Other persistent mental disorders due to conditions classified elsewhere 294.9 Unspecified persistent mental disorders due to conditions classified elsewhere 331 Other cerebral degenerations 331.0 Alzheimer’s disease 331.1 Frontotemporal dementia 331.11 Pick’s disease 331.19 Other frontotemporal dementia 331.2 Senile degeneration of brain 331.3 Communicating hydrocephalus 331.4 Obstructive hydrocephalus 331.7 Cerebral degeneration in diseases classified elsewhere 331.8 Other cerebral degeneration 331.82 Dementia with Lewy bodies
<b>Denominator Statement</b>	<p>The denominator is the total of all long-stay residents in the nursing facility who have at least two MDS assessments which may be an admission annual, quarterly, significant change or significant correction assessment during the selected quarter and who do not meet the exclusion criteria.</p> <p>The denominator includes (i) residents with Section C Brief Interview for Mental Status (BIMS) score &lt;8 on most recent target assessment and a BIMS &lt; 8 on the prior assessment; or (ii) residents with a staff assessment for cognitive status on both the most recent target assessment and the prior assessment that shows severe cognitive impairment.</p>
<b>Denominator Details</b>	<p><b>Time Window:</b> Time Window: Denominator data come from MDS 3.0 annual, quarterly, significant change or significant correction MDS, assessments conducted during each quarter (3-month period).</p> <p>Residents are included in the denominator if they meet any of the following criteria:</p> <ol style="list-style-type: none"> <li>Section C Cognitive Patterns CO100 = 1 (yes) and BIMS is completed. The BIMS is a validated cognitive screening tool now embedded in the new Minimum Data Set (MDS) 3.0 resident assessment tool used for all nursing home patients nationwide and is thus readily available. The BIMS is the accepted tool for evaluating cognitive status in the long term care population, including by the Centers for Medicare and Medicaid Services (CMS). Residents with BIMS score &lt;8 are considered to have severe cognitive impairment and should be evaluated for dementia.</li> </ol> <p>Resident is included in the denominator if C0500 = 0 – 7 (BIMS summary score) on both the target and prior assessment (i.e. on two consecutive assessments).</p> <ol style="list-style-type: none"> <li>If C0500 = missing, the resident is unable to complete the BIMS interview (CO100 = 0) and C600 = 1 (resident was unable to conduct BIMS interview and staff conduct interview for cognitive status). In this case, resident is included in denominator if resident meets CMS definition of severe cognitive impairment based on staff assessment on both most recent and target assessment (i.e., on two consecutive assessments): C0700 = 1 (short term memory problem) and C1000 Cognitive Skills for Daily Decision Making &gt; 0 (1 = Modified independence - some difficulty in new situations only. 2 = Moderately impaired - decisions poor; cues/supervision required. 3 = Severely impaired - never/rarely made decisions).</li> </ol>
<b>Exclusions</b>	<p>Residents who are hospice or end of life, or who are comatose or with delirium, or with psychotic disorders including hallucinations, anxiety disorder, manic depressive disease, post-traumatic stress disorder, bipolar disorder or schizophrenia will be excluded from the denominator.</p>
<b>Exclusion Details</b>	<ol style="list-style-type: none"> <li>Exclude if resident is comatose (B0100 = 1) on target and/or prior assessment.</li> <li>Exclude if resident is in Hospice (00100K2 = 1) and/or diagnosed as end of life (J1400 Prognosis =1) on</li> </ol>

