

Q&A 2024 Expert to Expert New Measure Review Webinar – Global Malnutrition Composite Score (GMCS) eCQM

Broadcast February 22, 2024

Question Asked	Answer Given
Screening Questions	
What if no screening is done on an eligible patient? Component one is null. How does that effect the scoring?	For an eligible patient the score would be $0/4 = 0\%$. If no nutrition risk screening is completed and documented, the score for component 1 will be 0. Components 2-4 will not be counted. This means the numerator will have a value of 0, and the denominator will have a value of 4, which creates a composite score of 0% for this encounter. However, the presence of a completed Hospital Dietitian Referral will allow the measure to move into component 2, even though the score for component 1 will still be 0. In this last scenario, the denominator will be dependent on the completion of component 2. You can find more calculation scenarios in the Resources Section of the https://www.cdrnet.org/GMCS webpage.
I was told that an evidence-based and validated screening tool is recommended for this, but that it is not required.	You are correct. Valid and reliable tools are recommended, but not required.
Regarding the previous question about screening tools, what else would count as a screening tool? We have the Malnutrition Universal Screening Tool (MUST) score implemented but, does that mean if the MUST isn't completed and the RDN gets notified another way, that counts as a screen?	Valid and reliable tools are recommended for screening and the screen must be documented to be counted as complete for Measure observation 1. If notification for the Registered Dietitian to assess a patient is done in a different way, the Registered Dietitian should contact the professional that typically completes the screen to ensure that this data element is completed and counted for the score, or complete the nutrition risk screen themselves to ensure Measure observation 1 is given a value of 1 in the measure calculation.
Why doesn't the Nutrition Referral Order count in Measure 1?	Historically, the Referral order was intended to capture workflows in which assessment takes place despite Not at Risk results from the Malnutrition Risk Screening. We are examining how to count the presence of the Referral Order in performance scoring in the current Annual Update process.

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Can the diet technician do the nutrition screening?	In the current header information, a diet technician is not listed. However, the logic does not specify any person to complete each step. Updates to the header in this Annual Update cycle will include other professionals that complete nutrition screening, including dietetic technicians and those authorized and competent to complete the screening.
Just to clarify, the score will always be 0% if the nutrition screen was not complete? Even if 2-4 was complete as the Registered Dietitian Nutritionist (RDN) may have assessed the patient based on other nutrition risks (i.e., wounds, LOS, etc.).	In the absence of a Hospital Dietitian Referral, this is correct. The presence of a completed Hospital Dietitian Referral will allow the measure to move into component 2, even though the score for component 1 will still be 0. In this last scenario, the denominator will be dependent on the completion of component 2. You can find more calculation scenarios in the Resources Section of the https://www.cdrnet.org/GMCS webpage.
What if component 1 documentation is 'not at risk', no RDN referral/consult but was later assessed by an RDN and given a 'severe malnutrition.' This will give the total score of over 100% based on the denominator. How would we approach this?	In the scenario of a Not At Risk Result without an Hospital Dietitian Referral, measure performance stops, even if additional components are completed. In this scenario, the encounter score would be 1/1=100%. You can find more calculation scenarios in the Resources Section of the https://www.cdrnet.org/GMCS webpage. For Reporting Period CY 2024 / Submission Period CY 2025, this scenario contributes to a Known Issue leading to erroneous measure scoring, with information found here: https://oncprojectracking.healthit.gov/support/browse/EKI-21 , we are working to update the logic in the current Annual Update process to address this issue.

Question Asked	Answer Given
<p>Can a nutrition screening be completed more than once during a hospital encounter? If the results (not at risk/at risk) differ, which counts for the measure?</p>	<p>We acknowledge that screening may take place more than once in one inpatient encounter. For Reporting Period CY 2024 / Submission Period CY 2025, this scenario contributes to a Known Issue leading to erroneous measure scoring. The scoring of the numerator does not stop even when there is a component not completed. The additional component present, but not the denominator, contribute to the Global Malnutrition Composite Score being >100%, when the expected value should be ≤100%. For more information on the Known Issue and how to address it, please visit https://oncprojectracking.healthit.gov/support/browse/EKI-21. We are working to update the logic in the current Annual Update process to address this issue in Reporting Period CY 2025 / Submission Period CY 2026.</p>
<p>What if MST screen is inappropriate, but malnutrition is identified at length of stay that warrants and Registered Dietitian intervention and assessment?</p>	<p>If the screen results in At Risk for malnutrition status, then a nutrition assessment by the Registered Dietitian is indicated. If the screen results in a Not At Risk for malnutrition status, the progression through the GMCS stops. This does not mean the Registered Dietitian should not do an assessment if malnutrition or other nutrition diagnosis is suspected. It does mean that steps after the screening will not need to be counted toward the GMCS measure. Our team acknowledges the importance of a positive screening result, and we are diligently studying options to address this need.</p>
<p>Does the MST need to be completed by a Registered Dietitian or RN, or would either be ok? How about if it's completed by the medical team (PA, interns, or residents)?</p>	<p>It can be completed by either / or any eligible professional, as stipulated by applicable federal, state, or local regulation and/or professional licensure, as well as per hospital policy</p>

