Quarterly Spotlight on Malnutrition:
Global Malnutrition Composite Score Town Hall
August 3rd, 2023

The Commission on Dietetic Registration's (CDR) Quality, Standards, and Interoperability Team worked diligently to answer the questions submitted via the Q&A chat and the pre-event survey to the best of our ability. Please note, that similar questions were grouped together into one to help provide a quicker answer and simplify the document as possible. The questions that were addressed during the event presentation, as well as questions outside of the scope of the presentation, will not be included in this document. Additional resources and calculation tools can be found at www.cdrnet.org/GMCS. If you would like further information, please email us at quality@eatright.org. We would love to have an opportunity to support you in all your credentialed professional needs.

Questions Submitted Through the Q&A or Pre-Event Survey Not Addressed During the Presentation

Subject: Background and Development of the GMCS

- **In which country did the GMCS originate? What is a brief historical timeline of why and how this was developed?**

  The Global Malnutrition Composite Score (GMCS) was developed in the United States of America, to be used as an electronic Clinical Quality Measure (eCQM) under the Inpatient Quality Reporting (IQR) Program of the Centers for Medicare and Medicaid Services (CMS). The process to develop this measure started in 2013 when the Academy Quality Strategies Task Force identified malnutrition as a key quality measure. Throughout 10 years of development, there have been several stakeholders including CDR as the Measure Steward, Avalere as the measure developer and the Malnutrition Quality Improvement Initiative's (MQii) Learning Collaborative of 300+ hospitals that were involved in measure testing.

- **How has the Malnutrition Quality Improvement Initiative (MQii)/GMCS program been communicated with hospitals thus far? How do you gain buy-in from hospital leaders?**

  The Malnutrition Quality Improvement Initiative (Mqii) is a multi-year effort that began in 2013, established in partnership with the Academy of Nutrition and Dietetics, Avalere Health, and other stakeholders, providing guidance through key technical expert and advisory roles. MQii is a separate entity from the Academy/CDR. GMCS has been publicized in a variety of ways starting with its formal approval in 2022. Presentations, including the Quarterly Spotlight on Malnutrition in August 2022, November 2022, January 2023, May 2023, and August 2023 have provided information on different topics of the GMCS. The recorded presentations can be accessed at www.cdrnet.org/GMCS under Resources, where you can also find additional resources, including an FAQ and Specifications Manual.

In addition, CMS does their own notifications when measures are approved and available for all matters related to the Inpatient Quality Reporting Program, via their listserv signup at Sign Up for Email Updates (cms.gov). Also, the Quality Department in acute care and critical access settings should have access to notification and information on the eCQM program.

The CDR Quality, Standards, and Interoperability team remains committed to promotion and adoption of the GMCS. For any specific questions and/or presentation inquiries, please email quality@eatright.org.

- **In relation to the population included in the GMCS, why did CDR decide on only including adults in acute care settings? Why not include children, long-term care, outpatient clinics or Skilled Nursing Facilities? Is there a plan for them?**

  The GMCS is intended for use in acute care and critical access settings, in patients admitted that are 65 years of age or older on admission and that have a length of stay of 24 hours or more. Because of the significant body of evidence reporting complications of malnutrition in hospitalized older adults, this population was prioritized. However, CDR and its partners continue to work with CMS to explore additional care settings and populations.

Subject: Initiation and Implementation of the GMCS

- **Can the categories associated with Composite #1, #2, #3, and #4 be reviewed?**

  The below table reviews components #1-#4.

Component Title	Measure Observation Details	Staff Involved
Component Measure 1: Malnutrition Risk Screening	Hospital encounters where a "Malnutrition Risk Screening" was performed with a current identified "Not At-Risk Result" or "At Risk Result"	Documented by a nursing professional, RD/RDN
Component Measure 2: Nutrition Assessment	Hospital encounters where a "Nutrition Assessment" was performed with an identified result of “Not or Mildly Malnourished", "Moderately Malnourished" or "Severely Malnourished"	Documented by an RD/RDN
Component Measure 3: Malnutrition Diagnosis	Hospital encounters with a current "Malnutrition Diagnosis", after a documented "Nutrition Assessment" was performed with a result of "Moderately Malnourished" or "Severely Malnourished"	Documented by a physician or eligible clinician
Component Measure 4: Nutrition Care Plan	Identifies hospital encounters where a current "Nutrition Care Plan" was performed where a "Nutrition Assessment" was performed with an identified result of “Moderately Malnourished" or "Severely Malnourished"	Documented RD/RDN

- **Can you confirm Medicare disability patients < 65 years old are not included in these measures?**

  The measure captures all individuals 65 years and older at the time of admission, with a hospitalization of 24 hours and greater.