<b>2091 Persistent Indicators of Dementia without a Diagnosis—Long Stay</b>	
	<p>target or prior assessment.</p> <p>3. Exclude residents with Delirium as measured by Section C1300 Residents with delirium (from CAM©). Residents with If C1300 &gt; 0 on target or prior assessment are excluded from denominator.</p> <p>4. Exclude residents with one or more psychotic disorders, including (i) residents with E0100 Psychosis &gt;= 1 (E0100A hallucinations = 1 or E0100B delusions = 1) or (ii) Residents with Section I5700 Anxiety Disorder = 1 or I5800 Depression (other than bipolar) = 1 or I5900 Manic Depression (bipolar disease) = 1 or I5950 Psychotic Disorder (other than schizophrenia) = 1 or I6000 Schizophrenia (e.g., schizoaffective and schizophreniform disorders) = 1 or I6100 Post Traumatic Stress Disorder (PTSD) = 1 or Section I0800 a-j includes one or more of ICD-9 Codes: I3a-e = 295.00-295.9; 297.00-298.9 (Types of schizophrenia) or schizophrenia (I1gg = 1) or manic depressive disease [ICD-9 Codes: I3a-e = 296.00-296.9 or I1ff = 1] or Total Brain Injury [ICD-9 code 854.0] or Encephalopathy [ICD-9 code 348.30] on target or prior assessment</p> <p>5. Exclude residents with severe depression as measured by PHQ9 total severity score range 20 – 27 or PHQ9-OV (staff assessment) total severity score range 20 - 30. If D0300 &gt;= 20 on target and/or prior assessment, exclude resident from denominator or if D0600 &gt;= 20 on target or prior assessment exclude resident from denominator.</p>
<b>Risk Adjustment</b>	No risk adjustment or risk stratification
<b>Stratification</b>	N/A
<b>Type Score</b>	Rate/proportion better quality = lower score
<b>Algorithm</b>	<p>Denominator Algorithm Narrative for Long-Stay Nursing Facility: Measure Population</p> <p>Denominator: Number of all long-stay residents in the nursing facility that has at least two MDS assessments which may be an admission annual, quarterly, significant change or significant correction assessment during the selected quarter and who do not meet the exclusion criteria.</p> <ol style="list-style-type: none"> <li>1. Start Long-Stay Nursing Facility Population Logic (cases eligible for Persistent Indicators of Dementia without a Diagnosis Measure Set)</li> <li>2. Process all cases of long-stay nursing facility residents who have at least two MDS assessments</li> <li>3. Check Resident Impairment Status <ol style="list-style-type: none"> <li>a. If the resident received a BIMS summary score =8 on two consecutive assessments (i.e. the most recent and prior target assessments) or did not meet CMS' definition of severe cognitive impairment on two consecutive staff assessments (i.e. the most recent and prior target assessments), Then the patient is not eligible to be sampled for the Persistent Indicators of Dementia without a Diagnosis Measure Set. Set the Long-Stay Nursing Facility Population Reject Case Flag to YES. Stop processing case.</li> <li>b. If the resident received a BIMS summary score &lt;8 on two consecutive assessments (i.e. the most recent and prior target assessments) or met CMS' definition of severe cognitive impairment on two consecutive staff assessments (i.e. the most recent and prior target assessments), Then continue processing and proceed to Check for Comatose</li> </ol> </li> <li>4. Check for Comatose <ol style="list-style-type: none"> <li>a. If the resident received a 1 for comatose on the MDS assessment tool, Then the patient is not eligible to be sampled for the Persistent Indicators of Dementia without a Diagnosis Measure Set. Set the Long-Stay Nursing Facility Population Reject Case Flag to YES. Stop processing case.</li> <li>b. If the resident received a 0 for comatose on the MDS assessment tool, Then continue processing and proceed to Check for Hospice</li> </ol> </li> <li>5. Check for Hospice <ol style="list-style-type: none"> <li>a. If the resident received a 1 for hospice on the MDS assessment tool, Then the patient is not eligible to be sampled for the Persistent Indicators of Dementia without a Diagnosis Measure Set. Set the Long-Stay Nursing Facility Population Reject Case Flag to YES. Stop processing case.</li> <li>b. If the resident received a 0 for hospice on the MDS assessment tool, Then continue processing and proceed to Check Delirium Score</li> </ol> </li> <li>6. Check Delirium Score</li> </ol>

**2091 Persistent Indicators of Dementia without a Diagnosis—Long Stay**

a. If the resident received a delirium score >0 (from CAM©), Then the patient is not eligible to be sampled for the Persistent Indicators of Dementia without a Diagnosis Measure Set. Set the Long-Stay Nursing Facility Population Reject Case Flag to YES. Stop processing case.

b. If the resident received a delirium score = 0 (from CAM©), Then continue processing and proceed to Check Psychosis Score

7. Check Psychosis Score

a. If the resident received a psychosis score >=1 on the MDS assessment tool, Then the patient is not eligible to be sampled for the Persistent Indicators of Dementia without a Diagnosis Measure Set. Set the Long-Stay Nursing Facility Population Reject Case Flag to YES. Stop processing case.

b. If the resident received a psychosis score = 0 on the MDS assessment tool, Then continue processing and proceed to Check ICD-9 CM Code

8. Check ICD-9 CM Code

a. If the resident received an ICD-9 CM Code = 295.00-295.9; 296.00-296.9; or 297.00-298.9 on the MDS assessment tool, Then the patient is not eligible to be sampled for the Persistent Indicators of Dementia without a Diagnosis Measure Set. Set the Long-Stay Nursing Facility Population Reject Case Flag to YES. Stop processing case.

