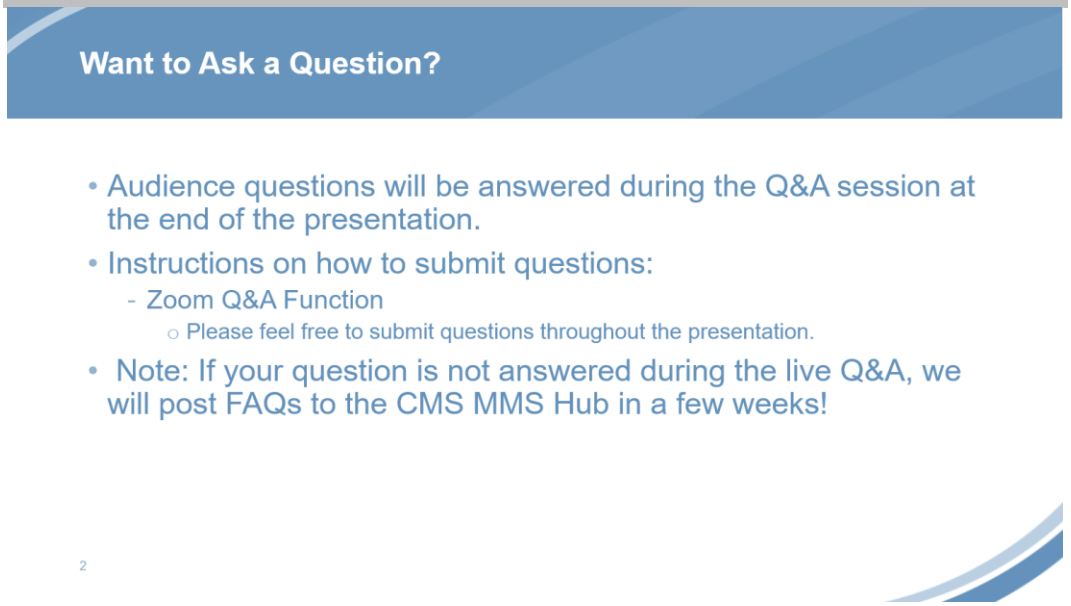
2025 MMS Information Session: The Malnutrition Care Score: From Ideas to CMS Quality Measure Transcript

[SLIDE 1]

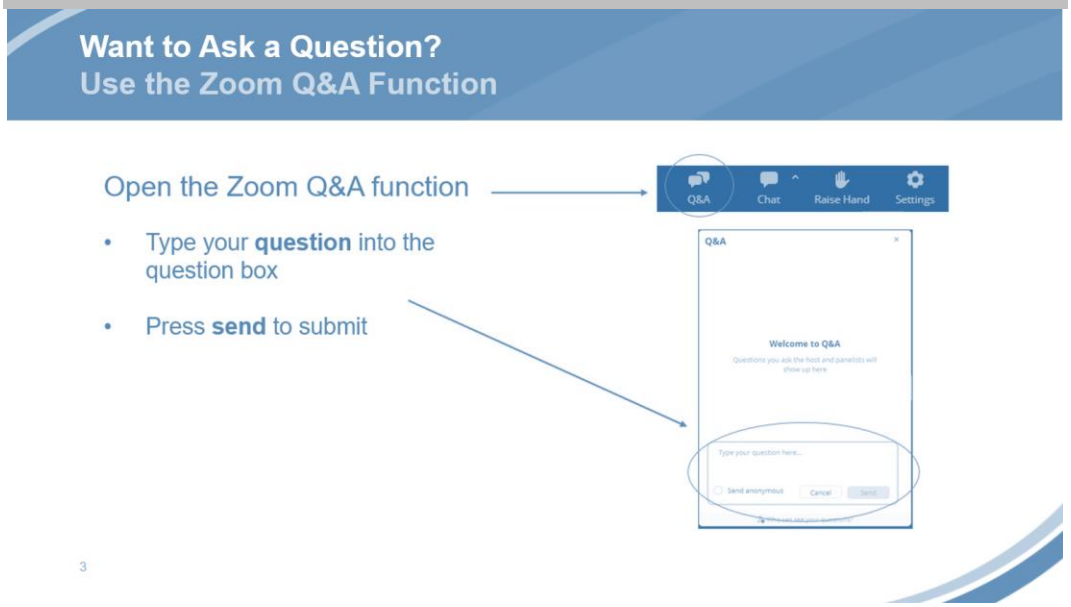
GHUNNEY: Good afternoon, everyone. Thank you so much for joining us for today's CMS Measures Management System (MMS) Information Session, "The Malnutrition Care Score: From Idea to CMS Quality Measure." My name is Aya Ghunney, and I work for Battelle in support of MMS. This webinar is just one aspect of MMS education and outreach, and so I invite you to visit the MMS Hub website to learn more about MMS and how to get involved in quality measurement.

[SLIDE 2]



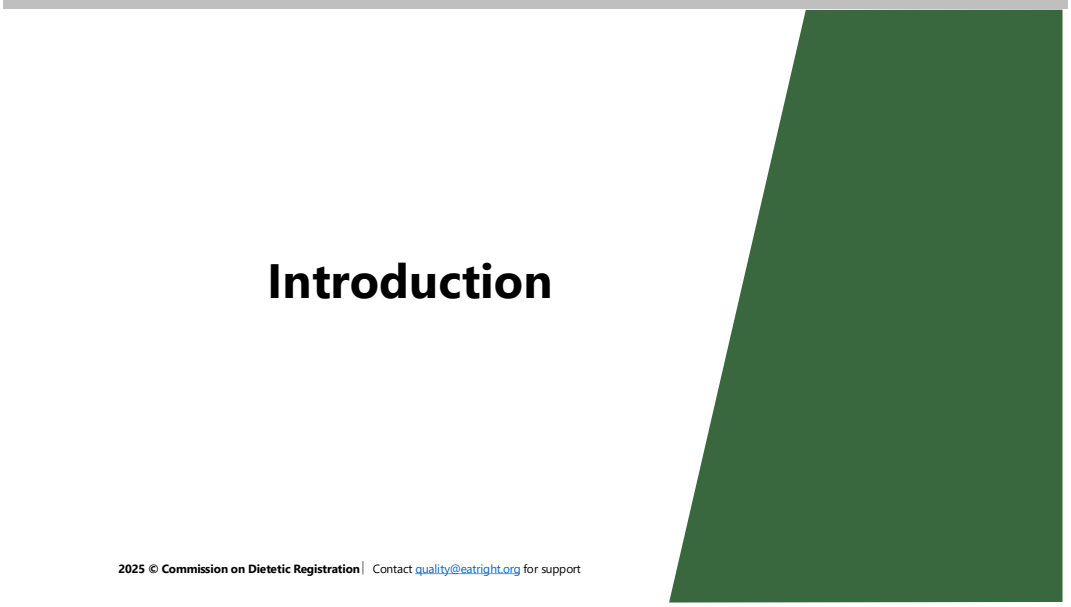
GHUNNEY: So throughout today's presentation, I highly encourage you to submit questions using the Q&A feature, which you're going to find near the bottom of your screen. We'll address questions during the live Q&A at the end of the presentation. And then following the meeting we'll share a Q&A summary to answer some of the in-scope questions we received.

[SLIDE 3]



GHUNNEY: And so you'll see just again, if you're not sure where that Q&A function is, you'll see it right down at the bottom when you open it up. You can just type your question into the box and hit "send," and we will get to as many questions as we are able to throughout the session.

[SLIDE 4]



GHUNNEY: We can go to the next one.

[SLIDE 5]

Quality, Standards, and Interoperability Team
Malnutrition Care Score Measure Steward and Developer Team

Angela Lago
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Senior Director, Quality, Standards & Interoperability

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Tamairé Ojeda
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Director, Quality Initiatives and Improvement

GHUNNEY: So today we're really excited to welcome the Quality Standard and Interoperability Team for the Malnutrition Care Score (MCS) measure steward and developer team. So Angela Lago will be presenting today, and some of the other team members you see here will be available to answer questions at the end of the session.

[SLIDE 6]

GHUNNEY: And we're also excited to welcome the Malnutrition Quality Improvement Initiative (MQii) team at Avalere Health. Today they'll be represented by Shelby Harrington.

[SLIDE 7]

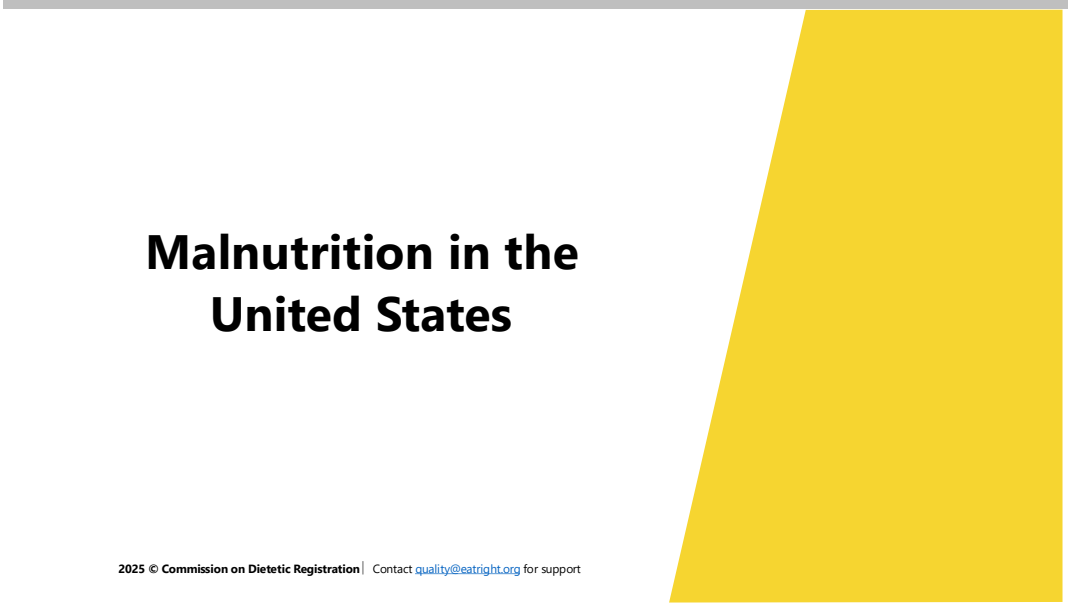
Learning Objectives

- Recognize the importance of RDNs identifying, diagnosing and treating malnutrition in acute care settings.
- Understand why the Malnutrition Care Score (MCS) as an electronic clinical quality measure is essential to improving malnutrition quality care.
- Evaluate and apply quality improvement strategies for malnutrition care.
- Examine the history of the Malnutrition Care Score and successful malnutrition quality improvement stories.
- Understand the steps necessary for successful measure development.

