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00:00:00,799 --> 00:00:08,527

Hello, on behalf of the Academy of Nutrition and Dietetics and the quality measure team, we are excited to welcome you to this video.

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00:00:09,498 --> 00:00:21,716

Our goal is to demonstrate how patient data moves from documentation to reporting submission in an electronic clinical quality measure or eCQM as applied to the malnutrition care score.

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00:00:22,728 --> 00:00:35,068

To understand how value sets are used in an electronic clinical quality measure, it is important to know that eCQMs are transmitted to the Centers for Medicare and Medicaid Services (CMS) in a standard electronic format.

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00:00:35,634 --> 00:00:44,535

This means that data is directly extracted from the electronic health record, or EHR, or the available clinical information technology system.

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00:00:45,345 --> 00:00:54,327

This data is then used to assess the quality of healthcare provided and to support a variety of quality reporting value-based purchasing programs under CMS.

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00:00:55,298 --> 00:01:04,522

More information on eCQMs and how they are structured and developed can be found at the eCQI Resource Center on the website link shown here.

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00:01:05,412 --> 00:01:08,406

With this in mind, let's discuss what value sets are.

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00:01:11,481 --> 00:01:16,255

A value set is a list of unique codes representing a specific clinical concept.

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00:01:16,660 --> 00:01:23,658

They may be composed of terms from clinical terminologies such as ICD-10, SNOMED CT, and LOINC.

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00:01:24,347 --> 00:01:27,503

In other words, they are groupings of terms that are similar.

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00:01:28,150 --> 00:01:35,271

Essentially, the value set is the umbrella and all the terms underneath represent the umbrella concept in some way.

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00:01:36,404 --> 00:01:45,871

This is important because it is a way of organizing documentation language and transforming it into machine readable data so that care provided can be measured.

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00:01:46,923 --> 00:01:58,090

This machine readable data is a way for all electronic medical records to submit information to CMS through measure logic individually defined for each quality measure.

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00:01:59,061 --> 00:02:06,303

All value sets are maintained by the National Library of Medicine's Value Set Authority Center, or VSAC.

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00:02:07,153 --> 00:02:15,649

As an eCQM, the MCS uses value sets that represent care provided based on the nutrition care process and malnutrition care standards.

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00:02:16,378 --> 00:02:23,579

This graphic shows how relevant documentation is processed and tracked so it can be reported as part of an MCS observation.

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00:02:25,036 --> 00:02:35,393

As shown on the green box, for any MCS-related step to be included, it must first be documented as discrete data, normally seen as drop-down menus or click boxes.

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00:02:36,769 --> 00:02:46,317

Then as we move to the red box, that discrete data is linked to a diagnosis procedure intervention code or standardized terminology from the corresponding code system.

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00:02:47,046 --> 00:02:57,970

As we continue to move down, these codes are then grouped into value sets which are identified into MCS measure logic being reported as an eCQM to CMS.

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00:02:59,912 --> 00:03:17,147

Let's walk through an example of how this works and how the value set connects to documentation using measure observation three malnutrition diagnosis in an 18 year

old or older patient admitted as inpatient for 24 hours or more.

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00:03:18,361 --> 00:03:26,534

First, the patient screens at risk for malnutrition is assessed and then found to have moderate malnutrition by the registered dietitian.

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00:03:27,667 --> 00:03:36,244

Based on this assessment, an eligible provider assigns a corresponding ICD-10 code for the malnutrition diagnosis in the EHR.

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00:03:37,458 --> 00:03:48,139

That code maps to the M03 or Measure Observation 3 value set within the measure logic, and the malnutrition diagnosis value set is activated.

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00:03:49,272 --> 00:03:57,930

So when reporting and data extraction occur, the system recognizes the code and counts M03 as documented.

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00:03:59,305 --> 00:04:05,375

All this information is then transferred to CMS directly from the organization system when reporting.

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00:04:06,588 --> 00:04:18,644

For each step to count toward the measure calculation, the relevant EHR documentation template must be mapped or linked to a code in the value set representing that step.

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00:04:19,535 --> 00:04:22,691

This is what confirms the step was documented.

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00:04:23,338 --> 00:04:37,014

In addition, the measure is built so that any of the steps can be documented in any order and can be captured in an observation or emergency department visit linked to the inpatient visit or encounter.

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00:04:38,106 --> 00:04:44,944

Let's look at another example, but this time how the registered dietitians work gets captured as measure observation number two.

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00:04:45,996 --> 00:04:55,948

The first step into the measure is always going to be identifying the patient as 18 years or older, admitted as an inpatient for 24 hours or longer.

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00:04:56,677 --> 00:05:04,121

If the patient is screened as at risk for malnutrition, the MCS logic will then look for the registered dietitian's assessment.

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00:05:05,011 --> 00:05:13,184

Once assessed, the registered dietitian finds the patient to have moderate malnutrition with the information documented in a standardized template.

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00:05:14,155 --> 00:05:28,073

Within the standardized template, the registered dietitian documents the nutrition diagnosis from a drop-down menu, selecting moderate chronic disease or condition-related malnutrition, linked or mapped to a corresponding NCPT code.

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00:05:29,125 --> 00:05:36,489

This NCPT code is connected to two LOINC codes and one SNOMED code as shown in the graphic.

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00:05:37,945 --> 00:06:03,434

These LOINC and SNOMED codes are included in the MCS nutrition assessment status finding of moderately malnourished value set, which then leads the measure observation 2 logic to recognize the value set codes, and consequently, measure observation number 2 is recognized by the system as documented and completed with MCS reporting.

