Academy of Nutrition and Dietetics
From Readiness to Results: Practical Strategies to Implementing the Malnutrition Care Score
July 29, 2026
Webinar Transcript

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00:00:03,170 --> 00:00:06,250
Good afternoon or good morning wherever you're joining us from.

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00:00:06,410 --> 00:00:17,050
And thank you for joining us for today's webinar, From Readiness to Results, Practical Strategies to Implementing the Malnutrition Care Score.

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00:00:20,250 --> 00:00:23,690
My name is Angela Lago and I will be your moderator for today.

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I am the Senior Director of Quality Management and Practice Competence at the Academy of Nutrition and Dietetics.

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Joined today by our amazing speakers, Natali Jouzi, Advanced Inpatient Dietitian from the Mayo Clinic, Stacy Pelekhaty, Senior Clinical Nutrition Specialist at R.

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00:00:44,650 --> 00:00:56,410
Adams Cowley Shock Trauma Center, University of Maryland Medical Center, and Carrina Burke, Client Executive, Clinical Services at New York City Health and Hospitals.

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00:00:57,130 --> 00:01:24,330
I am very excited to hear from all three of these leaders today because while it's very important to learn all about the technical aspects of the malnutrition care score and the updates, which I will be presenting today, it's very meaningful to hear how organizations are actually pursuing implementation and for all of us to learn from their successes and lessons learned that they will be sharing with us today.

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00:01:28,010 --> 00:01:31,770
Here are our disclosures for today's presentation.

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00:01:36,490 --> 00:01:39,930

And here are our objectives for the presentation today.

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00:01:39,930 --> 00:01:42,410
I'll give you just a few moments to review those.

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00:01:49,150 --> 00:01:56,190
Alright, so a few important announcements as far as communicating during today's webinar.

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00:01:57,050 --> 00:02:04,890
If you have any technical issues at all, please use the chat function at the bottom of your screen.

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00:02:05,850 --> 00:02:14,650
If you have issues with links, if possibly you didn't receive the handouts, please e-mail quality@eatright.org.

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00:02:15,130 --> 00:02:17,690
And if you have questions for the presenters today,

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00:02:18,250 --> 00:02:28,730
or the Academy's Measure Developer team who will be joining us for the Q&A section, please use the Q&A function or button at the bottom of your screen.

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00:02:29,770 --> 00:02:33,530
We will not be using the raised hand feature today during the webinar.

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However, we do have individuals waiting for you in the chat, in the e-mail, and in the Q&A box to assist you with anything that may come up during today's webinar.

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Okay, so let's get started with today's presentation by first talking a little bit about the basics of quality measurement.

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I'm going to spend approximately 20 minutes reviewing this and then we will jump right into hearing from each of our organizations and then we will have a robust Q&A session at the end.

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So a quality measure is a way to measure how well something is being done, using data to show whether the results meet a desired standard or best practice.

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Quality measures help us understand our current performance and identify opportunities to improve that performance.

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A health care quality measure is a way to check whether patients are getting the right care at the right time and achieving great health outcomes, which would be all of our goals, right?

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So more or less, a report card that helps us see how well a doctor, a hospital, or even a dietitian is doing at delivering safe, effective, and timely care.

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So basically, what are we trying to do?

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How do we know if we're doing it well?

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And how can we improve based on the results that we're getting to see through measurement?

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00:04:18,810 --> 00:04:22,490
I've linked the care compare website for you on this slide.

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And that takes you to the medicare.gov website where you can compare different types of Medicare providers.

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You can compare

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00:04:31,770 --> 00:04:43,130
scores, compare cost of procedures between different organizations for example to

show you an example of where and how some of this data can be used.

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00:04:48,330 --> 00:04:58,570
The Center for Medicare and Medicaid Services or CMS, as most of you probably are most familiar with, collects and analyzes information to produce reports

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utilizing quality improvement and quality measurement data.

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Within the CMS program is the inpatient quality reporting program, or you may hear it referred to as IQR, which is a pay for reporting initiative that requires hospitals to submit quality and safety data to reduce complications or lower mortality rates and deliver high quality care.

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Electronic clinical quality measures, which you can see nestled there in the green circle, are part of the IQR program.

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And they leverage data that's extracted from the medical record to assess quality and care quality.

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So hospitals submit this eCQM data, such as the malnutrition care score, to CMS directly through and from these systems.

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This kind of gives you an idea how all of that is connected.

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So when we're looking at the timeline for eligible hospitals and critical access hospitals, it's important to understand how and when data is gathered, reported, and when payment is received.

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So using this image for calendar year 2026 reporting for that reporting period, eligible hospitals and critical access hospitals that participate in the IQR program must report four quarters of data on five mandatory eCQMs and three optional or self-selected eCQMs.

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And this is reported annually.

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So currently the malnutrition care score is one of the optional or self-selected eCQMs.

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I have included the link over to the right in the green box to QualityNet for you to reference after the webinar if you'd like further information on

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00:07:08,730 --> 00:07:17,530
which measures are mandatory, which are self-selected, and you will see the malnutrition care score among those when you check that out.

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But it's interesting to look a little more into that.

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So if you're interested in that, please visit that website.

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So when implementing the malnutrition care score at your organization, it's important to understand key reporting terms.

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00:07:34,410 --> 00:07:35,090
and period.

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So the reporting period is the calendar year that the data is collected.

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The data that's collected is then submitted the following year during the submission period.

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And then ultimately the data that's reported and submitted will be directly linked to the payment period fiscal year that corresponds to the year after the submission period.

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So I know that probably sounds somewhat confusing

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But for example, for the 2026 payment period, that data was collected in 2024 and submitted in 2025.

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So hopefully that helps you understand that a little bit.

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Again, you can look at that website that I've attached if it helps explain a little more.

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00:08:29,650 --> 00:08:33,210
Okay, so diving in a little more to

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away from just the basics of quality measurement and into the malnutrition care score specifically.

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As mentioned the malnutrition care score or MCS is how you'll probably hear it referred to in this presentation is one of the electronic clinical quality measures also known as ECQMs and as I said this is currently a voluntary measure for the IQR program.

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The MCS assesses adults age 18 years and older at the start of the measurement period with a length of say equal to or greater than 24 hours.

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And we're looking to see that these patients received optimal malnutrition care where the care that was provided was appropriate to the patient's level of malnutrition risk or severity.

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As many or most of you on this call know, malnutrition care best practices recommend that adult inpatients are screened for malnutrition risk or receive a

dietitian referral order, are assessed by a registered dietitian to confirm findings of malnutrition risk, and if identified with a moderate or severe malnutrition status,

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receive a moderate or severe malnutrition diagnosis by a physician or eligible clinician.

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And then finally have a current nutrition care plan performed by dietitian, RD

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or RDN.

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Now some of you may not be aware of this yet but the MCS is proposed to become mandatory.

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We will find out during the final rule hopefully in August.

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If this is passed, inpatient acute care hospitals that are participating in the IQR program would begin mandatory reporting in 2028.

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So if this happens, this would be huge for the profession and it would ultimately increase visibility of the malnutrition care score tremendously.

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So this graphic shows key roles that different professions

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can offer to help achieve successful implementation of the malnutrition care score.

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Excuse me.

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I'm sure that you will hear multiple, if not all of these areas discussed when we hear our subject matter experts from the different organizations present later.

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Many of these people are just key in getting this successfully implemented in your organization.

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So

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While I believe CNMs and nutrition leaders should ultimately drive implementation within their organizations, this is not something that you can or should try to do alone.

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It's nearly impossible.

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So you'll need to garner support from a variety of key players within your organizations and perhaps start a malnutrition task force or a malnutrition work group.

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It's important to think strategically about this as well because

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You don't want to think about just getting implementation done.

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You want to think about sustainability and quality improvement.

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You want to keep all of that in mind as you're working through this process.

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So the MCS is designed to measure as I said whether patients received evidence-based malnutrition care throughout their hospital stay.

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So rather than focusing on only

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One aspect, which is was malnutrition identified, we, or I should say the measure is evaluating whether each critical step in the clinical care pathway was completed according to established nutrition guidelines.

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So this means the score reflects the quality and completeness of malnutrition care that's provided by reflecting adherence to evidence-based nutrition care guidelines,

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identifying gaps in care such as patients who were screened but never assessed, or maybe patients that were assessed but not diagnosed and treated.

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Additionally, by encouraging multidisciplinary coordination among nurses, dietitians, physicians, and other healthcare professionals, and supporting quality improvement initiatives by measuring the reliability of the complete malnutrition care process rather than individual isolated tasks.

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So I'm not sure if you have had a chance to visit the eatrightpro website where we have a plethora of open access MCS related quality improvement and implementation resources.

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If you have not had a chance to do that, please do so.

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The link is at the bottom of the slide.

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And take advantage of everything that is available for your use.

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So this includes things like evidence-based guidance to support malnutrition care, the image that we just saw in the previous slide, links also to important measure related websites, some of which I've shared with you already today.

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There are videos on malnutrition identification and documentation, implementation resources, a malnutrition

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calculator or an MCS calculator, excuse me, an FAQ document and much more.

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So the measure development and steward team is consistently updating those documents and trying to even possibly take recommendations on things that would be helpful as you're implementing.

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We love creating those resources for you guys.

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00:14:30,810 --> 00:14:30,930
Okay.

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So let's dive into some of the updates or all of the updates to the MCS for reporting year 2027.

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So the malnutrition care score is reviewed and updated annually through a standardized process that's used actually for all electronic clinical quality measures.

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This review process aims to balance high quality care with the technical feasibility and implementation across

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diverse electronic health record systems and hospital settings.

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So as you can imagine with, I guess there's over a thousand, close to 2,000 people on this call right now, you can imagine the variety of flow sheets that you have set up, the variety of medical record vendors that you're using.

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There's so much variation.

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So our goal is to help make that feasible across all of those settings.

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For reporting year 27 or RY27, the revisions are focused on refining exclusion criteria, updating terminology, and fine-tuning measure logic.

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So not necessarily as many updates as we've had in previous years, but still significant updates that are impactful.

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So this is a summary of value set revisions to the malnutrition care score for reporting year 2027.

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The Academy's measure developers made two main value set updates.

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So one of which is expanding the diagnostic criteria included in the measure observation and maintaining clinical terminology by removing inactive codes.

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So

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During the webinar today, we will not dive in heavy to value sets, but we do have some resources.

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We're actually working on creating a new resource to explain the importance of value sets as we speak.

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So stay tuned for that.

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Additionally, the malnutrition diagnosis value set was expanded to include the ICD-10CM code E88A, which is wasting disease.

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And measure developers also reviewed value sets to confirm that codes remain active.

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So this is where we're talking about removing inactive codes.