Microsoft Stock Photo

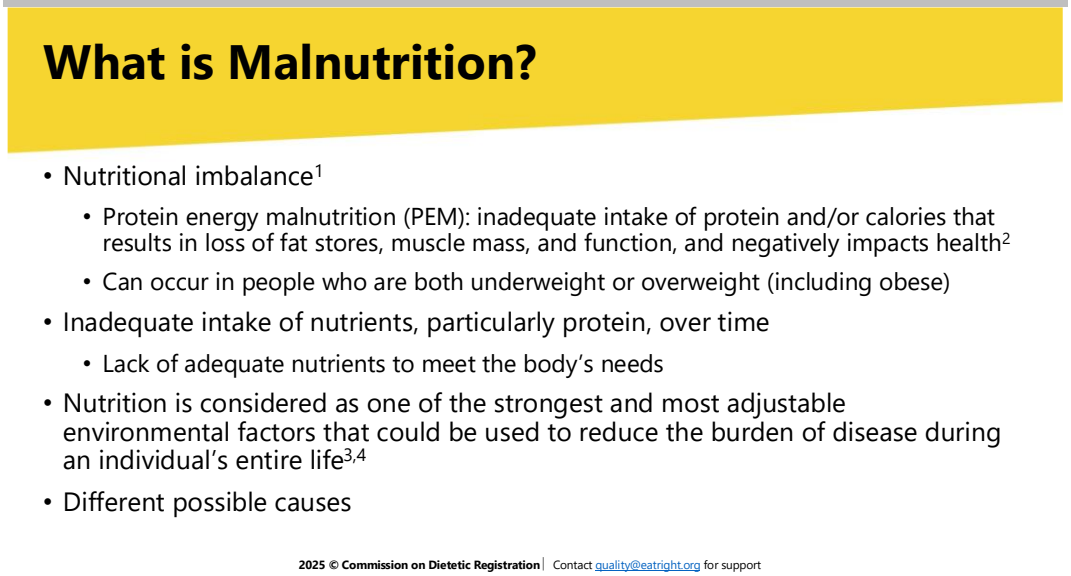
GHUNNEY: Okay, so let's get into today's learning objectives. Over the course of today's webinar we'll recognize the importance of RDNs; identifying diagnosing and treating malnutrition in acute care settings. We'll understand why the MCS as an eCQM is essential to improving malnutrition quality care. We'll evaluate and apply quality improvement strategies for malnutrition care. We'll examine the history of the MCS, and successful malnutrition quality improvement stories. And then we'll also understand the steps necessary for successful measure development. And with that, I'm going to turn it over to Angela to get us started.

[SLIDE 8]



LAGO: Okay, thank you, Aya, for that wonderful introduction.

[SLIDE 9]



LAGO: So I'm very happy to be with you all here today talking about malnutrition quality and the Malnutrition Care Score (MCS). We're going to start out this afternoon by defining exactly what malnutrition is. Malnutrition is a nutritional imbalance between the nutrient your body needs to function and the nutrients it is actually receiving, or absorbing. Specifically, when we're looking at protein energy malnutrition (PEM), that is the inadequate intake of protein and/or calories that results in the loss of fat stores and muscle mass. It can have a negative effect on your health, as you can imagine, and this can occur in individuals who are both underweight and overweight from various causes and over various lengths of time. Nutrition, however, is one of the strongest factors that can be used to reduce the burden of diseases, including and especially malnutrition, during an individual's lifetime.

[SLIDE 10]

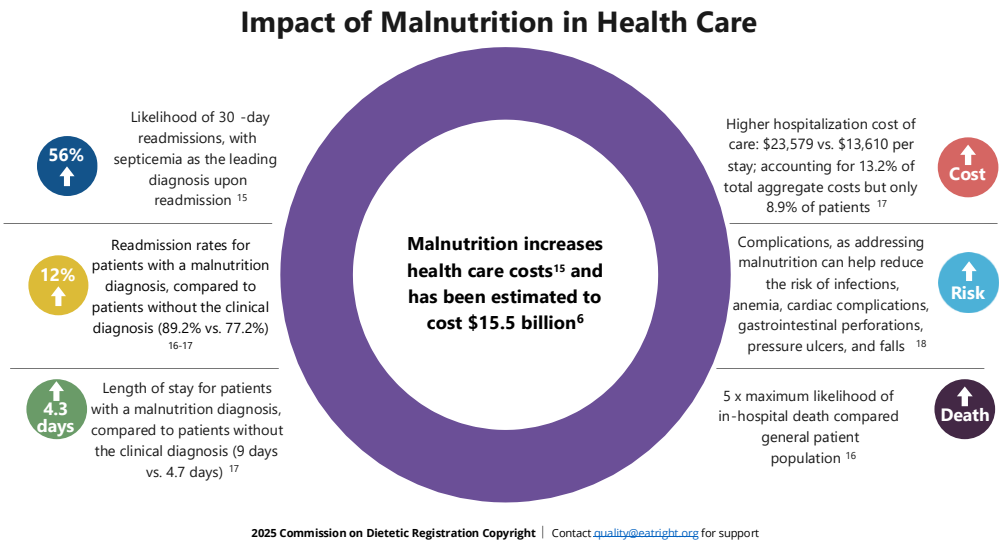
Malnutrition in Acute Care

- Malnutrition could be present in all ages
  - 1 in 3 hospitalized patients are at risk for malnutrition[5]
- Malnutrition is not always identified and diagnosed at any adult age
  - 8% of non-neonatal and non-maternal adult hospitalizations were coded for malnutrition[6,7]
- Evidence supports:
  - Identification of malnutrition risk can predict certain patient outcomes, including length of stay, mortality, and post-operative complications [5, 8-12]
  - A measure that incentivizes early malnutrition screening, identification, diagnosis, intervention, and effective transitions of care[13-14]

LAGO: So in the acute care setting malnutrition can be present in all ages, and malnutrition risk can be and often is prevalent in as many as one in three hospitalized patients. Additionally, a study published in 2018 showed that only 8% of adult hospitalized patients — those would be non-neonatal, nonmaternal — were coded for malnutrition which shows a well-defined gap in care and services.

When we're looking at the evidence, evidence strongly supports that the identification of malnutrition risk can predict certain patient outcomes — things such as length of stay (LOS), mortality, and post-operative complications. Evidence also supports having a quality measure, which we're going to talk about today, that incentivizes early malnutrition screening, identification, diagnosis, intervention, and effective transitions of care.

[SLIDE 11]



LAGO: So there's a lot of information on this slide, and hopefully you all will be able to refer back to it after this presentation. But, as you can see, malnutrition has a significant impact on the cost of healthcare in the United States. Data shows a 56% increase in the likelihood of a 30-day readmission for malnourished patients; a 12% increase in the readmission rates for patients with a malnutrition diagnosis; a longer length of stay (LOS) by 4.3 days, and a higher cost of care while hospitalized by about $10,000 per patient per stay.

Additionally, we know that malnourished patients are at an increased risk of complications. We're looking at things such as infections, pressure ulcers and falls, just to name a few. And malnourished patients are five times more likely to experience an in-hospital death when compared to the general hospitalized patient population. We also know that there is strong evidence to support the fact that tackling malnutrition not only improves patient outcomes, but delivers millions in cost savings. So then that not only enhances the quality of patient care when we're tackling malnutrition, but it also serves as a business incentive for organizations.

[SLIDE 12]

Clinical Guidelines for Addressing Malnutrition in Acute Care Settings[22]

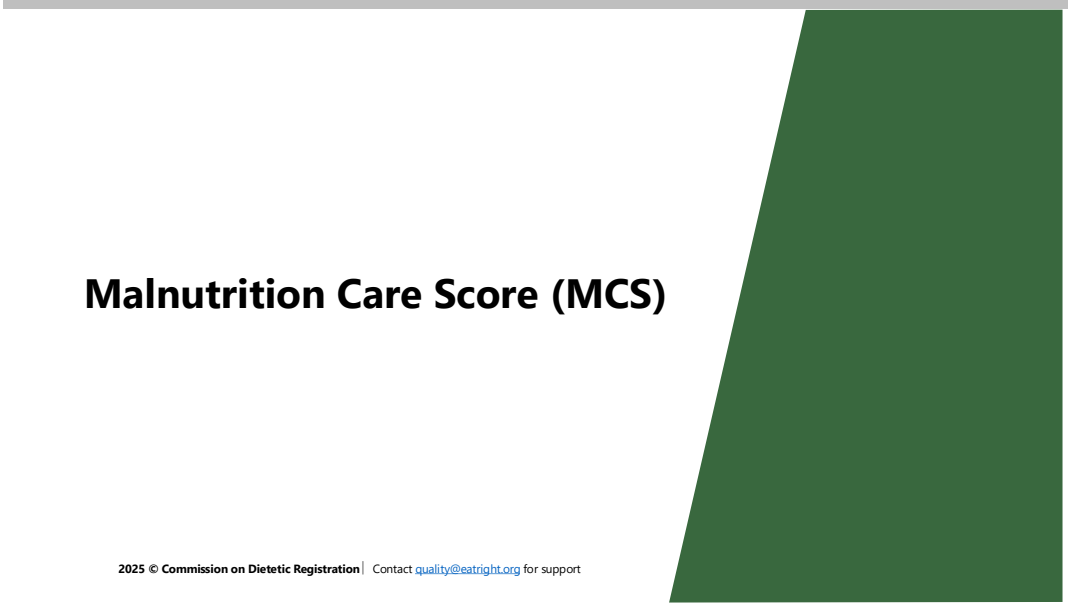
Study Type	Major Findings
Clinical Guideline	• Screening for nutrition risk for hospitalized patients (Level V); • Nutrition assessment is suggested for all patients who are identified to be at nutrition risk by nutrition screening (Level V); and • Nutrition support intervention is recommended for patients identified by screening and assessment as at risk for malnutrition or malnourished. (Level III)

Levels of Evidence: I-Large randomized trials with clear-cut results; low risk of false-positive and/or false-negative error; II-Small, randomized trials with uncertain results; moderate to high risk of false-positive and/or false-negative error; III-Nonrandomized cohort with contemporaneous controls; IV-Nonrandomized cohort with historical controls; V-Case series, uncontrolled studies, and expert opinion.