- **What impact will this measure have on Joint Commission surveys?**

  Joint Commission does not directly use eCQMs in their accreditation process. However, Joint Commission does have a strong focus on quality improvement and patient safety. Joint Commission does mandate nutritional and functional screening; information can be found on their website. Additionally, the GMCS directly addresses social determinants of health and food insecurity for The Joint Commission's new requirements to Reduce Health Care Disparities Leadership Standard.

- **Does anyone know how many medical facilities have selected this eCQM as an option?**

  Measure reporting begins Calendar Year 2024, so utilization of the measure is currently unknown.

- **Do you have to measure the GMCS for ALL patients that qualify, or just a certain number per quarter or month?**

  The measure is built to include all admissions of all patients 65 years of age and older and with a hospital stay of 24 hours or more. Reports are to be done per quarter based on CMS guidance. However, each hospital may have a different procedure for how they report to CMS. Consider partnering with your quality department to determine the best way to report on the GMCS.

- **For large health systems, is this data submitted to CMS for an individual hospital or for a health system that has hospitals in numerous states?**

  Each hospital submits their individual data.

- **If a patient is admitted many times over a year, does each admission need to be evaluated as to whether there was a nutrition screening/nutrition assessment/care plan? Do we need to collect data that there was not any nutrition intervention for each admission for that patient?**

  Yes, if the patient is 65 years of age or older on admission, and the length of stay is 24 hours or more, the measure is calculated for every individual visit. This measure has no exclusions. Every person admitted as an inpatient, of 65 years of age and older, and a length of stay of 24 hours or more is included in the population. Nutrition Intervention in the Care Plan Component Measure (#4) only needs to be collected if the patient is found to have severe or moderate malnutrition by the RD/RDN assessment (Component Measure #2).

- **Are hospital observation encounters included in the GMCS measure population?**

  Patients under observation status are not considered for the GMCS measure, even if they meet the criteria of a length of stay of 24 hours or longer and that are 65 years of age or older. However, the GMCS measure was designed to include data collected from an emergency department or observation status visit. This means if a hospitalization has an emergency department or observation visit that ends 1 hour or less prior to the eligible hospital encounter, documentation from the emergency department or observation visit may be used to calculate performance for the applicable measure observations.

- **Some patients develop malnutrition during their hospitalization. How will the GMCS reflect these patients since their admission screening may be negative?**

  If a patient is rescreened at any point during their admission and becomes at risk for malnutrition, then they become eligible for the remaining components of the GMCS. Consider developing a policy or Standard Operating Procedure that rescreens patients after they have been admitted at a standard amount of time based on your population needs.

- **At the last Academy webinar, it was said that only a physician can document the malnutrition diagnosis for the GMCS. Is this physician requirement anticipated to change in the future, to also include other qualified clinicians?**

  After a detailed review of the measure definitions, we are happy to inform you that for Measure Observation #3, Malnutrition Diagnosis, the medical diagnosis can be made by any physician or other eligible clinician, based on CMS, State and Local guidelines.

- **Can Non-RDs aside from nursing, such as Dietetic Technicians, Registered (DTR/NDTR), complete the Nutrition Screening (Component Measure #1)?**

  Only those with the scope of practice to perform a nutrition screening are able to do so. At this time, the measure is written for only Registered Nurses and Registered Dietitians (RDs/RDNs) to be able to perform the nutrition screening. However, after a detailed review, it was concluded that the eligible clinical professionals allowed to complete nutrition screening will vary based on state and local guidance as well as hospital-specific policies. The measure steward and developer will work diligently to address this in the Annual Update process for 2024.

- **To meet the NCP plan, does the patient need to have local resources provided to meet the component for #4?**

  The Care Plan should include a plan to support the patient in what they need to improve their malnutrition status. The Care Plan should be individualized to the patient's needs, which may or may not include local resources.