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We had one inactive SNOMED CT concept which was nutrition feeding management regime therapy was removed from the nutrition care plan value set.

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And this update did not have any effect on the measure's intent.

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Okay.

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A key reporting year 2027 update is the way that the measure identifies and excludes patients that are receiving hospice care.

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The intent of this exclusion, which is to remove hospice patients from the measure population, remains unchanged.

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And just to clarify, this doesn't mean

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00:17:48,970 --> 00:17:51,690
that hospice patients don't receive malnutrition care.

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It just means that they're not included in this measure.

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So for reporting year 27, a value set consisting of nine SNOMED CT codes has been replaced with two extensional value sets to provide a closer semantic match to the discharge data element without changing the exclusions intent.

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So the hospice exclusion intent remains unchanged.

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And then the measure logic refinements, so standard logic refinements occurred to improve the measure's clarity and consistency.

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These changes did not change the way that the measure is scored.

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So in summary, for reporting year 2027,

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the updates are targeted modifications to improve the precision, clarity, and terminological alignment of the MCS without changing its structure or intent.

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And finally, for my portion of the presentation, I have listed steps to consider when implementing the malnutrition care score in your facility.

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Now,

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This information or steps for consideration can apply to any large or small quality improvement project, process improvement project that you'd like to implement.

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But this is based off of experience in my previous role as a clinical nutrition manager.

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So maybe it's useful for the MCS, maybe it's useful for other projects that you're working on.

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But I think it's important to consider if you're just getting started,

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00:19:50,250 --> 00:19:51,770
Where are you now?

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00:19:52,610 --> 00:19:56,890
What is your baseline status and your launching point?

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00:19:56,890 --> 00:20:03,130
So that's important to determine, to iron out the next steps that you'll need to take.

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00:20:03,770 --> 00:20:06,810
It's also really important to know who needs to be at the table.

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You need leadership support.

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You need a project team, as I mentioned, possibly a malnutrition task force, some type of work group.

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00:20:16,170 --> 00:20:19,290
You likely need, depending on the size of your organization,

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malnutrition champions, some type of champions from the technology, the techie side.

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And I'm sure we're going to hear a lot about that from our presenters today.

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00:20:31,930 --> 00:20:40,250
Boots on the ground, the type of support that they needed and the voices that they needed at the table because you're going to need leadership support to help push this through.

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00:20:41,770 --> 00:20:45,210
Then you also want to consider training and education needs.

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So

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00:20:46,730 --> 00:20:49,770
Do your dietitians, do your diet technicians need training?

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00:20:49,890 --> 00:20:51,690
Do they need training on NFPE?

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00:20:52,090 --> 00:20:59,850
Maybe diagnosing nutrition, malnutrition, using the nutrition care process, documenting in standardized fields.

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00:20:59,850 --> 00:21:01,450
What kind of training do they need?

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00:21:02,090 --> 00:21:03,610
Do the providers need training?

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00:21:03,770 --> 00:21:09,690
What kind of relationship do you have with the coding and the CDI staff within your organization?

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00:21:09,690 --> 00:21:14,650
And what type of education might you be able to collaborate with those individuals on?

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00:21:16,970 --> 00:21:21,210
You'll also need to consider what type of communication plan that you'll need.

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00:21:21,210 --> 00:21:23,650
This will vary depending on the size of your organization.

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00:21:23,650 --> 00:21:33,530
If you have a small rural hospital or if you have a large system with hospitals in

multiple states, it will vary depending on the size of your organization.

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00:21:33,530 --> 00:21:38,090
But this information will need to be disseminated and you'll want to

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00:21:40,090 --> 00:21:51,370
Give your staff and the people that are on your project team pats on the back as you're going along too, because it's going to take a lot of dedicated time and you want your leaders to know what you're doing and the efforts that you're making.

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00:21:53,370 --> 00:21:57,130
You'll also want to consider what kind of documentation requirements.

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00:21:57,450 --> 00:22:00,810
So what are the elements that the MCS requires?

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00:22:01,850 --> 00:22:04,490
How does that vary from what your organization requires?

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00:22:04,930 --> 00:22:19,450
What kind of leading into the next with data capture, how do you know what you need to show impact and progress as you're implementing malnutrition quality leading up to malnutrition care score implementation?

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00:22:19,450 --> 00:22:22,090
So you want to know what those requirements are.

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00:22:22,290 --> 00:22:26,570
where your staff needs to be documenting to be able to capture that data.

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00:22:28,090 --> 00:22:32,170
And then what do you want to do once you reach your goal?

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00:22:32,170 --> 00:22:35,210
Or what if you're having a hard time reaching your goal?

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00:22:35,410 --> 00:22:37,050
Like what are your next steps?

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00:22:37,210 --> 00:22:38,650
Do you have an alternate plan?

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00:22:38,730 --> 00:22:45,370
So maybe you go in full force and then realize that it's a little bit too much too fast.

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What is your plan to break this down into smaller projects that are more manageable for your organization and for your staff?

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So I think it's important not to take your eye off the ball, but just determine what you need to reach your goal.

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And then finally, sustainability.

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00:23:04,090 --> 00:23:09,930
That's really important to keep in mind because the goal isn't just to get it running.

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00:23:09,930 --> 00:23:14,010
The goal is to have consistency and to

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00:23:16,170 --> 00:23:19,770
not only reach your goal, but be able to sustain the improvements that you're making.

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00:23:19,770 --> 00:23:25,050
So what is going to be required to sustain your program and to sustain your processes?

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00:23:25,050 --> 00:23:29,450
So these are all important steps to consider.

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00:23:29,450 --> 00:23:34,970
I'm sure there's a ton more that I could have talked about, but for the purposes of today, I hope these are helpful.

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And I'm sure, like I said, we'll hear from these as our presenters start talking about their individual experiences with implementing the MCS.

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00:23:43,450 --> 00:23:48,730
So now I am going to turn it over to Natali and we're going to learn about her organization's efforts.

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00:23:49,090 --> 00:23:49,410
Thank you.

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00:23:49,490 --> 00:23:50,650
All right.

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00:23:50,890 --> 00:23:51,770
Thanks, Angela.

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00:23:52,170 --> 00:23:52,730
All right.

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00:23:52,730 --> 00:24:10,170
So now that we've reviewed implementation considerations, I'd like to focus on the first two measures in MCS specifically, improving malnutrition screening and the nutrition diagnosis, as they both have a significant impact on the malnutrition care score performance.

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So some of the strategies I'll talk about today are examples and lessons that are drawn from work that I completed at a 346 bed regional hospital serving a predominantly rural population in North Iowa.

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All right, next slide.

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00:24:30,170 --> 00:24:36,170
So before we talk about specific strategies, I want to talk first is, you know,

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00:24:38,010 --> 00:24:39,810

there's a, let me go back to the last slide.

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00:24:39,810 --> 00:24:40,290
Where is it?

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00:24:40,570 --> 00:24:41,130
Skip the slide.

193
00:24:41,130 --> 00:24:41,490
There we go.

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00:24:42,090 --> 00:24:53,210
So before we talk about specific strategies, I'd like to frame this discussion using a quality improvement approach that many of us are already familiar with, which is the PDSA cycle.

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00:24:53,690 --> 00:24:55,130
Plan, Do, Study, Act.

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00:24:55,450 --> 00:25:08,170
While we often think of PDSA in the context of a formal quality project, it also provides a useful framework for improving malnutrition screening and nutrition diagnosis.

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00:25:08,570 --> 00:25:10,650
So the first step is plan.

198
00:25:11,370 --> 00:25:13,290
We need to understand our current state.

199
00:25:13,610 --> 00:25:16,730
How are we performing as a hospital or ministry?

200
00:25:17,450 --> 00:25:18,570
Where are the gaps?

201
00:25:18,570 --> 00:25:20,570
Are patients being screened on time?

202
00:25:20,570 --> 00:25:23,050
Are positive screens reaching the dietitians?

203
00:25:23,290 --> 00:25:26,570
Are diagnoses being documented consistently?

204
00:25:26,970 --> 00:25:29,850
So what are tools that you could do to capture this?

205
00:25:30,330 --> 00:25:39,610
It's baseline data collection through chart audits, gap analysis, workflow mapping, looking at root cause analysis, developing fishbone diagrams.

206
00:25:39,610 --> 00:25:42,890
So many things that you can do in this frame.

207
00:25:43,930 --> 00:25:49,290
Next, once we've identified opportunities for improvement, we move into do.

208
00:25:49,530 --> 00:25:53,370
This is where organizations implement targeted interventions, right?

209
00:25:53,570 --> 00:26:08,730
Whether that's improving screening workflows, optimizing the EHR, electronic health record, standardizing assessment templates, or strengthening documentation practices, there are several things you can do with this phase.

210
00:26:09,850 --> 00:26:11,370
And next study.

211
00:26:11,610 --> 00:26:15,050
So we evaluate what we did in the do phase.

212
00:26:15,050 --> 00:26:19,130
So we evaluate whether those changes are making a difference in what we're doing.

213
00:26:19,370 --> 00:26:21,370
So are screening rates improving?

214
00:26:21,610 --> 00:26:25,130
Are assessments happening more quickly or in a timely manner?

215
00:26:25,450 --> 00:26:29,530
Are we seeing more consistent malnutrition diagnosis documentation?

216
00:26:30,250 --> 00:26:32,010
And then finally, we act.

217
00:26:32,410 --> 00:26:39,450
We take what we've learned in the previous phases and decide what should be standardized, refined, or scaled.

218
00:26:39,690 --> 00:26:46,330
The goal is not just improvement, but like Angela mentioned, it's sustainable improvement.

219
00:26:46,610 --> 00:26:51,450
When you think about it, improving malnutrition care follows the same cycle.

220
00:26:51,450 --> 00:26:52,970
We assess our patients, right?

221
00:26:53,250 --> 00:26:59,890
We then provide the intervention, we monitor and evaluate the patient's progress, and then we continue refining our intervention.

222
00:27:00,170 --> 00:27:00,890
over time.

223
00:27:01,210 --> 00:27:04,290
So during the patient stay to help improve their outcomes.

224
00:27:04,290 --> 00:27:07,690
So kind of that same framework with the PDSA.

225
00:27:08,810 --> 00:27:23,770

So as I move through the next few slides, you'll see examples of strategies that may align with each step of the PDSA framework that can help you create a more reliable approach to improving your malnutrition screening and nutrition diagnosis.

226
00:27:25,370 --> 00:27:36,810
So let's start with the first step, but first I want to move on to understand where organizations commonly experience breakdowns in the screening and diagnosis process.

227
00:27:38,970 --> 00:27:39,250
All right.

228
00:27:39,850 --> 00:27:42,890
So where organizations commonly struggle, struggle.