LAGO: As credentialled nutrition and dietetic practitioners, so individuals such as registered dieticians (RDs) and NDTRs, providing evidence-based care while using clinical guidelines to diagnose and treat malnutrition is essential. For the purposes of this presentation today that care consists of screening, assessment, diagnosis, and care planning. This slide that you can see here shows key recommendations from ASPEN. These are guidelines that were published in 2011, emphasizing an approach for care, for hospitalized patients which includes screening.

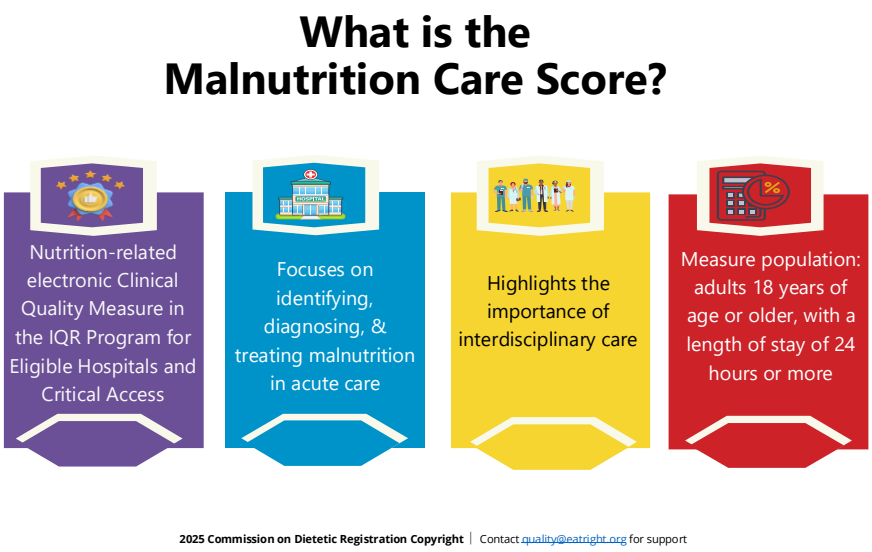
So screening for all hospitalized patients for nutrition risk; conducting a nutrition assessment on all patients who are identified to be at nutrition risk through that nutrition screening, and providing nutrition support interventions for patients that are identified by screening and assessment as being at risk for malnutrition, or already being malnourished. This evidence reinforces and demonstrates the importance of evidence-based inpatient care and early nutrition intervention from the nutrition care team.

[SLIDE 13]



LAGO: Okay, one more slide, please.

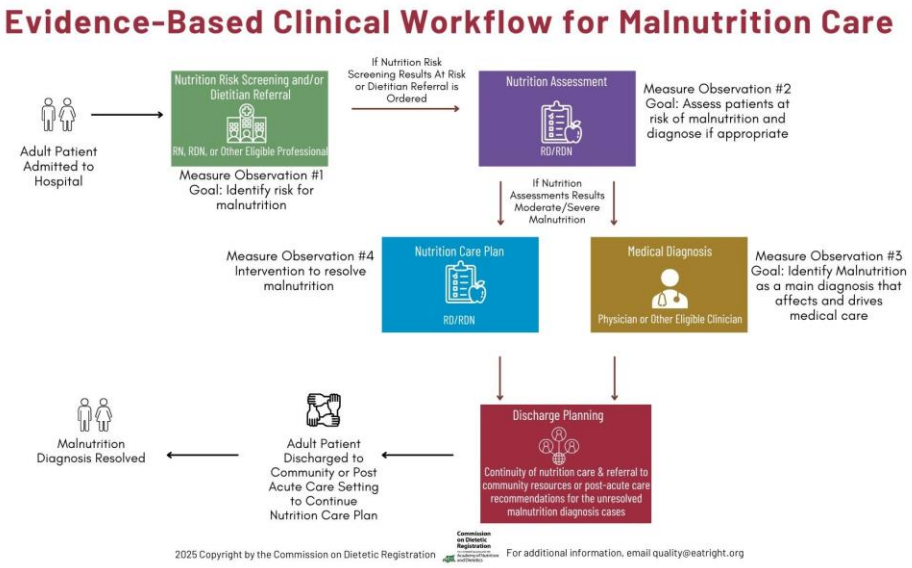
[SLIDE 14]



LAGO: This leads us to the importance of having a malnutrition quality measure. So the measure we're talking about today is known as the "Malnutrition Care Score (MCS)." This was formerly called the "Global Malnutrition Composite Score (GMCS)." Some of you may be more familiar with that name.

The Malnutrition Care Score (MCS) is an electronic clinical quality measure (eCQM) in the IQR program for eligible hospitals (EHs) and critical access hospitals (CAHs). So this measure focuses on the identification, diagnosis, and treatment of malnutrition in acute care settings which highlights the importance of that interdisciplinary care team within that acute care setting. The measure population consists of adults ages 18 years and older with a length of stay (LOS) of 24 hours or longer.

[SLIDE 15]



LAGO: So as you walk through the workflow of malnutrition care for this measure, you'll see that there are some stopping points indicated by the colorful boxes that you can see on the screen. The first four boxes show the four key measures of observations. This workflow also shows how our care directly powers the quality measure score, which tracks those four key measures as measure observations.

So Measure Observation 1, which is the green box, is *screening* which first confirms that a malnutrition screening was completed during that hospital stay or a dietician referral was ordered. Measure Observation 2, which is the purple box, is for assessment, *nutrition assessment*, which then verifies that a dietician documented a full assessment and diagnosis. The result of that assessment determines whether we continue to move forward in the measure, or if we stop there. If that dietician diagnoses the

patient with moderate or severe malnutrition, then the measure continues on to Measure Observations 3 and 4.

Measure Observation 3, the brown box, is *physician diagnosis*, which looks for the physician's formal malnutrition diagnosis in the medical record. Measure Observation 4, the blue box, is for *care plan*, which last but not least, checks to see that a nutrition care plan was implemented to treat the diagnosis of malnutrition.

So this process can continue on into the discharge planning portion of the patient's care, which is indicated by the red box, but for the purposes of the actual measure the first four boxes are the identified elements of the Malnutrition Care Score (MCS) measure.

[SLIDE 16]

MCS Data Elements and Attributes

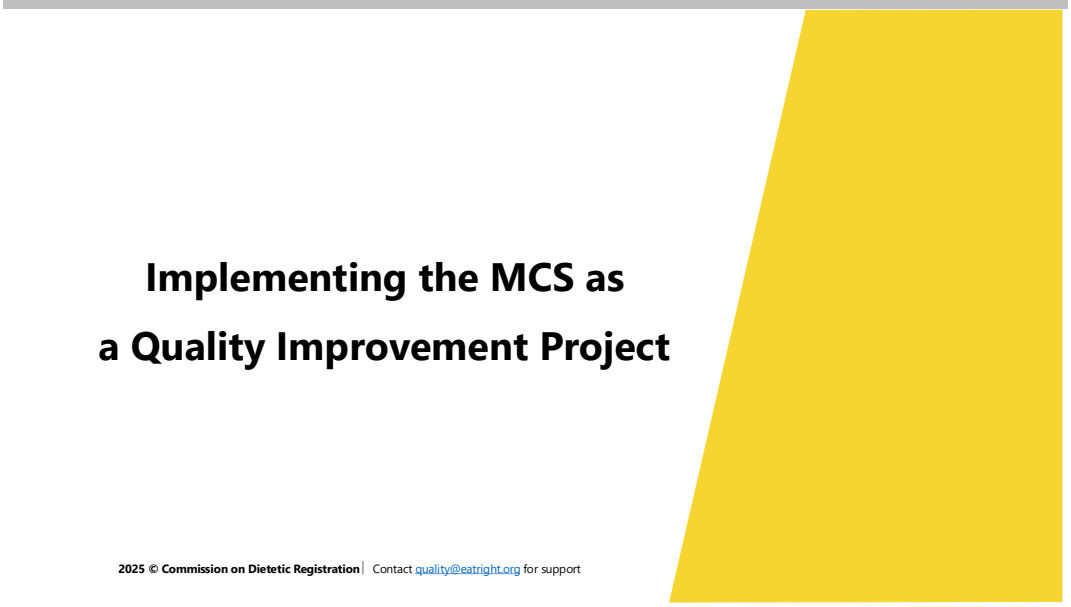
MCS Data Element & Attributes*	#1 Screen	#2 Assess	#3 Diagnose	#4 Care Plan
Encounter Type+	√	√	√	√
Inpatient Admission Time+	√	√	√	√
Inpatient Discharge Time+	√	√	√	√
Date of Birth+	√	√	√	√
Completed Malnutrition Risk Screening	√	√		
Completed Malnutrition Risk Screening Time Stamp	√	√		
Completed Malnutrition Risk Screening Result	√	√		
Dietitian Referral	√	√		
Completed Nutrition Assessment		√	√	√
Completed Nutrition Assessment Time Stamp		√	√	√
Completed Nutrition Assessment Result			√	√
Active Malnutrition Diagnosis			√	
Malnutrition Diagnosis Time Stamp			√	
Completed Nutrition Care Plan				√
Completed Nutrition Care Plan Time Stamp				√

*All MCS data elements are readily available in an EHR
+Data elements used in other eCQMs
NOTE: Data elements in the same color bundle indicate linked data elements

LAGO: So in order to capture the various components of the score, these are the data elements that need to be identified within your electronic medical record (EMR), within the documentation, and mapped to the measure value sets or codes for the measure to be calculated correctly. For example, you would need to identify where the nutrition assessment is completed by the dietician within the medical record and work with your facility on matching those codes with where the assessment is found, where the result of the assessment is recorded, and where that can be found within the medical record so that you can map those things together. You'll see little red crosses on the first four items on this list, and those are data elements that are present in other electronic clinical quality measures (eCQMs). So those are already being used. The additional elements below that are unique to this measure.

