Interprofessional Implementation of the Global Malnutrition Composite

October 19, 2022 • 12:00 – 1:00 PM ET

Moderator
Ainsley Malone, MS, RD, CNSC, FAND, FASPEN
American Society for Parenteral and Enteral Nutrition
Silver Spring, MD

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Data Underlying the Global Malnutrition Composite Score and Connection to Health Equity

Christina Badaracco, MPH, RDN, LDN
Research Scientist
Avalere Health
Washington, DC
Disclosures

- Abbott; Consultant
- Kroger; Consultant

Learning Objectives

Upon completion of this educational activity, the learner will be able to:

1. Understand the creation and structure of the Global Malnutrition Composite Score (GMCS) and the data reflected by its 4 component measures
2. Explain how malnutrition and its risk affect health equity and how they can be addressed in tandem
3. Access pertinent resources to learn more about the GMCS and how to prepare for future reporting
GMCS Performance Is Based on Average of 4 Component Measures

- To calculate a final GMCS score, each component measure is scored individually
- Calculating the average of the 4 component measures provides a final GMCS score
- A hospital must have at least 20 cases in the denominator for each component measure and at least 3 scorable component measures to receive an overall GMCS score

Global Malnutrition Composite Score Is a Composite Measure Derived from 4 Individual eCQMs

<table>
<thead>
<tr>
<th>Component Measures</th>
<th>Numerator</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completion of a Malnutrition Screening</td>
<td>Patients in the denominator who have a malnutrition screening documented in the medical record</td>
<td>Patients age 65 years and older at time of admission who are admitted to an inpatient hospital</td>
</tr>
<tr>
<td>Completion of a Nutrition Assessment for Patients Identified as At Risk for Malnutrition</td>
<td>Patients in the denominator who have a nutrition assessment documented in the medical record</td>
<td>Patients age 65 years and older at time of admission who are admitted to an inpatient hospital and were identified as at risk for malnutrition upon completion of malnutrition screening</td>
</tr>
<tr>
<td>Appropriate Documentation of Malnutrition Diagnosis</td>
<td>Patients in the denominator with a diagnosis of malnutrition documented in the medical record</td>
<td>Patients age 65 years and older at time of admission who are admitted to an inpatient hospital with findings of malnutrition upon completion of nutrition assessment</td>
</tr>
<tr>
<td>Nutrition Care Plan for Patients Identified as Malnourished after a Completed Nutrition Assessment</td>
<td>Patients in the denominator who have a nutrition care plan documented in the medical record</td>
<td>Patients age 65 years and older at time of admission who are admitted to an inpatient hospital with findings of malnutrition upon completion of nutrition assessment</td>
</tr>
</tbody>
</table>

Denominator Exclusions: Patients with a length of stay less than 24 hours and those discharged to hospice care or who left against medical advice are excluded from the composite measure calculation.

Anchoring Clinical Workflow by the GMCS Component Measures Can Help Address Nutrition Post-Discharge

Hospital Admission/Intake
- Nurse
  - Component Measure #1

Nutrition Assessment
- RDN
  - Component Measure #2

Nutrition Care Plan
- RDN
  - Component Measure #4

Medical Diagnosis
- Physician
  - Component Measure #3

Discharge Planning
- Discharge plan includes continuity of nutrition care & referral to community resources

GMCS Performance Data Reveal Opportunities to Provide Equitable Nutrition Care

Performance data indicate that malnutrition care and associated outcomes vary widely across diverse demographic groups.

GMCS Performance Scores By Age Strata and Race/Ethnicity Categories

GMCS Scores By Age Strata & Urban/Rural Geography

Malnutrition Outcomes Stratified By Race/Ethnicity Categories

Note: Data on malnutrition care and outcome disparities were presented to the NQF Prevention and Population Health Endorsement Committee in 2021. N=429,396 for GMCS analysis and N=179,336 for outcomes study.