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00:27:43,050 --> 00:27:52,570
So when I talk about talk with dietitians from across different organizations, the, you know, the challenges and our struggles are remarkably similar.

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00:27:52,930 --> 00:27:56,330
It's usually not that people don't care or don't know what to do.

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00:27:56,650 --> 00:28:00,810
The problem is that somewhere in the process, things fall through the cracks.

232
00:28:01,130 --> 00:28:08,450
Maybe a screen isn't completed, maybe a positive screen doesn't trigger a referral, maybe an assessment is delayed because of competing

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00:28:08,490 --> 00:28:14,970
priorities or staffing issues, or maybe the nutrition diagnosis isn't clearly documented.

234
00:28:15,450 --> 00:28:26,490
Each individual gap may seem small, but when they add up, they can significantly impact on patient care and the quality outcomes and the MCS score.

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00:28:26,890 --> 00:28:31,530
And that's why it's important to look at the entire process and not just one piece of it.

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00:28:31,770 --> 00:28:36,570
But for my section today, I'll be focusing again on the screening and the diagnosis sections.

237
00:28:40,890 --> 00:28:47,290
So our first strategy that I'll focus on is so you can diagnose what you don't identify.

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00:28:47,690 --> 00:28:51,450
Strategy one, building a consistent screening process.

239
00:28:51,770 --> 00:28:56,090
So this strategy focuses on building a more consistent screening process.

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00:28:56,170 --> 00:29:01,370
As we know, most organizations already have a screening tool in place, right?

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00:29:01,690 --> 00:29:11,850
The challenge is making sure that the tool is used consistently and the process works the same way across every unit, every shift and every patient admission.

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00:29:12,170 --> 00:29:20,170
So one of the most effective approaches is standardizing the use of a validated screening tool, for example, the MST tool.

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00:29:20,570 --> 00:29:28,410
across the organization, and this helps reduce variation and ensures patients are being evaluated using the same criteria.

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00:29:29,610 --> 00:29:32,810
Another important consideration is workflow integration.

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00:29:32,810 --> 00:29:39,210
So screening should be embedded into the admission process with clear accountability for completion.

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00:29:39,450 --> 00:29:47,530
So the easier it is to complete and the clearer the responsibility of who is doing

the screening, the greater the likelihood it gets done consistently.

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00:29:48,970 --> 00:29:50,890
And next, technology.

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00:29:51,130 --> 00:29:53,130
Technology can be a powerful ally.

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00:29:53,530 --> 00:30:08,810
So using EHR tools like BPA alerts, dashboards, data dashboards, and real-time monitoring help make missed screenings visible so they can be addressed before they result in missed opportunities for patient care.

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00:30:10,810 --> 00:30:13,530
And the next strategy is to generate data reports.

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00:30:13,690 --> 00:30:17,850
Data is important and this is what MCS is all about, right?

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00:30:18,570 --> 00:30:25,050
Organizations can gain valuable insights by reviewing screening performance at the unit or the facility level.

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00:30:25,770 --> 00:30:36,410
Looking at this data, you know, this way often help identify pockets of success, like what are we doing really well and where do we need additional support?

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00:30:37,530 --> 00:30:48,410
So although us dietitians, we're not typically responsible for the screening, most of the time it's nursing completing this, we do play an important role in supporting the process.

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00:30:48,410 --> 00:31:02,730
Therefore, like collaborating with nursing leaders and unit champions can help reinforce education, improve workflow adherence, and maintain focus on the importance of timely screening so we can do our job better.

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00:31:03,290 --> 00:31:07,850
And finally, establishing an escalation pathway.

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00:31:08,410 --> 00:31:15,690
So high-performing organizations establish clear follow-up procedures for incomplete or overdue screenings.

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00:31:15,690 --> 00:31:22,650
So defining what happens when a screening isn't completed helps prevent patients from falling through the cracks.

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00:31:22,650 --> 00:31:30,970
At the end of the day, our goal is straightforward, ensure every patient gets screened every time.

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00:31:31,370 --> 00:31:34,490
And through those strategies you can help ensure this.

261
00:31:38,090 --> 00:31:38,490
Alright.

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00:31:38,490 --> 00:31:44,410
So our second strategy, it focuses on optimizing the electronic health record workflows.

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00:31:44,810 --> 00:31:52,250
So my main thing is that technology can't replace clinical judgment, but it can prevent missed opportunities.

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00:31:52,650 --> 00:31:57,530
So really the goal here is simple, reduce the number of manual steps in the process.

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00:31:57,530 --> 00:32:04,570
If we can automate things or make things better to improve patient care and outcomes, let's do it, right?

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00:32:04,970 --> 00:32:10,330
So think about where things are commonly break down in your organization.

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00:32:11,370 --> 00:32:15,050
A patient screens positive, but the consult isn't placed.

268
00:32:15,330 --> 00:32:17,930
An assessment is needed, but it isn't prioritized.

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00:32:17,930 --> 00:32:21,450
A screening is missed and no one realizes it until days later.

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00:32:21,930 --> 00:32:24,650
Those aren't necessarily clinical problems.

271
00:32:25,050 --> 00:32:27,130
They're workflow problems, right?

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00:32:27,450 --> 00:32:33,130
So this is where thoughtfully designed EHR tools can make a significant difference.

273
00:32:33,530 --> 00:32:36,570
For example, you can automate referrals.

274
00:32:37,130 --> 00:32:40,090
This can help ensure that positive screens

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00:32:41,290 --> 00:32:44,330
Can result in consistent Rd.

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00:32:44,410 --> 00:32:53,090
referrals, and then instead of relying on someone to remember to place a consult, for example, the next thing is.

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00:32:53,170 --> 00:32:54,170
BPA alerts.

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00:32:54,650 --> 00:33:00,170
BPA alerts can help identify and complete or overdue screenings, while Rd.

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00:33:00,170 --> 00:33:08,330
work lists that you create could make it easier to quickly identify patients requiring assessments and help prioritize our work.

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00:33:08,810 --> 00:33:21,450
So organizations can also use overdue assessment alerts like we talked about to help ensure patients don't wait too long for a nutrition evaluation, particularly in facilities that

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00:33:22,250 --> 00:33:26,570
have high census, for example, or limited staffing resources.

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00:33:27,770 --> 00:33:30,810
And beyond those tools, you can use data dashboards.

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00:33:30,810 --> 00:33:32,010
You can develop those.

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00:33:32,650 --> 00:33:36,410
This will help allow your team to step back and look at the bigger picture.

285
00:33:36,690 --> 00:33:38,290
Where are the delays occurring?

286
00:33:38,290 --> 00:33:40,810
Which units are performing well?

287
00:33:40,810 --> 00:33:42,690
Where do we need additional support?

288
00:33:42,690 --> 00:33:45,770
And finally, standardized documentation.

289
00:33:45,850 --> 00:33:47,130
That's really important.

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00:33:47,450 --> 00:33:48,890
The goal isn't to create

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00:33:50,690 --> 00:33:55,770
You know, when you standardize documentation templates, for example, you can help

reduce variation.

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00:33:56,090 --> 00:34:02,890
You can improve the consistency in both assessment and diagnosis documentation.

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00:34:03,050 --> 00:34:10,770
But again, the goal isn't to create more alerts and more complex tools in the HR or create more clicks.

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00:34:10,770 --> 00:34:17,130
You're trying to simplify the process and reduce the manual steps to help make your work more efficient, right?

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00:34:17,610 --> 00:34:18,090
So

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00:34:19,370 --> 00:34:27,050
When you build those workflow, you make the right action, the easiest action, and you help ensure, as I said, things are more efficient.

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00:34:28,170 --> 00:34:39,930
So when using those tools strategically, you can help reduce missed referrals, you can improve timeliness of care, and also support a more consistent nutrition care process.

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00:34:47,130 --> 00:34:47,530
There we go.

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00:34:48,090 --> 00:34:57,130
And the third strategy, so consistent documentation supports consistent diagnosis because that's a very important component of MCS measure.

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00:34:57,450 --> 00:35:02,330
So the third strategy again focuses on consistency in nutrition diagnosis.

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00:35:02,650 --> 00:35:08,010
And most organizations, you know, we have incredibly talented dietitians everywhere.

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00:35:08,410 --> 00:35:13,530
But sometimes documentation can still vary from dietitian to dietitian, right?

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00:35:13,850 --> 00:35:23,210
So standardizing helps ensure that regardless of who's completing the assessment, the documentation is thorough, it's consistent and supported by evidence.

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00:35:23,930 --> 00:35:29,290
So these strategies, what you could do is you can create standardized templates for your team.

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00:35:30,010 --> 00:35:39,770
You can have better documentation tools, smart phrases, utilize peer reviews, chart audits, competency validations, and ongoing education.

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00:35:40,330 --> 00:35:48,170
All of these will help improve your nutrition diagnosis documentation, hence improving the MCS score.

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00:35:49,930 --> 00:35:53,130
And the goal isn't to make everyone's practice the same way.

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00:35:53,130 --> 00:35:54,170
That's not what I'm saying.

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00:35:54,170 --> 00:36:00,730
What I'm saying, it's to make sure that we're speaking the same language and documenting our nutrition diagnosis consistently.

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00:36:00,730 --> 00:36:08,970
So then when providers or coders review our notes, you know, it's all consistent and they all understand what we're trying to communicate.

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00:36:12,370 --> 00:36:20,890
And next slide talks a little bit about more sources of variation that we see in documentation, like for example, incomplete documentation of malnutrition.

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00:36:21,130 --> 00:36:38,170
So a strategy here is making sure that your team uses the aspen documentation prompts and you have a standardized documentation guidance or a template that you

create to make sure that those criterias are included in your notes as that supports a stronger malnutrition diagnosis.

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00:36:38,890 --> 00:36:43,770
Sometimes differences in documentation, style and interpretation and interpretation.

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00:36:43,770 --> 00:36:44,690
Things are different.

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00:36:44,690 --> 00:36:46,090
We don't write the same way, right?

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00:36:46,410 --> 00:36:55,530
So peer review and chart audits are important just for good feedback and to make sure that we're more consistent across our team.

317
00:36:56,090 --> 00:36:58,250
and variability and experience and training.

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00:36:58,250 --> 00:37:03,850
You know, we have dietitians that are just starting and there are those that have been practicing for years.

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00:37:04,170 --> 00:37:15,770
So again, competency validation and ongoing education is very important when you're wanting to improve that component, especially of MCS and your malnutrition care process.

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00:37:20,330 --> 00:37:30,010
All right, so now that we've discussed some strategies to improve screening and nutrition diagnosis, the next question is, is how do we know if those strategies are actually working?

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00:37:30,410 --> 00:37:33,170
So that's where data and metrics come in place, right?

