Welcome to Today’s Expert Webinar for the 2020 MQii Learning Collaborative:

“A Closer Look into the Role of Nutrition in ERAS Protocols”

Wednesday, April 22, 2020

We will get started promptly at 11:00 AM ET
(10:00 AM CT; 9:00 AM MT; 8:00 AM PT)

All phone lines have been muted
Before We Get Started…


April 22, 2020
We will start promptly at 11:00 AM ET (10:00 AM CT; 9:00 AM MT; 8:00 AM PT)
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<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Presenter</th>
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| Welcome and Introduction                                                  | Christina Badaracco, MPH, RD  
*Research Scientist at Avalere Health*                                                                                                      |
| Evidence and best practices for supporting nutrition care for surgical patients from pre-admission through discharge | Paul Wischmeyer, MD, EDIC, FASPEN, FCCM  
*Professor of Anesthesiology and Surgery*  
*Associate Vice Chair for Clinical Research, Anesthesiology*  
*Physician Director, TPN/Nutrition Support Service*  
*Duke University School of Medicine*                                                                 |
| Example of a successful incorporation of nutrition care into an ERAS program including strategies to change culture, tools to overcome barriers, and measures of success | Gina Ward, MS, RDN, CDE  
*Clinical Nutrition Manager and Certified Diabetes Educator*  
*Davis Hospital & Medical Center*                                                                                           |
| Questions – 15 mins                                                        |                                                                                                                                            |
• Share evidence and best practices for supporting nutrition care for surgical patients from pre-admission through discharge
• Describe innovative example of care team at Duke University Hospital

Paul Wischmeyer, MD, EDIC, FASPEN, FCCM
Professor of Anesthesiology and Surgery
Associate Vice Chair for Clinical Research, Anesthesiology
Physician Director, TPN/Nutrition Support Service
Duke University School of Medicine
• Review best practices to support nutrition care for surgical patients from pre-admission through discharge

• Share examples of successful incorporation of nutrition care into an ERAS program, including strategies to change culture, tools to overcome barriers, and measures of success

I have no financial disclosures.
ERAS: An Opportunity for Malnutrition Quality Improvement

https://erassociety.org/
Enhanced Recovery After Surgery: Review

• Perioperative malnutrition is a challenge to define, diagnosis, and treat. Poor nutrition status is a strong predictor of negative postoperative patient outcomes.¹

• Malnourished surgical patients have significantly higher:
  – Post-op mortality and morbidity
  – Length of stay (LOS)
  – Readmission rates and overall hospital costs²–³

Enhanced Recovery After Surgery: Review

- Studies estimate that 24–65% of surgical patients are at higher nutritional risk.\(^3\)\(^–\)\(^6\)
- Undernourished patients or patients at risk for malnutrition are twice as likely to be readmitted within 30 days of colorectal surgery.\(^7\)

• ACS National Surgical Quality Improvement Program defines malnutrition as one of the few modifiable preoperative risk factors associated with poor surgical outcomes.⁸⁻⁹

• The risk of malnutrition is most often associated with major GI and oncology surgery²⁻³ because these patients are at greatest risk for baseline malnutrition (~65%).³,⁵,⁹

For more information: https://www.facs.org/quality-programs/acs-nsqip

Enhanced Recovery After Surgery: Best Practices

Figure 1. Facts and data for perioperative nutrition screening and therapy. Data drawn from Awad and Lobo, Williams and Wischmeyer, and Philipson et al. R.I.P indicates rest in peace.

For clinical nutrition managers who have implemented MQii and are struggling to implement ERAS, keep in mind that the same general principles apply to implement change at your facilities:

1. Seek leadership support.
2. Build your team.
4. Implement QI and eCQM data collection.
Davis Hospital and Medical Center (DHMC) opened in 1976 with four operating rooms, 100 beds, and 105 employees. Today, Davis Hospital and Medical Center has 220 beds, over 550 employees, and 200+ active medical staff.

