

WEBVTT

00:00:03.000 --> 00:00:11.000

Thank you for joining us for today's live webinar on implementation of the Malnutrition Care Score.

00:00:11.000 --> 00:00:21.000

A couple of housekeeping notes before we begin. This webinar is for information only and does not award CPE.

00:00:21.000 --> 00:00:30.000

Closed captioning is available for this event. Click the captions button in the bottom toolbar of your meeting window to activate.

00:00:30.000 --> 00:00:41.000

We will have a live Q&A session with our panel at the end of this event. But please feel free to submit any questions you have throughout the the event through the Q&A tab.

00:00:41.000 --> 00:00:55.000

We received so many questions from you all, so thank you so much for that. And any questions that are not answered during the live Q&A will be sent via email within 2 to 3 weeks following today's presentation.

00:00:55.000 --> 00:01:02.000

They will also be posted on our website under the Mcs resources page.

00:01:02.000 --> 00:01:13.000

My name is Angela Lago, and I will be your moderator for today. I am the Senior Director of Quality Management and Practice Competence at the Academy of Nutrition and Dietetics.

00:01:13.000 --> 00:01:28.000

During the Q&A portion of today's presentation, we will be joined by our amazing panel, the measure, steward, and developer team at the Academy, which includes Tammy Ojeda, Director of Quality Initiatives and Improvement

00:01:28.000 --> 00:01:45.000

Constantina Papoutsakis, Senior Director of the Data Science Center. Michelle Ashafa, Director of Quality Measurement and Interoperability. And Rebecca Niitzel, Senior Manager of Quality and Terminology

00:01:45.000 --> 00:01:52.000

So thank you all for being here today. And I'm really looking forward to the Q&A portion of this presentation.

00:01:52.000 --> 00:01:58.000

So before we get started, here are our disclosures for today.

00:01:58.000 --> 00:02:05.000

And our learning objectives.

00:02:05.000 --> 00:02:08.000

Okay, so let's get started.

00:02:08.000 --> 00:02:22.000

So most of you here, I'm sure, have heard a little bit about the Malnutrition Care Score. We've been talking about it a lot lately. Today, during the presentation, I will reference it most times as the MCS

00:02:22.000 --> 00:02:36.000

So the Malnutrition Care Score is an electronic clinical quality measure or eCQM that uses data extracted from electronic health records to assess the quality of care provided.

00:02:36.000 --> 00:02:53.000

So the MCS specifically assesses adults ages 18 years of age and older at the start of the measurement period, with a length of stay equal to or greater than 24 hours who received optimal Malnutrition care

00:02:53.000 --> 00:02:58.000

appropriate to the patient's level of malnutrition risk.

00:02:58.000 --> 00:03:04.000

Malnutrition care best practices, which many of you, I'm sure, already do, include

00:03:04.000 --> 00:03:11.000

One, screen for malnutrition risk or have a dietitian referral order placed

00:03:11.000 --> 00:03:22.000

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

00:03:22.000 --> 00:03:28.000

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

00:03:28.000 --> 00:03:37.000

And finally, four, have a current nutrition care plan performed by a registered dietitian.

00:03:37.000 --> 00:03:52.000

Measure population exclusions for the MCS include individuals with a discharge to home for hospice care or discharge to a healthcare facility for hospice care

00:03:52.000 --> 00:03:58.000

This does not include referrals for hospice care evaluation.

00:03:58.000 --> 00:04:04.000

orders for palliative care or comfort measures only.

00:04:04.000 --> 00:04:17.000

The Malnutrition Care Score will become mandatory for all inpatient acute care hospitals that participate in the CMS IQR program beginning in 2028.

00:04:17.000 --> 00:04:23.000

This measure is also not applicable for pediatrics or neonates

00:04:23.000 --> 00:04:31.000

Outpatient facilities, skilled nursing facilities, or long-term care facilities.

00:04:31.000 --> 00:04:38.000

So this image shows how the Malnutrition Care Score fits into the National Quality Framework.

00:04:38.000 --> 00:04:46.000

It all starts with the Center for Medicare and Medicaid Services, which drives quality initiatives nationwide.

00:04:46.000 --> 00:05:00.000

Nestled just below that in the red, you can see payment systems like IPPS or the inpatient prospective payment system, which rewards hospitals for value and quality.

00:05:00.000 --> 00:05:11.000

Hospitals then report their performance through programs like IQR, inpatient quality reporting programs, using eQMs from health records.

00:05:11.000 --> 00:05:15.000

This participation is later tied to payment.

00:05:15.000 --> 00:05:28.000

The MCS is designed to be one of these key electronic measures, ensuring that nutrition is recognized as a critical part of quality care.

00:05:28.000 --> 00:05:35.000

So the Academy of Nutrition and Dietetics is the measure, steward, and developer of the MCS.

00:05:35.000 --> 00:05:46.000

And we're very proud of this because we're able to highlight RDs and NDRs as subject matter experts on identifying and addressing Malnutrition

00:05:46.000 --> 00:05:54.000

This helps ensure that nutrition is represented in federal quality reporting programs.

00:05:54.000 --> 00:06:03.000

The Malnutrition Care Score highlights RDs and NDRs as subject matter experts on identifying and addressing malnutrition.

00:06:03.000 --> 00:06:16.000

It also establishes credential practitioners or RDNs at NDTRs. You'll kind of hear that used interchangeably in today's presentation. As an essential part of acute care and patient outcomes.

00:06:16.000 --> 00:06:23.000

The MCS promotes evidence-based guidelines while ensuring an interdisciplinary approach

00:06:23.000 --> 00:06:29.000

And guides and supports quality improvement efforts for malnutrition and acute care setting.

00:06:29.000 --> 00:06:37.000

You can also see that the MCS is directly aligned with three strategic priorities of the Academy.

00:06:37.000 --> 00:06:46.000

which are defined identity partners and communities and professional empowerment.

00:06:46.000 --> 00:06:57.000

The timeline for eligible hospitals and critical access hospitals can be seen here. This information is also available on our website.

00:06:57.000 --> 00:07:07.000

eQCM data is often reported on a quarterly cadence, although how it's reported and the cadence of that will be organization dependent.

00:07:07.000 --> 00:07:22.000

This graphic shows the timeline for reporting, submission, and payment periods. For example, the bottom row in red shows that for 2028, which is also the year that reporting MCS will become mandatory.