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00:37:33,170 --> 00:37:48,730
We have the MACS score that we can look at our data, but there are several other datas you can start collecting and seeing what your current state is, whether that

you're working on improving or you're just starting to see if how successful you are in

323
00:37:49,330 --> 00:37:51,370
nutrition screening and diagnosis.

324
00:37:51,930 --> 00:37:54,890
So when I think about measurement, I like to keep it simple.

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00:37:55,370 --> 00:37:59,530
We're really following the patient's journey through the malnutrition care process.

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00:38:00,010 --> 00:38:03,130
So are we reliably identifying patient risk?

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00:38:03,130 --> 00:38:05,450
Are we assessing patients in a timely manner?

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00:38:05,770 --> 00:38:08,490
Are we making and documenting accurate diagnosis?

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00:38:08,490 --> 00:38:11,050
These are some things that you could measure.

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00:38:11,530 --> 00:38:14,490
So first, let's look at the screening.

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00:38:14,570 --> 00:38:20,570
So within 24 hours of admission is something that you can see measure in your EMR.

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00:38:20,890 --> 00:38:25,530
So you can collect data and see how many patients have been screened within 24 hours.

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00:38:25,530 --> 00:38:33,450
And you can have an example percentage target of you want more than 95% of your patients screened within 24 hours.

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00:38:33,450 --> 00:38:38,330
If it's less, you can look and do a gap analysis like why is this not happening?

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00:38:39,530 --> 00:38:40,810
And the same thing with the other

336
00:38:41,610 --> 00:38:42,570
strategy areas.

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00:38:42,570 --> 00:38:56,730
So this is usually when you start looking at the screening metric, this is often the earliest opportunity for success or failure because if patients aren't screened, then they may never enter the nutrition care pathway, right?

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00:38:57,130 --> 00:39:03,210
So while dietitians, as I said before, we may not own the screening process, but we can absolutely influence it.

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00:39:03,530 --> 00:39:08,170
And that could be through education, workflow redesign and collaborating with nursing team.

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00:39:09,450 --> 00:39:12,090
And next is positive screens referred to the Rd.

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00:39:12,570 --> 00:39:19,130
So I always encourage teams to ask themselves, what happens after a patient screens at risk?

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00:39:20,010 --> 00:39:25,330
If the referral process isn't reliable, so patients can fall through the cracks.

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00:39:25,330 --> 00:39:28,890
So you want to make sure you have a good referral system.

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00:39:29,290 --> 00:39:32,730
So ideally every positive screen should result in an Rd.

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00:39:32,730 --> 00:39:33,530

assessment.

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00:39:34,650 --> 00:39:39,370
The third metric that I have here is a timeliness of assessments.

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00:39:39,690 --> 00:39:43,370
So you can measure if an assessment was done within 48 hours.

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00:39:43,690 --> 00:39:50,570
We often spend a lot of time focusing on the screening rates, but timely assessment is also so important.

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00:39:50,810 --> 00:39:54,250
It's where the dietitian really starts to impact patient care.

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00:39:54,530 --> 00:40:00,570
And delayed assessments can mean missed opportunities for diagnosis and intervention and delayed care.

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00:40:01,530 --> 00:40:05,290
So from there, we move into the diagnosis quality.

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00:40:05,290 --> 00:40:14,410
So we looked at how well we're screening, how well we're referring, and our timeliness of care, but what is the quality of our work?

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00:40:14,730 --> 00:40:22,570
For example, you can collect data on complete NFPE documentation, and you can do that through chart audits, for example.

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00:40:22,810 --> 00:40:26,410
Or if you can pull data from your EHR,

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00:40:26,970 --> 00:40:32,250
If you document your NFPE findings in the EHR, you could also pull data from there.

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00:40:32,930 --> 00:40:39,530
And this data set can tell us a lot about the consistency of our work and the thoroughness of our assessments.

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00:40:39,930 --> 00:40:53,530
So if an audit shows gaps in NFPE documentation, for example, that usually is an opportunity, again, for education, standardization, whether improving your templates or your workflow again, et cetera.

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00:40:54,690 --> 00:41:07,610
And similarly, you could do the same thing with looking at whether the dietitian has completed aspen criteria documentation for malnutrition, whether NPS statement was documented.

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00:41:07,610 --> 00:41:14,090
Again, you could do that through pulling data on the HR or through charts, audits, and evaluations.

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00:41:14,090 --> 00:41:16,490
So you could do it that way too.

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00:41:18,090 --> 00:41:20,330
And lastly, another important measure

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00:41:21,450 --> 00:41:25,770
we have is provider document, the documentation success.

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00:41:26,090 --> 00:41:32,010
I think that's very important, looking at whether the provider has documented.

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00:41:32,650 --> 00:41:37,130
malnutrition or of the dietitian identified malnutrition.

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00:41:37,450 --> 00:41:44,410
So even when us dietitians do everything right, you know, we documented, we reported malnutrition, there can still be a disconnect.

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00:41:44,650 --> 00:41:49,210
So if the diagnosis isn't acknowledged and documented by the provider, it doesn't count.

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00:41:49,610 --> 00:41:56,250

So this metric often reflects the strength of collaboration between dietitians, physicians,

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00:41:56,770 --> 00:42:00,930
advanced practice providers, our informatics specialists.

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00:42:00,930 --> 00:42:13,210
So I feel like the documentation success is one of the most important ones to see that if you and the provider are aligned with malnutrition diagnosis and you can measure that through

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00:42:14,410 --> 00:42:16,490
Again, pulling data in the EHR.

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00:42:17,210 --> 00:42:23,610
I know some facilities have BPA alerts to physicians to alert them that we identify malnutrition.

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00:42:23,930 --> 00:42:29,370
So counting the BPA alerts and how often physicians respond or agree with the PPA alerts.

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00:42:29,770 --> 00:42:33,050
These are other ways you can measure and collect data.

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00:42:35,770 --> 00:42:36,410
All right.

375
00:42:37,690 --> 00:42:38,410
Next.

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00:42:38,970 --> 00:42:49,850
So we talked about metrics, but now if the metrics that I talked about at the previous slide were easy to achieve, we probably wouldn't be having this discussion today.

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00:42:50,810 --> 00:42:51,850
And I understand that.

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00:42:51,850 --> 00:42:55,450
We understand that every organization faces barriers.

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00:42:55,930 --> 00:43:05,050
Sometimes it's from short staffing, competing priorities, issues with documentation workflows or just delays in developing those.

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00:43:05,410 --> 00:43:13,450
And sometimes it's simply that a process has evolved so much over time without anyone stopping to ask if it's still working well.

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00:43:14,490 --> 00:43:20,570
The key is recognizing that most barriers aren't people problems, they're process problems.

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00:43:20,890 --> 00:43:29,050
So when we approach improvement with that mindset, we move away from, you know, the blame and towards finding better solutions.

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00:43:29,050 --> 00:43:33,930
So that's where some of the most meaningful and sustainable improvements can happen.

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00:43:36,570 --> 00:43:38,410
And lastly,

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00:43:39,450 --> 00:43:48,810
One final consideration before we move into our case study, I want to talk a little bit about creating a sustainable malnutrition care process.

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00:43:49,130 --> 00:43:53,090
Many organizations can achieve short-term improvement, especially

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00:43:53,330 --> 00:43:59,210
when a passionate dietitian, physician champion, or quality leaders driving these efforts.

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00:43:59,530 --> 00:44:10,970
So the real test is whether the process continues to perform well, especially when those individuals move into different roles, leave the organization, or shift their

focus to another initiative.

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00:44:11,450 --> 00:44:16,010
You want to make sure that what you were doing and to improve your process is sustainable.

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00:44:16,490 --> 00:44:21,130
So that's why sustainable improvement, I say, requires more than education alone.

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00:44:21,450 --> 00:44:24,890
The process needs to be built into everyday practice.

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00:44:25,130 --> 00:44:27,850
Organizations that sustain success.

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00:44:28,330 --> 00:44:31,850
typically monitor performance through data dashboards.

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00:44:31,850 --> 00:44:39,970
They conduct periodic chart audits, provide ongoing education, standardized documentation, always checking and seeing how well are we doing.

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00:44:40,010 --> 00:44:45,290
Again, going back to that PDSA cycle, looking at your gaps and seeing what you can do to improve.

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00:44:45,970 --> 00:44:51,690
And also lastly, I want to emphasize this, leadership support is also very critical.

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00:44:52,010 --> 00:44:56,810
When performance is reviewed by our leaders and leadership regularly,

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00:44:59,130 --> 00:45:02,010
our work is more visible, right?

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00:45:02,250 --> 00:45:08,650
And we have more opportunities to remain visible and also they can help us improve our processes.

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00:45:09,210 --> 00:45:12,330
So it's much easier to maintain that momentum over time.

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00:45:13,690 --> 00:45:19,490
So again, as you think about your own organization, I want you to consider this question.

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00:45:20,090 --> 00:45:28,010
If your strongest malnutrition champion left tomorrow, would your process continue to perform at the same level?

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00:45:29,130 --> 00:45:32,570
That's ultimately what sustainability looks like.

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00:45:33,970 --> 00:45:39,290
And now I will pass it on to Stacy, who will present a case study from her facility.

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00:45:40,730 --> 00:45:41,810
Great, thank you so much.

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00:45:41,810 --> 00:45:44,890
That was really phenomenal information, Natali.

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00:45:44,890 --> 00:45:54,650
And I think it leads really well into talking about how we translate our nutrition diagnoses into our medical malnutrition diagnoses.

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00:45:57,610 --> 00:46:06,330
So what I will present is from our experiences at the University of Maryland Medical Center, we are a large academically affiliated tertiary care facility.

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00:46:06,890 --> 00:46:09,770
We serve a large range of both

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00:46:10,410 --> 00:46:20,090
populations in terms of our care that we offer and in terms of the socioeconomic status of our patients and their cultural backgrounds.

411
00:46:20,090 --> 00:46:28,170
So we have multiple different drivers of malnutrition all kind of converging at once across a range of populations.

412
00:46:28,570 --> 00:46:37,130
So we see a very complex patient population and that feeds into a lot of different

413
00:46:37,850 --> 00:46:41,610
presentations of malnutrition and how the different faces that it wears.

414
00:46:43,610 --> 00:46:46,010
My presentation is going to follow this timeline.

415
00:46:46,650 --> 00:46:49,690
So we started with our gap analysis in January of 2020.

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00:46:49,690 --> 00:46:57,450
And then in February 2020, we worked on stakeholder buy-in, developing a process, working on education materials.

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00:46:57,930 --> 00:47:06,650
In March of 2020, which is really great timing if anybody remembers anything that was going on in March of 2020, that's when we decided to implement all of this.