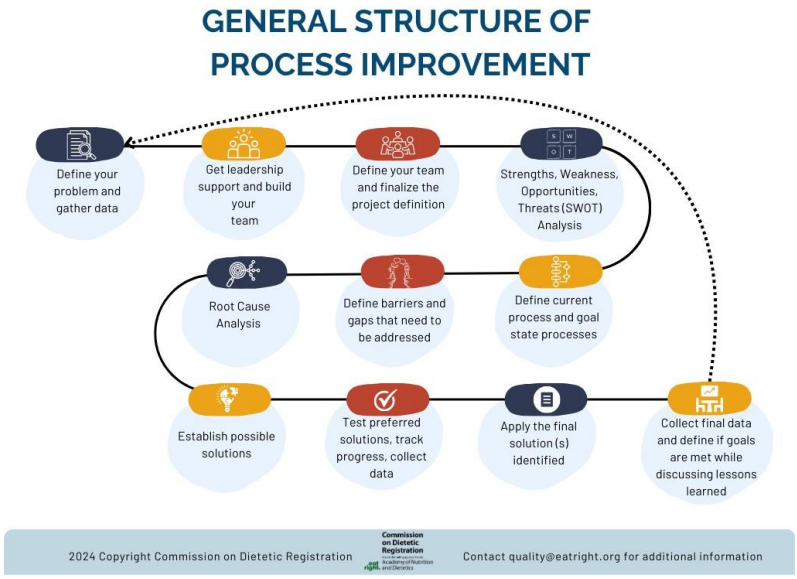
So, as we previously mentioned, those unique elements as the malnutrition risk screening or referral, the completed nutrition assessment, a malnutrition diagnosis and completed care plan — all are with a timestamp from that electronic medical record (EMR).

[SLIDE 17]



LAGO: So for this next portion of the presentation, before we move on to Shelby, I am going to walk through the recommended steps for implementing malnutrition QI in your facility. This portion of the presentation is particularly focused on any registered dieticians (RDs) and/or NDTRs with us today to help you get started in this journey.

[SLIDE 18]



LAGO: This image shows the general structure of process improvement, something that you can use whenever you're trying to start your own process improvement project. This is one pathway to consider as you implement QI. There are, as you all know, a variety of QI tools and methods out there to choose from. One of the tools that I like to talk about often is performing a gap analysis. So a gap analysis is when you are identifying the current state that you're in compared to the desired or ideal state. You're identifying that *gap* that exists between the two and then creating an action plan to bridge that gap.

As any of you that have tried to do quality improvement work before can attest to, the nature of QI often requires that we pivot and turn with new discoveries. So this pathway does leave room for modifications along the way. Today we won't walk through each of these steps, but I wanted to include this for you to use as a framework as you walk through these

processes on your own, or as you start moving forward with your own quality improvement project.

[SLIDE 19]

Initiating a Quality Improvement Project

Strategies & Structure

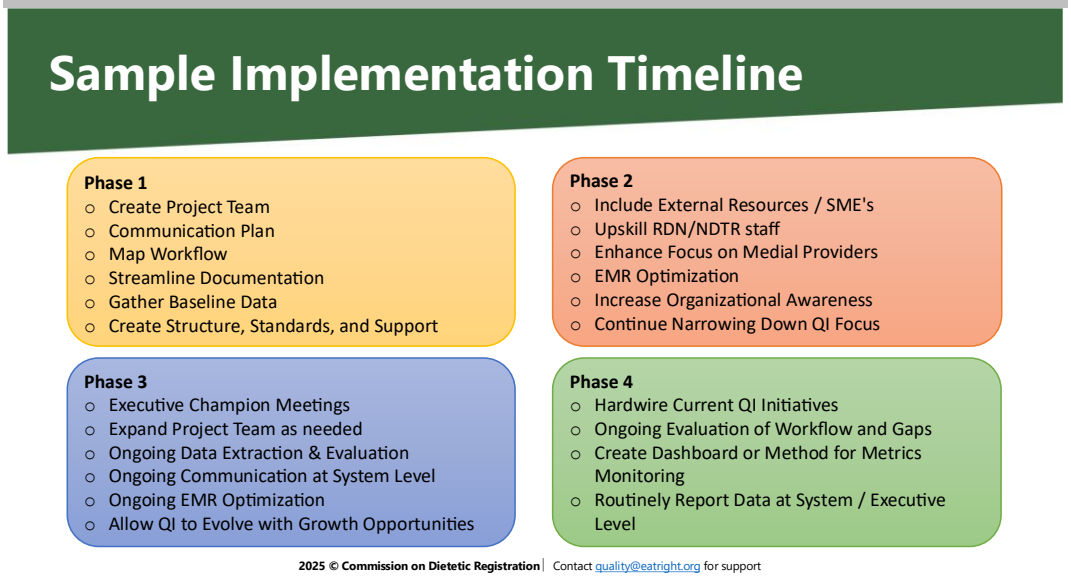
Questions to consider…

- Where are you now?
- Who needs to be at the table?
- What training/education is needed?
- What communication needs to be disseminated?
- Are there documentation requirements that need to be considered?
- What data needs to be captured?
- What is the next right step toward the goal?

LAGO: So continuing on with the gap analysis example, once you have identified the gap or your area of focus for quality improvement work, you really need to create a strategy and structure to guide your process, because you want the time and energy that you're putting in this to be successful. So you need to have some structure. This slide lists questions that I believe will be helpful to you and your team as you get started, and to use at regular intervals along the way. So if you're going to pull a couple of slides out from this presentation, this would probably be a good one to keep handy as you start your quality improvement work. Asking and answering these questions routinely can be vital to your success. So you will want to consider where you are now; who needs to be there with you; what training or education is needed; what needs to be communicated throughout your organization or with your leadership, and

how you will achieve that communication; what documentation requirements or electronic medical record (EMR) changes are needed, and what type of data you will need to support your efforts. And then what are the next steps to keep you moving step-by-step closer to your goal.

[SLIDE 20]



LAGO: So to dive into this a little further, let's look at a sample implementation timeline and the various phases that you may go through in getting a quality improvement project off the ground and to the sustainability phase. Now this isn't exactly a timeline by definition, but it does give you kind of an example of phases that you'll move through, but the depth and breadth of your QI project will determine how quickly you move through each of these phases. So I just kept the labeling generic.

This is based off of my prior experience in malnutrition quality improvement and may serve as a good template for you to use, or a checklist as you go along the way. And in each of these phases you'll

want to refer back to those questions on the previous slide that we just discussed to keep you moving forward to the next phase.

For example, in *Phase 1* you will want to start getting the footing together for your project and some of the tasks that you'll want to include are creating that initial project team. You'll want to map your workflow and perform a gap analysis, or some other type of tool or method within quality improvement work or process improvement methods.

You'll begin discussing that communication plan, gathering baseline data, possibly discussing various datapoints of interest. And then from personal experience I encourage you to focus on data from the very beginning and not wait until you're a year or two down the road, as it will be much harder to capture that retrospective data at that point. If you can have some data up front, it's much better for your project overall.

So as you move into *Phase 2*, some of the tasks that you'll want to incorporate include maybe expanding the depth and breadth of your project by including external resources and other subject matter experts (SMEs) possibly. It may be necessary to enhance the skills of your nutrition team. Maybe your dieticians or your NDTRs need additional training to help this project be more successful.

You would also want to start or continue increasing organizational awareness of your initiative by involving more medical providers, possibly more senior team members, and then continue working to optimize your medical record. This would be something you're doing throughout the entirety of your project for that ongoing data collection and care optimization.

Moving into *Phase 3*, you will begin or continue having regular meetings with your executive team lead or sponsor. I mean, this can happen much sooner than Phase 3. I definitely encourage it to happen the sooner the better, but you'll want that to be ongoing throughout the whole time so that they know what you're working on, the importance of it. You may need to continue upscaling your team and bringing on additional subject matter experts (SMEs). So maybe by this point you need an IT analyst, or you may need to be in touch with your electronic medical record (EMR) vendor, or clinical informaticist. Maybe you're finding out that there are different people that you need to bring onboard.

And then you will continue to conduct the ongoing data extraction and evaluation and maintaining that communication and EMR optimization. So the communication is key, because you want your organization to know what you're working on, and you want your dieticians also to be recognized as the experts on that work that's occurring.

And then finally in *Phase 4*, you'll want to work on hardwiring your QI project into your organization so that you can reach that sustainability phase. Now this may be two years into your work. This may be five years into your work. So you don't want to limit yourself. Like I said, it depends on the depth and breadth of your scope.

And then even in this final phase, you'll want to continuously evaluate your workflow. You may need to conduct another gap analysis or some other type of method of QI. And then you will identify any gaps that exist and continue to create ways to maybe monitor your data in real time such as a dashboard that's continuously updating, and so you can see where you are. And then you'll continue reporting out that information at the organization or system level.

[SLIDE 21]

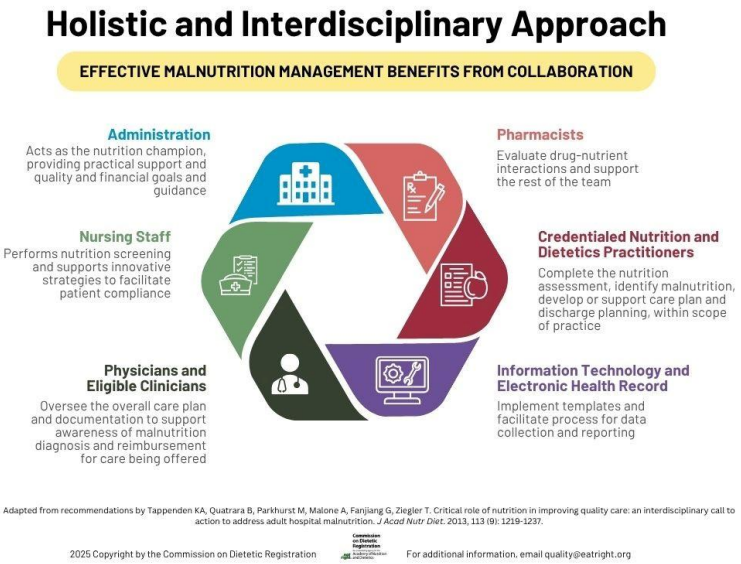
Data Considerations

- What data is important to your organizations?
  - Can you align with Mission, Vision, and Values.
  - What are the Key Performance Indicators your C-suite is looking at?
- How can you align?
- What data will speak to that alignment?
- Is it achievable and will it be meaningful?
- How will you show nutrition outcomes and the value of the RDN?

LAGO: So when it comes to data, I know I've mentioned this a couple of times already, but whether you're in a large organization or a smaller business, most, if not all companies, are going to have key goals that they're working toward. If you don't know what those goals are, I challenge you to make that your first priority and then consider how you can align your malnutrition quality improvement project to the goals of your organization.

It's important to consider and know what your organization's key performance indicators are, so you know how to align with them and what data you may need to show that alignment. And then if you're having a difficult time determining what data would be appropriate, what are other ways to capture the value that the dietician and NDTR bring to the patients and the organization?

