Hospitals are increasingly recognizing the value of using Enhanced Recovery After Surgery (ERAS®) protocols to improve patient outcomes and decrease adverse events that can trigger financial penalties such as surgical site infections and unwanted readmissions.

“Good surgical outcomes are always top-of-mind for hospitals and medical facilities. However, implementing ERAS® protocols is becoming a more important area of focus now that reimbursement dollars are tied to patient outcomes,” explained Sue Champion, RN, BSN, MBA, CNOR, clinical operations director at Dublin, Ohio-based Cardinal Health.

“It’s critical that we create the best environment to deliver the best patient outcomes. If we don’t it will first and foremost impact the patient and secondly, cost us,” Ms. Champion said.

Ms. Champion recently spoke with Becker’s Hospital Review about ERAS® protocols; why they are gaining traction and how hospital and health systems can more seamlessly integrate them to enhance patient outcomes and secure reimbursement.

Question: What is ERAS® and why is it gaining traction?

Sue Champion: ERAS® is designed to help ensure patients have the best outcomes following surgery. The ERAS® protocol offers evidence-based guidance on best practices providers can use before, during and after surgery to accelerate a patient’s recovery. ERAS® is now being talked about by many organizations and hospitals and continues to gain popularity because it includes processes that health systems can easily implement and control that support improved patient recovery. Further, ERAS® protocols are gaining traction because patient outcomes are now directly tied to reimbursement. In short, we just cannot afford to have poor patient outcomes. If there’s an adverse reaction such as an SSI or the patient must be readmitted for any reason, the facility is not reimbursed for the procedure or the necessary care to get the patient discharged the second time.

Q: How is ERAS® changing clinical and operational processes?

SC: It is changing the way clinicians think. In the past, everyone thought it was best that patients avoid ingesting anything by mouth eight hours before their surgery. However, ERAS protocols...
allow patients to ingest clear fluids up to two hours before their arrival to the facility for surgery. It goes against everything that many clinicians learned. From a clinical perspective, it’s changing best practices in the industry, including the way patients are prepped for surgery.

Q: How are healthcare facilities utilizing ERAS® protocols?

SC: There are various ways hospitals are executing ERAS® protocols. Since the surgeon is involved with ensuring optimal patient outcomes, many facilities have the surgeon or surgical and preoperative staff discuss the nutritional, pre-cleaning / skin preparation, pain management, respiratory support, etc. aspects of the protocol with patients. Some facilities opt to give patients a checklist that lists out everything they need to purchase on their own. Others realize it’s in their best interest to give the products to the patients directly and blend the cost into the total procedure cost.

The choice of a hospital to manage patients getting the products needed to follow their ERAS® protocol and absorbing the cost is often coupled with a cost avoidance comparison between the cost of ERAS® products against the financial burden of treating an SSI. In many instances, the absorbed cost to provide the products is worth incurring and is offset greatly by the cost to treat SSIs.

Q: What are some challenges hospitals are facing when implementing ERAS®?

SC: One challenge for hospitals is determining the best time to talk with the patient about ERAS® protocols and how to get the necessary products into the patient’s hands. Every facility is different, and sometimes each surgeon may have a different process. A non-standardized process to discuss the protocols with patients and ensure they have the products can make it challenging to execute and follow.

Q: What recommendations do you have for hospitals looking to implement ERAS®?

SC: I would recommend having a cross functional team in place, including anesthesiologist, surgeons, surgical and pre-admissions staff to analyze current processes. If possible, having someone specifically dedicated to ERAS® could help.

Further, understanding current surgical processes, the desired outcome, and why it matters before implementing ERAS® protocols is key. If the key stakeholders understand the process and the benefit (the why), it can be easier to get buy-in, which helps facilitate change.

In addition, finances can’t be ignored. Leaders need to assess resources needed including whether the facility can afford to provide the necessary items to patients or if it is in their financial best interest to send patients to purchase the products themselves. My recommendation is to provide the bundle of items the patient needs to help drive compliance. From a cost perspective, bundling makes it easier to keep tabs on how the supplies impact cost per procedure. From a patient experience perspective, it can be more efficient, less confusing, and convenient to receive everything needed in one place.

Lastly, never forget to go back and reevaluate periodically and always ensure you have the right team including internal and external partners that can help support integrating and managing your ERAS®.

To learn more about how Cardinal Health can help health systems integrate ERAS®, click here.