00:07:22.000 --> 00:07:31.000

2028 is the reporting year. That is the year the information is reported and then submitted in 2029.

00:07:31.000 --> 00:07:39.000

And then the payment occurs the following year in 2030.

00:07:39.000 --> 00:07:55.000

Now, this work has been ongoing for over a decade, starting back in 2013, and perhaps some of you are even like me and have been part of the early stages of this work years ago, possibly involved in learning collaboratives

00:07:55.000 --> 00:08:07.000

Or other initiatives to support conceptualization of the MCS. It was previously known as the GMCS, Global Malnutrition Composite Score.

00:08:07.000 --> 00:08:18.000

So, as you can see, a tremendous amount of time, work, and commitment has gotten the Academy and the dietetics profession where we are today with this measure.

00:08:18.000 --> 00:08:30.000

This is very dynamic. It's evolving, evolving, and it's very progressive work with large impacts for the profession.

00:08:30.000 --> 00:08:35.000

So now let's dive a little more into the specifics of the measure.

00:08:35.000 --> 00:08:44.000

The MCS is designed to measure whether patients receive evidence-based Malnutrition care throughout their hospital stay.

00:08:44.000 --> 00:08:58.000

Rather than focusing on whether malnutrition was identified, it evaluates whether each critical step in the clinical care pathway was completed according to established nutrition guidelines.

00:08:58.000 --> 00:09:05.000

This means the score reflects the quality and completeness of Malnutrition care provided.

00:09:05.000 --> 00:09:12.000

It reflects adherence, as I said, to evidence-based nutrition care guidelines, which we should all be aiming for

00:09:12.000 --> 00:09:21.000

It identifies gaps in care, such as patients who were screened but never assessed or possibly diagnosed but not treated.

00:09:21.000 --> 00:09:31.000

The MCS encourages multidisciplinary coordination among nurses, dietitians, physicians, and other healthcare professionals.

00:09:31.000 --> 00:09:43.000

And it also supports quality improvement initiatives by measuring the reliability of the complete Malnutrition care process rather than those isolated tasks.

00:09:43.000 --> 00:09:56.000

So on this slide, you can see measure observations one through four. These are probably already part of your everyday practice in the clinical acute care setting.

00:09:56.000 --> 00:10:04.000

So measure observation one, which is the magenta box at the top of this image, is nutrition screen

00:10:04.000 --> 00:10:09.000

measure observation 2 in the green box is nutrition assessment.

00:10:09.000 --> 00:10:21.000

Measure observation 3, the blue box is Malnutrition diagnosis, either moderate or severe by a medical provider.

00:10:21.000 --> 00:10:31.000

Measure observation 4. The red box is the care plan. So those 4 items already occur

00:10:31.000 --> 00:10:38.000

Most of your daily work, hopefully, hopefully these are happening every day with every patient.

00:10:38.000 --> 00:10:54.000

Measure observation 5, which is not pictured here, is the total Malnutrition score and measure observation 6 is the total Malnutrition score as a percentage. So this score is interpreted as a percentage

00:10:54.000 --> 00:11:14.000

And the greater the percentage, the higher the quality of malnutrition care that has been provided. There's currently no benchmark data for the MCS. That's one of the questions that some of you asked, and that information is not currently available.

00:11:14.000 --> 00:11:23.000

So RDNs and NDTRs are both very involved in various aspects of the MCS.

00:11:23.000 --> 00:11:30.000

Here you can see specific portions of the documentation that are appropriate for either

00:11:30.000 --> 00:11:34.000

RDNs and or NDTRs

00:11:34.000 --> 00:11:50.000

So both professions can complete the nutrition screening process as well as support identification and implementation of a validated screening tool. Registered dietitians perform and document the nutrition assessment results

00:11:50.000 --> 00:11:57.000

Utilizing a validated assessment and diagnostic tool to provide a nutrition diagnosis

00:11:57.000 --> 00:12:05.000

NDTRs can obtain and document data to contribute elements of the nutrition assessment.

00:12:05.000 --> 00:12:26.000

Registered dietitians determine nutrition prescriptions and initiate the nutrition care plan interventions. While NDTRs are very valuable in helping implement and oversee standard operating procedures and assist with individualized interventions and education as assigned

00:12:26.000 --> 00:12:36.000

So let's look at an example of how a registered dietitian's work gets captured looking specifically at measure observation 2.

00:12:36.000 --> 00:12:42.000

So the measure starts by identifying the patient as 18 years or older

00:12:42.000 --> 00:12:47.000

Admitted as an inpatient for 24 hours or longer.

00:12:47.000 --> 00:12:52.000

If the patient is screened at risk for malnutrition

00:12:52.000 --> 00:12:58.000

The MCS logic will then look for the registered dietitian's assessment

00:12:58.000 --> 00:13:06.000

Once assessed, as in this example, the registered dietitian finds the patient to have a moderate

00:13:06.000 --> 00:13:12.000

Malnutrition with the information documented in a standardized template

00:13:12.000 --> 00:13:25.000

Within the standardized template, the registered dietitian documents the nutrition diagnosis from a drop-down menu, selecting moderate chronic disease-related or moderately Malnourished.

00:13:25.000 --> 00:13:33.000

Linked or mapped to a corresponding NCPT code, nutrition care process and terminology.

00:13:33.000 --> 00:13:49.000

So behind the scenes in the medical record, the NCPT code is connected to two other codes. Many of you may not be familiar with these because they're behind the scenes. One is a LOINC code and one is a SNOMED code

00:13:49.000 --> 00:14:06.000

These codes are included in the MCS Nutrition Assessment Status finding of moderately Malnourished value set. So the codes and the value sets are probably going to be something that many of you are not familiar with, and that is okay. We will learn more about that as we go

00:14:06.000 --> 00:14:26.000

So that leads the measure observation to logic to recognize the value set codes and consequently measure observation two is recognized by the system as documented and completed when the MCS is reported.

00:14:26.000 --> 00:14:38.000

Now, it's important to note that when documenting indiscrete fields like drop down

menus or check boxes using standardized terminology provided by the NCPT

00:14:38.000 --> 00:14:47.000

This ensures that the information is machine readable and that the data can be collected and made available for internal and external reporting.

00:14:47.000 --> 00:15:01.000

By using these discrete data points, your care is captured and you can create reports that measure outcomes or changes, demonstrating your value and the care that you're providing.