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00:47:06,650 --> 00:47:09,130
High marks, 10 out of 10, no notes.

419
00:47:09,770 --> 00:47:21,050
And then we followed up throughout 2020 and 2021 on how we were doing in terms of acceptability, feasibility, fine tuning the workflows.

420
00:47:22,890 --> 00:47:35,690
So starting with our gap analysis, this was done by our dietetic interns as their QI project for this year, which I think is a really great plug for what dietetic internship programs can offer back to organizations.

421
00:47:36,170 --> 00:47:43,210
Their project focused on how the diagnosis of malnutrition differed between

dietitians

422
00:47:43,530 --> 00:47:46,770
as well as licensed independent providers, LIPs.

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00:47:46,890 --> 00:47:53,770
So this is any provider within the organization who is credentialed to generate a billable codable diagnosis.

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00:47:55,610 --> 00:48:00,570
So the dietitians at this time were using the Aspen Academy indicators of malnutrition.

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00:48:00,890 --> 00:48:06,810
I noticed a couple questions popping up about the Global Leadership Initiative of Malnutrition Framework.

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00:48:07,850 --> 00:48:09,930
I will touch on that extremely briefly.

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00:48:09,930 --> 00:48:12,170
Maybe we'll all have time in the Q&A time.

428
00:48:16,170 --> 00:48:17,090
My mouse is haunted.

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00:48:17,450 --> 00:48:17,810
Sorry.

430
00:48:18,890 --> 00:48:28,330
And while we are using a validated structured framework, our LIPs are essentially using clinical judgment.

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00:48:29,770 --> 00:48:37,050
So as you would expect, this would lead to differences in the types and volumes of malnutrition coded.

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00:48:37,050 --> 00:48:51,850
So not only did we see that dietitians were diagnosing malnutrition at a higher

rate, we also saw that there was a statistically significant difference in the classification of malnutrition between the groups.

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00:48:52,170 --> 00:49:03,130
So dietitians were primarily diagnosing severe malnutrition, where LIPs were primarily diagnosing unspecified malnutrition, essentially because

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00:49:03,370 --> 00:49:18,010
If you remember, LIPs may only get up to six hours of education around nutrition in total throughout their educational experience, whereas dietitians receive specialized training on diagnosing, preventing, and treating malnutrition.

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00:49:18,010 --> 00:49:21,850
So we were really able to get into the nuance of

436
00:49:22,250 --> 00:49:29,690
mild, moderate, and severe malnutrition, whereas our providers really, to tease that out, they don't necessarily have that training.

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00:49:29,690 --> 00:49:34,970
And that's where the collaboration that Natali just discussed becomes so, important.

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00:49:35,450 --> 00:49:41,370
At the same time that our dietetic interns were doing this, we also collaborated with a data analyst

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00:49:41,690 --> 00:49:43,650
to query our Vizient database.

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00:49:43,650 --> 00:49:53,210
If you're not familiar with Vizient, this is a third-party company that works with large medical organizations to support them in monitoring their outcome and quality metrics.

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00:49:53,770 --> 00:50:02,170
They compared our coding and billing of malnutrition to like organizations and found that our organization was sitting at the first quartile.

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00:50:02,570 --> 00:50:11,370

So we were underdiagnosing malnutrition compared to similar organizations, both in terms of size and complexity of patient populations.

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00:50:12,170 --> 00:50:31,770
This is important because as was already discussed, this impacts the complexity of illness scores, your infectious complication rates, your length of stay, and your risk of mortality, which has downstream quality metric impacts for your organization, even if you haven't operationalized MCS.

444
00:50:32,170 --> 00:50:41,450
So your malnutrition, your coded and billed malnutrition diagnosis feeds into your institutional case mix index, your case mix adjusted

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00:50:41,570 --> 00:50:46,810
length of stay, your observed over predicted mortality rate, and your readmission risk score.

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00:50:47,050 --> 00:50:51,130
So the last three of these are reportable eCQMs.

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00:50:56,490 --> 00:50:59,370
Once we identified the gap, that's when we started to address it.

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00:50:59,450 --> 00:51:05,770
First and foremost, we identified that those all of the stakeholders that we needed at the table and we started getting buy-in.

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00:51:06,330 --> 00:51:15,210
We were very fortunate that our vice president of quality and safety was identified to be our physician champion and she was extremely passionate about this work.

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00:51:15,610 --> 00:51:26,010
She helped support us by providing us her data quality or her quality data analyst to support not only the nutrition workflow acceptability,

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00:51:26,130 --> 00:51:37,210
but also in terms of the analysis from the quality metrics and outcomes that are going to be interesting at the institutional level, which is generally where the institutions are struggling, right?

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00:51:37,210 --> 00:51:45,050
Every hospital organization is struggling in some quality metric because we're all up against something somewhere.

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00:51:45,690 --> 00:51:55,610
And your data analysts are the people who really know the ins and outs of what is going to be the most impactful in terms of a data package for your leadership.

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00:51:56,410 --> 00:52:04,410
We also worked with our coding team to identify what they needed to make their jobs as streamlined and easy as possible.

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00:52:04,410 --> 00:52:13,450
What would need to be in a workflow for them to take a nutrition diagnosis and seamlessly translate that into a medical diagnosis.

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00:52:14,570 --> 00:52:18,970
And we also confirmed with them that any framework that we were using

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00:52:19,450 --> 00:52:35,290
was as long as it was within our institutional guidelines and practice assessment standards, and we provided that information to them to share with their coding and billing team, that was acceptable from a regulatory perspective.

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00:52:35,690 --> 00:52:45,290
From this information, we then developed our co-documentation note that includes all of the requirements identified by the coding and billing team.

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00:52:46,010 --> 00:52:50,170
And it uses the co-signature functionality in the electronic health record.

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00:52:50,170 --> 00:53:02,490
So once the LIP co-signs this note, the nutrition diagnosis is translated into the medical diagnosis and the coder can pick this up as a medical diagnosis of malnutrition.

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00:53:03,610 --> 00:53:08,010
At the same time as all of this was happening, we like to do all of these things at once.

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00:53:09,210 --> 00:53:31,930
We compared the A.S.P.E.N./Academy indicators of malnutrition to the Global Leadership Initiative on Malnutrition framework for diagnosing malnutrition to identify if, as we were asking our dietitians to pick up an additional workflow, would this help to streamline their work at the bedside in terms of generating these diagnoses and assessing the patients for malnutrition?

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00:53:32,330 --> 00:53:32,650
Now,

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00:53:33,290 --> 00:53:41,010
keeping in mind that GLIM is a diagnostic framework specifically for malnutrition and it doesn't necessarily change the way you're assessing your patient.

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00:53:41,010 --> 00:53:46,730
It doesn't change your nutrition focused physical exam, but it does streamline the diagnostic process.

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00:53:47,250 --> 00:53:55,050
And we did ultimately determine that making that transition was favorable for our practice and our institution.

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00:53:56,170 --> 00:53:58,410
We then educated our dietitians.

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00:53:58,650 --> 00:53:59,890
We developed different

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00:54:01,370 --> 00:54:05,930
quick start guides and different materials for them to have readily available.

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00:54:06,490 --> 00:54:08,130
And we notified our LIPs.

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00:54:08,610 --> 00:54:20,530
And I'll get into this a little bit more in the lessons learned section, but we don't have very robust LIP educational opportunities at my organization.

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00:54:20,530 --> 00:54:22,570
So we were limited to really

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00:54:25,290 --> 00:54:35,050
providing an e-blast, an e-mail blast to our LIPs, and then giving some very brief updates at some specific meeting.

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00:54:35,050 --> 00:54:38,970
So we really couldn't touch all LIPs at the organizational level.

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00:54:40,650 --> 00:54:44,410
This is a copy of the note that we used once it's completed.

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00:54:45,530 --> 00:54:51,770
So it includes the severity of malnutrition, including the ICD-10 code.

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00:54:53,170 --> 00:54:57,210
a cause of malnutrition or in PES language, the etiology.

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00:54:57,450 --> 00:55:00,010
And this can be using the AAIM or GLIM framework.

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00:55:01,530 --> 00:55:05,050
It could also be using SGA if your organization uses SGA.

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00:55:05,050 --> 00:55:06,890
SGA is also a validated framework.

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00:55:08,250 --> 00:55:16,730
And then the diagnostic criteria that are being used or the signs and symptoms in terms of PES language that are being used to make that diagnosis.

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00:55:16,970 --> 00:55:25,530
How the malnutrition is being treated and how that's impacting the patient's clinical course and how efficacy of treatment is being monitored.

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00:55:25,530 --> 00:55:34,010
So things that dietitians are already documenting, just pulling that out of our notes and translating that into this co-documentation note.

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00:55:34,810 --> 00:55:54,010
During the implementation process, our senior RDs who are clinical supervisors provided hands-on, at the elbow support to clinicians if they had questions about how to communicate with their teams, what were the steps required, how to utilize the GLIM framework as we were making the transition.

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00:55:54,330 --> 00:56:04,570
If we noticed we were really struggling with one particular service line, our physician champion would step in and communicate directly with that service line leadership to explain that this

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00:56:04,690 --> 00:56:11,210
was not only a nutrition initiative, this was a hospital initiative that had leadership buy-in and they really needed to come on board.

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00:56:12,210 --> 00:56:18,890
And so that's really where your champions become quit, like you cannot, they are worth their weight in gold.

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00:56:19,130 --> 00:56:30,570
You really can't replace them because there are times that you really need that peer-to-peer support to provide that extra credibility to your initiatives.

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00:56:31,850 --> 00:56:48,250
We also incorporated monthly auditing through reports that we generated in, created and generated in our EHR and we incorporated monitoring of this workflow into our quarterly chart audits that are part of our annual eval process.

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00:56:50,930 --> 00:56:53,850
I'm going to learn that I can't use my errors for this eventually, I promise.

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00:56:55,850 --> 00:56:58,730
Then we performed a post implementation analysis.

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00:56:58,730 --> 00:57:06,330
And this is a really, really critical part of any QI because you can't just do something and assume you did a great job and pat yourself on the back.

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00:57:06,330 --> 00:57:10,010
You have to actually make sure that you had the impact that you wanted to have in the 1st place.

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00:57:10,010 --> 00:57:15,450
And if not, you have to go back and figure out where things kind of veered off course.

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00:57:16,090 --> 00:57:22,330
So we queried the Vizient database again and we found that this workflow improved us to the median, which is exactly where we want to be.

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00:57:22,330 --> 00:57:24,730
We don't want to over diagnose malnutrition.

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00:57:25,730 --> 00:57:32,490
And we doubled our malnutrition coding capture over the course of about a year, year and a half time frame.

