Mild Cognitive Impairment Measures Public Comment Period

Public Comment Background

What is a public comment period?
A public comment period is a chance for the public to weigh in draft products before they are finalized. In this case, the AAN is providing a public comment period for patients, caregivers, healthcare providers, or any interested member of the public, to give their feedback on quality measures for patients at risk for memory loss and diagnosed with mild cognitive impairment. Quality measures are tools used to figure out how well doctors or other neurologic providers care for their patients.

What can you comment on?
You can comment on any aspect of the measures. You can say you like or dislike the measures. You can say how you might use the measures or how to change the measures to be more useful to you or your family. All input is helpful to make the measures as good as they can be.

Why participate in public comment?
Public comment allows you to help improve healthcare across the country. You can shape new quality measures that have not yet been finalized or put into use. These quality measures can greatly impact patients and their families. We need your help to make sure these measures are useful and meaningful to patients and their families.

How to Submit a Public Comment

How do you submit your comment?
• Enter your comments via this form: https://goo.gl/forms/u3mFjCSXSzQnPksn2
• The deadline for this public comment period is September 19, 2018.
• **Please do not include personal health information (PHI) in your comment.** PHI includes identifying information about yourself or someone else (for example, age, name, location), and information about physical or mental health conditions and care or treatment for those conditions. Please avoid mentioning individual’s names and locations, and dates of medical events (for example, hospital admission dates).
• If you are providing comments on behalf of an organization, include the organization’s name and your contact information.
• If you are commenting as an individual, submit your name and contact information.
• At the end of the public comment period, all public comments will be reviewed and measures edited as appropriate.

Mild Cognitive Impairment Measurement Summary
Six measures were drafted. The measures are:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Cognitive Health Assessment for Patients 65 years and Older</td>
<td></td>
</tr>
<tr>
<td>Cognitive and Functional Assessment for Patients with Mild Cognitive Impairment (MCI) or Memory Loss</td>
<td></td>
</tr>
<tr>
<td>MCI Diagnosis Disclosed</td>
<td></td>
</tr>
<tr>
<td>Patients with MCI Evaluated and Treated for Contributing Factors</td>
<td></td>
</tr>
<tr>
<td>Avoidance of Anticholinergic Medications for Patients with MCI</td>
<td></td>
</tr>
<tr>
<td>Education Provided to Care Partners of Patients with MCI</td>
<td></td>
</tr>
</tbody>
</table>
Mild Cognitive Impairment (MCI) is a syndrome rather than a disease. “MCI” is a term used to describe acquired objective cognitive deficits insufficiently severe to affect most usual daily activities. For purposes of this document the term “MCI” is used as a catchall phrase for diseases and disorders that cause acquired cognitive deficits not affecting a person’s usual activities. MCI does not necessarily represent a progressive dementia syndrome. Deficits have been observed or experienced for three months or more. MCI generally corresponds to the term “mild neurocognitive disorder” used in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).

What are we measuring?
The work group drafted 6 quality measures focused on annual cognitive assessment, evaluation for memory loss, disclosure of diagnosis, evaluation and treatment of contributing factors, avoidance of anticholinergic medications, and providing education to care partners. These measure scores capture how well a neurologic provider care for its patients either at risk for memory loss or diagnosed with mild cognitive impairment.

Why are we measuring this?
The prevalence of MCI increases as individuals age and is common in older populations. The AAN 2017 MCI guideline assessed the prevalence of MCI and cognitive impairment worldwide. MCI prevalence was 6.7% for those aged 60–64 years, 8.4% for those aged 65–69 years, 10.17% for those aged 70–74 years, 14.8% for those aged 75–79 years, 25.2% for those aged 80–84 years, and 37.6% for those aged 85 years and older.¹

Ton, et al. studied financial burden and healthcare utilization and found patients with aMCI found increasing financial burden due to lower annual household income and higher medical expenditures relative to those with normal cognition.² Zhu et al., estimated that annual direct medical costs for a person with MCI was $6,499 compared to $2,969 for those without MCI.³

Why are there six measures?
There is no requirement that all the measures in the measurement set be used. Providers and treatment teams are encouraged to identify the one or two measures that would be most meaningful to your patient population and implement those measures to drive performance improvement in practice. Data should be collected for an initial benchmark period, and results used to drive meaningful changes to improve performance and overall care provided to patients with MCI.

The work group proposed 27 measure concepts addressing causation, cognitive and functional evaluation, diagnostic imaging and testing, disclosure of diagnosis, medications, neuropsychological testing, management, legal planning, caregiver concerns, the role of exercise, enrollment in clinical trials, quality of life, and ongoing treatment and follow-up.

The AANI encourages work groups to focus development of measure concepts that are feasible, meaningful to quality improvement efforts, and address a known treatment gap. Ultimately the work group cannot develop all appropriate concepts due to resource limitations and efforts to reduce reporting burden for providers. The work group eliminated 8 proposed new concepts following a prioritization ranking. Those concepts were: clinical trial, exercise, legal planning, quality of life, and follow-up. The work group noted that there was opportunity to support use of existing measures already developed to address some of the proposed concepts rather than develop new measures specific to MCI. The work group recommends use of the following measures for this population to supplement the above MCI specific measures developed by the work group:
- CMS Advance care planning for patients 65 years and older
- AAN Advance care planning for patients 18 years and older with a primary neurologic disorder diagnosis
- CMS Maltreatment Screening
- AAN Axon Registry quality of life PROMIS measure

Following ranking, the work group bundled cognitive and functional assessment into one measure and bundled concepts into a causation or differential diagnosis measure. The work group rated measures on evidence, feasibility, and link to improved outcomes, and eliminated additional measures prior to discussion. These concepts were:

- Counseling regarding supplements
- Counseling regarding acetylcholinesterase inhibitors and/or memantine
- Care planning visits

Although, the eliminated measures were not included in this measurement set, they are high-value concepts that will be retained for future measurement set updates as more evidence may support development or a treatment gap in care at that time.

How can you help?
We want your input. We want to know what you think of these measures and how you or your family might use these measures. We welcome comments about any aspect of the measures.

More details about specific measures are in the draft measure specification file. Available at: https://www.aan.com/policy-and-guidelines/guidelines/guidelines-open-for-public-comment/

---