00:15:01.000 --> 00:15:17.000

It's also important to remember that the measure is designed around the workflow of dietitians and NDTRs. So as long as a screen is getting done, the patient's getting assessed, the providers pick up the Malnutrition diagnosis when applicable

00:15:17.000 --> 00:15:28.000

and a plan of care is being documented. Your workflow should not change significantly just because your organization decides to start reporting the MCS.

00:15:28.000 --> 00:15:51.000

I think the measure helps dietitians and NDTRs identify and focus on providing care for the most nutritionally at-risk patients. So it should not create a lot more work for dietitians and NDTRs. However, it may cause you to reprioritize how you triage your patients.

00:15:51.000 --> 00:15:57.000

So taking a closer look at the use of standardized terminology and eCQM reporting.

00:15:57.000 --> 00:16:00.000

We will start with CMS

00:16:00.000 --> 00:16:11.000

Who, after a rigorous annual review process, authorizes the electronic clinical quality measure logic that will be used for each measure.

00:16:11.000 --> 00:16:25.000

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

00:16:25.000 --> 00:16:34.000

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

00:16:34.000 --> 00:16:41.000

which builds these within templates that have discrete or established fields

00:16:41.000 --> 00:16:47.000

Discrete fields are typically seen as drop-down boxes or click lists.

00:16:47.000 --> 00:16:51.000

For the next step, CMS defines eligible clinician

00:16:51.000 --> 00:16:59.000

As a clinician who participates in CMS programs for quality reporting, which includes RDNs

00:16:59.000 --> 00:17:14.000

Once the eligible clinician assesses the patient, they document the visit in the discrete fields. Then the data is collected, utilizing standardized terminology. And consequently reported directly to CMS

00:17:14.000 --> 00:17:21.000

Completing the process. I apologize. My slides keep wanting to get ahead of me here.

00:17:21.000 --> 00:17:39.000

Now, this slide is probably a little confusing to some of you that aren't used to this backend process. So I encourage you to go back into the slides and look at this slide and the one before when you're thinking about this presentation. I think that would be helpful

00:17:39.000 --> 00:17:48.000

So the Malnutrition Care Scorespecifications recommend the use of valid and reliable screening and assessment tools.

00:17:48.000 --> 00:18:03.000

No matter what the screening, assessment, or diagnostic tool is that's being utilized, it's important that the RDN and NDTR have received proper training and that the tool is being utilized as intended

00:18:03.000 --> 00:18:09.000

in the population and setting that it is validated in and intended for.

00:18:09.000 --> 00:18:19.000

Here, you can see a list of validated screening and assessment slash diagnostic tools.

00:18:19.000 --> 00:18:31.000

So we have reviewed both front of house information, so the documentation piece that many of you do, screening, assessment, diagnosis, and care planning.

00:18:31.000 --> 00:18:42.000

We've also looked at some of the back of the house information, such as the logic, the Cms data transfer, NCPT and value sets

00:18:42.000 --> 00:18:58.000

Both of these processes, the front of the house and the back of the house, are equally important. And as I said, chances are many of you are already doing the front of the house work. It may just need to be streamlined or updated. Maybe you need to have the correct

00:18:58.000 --> 00:19:05.000

you know, links between the front of the house and the back of the house, so the data gets reported correctly.

00:19:05.000 --> 00:19:13.000

The EHR is set up to support the data collection is not something that NDTRs or RDNs will accomplish independently.

00:19:13.000 --> 00:19:35.000

We like to think of credential practitioners as advisors and collaborators in this area, because you will be the one helping connect IT connect the dots between where the RDNs document and where the data can be pulled from, so it's mapped correctly on the back end

00:19:35.000 --> 00:19:54.000

So as you are thinking about implementing the MCS, for many of you, it's not an option anymore. It's coming. And this next year will be full of learning opportunities, maybe some challenges. And we're definitely here to help you with that. But here are some things to consider when you start heading down this path.

00:19:54.000 --> 00:20:05.000

You want to think about where you are now. What is your current baseline status and what you need to move forward to the next steps.

00:20:05.000 --> 00:20:19.000

Who do you need at the table? Do you need leadership support? That's not going to be as hard for many of you anymore, because you're not having to convince your leaders that you need to start reporting the MCS. They know it's coming to most, most likely.

00:20:19.000 --> 00:20:31.000

So what kind of support do you need? Do you need to form a project team? Do you need project champions, possibly from different interdisciplinary teams to help bring this all together?

00:20:31.000 --> 00:20:46.000

What type of training is needed? Maybe your dietitians are not consistently doing the nutrition focused physical exam. Maybe you have a lot of opportunities there, or even opportunities with confidently diagnosing malnutrition

00:20:46.000 --> 00:20:51.000

Do the providers need educating? The coding team, CDI

00:20:51.000 --> 00:21:02.000

How do you want this to be communicated? That's something else that's really important. The dissemination of information to staff, organization leaders and providers.

00:21:02.000 --> 00:21:09.000

What are the documentation requirements? So what does the MCS require versus what you're doing right now?

00:21:09.000 --> 00:21:25.000

What are you doing right now compared to what your organization requires? There's probably, I could bet that there's plenty of opportunity to optimize the documentation that's currently happening to make room for more meaningful documentation

00:21:25.000 --> 00:21:35.000

What kind of data do you need to capture? How will you show progress with your team as you start implementing this? What are the MCS requirements for data?

00:21:35.000 --> 00:21:46.000

And then how are you going to reach your goal? And how will you know when you've reached it? Maybe you will be able to take on a big project all at one time, or maybe you might need to break this

00:21:46.000 --> 00:21:53.000

More manageable pieces. It's gonna obviously depend on the resources available to you at your organization.

00:21:53.000 --> 00:21:56.000

And then sustainability.

00:21:56.000 --> 00:22:13.000

What is required to sustain your program, your processes, to continue getting a better and better score once you start reporting the MCS to make sure that your team is performing appropriately.

00:22:13.000 --> 00:22:37.000

Okay, so we have so many resources. I've been at the academy for about a year and a half, and the team prior to me has been working on this relentlessly for years. So we have so much information for you. We've included here on this slide information from CMS quality measures, other eCQM information, the websites to reach that information

00:22:37.000 --> 00:22:50.000

We also have a ton of Malnutrition Care Scoreeducation resources on the Eat Right Pro website. We have multiple recordings. So many things for you to choose from.