b. If the resident did not receive an ICD-9 CM Code = 295.00-295.9; 296.00-296.9; or 297.00-298.9 on the MDS assessment tool, Then continue processing and proceed to Check for Severe Depression

9. Check for Severe Depression

a. If the resident received a severe depression total severity score range from 20-27 on the MDS assessment tool, Then the patient is not eligible to be sampled for the Persistent Indicators of Dementia without a Diagnosis Measure Set. Set the Long-Stay Nursing Facility Population Reject Case Flag to YES. Stop processing case.

b. If the resident did not receive a severe depression total severity score range from 20-27 on the MDS assessment tool, Then continue processing and proceed to Calculate Patient Age

10. Calculate Patient Age on Encounter Date (in years)

11. Check Patient Age

a. If the resident age <65 years, Then the patient is not eligible to be sampled for the Persistent Indicators of Dementia without a Diagnosis Measure Set. Set the Long-Stay Nursing Facility Population Reject Case Flag to YES. Stop processing case.

b. If the resident age =65 years, Then the patient is eligible to be sampled for the Persistent Indicators of Dementia without a Diagnosis Measure Set and in the Long-Stay Nursing Facility Population. Set the Long-Stay Nursing Facility Population Reject Case Flag to NO. Stop processing case and Return to Data Processing Flow (date transmission section).

Numerator Algorithm Narrative for Persistent Indicators of Dementia without a Diagnosis—Long Stay  
 Numerator: Number of adult patients 65 and older who are included in the denominator (i.e., have persistent signs and symptoms of dementia) and who do not have a diagnosis of dementia on any MDS assessment within the last 12 months.

1. Start

2. Run cases that are included in the Long-Stay Nursing Facility Population Algorithm and passed the edit defined in the Data Processing Flow through this measure. Proceed to ICD-9 CM Diagnosis Code

3. Check ICD-9 CM Diagnosis Code

a. If the resident received an ICD-9 CM Diagnosis Code for Dementia on the MDS assessment tool in the last 12 months, Then the case will not be in the numerator population. Stop processing case.

b. If the resident did not receive an ICD-9 CM Diagnosis Code for Dementia on the MDS assessment tool in the last 12 months, Then the case will be in the numerator population. Stop processing case.

Quality Measure (QM) Calculation  
 Percent of Residents with Persistent Indicators of Dementia without a Diagnosis—Long Stay = (Numerator / Denominator)\*100 Attachment Persistent\_Indicators\_of\_Dementia\_without\_a\_Diagnosis\_FlowChart\_7\_12\_12\_v.0.0.1-1--1-.pdf

	2091 Persistent Indicators of Dementia without a Diagnosis—Long Stay
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2092 Persistent Indicators of Dementia without a Diagnosis—Short Stay	
<b>Status</b>	New Submission
<b>Steward</b>	American Medical Directors Association
<b>Description</b>	Number of adult patients 65 and older who are included in the denominator (i.e., have persistent signs and symptoms of dementia) and who do not have a diagnosis of dementia on any MDS assessment.
<b>Type</b>	Process
<b>Data Source</b>	Electronic Clinical Data MDS 3.0 resident assessment instrument. Section A0310 Type of Assessment will capture the type of assessment. A0310.B. PPS Assessment. PPS Scheduled Assessments for a Medicare Part A Stay. 01. 5-day scheduled assessment. 02. 14-day scheduled assessment. 03. 30-day scheduled assessment. 04. 60-day scheduled assessment. 05. 90-day scheduled assessment. 06. Readmission/return assessment.
<b>Level</b>	Facility
<b>Setting</b>	Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility
<b>Numerator Statement</b>	Number of adult patients 65 and older who are included in the denominator (i.e., have persistent signs and symptoms of dementia) and who do not have a diagnosis of dementia on any MDS assessment.
<b>Numerator Details</b>	<p><b>Time Window:</b> Time Window: The numerator is based on the number of short-stay nursing facility residents who are included in the denominator and who do not have a diagnosis of dementia (defined below) on any PPS Scheduled Assessment completed as part of a Medicare Part A Stay (A0310B is 5-day, 14-day, 30-day, 60-day, 90-day or readmission/return).</p> <p>Included in the numerator are short-stay residents who meet the criteria on the target MDS 3.0 assessment [A0310.B=1,2,3,4,5,6,7]. Resident is included in the numerator if the resident does not have a diagnosis of dementia on the target assessment or any prior PPS assessment completed within 100 days of the most recent target assessment date coded as:</p> <ol style="list-style-type: none"> <li>Section I on the MDS, under Neurological, I4200 Alzheimer’s Disease = 0 and I4800 Dementia = 0. I4800 includes non-Alzheimer’s dementia such as vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as Pick’s disease; and dementia related to stroke; Parkinson’s or Creutzfeldt-Jakob disease.</li> <li>Section I0800 a-j does not include one of following ICD-9 –CM Diagnosis Code for dementia: <ul style="list-style-type: none"> <li>290 Dementias</li> <li>290.0 Senile dementia, uncomplicated</li> <li>290.1 Presenile dementia</li> <li>290.10 Presenile dementia, uncomplicated</li> <li>290.11 Presenile dementia with delirium</li> <li>290.12 Presenile dementia with delusional features</li> <li>290.13 Presenile dementia with depressive features</li> <li>290.2 Senile dementia with delusional or depressive features</li> <li>290.20 Senile dementia with delusional features</li> <li>290.21 Senile dementia with depressive features</li> <li>290.3 Senile dementia with delirium</li> <li>290.4 Vascular dementia</li> <li>290.40 Vascular dementia, uncomplicated</li> <li>290.41 Vascular dementia with delirium</li> <li>290.42 Vascular dementia with delusions</li> <li>290.43 Vascular dementia with depressed mood</li> <li>290.8 Other specified senile psychotic conditions</li> <li>290.9 Unspecified senile psychotic condition</li> <li>294 Dementia in conditions classified elsewhere</li> <li>294.10 Dementia in conditions classified elsewhere without behavioral disturbance</li> <li>294.11 Dementia in conditions classified elsewhere with behavioral disturbance</li> </ul> </li> </ol>

