



5 Tips for Improving TEAM Adoption of Enhancing Recovery After Surgery (ERAS) Guidelines

If TEAM has your hospital searching for an evidence-based toolkit to improve surgical outcomes and reduce recovery time, participating hospitals and their surgical teams should pay heed to [ERAS \(Enhanced Recovery After Surgery\) protocols](#). The guidelines are tailored to over twenty types of surgery as well as anesthesia and intensive care. They have been successful in reducing complications by 30 percent and lowering hospital stays.

Most of the TEAM procedures are covered within specialty guidelines addressing cardiac, colorectal, cytoreductive, orthopedic, and spinal fusion surgeries. There are significant common elements among the categories, facilitating a generalized implementation and education approach.

Your hospital or practice may already have adopted some ERAS guidelines, but most hospitals have uneven adoption across all surgery types and of the guidelines themselves. In addition, many of the pre-surgical guidelines demand a significant shift for hospitals' roles in surgical episodes. They demand coordination of care, a better registration and patient risk analysis, a primary care referral network, and patient education and action. But the patient's condition prior to surgery is a huge indicator of their likely complications during and after surgery. TEAM requires that hospitals take this on.

Here are best practices for how to adopt ERAS for TEAM:

- 1. Ensure that your hospital staff, operating room staff, clinicians and surgical teams are thoroughly aware of ERAS guidelines for the TEAM procedures and their evidence-based value.** Hold educational sessions and provide quick guides on recommendations for all three phases of the surgical episode (including pre-and post-surgery). Ensure that the guidelines that are common to all procedures are prioritized as a standard of care in surgery. If your hospital has not adopted ERAS guidelines for any surgery or if the guidelines have been adopted unevenly, convene an organization to address this gap.
- 2. Include adoption and measurement of ERAS guidelines in your collaboration agreements,** especially those for the pre-treatment and peri-operative phase of the episode.
- 3. Assign an ERAS coordinator to work with your Chief Medical Officer and principal physicians coordinating TEAM for each surgery department.** The coordinator's role is to identify issues with guidelines and to help clear obstacles to guidelines implementation.
- 4. To create the adoption of pre-surgical protocols, you will need a four- to five-week lead time prior to actual surgery to cover pre-treatment, smoking and alcohol cessation.** Ensure that you have developed your [primary care referral team](#) to address patient care pre-surgery. If you have an ACO, your ERAS or TEAM coordinator can work with its population health or care coordination functions to schedule patients for pre-treatment.
- 5. Involve your primary care referral sources in the pre-surgical education and adoption of ERAS protocols, many of which require lead time before surgery.** Provide feedback to them on their patients' status going into surgery, which is indicative of their risk mitigation success, and report any complications experienced during the episode.

We're ready to help you make TEAM successful. [Roji TEAM Episodes](#) are mapped to specifications CMS has provided for inclusions and exclusions, incorporating our robust analytics to take a deep dive into cost and quality. To the extent data permits, we will evaluate ERAS guidelines as part of this process. [Contact Roji Health Intelligence](#) to ensure peak performance.