- **Is the "care plan" equivalent to the "Intervention" and "Monitoring" section of NCP? Can the care plan in the NCP, be the Plan mentioned in Component Measure #4?**

  The Care Plan could be the Intervention section of the NCP or could be any other template or note that your institution and staff deem necessary to help support documentation and coding. During the implementation process, credentialed nutrition and dietetic practitioners should meet with the quality, IT, and coding departments to help define what is the best process to identify and code component measure #4 based ensuring the updated value set (link found at www.cdrnet.org/GMCS), is used.

- **Has the Global Malnutrition Composite Score been validated? If so, what population groups and what settings?**

  The GMCS has gone through a rigorous process of endorsement by the National Quality Forum (CMS' Certified Consensus Based Entity in 2021) and subsequent approval by CMS. The process of endorsement and approval requires submission of validity and reliability testing, which was based on data collected MQii Learning Collaborative, including adult patients in acute care hospitals across the country. The data validated is specific to the measure population criteria established for the GMCS.

- **If an RD/RDN determines that an 'at risk' patient does not qualify for malnutrition diagnosis, does this patient become part of the 'clinically eligible denominator'? How does this scenario impact the hospital GMCS score?**

  If a patient has an "At Risk" result for Component Measure #1 (Nutrition Screening), then the patient is eligible for Component Measure #2, Nutrition Assessment. If the RD/RDN assesses the patient and finds that the patient does not have a moderate or severe malnutrition diagnosis, then

the eligible denominator will be 2 and the measure will stop at that point. Given that Component Measure #1 and #2 have been completed in this scenario, the calculation will be (1+1) / 2= 100%. The Physician or eligible clinician documentation (Component Measure #3) and Nutrition Care Plan (Component Measure #4) are not part of the calculation if the RD does not find a severe or moderate malnutrition diagnosis.

- **Does the physician/eligible clinician need to document diagnosis for malnutrition and all other nutrition diagnosis?**

  In the presence of severe/moderate malnutrition identified by the RD/RDN, GMCS requires component measure #3 to be completed, with a Malnutrition Diagnosis documented by a physician or eligible clinician. Physicians/eligible clinicians document the diagnosis of malnutrition for this measure since it is an interdisciplinary measure. This does not mean that a Registered Dietitian Nutritionist/Registered Dietitian (RD/RDN) does not document malnutrition as part of the nutrition care process (NCP). In fact, the PES (problem, etiology, signs/symptoms) statement is the most concise way for the RD/RDN to communicate the presence, severity, and evidence of malnutrition to a physician/eligible clinician.

- **Though GMCS is currently a self-selected measure, do you anticipate at some point this may be mandatory? Maybe 2025 or beyond?**

  The determination for an eCQMs to become mandatory for all healthcare facilities is a decision that would ultimately be made by the Centers for Medicare & Medicaid Services (CMS) or other regulatory bodies. Keep an eye on announcements from CMS and other relevant organizations, as well as discussions in the healthcare policy community. It may also be beneficial to participate in public comment periods or other opportunities to provide input on proposed changes to healthcare regulations.

- **Is the composite score for NCP just for Plan and not necessarily that it is implemented for it to be counted?**

  Each measure observation (i.e., screen, assess, diagnose, and care plan) is scored independently, with a score of 1 if documented and 0 if not documented. It is the expectation that all documented care plans are implemented as part of the overall care of the patient.

- **Is there a benchmark for aggregate scores that hospitals should be looking to achieve? In other words, what is the score that GMCS is looking for each of the Total Components Score, Composite Score and Aggregate Score?**

  Because GMCS is a new eCQM, there is no established benchmark. However, the published score will be the aggregate score. Higher scores indicate better performance. Individual hospitals should establish their own benchmark and use the component scores of nutrition screening, assessment, care plan and malnutrition diagnosis to identify quality improvement projects. One of the goals of the eCQM program is to always strive to improve upon what the original score is.

- **How do you handle if the provider does not document?**

  Gaps in documentation are opportunities to explore with the interdisciplinary team and are areas for improvement, education about malnutrition, performance on the measure, and/or communication between professionals about findings. Consider discussing barriers with providers, and work with

them to solve any gaps or barriers they identify. For further help or ideas, please reach out to quality@eatright.org.

- **If there are no time constraints on the screening, then won't that mess with your score? The n will still be the number of patients over 65.**

  It is important to note that any of the steps can be done in any order necessary during that current hospitalization/episode. Although it is ideal that Component Measure #1 (Nutrition Risk Screening) is performed first, to streamline the process of those admitted patients that need a nutrition assessment by an RD/RDN.