*Non-Hispanic Black patients showed the largest disparities in terms of the malnutrition outcomes reported and are highlighted in these graphs.
Existing and Forthcoming Resources Offer Further Information About the GMCS and Reporting Opportunity

### Upcoming Events and Resources

<table>
<thead>
<tr>
<th>Event/Resource</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academy’s November Quarterly Spotlight on Malnutrition</td>
<td>November 2022</td>
</tr>
<tr>
<td>MQii Toolkit GMCS module</td>
<td>Fall 2022</td>
</tr>
<tr>
<td>MQii GMCS “quick start guide”</td>
<td>Fall 2022</td>
</tr>
<tr>
<td>GMCS FAQ document</td>
<td>Fall 2022 (and ongoing)</td>
</tr>
<tr>
<td>More trainings, documents, etc. (TBD)</td>
<td>2022 and beyond</td>
</tr>
</tbody>
</table>

References List


Interprofessional Implementation of the Global Malnutrition Composite Score - GMCS
How to Use for Quality Reporting

Sharon M. McCauley, MS, MBA, RDN, LDN, FADA, FAND
Executive Director
Commission on Dietetic Registration
Academy of Nutrition and Dietetics
Chicago, IL

Wednesday October 19, 2022    12:00pm ET

Disclosure

• No commercial relationships to disclose.
Malnutrition Significance and the MQii

**Malnutrition is a Critical Public Health and Health Equity Issue**

- **20-50%** of hospitalized patients have malnutrition.
- **<9%** are typically diagnosed as malnourished.
- Costs are **34%** higher for hospitalized patients with malnutrition than for non-malnourished patients.

Social risk factors and existing chronic conditions increase malnutrition risk, disproportionately burdening vulnerable populations.

**Implementation of the GMCS clinical quality components is associated with improved patient/hospital outcomes and supports the RDN’s critical role in hospital care through:**

- Reducing hospital length of stay and readmission rates and 30-day hospital readmissions.
- Lowering healthcare costs and advancing health equity.
- Identifying at-risk patients and facilitating RDN engagement to ensure appropriate assessment and intervention/nutrition care plan.
- Documenting relevant nutrition diagnosis and discharge plans to ensure continuity through care transitions.

**Why Act?**

Studies of nutrition screening effectiveness have demonstrated that both patient health outcomes and hospital economic outcomes are improved when malnutrition is more effectively identified and treated.

Appropriate nutrition assessment, intervention, and monitoring and evaluation can play a role in preventing hospital readmissions that are related to malnutrition.


Malnutrition Quality Improvement Initiative

Academy of Nutrition and Dietetics, along with Avalere Health and other stakeholders, developed and implemented the Malnutrition Quality Improvement Initiative (MQii), a national nutrition-focused quality improvement initiative.


MQii Toolkit

The MQii Toolkit is a guide for identifying and implementing clinical quality improvements for malnutrition care. It is designed to support changes among the care team’s clinical knowledge and raise awareness of best practices for optimal nutrition care delivery.

MQii Learning Collaborative

- Community of clinicians committed to improving delivery of malnutrition care in hospitals and health systems across the US.
- Undertake a data-driven, patient-centered, malnutrition quality improvement project at their respective institutions using a best practices Toolkit and are encouraged to use malnutrition eCQMs to track and monitor improvement.


History of Measures Development

Measurement Development Timeline

Source: Academy of Nutrition and Dietetics. Quality Initiatives. Access here
Global Malnutrition Composite Score – Endorsed “Best in class”!

The Consensus Standards Approval Committee (CSAC) Voting Results and Decisions for Fall 2020 Measures: 
https://www.qualityforum.org/About_NQF/CSAC/Meetings/2021_CSAC_Meetings.aspx

GMCS Reporting Begins in January 2024

The FY 2023 IPPS final rule was released on 08/01/2022 and contains exciting updates to the Hospital IQR Program with specific implications for nutrition

60-day public comment window

Early April 2022
FY 2023 IPPS Proposed Rule Release

Early August 2022
FY 2023 IPPS Final Rule Release

October 1, 2023
FY 2023 IPPS Final Rule Implemented

January 1, 2024
FY 2023 IQR Program Changes Implemented

Fiscal Year; IPPS: Inpatient Prospective Payment System; IQR: Inpatient Quality Reporting

**CY2024 Mandatory eCQMs**

- Beginning CY2024, hospitals would be required to report data for three measures related to opioids and maternal care.
- Hospitals must also choose three self-selected eCQMs from the below list: why choose the GMCS?

