Working together to improve health care quality, outcomes, and affordability in Washington State.

Total Knee and Total Hip Replacement Bundle and Warranty

2017
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Related Documents:
  Total Knee and Total Hip Replacement Warranty: LINK
  Total Knee and Total Hip Replacement Evidence Table: LINK

Dr. Robert Bree Collaborative – Accountable Payment Models Workgroup
INTRODUCTION

Background
The Washington State legislature created the Robert Bree Collaborative in 2011 to provide a forum in which public and private health care stakeholders can work together to improve quality, health outcomes, and cost-effectiveness of care. In 2012, the Bree Collaborative identified reducing avoidable hospital readmissions as a priority. To pursue this issue, the Bree Collaborative convened a workgroup to develop accountable payment models that would include a warranty against avoidable readmissions. Additional elements were added to the model to facilitate value-based purchasing including: bundled pricing, explicit community-based standards for quality supported by medical evidence published in the public domain, and market-relevant quality indicators reported directly to purchasers from providers. The Accountable Payment Models workgroup started by developing a bundled payment model for total knee and total hip replacement surgery in November 2013 and used that initial format to develop additional models for lumbar fusion, coronary artery bypass surgery, and bariatric surgery in September 2014, September 2015, and October 2016, respectively. The initial workgroup agreed to review the bundled payment model after three years and the Accountable Payment Models workgroup re-convened to review the original total knee and total hip replacement model from December 2016 – XXX 2017.

See Appendix A for a list of Bree Collaborative members and Appendix B for a list of Accountable Payment Model workgroup members selected by the Bree Collaborative and representing purchaser, provider, payer, and quality sectors. The workgroup reports to the full Bree Collaborative that in turn reports to the Washington State Health Care Authority. A public comment period is included in the design phase to enlist broad critique. Final documents are in the public domain for any individual or organization to use.

Structure of the bundle
This total knee and total hip replacement bundle and warranty are for elective surgeries. The four-cycle bundle extends well beyond the surgical procedure itself. The first cycle is an appropriateness standard for total joint replacement, outlining requirements for a trial of non-surgical care. The second cycle sets forth requirements for fitness for surgery. The third cycle specifies elements of best practice surgery and the fourth cycle lists components of care aimed at our ultimate outcome, rapid return to function. Elements of the bundle are supported by an evidence table that includes over X appraised citations. Where medical evidence is absent or of marginal quality, we have declared standards based on consensus of stakeholders.

Providers are responsible for gathering all of the necessary documentation to demonstrate that bundle conditions and quality standards have been met. An appeal process should be in place for cases in which a provider recommends proceeding with TKR/THR surgery for a patient who does not meet appropriateness standards.

Prior to surgery, candidates for elective joint replacement surgery should have clearly documented impairment and radiographic evidence of primary osteoarthritis. This bundle may be used for secondary arthritis (post-traumatic arthritis, rheumatoid arthritis, and other secondary causes), or osteonecrosis.

We believe this surgical bundle represents an incremental advance in helping to create a market for quality in health care. We will continue to refine and improve the bundle as new information becomes available and encourage purchasers to contribute to the success of this bundle by reimbursing for essential services such as for a health coach or for care coordination.
I. IMPAIRMENT DUE TO OSTEOARTHRITIS DESPITE NON-SURGICAL THERAPY

Prior to surgery, candidates for joint replacement therapy should have clearly documented impairment and evidence of osteoarthritis according to standardized radiographic criteria. Unless highly disabling osteoarthritis is evident at the time the patient first seeks medical attention, a trial of conservative therapy is appropriate.

A) Document impairment
   1. Document impairment according to Knee Injury and Osteoarthritis Outcome Score (KOOS) Jr. or Hip Dysfunction and Osteoarthritis Outcome Score (HOOS) Jr.*
   2. Document self-reported loss of function with the Patient Reported Outcomes Measurement Information System-10® (PROMIS-10)
   3. Providers may also wish to document:
      a. Function on lower extremity activity scale or
      b. Pain on numeric pain rating scale.

B) Document radiological findings
   1. Review standard x-ray (non-weight bearing hip, weight bearing knee) of the affected joint and interpret according to Kellgren-Lawrence scale. Total joint replacement therapy generally requires a grade of 3 or 4.
      a. Standard hip radiographs may include:
         i. Anterior posterior (AP) pelvis view (weight bearing or non-weight bearing)
         ii. Lateral hip view (cross table or frog leg, non-weight bearing)
      b. Standard knee radiographs may include:
         i. Weight bearing anterior posterior (AP) view
         ii. Weight bearing notch (Rosenberg) view
         iii. Lateral view (non-weight bearing)
         iv. Sunrise view (non-weight bearing)
   2. If appropriate femur, tibia/fibula, or long leg radiographs in patients with concomitant deformities.
   3. X-rays are the preferred diagnostic test for joint arthritis. MRI studies are not recommended.

C) Shared decision-making. Patient must participate in shared decision-making. A Washington State-approved patient decision aid, should be used when available. As part of the shared decision making process, the surgeon should discuss the type of implant under consideration including year the implant was introduced, the reported failure rate at 1, 5 and 10 years (if known) from available registries, and the surgeon’s level of experience with the device.