2092 Persistent Indicators of Dementia without a Diagnosis—Short Stay	
	294.8 Other persistent mental disorders due to conditions classified elsewhere 294.9 Unspecified persistent mental disorders due to conditions classified elsewhere 331 Other cerebral degenerations 331.0 Alzheimer’s disease 331.1 Frontotemporal dementia 331.11 Pick’s disease 331.19 Other frontotemporal dementia 331.2 Senile degeneration of brain 331.3 Communicating hydrocephalus 331.4 Obstructive hydrocephalus 331.7 Cerebral degeneration in diseases classified elsewhere 331.8 Other cerebral degeneration 331.82 Dementia with Lewy bodies
<b>Denominator Statement</b>	<p>The denominator is the total of all short-stay residents in the nursing facility who have at least two MDS PPS assessments (A0310 = 01. 5-day scheduled assessment or 02. 14-day scheduled assessment or 03. 30-day scheduled assessment or 04. 60-day scheduled assessment or 05. 90-day scheduled assessment or 06. Readmission/return assessment), and who do not meet the exclusion criteria.</p> <p>The denominator includes (i) residents with Section C Brief Interview for Mental Status (BIMS) score &lt;8 on most recent target assessment and a BIMS &lt; 8 on the prior assessment; or (ii) residents with a staff assessment for cognitive status on both the most recent target assessment and the prior assessment that shows severe cognitive impairment.</p>
<b>Denominator Details</b>	<p><b>Time Window:</b> Time Window: Denominator data come from MDS 3.0 PPS assessments completed as part of a Medicare Part A stay. Residents are counted if they are short-stay residents, defined as residents whose length of stay is less than or equal to 100 days. The short-stay sample includes residents meeting any of the following conditions: PPS assessment with A0310.B=1,2,3,4,5,6,7.</p> <p>Residents are included in the denominator if they meet any of the following criteria:</p> <ol style="list-style-type: none"> <li>Section C Cognitive Patterns CO100 = 1 (yes) and BIMS is completed. The BIMS is a validated cognitive screening tool now embedded in the new Minimum Data Set (MDS) 3.0 resident assessment tool used for all nursing home patients nationwide and is thus readily available. The BIMS is the accepted tool for evaluating cognitive status in the long term care population, including by the Centers for Medicare and Medicaid Services (CMS). Residents with BIMS score &lt;8 are considered to have severe cognitive impairment and should be evaluated for dementia.</li> </ol> <p>Resident is included in the denominator if C0500 = 0 – 7 (BIMS summary score) on both the target and prior assessment (i.e. on two consecutive PPS assessments).</p> <ol style="list-style-type: none"> <li>If C0500 = missing, the resident is unable to complete the BIMS interview (CO100 = 0) and C600 = 1 (resident was unable to conduct BIMS interview and staff conduct interview for cognitive status). In this case, resident is included in denominator if resident meets CMS definition of severe cognitive impairment based on staff assessment on both most recent and target assessment (i.e., on two consecutive assessments): C0700 = 1 (short term memory problem) and C1000 Cognitive Skills for Daily Decision Making &gt; 0 (1 = Modified independence - some difficulty in new situations only. 2 = Moderately impaired -decisions poor; cues/supervision required. 3 = Severely impaired - never/rarely made decisions).</li> </ol>
<b>Exclusions</b>	Residents who are hospice or end of life, or who are comatose or with delirium, manic depressive disease, bipolar disorder or schizophrenia will be excluded from the denominator.
<b>Exclusion Details</b>	<ol style="list-style-type: none"> <li>Exclude if resident is comatose (B0100 = 1) on target and/or prior assessment.</li> <li>Exclude if resident is in Hospice (00100K2 = 1) and/or diagnosed as end of life (J1400 Prognosis =1) on target or prior PPS assessment.</li> <li>Exclude residents with Delirium as measured by Section C1300 Residents with delirium (from CAM©). Residents with If C1300 &gt; 0 on target or prior PPS assessment are excluded from denominator.</li> </ol>