DHMC was acquired by Steward Health Care in 2018. Steward is the largest private, tax-paying physician-led health care network in the United States. Headquartered in Dallas, Texas, Steward operates 37 hospitals in the United States and the country of Malta. Steward employs ~42,000 health care professionals.
Davis Hospital & Medical Center Services

- **ER Trauma Center** Board-certified emergency physicians and specialized trauma surgeons, Trauma Center Level 3
- **Chest Pain Center of Excellence** Interventional cardiology/cardiac catheterization, accredited by American Heart Association.
- **Stroke Receiving** American Heart Association Gold-Plus, Honor Roll Elite Recognition
- **Neurological Services** Diagnostic and surgical procedures for minimally invasive brain, spinal cord and nervous system issues
- **Women’s Care** OB/GYN surgical services, maternity care, Level III NICU, on-site spa services, 3-D mammography
- **Cancer Center** Tomotherapy® and Brachytherapy. Certified nurse patient navigators coordinate care.
- **Surgical Services** Inpatient (hospital) and outpatient (Davis Surgical Center), including robotic-assisted gynecologic, colorectal, urologic and general surgeries.
- **Orthopedic Program** Surgeons and fellowship-trained sports medicine specialists provide non-surgical and surgical treatment options, focus on foot/ankle, hand and upper extremities, total joints (knee and hip).
- **Diabetes & Nutrition** Comprehensive resource center staffed by Diabetes Educator and Care Specialists as well as Registered Dietitians provide inpatient and outpatient education, certified by the American Diabetes Association Education Recognition Program.
- **Wound Care** Inpatient and outpatient wound care, including hyperbaric therapy
- **Weber Campus** Satellite campus offers 24-hour full-service emergency care, imaging and laboratory services for patient convenience for the convenience of communities west of I-15.

The nutritional status of patients impacts patient outcomes for every service DHMC offers. Improving transitions of care is an opportunity for quality improvement!
Stakeholder identification: **WHY** should the following individuals care? **HOW** does your QI help these individuals achieve **their** goals?

- RDs
- Anesthesiologists
- Surgeons/Providers
- Nursing
- Case Management (Discharge planning)
- CDI (Coding)
- Quality Director

- Wound Therapy
- PT/OT/SLP
- Admin (CEO, CFO, CNO, etc.)
- Information Systems
- SNFs/Rehab Facilities
- Patients/Families
- And many more . . . .
**Preoperative Nutrition Best Practices**

- If you do not have a pre-admission clinic, consider educating providers (general and trauma surgeons, ENT, oncology—those with high-risk patients) on outpatient screening and appropriate referrals.
- Develop screening tools that refer to your services for surgical providers to use.

Pre-Surgery: Outpatient Screening Tools

The National Council on Aging (NCOA) has a variety of validated screening tools that you could reference for outpatient screening/physician education:
- Validated Malnutrition Screening & Assessment Tools: Comparison Guide
- Malnutrition Screening Tool (MST)
- Nutritional Assessment (MNA®)
- Malnutrition Universal Screening Tool (MUST)
- Nutrition Risk Screening (NRS-2002)
- Seniors in the Community: Risk Evaluation for Eating and Nutrition (SCREEN©)

Consider creating hospital-specific outpatient screening tools for physicians (which could be automated and downloaded by providers from hospital intranet) for both general malnutrition (MQii) and surgical nutrition (ERAS).

_This would be IDEAL if linked to your referral process!_

https://www.ncoa.org/center-for-healthy-aging/resourcehub/community-orgs-and-professionals/professional-resources/malnutrition-screening-tools/
• For patients identified at high nutrition risk, provide a way for them to acquire oral nutrition supplements (ONS) at minimal cost prior to surgery.

• At our facility, patients receive a prescription for the appropriate nutrition intervention w/ purchasing instructions from the hospital cafeteria.