Question Asked	Answer Given
<p>I noticed that Value Set Malnutrition Risk Screening deleted SNOMED codes specific to the MUT or malnutrition universal screening tool, leaving only LOINC codes associated with the NRS 2002 screening tool. Does this mean that the MUT should not be used and only the NRS in screening? Or does this change represent the preference to use LOINC codes (MUT does not have LOINC representation while NRS does)?</p>	<p>The SNOMED codes were deleted because these were not the appropriate code system for this data element. The LOINC value set should be used. Additionally, there is no requirement to use the NRS-2002 screening tool. Any of the codes present for Reporting Period CY 2024 and Submission Period CY 2025 (i.e., 84291-4 Nutrition and dietetics Risk assessment and screening note, 98967-3, Nutritional Risk Screening 2002 panel, 8968-1 Initial screening NRS_2002, 98972-3 Final screening NRS_2002) can be used. Therefore, other valid and reliable tools can be mapped to the value set code, 84291-4 Nutrition and dietetics Risk assessment and screening note.</p>
<p>What is the definition of the Malnutrition risk screen? For example, our facility uses the Malnutrition screening tool.</p>	<p>Screening is intended to identify whether patients are at risk for malnutrition. The GMCS recommends the use of a valid nutrition risk screening tool. The Malnutrition Screening Tool (MST) is a valid and reliable tool based on evidence analyses and should be mapped to the correct value set (e.g., 84291-4 Nutrition and dietetics Risk assessment and screening note) since that is a code that is not associated with a specific tool.</p>
<p>Why is the denominator calculation (specifically for a denominator of 1) looking for the presence of a Registered Dietitian referral? Shouldn't it be looking for the completion of a nutrition assessment and identified status? If the Registered Dietitian sees a patient, assesses the patient, and identifies as malnourished but no screening was completed, can we get scores for measure 2 - 4?</p>	<p>The team recognizes that there are many possible scenarios that can occur under a Registered Dietitian scope of practice. For the purpose of the GMCS, in the presence of a Not At Risk Result without a Hospital Dietitian Referral, performance calculation stops at Measure Observation 1, despite the completion of additional measure observations. This is one of the reason why the Hospital Dietitian Referral was added to support the inclusion of the Registered Dietitian's work when a patient is suspected to be at risk of, or found to have malnutrition.</p>
<p>So, to clarify, the referral to the Registered Dietitian is not required, but can be used to satisfy measure 1?</p>	<p>At this time, the referral does not count a completion of measure observation 1. It simply allows for the measure process to continue into observation 2 in the setting of either a Not at Risk Result or the absence of Malnutrition Risk Screening. Otherwise, the measure process would stop at observation 1 if the results for this step were Not at Risk or the Malnutrition Risk Screening was not completed.</p>

