DSKE
DANSK SELSKAB for KLINISK ERNÆRING

25. ÅRSMØDE I KLINISK ERNÆRING

8. april 2016, Auditorium 2, Rigshospitalet

Program:

9:00 – 9:30	Registrering og morgenmad
9.30-	Velkomst
9.30-10.30	Nutrition Care in Palliative Cancer Patients *Lene Thoresen, Norge*
10.30-10.35	Uddeling af Nutricias Uddannelseslegat
10.35-11.05	Kaffe
11.05-11.35	Refeeding syndrom hos kritisk syge – ny viden fra et randomiseret forsøg *Matilde Allingstrup*
11.35-12.00	Overrækkelse af Jens Kondrup Prisen og prisforelæsning
12.00-13.00	Frokost
13.00-14.00	Implementation of Nutrition Support – guidelines, cost effectiveness, DRG and ONCA *Johann Ochenga, Tyskland*
14.00-15.30	Frie foredrag i separate sessioner for Læger og cand. scient.'er (auditorium 1) Sygeplejersker og Kliniske diætister (auditorium 2)
15.30-16.00	Kaffe
16.00-16.05	Kåring af bedste abstract som både er sendt til årsmødet og til ESPEN 2016
16.05-16.20	Forum for underernæring *Susanne Kofoed*
16.20-16.40	Hvad fandt jeg, da jeg ryddede mit kontor? *Jens Kondrup*
16.40-16.45	Afslutning
16.45-	Generalforsamling (auditorium 2). *Kun for medlemmer af DSKE.*

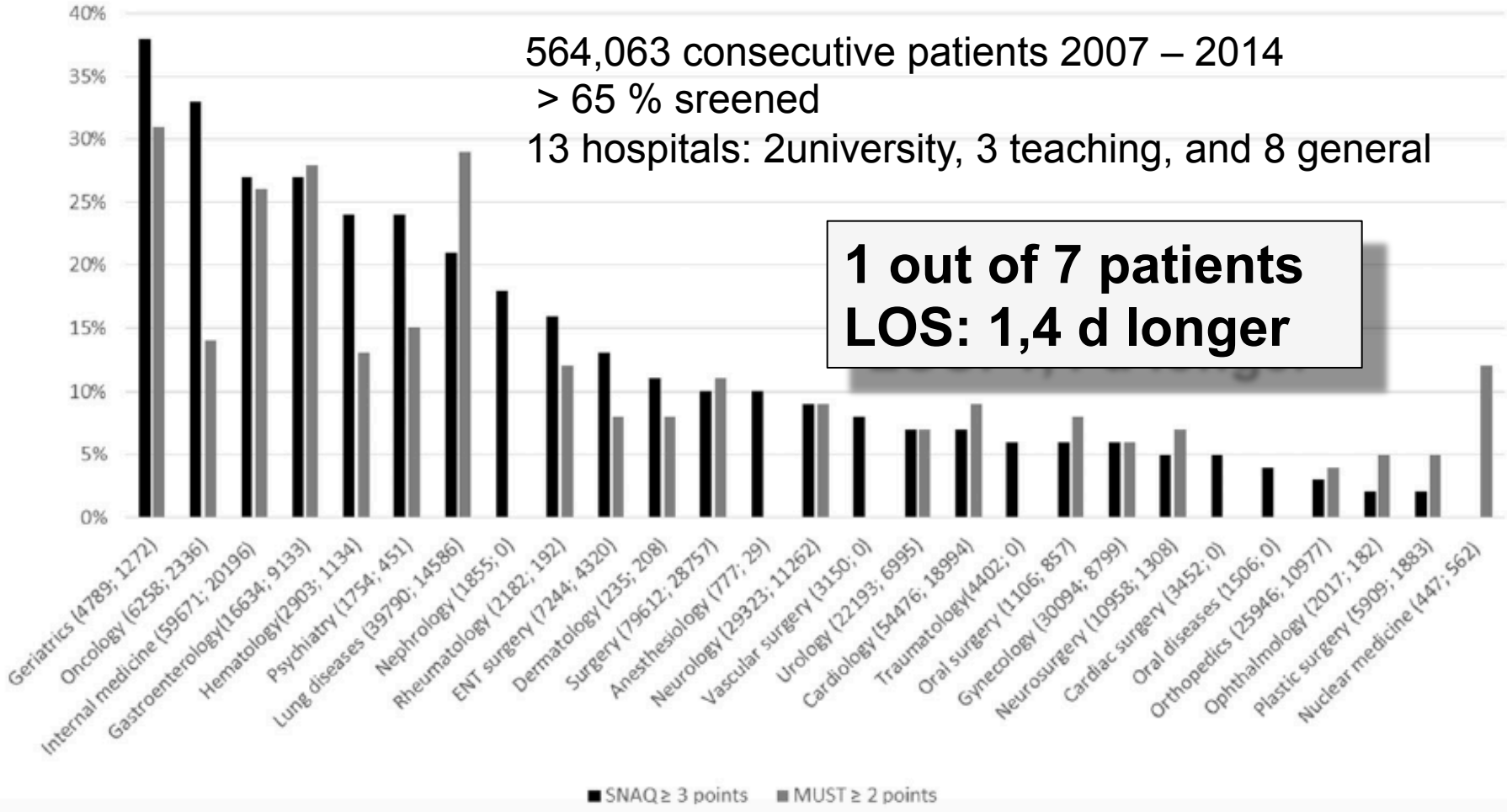
Implementation of Nutrition Support

Johann Ockenga
Bremen, FRG

Gesundheit Nord

- vier große Krankenhäuser
- fast 60 Fachkliniken und Institute
- ca. 7500 Mitarbeiter
- Zahlreiche Tageskliniken und Ambulanzen
- Umsatz ca 500 Mill/Euro

Prevalence of Malnutrition per Medical Specialty

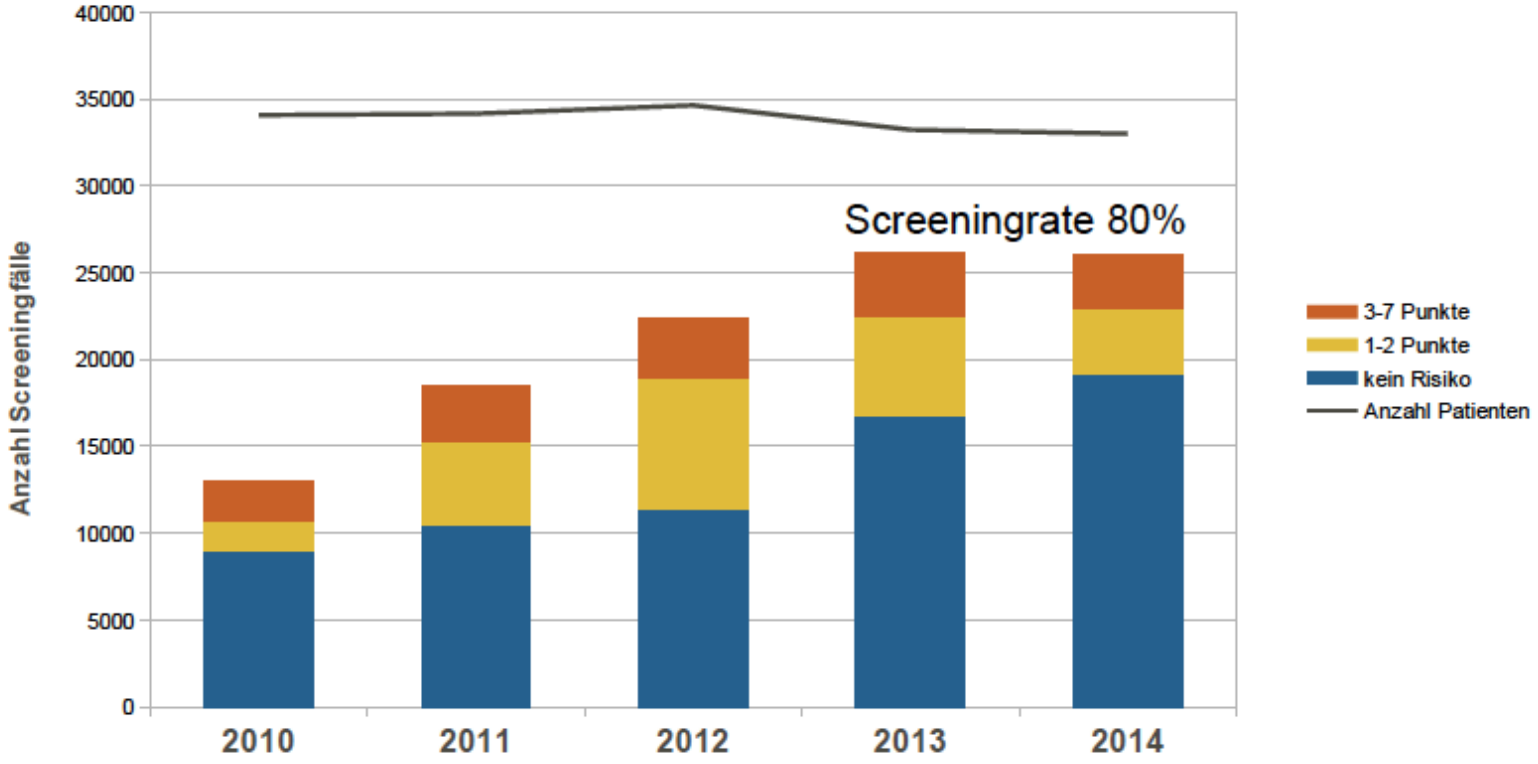


564,063 consecutive patients 2007 – 2014
> 65 % sreened
13 hospitals: 2university, 3 teaching, and 8 general

1 out of 7 patients
LOS: 1,4 d longer

Kruizenga H. Et al. Am J Clin Nutrition; online 9 March 2016

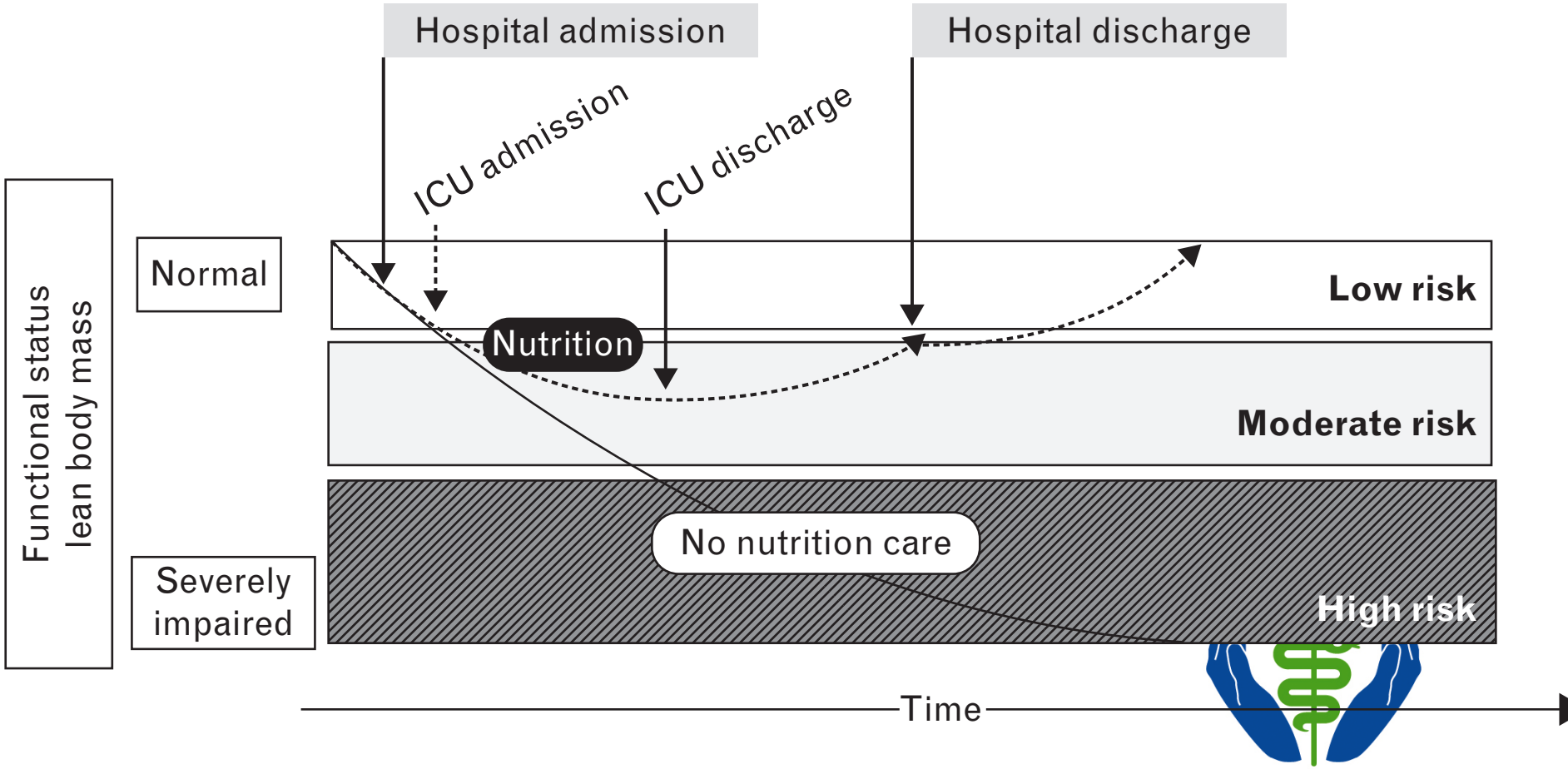
Nutritional Risk Score
Universitätsklinikum Frankfurt