00:22:50.000 --> 00:23:01.000

Additionally, we have a plethora of open access MCS-related quality improvement and implementation resources available on the Eat Right Pro website.

00:23:01.000 --> 00:23:15.000

Please make sure to visit this website, see everything that we have going on, all of the things that we make available specifically for you, which includes things like evidence-based guidance to support Malnutrition care

00:23:15.000 --> 00:23:30.000

links to important measure related websites, videos on Malnutrition identification and documentation, implementation resources, a very handy MCS calculator, so you can look at different scenarios and see what your score would be

00:23:30.000 --> 00:23:48.000

If it's, you know, 50 out of 100, 25 out of 100, 100 out of 100, and much more. So many resources there. And we also have a very large FAQ document that has a lot of commonly asked questions and our answers to those

00:23:48.000 --> 00:24:03.000

Okay, so the part that you've all been waiting for, we're now going to move into our Q&A session of this town hall, and as I said before, we received so many questions from you guys

00:24:03.000 --> 00:24:15.000

I don't know, Tammy, maybe 200 questions. I mean, it was a ton of questions. So we will work diligently to answer as many as we can, most of which will be after this presentation today.

00:24:15.000 --> 00:24:24.000

But any topic-related relevant questions that, like I said, we don't get to will be in that document.

00:24:24.000 --> 00:24:33.000

All right, so we have our panel that has joined us for today. And I think we'll start with you, Tammy.

00:24:33.000 --> 00:24:50.000

So how do you think that the MCS differs from current Malnutrition screening and nutrition care practices such as the MST? What are the important most important changes RTM should prepare for

00:24:50.000 --> 00:25:01.000

Okay, so the MCS, what it does is that it establishes the evidence-based workflow, at least how I present it to people that ask that question.

00:25:01.000 --> 00:25:16.000

How the facility or organization and the practitioners decide to establish or implement that workflow depends on their resources, how many staff members they have the population they're serving

00:25:16.000 --> 00:25:22.000

The needs and then, of course, state and federal regulations. So

00:25:22.000 --> 00:25:37.000

We... we purposefully, when we were developing the MCS, did not establish a specific tool to use in any of the steps or specific anything, because that really depends on the organization. And again, their resources

00:25:37.000 --> 00:25:49.000

So our biggest encouragement for this is for RDNs and MDTRs that are supporting the process to work towards aligning that Malnutrition care, that improvement

00:25:49.000 --> 00:26:04.000

process that the workflow supports and encourages with the efforts of the MCS. So making sure that what you're doing over here with the MCS improvement, right? Apologies, the Malnutrition improvement

00:26:04.000 --> 00:26:20.000

aligns with what the MCS workflow and the MCS measure is actually requesting or requiring. For example, it requires a nutrition screening, nutrition risk screening, or a dietitian referral, so that there is a process then

00:26:20.000 --> 00:26:24.000

that the facility organization has to

00:26:24.000 --> 00:26:36.000

have a process in place, right, for screening or referral. An easy play, you know, an easy way that there's a click, a discrete data template, etc.

00:26:36.000 --> 00:26:46.000

Okay. And kind of bouncing off of that, do you know if there are any other measures reported to CMS that are similar to the MCS?

00:26:46.000 --> 00:27:01.000

So we are not aware that there is. That doesn't mean there isn't. We're just not aware that there is. We are one of the few that has the six observations, et cetera. So that we are aware of

00:27:01.000 --> 00:27:11.000

We are the one, which is a pretty proud moment for the academy and dietitians at NDTRs to be able to say that we have that. So celebrate that for us.

00:27:11.000 --> 00:27:13.000

Yeah.

00:27:13.000 --> 00:27:28.000

So I'm going to jump to Rebecca now with this question. What do you think are the most important lessons or words of wisdom you would share with RDNs and healthcare organizations preparing to implement the MCS?

00:27:28.000 --> 00:27:47.000

That's... I love this question so much, and I think that probably everyone on this panel might have a different answer. But to me, I think the most important thing that I would just want everyone to walk away with is that the MCS is meant to capture what

00:27:47.000 --> 00:27:58.000

Dietitians are currently doing in practice already. So for all of the RDs out there

who this might be the quality measurement space might be

00:27:58.000 --> 00:28:03.000

new and a little confusing, I want you to know that

00:28:03.000 --> 00:28:19.000

You are already using the nutrition care process. You are already documenting malnutrition using evidence-based tools. You are planning and implementing interventions for your patients. You are giving

00:28:19.000 --> 00:28:35.000

Excellent care to your patients, right? Based on the nutrition care process. And I know that you're also documenting using NCPT because that's a big part of it. And so I think what I would really want everyone to just remember when maybe it sounds a little overwhelming

00:28:35.000 --> 00:28:43.000

Is that all we are trying to do with the Malnutrition Care Score is capture what you're already doing

00:28:43.000 --> 00:28:55.000

The Malnutrition Care Score is built directly on the framework of the nutrition care process. So everything that you're doing for your patients is

00:28:55.000 --> 00:29:11.000

amazing and great, and you should keep doing that and the work becomes how do we actually physically capture that in the electronic health record? So I hope that that is helpful for everyone

00:29:11.000 --> 00:29:12.000

Yes.

00:29:12.000 --> 00:29:36.000

Yeah, I think that's super beneficial because I know that's one of the questions that we get a lot and concerns that we hear is, you know, this is going to make us even busier. You know, we're already so busy. How are we going to have time to do this? We're understaffed. And I think that's an important point, Rebecca. And I know I said it multiple times in my presentation, I think because we hear it so often is that it is built around the way that dietitians work

00:29:36.000 --> 00:29:46.000

So a lot of the legwork is on the back end actually getting it set up to capture what you're already doing.

00:29:46.000 --> 00:29:51.000

So Michelle, I'm going to kick this question to you. Or do you have something to add, Tammy?

00:29:51.000 --> 00:30:15.000

I was gonna... yeah, I was gonna add, I kind of mirror Rebecca on that. This is one of

my favorite questions because I always like to say, you got to remember and kind of same as Rebecca, this is the work we're already doing and we dietitians and NDTRs are the subject matter experts in malnutrition. We are the people, the professional that can identify it, that has the tools to identify it, that can support the

00:30:15.000 --> 00:30:28.000

Doctors and PAs and Ps, whoever you have in your facility, we are the ones that support them in that diagnosis. So it is a very huge proud moment for us in our profession.