- **If components 1,2,4 & 5 are done but pt does not meet criteria for malnutrition and thus the provider does not document malnutrition, does that result in a lower score?**

  Not necessarily. The need to document Component #2 (Nutrition Assessment) is based on the result of Component #1 (Nutrition Risk Screening). If the result of Component #1 is documented as Not at Risk, the measure calculation ends with a score of 1/1=100%.

  If Component Measure #1 results in a documented At-Risk status, and the RD/RDN completes and documents the assessment, identifying the patient as not malnourished, the measure again stops, and the score would be 2/2=100%. Therefore, the absence of a physician diagnosis will not impact overall score performance.

  Component Measure #5, Total Malnutrition Component Score, will always be affected by the status results of Component Measure #1 and/or #2.

- **For those who don't have GMCS already implemented in their system, when are we supposed to initiate it? Is there a deadline?**

  GMCS reporting begins in Calendar Year 2024, so this is a good time to be discussing selection of this measure with quality and IT department colleagues.

- **If the assessment isn't completed after the initial screen due to discharge, does this impact the score? What if the pt is discharged within 48 hours of admin? Can this be negated?**

  Yes, it impacts the score if the Nutrition Risk Screening has a result of At-Risk status. With an At-Risk result for Component Measure #1, the Nutrition Assessment should be completed prior to discharge to achieve the highest performance scores. Consider working with your facility to evaluate the frequency of patients discharged prior to 48 hours and establish a process for RD/RDNs to assess patients if this is a high frequency occurrence. Additionally, it may be helpful to ensure the staff completing the Nutrition Screening understand the importance of appropriate answers and to educate them, if needed, on the correct way to complete the Nutrition Risk Screening for a reliable result.

- **How are patients >65 years old who are NOT screened as malnourished and thus do not end up meeting the subsequent components of RD assessment and care plans, etc., factored into the score/numbers?**

  A patient that has been admitted for 24 hours or more and is 65 years of age or older, should be screened on each admission. If the nutrition risk screening results in a Not-At-Risk status, the measure calculation stops and the Total Component Score as Percentage will be 100%, regardless of if the patient had a nutrition assessment.

- **Does GMCS dictate what malnutrition criteria can/should be used? E.g., ASPEN vs. GLIM**

  The GMCS does not mandate any specific tool for identifying malnutrition. Individuals are encouraged to use valid and reliable tools and approaches for diagnosing malnutrition.

- **For component 3, does the physician adding the malnutrition diagnosis in the diagnosis and problem list suffice, or do they need to also include documentation in their own notes?**

  For the measure, specific value sets define the concepts required in documentation to meet the requirements for diagnosing malnutrition. Where the information is placed in an Electronic Health Record (EHR) depends on a hospital's policy and practice. The criteria to meet for component Measure #3 is the documentation of the diagnosis and consequent coding with using any of the terms in the value set.

- **If the nutrition screening is not used in the way that it was validated, (like MST triggers RD consult on 3 or higher instead of 2 or higher), does it still count for the GMCS?**

  Yes. Component Measure #1 requires completion of a nutrition risk screening, but no specific tool is required. It is recommended that valid and reliable tools are used, and facility policies and procedures establish a standard of use for all clinicians.

- **Is there an overall score which could measure how the hospital is managing how well they are doing with malnourished individuals? This score includes if we are screening everyone, so if someone is well nourished, it influences the score, so you apparently don't know how well doing with malnourished.**

  The GMCS is meant to be able to evaluate how well a facility provides malnutrition care. A low overall score can mean several things thus, examining each component score performance is essential to determine areas of excellence and opportunities for improvement.

- **What if the patient is diagnosed with malnutrition by the RD/RDN but component 1 MST score was < 2?**

  If a patient has an "Not at Risk" result for Component Measure #1, then the measure calculation will not go forward to measure components #2-4, even if the RD/RDN identifies the patient as Severely or Moderately Malnourished. However, the RD/RDN can rescreen the patient if new information has surfaced and the patient is considered At Risk. Once the Nutrition Screening component measure has an At-Risk result, then Component Measure #2, Nutrition Assessment, will count towards the score.