<table>
<thead>
<tr>
<th>Short Name</th>
<th>Measure Name</th>
<th>NQF No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>HII-02</td>
<td>Hospital Harm—Severe Hyperglycemia Measure</td>
<td>3553e</td>
</tr>
<tr>
<td>HII-01</td>
<td>Hospital Harm—Severe Hypoglycemia Measure</td>
<td>3550e</td>
</tr>
<tr>
<td>STK-02</td>
<td>Discharged on Antithrombotic Therapy</td>
<td>0435</td>
</tr>
<tr>
<td>STK-03</td>
<td>Anticoagulation Therapy for Atrial Fibrillation/Flutter</td>
<td>0436</td>
</tr>
<tr>
<td>STK-05</td>
<td>Antithrombotic Therapy by the End of Hospital Day Two</td>
<td>0438</td>
</tr>
<tr>
<td>VTE-1</td>
<td>Venous Thromboembolism Prophylaxis</td>
<td>0371</td>
</tr>
<tr>
<td>VTE-2</td>
<td>Intensive Care Unit Venous Thromboembolism Prophylaxis</td>
<td>0372</td>
</tr>
<tr>
<td>Safe Use of Opioids*</td>
<td>Safe Use of Opioids—Concurrent Prescribing</td>
<td>3316e</td>
</tr>
<tr>
<td>ePC-07/SMM***</td>
<td>Severe Obstetric Complications</td>
<td>NA</td>
</tr>
<tr>
<td>ePC-02***</td>
<td>Cesarean Birth</td>
<td>NA</td>
</tr>
<tr>
<td>GMCS****</td>
<td>Hospital Harm Opioid-Related Adverse Event</td>
<td>3592e</td>
</tr>
<tr>
<td>GMCS****</td>
<td>Global Malnutrition Composite Score</td>
<td>3592e</td>
</tr>
</tbody>
</table>

*Reporting the Safe Use of Opioid Concurrent Prescribing eCQM is mandatory beginning with the CY 2022 reporting period.

***If finalized as proposed, reporting Severe Obstetric Complications and Cesarean Birth (ePC-02) will be mandatory beginning with the CY 2024 reporting period.

****Newly proposed in this proposed rule to add to the eCQM measure set, beginning with the CY 2024 reporting period.

Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS). Final rule. 8/10/2022. Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2023 Rates; Quality Programs and Medicare Promoting Interoperability Program Requirements for Eligible Hospitals and Critical Access Hospitals; Costs Incurred for Qualified and Non-Qualified Deferred Compensation Plans; and Changes to Hospital and Critical Access Hospital Conditions of Participation. https://www.federalregister.gov/documents/2022/08/10/2022-16472/medicare-program-hospital-inpatient-prospective-payment-systems-for-acute-care-hospitals-and-the-

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**Resources Package**

- **September 2019 JAND Supplement**
- **August 2022 JAND President’s Page**
- **October 2022 JAND Supplement**
VALUE, REPORTING, & QUALITY: A BENEFICIAL RELATIONSHIP
Interprofessional Implementation of the Global Malnutrition Composite Score Webinar

MATTHEW BECHTOLD MD, FASGE, FACG, AGAF, FASPEN
PROFESSOR OF CLINICAL MEDICINE
DIRECTOR OF ENDOSCOPY
DIRECTOR OF GI AMBULATORY SERVICES
UNIVERSITY OF MISSOURI
COLUMBIA, MO

Disclosure

- Exact Sciences – Speaker
- Medtrition – Advisory Board
- Nestle Nutrition Institute – Speaker
Learning Objectives

Upon completion of this educational activity, the learner will be able to:

1. Understand the value of the treatment of malnutrition
2. Recognize the importance of inpatient reporting
3. Identify and implement quality improvement measures

We will not cover the following:

1. Why is abbreviation such a long word?
2. Why is there neither pine nor apple in pineapple?
3. What happens when you get scared half-to-death twice?
Value is an integral part of practice

\[ \text{VALUE} = \frac{\text{QUALITY}}{\text{COSTS}} \]

- LENGTH OF STAY
- QUALITY OF CARE
- HOSPITAL-ACQUIRED CONDITIONS

**VALUE OF NUTRITION**

Special Report

Value of Nutrition Support Therapy: Impact on Clinical and Economic Outcomes in the United States

**Total Savings** = $580,000,000
**VALUE OF NUTRITION IN HAIs**

**CLINICAL RESEARCH**

Impact of a nutrition support therapy on hospital-acquired infections: A value analysis

Matthew L. Bechtold MD 1, Hariharan Renganathan MD 2, Renay Tyler DNP, ACNP 3, Peggi Guenter PhD, RN 4, Albert Barrocas MD 5, Nilsa A. Collins RDN, MBA 6

- 21% REDUCTION IN HAIs WITH NUTRITION SUPPORT THERAPY
- DECREASE IN LOS IN PATIENTS RECEIVING NUTRITION SUPPORT THERAPY

**TOTAL ANNUAL SAVINGS FOR CMS WITH NUTRITIONAL SUPPORT THERAPY VS NO NUTRITION SUPPORT THERAPY FOR HAIs = $104,673,000**

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**VALUE OF NUTRITION IN GI MALIGNANCIES**

Value of nutrition support therapy in patients with gastrointestinal malignancies: a narrative review and health economic analysis of impact on clinical outcomes in the United States

Jose M. Pimiento 1, David C. Evans 2, Renay Tyler 3, Albert Barrocas 4, Beverly Hernandez 5, Krysmara Araujo-Torres 6, Peggi Guenter 7; ASPEN Value Project Scientific Advisory Council

**TOTAL ANNUAL SAVINGS FOR CMS WITH NUTRITIONAL SUPPORT FOR GI MALIGNANCIES = $242,000,000**

**POST-OP EARLY vs LATE EN FOR GI CANCER PATIENTS**

**POST-OP ENHANCED RECOVERY AFTER SURGERY vs CONVENTIONAL GROUP FOR GI CANCER PATIENTS**
INPATIENT REPORTING

CMS REPORTING

ADVERSE EVENTS
QUALITY IMPROVEMENT INITIATIVES
INCREASE REIMBURSEMENT

HOSPITAL-ACQUIRED INFECTIONS
## QUALITY IMPROVEMENT

<table>
<thead>
<tr>
<th>ASPECT</th>
<th>IMPROVEMENT</th>
<th>ACCOUNTABILITY</th>
<th>RESEARCH</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIM</td>
<td>IMPROVE CARE</td>
<td>COMPARISON, CHOICE, ASSURANCE</td>
<td>NEW KNOWLEDGE</td>
</tr>
<tr>
<td><strong>METHODS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TEST OBSERVABILITY</td>
<td>TEST OBSERVABLE</td>
<td>NO TEST, EVALUATE CURRENT PERFORMANCE</td>
<td>TEST BLINDED OR CONTROLLED</td>
</tr>
<tr>
<td>BIAS</td>
<td>ACCEPT CONSISTENT BIAS</td>
<td>MEASURE/ADJUST TO REDUCE BIAS</td>
<td>DESIGN TO ELIMINATE BIAS</td>
</tr>
<tr>
<td>SAMPLE SIZE</td>
<td>&quot;JUST ENOUGH&quot;: SMALL SEQUENTIAL SAMPLES</td>
<td>OBTAIN 100% OF AVAILABLE, RELEVANT DATA</td>
<td>&quot;JUST IN CASE&quot; DATA</td>
</tr>
<tr>
<td>FLEXIBILITY OF HYPOTHESIS</td>
<td>CHANGES AS LEARNING TAKES PLACE</td>
<td>NO HYPOTHESIS</td>
<td>FIXED HYPOTHESIS</td>
</tr>
<tr>
<td>TESTING STRATEGY</td>
<td>SEQUENTIAL TESTS</td>
<td>NO TESTS</td>
<td>ONE LARGE TEST</td>
</tr>
<tr>
<td>DETERMINING IF CHANGE IS IMPROVEMENT</td>
<td>RUN CHARTS/ CONTROL CHARTS</td>
<td>NO CHANGE FOCUS</td>
<td>HYPOTHESIS, STATISTICAL TESTS (T-TEST, F-TEST, CHI SQUARE) P VALUES</td>
</tr>
<tr>
<td>CONFIDENTIALITY</td>
<td>DATA USED ONLY BY THOSE INVOLVED IN IMPROVEMENT</td>
<td>DATA AVAILABLE FOR PUBLIC REVIEW</td>
<td>RESEARCH SUBJECTS’ IDENTITIES PROTECTED</td>
</tr>
</tbody>
</table>