Question Asked	Answer Given
What is the score result if a patient is identified in screening as "at risk", but discharges or leaves before the Registered Dietitian gets to see the pt? For example, our current policy is to see those "at risk" within 48hrs.	For this example, the score would be 1/4 = 25%. You can find more calculation scenarios in the Resources Section of the www.cdrnet.org/GMCS webpage.
Coding Specific	
If the Malnutrition Diagnoses is added by Coding or CDI after Discharge, does this fulfill Step 4 as a 1/Yes?	This will be something that your facility defines during the implementation stage. As long as your IT team utilizes these components to map to the GMCS components, the billing diagnoses can be used for the GMCS. The source used to capture the physician diagnosis is the location of the physician's note or documentation that contains the diagnosis that has been identified by the mapped data element during the implementation process. Therefore, it is important that the diagnosis codes are mapped to the correct value set code in your EHR. Please work with your documentation/IT specialist to further understand how your facility will map each component.
As it relates to component #3, can we use the final diagnoses used for coding to get credit?	
What sources will be used to capture the physician diagnosis of malnutrition?	
Assessment Questions	
Is there a recommendation for a validated assessment tool (not screening tool, but the actual assessment completed by the RDN)? Such as the PG-SGA (Patient-Generated Subjective Global Assessment)?	For the purpose of this measure, it is recommended—though not required, that a nutrition assessment be performed using a validated nutrition assessment tool, such as one of the following: <ul style="list-style-type: none">• Subjective Global Assessment• Patient Generated Subjective Global Assessment• Mini Nutritional Assessment Long Form• Academy/ASPEN indicators for adult and pediatric malnutrition (AAIM)
To clarify a previous question, does the scoring stop if the Registered Dietitian does not see the patient prior to discharge? So if there's a score of 1 for the first observation, a zero for the Registered Dietitian assessment, does the rest of the scoring result in NA? So an automatic 50%?	For the Reporting Period CY2024 / Submission Period CY2025, this scenario would receive a score of 25% (1+0+0+0=1; 1/4). For additional examples of scenario calculations, you can visit the Resources Section of the www.cdrnet.org/GMCS webpage. All updates will be published on this website as well.

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If the diagnosis is Mild Malnutrition, it would not be included in the composite score?	That is correct. A diagnosis of Mild malnutrition from the nutrition assessment stops performance measurement at the Nutrition Assessment observation but can be counted toward completion. If the Nutrition Risk Screening was completed, with an At Risk result, then the score would be $2/2 = 100\%$. For additional examples of scenario calculations, you can visit the Resources Section of the www.cdrnet.org/GMCS webpage.
When a nutrition assessment is completed, if the patient does meet the criteria for malnutrition, does the Registered Dietitian need to document in their assessment that the patient does not meet malnutrition in order for that encounter to be counted?	That is correct. For measure observation 2 to obtain a value of 1, a completed nutrition assessment with documentation of any degree of malnutrition, including its absence, needs to be included in the patient record. The nutrition assessment documented needs to be mapped to the corresponding data element and value set selected.
Diagnosis Questions	
If the Registered Dietitian documented a patient as severe, however the provider documents Moderate malnutrition - or vice versa. Would this result in a 1 or 0?	There does not need to be alignment between severity of malnutrition diagnosis between the Registered Dietitian and the medical diagnosis by an eligible provider. In addition, if the RD does not identify severe or moderate malnutrition as a diagnosis during the nutrition assessment, the GMCS measure process stops in observation 2, regardless of a medical diagnosis for malnutrition being present or not. For additional examples of scenario calculations, you can visit the Resources Section of the www.cdrnet.org/GMCS webpage.
Does the MD diagnosis severity need to match the Registered Dietitian diagnosis severity? What if the Registered Dietitian diagnosis severe and the MD diagnoses unspecified?	
Does the Provider's diagnosis of malnutrition need to match the RDN? Component 4	
Does Registered Dietitian diagnosis of malnutrition count for component 3 or does it only count if the physician diagnoses malnutrition? What if the physician documents malnutrition however Registered Dietitian does not agree what is the score for component 3	
Do they need to have been diagnosed with malnutrition by both the doctor and Registered Dietitian for component 3?	For component 3, the diagnosis would need to be completed by the doctor or eligible clinician. However, in order for component 3 to be counted towards the score, the RD needs to have documented a nutrition assessment with a moderate or severe malnutrition diagnosis. Otherwise, the process will stop at component 2, if there is no nutrition assessment documented, or the result documented is a nutrition diagnosis of not or mildly malnourished.