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00:57:33,450 --> 00:57:44,250
This also was associated with increased complexity of illness in 90% of malnutrition cases and impacted the risk of mortality in 50% of cases.

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00:57:44,650 --> 00:57:52,330
These are really important secondary analyses on your malnutrition documentation and your malnutrition diagnoses.

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00:57:52,650 --> 00:58:01,530
because it emphasizes that the malnutrition diagnosis is impacting these clinical outcomes that we know that they impact.

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00:58:01,850 --> 00:58:16,730
So if we were increasing our diagnosis, but the malnutrition wasn't associated with these clinical outcomes, it would cause us to want to go back and make sure that we're really doing our due diligence when we're diagnosing malnutrition to make sure we're diagnosing it accurately.

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00:58:18,410 --> 00:58:25,770
We can also take that information back to our organizations and say, look at how we are impacting our outcome metrics.

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00:58:25,770 --> 00:58:37,050
Even when we haven't implemented the MCS, we're still impacting these quality

metrics because your risk of mortality is a huge, huge quality metric driver.

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00:58:38,330 --> 00:58:41,610
So a couple lessons learned very quickly.

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00:58:42,010 --> 00:58:44,490
Identify your project team members in advance.

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00:58:44,890 --> 00:58:59,690
This echoing what Natali already said, your coding and billing leadership, your data analysts and champions, particularly if you know you have groups that are going to be more challenging to obtain buy-in, make sure you have champions, one or more champions in that group.

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00:59:00,490 --> 00:59:02,570
Identify education strategies.

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00:59:03,370 --> 00:59:14,970
I really do wish that my organization had more comprehensive information sharing platforms for our LIPs, that we had the ability to educate them in advance rather than trying to educate them in real time on the fly.

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00:59:16,890 --> 00:59:24,250
And setting clear expectations with the nutrition team so that they really understand what they're supposed to be doing when and how.

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00:59:25,930 --> 00:59:28,370
And then plan for how you will assess.

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00:59:28,370 --> 00:59:30,810
When will you assess your impact?

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00:59:30,970 --> 00:59:32,410
How are you going to do that?

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00:59:32,410 --> 00:59:33,850
What data do you need?

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00:59:34,090 --> 00:59:37,530

This will then also tell you, do you need to create new reports?

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00:59:37,930 --> 00:59:40,490
Who do you need to work with to create those new reports?

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00:59:40,730 --> 00:59:46,410
When do you need to get those requests in by to have the reports available when you need to be running the analyses?

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00:59:47,290 --> 00:59:56,810
Are there people in finance who can support you in doing a finance analysis to show how you're impacting the hospital's bottom line with any of these initiatives?

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00:59:58,810 --> 01:00:04,650
These are definitely things that I think we learned from this major initiative.

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01:00:05,210 --> 01:00:12,810
And with that, I will turn it over to the next presenter for the next stage of a case study presentation.

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01:00:17,330 --> 01:00:18,090
Thank you, Stacy.

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01:00:18,730 --> 01:00:20,130
So my name is Carrina.

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01:00:20,490 --> 01:00:24,970
I lead the clinical nutrition program for New York City Health and Hospitals with Sodexo.

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01:00:25,450 --> 01:00:27,130
A little bit about our health system.

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01:00:27,370 --> 01:00:31,130
It is the largest municipal healthcare organization in the United States.

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01:00:31,450 --> 01:00:36,170
We have 11 acute care hospitals across four of the five boroughs in New York City.

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01:00:36,810 --> 01:00:39,370
I have about 15 directors of clinical nutrition.

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01:00:39,770 --> 01:00:48,650
and around 150 clinical dietitians that range from outpatient, inpatient, and not even including our five post-acute facilities.

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01:00:49,210 --> 01:00:51,530
A little bit about our patient demographics.

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01:00:52,170 --> 01:00:58,010
We serve over 1 million patients annually, and we are considered a safety net system.

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01:00:58,330 --> 01:01:07,370
A large portion of our population is either underinsured or uninsured or are on managed Medicaid and are affected

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01:01:07,690 --> 01:01:15,130
disproportionately by social drivers of health, including chronic disease, homelessness, and food insecurity.

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01:01:19,050 --> 01:01:27,370
So I'll talk a little bit about the roadmap of how we got to the malnutrition care score implemented within all 11 hospitals within our system.

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01:01:27,610 --> 01:01:34,250
It started in the beginning of 2021, where we had now transitioned out of the pandemic.

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01:01:34,250 --> 01:01:41,210
We were all in the same medical record, the same EHR, and we were focusing on the basics of improving malnutrition diagnosis.

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01:01:41,530 --> 01:01:47,770
We were identifying these patients, we were documenting in the medical record, but it wasn't translating to the providers.

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01:01:48,170 --> 01:01:48,890

So we identified

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01:01:49,450 --> 01:01:54,410
We started with education for all the providers.

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01:01:54,410 --> 01:02:09,690
We implemented some workflows in the EHR, like pending the malnutrition order or the diagnosis with the codes that if they agreed and they signed, it got onto the problem list and it got put into the note with the appropriate code.

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01:02:10,330 --> 01:02:18,890
And we also implemented a bunch of educations where annually every June or every July, our residents get a mandatory

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01:02:19,690 --> 01:02:34,090
training electronically on the basics of nutrition at health and hospitals, including a whole section on malnutrition and why it's important to either identify it or work with the dietitians in order to identify it appropriately and timely.

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01:02:35,370 --> 01:02:40,090
The next piece we moved into is 2022 is where we implemented a validated screening tool.

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01:02:40,290 --> 01:02:44,450
So we transitioned from a criteria-based screening to a validated screening tool.

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01:02:44,450 --> 01:02:45,530
We used the MST.

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01:02:45,850 --> 01:02:47,370
That involved

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01:02:48,090 --> 01:02:58,490
getting nursing, we had to get it approved by nursing and how we had to approve, they had to approve it in order to say, yes, we're going to move from this and makes it easier for them.

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01:02:58,890 --> 01:03:00,890
And we track that data as well.

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01:03:01,450 --> 01:03:04,570
2023, we started to look at our notes.

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01:03:04,810 --> 01:03:12,410
So we had, due to a large rollout of our EHR across all 11 hospitals,

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01:03:12,810 --> 01:03:28,410
They we were piecemealing our notes together and now that everybody was on one, we took a deep dive into how do we get these structured data points built in versus a free text in order to prepare ourselves to do this reporting.

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01:03:28,650 --> 01:03:41,050
So we gathered together a group of super user dietitians to engage our staff where they were gonna they were bought in to

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01:03:41,890 --> 01:03:46,970
push forward these changes and bring it back down to the rest of the dietitian staff.

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01:03:46,970 --> 01:03:52,170
So it wasn't just driven from management, it was driven from the dietitian peers as well.

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01:03:53,130 --> 01:04:05,850
In 2024, now that all the structure was in place, we wanted to see how we were doing baseline knowing that the malnutrition care score was going to be coming into play even as a voluntary metric.

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01:04:06,170 --> 01:04:08,250
So we started to build out reports.

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01:04:09,210 --> 01:04:17,930
with our analysts for EHR manually and be able to test these data fields to see where are we missing, what are our fallouts.

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01:04:18,330 --> 01:04:26,090
And it was very cumbersome, but we were able to establish a baseline at each of our sites to know how we were doing and what we need to adjust.

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01:04:26,450 --> 01:04:40,090
And then finally, this past year, our EHR finally updated in the fall to allow for the, to build in the, specifically the MCS into the eCQM dashboard in our EHR.

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01:04:40,410 --> 01:04:48,010
We partnered with quality and IT to make sure that it was added appropriately and be able to guide them as to where all these things lived.

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01:04:51,290 --> 01:05:02,890
So previously, prior to implementing the MCS, we collected our monthly performance improvement, our timeliness of assessments, our malnutrition identification,

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01:05:03,370 --> 01:05:14,410
how often were our acceptance of our recommendations, including malnutrition diagnosis were done, nursing screen accuracy and timeliness within the 24 hours.

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01:05:14,570 --> 01:05:17,610
So we reported all that data at our local quality departments.

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01:05:17,930 --> 01:05:20,490
It satisfied the regulatory compliance, but not much else.

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01:05:20,490 --> 01:05:29,690
It wasn't painting the entire picture or showing what the true value of what dietitians could do or what we were actually doing and how we were affecting our patient population.

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01:05:32,810 --> 01:05:39,770
So these are the barriers that we, so again, I mentioned, and it's been mentioned across this presentation is structured data.

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01:05:40,010 --> 01:05:42,490
We're reviewing the nutrition workflow.

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01:05:42,730 --> 01:05:53,170
We streamlined it for dropdown lists, consistent data across all of our 11 hospitals, radio buttons to make it easier for the dietitian to document.

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01:05:53,210 --> 01:06:12,330
And again, we made sure they were heavily involved in the process. It was driven by

them, their suggestion because they're doing the work. And that was really important to get the rest of the dietitians on board in order to say, yes, they voted and this is how we implemented our template. We've reduced the number of fields and

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01:06:13,090 --> 01:06:37,530
while maintaining the nutrition care process, and we standardized the terminology across all facilities. That was a vestige from before our old EHR and moving to a new one and finally getting that in place. The next one was the MD documentation that I mentioned. We increased our in-services. We added that module to the annual resident orientation. We do spot educations.

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01:06:38,090 --> 01:07:04,970
Every year now for Malnutrition Awareness Week, we've been starting to do a system-wide education of CE and we're gonna be filing for CME this year just so we can get the doctor, the nurses on board to say why is malnutrition relevant to them. And then we improve that efficiency of that workflow as well for the documentation on their end for the EHR.

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01:07:06,010 --> 01:07:34,890
Last was the homegrown report was the reporting. We built monthly reports in the HR to capture components of the MCS prior to going, getting built in. We exported it. was very, very cumbersome. We exported it to the Excel. And then we built in the formulas to see how it would kind of shake out. It was very labor intensive for all of our directors. I give a very big credit to my team for helping build all of these things. But we did identify some gaps in where we were falling out.