- **If the screen is done incorrectly by the RN (measure would stop) but the RD rescreens and the patient is actually at risk, can the measure then move on to the assessment step?**

  Yes, an At-Risk screen result at any time during the hospitalization qualifies the patient for inclusion of measure observation #2, nutrition assessment.

- **Is it a GMCS problem if the provider documents malnutrition (based on some criteria, often albumin or prealbumin levels), and the RD documentation does NOT identify malnutrition?**

  It is the measure intent that the score calculation will only progress to Component Measure #3 (Malnutrition Diagnosis) if there is a Nutrition Risk Screening with a documented At-Risk result (or a Hospital Dietitian Referral) and a Nutrition Assessment documented by an RD/RDN (Component Measure #2) with a result of Severe or Moderate Malnutrition. If the RD/RDN does not identify

malnutrition during the nutrition assessment, the provider Malnutrition Diagnosis will not be included in the measure calculation. If discrepancies exist between RD/RDN and provider malnutrition diagnoses, consider development of a process improvement project to address all barriers and misconceptions identified.

- **If you have non-malnutrition components adding 1 to your measure, wouldn't that skew your results?**

  If this question refers to Nutrition Assessment and Care Plan that is done for other nutrition problems identified, that should not be skewing the score. eCQMs are based on value sets particular to the measure, and in this case, the diagnosis of malnutrition. For each Component Measure to count, certain malnutrition related results should be documented or identified.

- **Please clarify what you said earlier: GMCS is not weight dependent? How do we address an underweight status related to malnutrition?**

  The presence of malnutrition is not necessarily weight dependent. How the clinician addresses the malnutrition is dependent on the patient's individual needs and community resources. This is why it is not in the purview of the GMCS how the clinician addresses the individual needs of the patient. GMCS focuses on identifying malnutrition (Component Measure #1-3) and having steps in place to individually address what the malnutrition cause and individual needs are for the patient.

- **Will CMS take in old/retrospective malnutrition cases towards GMCS?**

  eCQM data are collected over a calendar year. The data is to be reported to CMS the following calendar year.

- **How is the process influenced by patients who are on hospice or transition to hospice care? How do you recommend handling patients that are Hospice or Comfort Care Programs? Dietitians may not complete assessments on nutrition risk screens if the patient is on hospice care.**

  This depends on what your facility defines as an inpatient encounter in their policies and procedures. Follow guidelines and regulations established by CMS and state/local agencies. GMCS focuses on identifying and addressing malnutrition. If the facility includes hospice care in the inpatient admission, the screening and assessment can still be done, and the care plan can provide an individualized plan for the hospice patient.

- **Can you elaborate on what exactly will qualify for meeting the criteria for Nutrition Care Plan? Can the information such as goals, intervention, etc. be in a dietitian progress note or does this mean it needs to be in the Care Plan activity of the EHR? Is there specific language that needs to be included to count towards the score? If not, what additional form/documentation is recommended?**

  The Nutrition Care Plan structure used to address malnutrition can be defined at the institution level. For the measure, specific value sets of terms define the concepts required in documentation to meet the requirements. Visit the list of terms above and ensure your documentation process includes the appropriate codes.

- **Can you use the ICD-10 malnutrition code as proof of MD documentation?**

  For the measure, specific value sets of terms define the concepts required in documentation to meet the requirements. Both ICD-10 and SNOMED CT codes are approved for the diagnosis of malnutrition. Visit the defined value set list found on www.cdrnet.org/GMCS.

- **For the care plan, is the RDN's documentation sufficient or does the MD need to document care plan as well?**

  The measure requires an RD/RDN nutrition care plan to meet the criteria for development of a nutrition care plan. Based on local/state and CMS guidelines, the physician/eligible clinician may be required to document justification of the malnutrition diagnosis, but it is not part of the GMCS measure itself.

- **Are there time frames for when certain steps of the process need to be completed, i.e., when the nutrition assessment has to be completed after the malnutrition risk screen?**

  No timeline is required for completion of any of the four measure observations for the GMCS and observations can be completed in any order. Please follow the policy at your hospital for the timing of completion of the measure observations. The GMCS measure does require that all qualifying components are met prior to discharge.