Question Asked	Answer Given
You referenced a medical diagnosis entered by a physician. Could that diagnosis also be entered by a qualified practitioner such as a PA (physician assistant) or NP (nurse practitioner)? Could a Registered Dietitian qualify to add the diagnosis?	Any eligible provider, as defined by CMS, state and local regulations, and your facility policies, can complete the nutrition diagnosis for completion of measure observation 3.
I apologize, this question was answered both ways: if the physician diagnoses malnutrition but the pt was discharged prior to Registered Dietitian assessing, is that a zero for the Registered Dietitian assessment but a 1 for the MD diagnosis?	We apologize for the confusion. In the absence of a completed Nutrition Assessment <u>with</u> a Moderate or Severe Malnutrition Diagnosis, completion of Measure Observation 3 will not be counted. For additional examples of scenario calculations, you can visit the Resources Section of the www.cdrnet.org/GMCS webpage.
Timing Questions	
Does the nutrition assessment for component 2 need to be completed within 24 hours of nutrition screen to receive the 1 score?	There is no timing element for any of the measure observations. They can be completed in any order, at any time during the eligible encounter. Measure observations simply must be completed during the inpatient encounter, and/or during the related observation or ED encounter. The nutrition screen does not need to be completed within 24 hours of the inpatient admission. However, it does need to be completed within that admission (inpatient stay) period.
Do components 1 & 2 require a time for completion? (i.e., the screening has to be done in 24 hours and the assessment in 48hr)	
This is great, but it does not seem to address the organic and changing nature of nutritional status during admission. Will efforts be made to adjust this? (e.g., 30% of well-nourished patients experience a decline in nutritional status during admission)	We acknowledge that screening may take place more than once in one inpatient encounter. Currently, this scenario contributes to a Known Issue leading to erroneous measure scoring, with information found here: https://oncprojecttracking.healthit.gov/support/browse/EKI-21 . We are evaluating options to address this need.
Care Plan Questions	
From what I understood from AND (Academy of Nutrition and Dietetics) presentations, the Registered Dietitian Intervention addressing malnutrition counts as the Nutrition Care Plan, is that correct?	Yes, this is correct, as long as your facility has defined it as such during the implementation stage. Your IT team needs to ensure this documentation component is mapped to the corresponding GMCS component data element and selected value set. The corresponding LOINC codes are necessarily broad so implementers can map other reliable and valid tools that lack specific LOINC codes.

Question Asked	Answer Given
Can you define Nutrition Care Plan? Is this a Nutrition Assessment? Or does it have to be in the Plan of Care?	Often the Registered Dietitian completes the nutrition assessment and nutrition care plan at the same time as part of the normal workflow. Where it is located in different EHRs may vary based on the workflow established in the institution. The value sets identify the codes that reflect the completion of a nutrition care plan, and these should be mapped for counting of the care plan. During the implementation process, IT staff should make sure to map the correct EHR component to the corresponding GMCS component.
Does the RDN care plan need to contain certain pieces of information or be documented in a specific format (within ADIME format, for example)?	The value sets for the care plan can be found on VSAC and those should be mapped to the RDN documentation. Your IT team needs to ensure this documentation component is mapped to the corresponding GMCS component data element and selected value set. The corresponding LOINC codes the rest are necessarily broad so implementers can map other reliable and valid tools that lack specific LOINC codes. The ADIME format is not required, but it is encouraged as a systematic documentation for Registered Dietitians.
Benchmarking Questions	
What is considered a "good" score, if close to 80% still needs improvement?	Because this is a new measure, we do not currently have benchmarking data provided by reporting facilities. Higher scores indicate better performance, while lower scores indicate opportunities for quality improvement. In the example given, 80% mainly expresses that there is a 20% gap in care to address malnutrition. Quality improvement is a continuous process that aims to improve patient care by addressing the identified gaps in service.
Where do we find eCQM benchmarks?	CMS's Care Compare website is an excellent resource for locating and comparing eCQM performance. Additional data can be found at https://data.cms.gov/provider-data/
When is a benchmark expected to be released?	Reporting for 2024 performance will be reported in Spring 2025. CMS determines when the information is published for public access. Once published, data can be found here: https://data.cms.gov/provider-data/
Inpatient Status Clarification	
Do swing beds count or strictly inpatient beds?	