<b>2092 Persistent Indicators of Dementia without a Diagnosis—Short Stay</b>	
	<p>4. Exclude residents with one or more psychotic disorders, including (i) residents with E0100 Psychosis <math>\geq</math> 1 (E0100A hallucinations = 1 or E0100B delusions = 1) or (ii) Residents with Section I5700 Anxiety Disorder = 1 or I5800 Depression (other than bipolar) = 1 or I5900 Manic Depression (bipolar disease) = 1 or I5950 Psychotic Disorder (other than schizophrenia) = 1 or I6000 Schizophrenia (e.g., schizoaffective and schizophreniform disorders) = 1 or I6100 Post Traumatic Stress Disorder (PTSD) = 1 or Section I0800 a-j includes one or more of ICD-9 Codes: I3a-e = 295.00-295.9; 297.00-298.9 (Types of schizophrenia) or schizophrenia (I1gg = 1) or manic depressive disease [ICD-9 Codes: I3a-e = 296.00-296.9 or I1ff = 1] or Total Brain Injury [ICD-9 code 854.0] or Encephalopathy [ICD-9 code 348.30] on target or prior PPS assessment</p> <p>5. Exclude residents with severe depression as measured by PHQ9 total severity score range 20 – 27 or PHQ9-OV (staff assessment) total severity score range 20 - 30. If D0300 <math>\geq</math> 20 on target and/or prior assessment, exclude resident from denominator or if D0600 <math>\geq</math> 20 on target or prior assessment exclude resident from denominator.</p>
<b>Risk Adjustment</b>	No risk adjustment or risk stratification NA
<b>Stratification</b>	
<b>Type Score</b>	
<b>Algorithm</b>	<p>Denominator Algorithm Narrative for Short-Stay Nursing Facility: Measure Population</p> <p>Denominator: Number of all Short-stay residents in the nursing facility that has at least two MDS assessments which may be an admission annual, quarterly, significant change or significant correction assessment during the selected quarter and who do not meet the exclusion criteria.</p> <ol style="list-style-type: none"> <li>1. Start Short-Stay Nursing Facility Population Logic (cases eligible for Persistent Indicators of Dementia without a Diagnosis Measure Set)</li> <li>2. Process all cases of Short-stay nursing facility residents who have at least two MDS assessments</li> <li>3. Check Resident Impairment Status <ol style="list-style-type: none"> <li>a. If the resident received a BIMS summary score <math>\geq</math>8 on two consecutive assessments (i.e. the most recent and prior target assessments) or did not meet CMS’ definition of severe cognitive impairment on two consecutive staff assessments (i.e. the most recent and prior target assessments), Then the patient is not eligible to be sampled for the Persistent Indicators of Dementia without a Diagnosis Measure Set. Set the Short-Stay Nursing Facility Population Reject Case Flag to YES. Stop processing case.</li> <li>b. If the resident received a BIMS summary score <math>&lt;</math>8 on two consecutive assessments (i.e. the most recent and prior target assessments) or met CMS’ definition of severe cognitive impairment on two consecutive staff assessments (i.e. the most recent and prior target assessments), Then continue processing and proceed to Check for Comatose</li> </ol> </li> <li>4. Check for Comatose <ol style="list-style-type: none"> <li>a. If the resident received a 1 for comatose on the MDS assessment tool, Then the patient is not eligible to be sampled for the Persistent Indicators of Dementia without a Diagnosis Measure Set. Set the Short-Stay Nursing Facility Population Reject Case Flag to YES. Stop processing case.</li> <li>b. If the resident received a 0 for comatose on the MDS assessment tool, Then continue processing and proceed to Check for Hospice</li> </ol> </li> <li>5. Check for Hospice <ol style="list-style-type: none"> <li>a. If the resident received a 1 for hospice on the MDS assessment tool, Then the patient is not eligible to be sampled for the Persistent Indicators of Dementia without a Diagnosis Measure Set. Set the Short-Stay Nursing Facility Population Reject Case Flag to YES. Stop processing case.</li> <li>b. If the resident received a 0 for hospice on the MDS assessment tool, Then continue processing and proceed to Check Delirium Score</li> </ol> </li> <li>6. Check Delirium Score <ol style="list-style-type: none"> <li>a. If the resident received a delirium score <math>&gt;</math>0 (from CAM©), Then the patient is not eligible to be sampled for the Persistent Indicators of Dementia without a Diagnosis Measure Set. Set the Short-Stay Nursing</li> </ol> </li> </ol>