Mit freundlicher Genehmigung von Frau Marienfeld

Nutritional Status during Clinical Course

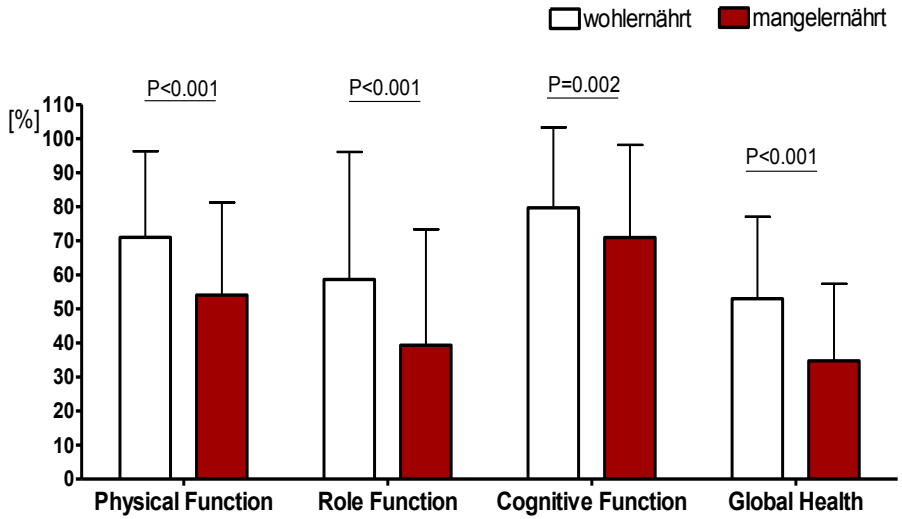
Hiesmayer M. Curr Opin Clin Nutr Metab Care 2012, 15:174 – 180



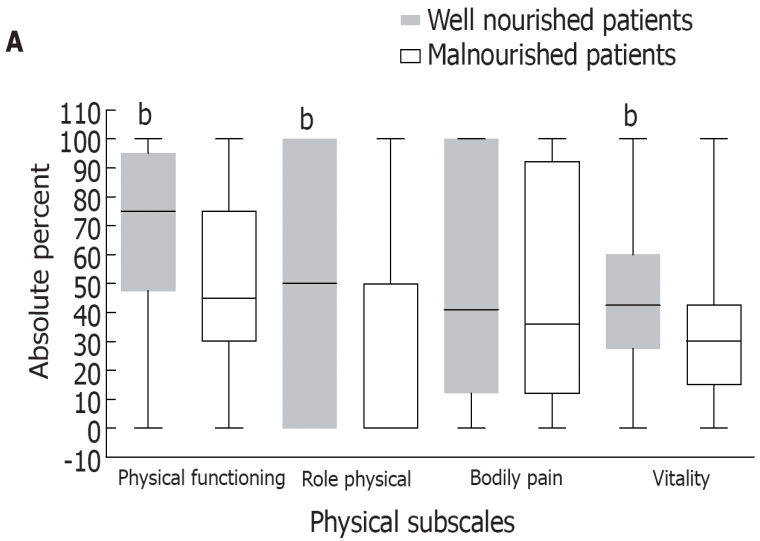
Malnutrition an Quality of Life: EORTC

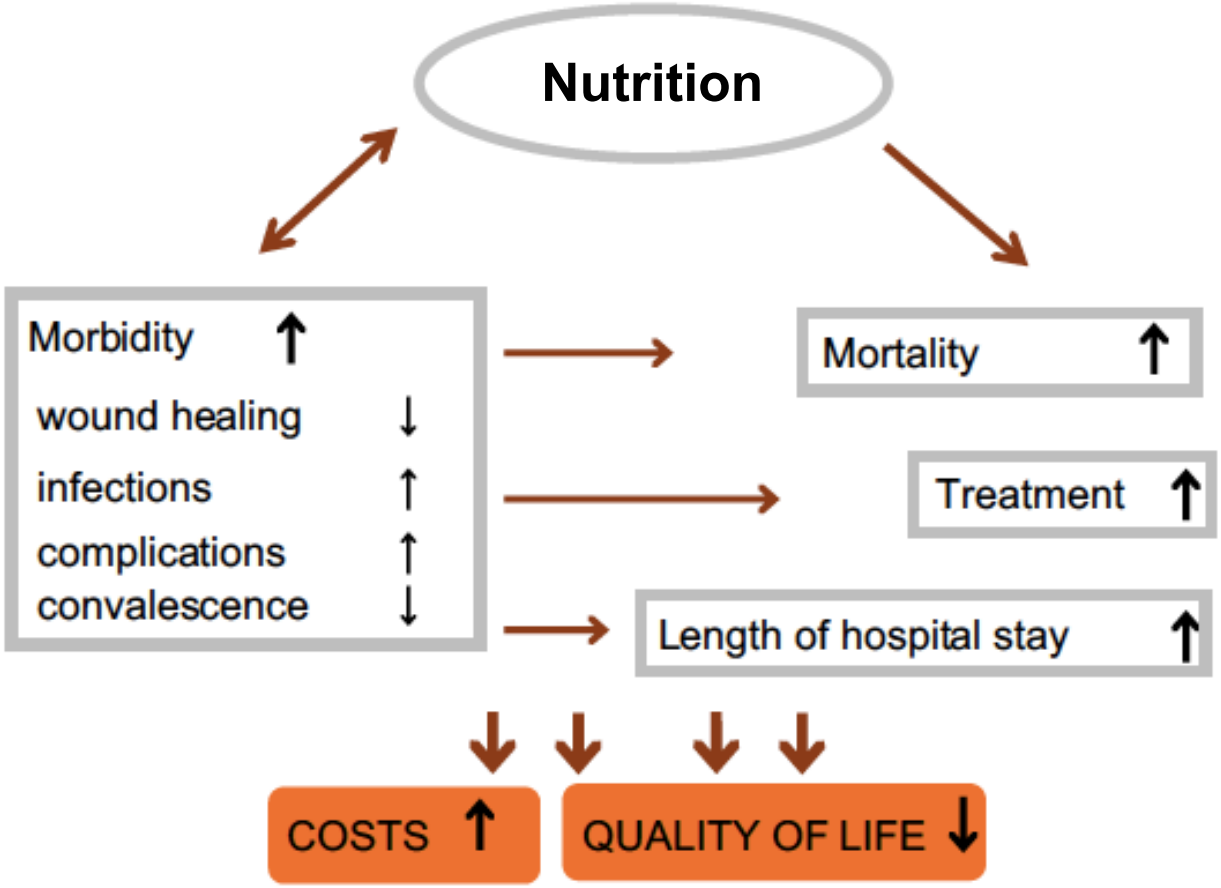
Norman K et al. Clin Nutr. 2010 Oct;29(5):586-91/ Worl J Gastroenterol 2006; 12

Malignant Disease (n=400)



Benigne Disease (n=200)