D) Document conservative therapy for at least three months unless symptoms are severe and x-ray findings show advanced osteoarthritis (such as with a Kellgren-Lawrence grade 4)
   1. The length of time and intensity of conservative therapy will vary by patient-specific factors such as severity of symptoms and ability to engage actively in treatments such as physical therapy. The Bree Collaborative recommends patient-customized conservative treatments for at least three months, focusing on improving functionality and helping patients adapt expectations around persistent functional limitations.
   2. Trial of one or more of the following physical measures:

* The HOOS Jr and KOOS Jr are subsets of the HOOS and KOOS. The full HOOS and KOOS satisfy this requirement if used instead of the shorter versions.
a. Weight loss, if indicated  
b. Strengthening exercises  
c. Activity modification  
d. Assistive devices  
e. Bracing if judged appropriate

3. Trial of one or more of the following medications, if not contraindicated:
   a. Oral non-steroidal anti-inflammatory drugs  
   b. Topical non-steroidal anti-inflammatory drugs  
   c. Acetaminophen  
   d. Intra-articular injection of corticosteroids

E) Document failure of non-surgical therapy
   1. Document impairment according to Knee Injury and Osteoarthritis Outcome Score (KOOS) Jr. or Hip Dysfunction and Osteoarthritis Outcome Score (HOOS) Jr.
   2. Document self-reported loss of function with the Patient Reported Outcomes Measurement Information System-10® (PROMIS-10).
   3. Providers may also wish to document:
      a. Function on lower extremity activity scale or  
      b. Pain on numeric pain rating scale.

† May be contraindicated within 12 months of surgery due to increased risk of infection.
‡ The HOOS Jr and KOOS Jr are subsets of the HOOS and KOOS. The full HOOS and KOOS satisfy this requirement if used instead of the shorter versions.
II. FITNESS FOR SURGERY

Prior to surgery, candidates for joint replacement therapy should meet minimal standards to ensure their safety and commitment to participate actively in return to function. If a patient does not meet fitness for surgery standards the case should be discussed in a multidisciplinary conference with members relevant to the standard in question as chosen by the surgeon.

A) Document requirements related to patient safety

1. Patient should meet the following minimum requirements prior to surgery:
   a. Body Mass Index less than 40
   b. Hemoglobin A1c less than 8% in patients with diabetes
   c. Adequate peripheral circulation to ensure healing
   d. Adequate nutritional status to ensure healing
   e. Sufficient liver function to ensure healing
   f. Control of opioid dependency, if present and when possible consider tapering off opioids prior to surgery
   g. Avoidance of smoking for at least four weeks pre-operatively
   h. Absence of an active, life-limiting condition that would likely cause death before recovery from surgery
   i. Absence of severe disability from a condition unrelated to osteoarthritis that would severely limit the benefits of surgery
   j. Absence of dementia that would interfere with recovery – performing total joint surgery for a patient with such dementia requires preauthorization, informed consent of a patient’s durable power of attorney for health care, and a contract with the patient’s primary care provider
   k. Screen for alcohol overuse, with management plan if screen is positive
   l. Screen for depression with management plan if positive
   m. Develop pre-operative plan for post-operative return to function

B) Document patient engagement

1. Patient should designate a personal care partner§ who actively participates in the following:
   a. Surgical consultation
   b. Pre-operative evaluation
   c. Joint replacement class and/or required surgical and anesthesia educational programs
   d. In-hospital care
   e. Post-operative care teaching
   f. Patient’s home care and exercise program

2. If patient cannot or will not designate a care partner, the surgical team should discuss how to best support the patient post-surgery

3. Patient should be encouraged to participate in end-of-life care planning, including completion of an advance directive and designation of durable power of attorney for health care

C) Document optimal preparation for surgery

1. Perform pre-operative history, physical, and screening lab tests based on review of systems:
   a. Evaluate for cardiac and pulmonary fitness

§ In addition to friends, neighbors, and family members, individuals who have already had knee or hip replacement surgery have been effective care partners in existing programs.
b. If indicated, obtain basic lab profile, plasma glucose, prothrombin time, complete blood count, urinalysis with culture  
c. Treat nasal passages for possible staphylococcal carrier state or culture nasal passages and treat if positive  
d. Ensure A1c 8% or less in patients with diabetes  
e. Perform x-rays of knee or hip, if not performed within previous 12 months  
f. Screen for predictors of delirium  

2. Obtain relevant consultations:  
a. Evaluate for good dental hygiene with dental consultation as necessary  
b. Refer to anesthesia for pre-operative assessment (e.g., sleep apnea, pulmonary hypertension)  
a. Consider consulting physical therapy to instruct in strengthening of upper and lower extremities  
c. Request additional consults as necessary  

3. Provide education regarding self-care at home following discharge, (e.g., joint replacement class or video, home safety assessment, fall avoidance, expected emotional response to surgery, expectations of surgical outcomes)  

D) Discuss the case in a multidisciplinary conference with members as defined by the surgeon if patient does not meet fitness for surgery standards.
III. REPAIR OF THE OSTEOARTHRITIC JOINT

An experienced surgical team should use evidence-based practices to avoid complications related to implanted hardware; preventing infection, venous thrombosis, and blood loss; managing pain while avoiding side effects; and managing pre-existing medical problems carefully.