**2092 Persistent Indicators of Dementia without a Diagnosis—Short Stay**

Facility Population Reject Case Flag to YES. Stop processing case.

b. If the resident received a delirium score = 0 (from CAM©), Then continue processing and proceed to Check Psychosis Score

7. Check Psychosis Score

a. If the resident received a psychosis score  $\geq 1$  on the MDS assessment tool, Then the patient is not eligible to be sampled for the Persistent Indicators of Dementia without a Diagnosis Measure Set. Set the Short-Stay Nursing Facility Population Reject Case Flag to YES. Stop processing case.

b. If the resident received a psychosis score = 0 on the MDS assessment tool, Then continue processing and proceed to Check ICD-9 CM Code

8. Check ICD-9 CM Code

a. If the resident received an ICD-9 CM Code = 295.00-295.9; 296.00-296.9; or 297.00-298.9 on the MDS assessment tool, Then the patient is not eligible to be sampled for the Persistent Indicators of Dementia without a Diagnosis Measure Set. Set the Short-Stay Nursing Facility Population Reject Case Flag to YES. Stop processing case.

b. If the resident did not receive an ICD-9 CM Code = 295.00-295.9; 296.00-296.9; or 297.00-298.9 on the MDS assessment tool, Then continue processing and proceed to Check for Severe Depression

9. Check for Severe Depression

a. If the resident received a severe depression total severity score range from 20-27 on the MDS assessment tool, Then the patient is not eligible to be sampled for the Persistent Indicators of Dementia without a Diagnosis Measure Set. Set the Short-Stay Nursing Facility Population Reject Case Flag to YES. Stop processing case.

b. If the resident did not receive a severe depression total severity score range from 20-27 on the MDS assessment tool, Then continue processing and proceed to Calculate Patient Age

10. Calculate Patient Age on Encounter Date (in years)

11. Check Patient Age

a. If the resident age  $< 65$  years, Then the patient is not eligible to be sampled for the Persistent Indicators of Dementia without a Diagnosis Measure Set. Set the Short-Stay Nursing Facility Population Reject Case Flag to YES. Stop processing case.

b. If the resident age  $= 65$  years, Then the patient is eligible to be sampled for the Persistent Indicators of Dementia without a Diagnosis Measure Set and in the Short-Stay Nursing Facility Population. Set the Short-Stay Nursing Facility Population Reject Case Flag to NO. Stop processing case and Return to Data Processing Flow (date transmission section).

Numerator Algorithm Narrative for Persistent Indicators of Dementia without a Diagnosis—Short Stay

Numerator: Number of adult patients 65 and older who are included in the denominator (i.e., have persistent signs and symptoms of dementia) and who do not have a diagnosis of dementia on any MDS assessment within the last 12 months.

1. Start

2. Run cases that are included in the Short-Stay Nursing Facility Population Algorithm and passed the edit defined in the Data Processing Flow through this measure. Proceed to ICD-9 CM Diagnosis Code

3. Check ICD-9 CM Diagnosis Code

a. If the resident received an ICD-9 CM Diagnosis Code for Dementia on the MDS assessment tool in the last 12 months, Then the case will not be in the numerator population. Stop processing case.

b. If the resident did not receive an ICD-9 CM Diagnosis Code for Dementia on the MDS assessment tool in the last 12 months, Then the case will be in the numerator population. Stop processing case.