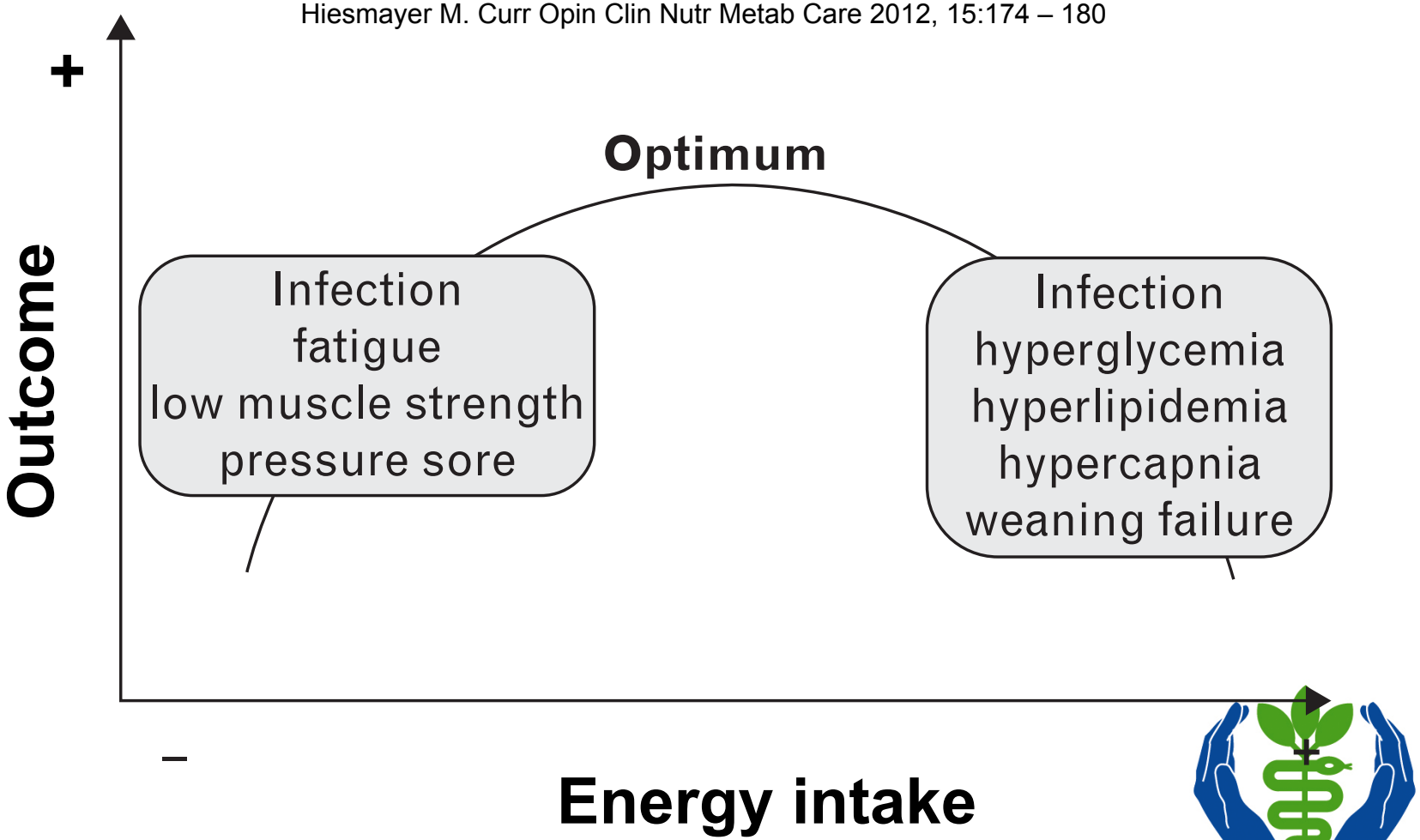




Norman K et al. Clinical Nutrition (2008) 27, 5–15

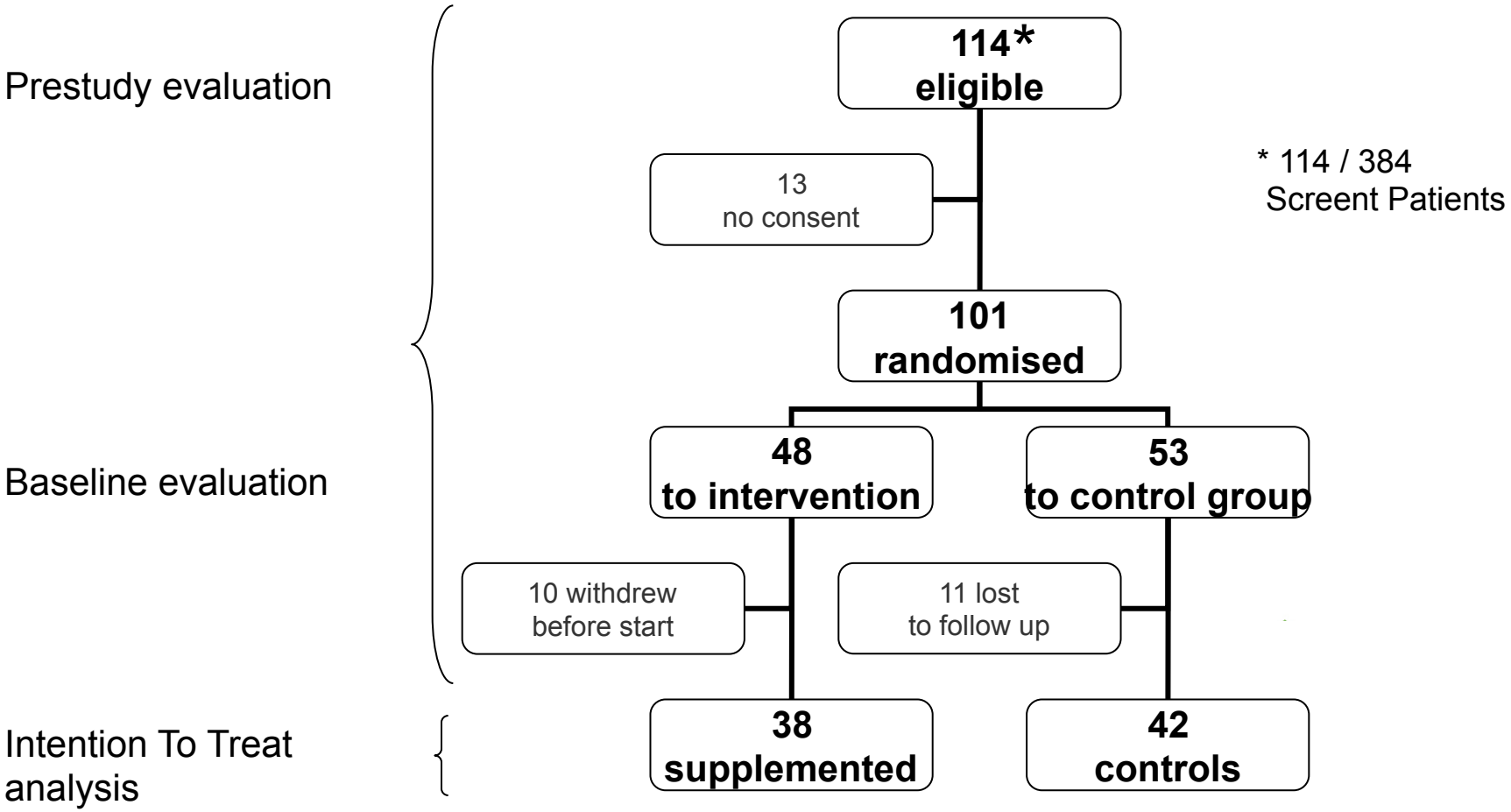
Optimal Nutritional Support

Hiesmayer M. Curr Opin Clin Nutr Metab Care 2012, 15:174 – 180



Nutritional Support in GI Patients

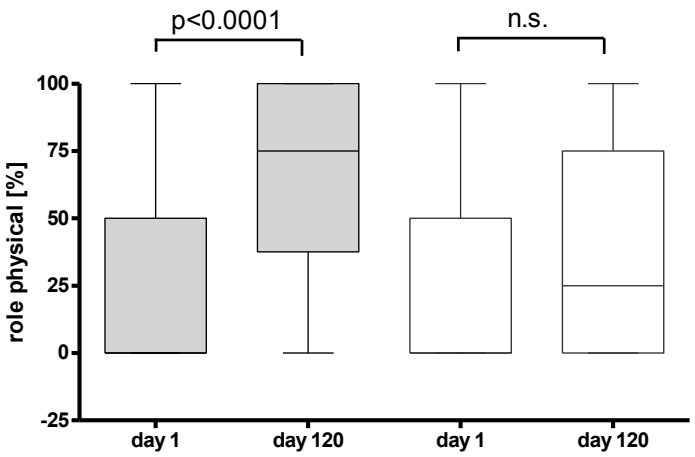
Normann et al. Clin Nutr. 2008 Feb;27(1):48-56.



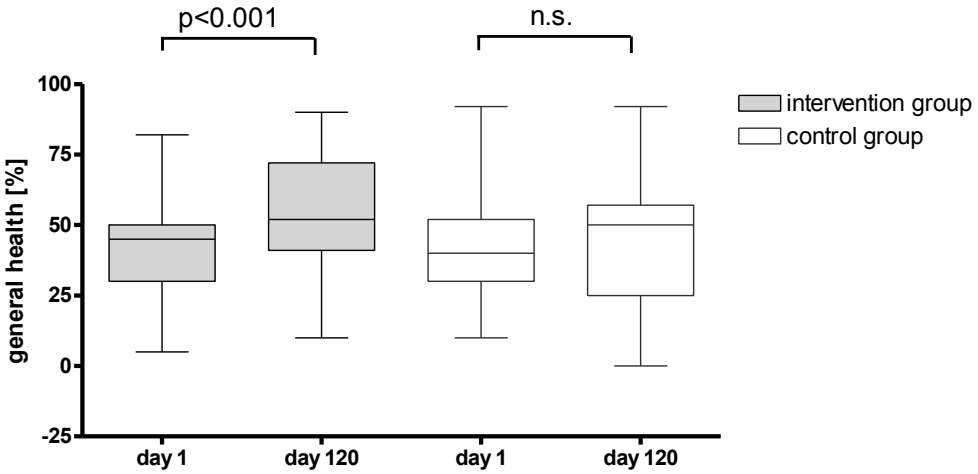
Nutritional Support in GI Patients

Normann et al. Clin Nutr. 2008 Feb;27(1):48-56.

Körperliche Aktivität



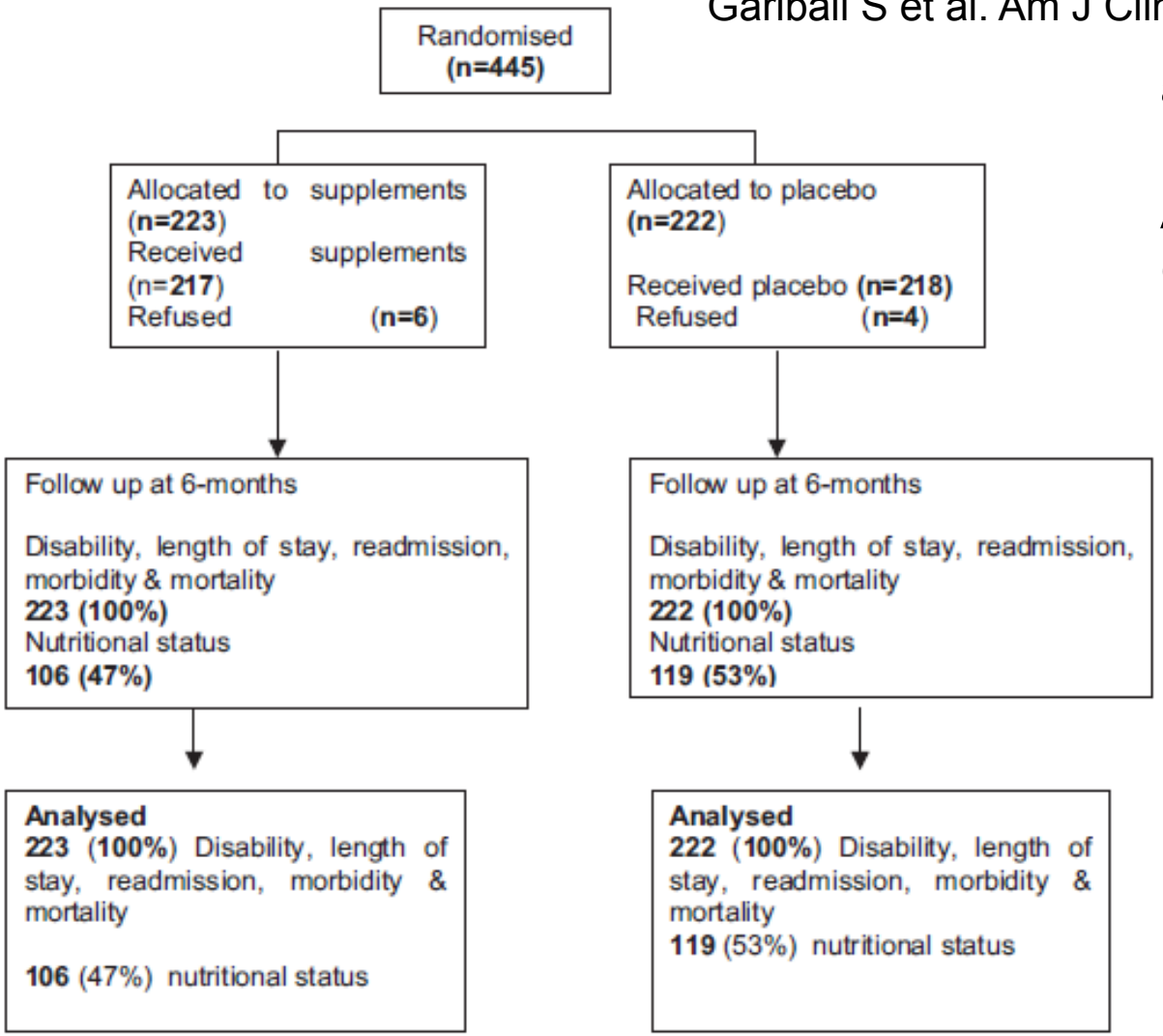
Allgemeinbefinden



Reduced re-admissionrate after 3 months
10/38 (26%) versus 20/43 (46%)

Routine Supplementation in acute-ill geriatic patients

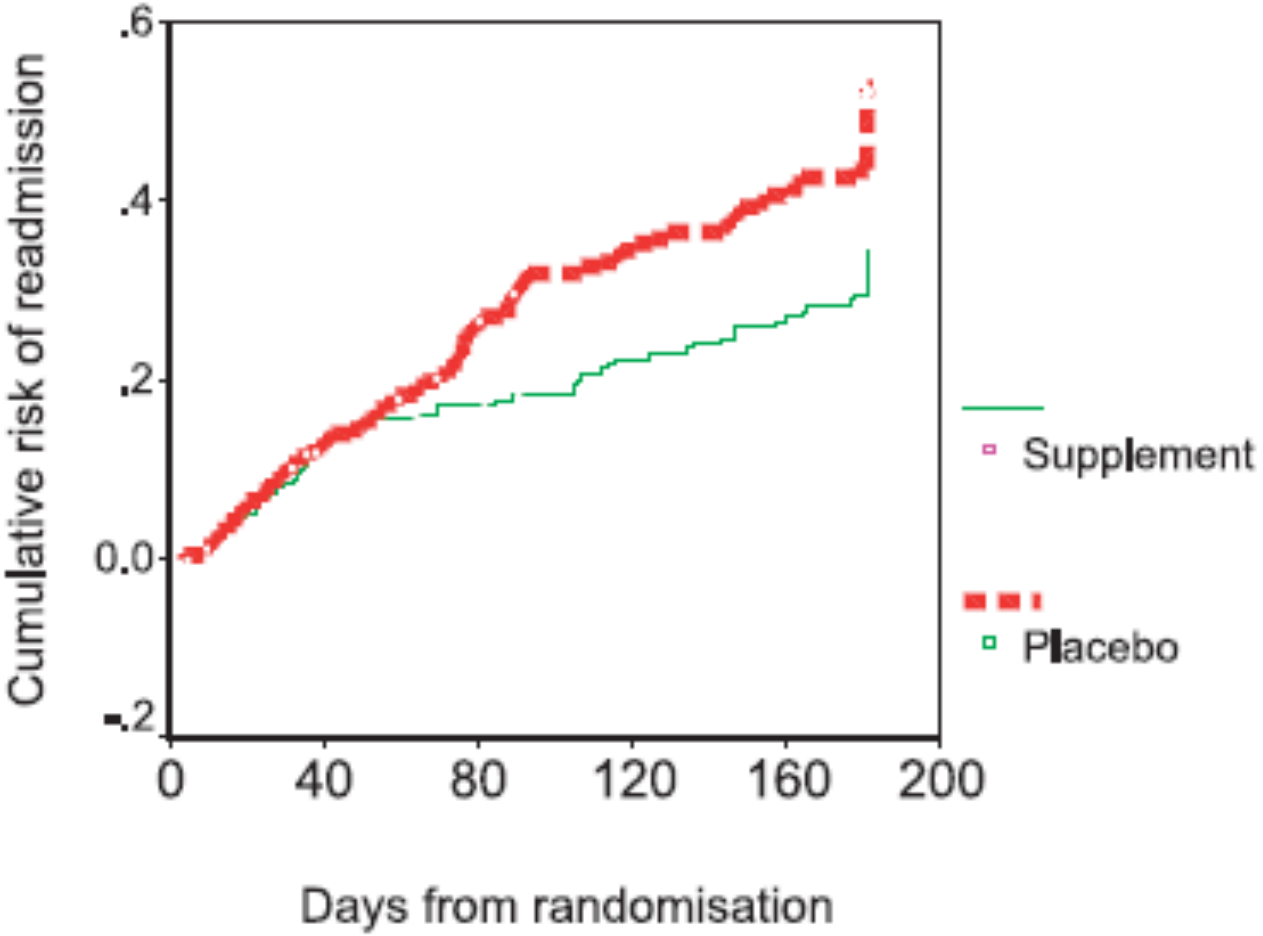
Gariball S et al. Am J Clin Nutr 2006;116:693