For pre-op nutrition clinic/dietitian, check out the MNT Works for Seniors Toolkit from The Academy of Nutrition & Dietetics (which is complimentary for members).

https://www.eatrightpro.org/payment/medicare/mnt-works-for-seniors-toolkit-form
ERAS Perioperative Pathway

**Pre-operative Nutrition Optimization**
Ensure Surgery (Immunonutrition) BID 5-7 days prior to scheduled surgery
Ensure Pre-surgery (clear liquid carbohydrate loading) 2 bottles night before surgery
Product provided at surgical clinic/center

**ERAS Pathway @ DHMC**

- **Pre-op**
  - Ensure Pre-surgery (clear liquid carbohydrate loading) – up to 2 hours prior to surgery

- **Home**

- **Admission**

- **Pre-op**

- **OR** → **PACU** → **Medical/ Surgical Floor** → **Discharge**

**Post-Surgery Diet Transition**
- Tube Feeding – Pivot 1.5 @ 20 ml/hour + nutrition consult
- Clear Liquid – Ensure Clear BID + Juven 1 Packet BID
- Fulls, Regular – Ensure Surgery (Immunonutrition) BID

**Discharge on Nutrition (Samples and Coupons)**
- Ensure Enlive BID for 30 Days
- Or
- Ensure High Protein BID for 30 days
- Or
- Glucerna BID for 30 days

DHMC: Davis Hospital and Medical Center
Automating Inpatient Processes

For physicians who choose to implement ERAS:
• Automate RD consult on order sets
• Automate ONS or order sets
• Automate discharge Rx for ONS where possible

Dietitians should consider:
• Automate ONS on clear and full liquid diets
• Consults for wound care should trigger RD consult
• Automate order sets and discharge Rx for providers

RD consults are automated (MST) but can be ordered by any nurse or provider.
Automating Inpatient Processes

Dietitians should educate team members on their responsibilities:

- **Physicians**: Order appropriate consultations, diagnose malnutrition when appropriate, and order discharge Rx for ONS
- **RDs**: Monitor adequacy of oral intake, determine appropriate ONS, and provide education and recommend discharge Rx for ONS
- **Nurses**: Encourage protein/oral intake, document oral intake (ONS separately, if possible), and consult RD if problems arise

Formulary options should include ERAS products which can be ordered by MD/RD team.
Automating Inpatient Processes

- Remember that best practice is: oral before enteral before parenteral.
- Make it easy for providers to order enteral (trophic feedings) or parenteral if needed.
- Physicians will market their success with ERAS workflows to other providers for you!

I have created nutrition support (4.25% Clinimix PPN and 5-15% Clinimix TPN order sets for providers. They can select “Shared” and type in my name to see this list and then save in their favorites list.

This is a physician favorite and we have a lot less issues with orders to pharmacy with order sets in place. Providers tell NEW providers about these order sets for me!
Orchestrating the Discharge Rx

- **Physicians** can select from discharge ONS Rx that are already set up for them.
- **Dietitians** can also select from this list and recommend them for physicians.

The easier the workflow or process, the more likely it is to be implemented!
### Follow-Up: The TEAM approach to care!

**Physicians:** Emphasize good nutrition peri-operatively, diagnosis if appropriate, and make referrals. In surgery, physicians work with RDs to lead the team.

**Dietitians:** Assess, educate, implement nutrition interventions, and ensure meeting patient needs. RDs lead.

**Nurses:** Help implement nutrition interventions, encourage and document intake, and make referrals when appropriate.

**Nutrition education of all team members is a huge component of RD leadership in MQii and ERAS implementation. Utilize resources, do your homework, anticipate barriers, and find out how to get what matters to YOU matter to OTHERS!**

For more information: [https://anhi.org/resources/printable](https://anhi.org/resources/printable)
“Achieving high value for patients must become the overarching goal of health care delivery, with value defined as the health outcomes achieved per dollar spent. This goal is what matters for patients and unites the interests of all actors in the system.”