00:30:28.000 --> 00:30:39.000

What the MCS does is really ensure I had to write down because I didn't want to forget it, is to really ensure that that work that we are already doing is being highlighted

00:30:39.000 --> 00:30:58.000

And not only that, it moves us a little bit forward, especially now that it's mandatory to allow us to close those gear gaps that we had before, whether it's the screening, the diagnosis, or, you know, implementing the care plan, or whatever it is in your organization, that gap in care for Malnutrition is

00:30:58.000 --> 00:31:14.000

Having this measure supports and promotes what we need to do so that those care gaps are closed and your patient outcomes are improved and they get the care they need to get better. So that was it. Thanks.

00:31:14.000 --> 00:31:37.000

I gave Michelle a little bit of time to prepare to be asked a question. So Michelle, kind of along the lines of implementation, what are the most common barriers or roadblocks that you hear from organizations that they've encountered when they've started implementing, and what strategies have helped them overcome that?

00:31:37.000 --> 00:31:48.000

Yeah, so we've spoken to a number of facilities over time and everybody's a bit unique, but I would say some of the common themes

00:31:48.000 --> 00:31:53.000

We get our difficulties with capturing the screening

00:31:53.000 --> 00:31:57.000

Missed referrals

00:31:57.000 --> 00:32:07.000

Capturing information that the measure needs that's actually in free text spaces within their system.

00:32:07.000 --> 00:32:16.000

And some of the resolutions or brainstorming, you know, again, it depends on the facility and them

00:32:16.000 --> 00:32:24.000

identifying which area they struggle with, but some brainstorming that we've come up, and some that have helped

00:32:24.000 --> 00:32:39.000

is for the screening, especially, is having it built into their normal admission checklist. Another one is having for the referral part is having an automated

00:32:39.000 --> 00:32:56.000

referral order that is triggered with the result of the screen. Instead of having to manually get that order, because sometimes that's a roadblock to get that referral order from the physician or

00:32:56.000 --> 00:33:11.000

Whoever the NP or PA, whoever is ordering that. But also one creative way of getting some of that information, that documentation, especially for the diagnoses, is pulling

00:33:11.000 --> 00:33:28.000

That note into the physician note. We see that actually as a resolution that's very, very, very common. So they do have to acknowledge, you know, that they're confirming your diagnoses of malnutrition, but it pulls right into their

00:33:28.000 --> 00:33:33.000

their notes so they can use that, especially for reimbursement.

00:33:33.000 --> 00:33:53.000

For the free text part, you know, everybody doesn't want to be limited with how they express their assessments. So incorporating some like drop downs and radio buttons, radio buttons are like the buttons with, I'm sorry, I'm using my hands like it's just a circle and you just click it and it, you know, it grays out

00:33:53.000 --> 00:34:04.000

Incorporating some of those things within your documentation so that it's captured in a structured way. But I would say the number one

00:34:04.000 --> 00:34:21.000

The number one resolution, I think, to prevent some of these roadblocks is engaging your informatics team, your quality team, your IT team, like whatever team that deals in your quality measure space

00:34:21.000 --> 00:34:25.000

is contacting them early and soon

00:34:25.000 --> 00:34:27.000

Like now. Now

00:34:27.000 --> 00:34:45.000

And talking to them about like, hey, we got a measure coming up, you know, we've got some things we need to identify, maybe we need to change our charting a bit so we

can make sure we capture those structured items that can pull for the measure

00:34:45.000 --> 00:34:52.000

But that would probably be some of the strategies and some of the barriers that have come along.

00:34:52.000 --> 00:34:53.000

Yeah.

00:34:53.000 --> 00:34:57.000

Yeah, so really utilizing and taking advantage of automation

00:34:57.000 --> 00:35:13.000

the, all of the things that the electronic health records are capable of doing, if you can get to the right people to get them to do that. Sometimes that can be a challenge, I think, within organizations, you just have to find that right person that knows all the little tricks

00:35:13.000 --> 00:35:31.000

To make this happen for your team. And so kind of along that line, I was going to answer a question. We had so many questions about AI driven Malnutrition risk screening. So we wanted to make sure to answer that. And that's something that's evolving, obviously.

00:35:31.000 --> 00:35:49.000

We're kind of, you know, keeping our eye on the pulse of that. But one of the specific questions was, can AI driven or other electronic risk screening tools satisfy the MCS screening requirements? And what consideration should organizations have when evaluating these technologies

00:35:49.000 --> 00:36:06.000

So when it comes to the measure, as far as Malnutrition risk screening, the measure logic is looking for at-risk or not at risk. It's pretty much black and white. You're either at risk or not

00:36:06.000 --> 00:36:17.000

So there are various screening tools that can be used for that, including AI-driven screening tools to reach that at-risk or not-at-risk decision.

00:36:17.000 --> 00:36:36.000

The measured specification does call out eligible clinician as the individual completing the screen. So at this time, our recommendation is determined to determine how to handle that at an organization level. So that is something that will need to be a discussion and a decision

00:36:36.000 --> 00:36:39.000

At your organization.

00:36:39.000 --> 00:36:55.000

Other considerations that organizations should have include, you know, as I said in

the presentation, use of valid and reliable tools for screening the population at hand, making sure that your practitioners have a clear understanding of

00:36:55.000 --> 00:37:05.000

The use and functionality of that tool and the tool being appropriate for the environment in which it's being used. So

00:37:05.000 --> 00:37:15.000

To answer the question a little more briefly, yes, AI driven screening tools can satisfy the measure.

00:37:15.000 --> 00:37:23.000

If they come to the conclusion of at-risk or not at risk, but that's a lot of conversation that needs to happen within an individual organization.

00:37:23.000 --> 00:37:30.000

So hopefully that answers some questions on that because we did get quite a few questions.

00:37:30.000 --> 00:37:44.000

Let's see. Tina. I hope you're not feeling left out. Would you like to discuss some of the most recent updates to the Malnutrition Care Score?

00:37:44.000 --> 00:37:59.000

You're muted.

00:37:59.000 --> 00:38:00.000

There you go.