Question Asked	Answer Given
Is this applicable to admitted Behavioral Health patients 65 and over with LOS > 24 hours?	Swing Bed patients are not acute hospital patients, and are not included in the HIQR program measures. Only encounters that are coded as an inpatient encounter with a length of stay (LOS) of at least 24 hours, and are 65 years of age or older, is an eligible encounter, regardless of the patient's physical location. Once the patient is discharged from the inpatient encounter, the components documented after discharge will not be counted towards the measure score.
What happens if the patient meets the criteria for malnutrition while they are an inpatient, then later convert to swing bed? Are they eligible to have another dx for malnutrition because technically they discharge from inpatient and admit to swing status?	
If a CAH designates their swing beds as non-inpatient, my understanding is that they will not be included, even if they have a LOS > 24 hours. Is this correct?	
Is the LOS >24 hours counted from arrival (to the ED for example) or from time of the inpatient (IP) order? (For another example, if observation then to IP, what time is counted?)	The inpatient encounter itself must be at least 24 hours to be deemed an eligible encounter. While components completed during an associated ED/observation stay can be counted toward performance, lengths of stay in these settings do not count toward the required 24 hours of inpatient encounter.
If the patient is admitted as an Observation status patient, briefly is made an Inpatient, but ends up being discharged as an Observation status patient, does this patient count for this measure?	The patient must have an inpatient LOS of at least 24 hours, regardless of their observation status before or after the inpatient encounter.
General eCQM Questions	
I don't have a sign-on for value sets; how can I get permissions to enter?	You can request a UMLS account to access the VSAC here: https://uts.nlm.nih.gov/uts/signup-login
Where can you see the chart for what eCQMs are required for 2024?	CMS has published a document that provides an excellent overview of eCQMs, including the delineation of which measures are optional versus mandatory. You can find the document here https://www.qualityreportingcenter.com/globalassets/2024/01/iqr/ecqm_cy-2024-ecqm-submission-overview_final508.pdf .
What score will need to be reported at the CCN level (aggregate)?	The eCQM is reported at patient level data, for each CCN.
How is the data usually obtained from EMR and reported to CMS?	The data is captured by utilizing the value sets within the eCQMs measure package and mapping them to the fields that the data can be found in the EMR. A QRDA file is extracted and reported to CMS for the reporting period.

Question Asked	Answer Given
Does this measure apply to LTACH facilities?	This measure applies only to Eligible Hospitals/Critical Access Hospital at this time. All eligible hospitals and critical access hospitals (CAH) are expected to report on a total of 6 eQMs for Reporting Period Calendar Year 2024, Submission Period Calendar Year 2025. Of these, 3 are self-selected and 3 are mandatory. This measure is one of 3 self-selected eCQM options available for Reporting Period Calendar Year 2024.
How does this effect CAH hospitals? Is this mandatory for a CAH?	
Will this eCQM be mandatory at some point?	
Is this measure going to be mandatory for reporting?	The eCQM is voluntary at this time. Any potential changes to the eCQM requirement would be proposed in the IPPS/LTCH PPS rule.
I thought that I heard that the GMCS was perhaps going to expand to patients >18 years of age. Is this still being considered?	The GMCS expansion to include all hospitalized adults aged 18 and over was submitted to CMS and is currently in the Measures Under Consideration (MUC) review process.
At this time, the measure is only focused on screening and not actually implementation of nutritional interventions or prevention of further/worsening malnutrition. Is there any discussion of furthering this eCQI?	This eCQM includes screening, nutrition assessment, diagnosis, and development of a nutrition care plan. There is not a plan at this time to evaluate the outcomes of the care plan implemented.
I also wonder if this will be punitive for hospitals that have a very low LOS. Are interventions and care plans really effective for patients that are only in house for 24 hours?	This measure is not intended to be punitive. If the patient stay is under 24 hours, that patient will not be included as part of the measure population. They need to be in the hospital for 24 hours or more, in an inpatient status.
Operational Questions	
For the issue listed in FAQ#1, as per the JIRA ticket https://oncprojectracking.healthit.gov/support/browse/CYPR-ESS-2644 - the certification system (Cypress) performs calculations using the published eCQM specification. Therefore, in order to pass certification we will need to implement the system as specified in the eCQM specification - and since the eCQM specification has an error, we will need to implement the system with the error. Unfortunately, this means our certified system will have the error listed in FAQ#1 and it will only be fixed when CMS updates the eCQM specification which hopefully will be for CY2025 annual updates. How is TJC DDSP implementing this specification?	At this time, the Joint Commission's DDSP will implement what is written in the measure specification and will be in alignment with CYPRESS on this.

Question Asked	Answer Given
<p>Is this webinar not approved by CDR (Commission on Dietetic Registration) for Registered Dietitians to receive CPEU credit?</p>	<p>Joint Commission is accredited by the entities listed on slide 5 of the presentation. However, many other professional societies accept certificates and will honor the credits for the webinar. We will investigate gaining approval from other dietetic entities for future webinars on this topic. Live events that are dietetics-related do not need prior approval by CDR. Please refer to your Professional Development Portfolio (PDP) Guide for additional information regarding live events. Locate your PDP Guide at https://www.cdrnet.org/PDPGuide.</p>