Subject: Nutrition Care Process & Terminology

- **Beyond the benefit of standardizing language for dietitians to use for documentation, is it the hope that one day this language will be standardized for all healthcare clinicians, and this will eventually be associated with reimbursement/revenue? Also, do you believe it would be beneficial for every type of healthcare care provider to develop their own standardized language as dietitians and nurses have done?**

  Standardized language in healthcare promotes clarity and interoperability. And each profession has their own needs to communicate patient findings that can be understood by their own profession and that of other professions as a way of improving efficiency and communication. CDR works closely with SNOMED CT and LOINC to support inclusion and standardization of the Nutrition Care Process Terminology.

- **Now that we have standardized dietitian terminology would it be beneficial to standardize a nutrition assessment for medical electronic health records? Would this not help us do better at tracking outcomes on dietitian interventions and practice?**

  Standardizing language and simplifying documentation can be beneficial in documentation and tracking of results. Nutrition and dietetics professionals are encouraged to work with their EHR colleagues to promote the benefit of standardized nutrition care process and terminology templates.

- **Is the word "Intervention" the key to verifying that the nutrition care plan has been completed? Are the word Nutrition Prescription and Nutrition Intervention the key words or smart words that are used to currently document the existence of a nutrition care plan?**

  For the measure, specific value sets of terms define the concepts required in documentation to meet the requirements. These concepts, though, are not required in the user interface. Professionals just

need to be certain that they select the words that meet the GMCS criteria based on the value set. The value sets can be found at www.cdrnet.org/GMCS.

- **Is it true that, ultimately, it is ideal to get all 4 components of the GMCS into a "structured data field" as discrete data? If so, how do we go about reporting that to CMS?**

  Yes, structured data fields are ideal to facilitate reporting of the GMCS components. Specific value sets of terms define the concepts required in documentation to meet the requirements. The value set can be found at www.cdrnet.org/GMCS or https://vsac.nlm.nih.gov/valueset/expansions?pr=ecqm&rel=eCQM Update 2023-05-04&q=CMS986v2.

- **Are reviewers looking for the nutrition diagnosis of "malnutrition" as the diagnostic term or could it be a related term with evidence that includes meeting criteria for malnutrition?**

  The terminology used to complete Component Measure #3; Malnutrition Diagnosis should follow the specific value set established. The value set can be found at www.cdrnet.org/GMCS or https://vsac.nlm.nih.gov/valueset/expansions?pr=ecqm&rel=eCQM Update 2023-05-04&q=CMS986v2. To assist physicians and eligible clinicians with proper identification of malnutrition, the PES (problem, etiology, signs/symptoms) statement is the most concise way for an RDN/RD to communicate the presence, severity, and evidence of malnutrition to a physician/eligible clinician.

- **Help me understand what the desired score should be? Not all patients assessed by the RDN will be found to be malnourished so there could be a lot of zeros in that position.**

  Higher scores, that is, those closer to 100% indicate better performance. Lower scores indicate room for improvement. The measure was developed to evaluate complete nutrition care for patients identified with risk for malnutrition. Additionally, only patients identified as severely or moderately malnourished are expected to have the Malnutrition Diagnosis and the Nutrition Care Plan.

Subject: Electronic Health Records (EHR) and Information Technology Systems

- **Any advice about collecting data out of Epic?**

  Structured data fields are ideal to facilitate obtaining data from any EHR system. Refer to the value set developed for the measure (found at www.cdrnet.org/GMCS or https://vsac.nlm.nih.gov/valueset/expansions?pr=ecqm&rel=eCQM Update 2023-05-04&q=CMS986v2) and make sure that the value set is used when building the templates and steps for collecting the data for GMCS.

- **Is the GMCS a part of any software program used by independent private practice dietitians? Is there software that is GMCS-friendly?**

  The GMCS eCQM is currently a quality measure for acute care hospitals and critical access hospitals The choice of software systems should align with the specific needs and capabilities of a facility or healthcare organization. The software should be certified for eCQM reporting by the Office of the National Coordinator for Health Information Technology (ONC). The ONC's Certified Health IT Product List (CHPL) can be used to check whether a particular software product is certified for eCQM reporting.

- **Most of our EHR systems do not have the NCP codes included (in the value sets). How do we ensure those are included in EHR systems that are structured and easily captured when the EHR decisions are often made at the corporate level, not the local level?**

  Structured data fields are ideal to facilitate reporting of the GMCS components and any quality related data. Specific value sets of terms define the concepts required in documentation to meet the requirements. These include some of the NCP concepts and some additional codes used by other professionals in the reporting of this measure. However, every EHR build, and level of service will vary based on facility. Though it would certainly be helpful if eCQMs are built into the EHR system, it is not the purview of the eCQMs measure stewards/developers or CMS to direct EHR providers as to how to develop their products.