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Solberg LI et al. Jt Comm J Qual Improv 1997
QUALITY IMPROVEMENT

PDSA MODEL

“COMPLEX RULES GIVE RISE TO STUPID BEHAVIORS. SIMPLE RULES GIVE RISE TO ADAPTIVE BEHAVIOR.”

- DEE HOCK FOUNDER OF VISA

QI PROJECT

IMPROVING GI CLINIC ACCESS FOR NEW PATIENTS

AIM STATEMENT: To improve GI clinic access for new patients ≤ 10 days by assessing past statistics (2012), evaluating current demand (December 2012 and January 2013), implementing a plan of action to improve outcomes to >70% by March 2013.

PLAN: Access to subspecialty clinics is an extremely important healthcare issue for patient care, referring physicians, and downstream revenue. Our plan is to track current practice over the past year at the Digestive Health Center, implement changes within the system, and compare it to those performed from January 2013 to present.

STUDY THE RESULTS:

1. Numerator = # of new patients ≤ 10 days
2. Denominator = # of total new patients
3. Performance Indicator: % of new patients ≤ 10 days

DO:

1. Establishment of a new Director of Ambulatory Services – Matthew Bechtold MD, FASGE, FACG – 12/1/12
2. Education of faculty regarding improvement of return patient intervals – 12/5/12
3. Education of faculty and fellows regarding open access clinic – 12/5/12
4. Creation and implementation of new clinic directive in which all PSRs are to notify new Director of Ambulatory Services if a new patient cannot be seen ≤ 10 days – 12/26/12
5. Patient scheduled by Director of Ambulatory Services to meet goal by asking the referred provider to overbook, overbook the Director’s clinic, or by creating a special clinic after-hours to see patient (unless otherwise specified by patient) – 12/26/12
6. Implementation of open access model – 1/14/13
7. Implementation of 60/40 rule – 60% returns and 40% new – 7/10/13

ACT:

1. Education performed – 12/5/12
2. Policy initiated – 12/26/12
3. Open access initiated – 1/14/13

TEAM MEMBERS:

Matthew Bechtold  Ashley Sliger  Laura Burnett  GI
Melissa Mathews  Belle Florence  Pamela Hicks  Faculty & Fellows

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Matthew Bechtold  Ashley Sliger  Laura Burnett  GI
Melissa Mathews  Belle Florence  Pamela Hicks  Faculty & Fellows

Demand Analysis – December 2012

Demand Analysis – December 2012
Learning Assessment Questions
Summary

• Is there value in identification and treatment of malnutrition?
  ≫ Absolutely, in both improved patient outcomes and $

• Is inpatient reporting important?
  ≫ Yes it is. Although cumbersome, inpatient reporting improves patient outcomes, stimulates QI initiatives, and increases reimbursement

• How do you initiate a QI project?
  ≫ Identify a problem → Do a PDSA cycle → Remeasure → Repeat

References List


Implementation of Malnutrition Quality Measures
A Practical Journey

Ken Nepple, MD FACS
Clinical Professor of Urology, Associate Chief Medical Information Officer, Physician Value Officer, Clinical Documentation Improvement Advisor.

University of Iowa Hospitals & Clinics
Iowa City, Iowa
Disclosure

- No commercial relationships to disclose.