00:38:00.000 --> 00:38:08.000

I managed that one. Okay. Thank you for giving me the podium, Angela

00:38:08.000 --> 00:38:24.000

And I would add, I am a recent addition to the Malnutrition Care Score team, so I'm very happy to be listening in to all your input and

00:38:24.000 --> 00:38:26.000

expert feedback

00:38:26.000 --> 00:38:39.000

I always feel I learn while listening to you all on our team, having worked on the Malnutrition Care Score for several years

00:38:39.000 --> 00:38:46.000

And the Academy has been working for almost a decade, I want to say

00:38:46.000 --> 00:38:53.000

on where we are today with this important

00:38:53.000 --> 00:38:58.000

measure for the profession. So, in terms of your question

00:38:58.000 --> 00:39:00.000

Annual

00:39:00.000 --> 00:39:17.000

updates for reporting here 2027. They're not major, but they're important. and they focus on exclusion criteria. They focus on Malnutrition value sets and terminology

00:39:17.000 --> 00:39:20.000

And also measure logic

00:39:20.000 --> 00:39:28.000

So I'll try to give an overall view of what these changes entail

00:39:28.000 --> 00:39:37.000

The updates refine the Malnutrition care processes and also support implementation efforts.

00:39:37.000 --> 00:39:47.000

In terms of exclusions, a new exclusion focuses on identifying and excluding patients receiving hospice care.

00:39:47.000 --> 00:40:00.000

And in terms of value sets, and before I start talking about value sets, value sets are groups of terms that are used for a specific purpose.

00:40:00.000 --> 00:40:07.000

So there is a specific topic in each value set

00:40:07.000 --> 00:40:18.000

And, a set of selections in that value set under that topic, the same way we have

00:40:18.000 --> 00:40:29.000

In a restaurant menu. A header for appetizers, and below that we have a number of choices we can select from

00:40:29.000 --> 00:40:39.000

So, the Academy made two main value set updates, expanding the diagnostic criteria included in the measure

00:40:39.000 --> 00:40:49.000

Observation and maintaining clinical terminology by removing inactive codes, which is quite appropriate.

00:40:49.000 --> 00:41:00.000

So, first, the Malnutrition diagnosis value set was expanded to include the ICD-10 code E88

00:41:00.000 --> 00:41:04.000

dot a wasting disease

00:41:04.000 --> 00:41:23.000

And why did we do this? Adding wasting disease, in fact, broadens the scope of diagnoses recognized by the measure and aligns it more closely with common clinician wording for documenting malnutrition

00:41:23.000 --> 00:41:33.000

Also, a bit of a more detailed piece of information. Nutrition slash feeding management

00:41:33.000 --> 00:41:40.000

was removed from the nutrition care plan value set. And

00:41:40.000 --> 00:41:48.000

That was a maintenance step on our team's part with no effect on the measures intent.

00:41:48.000 --> 00:42:02.000

Now, logic refinements, which is the third category of changes for this past year, streamlined the measure by eliminating redundancies and improving clarity and precision

00:42:02.000 --> 00:42:07.000

These changes did not, again, impact the measure's scoring

00:42:07.000 --> 00:42:22.000

For all of you who are looking for more granular details, our team every year publishes a paper in the Journal of the Academy of Nutrition and Dietetics

00:42:22.000 --> 00:42:27.000

And with no exception, all these changes that I skimmed through

00:42:27.000 --> 00:42:33.000

are detailed in a janned article that just came out this past September

00:42:33.000 --> 00:42:37.000

So I'll turn it over to you, Angela, with more exciting questions.

00:42:37.000 --> 00:42:54.000

Thank you, Tina. I always love her menu analogy. I love analogies, so that helped me understand the value sets a lot. But kind of along that same topic, because I think NCPT terminology is

00:42:54.000 --> 00:43:05.000

You know, there's some dietitians that are super strong in that and other people that struggle or may not understand the connection as much. So when it comes to the Malnutrition care score

00:43:05.000 --> 00:43:22.000

This is for Rebecca. Does the MCS require specific terminology or formatting, such as eNCPT terminology, and how might changes to ICD coding affect MCS documentation and reporting? And it was like a loaded question there.

00:43:22.000 --> 00:43:38.000

Yeah, there's a few parts to that, but I'm so excited that people are asking these questions. It means everyone's really paying attention. I loved talking about terminology and I'm seeing a lot of questions about this also in the Q&A. So thank you so much, everyone, for engaging in that

00:43:38.000 --> 00:43:50.000

So to answer that first question, I think, yeah, so standardized terminology, documentation, using, like, discrete fields like everyone else has been saying

00:43:50.000 --> 00:44:00.000

It's going to be really essential for any eQCM, or measure, just because that's how the measure

00:44:00.000 --> 00:44:22.000

captures the data. It needs something to read, and so standardized terminology is going to be one of those vehicles that it uses. And so in other words, you have to be able to capture the data to measure it. So the good news is, again, because this measure is built specifically off of the nutrition care process

00:44:22.000 --> 00:44:40.000

Which should include the use of NCPT that does some of the work for you because the NCPT is connected or mapped to other code systems such as ICD, which I'm seeing a lot of questions about

00:44:40.000 --> 00:44:50.000

Other code systems like LOINC and SNOMED and all of those codes are in the measure and help calculate the measure score.

00:44:50.000 --> 00:45:03.000

So I hope that that answers that question. It can get a little bit more detailed, and I could really talk about it for a long time, so I'll cut myself off there. But for that second question, so

00:45:03.000 --> 00:45:17.000

Specifically about ICD-11, when any code system, just like ICD, is updated, the codes in any measure's logic will be updated because

00:45:17.000 --> 00:45:32.000

Those changes again affect how the measure's logic is captured. And so each year, like Tina said, the measure development team reviews any updates to these code systems so that

00:45:32.000 --> 00:45:49.000

Inactive codes are taken out or new codes are put in, we can't at this point tell you exactly how the new ICD-11 under nutrition codes will fit in because this has

not been implemented in the US yet

00:45:49.000 --> 00:46:04.000

But what I can say is that the academy is watching this closely, and we will release any resources or anything that we need to to help clarify that. But at this time there are no changes being made because

00:46:04.000 --> 00:46:08.000

That has not been implemented here

00:46:08.000 --> 00:46:09.000

Thanks.

00:46:09.000 --> 00:46:10.000

I want to add a plug if it's okay.

00:46:10.000 --> 00:46:11.000

Yeah, go ahead.