[SLIDE 22]



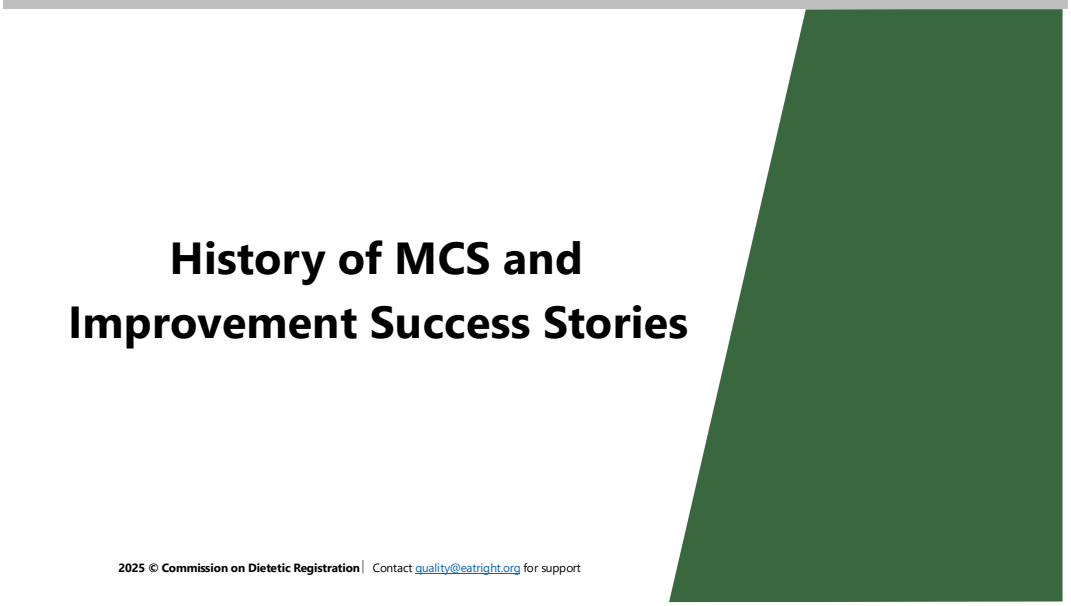
LAGO: So in conclusion, it's important to recognize that implementing the Malnutrition Care Score (MCS) is an interdisciplinary process. This is not something that a dietician and a hospital and an organization can do alone. This measure's success involves a variety of areas and disciplines. It is designed to be a collaborative measure. It promotes the credentialed nutrition and dietetics practitioners to get involved and interact within departments, that maybe they have previously not interacted with. For example, the clinical nutrition manager or lead dietician can present and promote the measure by focusing on the patient and improving the quality of care within the organization. They can communicate with hospital executives, IT, and quality departments.

The electronic health record (EHR) companies can support by helping with the alignment of data collection and reporting needs. IT and informatics can help identify and collect the data within the EHR as well and ensure

that the systems that you have are able to collect data to meet CMS requirements.

And then finally, hospital executives can support and champion the measure, which is why it's so important to have them involved and knowing what's going on as close to the beginning as possible. All right. So now we're going to move into the next portion of the presentation with Shelby. I'll turn it over to you.

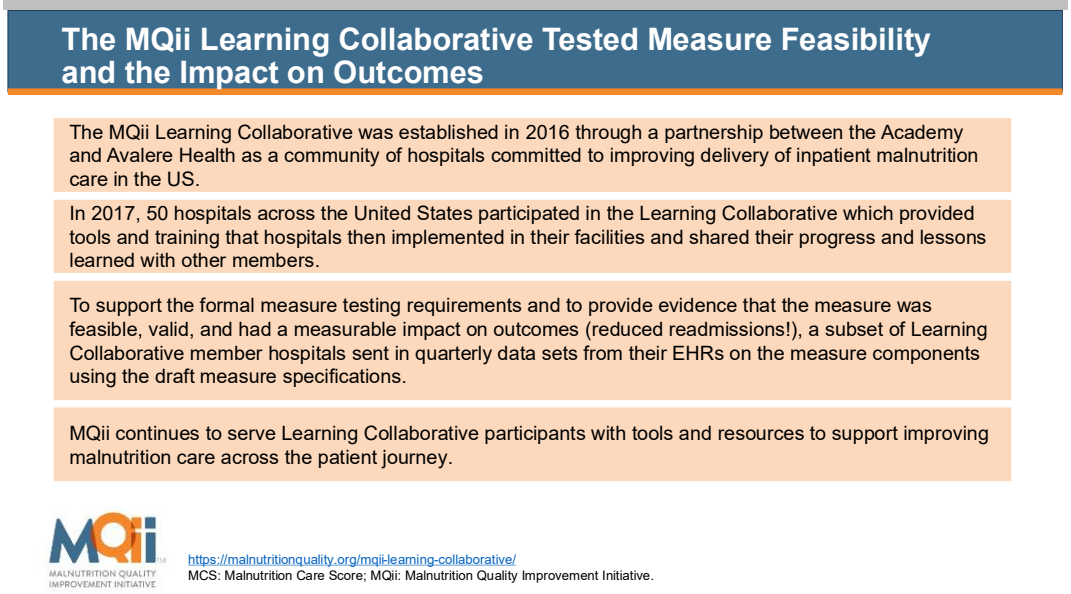
[SLIDE 23]



HARRINGTON: Thanks, Angela. I'm going to go through the history of the MCS for those of you that have been around for a while, the GMCS is what you might remember, but it has been officially renamed. So for those of you that are interested in the measure development process, you'll learn about how we went developing the measure and some lessons we learned along the way. I'm also going to share a couple of implementation and improvement success stories from hospitals that participated with our

learning collaborative and incubated and refined the measure over the years of development.

[SLIDE 24]



HARRINGTON: MQii, the Malnutrition Quality Improvement Initiative, was founded in 2016 as a partnership between the team at the Academy of Nutrition and Dietetics and their Commission on Dietetic Registration (CDR), and Avalere Health, with the goal of improving the quality of malnutrition care in the hospital setting.

The ultimate vision of this partnership was to create a quality measure for the inpatient quality reporting program for IQR focused on nutrition, knowing that having a measure in a major reporting program is a very powerful tool for driving improvement on a broad scale. As you know, evidenced by the number of people that are on this webinar today, it's a really powerful way to get attention to the role of nutrition in hospital care. So we recruited hospitals from across the country to participate in a

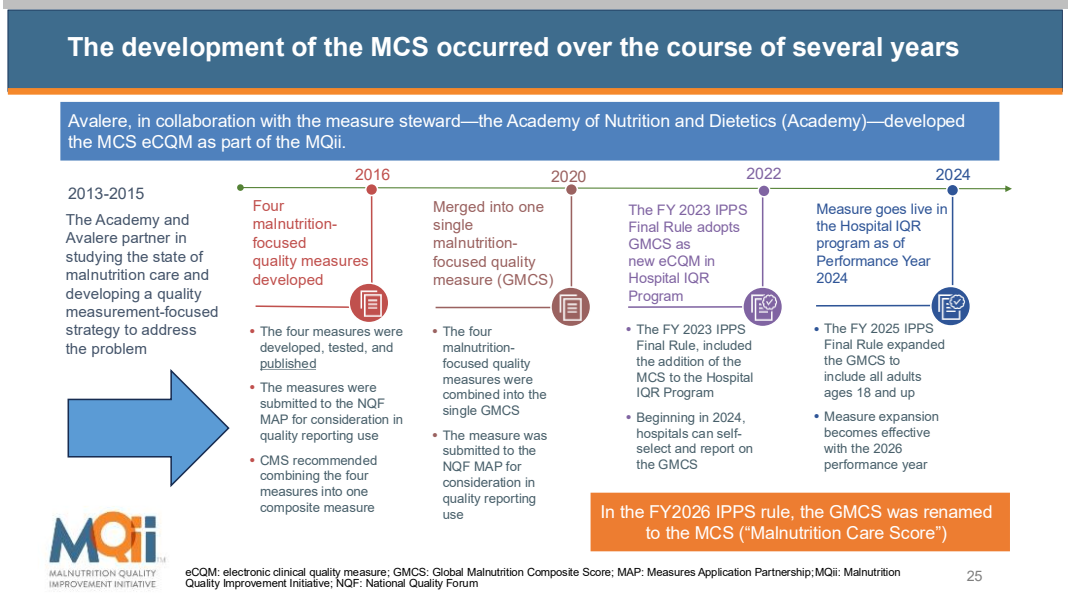
learning collaborative in which MQii provided the tools and the training for how to optimize nutrition care processes, and then the participating hospitals shared their experiences and learned from one another on what worked and what didn't.

Concurrently, we were designing the initial draft of the MCS, the initial skeleton of what would become the measure itself, which if you've been through the measure development process you know that this requires real-world data to show that your measure is valid, feasible, reliable, and ultimately that it positively impacts outcomes.

In our case, we had a subset of learning collaborative members who very graciously volunteered to share not only their measure data, but also their outcomes data, so that we could show that improving malnutrition care would improve outcomes. Specifically, we showed that increasing rates of improved nutrition care had a significant improvement in readmissions.

MQii, as it exists today, posts resources on our website malnutritionquality.org to support hospitals and others in the healthcare ecosystem and understanding the value of the MCS and really the value of nutrition care in general and how to successfully report. We're also sharing news and resources on developments in the nutrition space and guidance on expanding nutrition care into other care settings outside the hospital, and so we encourage you to check out the website.

[SLIDE 25]



HARRINGTON: Measure development is a long process, and our partnership with the academy goes back more than 12 years to when we first started studying the state of malnutrition care and thinking about strategies to address the gap in quality that we were seeing. We first conceived of this idea of developing a measure back in 2016 and then developed actually four separate measures. As many of you know, the MCS in its current state has four components. So we had actually created it as four separate measures, but CMS recommended, and rightly so honestly, that it be merged into a single measure.

So we refined the specifications accordingly. We tested them through the learning collaborative. And then we submitted them to the measure contractor at the time that was measuring the MMS system for CMS. And then after going through the whole consideration process which involves submitting the data covering a range of qualifications of your evidence-

based justifying the measure concepts, and the testing data that shows our measure was reliable, valid, and feasible.

We were thrilled to see that the measure was officially proposed and then finalized in 2022 for implementation beginning with the 2024 performance year. We are eagerly awaiting the release of the 2024 data from CMS to see how many hospitals chose to submit the measure in 2024 and what their performance rates looked like, but along the way we've also had some significant changes in the measure.