- **Any insight or tools/resources for Cerner enhancements to streamline the malnutrition diagnosis capture? If any facilities have Cerner and have had success in a build/enhancement that have improved this process.**

  Every EHR build and level of service will vary based on facility. Consider a conversation with the EHR provider, IT, quality and nutrition and dietetics credentialed practitioners to develop a plan for the EHR that best suits the facility you are in.

- **How should I work with my organization to track outcomes without going back and reading previous notes? Is there a standard location in my EMR to find this information?**

  Using structured data fields can be a solution to tracking outcomes. Structured data, also known as discrete data, is data that resides in fixed fields. Templates, standardized forms, or checklists can also be ways to present discrete data, whereas unstructured data would be a clinician note in a text box. This will aid in working with your IT/quality/informatics time to implement the measure and easily identify where the data elements for the measure are located with your documentation. Value sets help to standardize the terminology used in the structured data fields. By using specific codes, you can ensure that the required patient and condition are being measured. For example, the data element malnutrition diagnosis would be associated with the value set that contains all relevant codes for malnutrition diagnosis. For more information, work with your IT/quality/informatics team.

Subject: Other

- **We are finding that we are being denied insurance malnutrition reimbursement because insurance companies are looking for GLIM parameters - not ASPEN's, what are others doing about this? Will GLIM be viewed as a validated tool? It is hard to have ASPEN criteria and then GMCS - it seems like we are documenting twice, a difficult task when short-staffed. Can you offer guidance on how these two criteria work together?**

  Insurance reimbursement criteria are established by each insurer making it a challenge when the literature is evolving. GMCS does not recommend specific tools to use for malnutrition screening and diagnosis, only that the tools used are validated for the population. For malnutrition diagnosis, the Academy and ASPEN have published recommendations regarding evaluation of characteristics that can be used for identification and documentation of adult malnutrition. Once the Registered Dietitian (RD/RDN) establishes a malnutrition diagnosis through a comprehensive assessment, it is the purview of the physician or eligible clinician to diagnose malnutrition as a medical diagnosis.

Outreach by your hospital to insurers to understand the evidence for malnutrition reimbursement is recommended.

- **Is ASPEN working on changing the malnutrition criteria?**

  Any questions related to ASPEN should be directed to them. For a form to submit questions please visit here.

- **What is the goal timeframe for hospitals to choose their eCQMs for 2024? Is there a period of time to prepare and assure all of the components are in place prior to the start of 2024?**

  GMCS is a self-selected measure. Data is due annually and selected eCQM for the calendar year reporting must be the same across quarters. During the submission period calendar year, you would be reporting data from the prior calendar year, which could affect payment for the fiscal year after. We encourage institutions, whether they are submitting the data or not, to evaluate the data corresponding to GMCS. This would help the institution establish a benchmark and develop process improvement projects, if needed, to support the improvement of the data.

- **Will this have an impact or change OIG evaluations of malnutrition diagnoses with this new CMS eCQM measure?**

  We are unable to speak for impact in OIG evaluations.

- **Is there a recommended tool to capture malnutrition scores in outpatient settings?**

  In general, use of a validated tool is recommended for nutrition screening and assessment.

- **How can we anticipate GMCS to carry down to SNF/LTC malnutrition scores and coding/rates through the continuum of care? What kind of work has been done regarding GMCS and application within SNF/LTC?**

  The GMCS is intended for use in acute care and critical access settings, in patients admitted that are 65 years of age or older on admission and that have a length of stay of 24 hours or more. Because of the significant body of evidence reporting complications of malnutrition in hospitalized older adults, this population was prioritized. However, CDR and its partners continue to work with CMS to explore additional care settings and populations.

- **I work in an ACEND accredited Graduate Program - Future Education Model. Ideally, how would you like us to teach this to future practitioners?**

  CDR recognizes the importance of training not only practicing credentialed nutrition and dietetics professionals, but also those that are in the process of becoming credentialed. We have begun conversations with the Accreditation Council for Education on Nutrition and Dietetics (ACEND). If you need to reach out to the Quality Team for direct support to include GMCS in your current program of education, please email us at quality@eatright.org.