00:46:11.000 --> 00:46:30.000

Can I add a plug? So the MCS web page has a ton like Angela mentioned already, I'm going to remind you, eDrive.org, eDrive.org/MCS. There is a tab that says resources, implementation resources, go there. There's a ton of resources that can help you understand

00:46:30.000 --> 00:46:46.000

Everything MCS related, the value sets, the codes that are linked to what, the data elements, all of that. So if you are looking at building your templates, if you're looking at starting from zero, I would strongly recommend go there. And if you

00:46:46.000 --> 00:46:55.000

Do not find something that you're looking for. Email us at quality@ubai.org, and let me see if I can get you some additional help, okay? But that was it.

00:46:55.000 --> 00:46:56.000

Thank you, Tammy.

00:46:56.000 --> 00:46:57.000

Yeah.

00:46:57.000 --> 00:47:09.000

Michelle, where is the best place in the EMR to connect the medical diagnosis of malnutrition if the problem list is not currently utilized?

00:47:09.000 --> 00:47:28.000

I should add this to the barriers question that I answered earlier, because that is a common thing. Things are changing and evolving in everybody's EHR system. So every system, which I know you guys aren't going to like this, but every system

00:47:28.000 --> 00:47:43.000

And every facility is so unique. Their workflows are unique, the way that the instance of their EHR system is all unique. Some utilize problem lists, some don't, some put it somewhere else

00:47:43.000 --> 00:47:56.000

So as a measure developer in this whole quality measure space, we really recommend you work with your EHR vendor and your quality team

00:47:56.000 --> 00:48:04.000

in identifying the most accurate location of where to capture that medical diagnosis

00:48:04.000 --> 00:48:16.000

We're not unique in the sense we're capturing medical diagnoses. There's many other measures that do. So it should be an easy question to find as they can just

00:48:16.000 --> 00:48:31.000

map wherever other diagnoses are being captured for other measures with where the MCS diagnoses would be captured. So yes, that is my unfortunate answer to everybody. I know I don't have

00:48:31.000 --> 00:48:40.000

I don't, you know, I can't tell you exactly where, because it's a wild, wild west out there. So

00:48:40.000 --> 00:48:56.000

And that really leads into this next question that I'm going to send over to Tammy. And Tina alluded to it a little bit with the annual updates, but as Michelle was saying, things are constantly evolving and changing. It's not

00:48:56.000 --> 00:49:12.000

everyone's going to implement the MCS, and then, like, oh, we can wipe our hands of it. We're done. It's a constantly changing and evolving practice, basically. So Tammy, as changes and enhancements are made to the Mcs, how I mean, I guess

00:49:12.000 --> 00:49:25.000

I should back up a little bit. Are there changes coming that people should anticipate? And also, how can they stay informed as things are evolving over time with the measure?

00:49:25.000 --> 00:49:39.000

Yeah, so that is what I do. That's part of most of my job. So I love to answer this question. So currently the team, as we have mentioned, is working on the current annual updates cycle.

00:49:39.000 --> 00:49:57.000

Our updates this year are very minor. This is because of CMS guidelines. We are considering different updates for the future after the current annual update cycle ends. But we are following CMS guidelines to just keep all updates minor

00:49:57.000 --> 00:50:07.000

So it's just really streamlining the logic, making things simpler for the computer side to function, etc.

00:50:07.000 --> 00:50:27.000

As far as where you can find any future updates, we do our best to, by the summer, usually June is when we publish everything in our www.eatrightpro.org/mcs. It's also in the chat. I heard, I heard that I say it too fast, so it's also in the chat

00:50:27.000 --> 00:50:43.000

So go there, usually by June, in the resources tab, you'll have the next year's resources, including a frequently asked questions, any kind of value set updates, and then typically.

00:50:43.000 --> 00:50:54.000

Tina mentioned, in August, September timeline, we have our published paper with all the updates for that year, and around July is when we do

00:50:54.000 --> 00:51:02.000

webinar that covers all the updates and some other things that we try to to keep things interesting with

00:51:02.000 --> 00:51:16.000

So, yes, updates will be usually public by the summer, so that's when you want to keep an eye on for future references on anything that you need to look at

00:51:16.000 --> 00:51:17.000

Okay.

00:51:17.000 --> 00:51:32.000

You can also email us at quality@eright.org. Try to say it slower again, sorry, so that you can, if you have any questions, anything that you need the team's help, we are here for you. So feel free to email us.

00:51:32.000 --> 00:51:43.000

Thank you, Tammy. And so I'm going to attempt to answer a couple of questions. I feel like I'm opening a can of worms here, but these are questions that we get often and

00:51:43.000 --> 00:51:59.000

There are also answers that you guys may not love, kind of like Michelle was saying. It's just kind of the way it is right now. But so the 1st question is, do we need to be specifically documenting well nourished or

00:51:59.000 --> 00:52:19.000

No Malnutrition on patients who do not meet the criteria for malnourished. So there has been some concern shared with us that individuals may not feel comfortable saying well nourished just because the patient doesn't qualify for malnutrition because there is a gray area in there

00:52:19.000 --> 00:52:22.000

Well, with quality measures and logic

00:52:22.000 --> 00:52:29.000

As I said earlier, with the risk and not at risk, there is no gray area. So

00:52:29.000 --> 00:52:48.000

Yes, to satisfy the measure, if you have not diagnosed moderate or severe malnutrition, then you would select not Malnourished slash mildly malnourished slash well malnourished, depending on how that

00:52:48.000 --> 00:52:54.000

configured in your system. So we are aware of the concerns and recommendations from

00:52:54.000 --> 00:53:02.000

Some of you, and we will be considering this with future measure updates. Anytime you make a

00:53:02.000 --> 00:53:13.000

change like this to the measure logic. It's a tremendous amount of work, and there's a cascade effect. So, we encourage organizations to

00:53:13.000 --> 00:53:19.000

flex to the measure instead of the measure trying to flex to organizations, because as Michelle said

00:53:19.000 --> 00:53:30.000

It's the Wild West, and we can't make a quality measure that's suited to specific organizations. But does anyone else want to add

00:53:30.000 --> 00:53:35.000

To that answer.

00:53:35.000 --> 00:53:36.000

Okay.

00:53:36.000 --> 00:53:48.000

Just that we are looking into it, like you said, and just stay tuned. Like you said, there's many things that affect a measure and anything that we do in the measure is not just because we think it's the right thing.