Learning Objectives

Upon completion of this educational activity, the learner will be able to:

1. Describe how to spark interest in “win-win” malnutrition quality improvement
2. Discuss development of discrete data sources within the EHR for the Global Malnutrition Composite Score via technology-enabled workflow
3. Report our prior initial experience with malnutrition electronic clinical quality measures and future plans

Emphasis on practical advice on how to move forward malnutrition QI at your institution
Broad overview of initial malnutrition pilot
Our initial journey

Malnutrition Pilot
Interdisciplinary team: Nursing, Nutrition, Physician (GI and Surgical), APPs, Informatics, Clinical Documentation Improvement, Finance, Quality/Safety.
Malnutrition Pilot Outcomes

- Multidisciplinary group refined the process of inpatient evaluation, with a focus on communication and accurate malnutrition assessment in the EHR (electronic health record) using the Academy/ASPEN Consensus Statement.
- Malnutrition pilot of the new workflow on two inpatient units during a four month period (no additional FTEs required to implement).
- Malnutrition was then identified in 42% of patients on the two pilot units.
- Favorable impact on allowable length of stay and hospital reimbursement
- Hospital administration almost immediately added 6FTEs (from 25 to 31 FTEs to 33 to 37)
- The pilot malnutrition workflow was implemented hospital-wide.
- Preoperative and cancer center: no dietitian/program to dedicated dietitian/program (from “Hy-Vee grocery to comprehensive cancer center”)
Improvement in Hospital Malnutrition Diagnosis

<table>
<thead>
<tr>
<th></th>
<th>Adults Acute Inpatients</th>
<th>Adults Acute Inpatients with Malnutrition</th>
<th>% of Adults Acute Inpatients with Malnutrition</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2012</td>
<td>932</td>
<td>25,800</td>
<td>3.6%</td>
</tr>
<tr>
<td>FY 2013</td>
<td>1,388</td>
<td>25,921</td>
<td>4.6%</td>
</tr>
<tr>
<td>FY 2014</td>
<td>1,477</td>
<td>26,249</td>
<td>5.6%</td>
</tr>
<tr>
<td>FY 2015</td>
<td>2,182</td>
<td>26,500</td>
<td>8.2%</td>
</tr>
</tbody>
</table>

Pilot Evaluation of Electronic Clinical Quality Measures

Our initial journey
Data set creation

- Write rules to build an adult inpatient cohort from retrospective data *(can also be done real time)*

2,583 adult discharges in a month

- Some moderate effort in building a report
- Worked 1 on 1 with a reporting analyst
- Able to identify all hospital discharges >24 hours and pull discrete data elements including (age, diagnoses, discrete data, labs, time stamps, grouper based diagnoses)
Nursing Nutritional Screening

Component Measure 1: Inpatient hospitalizations for patients with a current screening for malnutrition risk performed at the time of admission.

Screening (initial data was for within 24 hours of admit)

Nutrition Screen: Nutrition Screening/Adult
Are you currently on CVN/PVN or tube feeding?: No
Have you recently been on tube feedings or TPN, or have a nutritional access device in place?: No
Have you been eating poorly because of a decreased appetite?: No
Food intake less than 50% of usual for greater than 7 days?: No
Have you lost or gained weight without trying within the last 6 months?: No
Chew/swallow difficulty: No
Emaciated: Yes
Chronic non-healing wound: No
Post Surgery greater than 77 y/o: Yes
Recent vomiting/diarrhea?: No
Pregnant/lactating: Not pregnant/lactating or unknown
OB patient only: N/A
Food allergies: No
Score/nutrition adult: 8

Data available:
- Questionnaire in EHR
- Entered by nursing as a “hard stop”
Admission Nursing Nutrition Screen