age	77 years
BMI	25 kg/m2
Albumine	37 g/l
CRP	50 mg/dl

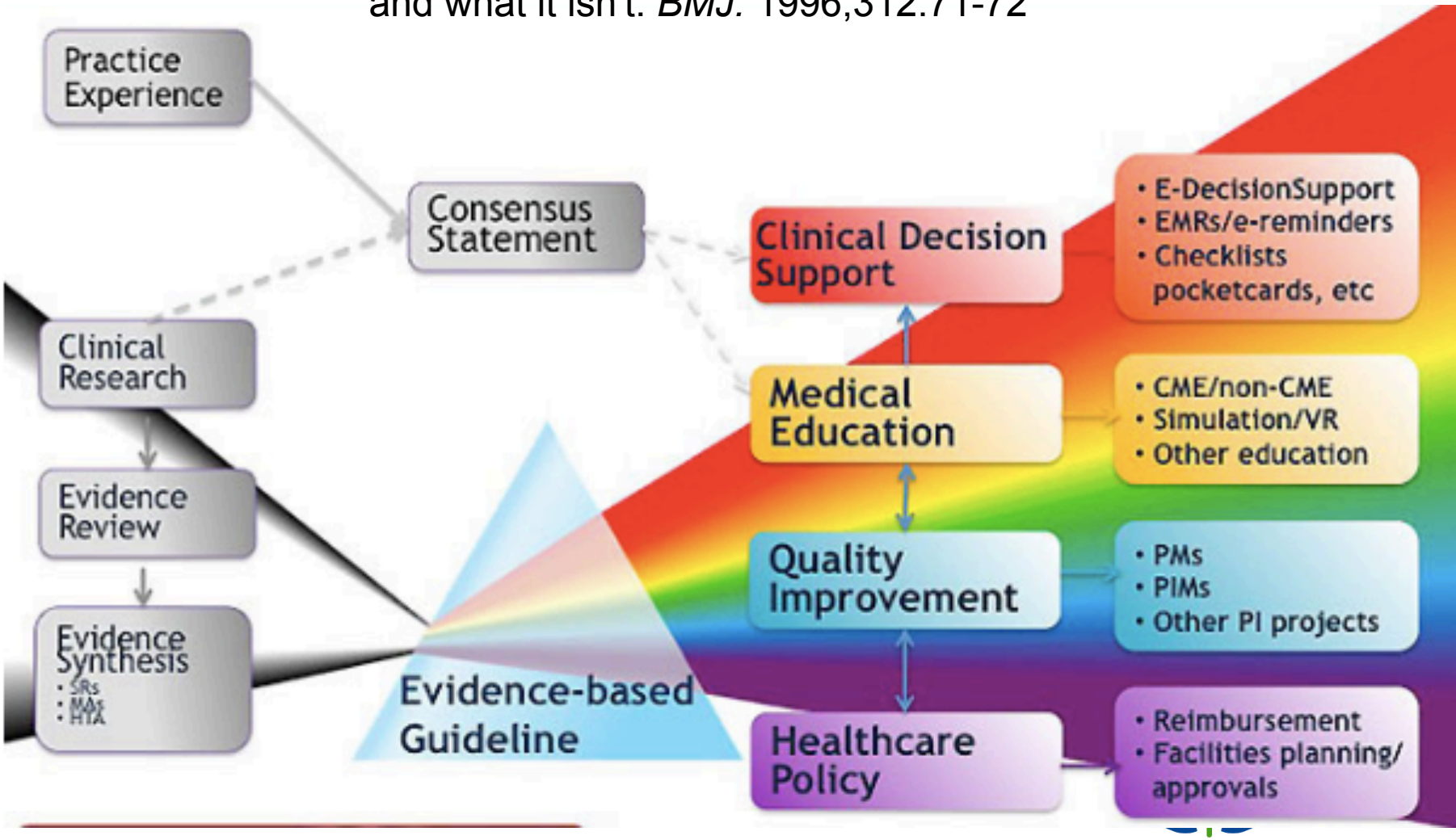
Re-Hospitalization Rate after 6 Months

Gariball S et al. Am J Clin Nutr 2006;116:693



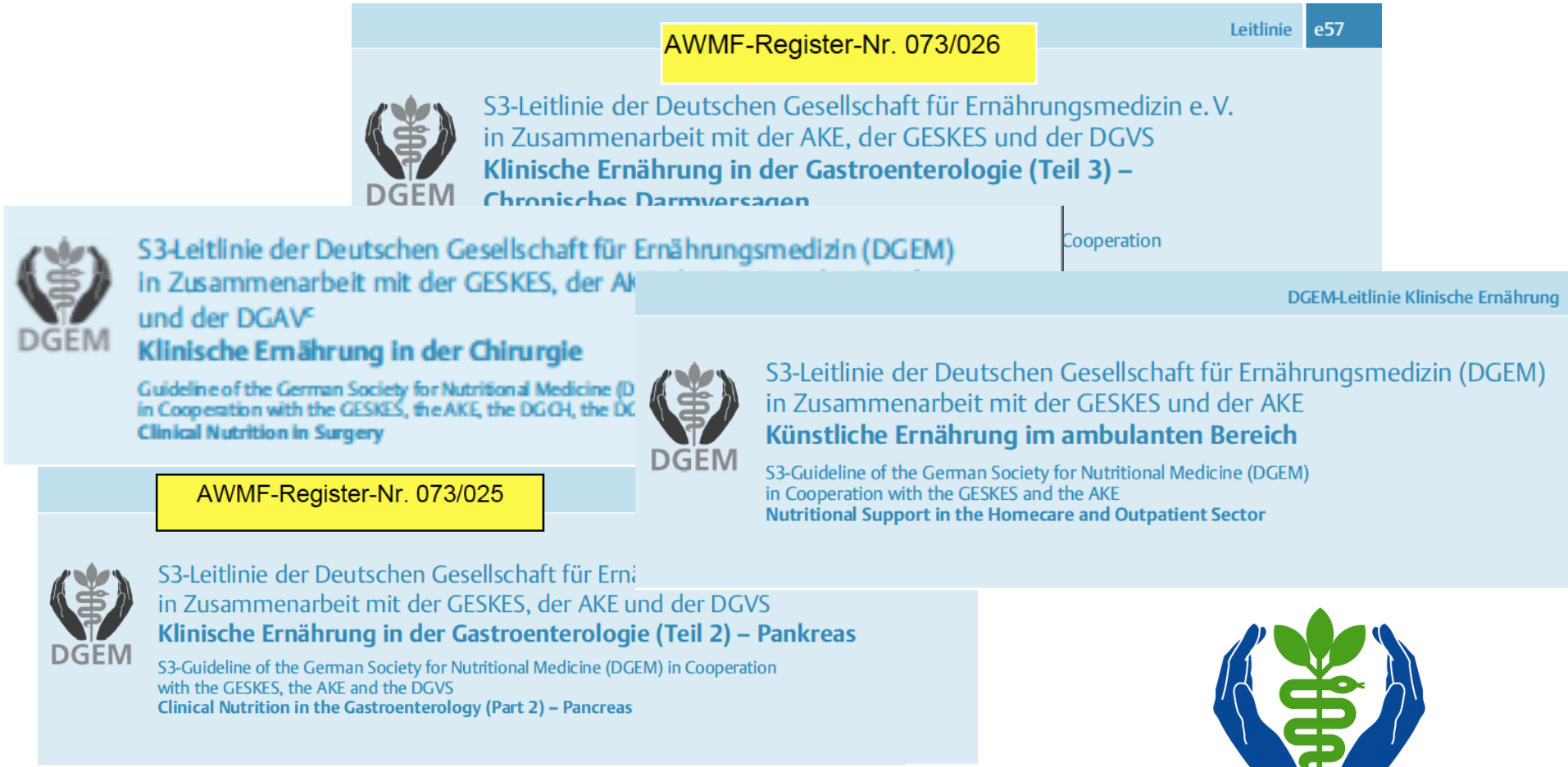
Evidence Based Medicine

Sackett DL et al. Evidence based medicine: what it is and what it isn't. *BMJ.* 1996;312:71-72



Evidenz für Ernährungstherapie
Leitlinienprogramm der DGEM

S3 Leitlinien für fast alle klinische Entitäten



DGEM Guideline Projects

1st round 2003 (Lochs)

- 10 (+ 3) Guidelines on EN
- Basis for ESPEN guidelines EN 2006

2nd round 2007 (Koletzko)

- 19 Guidelines on PN
- Basis for ESPEN guidelines PN 2009

3rd round 2013-15 (Bischoff)

- 12 (+3) EN/PN Combined guidelines on Clinical Nutrition

Why Guidelines ?

Compiling knowledge

Search for evidence

Instructions for practioneers

Awareness of relevance

Acceptance of Clinical Nutrition

Basis for Reimbursement

Availability of care

→ ONCA !

Guidelines – what do you need ?

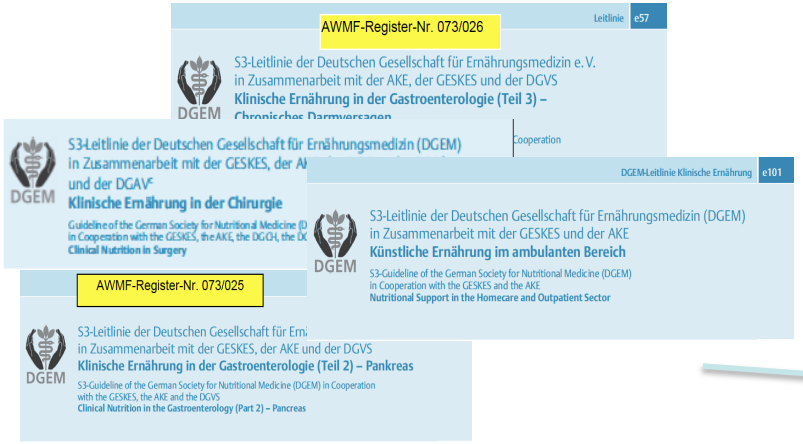
- Evidence (clinical trials)
- Highly motivated people (German Guidelines > 80 people)
- Straight Steering Group
- Methodologically support (AWMF)
- Financial support
- Transparency and Independence

ESPEN Clinical Guideline

- 1st Guideline round (2006-2009)
  - Based on German guidelines
- 2nd Guideline round (2010-2015)
  - Cystic fibrosis
  - Oncology
  - CIF
  - Dementia
- 3rd Guideline round (2015-2018)
  - New methodology
  - 12-15 new guidelines planed

Local acceptance ?

Developement of Quality Indicators



Why not following guidelines ?

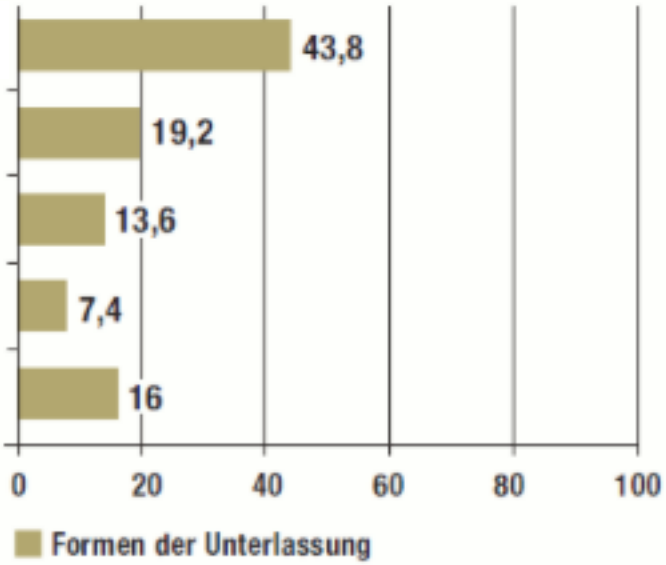
Recommendations not clear, conflicting.