As you know, the measure originally focused on older adults, age 65 and older, but recognizing that malnutrition is an important condition regardless of age, the measure has been expanded to cover ages 18 and older, which will go into effect with this coming performance year in 2026. Of course, the measure name has been simplified. We went from the "Global Malnutrition Composite Score (GMCS)" to the "Malnutrition Care Score (MCS)."

[SLIDE 26]

Two Hospitals' Experiences with Implementing Data Collection and Quality Improvement Strategies

Two Learning Collaborative members from two separate health systems were part of the initial cohort who tested the feasibility of data collection and the impact of efforts to raise MCS scores on patient outcomes.

Key components of their experiences included:

- Their work internally to adapt their EHR for optimal data collection aligned with clinical workflow
- The development of ongoing quality data reports,
- The gathering of a QI team for overall malnutrition care process improvement
- Their work to engage their leadership to prioritize the (G)MCS measure

Please note the two hospital case studies are longtime collaborators on the measure and some of the slide content reflects data elements/specifications that differ slightly from the most current specifications for CMS reporting. Please work with your EHR vendor and IT team to ensure your facility is using the most recent MCS measure specifications to design your processes.

MQii MALNUTRITION QUALITY IMPROVEMENT INITIATIVE

CMS: Center for Medicare & Medicaid Services; EHR: electronic health records; IT: information technology; GMCS: Global Malnutrition Composite Score; MCS: Malnutrition Care Score; QI: quality improvement.

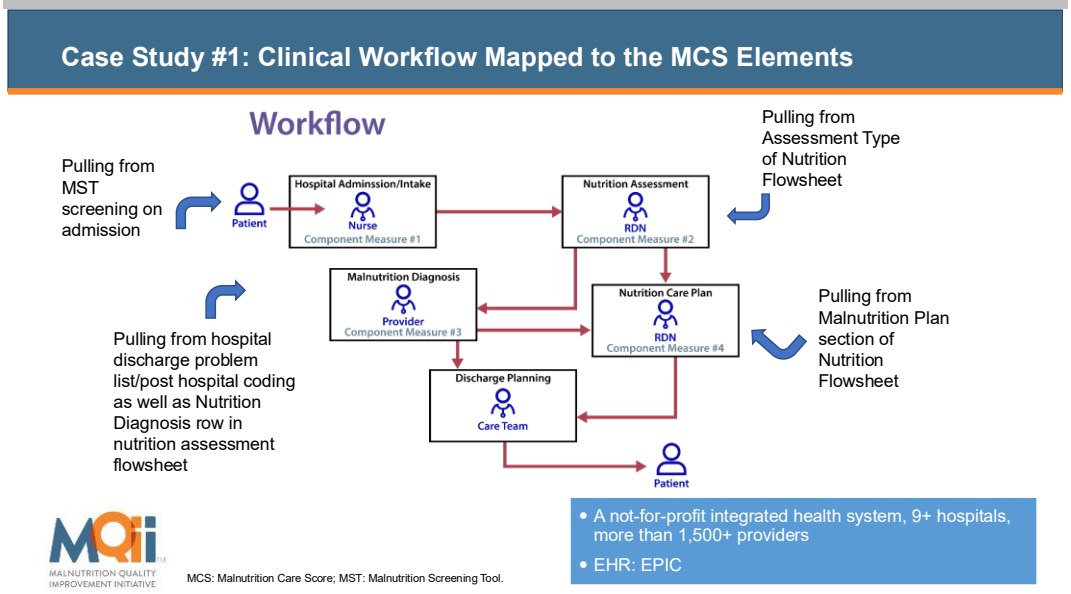
HARRINGTON: And over the years working with hospitals, I have some of the hospitals that are on the call today that participated in MQii. In implementing nutrition care strategies and the improvement processes and using the measure as a tool to drive their improvement strategies, we've learned quite a bit about the key success factors that really are important for both improving malnutrition care quality and in capturing the data needed to demonstrate that you are improving, and ultimately report that to CMS.

The four foundational components that we've heard over and over again, and we've really seen borne out in the hospitals we work with are that *one*, you really need to make sure that you're adapting the documentation and data entry flow in your EHR to the clinical workflow. You don't want the clinical workflow and the documentation workflow to be "at odds" with one another. They really need to reinforce and work well together.

Two, you need to be creating and actively using quality reporting that give closer to real-time insight into performance and not waiting until the end of a performance period. *Three*, that building an interdisciplinary quality improvement team to address all of the necessary changes that need to be made and sustain those changes and manage the change process is really essential. Finally, *four*, engaging hospital leadership for support.

I'm going to share a couple of case studies of hospitals we have worked with that have had success in implementing the MCS, and implementing the processes necessary to demonstrate high quality malnutrition care with the MCS. Just a note here as you see on the upcoming slides, you may see references to some of the older specifications of the measure. The intent here is just to show the process in these hospitals' improvement stories, and so make sure you're working with your EHR vendor and with your IT team to ensure you're using the most up-to-date and correct specifications of the measure for the year you're reporting.

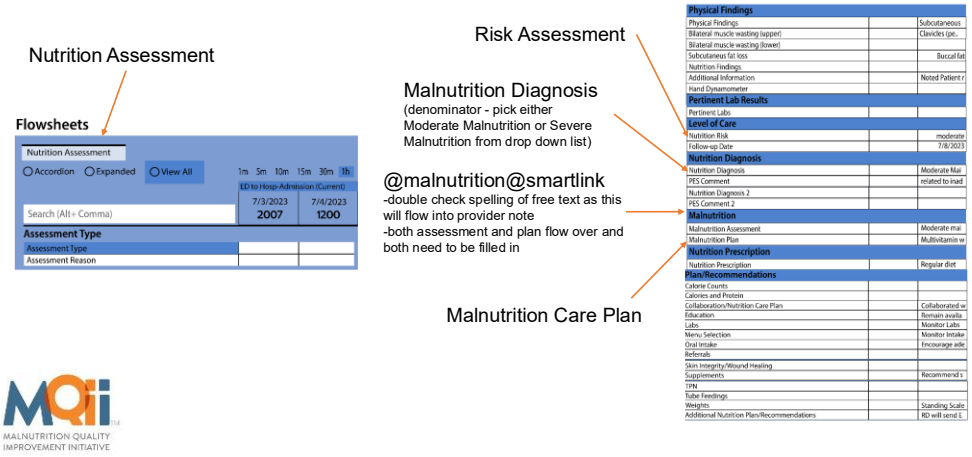
[SLIDE 27]



HARRINGTON: The first hospital that I want to highlight here, this was a large integrated health system. It had nine hospitals and growing throughout the measure development process. Their first stop was mapping their clinical workflow in their EHR configuration to the steps described in the elements of the MCS. They identified the place in the EHR where care would be delivered, where it would be documented, where that documentation would be stored, who would be performing the care, and how it aligns to the patient journey throughout the hospital stay. This visual representation is really important in identifying all of those key components up front, so that you can optimize how you make any changes in your EHR.

[SLIDE 28]

Flowsheets and Reports were Built to Mirror MCS Elements



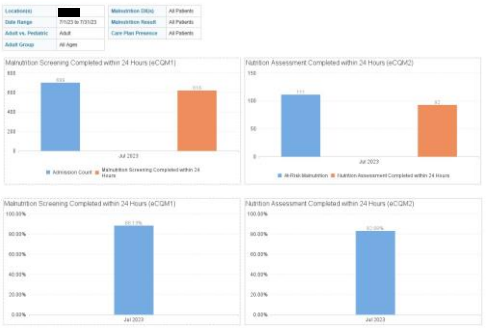
MALNUTRITION QUALITY IMPROVEMENT INITIATIVE

HARRINGTON: So what that allowed them to do is visually identify if there were any modifications that needed to be made and how they document; how their EHR was set up to make the process more intuitive. So instead of things that may have previously been entered in free text, if it was something that was amenable to creating a dropdown menu or a multi-select option, they modified the entry format. They also verified that the necessary information was showing up in the appropriate place for other care team members. So, for example, the physician was able to see the dietician's notes easily, or the registered dietician (RD) who was conducting an assessment was able to see the nurse's workstream and that documentation was in the correct places to make that possible.

[SLIDE 29]

The Hospital Used Real-Time Performance Reports to Track Each Measure Component and Stratify Results

Real-Time Performance Reporting



Performance Feedback Report

Date Range: 7/1/23 to 7/31/23

Metric	July 2023	Total
Malnutrition Screening Completed within 24 Hours (eCQM1)	88.13%	88.13%
Nutrition assessment Completed within 24 Hours (eCQM2)	82.88%	82.88%
Appropriate Diagnosis of Malnutrition (eCQM3)	62.22%	62.22%
Nutrition Care Plan Documentation (eCQM4)	97.22%	97.22%
Hospital Malnutrition Diagnosis Rate by Age Group	5.15%	5.15%
30 Day Readmission Rate (general population)	11.46%	11.46%
30 day Readmission Rate (with malnutrition dx)	25.00%	25.00%
Average Length of Stay (general population)	3.83	3.83
Average Length of Stay (with malnutrition dx)	6.96	6.96
Aggregate Total Malnutrition components Score as a percentage at the hospital Level	86.86%	86.86%

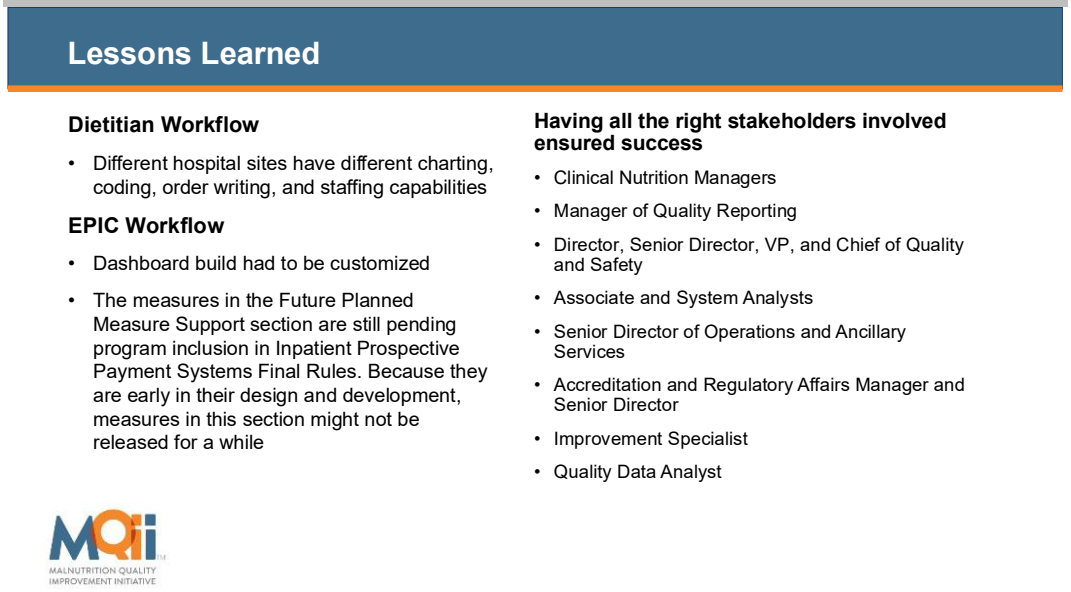
MALNUTRITION QUALITY IMPROVEMENT INITIATIVE

HARRINGTON: The hospital also knew that it was important to track their performance in as close to real time as possible, so that they could quickly identify and correct any problems they found, or figure out ways to improve their performance. They built performance reports that went beyond just the measure score, but included details like stratifying by age groups and including corresponding outcomes measures like length of stay (LOS) and readmissions.