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01:07:35,450 --> 01:07:59,370
when it came to the four pillars of the MCS. So we took all of that by building relationships with nursing, our medical, our providers, quality was a very big proponent of all these at each one of our facilities. And this is what it looks like today in our EHR. So

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01:08:01,210 --> 01:08:29,930
Yeah, so this is what it looks like. And so we have our quarters of data and it was able to look back and going forward. And then this is actually the, when you spread out from our patients, this is what it actually looks like. This is a snapshot from one of our facilities where it's saying we can look down and validate in real time where we're hitting and where we're missing. So we'll be able to, once we establish that baseline manually, we're able to do a look back monthly

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01:08:31,050 --> 01:08:57,290
But also in real time, we can look at discharge patients and current patients to say, where did we miss? Where are we missing these things? And where are we

recently discharged? Where did we miss these patients? And then we can go back and do some PI on it. So it's about it. It's been, we look back a year. Now we're going into our second just for data. And it's been really helpful to look at that. So we report in addition to just us

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01:08:57,970 --> 01:09:24,090
tracking this data. We do report it now quarterly at interdisciplinary councils, whether it be medical committee, quality council, or quarterly reviews with our clients as well because we are contractors. We also include in addition to that to paint a bigger picture is key demographic data. As I said, a lot of our patients are affected by social drivers of health and 30 day readmissions rates. And this helps

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01:09:24,570 --> 01:09:51,850
paint pictures for those in the room who typically aren't like your CEO, your COO, even your patient experience person where they're looking at a patient, but they're not, they look at it turnaround times, ED wait times, length of stay, but we don't get, you get to show them what the value of your dietitians are through this data and they get to see their patients in a different lens when sometimes they're not always looking at it from a nutrition point of view and how it affects the greater picture.

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01:09:52,890 --> 01:10:11,290
really shown that this has been able to help not change minds, but also to have them look at what we're doing as a valuable value add to the interdisciplinary team and the ancillary care team. So I've found that doing that and showing it to everybody has been really helpful.

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01:10:14,490 --> 01:10:38,330
All right, finally, so lessons learned was, the biggest piece was establishing the baseline was identifying those fallouts and the opportunities of where are we missing the mark? Was it the accuracy and the timeliness of the malnutrition of the MST? And we fixed that. Our notes, we got to make them more streamlined for our staff, but we also need to make sure that we're capturing the correct data.

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01:10:40,250 --> 01:11:08,970
My biggest takeaway is the know the where but not the how, is that you don't need to know how to code or build a report, but you do need to know where the data lives. So if you know where that piece goes, how to point that arrow to where that piece of data is, that will really help you when it comes to actually being architects, whoever they are, your analysts for your EHR, they can easily point it

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01:11:09,450 --> 01:11:34,010
to where it needs to be if where all of it lives. Again, more structure, the

better. If you have, it reduces the documentation time, but also, again, it makes it easier to point the analyst in the right direction to pull the data that you are actually trying to show that you're getting done. And then making it valuable is showing that MCS is an opportunity to show the value of nutrition and educate

580
01:11:34,610 --> 01:12:02,530
all stakeholders, not even ones that you would particularly think. I think we're at the point now, because we've been showing this for so long, some of them are, some of our facilities are actually going to switch it out and choose it as a voluntary metric, as opposed to, you know, they already have their set ones because it's facility by facility. And I'm excited to hear that, they actually really say, okay, well, your scores are good and you're showing the work. We're going to

581
01:12:03,170 --> 01:12:35,350
move ahead and switch out one of our voluntaries for the MCS. And with that, I am going to pass it back to Angela. All right. Thank you so much. That was amazing. I hope you guys all enjoyed that. I see you're giving a lot of kudos with your little symbols there, little reactions. So I'll ask everyone to come on to the camera now, all of our presenters and the Academy's measure development team.

582
01:12:36,090 --> 01:12:53,690
and we will begin our Q&A. We have approximately 15-ish minutes. Right. Again, thank you. Thank you guys so much. So the first question that we're going to address is for the measure development and steward team.

583
01:12:55,730 --> 01:13:22,170
Can someone provide a quick summary again of the fiscal year 27 changes and how often the malnutrition care score data is supposed to be reported? So that's actually kind of two questions. Who would like to take giving a summary again of the 27 updates? I will take it, I guess.

584
01:13:23,210 --> 01:13:51,850
Unless, Michelle, you want to share some of the more technical changes to the measure. But in general, this year we did very minimal changes that will impact the way dietitians do our work on this side of the fence. Michelle, do you have any thoughts on a summary? No, I mean, it's very minimal this year. So we just cleaned it up on the technical side, so not the front facing side.

585
01:13:53,610 --> 01:14:18,890
you as dietitians wouldn't see that. It's more what the computer, how it processes the measure. But the other two things that we mentioned earlier, that Angela mentioned was the value set. So we did some, you know, removals and some updates for the hospice exclusion. So if you go back to your handouts, I think it's maybe page 17 or something.

586
01:14:21,210 --> 01:14:43,770
So you can see those items more in detail. And that's pretty much it this year, thankfully. But of course, we love your feedback. And we will continue to refine each year. So as long as we get the information and data from you guys of what's working and what's not.

587
01:14:45,090 --> 01:15:12,570
Thank you. Thank you both. What was the second part of the question, Angela? How often is MCS data reported? Gotcha. So MCS data is reported once a year directly from the hospital to CMS. So it's once a year, typically around the end of February, beginning of March. And you are reporting using the graphic that you showed the prior year.

588
01:15:14,850 --> 01:15:39,490
Okay, thank you. So this is for any of our presenters today. What is the value or what value have you discovered with implementing this quality measure in your organization? And what would you say was a key first step to getting started? Who would like to take that one? I can take it. Carrina, okay.

589
01:15:40,810 --> 01:16:07,570
I would say the value was really showing the value of the work that we're doing in a more organized way. Again, we were doing, the way we were reporting things out from performance-wise was more focused around regulatory readiness and just touching on the, just kind of dipping our toe into malnutrition, where with this, it shows the value in a few ways where you

590
01:16:08,330 --> 01:16:33,770
We're doing a bulk of the identification, but it means that you're working well with the doctors understand the why. The nurses understand the why of the screening. So it shows you in a more, I guess, not a 3D, a 3D part of the team where you are not just, you're not just dietary, you're nutrition. And you're showing that you do have an impact on the patients.

591
01:16:34,250 --> 01:16:52,930
beyond that. So I think that's what the value has shown for us in getting people's attention just to look at it in a way that affects the patients and also the staff more broadly than they had previously thought. Thank you. Stacy, you're next.

592
01:16:53,210 --> 01:16:54,970
Natali, would you like to add anything to that?

593

01:16:55,530 --> 01:17:05,690
Yeah, I can add as an organization that's still attempting to implement MCS, I think we're in that process, which I think a lot of people on the call probably are.

594
01:17:05,690 --> 01:17:14,610
So to build on what Carrina said, I think there's a huge benefit in the interprofessional collaboration piece.

595
01:17:14,610 --> 01:17:17,610
So whenever you have this shared documentation

596
01:17:18,410 --> 01:17:36,330
Even if you have really great relationships with your interprofessional teams, which we did at baseline, having your providers, your nurse practitioners, your attending level physicians cosign documentation that this patient has been diagnosed with malnutrition.

597
01:17:36,330 --> 01:17:38,570
And these are the things that are being done to address it.

598
01:17:38,970 --> 01:17:46,330
And this is how it's being monitored because this is impacting their quality of care and this is impacting their anticipated course.

599
01:17:46,810 --> 01:17:48,490
changes the dialogue.

600
01:17:48,490 --> 01:17:51,410
It changes their understanding about what's going on with the patient.

601
01:17:51,410 --> 01:18:07,050
And we've seen differences in the way that the approach to nutrition management in some of these patients is being addressed because the providers are needing to co-sign these notes, they're more aware of what's going on with the patient from a nutrition perspective.

602
01:18:07,050 --> 01:18:14,570
Even if you'd been having those conversations previously, when they're co-signing the note, it makes it a little bit, it hits different for them.

603
01:18:16,170 --> 01:18:32,810
The other thing that I'll say is this, the addition, even in the absence of adding the MCS, adding, having increased, doubling our coding capture of malnutrition changed the case mix index for our organization.

604
01:18:32,810 --> 01:18:38,530
And Maryland is unique in the state or in the country in the way that we reimburse hospital organizations.

605
01:18:38,530 --> 01:18:41,530
So hospitals are reimbursed based on the case mix index.

606
01:18:41,690 --> 01:18:45,970
So changing our hospital's case mix index changed our reimbursement

607
01:18:46,170 --> 01:18:46,730
score.

608
01:18:47,210 --> 01:18:53,450
So we actually changed how much money our hospital gets every year per patient admission.

609
01:18:54,170 --> 01:18:58,810
And that's something that you can take to the C-suite to demonstrate the value to the organization.

610
01:18:59,770 --> 01:19:00,290
Absolutely.

611
01:19:00,290 --> 01:19:03,890
I'm going to jump in there real quick and just do a quick plug.

612
01:19:03,930 --> 01:19:06,690
There is a really good webinar free of charge.

613
01:19:06,690 --> 01:19:14,010
You can access it on the quality webpage that has been put on the chat and it's in the slides that Angela shared.

614
01:19:14,650 --> 01:19:17,210
on how on reimbursement and how that works.

615
01:19:17,250 --> 01:19:21,250
And it's the spot quarterly spotlight from February 25.

616
01:19:21,250 --> 01:19:22,730
So I just want to put that plug there.

617
01:19:22,730 --> 01:19:25,130
Sorry, Angela, didn't mean to.

618
01:19:25,290 --> 01:19:26,010
But it's really good.

619
01:19:26,010 --> 01:19:30,090
It explains all that case mix index information that you mentioned.

620
01:19:30,090 --> 01:19:30,890
So there's that.

621
01:19:32,010 --> 01:19:32,370
Right.

622
01:19:32,370 --> 01:19:42,570
I was going to touch back on, I think it was in Stacy's presentation talking about the risk of mortality and severity of illness and how that is at a higher level within the organization.

623
01:19:42,850 --> 01:19:52,090
One of the impacts I think that this makes at an organization level, in addition to what Carrina was saying as far as

624
01:19:53,450 --> 01:19:56,410
the value that the staff feels that they're bringing to the table.

625
01:19:56,570 --> 01:19:58,650
They have something tangible to show for that.

626
01:19:58,650 --> 01:20:05,130
So I do want to bounce back to Carrina really quick because you were talking about the note templates.

627
01:20:05,130 --> 01:20:18,810
And I think this is like a big topic of conversation, especially for larger systems or hospitals with multiple sites of large facilities in preventing note bloat.

628
01:20:19,130 --> 01:20:20,650
It's a very real thing.

629
01:20:20,650 --> 01:20:21,290
And so

630
01:20:22,130 --> 01:20:31,530
The question is, did you have to come to a consensus, which I know you had a team that worked on this, but maybe how did you come to a consensus on an Rd.

631
01:20:31,530 --> 01:20:39,130
note template with other facilities with multiple CNMs, multiple, you know, nutrition directors?

632
01:20:39,450 --> 01:20:41,450
How did you avoid the note bloat?

633
01:20:42,210 --> 01:20:46,170
and find consistent consensus on required documentation.