Side effects of therapy

Alternative therapy, not in guideline

Different dosage

others



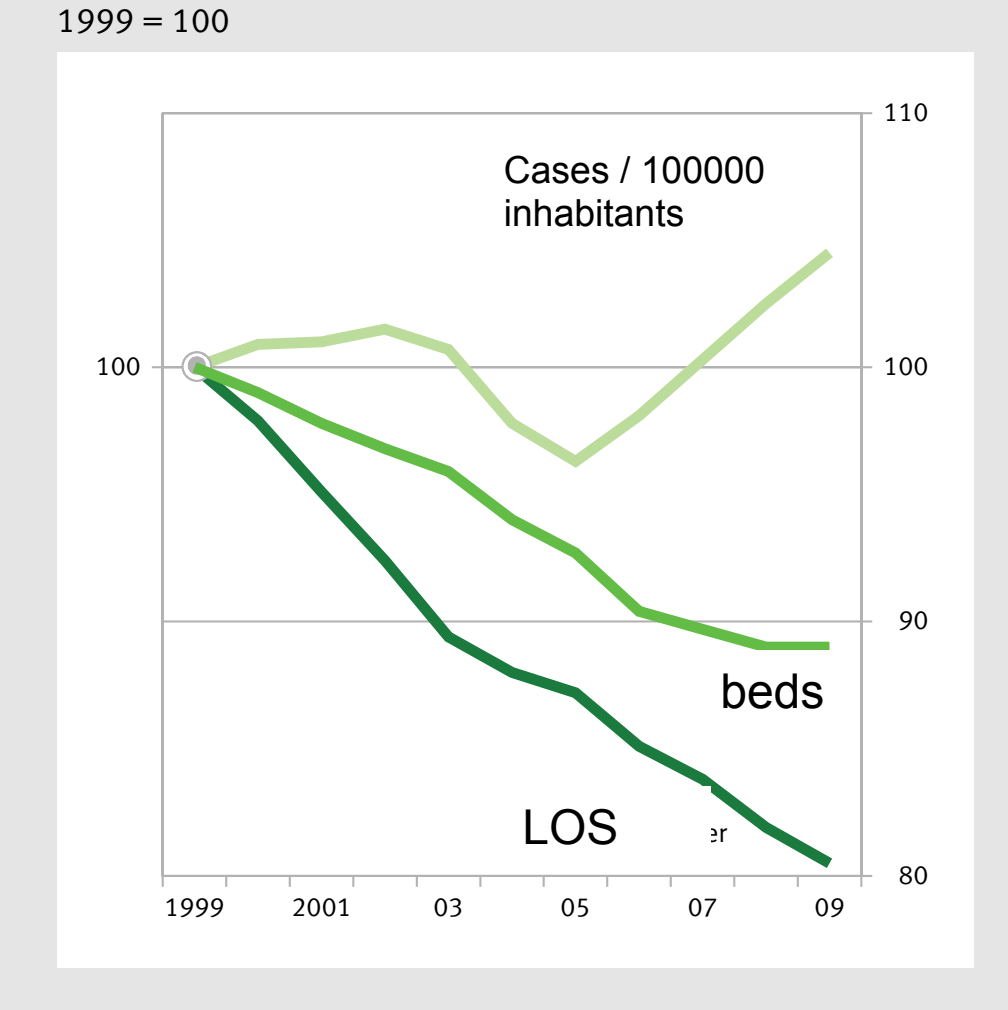
Basis: 4 162 Fälle

Keine Angabe: 19 Fälle

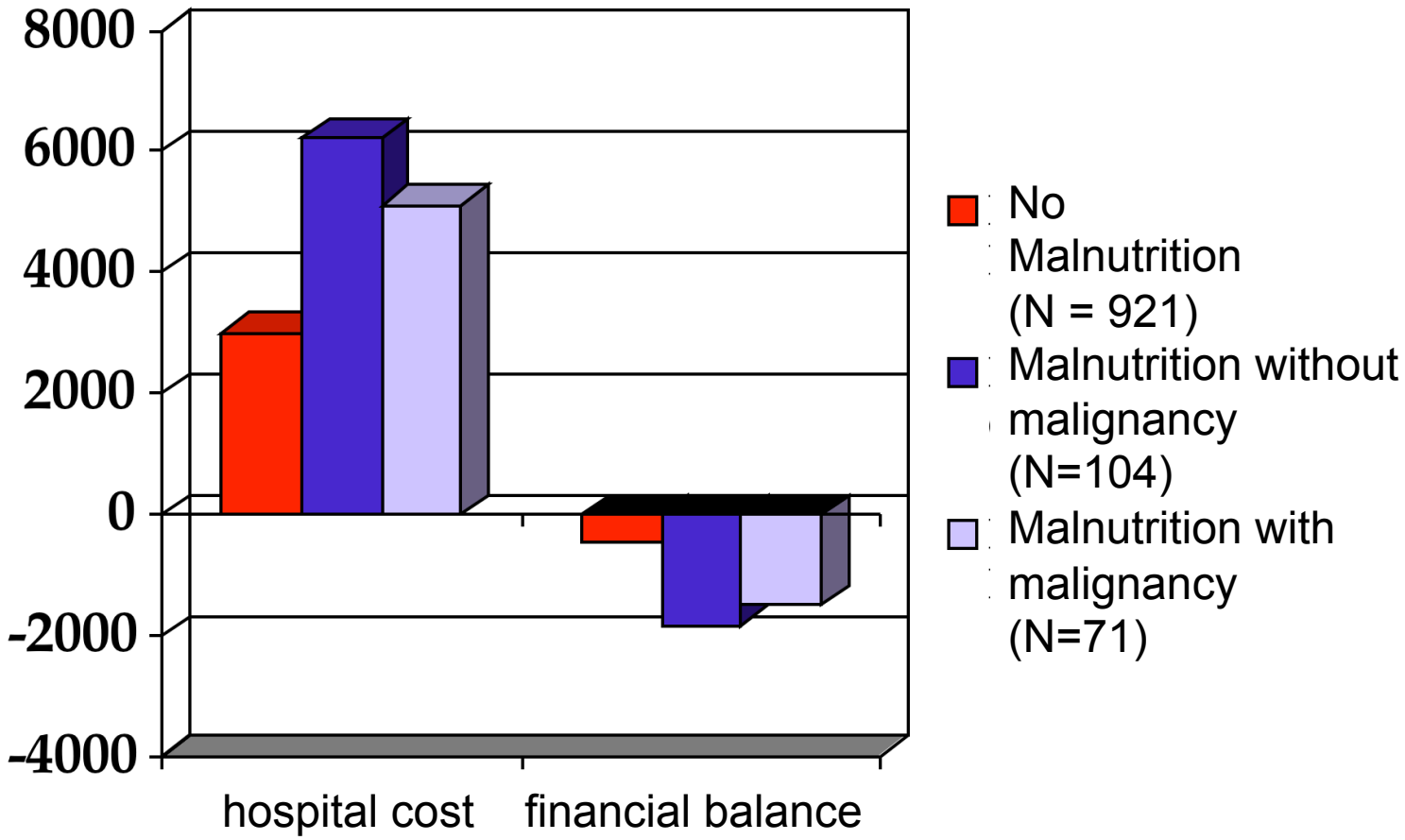
Choosing Wisely


1
EURO

Changes in the German Health Care System



Increased Risk for negativ Reimbursement Ratio with Malnutrition



Additional Cost for Nutritional Support in GI patientis

Ockenga J et al. Clin Nutrition 2006;

	Σ N	cost	total cost
counselling	116	x 6 €	696 €
inten. counselling	22	x 22 €	440 €
spec. diet	117	x 10 €	1740 €
sip feeding	309	x 2 €	618 €
enteral artific. nutrition	84	x 33 €	2772 €
TPN	58	x 69 €	4004 €

additional cost for nutritional support 10268 €

Total DRG reimbursement **142 000 € (7,3 %)**

Additional Cost for Nutritional Support in GI patientis

Ockenga J. et al. Clin Nutrition 2006

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Additional reimbursement according coding malnutrion/procedures 7869 €

World Health Organization

Endocrine, nutritional and metabolic diseases (E00-E90)

Malnutrition (E40-E46)

Note: The degree of malnutrition is usually measured in terms of weight, expressed in standard deviations from the mean of the relevant reference population. When one or more previous measurements are available, lack of weight gain in children, or evidence of weight loss in children or adults, is usually indicative of malnutrition. When only one measurement is available, the diagnosis is based on probabilities and is not definitive without other clinical or laboratory tests. In the exceptional circumstances that no measurement of weight is available, reliance should be placed on clinical evidence.

If an observed weight is below the mean value of the reference population, there is a high probability of severe malnutrition if there is an observed value situated 3 or more standard deviations below the mean value of the reference population; a high probability of moderate malnutrition for an observed value located between 2 and less than 3 standard deviations below this mean; and a high probability of mild malnutrition for an observed value located between 1 and less than 2 standard deviations below this mean.

Excludes: intestinal malabsorption (K90.-)
nutritional anaemias (D50-D53)
sequelae of protein-energy malnutrition (E64.0)
slim disease (B22.2)
starvation (T73.0)

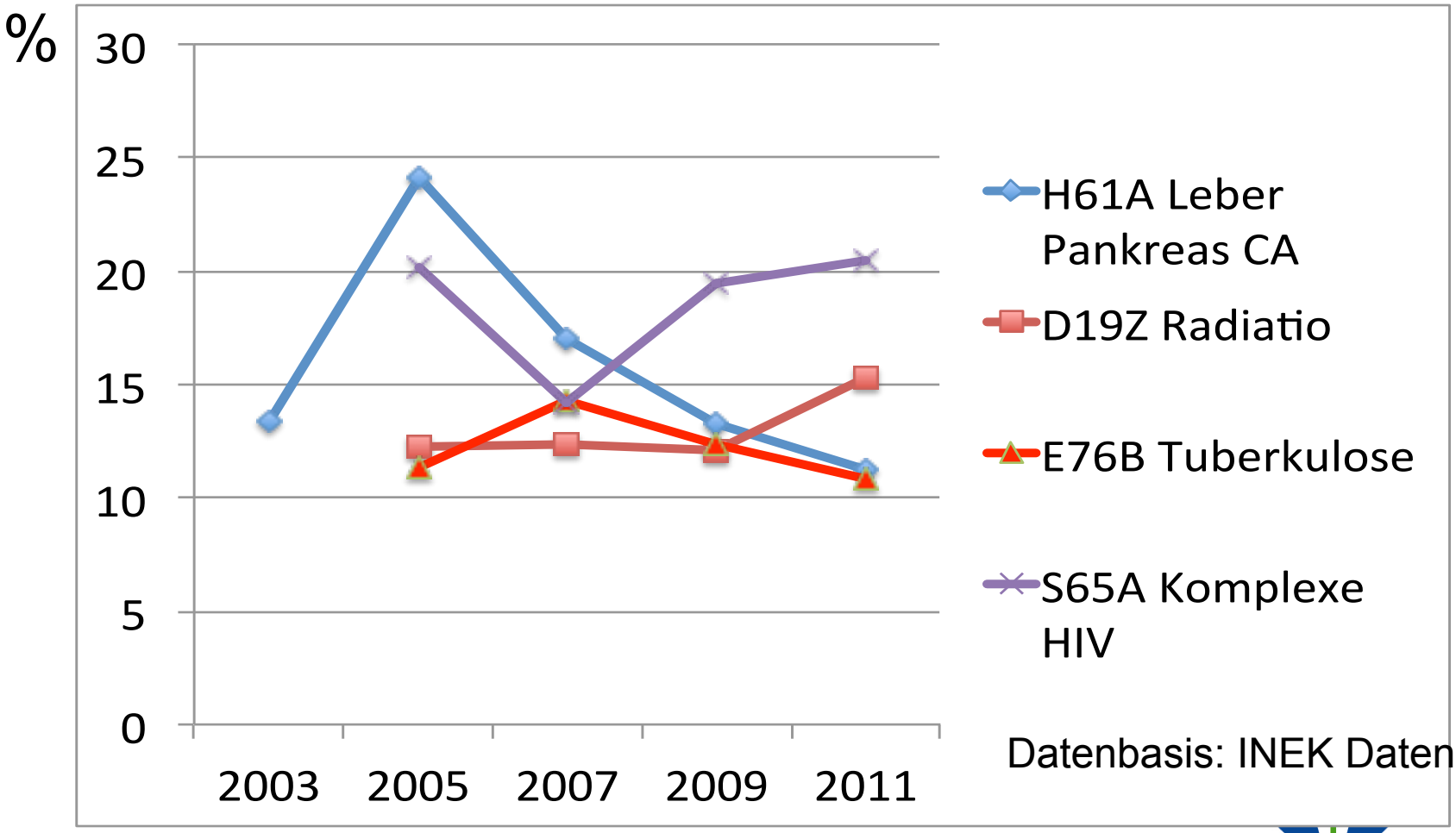
BMI-Categorie for Classification of Malnutrition according ICD-10

due to the German National Survey NVS II

example:
Male 40 Jahre
height 175 cm
weight: 45 kg

Männer					
Altersklasse	BMI		**E43**	**E44.0**	**E44.1**
	MW	SD	**- 3SD**	**- 2SD**	**- 1SD**
18-19	23,8	4,9	<9,1	<14,0	<18,9
20-29	24,7	4,1	<12,4	<16,5	<20,6
30-39	26,1	3,9	<14,4	<18,3	<22,2
40-49	27,2	4,2	<14,6	<18,8	<23,0
50-59	28,0	4,3	<15,1	<19,4	<23,7
60-69	28,6	4,2	<16,0	<20,2	<24,4
70-80	28,4	3,8	<17,0	<20,8	<24,6
Gesamt	26,9	4,6	<13,1	<17,7	<22,3

Heterogenity of Coding R64A Cachexia in different diseases: 2003 - 2011



Costeffectiveness of treating malnutrition

Norman K. et al. Eur J Clin Nutrition 2011; 65: 735-742.