Quality Measure (QM) Calculation

Percent of Residents with Persistent Indicators of Dementia without a Diagnosis—Short Stay =  $(\text{Numerator} / \text{Denominator}) * 100$  Attachment

Persistent\_Indicators\_of\_Dementia\_without\_a\_Diagnosis\_FlowChart\_\_short\_stay-7\_12\_12-\_v.0.0.1-1-.pdf

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<b>2111 Antipsychotic Use in Persons with Dementia</b>	
<b>Status</b>	New Submission
<b>Steward</b>	Pharmacy Quality Alliance
<b>Description</b>	The percentage of individuals 65 years of age and older with dementia who are receiving an antipsychotic medication without evidence of a psychotic disorder or related condition.
<b>Type</b>	Process
<b>Data Source</b>	Administrative claims Health Plan Medical and Pharmacy Claims. Health Plan member enrollment information.
<b>Level</b>	Health Plan
<b>Setting</b>	Post Acute/Long Term Care Facility : Nursing Home/Skilled Nursing Facility, Other, Pharmacy
<b>Numerator Statement</b>	The number of patients in the denominator who had at least one prescription and > 30 days supply for any antipsychotic medication during the measurement period and do not have a diagnosis of schizophrenia, bipolar disorder, Huntington’s disease or Tourette’s Syndrome.
<b>Numerator Details</b>	<p><b>Time Window:</b> The measurement year.</p> <p>The number of patients in the denominator who had at least one prescription and &gt; 30 days supply for any antipsychotic medication during the measurement period (See Table Dementia C) and do not have a diagnosis for schizophrenia, bipolar disorder, Huntington’s disease or Tourette’s Syndrome (See Table Dementia D)</p> <p>Table Dementia C: Antipsychotic Medications</p> <ul style="list-style-type: none"> <li>Aripiprazole</li> <li>Asenapine</li> <li>Chlorpromazine</li> <li>Clozapine</li> <li>Fluphenazine</li> <li>Haloperidol</li> <li>Iloperidone</li> <li>Loxapine</li> <li>Lurasidone</li> <li>Mesoridazine</li> <li>Molindone</li> <li>Olanzapine</li> <li>Paliperidone</li> <li>Perphenazine</li> <li>Pimozide</li> <li>Quetiapine</li> <li>Risperidone</li> <li>Thioridazine</li> <li>Thiothixene</li> <li>Trifluoperazine</li> <li>Triflupromazine</li> <li>Ziprasidone</li> </ul> <p>Note: The active ingredients are limited to oral, sublingual, injectable and intramuscular formulations only. Includes combination products.</p> <p>Table Dementia D: ICD-9 Codes for Specific Psychotic Disorders or Related Conditions (Disease Codes to Identify Accepted Indications for Antipsychotic Medications).</p> <p>Schizophrenia: 295.0x to 295.9x</p> <p>Bipolar/Manic Disorder: 296.0x 296.1x 296.4x to 296.9x</p> <p>Huntington’s disease</p>

<b>2111 Antipsychotic Use in Persons with Dementia</b>	
	333.4 Tourette's Syndrome 307.23
<b>Denominator Statement</b>	All patients 65 years of age and older continuously enrolled during the measurement period with a diagnosis of dementia and/or two or more prescription claims and >60 days supply for a cholinesterase inhibitor or an NMDA receptor antagonist.
<b>Denominator Details</b>	<p><b>Time Window:</b> The measurement year.</p> <p>All patients 66 years of age and older as of the last day of the measurement year who were continuously enrolled (i.e., had not disenrolled or died) during the measurement year with both pharmacy and medical benefits and had a diagnosis of dementia (Table Dementia A) and/or two or more prescription claims and &gt;60 days supply for a cholinesterase inhibitor or an NMDA receptor antagonist (Dementia Table B). For a beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 consecutive days] is not considered continuously enrolled).</p> <p>Dementia Table A: ICD-9 Codes to Identify Dementia 290.0 290.1x 290.2x 290.3 290.4x 294.10 294.20 331.0 331.82</p> <p>Table Dementia B: Cholinesterase Inhibitors and NMDA Receptor Antagonists donepezil rivastigmine tacrine galantamine memantine Note: The active ingredients are limited to oral and transdermal formulations only.</p>
<b>Exclusions</b>	N/A
<b>Exclusion Details</b>	N/A
<b>Risk Adjustment</b>	No risk adjustment or risk stratification N/A
<b>Stratification</b>	N/A
<b>Type Score</b>	Rate/proportion    better quality = lower score
<b>Algorithm</b>	<p>Step One: Calculate the denominator by identifying the number of all eligible patients with either: 1) A diagnosis of dementia (Table Dementia A) and/or 2) Individuals with two or more prescription claims and &gt;60 days supply for a cholinesterase inhibitor or an NMDA receptor antagonist (Table Dementia B)</p> <p>Step Two: Calculate the numerator by identifying the number of persons in the denominator who have greater than 30 days supply for any antipsychotic medication during the measurement period. (Table Dementia C) and do not have a diagnosis for schizophrenia, bipolar disorder, Huntington's Disease or Tourette's Syndrome (Table Dementia D)</p> <p>Step Three:</p>