634
01:20:46,170 --> 01:20:56,410
So I think this is a really important point to really optimize the time of dietitians, because I think we can document a lot of stuff that really is unnecessary.

635
01:20:56,410 --> 01:20:58,330
It's documented 10 other places on the chart.

636
01:20:58,330 --> 01:21:00,970
So how did you narrow that down for your template?

637
01:21:01,930 --> 01:21:06,650
So I guess the first step was getting with and

638
01:21:07,450 --> 01:21:16,890
We are fortunate where the directors, we work very well together and we've established what we call this nutrition council, which is where we drive the policy for the system.

639
01:21:17,290 --> 01:21:22,010
And we kind of bounce everything off of, it's not a dictatorship.

640
01:21:22,410 --> 01:21:30,410
So I make sure that we bring every, so and I have people from different, so my directors all have their own specific skills and specialties, which has been really helpful.

641
01:21:31,210 --> 01:21:37,850
So bringing them together and say, hey, what are your, what is the feedback from your dietitians or dietitians, our unionized dietitians as well?

642
01:21:38,570 --> 01:21:44,090
What are their pain points from this new, at the time, newer medical record, EHR?

643
01:21:44,650 --> 01:21:47,330
And what are you doing in your chart?

644
01:21:47,330 --> 01:21:53,770
What are you seeing in your chart reviews that are unnecessary or excessive and taking up a lot of time?

645
01:21:53,770 --> 01:21:55,930
So they went back to their staff, they got that.

646
01:21:56,330 --> 01:22:01,090
We also looked at our chart, like we kind of look at our chart reviews and said, hey, what are these audits?

647
01:22:01,090 --> 01:22:02,730

What are these audits telling us?

648
01:22:03,050 --> 01:22:06,570
And then we said, okay, let's look at this note.

649
01:22:07,170 --> 01:22:08,490
Let's look at this flow sheet.

650
01:22:08,730 --> 01:22:09,890
How can we utilize it better?

651
01:22:09,890 --> 01:22:11,370
Because not everybody was using it.

652
01:22:11,850 --> 01:22:17,090
So we went through it and said, we slashed this, we're saying this, we're going to make a drop down here.

653
01:22:17,090 --> 01:22:18,090
And we went through it.

654
01:22:18,730 --> 01:22:33,770
And then we got volunteers of on staff dietitians and we had them who were also identified as super users of the HR a lot of the times said, all right, this person's notes are stellar.

655
01:22:34,930 --> 01:22:36,170
let's get them on this committee.

656
01:22:36,170 --> 01:22:43,690
And then we kind of presented to them as like a first pass and said, for inpatient, what do you think for this?

657
01:22:43,690 --> 01:22:44,650
is for adults.

658
01:22:44,650 --> 01:22:45,610
We have pediatrics.

659
01:22:45,610 --> 01:22:47,610
We have a NICU, we have NICUs all over the place.

660
01:22:47,610 --> 01:22:48,490
We have behavioral health.

661
01:22:49,250 --> 01:22:50,490
what do you think about this?

662
01:22:50,490 --> 01:23:00,090
And so they took it, they wrote their own notes, and they met together with one of our directors as the facilitator, but kind of more of a hands off thing.

663
01:23:00,250 --> 01:23:03,130
They came to a consensus eventually, they tested it.

664
01:23:03,370 --> 01:23:06,010
So we made it as we saved it and we had them test it out.

665
01:23:06,330 --> 01:23:07,210
And then once

666
01:23:07,610 --> 01:23:10,010
Everyone came to that and then they shared it with their team.

667
01:23:10,010 --> 01:23:15,530
They got team feedback, layers upon layers and layers, and then said, yes, this is what we're going to do.

668
01:23:15,530 --> 01:23:19,130
Then we went to our epic analyst and said, these are the changes we want to make.

669
01:23:19,330 --> 01:23:20,730
And once that was done,

670
01:23:21,050 --> 01:23:27,130
the official thing got changed and the other one got retired and then that went to, it gets pushed, got pushed down to everybody else.

671
01:23:27,130 --> 01:23:29,610
So that was a very lengthy answer, but that was the process.

672
01:23:30,410 --> 01:23:37,770
To make sure that the dietitians were, they own, they bought in because if they don't, they're just, they could just save a note and do their own thing.

673
01:23:38,050 --> 01:23:38,210
Right.

674
01:23:38,690 --> 01:23:38,810
Yeah.

675
01:23:38,890 --> 01:23:46,090
I think it's very important for it to not be a top down process or for one person making the decision for 50.

676
01:23:46,450 --> 01:23:50,650
100 dietitians, you know, it's important for that to be a collaborative process.

677
01:23:50,890 --> 01:23:55,130
And a lot most of the time, the people closest to the work are the ones that understand it the best.

678
01:23:55,290 --> 01:23:55,450
Yes.

679
01:23:55,610 --> 01:23:56,850
So I appreciate that.

680
01:23:56,850 --> 01:23:57,170
Thank you.

681
01:23:57,930 --> 01:23:59,530
Angela, can you hear me?

682
01:24:00,050 --> 01:24:00,410

Yes.

683
01:24:02,010 --> 01:24:04,250
This is Constantina Papoutsakis.

684
01:24:04,330 --> 01:24:11,770
I'm the Senior Director for the Data Science Center for the Academy and part of the measure team.

685
01:24:12,890 --> 01:24:42,490
Another suggestion I would have for everyone out there looking on how to streamline the length of the note and having a validated way to validate how the NCP is being applied is taking a careful look at the NCP Quest, which is a validated tool that helps apply it in notes and in teachings of dietitians

686
01:24:42,970 --> 01:24:54,250
so that the word count can come down and make the note way tighter, whether that's for malnutrition or any other type of nutrition care.

687
01:24:55,130 --> 01:25:05,450
The Academy developed this with the support of the VA, who took a lead in also developing

688
01:25:06,090 --> 01:25:12,250
a manual and anyone who would need that, we would make that available to them.

689
01:25:12,410 --> 01:25:13,210
So thank you.

690
01:25:14,610 --> 01:25:15,290
Thank you, Tina.

691
01:25:16,450 --> 01:25:18,570
Okay, the next question I have is for Natali.

692
01:25:19,130 --> 01:25:25,130
And do you have smaller facilities, Natali, within your organization?

693
01:25:26,810 --> 01:25:29,690

I just want to make sure this question is appropriate.

694
01:25:30,570 --> 01:25:37,210
Currently not, but in my previous role, yes, we had smaller facilities that we were working with critical access hospitals.

695
01:25:37,410 --> 01:25:39,290
Okay, I'm going to give this a shot then.

696
01:25:39,770 --> 01:25:42,090
So how do you handle timely Rd.

697
01:25:42,130 --> 01:25:49,450
assessments in the rural community access hospital space where there's not a full-time dietitian?

698
01:25:50,170 --> 01:25:54,650
So in this individual's facility, 72 hours is somewhat of a stretch.

699
01:25:56,090 --> 01:26:00,650
Yeah, especially when you're short in a rural facility, there's not enough staffing.

700
01:26:01,130 --> 01:26:03,850
Timely assessments is often a challenge.

701
01:26:05,050 --> 01:26:13,690
Usually what we use to emphasize is, you know, yes, we care about timely care, but also prioritizing the patients that really need to be seen, seen first.

702
01:26:14,490 --> 01:26:29,050
We would prefer those patients like those with enteral nutrition, nutrition support, TPNs, and more complex patients in the rural setting to be seen first, and those in a timely manner than the more lower priority ones.

703
01:26:29,050 --> 01:26:29,730
It is a challenge.

704
01:26:30,970 --> 01:26:32,170

Yeah, exactly.

705
01:26:32,170 --> 01:26:40,810
We used to come up with a prioritization list, and those at top priority, we emphasize that they should be seen timely versus the length of stays.

706
01:26:41,490 --> 01:26:44,290
Right, which obviously malnutrition would be right at the top of that list.

707
01:26:44,650 --> 01:26:45,130
Exactly.

708
01:26:46,050 --> 01:26:57,770
Okay, Stacy, how do you determine how a dietitian's malnutrition diagnosis translates to the ICD codes?

709
01:26:59,770 --> 01:27:07,450
So in working with our coding and billing team, we just aligned the moderate malnutrition

710
01:27:08,330 --> 01:27:16,090
to the moderate malnutrition ICD-10 code and the severe to the severe ICD-10 code.

711
01:27:17,290 --> 01:27:19,130
We are also in talks.

712
01:27:19,130 --> 01:27:33,210
I know people on the call may be aware that ICD-11 has been proposed and it is anticipated to roll out sometime in 2027 in the United States.

713
01:27:34,810 --> 01:27:40,290
So that coding will shift slightly some of the language.

714
01:27:40,290 --> 01:27:45,290
And so we have been working with our coding team to see if we will need to adjust any of that moving forward.

715
01:27:45,290 --> 01:27:53,170
We do not have anything aligned to the mild code because there is not currently

none of the frameworks

716
01:27:53,370 --> 01:27:57,530
except for SGA have anything for mild, we don't use SGA.

717
01:27:57,850 --> 01:28:07,690
I do know the Global Leadership Initiative on Malnutrition work group is working on providing and validating a mild diagnostic category.

718
01:28:08,250 --> 01:28:09,890
Hopefully that answers the question.

719
01:28:09,930 --> 01:28:22,090
Yes, I'm wondering if this question was more focused possibly on like the billing and coding, which as most of you alluded to, I would work with your coding and CDI, you know,

720
01:28:22,570 --> 01:28:28,330
make good connections with those individuals within your organizations if the question was geared more toward billing.

721
01:28:28,970 --> 01:28:31,410
But I do think that we're out of time for questions.

722
01:28:31,410 --> 01:28:33,130
We're right at 2.30.

723
01:28:33,490 --> 01:28:38,090
And I think there's a couple of informational slides here I'll touch on real quick.

724
01:28:38,970 --> 01:28:41,850
Thank you guys all for answering those questions.

725
01:28:42,330 --> 01:28:47,530
So you will receive an e-mail within two days with a link to the CPEU certificate and our survey.

726
01:28:47,530 --> 01:28:48,890
Please make sure to take that survey.

727
01:28:48,890 --> 01:28:50,970
We take that feedback to heart.

728
01:28:51,530 --> 01:28:53,770
And you'll have 15 days to complete that.

729
01:28:53,770 --> 01:29:02,250
And this webinar recording will be posted on quality, eatrightpro.org/quality within two weeks.

730
01:29:05,370 --> 01:29:07,130
And that's all we have for you guys today.

731
01:29:07,130 --> 01:29:13,530
Thank you so much for joining us and we hope that you enjoyed this webinar and found it very insightful.

732
01:29:14,330 --> 01:29:14,730
Thank you.