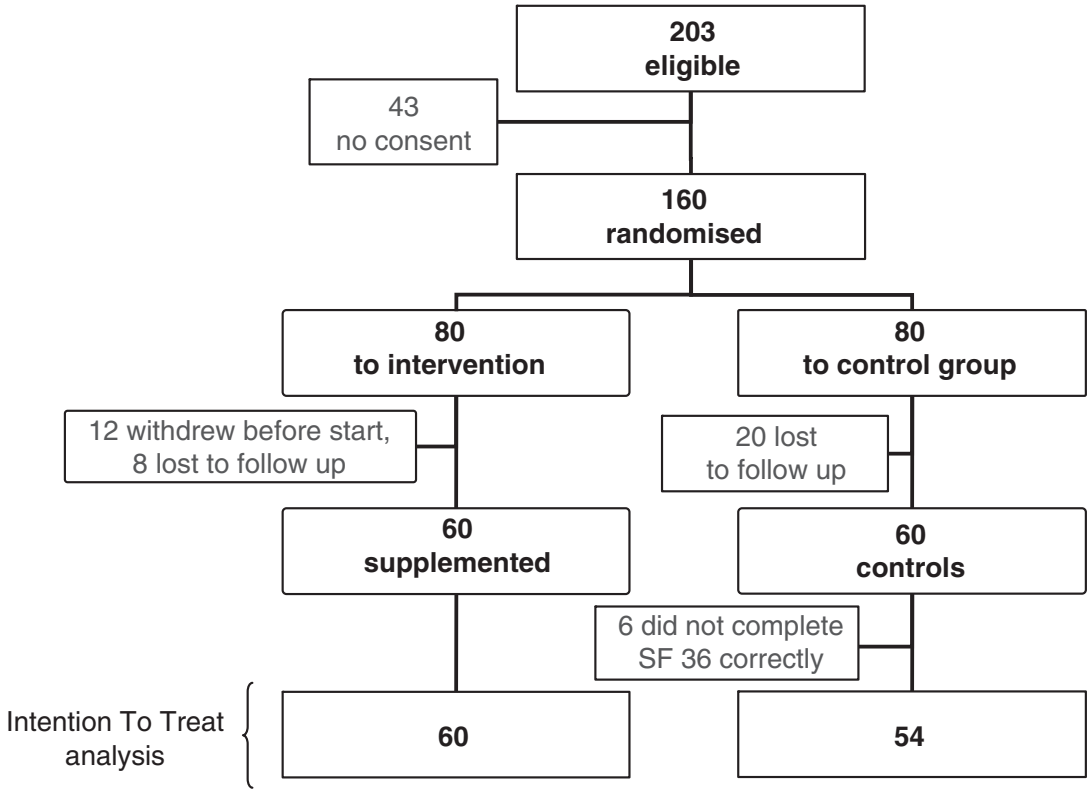
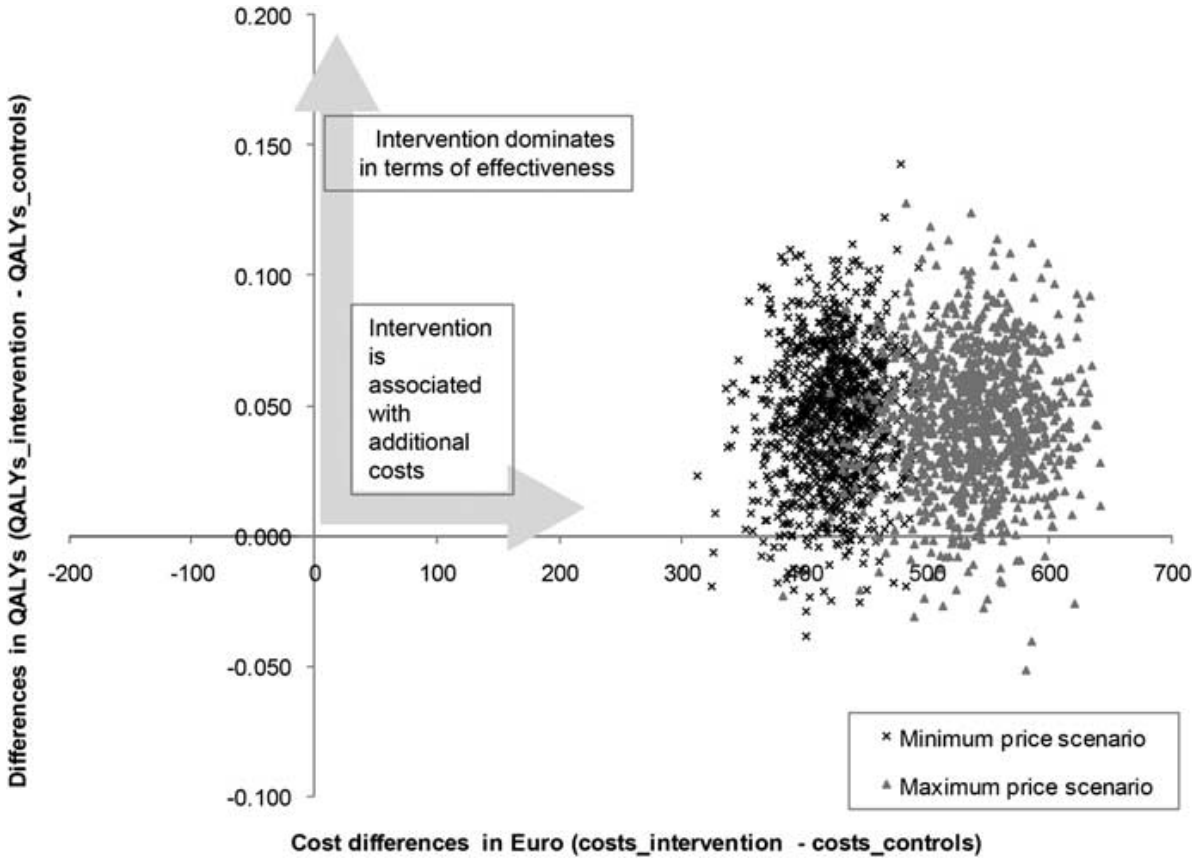


Figure 1 Trial diagram of patients from inclusion to analysis.

Costeffectiveness of treating malnutrition

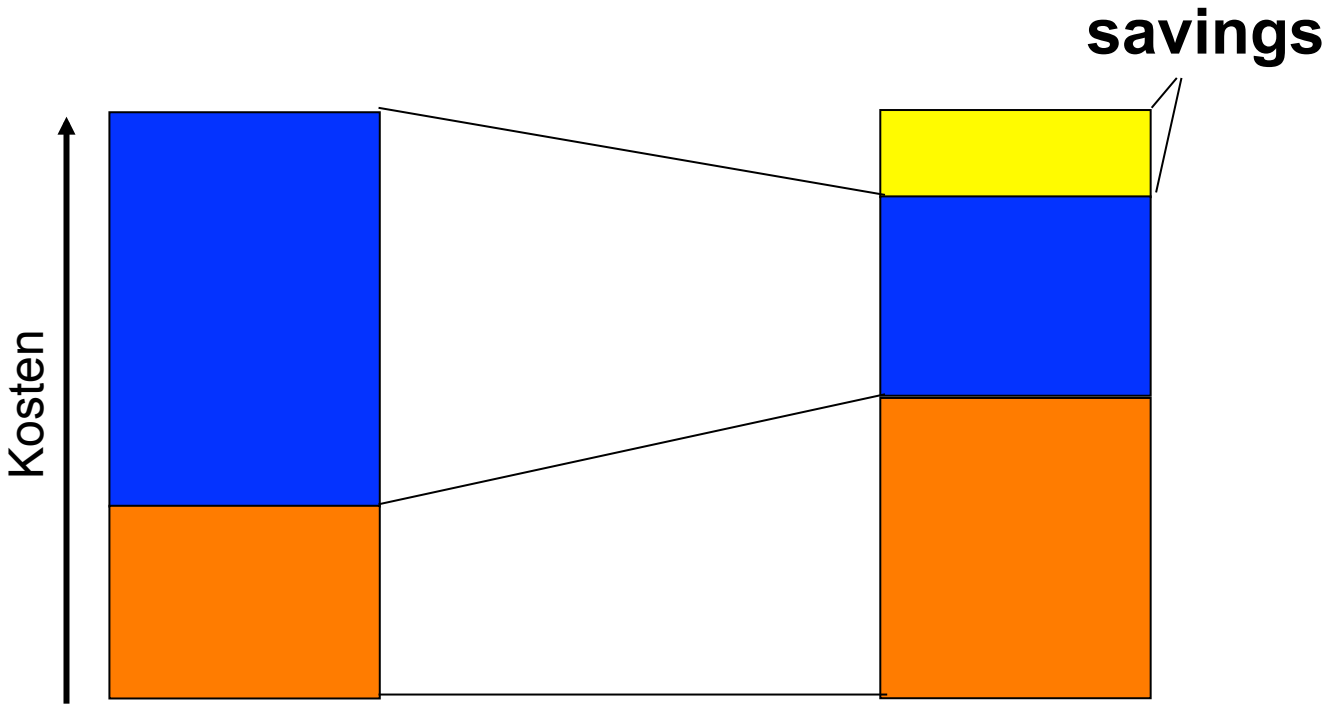
Norman K. et al. Eur J Clin Nutrition 2011; 65: 735-742.



Mean cost
Minimum: 440 €
Maximum: 562 €

ICR
Minimum: 9467 €
Maximum: 12099 €
(per addit. QUALY)

Combinened Effect
Hospital - Ambulatory Care



Expert Standard Nutritional Support for Nursery Staff

Deutscher Pflegerat e.V.
Bundesarbeitsgemeinschaft Pflege- und Hebammenwesen

Präsidium
Salzufer 6
10587 Berlin

08.10.2008

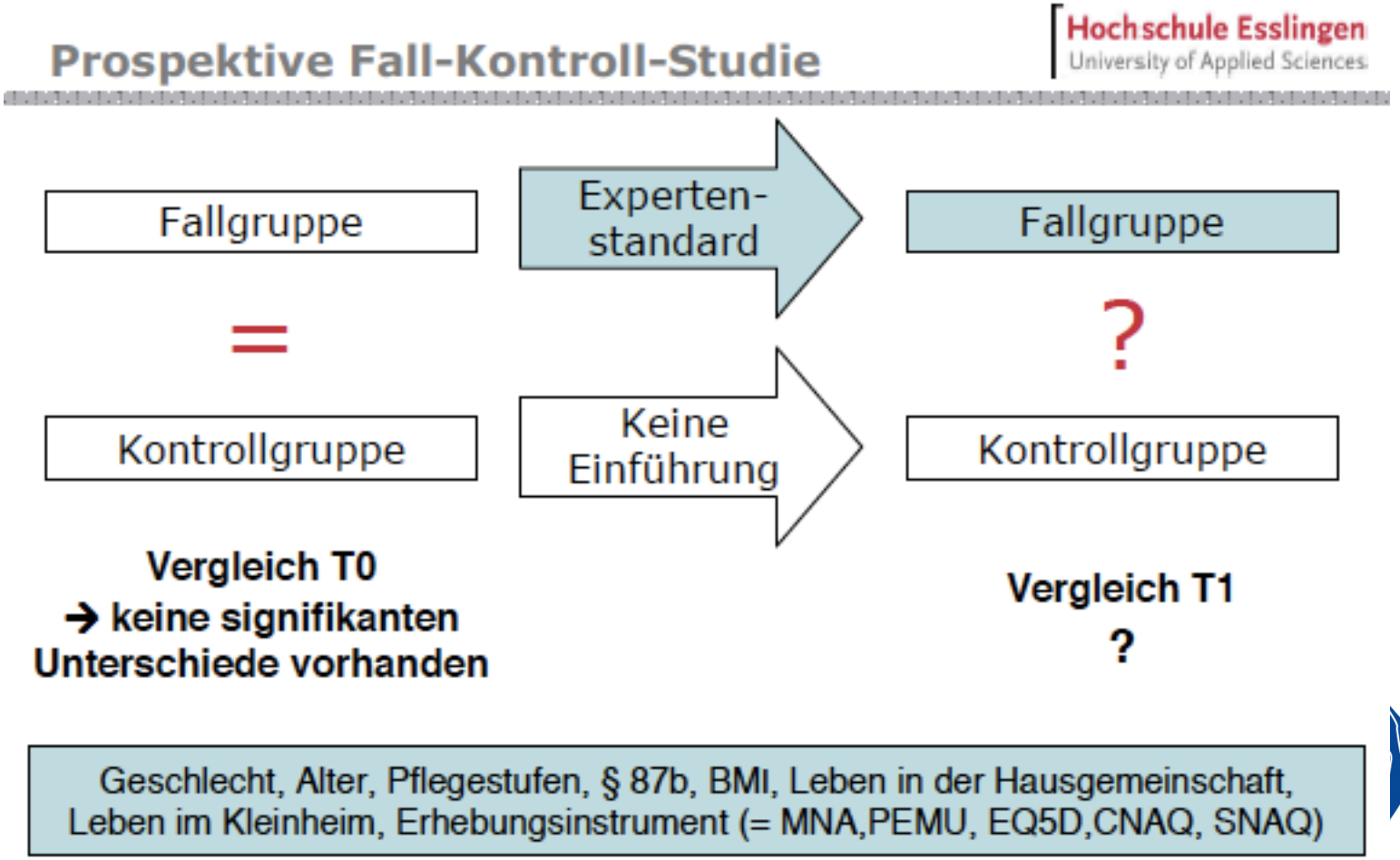
7. Konsensuskonferenz des Deutschen Netzwerk für Qualitätsentwicklung in der Pflege (DNQP)

„Ernährungsmanagement zur Sicherstellung und Förderung der oralen Ernährung in der Pflege“

Erklärung des Deutschen Pflegerats an die 700 Teilnehmerinnen und Teilnehmer der Konsensuskonferenz am 08.10.2008 in Osnabrück