	<b>2111 Antipsychotic Use in Persons with Dementia</b>
	Divide the numerator (step two) by the denominator (step one) and multiply times 100 to calculate the rate as a percentage.
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## Appendix B: Project Steering Committee and NQF Staff

### STEERING COMMITTEE

**David Knowlton, MA (Co-Chair)**

New Jersey Health Care Quality Institute  
West Trenton, NJ

**David Tirschwell, MD, MSc (Co-Chair)**

University of Washington, Department of Neurology  
Seattle, WA

**A. M. Barrett, MD**

Stroke Rehabilitation Research, Kessler Foundation  
West Orange, NJ

**William Barsan, MD**

University of Michigan Health System  
Ann Arbor, MI

**Jocelyn Bautista, MD**

Cleveland Clinic  
Cleveland, OH

**Ramon Bautista, MD, MBA**

University of Florida HSC/Jacksonville  
Jacksonville, FL

**Gwendolen Buhr, MD**

Duke University  
Durham, NC

**Gail Austin Cooney, MD, FAAHPM**

Hospice of Palm Beach County/Spectrum Health Inc  
West Palm Beach, FL

**John Duda, MD**

Philadelphia VA Medical Center and Perelman School of Medicine, University of Pennsylvania  
Philadelphia, PA

**Jordan Eisenstock, MD, CPE**

UMass Memorial Medical Center  
Worcester, MA

**Sam Fazio, PhD**

Alzheimer's Association  
Chicago, IL

**Risha Gidwani, DrPH**

Stanford University Medical Center  
Palo Alto, CA

**David Hackney, MD**

Beth Israel Deaconess Medical Center  
Boston, MA

**Michael Kaplitt, MD, PhD**

Weill Cornell Medical College  
New York, NY

**Daniel Labovitz, MD, MS**

Montefiore Medical Center  
Bronx, NY, NY

**Therese Richmond, PhD, CRNP, FAAN**

University of Pennsylvania, School of Nursing  
Philadelphia, PA

**Jack Scariano, MD, PLLC**

Neurologist, Fort Sanders Parkwest Medical Center, and Tennova West Medical Center  
Knoxville, TN

**Peter Schmidt, PhD**

National Parkinson Foundation  
Miami, FL

**Raj Sheth, MD**

Nemours Children's Clinic  
Jacksonville, FL

**Jolynn Suko, MPH**

Virginia Mason Medical Center  
Seattle, WA

**Jane Sullivan, PT, DHS, MS**

Northwestern University Feinberg School of Medicine  
Chicago, IL

**Fredrik Tolin, MD, MBA, FACS**

Humana  
Chicago, IL

**Mary Van de Kamp, CCC-SLP**

RehabCare, Kindred Healthcare  
Louisville, KY

**Salina Waddy, MD**

National Institutes of Health  
Bethesda, MD

**NQF STAFF**

**Helen Burstin, MD, MPH**

Senior Vice President  
Performance Measures

**Heidi Bossley, MSN, MBA**

Vice President  
Performance Measures

**Karen Johnson, MS**

Senior Director  
Performance Measures

**Suzanne Theberge, MPH**

Project Manager  
Performance Measures

**Jessica Weber, MPH**

Project Analyst  
Performance Measures

## Appendix C: Measures Endorsed in Neurology Since January, 2011

NQF Number	Title	Steward
0661	Head CT or MRI scan results for acute ischemic stroke or hemorrhagic stroke patients who received head CT or MRI scan interpretation within 45 minutes of ED arrival	Centers for Medicare and Medicaid Services
0668	Appropriate head CT imaging in adults with mild traumatic brain injury	Partners HealthCare System, Inc.



National Quality Forum  
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