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00:06:04,891 --> 00:06:25,444

It is important to note that when documenting in discrete fields like dropdown menus or checkboxes, using standardized terminology provided by the Nutrition Care Process terminology ensures that the information is machine readable and the data can be collected and made available for internal and external reporting.

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00:06:26,253 --> 00:06:28,114

By using discrete data points,

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00:06:28,681 --> 00:06:37,096

your care is captured and you can create reports that measure outcomes or changes, demonstrating your value and the care you are providing.

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00:06:38,229 --> 00:06:48,263

Another important detail to remember when looking at reporting an eCQM is that for data to travel from the hospital to CMS, it requires standardization of terminology and processes.

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00:06:48,627 --> 00:06:50,691

Let's take a closer look at what this means.

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00:06:51,338 --> 00:06:52,794

We will start with CMS.

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00:06:53,199 --> 00:07:00,401

who, after a rigorous annual review process, authorizes the eCQM logic that will be used for each measure.

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00:07:01,574 --> 00:07:11,082

eCQM logic is the set of precise machine-readable rules and expressions that use patient data from electronic health records to evaluate healthcare quality.

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00:07:12,538 --> 00:07:18,365

Once the hospital receives the file from CMS, the logic and value sets are applied within their EHR.

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00:07:19,417 --> 00:07:24,514

which then builds these within templates that have discrete or established fields.

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00:07:25,647 --> 00:07:30,260

These discrete fields often look like dropdown boxes or click lists.

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00:07:31,392 --> 00:07:40,860

For the next step, CMS defines eligible clinician as a clinician who participates in CMS programs for quality reporting, including RDNs.

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00:07:42,074 --> 00:07:47,819

So once the eligible clinician assesses the patient, they document the visit in the discrete fields.

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00:07:48,709 --> 00:07:58,015

Then the data is collected utilizing standardized terminology and consequently reported directly to CMS, completing the process.

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00:07:59,308 --> 00:08:05,783

Now let's take an overall look at how medical information moves through the reporting process for the malnutrition care score.

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00:08:06,916 --> 00:08:12,418

The MCS combines evidence-based malnutrition care into a single reporting flow.

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00:08:13,146 --> 00:08:17,840

As an eCQM, all information needed for the measure moves within the EMR.

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00:08:19,701 --> 00:08:27,550

starts when a patient that is 18 years or older at the moment of admission has been classified as inpatient for 24 hours or more.

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00:08:28,278 --> 00:08:32,486

These are also patients that have not been discharged to hospice care.

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00:08:35,155 --> 00:08:44,381

At this point, it is when the evidence-based malnutrition care workflow characterized by measure observations starts to be documented as needed.

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00:08:45,190 --> 00:08:58,218

Each measure observation is based on the nutrition care process in order to capture malnutrition care best practices, such as screening, nutrition assessment, the malnutrition diagnosis, and the nutrition care plan.

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00:09:00,241 --> 00:09:12,055

Each measure observation is confirmed through a clinical action, the actual work performed by the care team, as in screening a patient or assessing and diagnosing with malnutrition.

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00:09:13,430 --> 00:09:19,823

Clinical actions should be supported by evidence-based guidelines and valid and reliable tools.

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00:09:20,470 --> 00:09:27,672

It is at this point when the clinical action plan is mapped to specific codes designed to meet specific standardized terminology.

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00:09:28,158 --> 00:09:39,405

This is where standardized terms under codes from code systems like ICD-10, SNOMED CT, and LOINC translate the documentation into machine-readable data supporting interoperability.

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00:09:40,053 --> 00:09:54,051

In the example shown here, for this specific patient, as we move from top to bottom, there was no dietitian referral, but there was a malnutrition risk screening completed and was found at risk of malnutrition during observation 1.

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00:09:54,699 --> 00:10:03,923

Then assessed and found to have moderate malnutrition by the RDN, as well as medically diagnosed with moderate protein malnutrition, and a nutrition care plan in place.

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00:10:04,652 --> 00:10:06,917

All the corresponding codes are shown here.

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00:10:07,969 --> 00:10:16,061

Those codes are then contained within a value set, which is a structured grouping of codes maintained by the Value Set Authority Center, or VSAC.

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00:10:16,628 --> 00:10:25,205

When a documented code matches one in the relevant value set, the value set is activated and recognized within the Malnutrition Care Score logic.

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00:10:26,823 --> 00:10:38,799

As shown here, it is consistent discrete documentation using standardized terminology, what allows the care to be captured, coded, and ultimately reported as the malnutrition care score.

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00:10:39,932 --> 00:10:46,122

The measure logic turns the machine readable patient data from the EHR into a report submitted to CMS.

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00:10:46,972 --> 00:10:55,468

As we just finished discussing, each measure observation produces a measure performance result recognized through codes in the measure value set,

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00:10:56,278 --> 00:11:02,670

Each observation result is counted as documented and completed or not based on the

measure logic.

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00:11:03,479 --> 00:11:07,525

The measure logic is applied once again to obtain the result for measure.

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00:11:07,647 --> 00:11:17,721

measure observation 5, known as the total malnutrition component score, and measure observation 6, known as the total malnutrition care score as percentage.

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00:11:18,530 --> 00:11:28,968

The measure submission is finalized when the hospital submits an electronic file that contains all the individual scores for the encounter level MCS value.

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00:11:30,142 --> 00:11:32,367

And that brings us to the end of this video.

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00:11:32,691 --> 00:11:35,847

Thank you so much for your interest in learning how value sets work.

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00:11:36,413 --> 00:11:44,869

Additional information can also be found by visiting our web page www.eatrightpro.org/mcs.

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00:11:45,799 --> 00:11:50,816

If any questions come up, please reach out to us at quality@eatright.org.