Expert Standard Nutritional Management

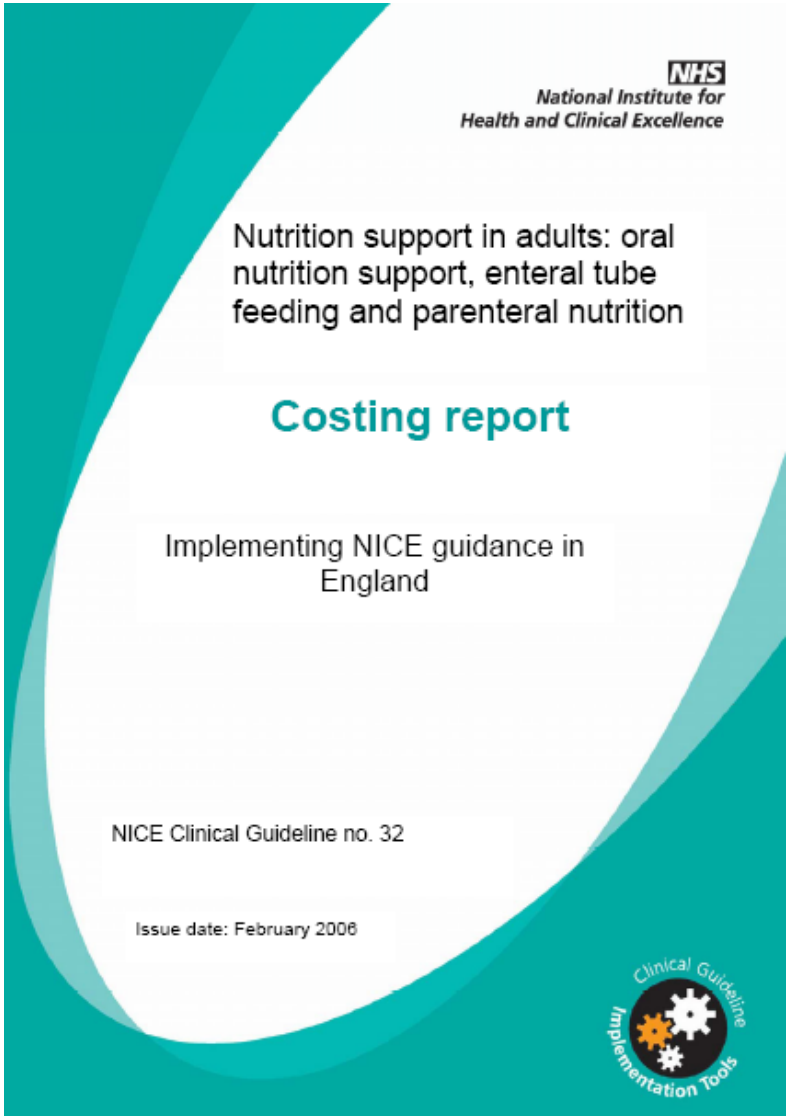
EVE, Prof. Wolke Fachhochschule Esslingen persönl. Mitteilung



Expert Standard Nutritional Management: Benefit and Cost

- less patients ‚at risk' for malnutrition
- better Quality of Life (EQ-5D visuell analog scale)
- less drops

- per institution cost of 11.127 Euro for implementation
- yearly cost of 7265 – 10 540 € per institution


NHS
National Institute for
Health and Clinical Excellence
Nutrition support in adults: oral nutrition support, enteral tube feeding and parenteral nutrition
Costing report
Implementing NICE guidance in England
NICE Clinical Guideline no. 32
Issue date: February 2006
Clinical Guideline
Implementation Tools

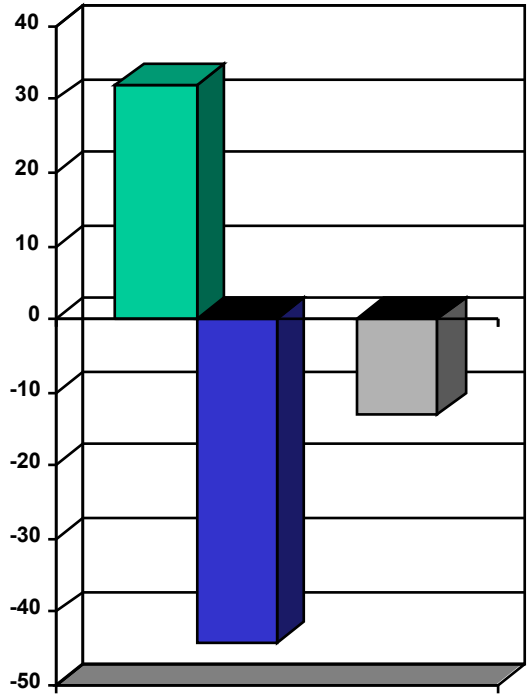
NICE – Implementation of Nutrional Support

GESUNDHEIT NORD
KLINIKUM BREMEN-MITTE

Summary of annual revenue changes

Recommendations with significant resource impact	Annual cost £000
Screening for malnutrition	12,264
Nutritional assessment of malnourished patients	4,618
Nutrition interventions	13,113
Total cost for screening, assessment and treatment	**29,995**
Additional specialist nutrition support nurses	2,218
Total annual additional cost of implementation	**32,213**
Reduced inpatient length of stay	−44,842
Reduced GP visits	−83
Reduced outpatient attendances	−60
Reduced admissions	−479
Total potential annual saving	**−45,464**
Total annual net saving	**−13,251**

Cost per year [Mill.£]



National Institute for Health and Clinical Excellence, UK; No. 32

Cost effectiveness (QALY) for Screening and Nutritional Support

GESUNDHEIT NORD
KLINIKUM BREMEN-MITTE

Table 9: Cost-effectiveness (cost per QALY gained) of screening inpatients, by malnutrition risk and baseline mortality

Patients at moderate or high malnutrition risk	All-cause mortality in 60 days from admission						
	1.0%	1.5%	2.0%	2.5%	3.0%	3.5%	4.0%
1%	65,300	44,400	33,900	27,600	23,400	20,400	18,200
2%	37,800	26,000	20,000	16,500	14,100	12,500	11,200
3%	28,600	19,800	15,400	12,800	11,100	9,800	8,900
4%	24,000	16,800	13,100	11,000	9,500	8,500	7,700
5%	21,200	14,900	11,700	9,800	8,600	7,700	7,000
6%	19,400	13,700	10,800	9,100	8,000	7,100	6,500
7%	18,100	12,800	10,200	8,600	7,500	6,800	6,200
8%	17,100	12,200	9,700	8,200	7,200	6,500	6,000

International Benchmark < 50.000 €/QUALY

NHS
National Institute for Health and Clinical Excellence
www.nice.org.uk/CG032

Published by the National Collaborating Centre for Acute Care at The Royal College of Surgeons of England, 35-43 Lincoln's Inn Fields, London, WC2A 3PE

Economic Effect (Modell) of oral Nutritional Support in Visceral Surgery in the Netherland

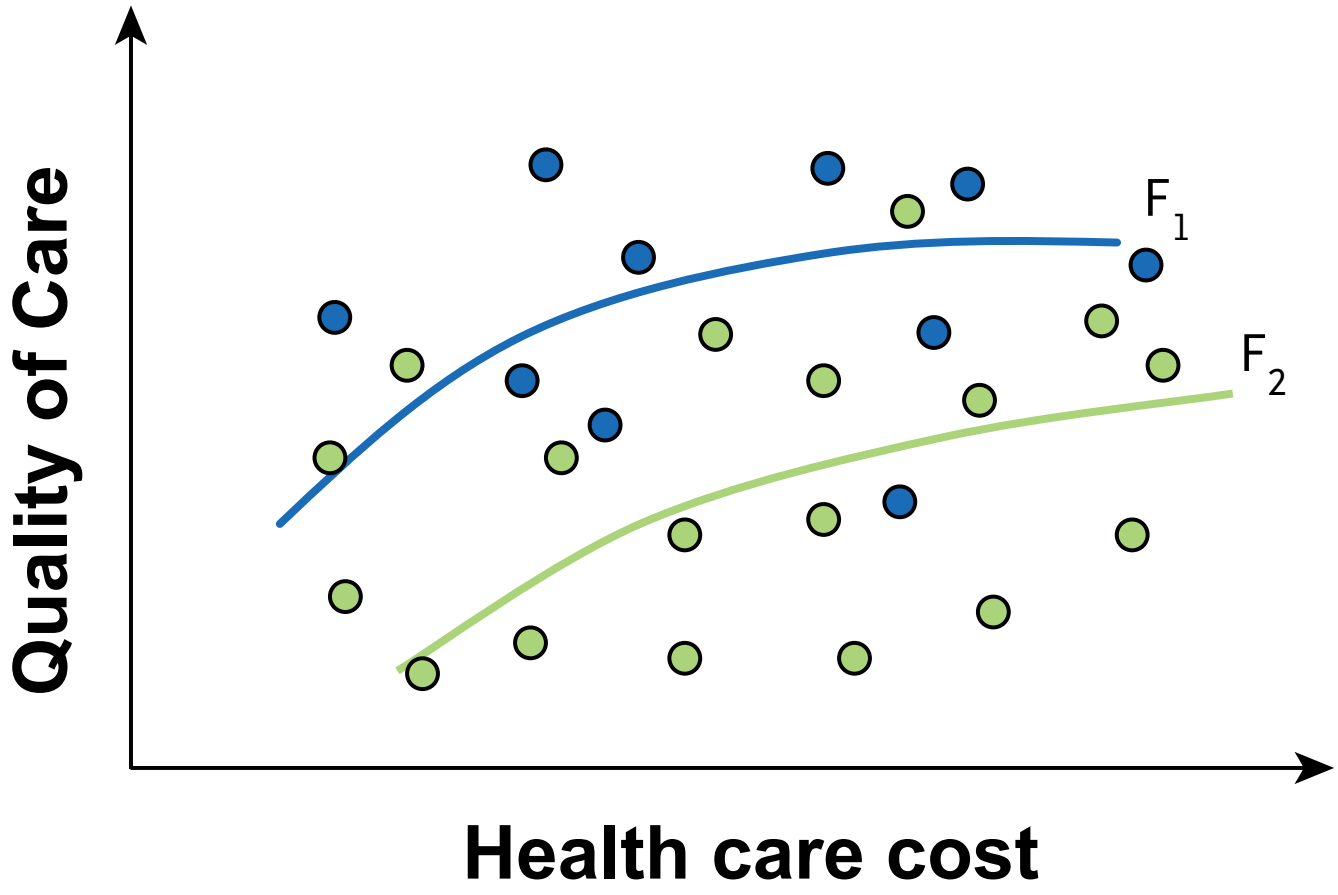
GESUNDHEIT NORD
KLINIKUM BREMEN-MITTE

Freijer K et al. European Journal of Clinical Nutrition **64**, 1229-1234

Hospital cost without nutrition	3318€	
with nutrition	3044€	-8,3%
Total saving per patient	252€	-7.6%
Netherland	min. 40 Mill € / Jahr	

‚Effectiveness‘

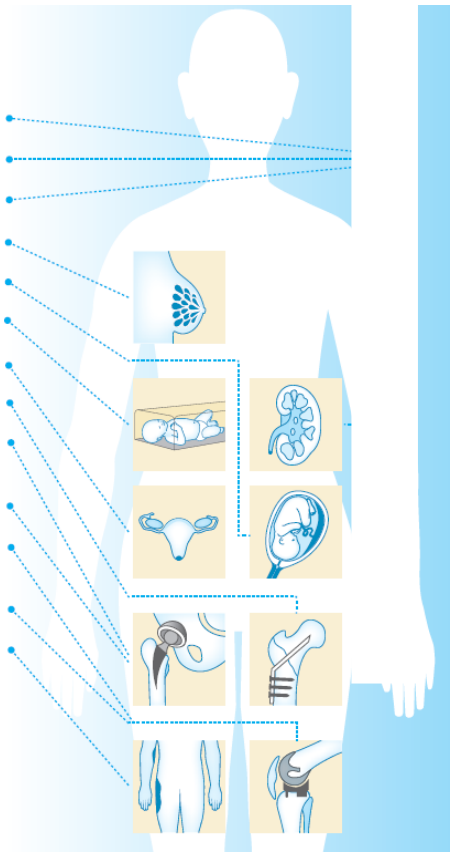
Weinstock et al. NEJM 2010

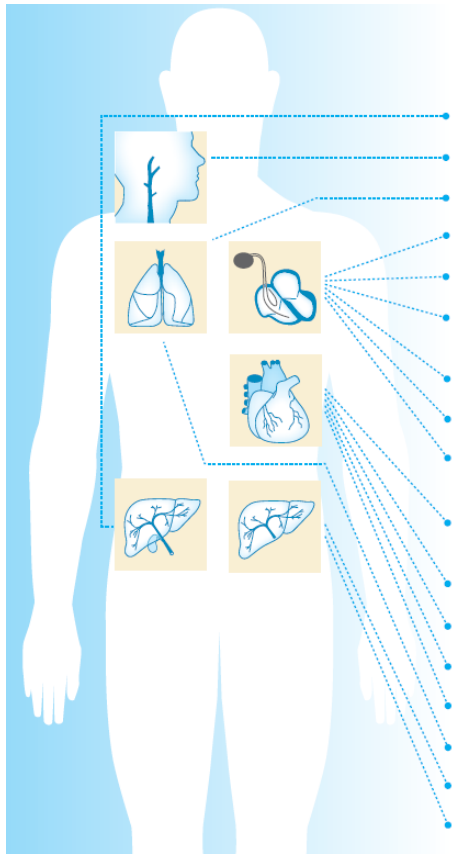


Quality in Medicine
– a German Approach -

GESUNDHEIT NORD
KLINIKUM BREMEN-MITTE

- Nierentransplantation
- Nierenlebendspende
- Pankreas- und Pankreas-Nierentransplantation
- Mammachirurgie
- Geburtshilfe
- Neonatologie
- Gynäkologische Operationen
- Hüftgelenknahe Femurfraktur
- Hüft-Endoprothesen: Erstimplantation
- Hüft-Endoprothesen: Wechsel und Komponentenwechsel
- Knie-Totalendoprothesen: Erstimplantation
- Knie-Endoprothesen: Wechsel und Komponentenwechsel
- Pflege: Dekubitusprophylaxe