This hospital shared that they learned quite a bit through this experience, to both help them to improve their nutrition care, but also help them really in how they approach other measures and eCQMs in particular. As is common in large health systems that grow by merger and acquisition, different hospitals had different templates and different approaches to charting. At the time they also had to create a custom dashboard, because this was before the measure had been officially implemented.

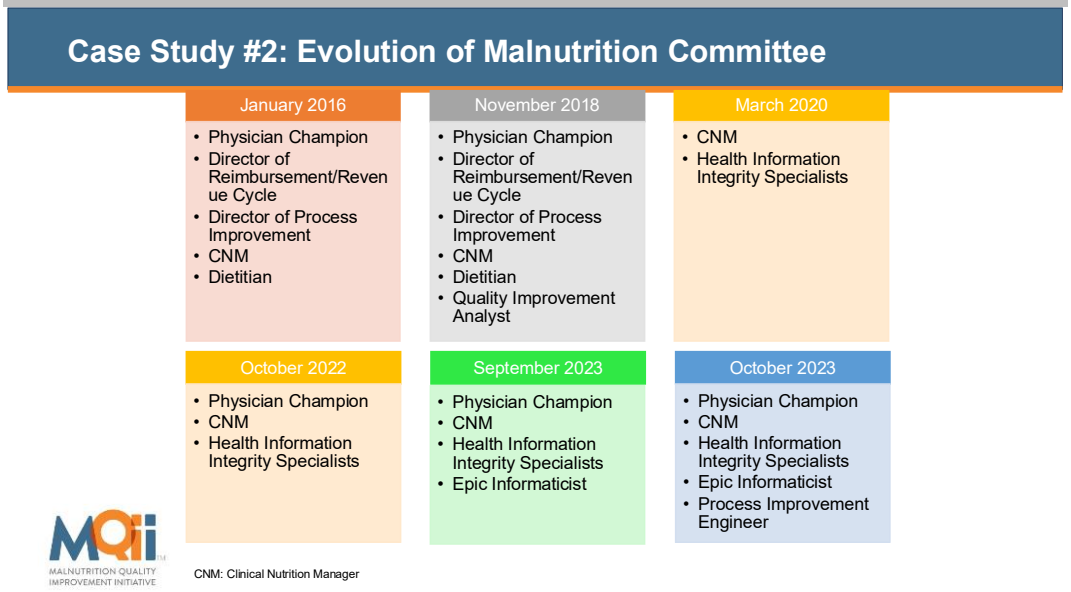
So Epic hadn't yet built the MCS into their eCQM module. So they had to build a custom dashboard, because they were working with us in the early stages of the measure. As we mentioned earlier, they learned about how they had to have the right stakeholders involved. It went well beyond the nutrition team alone to include other clinical team members, to include quality leaders, data analysts, IT report writers, and regulatory leaders.

[SLIDE 30]



HARRINGTON: And then this is just an example of some of the different leaders that they had involved in their team.

[SLIDE 31]

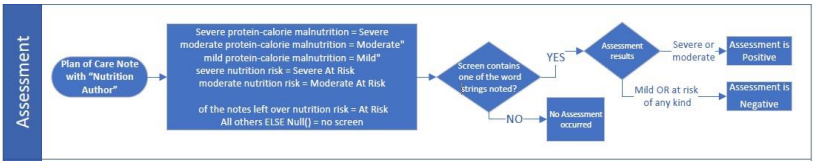


HARRINGTON: Our second hospital had a similar experience and learned over time that they needed to engage different stakeholders to participate, to support the project, and this evolved over time. Some team members needed to be involved as one-time consults. Some team members needed to be involved on an ongoing basis, and some were intermittent. They made sure that they included a physician champion as a key leader to champion the effort, as well as nutrition leaders, quality improvement specialists, IT team members, and revenue cycle leaders.

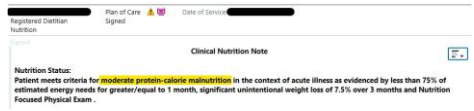
I know for many hospitals if there are changes in how documentation occurs that could have impacts to billing and coding, they need to be involved in that process. So often there's a clinical documentation improvement team, and they live within that revenue cycle department. They have a role to play in ensuring that documentation is compliant and that optimizes data capture through billing and coding processes.

[SLIDE 32]

MCS Implementation - Assessment



Clinical Nutrition Note



Clinical Nutrition Note

Nutrition Status:
Patient meets criteria for moderate protein-calorie malnutrition in the context of acute illness as evidenced by less than 75% of estimated energy needs for greater/equal to 1 month, significant unintentional weight loss of 7.5% over 3 months and Nutrition Focused Physical Exam .

Physician Query

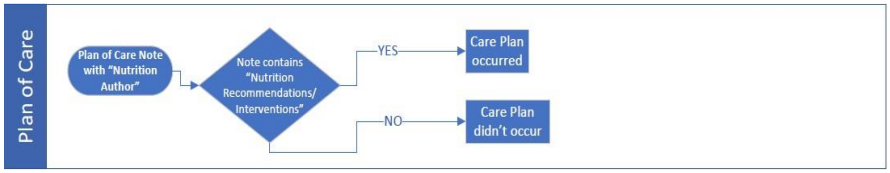
MALNUTRITION QUALITY IMPROVEMENT INITIATIVE

MCS: Malnutrition Care Score.

HARRINGTON: As you can see here, for each stage of the nutrition care process how the team mapped their workflow and dataflow in the EHR, and then how it appears in the EHR itself. So, for example, you can see here how for this particular hospital the clinical nutrition documentation was flagged by the clinical documentation improvement team for the physician to enter a malnutrition diagnosis, because the clinical nutrition note had all of the supporting evidence needed. This is where the physician query was entered, like you can add a malnutrition diagnosis here because the patient qualifies.

[SLIDE 33]

MCS Implementation – Nutrition Care Plan



Nutrition Recommendations/Interventions:

- Diet: heart healthy
- Supplements: Continue Ensure Enlive BID.
- Continue to encourage nutrient dense foods to optimize nutrition status.
- Request current weight.
- Recommend Thera M Plus multivitamin with minerals.
- Monitor wt,labs and po intake

MALNUTRITION QUALITY IMPROVEMENT INITIATIVE

MCS: Malnutrition Care Score.

HARRINGTON: So here we can see how the nutrition plan of care meets the measure criteria per this documentation map that they created; that there is a care note with a nutrition author that contains nutrition recommendations and interventions, and therefore it satisfies the care plan requirements. That can be mapped in the backend to the appropriate codes to meet the measure specifications.

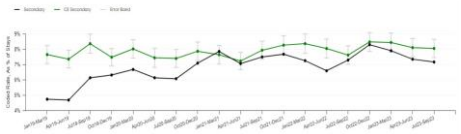
[SLIDE 34]

Hospital 2: Lessons Learned

Learnings & Adaptations

Monthly data shared departmentally and individually

- Colorectal, hospitalists, surgery, cardiothoracic, trauma, internal med, mid-level providers, pediatric
- Considered "low-hanging fruit"
- Individual able to see how they stand compared to department
- Improved awareness and ongoing education
- Monthly tipsheets



MQii
MALNUTRITION QUALITY IMPROVEMENT INITIATIVE

Barriers to Implementation

- Currently "siloed." The main hospital set up to capture data due to involvement in MQii. Able to capture "unofficial" score, but somewhat of a manual process
- Epic upgrade in 2024 to hopefully allow data capture across system
- Suspect that not all affiliates chart/document the same
- Physician buy-in
- MCS requires data entered by providers, nurses, RDs; difficult to know where to pull data from
- Identifying correct contact to set up measure to report to CMS

What Was Most Helpful

- **Must** have a TEAM!
- Physician Champion, Quality Improvement, Process Improvement, Informaticist, Health Information Integrity Specialists

HARRINGTON: And then this hospital learned that there is tremendous value in engaging the physicians, the midlevel providers, directly through those clinical departments, including sharing department-level data and comparisons between the providers themselves and the departments. They also provided provider-specific education and tip sheets for documenting the malnutrition diagnosis. They did encounter some barriers along the way that they learned to overcome. This hospital was involved in MQii before the official MCS went live in the IQR program. So they were well-positioned to capture and report the measure, but other hospitals in their same system were not. They realized that not all of their system hospitals had the same documentation process and were not set up in the EHR in the same way.

There also was not an established relationship between the clinical team that was focused on malnutrition care, and the team that was responsible

for selecting and submitting eCQMs to CMS. So that was a learning experience for them in connecting some siloed teams together or across the health system. Ultimately, again they emphasized that having a team was critical to their success and having leadership engagement.

[SLIDE 35]

Questions or Comments can be sent to:
Quality@eatright.org

HARRINGTON: So with that, I think we are going to maybe go to questions? I'll turn it back to someone else.

[SLIDE 36]

Q: "How does the MCS differentiate from other measures that measure frailty in older adults?"

OJEDA: So the frailty, the MCS, it's more specific to malnutrition in itself, the diagnosis of malnutrition. We know frailty can be many causes, many ideologies and diagnoses. So not only does it focus on malnutrition, it also focuses on identifying and addressing malnutrition, whereas other measures on frailty are mainly "identifying." The MCS focuses on identifying and addressing that diagnosis of malnutrition with the care plan and the medical diagnosis.