Hospital Quality Improvement

Hospital Value-Based Purchasing (VBP)

- Payment adjustments based on interventions and outcomes related to:
  - Patient/Caregiver-Centered Experience of Care
  - Safety
  - Clinical Care (Patient Outcomes)
  - Efficiency and Cost Reduction

Readmission Reduction Programs (HRRP)

Payment reduced to hospitals with excess readmissions (for applicable conditions readmitted within 30 days) as benchmarked against national averages

- Acute MI
- CHF
- Pneumonia
- COPD
- Total Joint Arthroplasty
- CABG

Hospital-Acquired Condition Reduction Program (HACRP)

Payment reduced for hospitals ranking in the bottom 25% of Hospital-Acquired Condition quality measures

- AHRQ Patient Safety indicators (wounds)
- Central Line-Associated Blood Stream Infections
- Surgical Site Infection for colon surgery
- MRSA, C. difficile

AHRQ: Agency for Healthcare Research and Quality; CABG: Coronary Artery Bypass Graft; CHF: Congestive Heart Failure; COPD: Chronic Obstructive Pulmonary Disease; MRSA: Methicillin-Resistant Staphylococcus Aureus
The 2019 Malnutrition QI had three goals:

1. Improve accuracy of malnutrition diagnosis (unspecified malnutrition versus mild, moderate or severe).
2. Improve accuracy of coding that calculates into DRG (affects LOS).
3. Develop staff and provider education/training.

### DHMC Malnutrition QI: Malnutrition Dx

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- **Mild, Moderate or Severe PCM**
- **Unspecified PCM**
- Down 1.5 FTEs RD staff, less NFPE done

### Reimbursement Implications
- E40 Malnutrition
- E43 Severe PCM
- E44.0 Moderate PCM
- E44.1 Mild PCM
- E46 Unspecified PCM
DHMC Malnutrition QI: Malnutrition Dx

Corrective Action (CAR#)

Hospitalist staff change, new medical residents, standardized training for malnutrition criteria and education on malnutrition documentation.

New hospitalist, staffing changes (many nurses now from a "float pool.") Delay in all staff training (nursing, providers, medical residents). **Intervention:** Standardized staff training and arranged two hour training for all new residents and providers on NFPE, malnutrition documentation requirements.

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<th>April</th>
<th>May</th>
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<td>Compliance Rate</td>
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<td>58%</td>
<td>91%</td>
<td>86%</td>
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Overcoming Barriers to ERAS Implementation

• **Budget.** Surgery often has a larger budget than other departments. Make friends with your head of anesthesiology and surgical director. Provide education (w/ food is best). Provide an order set/MEC policy proposal for their review and ask for feedback (scheduling, education needs, etc.) Market your ability to help them/their patients!

• **Data collection.** Enlist help of coding department. They can attest to the diagnosis-related group (DRG) assignment and how it impacts reimbursement for comorbidity and complication (CC) and major comorbidity and complication (MCC). This also impacts authorized length of stay.

• **Electronic health record/information systems.** Enlist the help of these individuals for reports, automation of triggers, and how to build order sets and discharge Rx in the system to make it easy for physicians.

• **Volunteer w/ a QI project.** Quality directors rarely get volunteers to help with their department. They will jump at the chance to have you help them!

• **Offer to educate.** Present at grand rounds, resident or nursing training, and staff education/meetings. Providers/colleagues appreciate your offer of help and you can recruit team members!

MEC: Medical Executive Committee
Other things I have learned:

• Excel. Don’t trust your E.H.R. to have every report that you need. Learn database basics and continue to learn. It’s daunting, but you get better with time.

• Listen. Some of your best ideas for overcoming barriers come from listening to others “vent.”

• Be tenacious and don’t give up! Reach out to others for help if you need it, because we all do from time to time . . .
Questions?

15 mins