- Cholezystektomie
- Karotis-Rekonstruktion
- Ambulant erworbene Pneumonie
- Herzschrittmacher: Implantation
- Herzschrittmacher: Aggregatwechsel
- Herzschrittmacher: Revision/Systemwechsel/Explantation
- Implantierbare Defibrillatoren: Implantation
- Implantierbare Defibrillatoren: Aggregatwechsel
- Implantierbare Defibrillatoren: Revision/Systemwechsel/Explantation
- Koronarangiographie und Perkutane Koronarintervention (PCI)
- Koronarchirurgie, isoliert
- Aortenklappenchirurgie, isoliert
- Kombinierte Koronar- und Aortenklappenchirurgie
- Herztransplantation
- Lungen- und Herz-Lungentransplantation
- Lebertransplantation
- Leberlebendspende

Auf Qualitätsindikatoren gestützte Qualitätssicherung (BQS)

Proposal for Linking Quality to DRG

	Patient-based	DRG/ disease-based (all cases with same DRG/ diagnosis)	Hospital-based (all cases within hospital)
Indication Quality	No payment if no indication	Deduction per DRG and share on case without indication; no payment if minimum quantity for specific treatments is not reached	
Structural Quality	Unverified procedure codes are neglected by grouping algorithm	Certain DRGs are not billable if specific structures are not in place (e.g. Stroke Unit)	Budget deduction if structural deviation from hospital plan
Process Quality	Hospital acquired infections are neglected by grouping algorithm	„Best practice" DRG-weights if costs for better quality are proven to be higher	
Outcome	Payment rules for unplanned readmissions	Surcharge for significant above average quality	
Reporting of Quality	No payment if quality data is not available	Deductions if quality data is not available for numerous cases	Base rate deduction if quality data is wrong or incomplete

According to Prof Busse, TU Berlin

Structure Quality in Clinical Nutrition

Schindler K et al. (2010) Clin Nutr 29:552-9

Quality indicator:
Giving additional sip feeding to patients at risk

	OR [95% CI]	p
• **Dietitians on the ward**	**1.9** [1.2; 3.2]	0.0125
• **Nutrition Team**	**1.5** [1.1; 2.1]	0.015
• **Screening-Routine**	**1.9** [1.4; 2.6]	< 0.0001

nDay 2007-2008 n=21.007

Determing Structur and Process Quality in Clinical Nutrition

Implementation of Nutrition Recommendations

- In Clinical Guidelines
  - DGVS guideline esohagus carcinoma
  - DGVS guideline stomach cancer
  - DGVS guideline pancreatic disease

- General hospital Certification systems (e.g. Screening in Joint commission)
- Disease specific certification systems or guidelines
  - OnkoZert – comprehensive cancer center

Still Problems in Germany ...

Clinical Nutrition

- is a relativ new subdivision in medicine
- is a cross section division affecting many subdi
- is not an subdisciplin(no own medical spe
- has different players in clinical routi
  - dietitians
  - physicians
  - nutritionist (acad
- is not well e d in the reimbursement system (DRG C
- is ity not the underlying main disease but an i t side problem in a patients career
- is often not recognized as prognostic relevant (awareness for morbity & mortality)

Time for more action ....!

MEMBERS

ACTIVITIES:

The Optimal Nutritional Care for All (ONCA) campaign

Launched in 2014, the Optimal Nutritional Care for All (ONCA) campaign is a multi-stakeholder initiative to facilitate greater screening for risk of disease-related malnutrition/undernutrition and nutritional care implementation across Europe. ENHA is the driving force behind the campaign, and has appointed a Steering Committee from its membership to lead the initiative through strategic guidance and engagement with partners at national level. The Steering Committee is made up of representatives from ESPEN, EUGMS, ESPEN, PGEU, HOPE, EFAD, EGAN and MNI.

Why was the campaign launched?

Up to 2010, ENHA worked extensively with members of the European Parliament and other stakeholders to organise political support to get disease-related malnutrition/undernutrition on the European health agenda. At a conference organised in November 2010 together with European Parliament members and the Belgian EU Presidency, one of the conclusions was to translate political support into action in the form of implementation at national level. Since 2011, ENHA developed collaborations with selected countries including Belgium and Ireland to engage in this implementation process. Several countries in Europe are now making progress in various ways towards improving nutritional care. ENHA felt that the time is right to speed up the process to make sure that all patients in Europe receive optimal nutritional care.

What are the key steps in the campaign?

The ONCA campaign aims to engage with diverse stakeholders in selected focus countries to:

- Encourage them to form/strengthen a national alliance of stakeholders and develop national nutritional care plans
- Facilitate these stakeholders to benchmark current status in order to develop an aligned view on the current state of play with respect to nutritional care in a given country
- Bring these stakeholders together at Implementation Conferences in **Brussels** and **Berlin**.
- **Bring these stakeholders together at a Workshop in Dubrovnik, Croatia on the 17 April 2015**
- Use these events to define and reconfirm the nutritional care strategies for subsequent

IN THIS SECTION:

VDD

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DGEM

Stephan Bischoff

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VDOE

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Erhard Hackler

BDEM

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Rainer Wirth

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Krebsgesellschaft

Jutta Hübner

The European Nutrition for Health Alliance

Bundesverband der Hersteller von Lebensmitteln für eine besondere Ernährung e.V.

diätverband

Norbert Pahne

Dagmar Dehler

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Goals & KPIs

Brüssel meeting 2014

MALNUTRION MUST BE IDENTIFIED THROUGH SYSTEMATIC SCREENING

- Definiton of appropriate screening tools (NRS2002 for hospitals, MUST for out-patients, NMS for elderly?)
- Screening as a mandatory step for coding and reimbursement
- Mandatory inclusion of nutrition assessment tools in quality management systems (e.g. ISO etc.)

MALNOURISHED INDIVIDUALS AND THOSE AT RISK OF MALNUTRITION MUST HAVE APPROPRIATE CARE PATHWAYS

- Care pathways documented and guideline-based (SOP)
- Documentation of nutrition care in hospitals (DRG) and in private practice (lack of tools at present)

FRONTLINE STAFF IN ALL CARE SETTINGS MUST RECEIVE ADEQUATE TRAINING ON THE IMPORTANCE OF GOOD NUTRITIONAL CARE

- Implemention of clinical nutrition in education (physicians, nurses etc.)
- Education for RNs (DNPQ-bases courses)
- Education for physicians ("Curriculum Ernährungsmedizin")
- LL and short LLL like education
- Toolbox (incl. New media) instakkation for education an teaching
- Teaching the chefs and the staff of the hospital kitchens

ORGANZATIONS MUST HAVE MANAGEMENT STRUCTURES IN PLACE TO ENSURE BEST NUTRITIONAL PRACTICE

- Define respnsible nutrition specialist in hospitals and other medical institutions
- Enhance percentage of NST and specialized professionals in larger institutions
- Define areas of responsibility of such specialists and NST
- Define SOP for discharge procedures
- Introducing a certification system for optimal nutritional care

PREVENTION OF MALNUTRITION / PUBLIC AWARENESS

- Representative questionsnaires among professional groups and in the general population about malnutrition knowledge
- Coordinated PR activity
- Participation in Nutrition day

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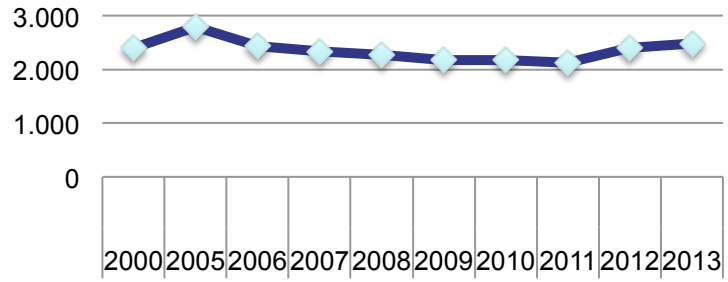
Goals & KPIs

Brüssel meeting identifying:
➢ 16 potential KPIs

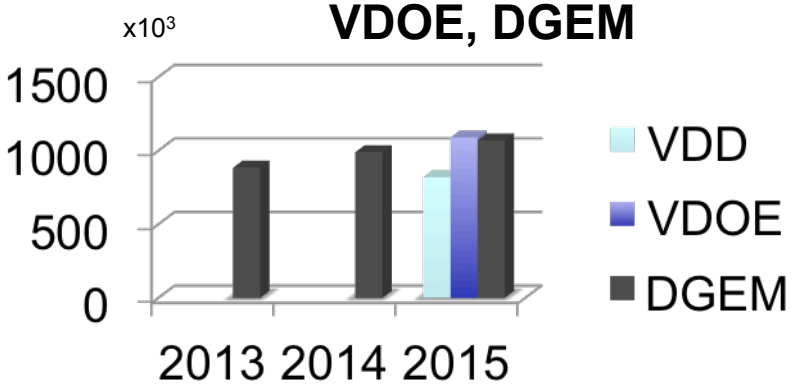
4 KPIs could be operated:

- Number of patients diagnosed with malnutrition according to ICD-10 GM (Bundesamt Statistik)
- Number of clicks at websites (DGEM, VDD, VDOe)
- Number of national SOP or guidelines on nutrition
- Count prevalence of malnutrion in representative target Groups (via Nutr. day)

Number* of ICD-10 GM Codes E40-46



Internet visit VDD, VDOE, DGEM



- 15 DGEM guidelines
- VDD SOP‘s

Nutrition day
- 53 units

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*http://www.gbe-bund.de/oowa921-install/servlet/oowa/aw92/WS0100/_XWD_PROC?_XWD_330/12/XWD_CUBE.DRILL/_XWD_358/D.000/3722

Achievements to date

Implementation of clinical nutrition in education (physicians, nurses etc.)

Education for RNs (DNPQ-based courses)

- Definition of adequate nutritional care in nursery (‚Expertenstandard‘)
- Special courses for nutrition in medical and health care

Education for physicians („Curriculum Ernährungsmedizin“)

- New curriculum for medical students
- Successful proposal for medical specialist Clinical Nutrition (Decision in May 2016 by the German Physician Association)
- Joining other medical disciplines (common sessions on congress from i.e. surgery, oncology, working in guideline groups)
- Special ONCA Session 2016 at the
  (i) German Association of Internal Medicine
  (ii) Nutrition 2016.

Participation in Nutrition day

- 53 units participate 2014 (2013: 19; 2012: 37)

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Achievements to date cont.

Documentation of nutritional care in hospital (DRG system) and private practise

- New special coding number (OPS-code) for enteral and parenteral nutrition in the DRG system as basis for reimbursement.
- Proposal for a new definition of malnutrition in the ICD-10 GM;
- Workshop on Malnutrition in the DRG System 13 Nov. 2016, Leipzig
- Special issue of our publication organ ‘Akt. Ernährungsmedizin’ describing the actual documentation and reimbursement of nutrition care In all facilities and institutes providing care

Core pathways documented and guideline based

- update and publication of S3 DGEM guidelines for enteral and parenteral nutrition (including paediatrics)
- Continuing Medical Education (CME) clinical nutrition in our national journal (Akt. Ernährungsmedizin)

Current activities

Inclusion of nutritional assessment tools in quality management systems (e.g. ISO, KTQ)

- Project group (DGEM, BDEM) : Certification system Clinical Nutrition in hospital, practice and nursing home based on recent DGEM guidelines 2014/2015

Documentation of nutritional care in hospital (DRG system) and private practise

- invitation to a workshop with the official classification group of the authority (DIMDI, 1.12.2015)
- debate with the core decision group of the ministry of health (gBA) on reimbursement of (oral) nutritional supplements (position paper, hearing).

Implementation of clinical nutrition in education (physicians, nurses etc.)

- Development of a guideline APP Clinical Nutrition for mobile devices
- New tool box at the website

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Current activities

Including more partner in the ONCA project

- Deutsche Krebshilfe, Seniorenliga, health authorities, reimbursement organisations, institute for quality in medicine, etc.

Coordinated PR activities

- Press conference, radio interviews and online interviews regarding current ONCA meeting
- Launching new website for
  - German ONCA Project
  - German PEN Society with new functions
- Regularly e-news letter

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