Q: "Does the measure specify which professional is required to complete the measure observations?"

OJEDA: So measure observations are not specified by who completes it; however, we do encourage that facilities look at local, state, and federal policies and regulations and make sure that whoever is completing those observations are the ones qualified within their scope of practice to complete those observations.

Q: "So how can eligible hospitals (EHs) or critical access hospitals (CAHs) start the implementation process?"

HARRINGTON: This is where I would go back to start with looking at the steps of the malnutrition care process. I've seen a few questions related to this, and so I'm going to comment specifically and Angela and Tammy, flag me if I say anything incorrect here. We've got the four steps. We've got screening, assessment, diagnosis, and the plan of care. That first step around screening should be implemented universally for your adult patient populations.

Remember that is not an assessment for malnutrition, because I've seen a couple questions come through the Q&A for that. That is a "screening for risk of malnutrition." Does this patient have factors that put them at higher risk, and therefore we should have a nutrition professional assess them to see if in fact they do have malnutrition? So it's just thinking about the step-by-step process and what needs to occur. So then if they do in fact flag as high risk, it's important to have the nutrition professional come and assess them. If that clinical nutrition professional finds they do in fact have malnutrition, then make sure you're putting the processes into place to ensure that your providers see that documentation, get that handoff and information, and then put the diagnosis on record. And then also they are working with that nutrition care professional to put interventions in place and to develop a plan of care for that person.

So you want to look both at the clinical workflow that needs to occur and does your hospital — particularly I know this is hard in some of the smaller and rural hospitals — does your hospital have the resources and the people necessary to do that? Do they have them 24 hours a day? Is this something where maybe it's harder for night admissions vs. day or weekend admissions vs. during the week? And then look at your EHR and see how it is set up to capture each of those steps. So take those as your first two steps. Just do an assessment of your current state. And then you can see the gaps from where you currently are to where you need to go.

And then to take it into more detail in looking at the specifications and the value sets of the measures to where it needs to live in codes to actually be captured in a way through the electronic clinical quality measure (eCQM). In each step in that process you're going to want to bring in more team members with expertise in that area to help you.

OJEDA: I smiled because that is kind of what I was going to say, "treat it as a process improvement project, right?" I do want to emphasize that theoretically the steps are steps that hospitals should be following at this point, right? They should have some kind of malnutrition screening, malnutrition risk screening tool. And then if that's positive, there should be some kind of way or process in place to address it. So if you are looking at implementing MCS, I completely agree with Shelby. Treat it as a process improvement project. Look at your resources. What is your ultimate goal? Can you with the resources that you have implement all of the four observations, or should you look at one at a time?

That's part of what the measure does for hospitals. Depending on the score that you have, it shows you where in that four-step process is your gap of service or opportunity for improvement, which is what quality measures are looking for. We're looking to improve the services that we offer to our patients.

Q: "What are some common challenges that early implementers have faced?"

HARRINGTON: Definitely, I'll mention a couple of things. Angela, I know you were one of those early implementers, and so you could speak to this from direct experience as well. Getting real-time reports built, custom reports that gave them the level of information needed to actually make improvements. So this is a common thing with many quality measures where the measure tells you that you have a gap in quality.

It doesn't necessarily tell you enough on how to fix it, and so for many of our hospitals, they were not doing great on the nutrition screening process, or maybe not doing great on the diagnosis process. But then they needed to go a level deeper to understand why that was happening so that they could figure out how to fix it.

So in your quality improvement team at your hospital, your quality professionals can help you with this because they're trained in how to do this and getting data to understand those key drivers. Looking at things like differences by nursing unit for that step. Do you have differences by admission type? Do you have differences at different times of the day, or days of the week? Trying to do some stratification and a deeper-dive analysis is really hard. Honestly, you've got to have some really good ways of collecting data, and that can be a barrier if you're not able to get

down into the weeds to figure out why you're not seeing the results that you are.

That was something that was encountered by some of our facilities and just figuring out what do we do, you know? What is the problem and how do we fix it? It's trying to get the data to do that.

LAGO: Yes, as Shelby said, the organization where I previously worked was one of the earlier implementers of the MQii, the process. We did not get to the point of actually reporting the Malnutrition Care Score (MCS), but getting the project started, I feel like for me — I was a clinical nutrition manager at the time — was knowing who do I need to bring to the table? What other resources do I need? And then just trying to figure out who can help me get where I need to go, and then forecasting out where is it that I need to go? What is the ultimate place that I'm trying to reach and who can help me get there?

So then for the data, I don't have a data-driven brain like some people do, so that was definitely a challenge for me was being the clinical person, the clinician sitting there with the electronic medical record (EMR) and then working with individuals from Avalere and the IT people from my organization and trying to figure out how to make this all work.

So I would say for me personally, the data, the reporting, getting my brain wrapped around that was a challenge for me, but that's why we emphasize the interdisciplinary team so much every time. I know with the academy when we talk about it, I'm sure Shelby and her team do the same thing, because it is not something that a dietician in a hospital can do alone. You need clinical informaticists. You need nursing. You need leadership. You need quality clinical documentation consultants, coding,

IT analysts and anything like that. People that can help you and come around and support you I think is key. It's vital, and at the very beginning just knowing who they are and getting buy-in from them to donate some of their time to you because it is time-consuming. So you're basically marketing something that maybe they've never heard of before and convincing them to give their time and resources to you. So I would say that could be a challenge for early implementers.

HARRINGTON: Yes, I am a pretty data-driven person, but I will also emphasize not discounting the qualitative information you can get from your team members. Don't forget that you can walk up to the unit, walk around, talk to nurses, talk to a clinical nutrition manager, and go talk to a handful of physicians and figure out their perspectives on what's going on.

Believe me, they will tell you if they think their EHR was set up wrong. "It's so hard; I have to do five clicks to get to this right place, and so I just skip it." They'll say, "Oh, we were told we didn't have to fill out that particular form." So do some walking rounds and talk to your team members to get their perspectives.

Q: "But even with IT working alongside us, our main barrier is creating accurate reports such as nursing, MST screening compliance, is this a common issue? How do we improve that?"

HARRINGTON: Yes, that's another one where it's going to take a lot of drilldowns and a lot of investigation and probably sitting with the IT person who has the data schema and the backend of the EHR structure pulled up on one screen. Maybe you've got the actual frontend of the EHR pulled up on another screen and you're mapping and looking step-by-step with one another. "Here's a field where this is being entered. Where's the field

where this is being stored in the backend?" It's going to get really tedious quite honestly, but it's a really important task to go through to make sure that where you think things are being documented and stored is in fact in the database where the IT folks can see it, the fields they are pulling from.

Q: "Does a care plan have to be an actual care plan as listed in some EMRs, or do notes signed by RDs count towards that aspect of the measure?"

OJEDA: So because this is an electronic clinical quality measure (eCQM) it really depends on how you have what we call "mapped" that element of the nutrition care plan to whatever piece of your record. So in reality it's up to the facility staff to decide where those elements like the nutrition care plan, the assessment, the medical diagnosis, are going to be let's say pulled from in your templates or records. So the answer is that it doesn't have to. You just have to as a facility get your staff together and decide where you are going to pull those data elements from, and then communicate that with your IT team so that they know exactly where to map it, because they can get creative. And then you have something mapped to where it's not really getting the information even though you're doing it, right? So that is the kind of short answer, but not so short. I don't know if Shelby has any more input, or Angela?

HARRINGTON: Yes, I think you explained it so well. To give an example in the slides that you'll have available we showed an example where for a particular hospital they knew in the way their EHR was set up and the way their clinicians were documenting that if there was a care note and the author of that care note had a classification as *nutrition* — we called that field "nutrition author," and that note contained a header for nutrition recommendations and interventions.

So it was a structured header in the note, and there was content underneath that header. They said, “We know that means there is a nutrition care plan.” So if those elements were met — those criteria were met — they mapped that. As Tammy was saying, that was mapped in the backend to one of the allowable codes from the measure specifications in the value set.

LAGO: And then just to add onto that a little bit, I think what this question was referring to there is an interdisciplinary care plan in many medical records, which is where my team pulls that information from for the care plan. It was from an interdisciplinary care plan where we have the nutrition. We could put malnutrition as an item on the care plan. And then I've also heard of individuals mapping it from the *intervention* section. Of course, it has to be discrete fields. It can’t be just free text, but from the intervention section in a dietician’s progress note. So those are other options as well.

Q: “What recommendations do you have for the small rural hospitals when considering how to submit for and meet a measure that is as complex as this one?”

HARRINGTON: I would say first to go slow. Give yourself, you know, the MCS is one of the optional measures. This is not one you’re required to report. We certainly would love it if people were required to report it, but as it stands in the program right now it is not. So I would say to give yourself time and go ahead and work towards implementing, documenting, and delivering the clinical care necessary as if you were going to report it, sort of as your training run.

Once you feel like you're in a good place and you've gone through those quality improvement cycles and are at a point where you're happy with the quality of the data — and you feel like your results are where you want them to be — then you can decide whether or not you want to move that into a measure that you actually report.

LAGO: Tammy may have been getting ready to say it, but when there are so many things that you feel like you have to do, it's like just start with one thing. Just start somewhere chipping away which kind of aligns with what Shelby was saying, too. Many elements of the measure, it's processes that dieticians should be following anyway. So it should not be a new workflow or task for dieticians. The screening should be being done, and we should be educating nurses and facilities on how to do that as a requirement.

The assessment, the diagnosis, and the care plan should be part of our workflow anyway. So in smaller rural hospitals sometimes maybe the consistency might be easier, because you're not dealing with 15 dieticians and trying to make sure everyone is doing the same thing. You have one, maybe three — one, two, three — dieticians. It might be a little easier to create some consistency in your documentation; although, I know resources are usually a little tighter in smaller hospitals, but I would also challenge you to try to think outside the box and not let that limit your vision for what can happen, because the impact could be even greater in a small hospital. Your chance as a nutrition and dietetics practitioner to stand out and provide that value is going to be even more evident in a smaller hospital, in my opinion.

GHUNNEY: We are at time, and so we're going to wrap up. Thank you, everyone for your questions and engagement in today's webinar. Thank you so much to our presenters and panelists for a wonderful session.

[SLIDE 37]

GHUNNEY: So as always, please visit the MMS Hub for upcoming events and opportunities, or reach out to us at MMSsupport@battelle.org. The materials for the meeting will be available on the MMS Hub following this meeting and in the coming weeks. Thank you again for attending today's session.

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