Old Screen

<table>
<thead>
<tr>
<th>Question</th>
<th>Point Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>CVN/PVN/tube feed</td>
<td>7</td>
</tr>
<tr>
<td>Food intake less than 50% of usual greater than 7 days</td>
<td>4</td>
</tr>
<tr>
<td>NPO/clear liquids greater than 5 days</td>
<td>4</td>
</tr>
<tr>
<td>Unintentional wt loss/gain greater than 9 lbs</td>
<td>4</td>
</tr>
<tr>
<td>Chew/swallow difficulty</td>
<td>4</td>
</tr>
<tr>
<td>Emaciated/Chronic non-healing wound</td>
<td>4</td>
</tr>
<tr>
<td>Post surgery greater than 77 y/o</td>
<td>4</td>
</tr>
<tr>
<td>Vomit/diarrhea greater than 3 days</td>
<td>2</td>
</tr>
<tr>
<td>Food allergies</td>
<td>2</td>
</tr>
<tr>
<td>Pregnant/lactating</td>
<td>4</td>
</tr>
<tr>
<td>OB patient only</td>
<td>7</td>
</tr>
</tbody>
</table>

FNS Documentation Guidelines:
- Nutrition screen must be completed by nursing within 24 hours of admission
- Once the nutrition screen is complete an initial assessment must be done by FNS staff as follows:
  - Patients with a total score of 7 or above (high risk) need to be assessed within 48 hours of the screen
  - Patients with a total score of 4-6 (moderate risk) need to be assessed within 72 hours of the screen
  - Patients with a score of 3 or lower (low risk) need to be rescreened by FNS staff on a weekly basis (every calendar week)
- Follow-up notes are due on a weekly basis (every calendar week)

Our documentation guidelines have not changed since we have implemented the new screen. Let me know if you have any questions

Screening (this data was for within 24 hours of admit)

Table 2. Baseline eCQM performance scores for pilot hospital

<table>
<thead>
<tr>
<th>Measure title (eCQM #)</th>
<th>Measure denominator</th>
<th>Measure numerator</th>
<th>Performance rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1: Completion of a malnutrition screening within 24 h of admission</td>
<td>2,756</td>
<td>1,949</td>
<td>70.7</td>
</tr>
</tbody>
</table>

Lessons Learned:
- Feasible
- ICU vs. non-ICU workflow
Dietitian Assessment

Component Measure 2: Inpatient hospitalizations for patients with a current assessment for malnutrition performed from an “at risk” finding in a current malnutrition screening.

Assessment
(within 24 hours of “at risk” screen for this data)

Data available:
- Dietitian data in consult note needed to be developed using technology-enabled workflow
Defining malnutrition assessment at the Project Meeting

**Defining Malnutrition:** The team identified that malnutrition is best defined using a 2012 Consensus Statement of the Academy of Nutrition and Dietetics (Academy) and American Society for Parenteral and Enteral Nutrition (ASPEN): Characteristics Recommended for the Identification and Documentation of Adult Malnutrition based on a minimum of 2 of the 6 clinical characteristics of inadequate energy intake, weight loss, fat loss, muscle loss, edema, reduced grip strength.

FROM THE ACADEMY

Consensus Statement

**Consensus Statement of the Academy of Nutrition and Dietetics/American Society for Parenteral and Enteral Nutrition: Characteristics Recommended for the Identification and Documentation of Adult Malnutrition (Undernutrition)**

Jara V. White, PhD, RD, FADA; Peggy Guiterre, PhD, RD, Gordon Jenam, MS, PhD, FADA; Andrew Maline, MS, RD, LDN; Marka Schmer, MS, RD, the Academy Malnutrition Work Group; and the ASPEN Board of Directors

**Abstract**

The Academy of Nutrition and Dietetics and the American Society for Parenteral and Enteral Nutrition (ASPEN) recommend a standardized set of diagnostic characteristics for identifying and documenting malnutrition to ensure clinical practice. An epidemiological-based data analysis has demonstrated a clinical understanding of the role of the dietary therapies on malnutrition-free status, progression, and mortality is prepared. (Internal use only: a simple set of diagnostic characteristics is used to improve the team's understanding of the role of the dietary therapies on malnutrition-free status, progression, and mortality)

**Malnutrition Pilot Specifics For Dietitian Assessment**

- **Improved Consult Workflow**
- **Changed Dietitian Assessment and Chart Note Format**

*Discrete data*

SmartData for malnutrition diagnosis based on ASPEN/Academy Consensus Statement criteria to assess as mild vs moderate vs severe malnutrition (subsequently evolved to also include GLIM Criteria when applicable)
**Assessment**