00:53:48.000 --> 00:53:57.000

too many things that affected. So keep an eye out next summer, each summer we'll be publishing whatever updates we do, if that is fun

00:53:57.000 --> 00:54:07.000

Right, and maybe this will be a good opportunity for one of you to share how people can submit tickets through Jira for questions.

00:54:07.000 --> 00:54:12.000

Can one of you share that process?

00:54:12.000 --> 00:54:29.000

Yeah, so if you have any if you're an implementer and you have a question or suggestion for the team, it's always encouraged to use the Jira platform and it's J-I-R-A. We'll put the link Michelle, if you don't mind, if you can put the link in the chat

00:54:29.000 --> 00:54:45.000

So that they can access it. That is the best way for your comments to not just be visible for us, but to be visible to the annual update team that manages the annual update process and CMS also has access to those

00:54:45.000 --> 00:54:53.000

comments and requests or questions. So, you can always email us as well, but if

00:54:53.000 --> 00:55:06.000

Things that are related to measure logic, measure updates, implementation, things like that. It's always best to use the Jira system. So yeah, anybody else wants to add anything?

00:55:06.000 --> 00:55:09.000

It was kind of scary, but

00:55:09.000 --> 00:55:10.000

Yeah

00:55:10.000 --> 00:55:15.000

Well, and that's how we keep track. That's how we keep track of the issues that are coming through. And so we have like a whole

00:55:15.000 --> 00:55:24.000

ticket management system, basically, that helps us keep track of everything. So if you were to email us a question and we answer it

00:55:24.000 --> 00:55:37.000

It's gonna get buried in the email somewhere, and we will answer it, but it... we won't be able to track it as well as if it's in this system with multiple other people outside of even the academy monitoring that.

00:55:37.000 --> 00:55:45.000

Okay, so the second question I was going to ask, and we have, we'll have time for a few more questions after this.

00:55:45.000 --> 00:55:49.000

And this one, oh, yes.

00:55:49.000 --> 00:55:50.000

It's okay.

00:55:50.000 --> 00:56:00.000

Angela, I'm so sorry to interrupt. Before you move on to a new topic. There is someone asking if you would please repeat what to document for not malnourished

00:56:00.000 --> 00:56:04.000

slash my late malnourished

00:56:04.000 --> 00:56:15.000

Yeah, it's maybe Michelle or someone can pop that in the chat the way that the logic actually looks, or we can send it out, but it's not slash mildly malnourished

00:56:15.000 --> 00:56:19.000

Or well nourished. It's it's

00:56:19.000 --> 00:56:25.000

That's the way I said it. I'm not sure if Michelle might type it differently in the in the chat.

00:56:25.000 --> 00:56:26.000

Yeah.

00:56:26.000 --> 00:56:27.000

Okay, just wanted to close the loop on that one. Thank you.

00:56:27.000 --> 00:56:28.000

Okay, thank you.

00:56:28.000 --> 00:56:41.000

So the next question is, how should facilities handle patients who screen positive but are discharged, transferred, or pass away before an RDN can complete the assessment?

00:56:41.000 --> 00:56:47.000

For example, the patient is discharged within 48 hours or admitted late on a Friday

00:56:47.000 --> 00:56:57.000

So in scenarios where the RDN is unable to get to the patient before discharge, transfer or death

00:56:57.000 --> 00:57:08.000

The measure score would be in that scenario, and this is where you could use the measure calculator that's on the website to show the patient screens

00:57:08.000 --> 00:57:16.000

The patient does not get assessed, the measure stops there. So that would be a 50% out of 100, because you're... you're getting the first

00:57:16.000 --> 00:57:32.000

screen, and then you're qualifying for the second, which is assessment, but you're not moving beyond that. So that would be a 50 out of 100 for that patient. So the facility is responsible for a measure observation one and measure observation 2 for

that patient

00:57:32.000 --> 00:57:35.000

But not the measure observations that follow

00:57:35.000 --> 00:57:50.000

that that's hard to to explain. It's easier to explain with a visual, but that's why I would encourage. If you're wondering about different scenarios to go on to that our MCS website, to the MCS calculator

00:57:50.000 --> 00:57:55.000

And you can put in all the different scenarios there.

00:57:55.000 --> 00:58:09.000

Okay, let's see. One more question. This is probably a quick one. So, Michelle, has timeliness of RD assessment been defined? For example.

00:58:09.000 --> 00:58:18.000

a hospital might have a policy of the patient being seen within 48 h. But is that defined in the measure, the timeframe?

00:58:18.000 --> 00:58:33.000

Yes, this is a quick one. No, there's no time constraints within the measure logic besides that all components need to be captured within the encounter

00:58:33.000 --> 00:58:38.000

And the encounter has to be 24 hours.

00:58:38.000 --> 00:58:52.000

Or more. So that is very facility driven. If you facility wants to put timeframes along when your assessments can be should be time, you know, finished or completed.

00:58:52.000 --> 00:59:00.000

Right. So there's the difference between the hospital, the policy of when it should be completed versus what the measure is looking for.

00:59:00.000 --> 00:59:01.000

Yep.

00:59:01.000 --> 00:59:03.000

So

00:59:03.000 --> 00:59:24.000

All right. Well, thank you guys so much. I hope everyone that's joined us today has found these answers helpful. Like I said, we've probably had close to 200 questions, so we couldn't not get to all of them. But I do want to take a minute before we leave to share some additional resources that we have coming up that you may be interested in.

00:59:24.000 --> 00:59:38.000

We have 3 virtual MCS implementation workshops coming up in the next several months. They are four hours each and pending 10 hours of CPEU approval from CDR.

00:59:38.000 --> 00:59:49.000

So those will be held on November 18th, December 15th, and January 19th. Registration is open for all three of those, I believe

00:59:49.000 --> 01:00:07.000

And I included the link here as well if you want to hop on over there and check that information out. We also will be offering technical assistance services for organizations that are interested in that level of assistance

01:00:07.000 --> 01:00:25.000

There will be more information coming on this. However, please email quality@eatright.org if this is something that your organization may be interested in, and we will provide more information for you on those services when it becomes available.

01:00:25.000 --> 01:00:43.000

So thank you all so much for joining us today for this town hall event. Please, as we've said a million times, visit our website for more information and feel free to email Tammy at qualityatright.org with questions. Have a great day, everyone.