(*within 24 hours of “at risk” screen for this data*)

<table>
<thead>
<tr>
<th>Measure title (eCQM #)</th>
<th>Measure denominator</th>
<th>Measure numerator</th>
<th>Performance rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2: Completion of a nutrition assessment for patients identified as at risk for malnutrition within 24 h of a malnutrition screening</td>
<td>346</td>
<td>98</td>
<td>28.3</td>
</tr>
</tbody>
</table>

**Lessons Learned:**
- Timing in workflow (24 vs 48 hr)
- Need to improve data granularity

**Physician Diagnosis**

Component Measure 3: Inpatient hospitalizations for patients with a current malnutrition diagnosed as a result of a "moderate" or "severe" malnutrition status from a current malnutrition assessment.
Malnutrition Pilot Specifics For Physician Diagnosis

- Improve Workflow using SmartPhrase (or similar EHR tool)
  - Electronic health record dot phrase (.malnutritiontext) can be used to insert the assessment and present on admission status from the dietitian assessment into progress notes, and can serve as a prompt for physician documentation

<table>
<thead>
<tr>
<th>Abbrev</th>
<th>Expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td>MALNUTRITIONTEXT</td>
<td>Pertinent Text from the FNS Malnutrition Evaluation</td>
</tr>
</tbody>
</table>

Also Encourage use of problem list

* Discrete data

Malnutrition Pilot Specifics For Physician Diagnosis

* Discrete data
Data available:
- Discrete problem/diagnosis list in EHR
- Text not available as discrete data

Lessons Learned:
- Challenge
- Variability in documentation
- Education on CDI (clinical documentation improvement)

### Table 2. Baseline eCQM performance scores for pilot hospital

<table>
<thead>
<tr>
<th>Measure title (eCQM #)</th>
<th>Measure denominator</th>
<th>Measure numerator</th>
<th>Performance rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appropriate physician documentation of a malnutrition diagnosis</td>
<td>32</td>
<td>18</td>
<td>56.3</td>
</tr>
</tbody>
</table>

Care Plan

Component Measure 4: Inpatient hospitalizations for patients with a current nutrition care plan performed as a result of a “moderate” or “severe” malnutrition status from a current malnutrition assessment.
**Care Plan**

**Table 2. Baseline eCQM\(^b\) performance scores for pilot hospital**

<table>
<thead>
<tr>
<th>Measure title (eCQM #)</th>
<th>Measure denominator</th>
<th>Measure numerator</th>
<th>Performance rate (%)(^b)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nutrition care plan for patients identified as malnourished after a completed nutrition assessment(^b)</td>
<td>32</td>
<td>27</td>
<td>84.4</td>
</tr>
</tbody>
</table>

**Data available:**
- In the EHR, but was not readily abstracted electronically as discrete data point

**Lesson Learned:**
- Opportunity for improved workflow for communication and to capture discrete data

**Care Plan**

- Over time, lead to development of an Advanced Nutritional Consult Service which is staffed by GI physician, dietitian, and pharmacist
- Currently in the process of transitioning dietitian care plan and ONS (oral nutritional supplements) to discrete data
Conclusions

Advice

• Emphasis on practical advice on how to move forward some malnutrition QI at your institution

• Automate some of the process

• Make some improvement in some thing

• Small things, done consistently, make major impact
  
  -David Allen
Reference List


Learning Objectives

Upon completion of this educational activity, the learner will be able to:

1. Define the composite score measure and its focus on components of the nutrition care process: screening, assessment, documenting diagnosis and implementing nutrition care plan

2. Review how adopting the measure and using a quality improvement process can benefit patient care, providers, and hospital outcomes

3. Discuss how the interprofessional team can partner with administrators to adopt and report on the composite score measure to improve patient outcomes and support health equity
Questions

- Submit your questions using the interactive panel on the left.
- Click Questions to submit your questions directly to the faculty.
- For technical support, please use the Request Support button at the bottom left of the webinar player.

Acknowledgement

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