A) General standards for a surgical team performing TKR/THR surgery
1. The surgeon should perform at least 50 arthroplasties annually and the hospital 100 arthroplasties annually or be able to demonstrate sufficient quality standards through internal data or publicly accessible data sources. We encourage purchasers to consider metrics including at minimum: infection rates, surgical complication rates as defined in the warranty, and 30-day hospital readmissions.
2. Members of the surgical team must have documented credentials, training, and experience
3. The roster of the surgical team should be consistent
4. Elective joint arthroplasty must be scheduled to begin before 5:00 pm
5. Facilities in which surgery is performed should have policies that align with the American College of Surgeons Statement on Health Care Industry Representatives in the Operating Room. The patient should be informed if there will be an industry representative in the room.

B) Elements of optimal surgical process
1. Optimize pain management and anesthesia:
   a. Use multimodal pain management format to minimize sedation and encourage early ambulation
   b. Minimize use of opioids
   c. Management of previously-identified anesthesia-related risk factors, if needed
2. Avoid infection:
   a. Require application of chlorhexidine skin prep by patient at bedtime and morning prior to surgery
   b. Administer appropriate peri-operative course of antibiotics according to Centers for Medicare and Medicaid Services (CMS) guidelines set forth in the Surgical Care Improvement Project and the 2016 World health organization global guidelines for the prevention of surgical site infections
   c. Restrict use of urinary catheter to less than 48 hours
3. Avoid bleeding and low blood pressure:
   a. Administer standardized protocols using appropriate medications to limit blood loss
   b. Use standardized IV fluid protocols including those implemented by RNs post-operatively with appropriate supervision and monitoring
4. Avoid deep venous thrombosis and embolism according to CMS guidelines set forth in the Surgical Care Improvement Project
5. Avoid hyperglycemia through standardized protocol to maintain optimal glucose control

C) Selection of the surgical implant
1. The recommended standard is that providers select an implant that has a <5% failure rate at ten years** An alternative for more recently introduced implants is registry data demonstrating a failure

** This performance standard is supported by evidence from both the Australian Orthopedic Association National Joint Replacement Registry and the National Joint Registry for England and Wales. The 2012 reports are available online: https://aoanjrr.dmac.adelaide.edu.au/annual-reports-2012 and www.njrcentre.org.uk/njrcentre/Portals/0/Documents/England/Reports/9th_annual_report/NJR 9th Annual Report 2012.pdf, respectively.
rate of less than 1% per year for the first 5 years, and then never > 5% between years 6-10. See section on shared decision making in Cycle II.
2. To track outcomes, all implants must be registered with a national joint registry such as the American Joint Replacement Registry

IV. POST-OPERATIVE CARE AND RETURN TO FUNCTION

A standard process should be in place to support the goals of avoiding post-surgical complications, ensuring rapid return to function, optimizing hospital length of stay, and avoiding unnecessary readmissions.

A) Standard process for post-operative care
1. Utilize a rapid recovery track to mobilize patients on the day of surgery:
   a. Provide accelerated physical therapy and mobilization if regional pain control is acceptable
   b. Provide a patient-oriented visual cue to record progress on functional milestones required for discharge
   c. Instruct patients in home exercise, use of walking aids and precautions
   d. Instruct care partner to assist with home exercise regimen
2. Patients that meet Medicare standards for placement in a skilled nursing facility will have their post-operative nursing and rehabilitative needs addressed
3. Hospitalists or appropriate medical consultants will be available for consultation to assist with complex or unstable medical problems in the post-operative period

B) Use standardized hospital discharge process aligned with Washington State Hospital Association (WSHA) toolkit
1. Arrange follow up with care team according to WSHA toolkit
2. Evaluate social and resource barriers based on WSHA toolkit
3. Reconcile medications
4. Provide patient and family/caregiver education with plan of care:
   a. Signs or symptoms that warrant follow up with provider
   b. Guidelines for emergency care and alternatives to emergency care
   c. Contact information for orthopedist and primary care provider
5. Ensure post-discharge phone call to patient by care team to check progress, with timing of call aligned with WSHA toolkit

C) Arrange home health services
1. Provide the patient and care partner with information about home exercises that should be done three times daily
2. Arrange additional home health services as necessary

D) Schedule follow up appointments
1. Schedule return visits as appropriate
2. Measure patient-reported functional outcomes with HOOS Jr./KOOS Jr. instrument at nine to twelve months.
3. If opioid use exceeds six weeks, develop a formal plan for opioid management
GUIDANCE ABOUT BUNDLE PAYMENT CONTRACTING AND DISTRIBUTION OF PAYMENT

The method of bundle payment contracting will need to be developed as part of the discussion and negotiations between the purchaser, provider, and payer. Therefore, this section provides only general comments rather than recommend any specific models.

The time windows for this bundle will be determined in the contracting process and include all four clinical components of the bundle. The recommended time window for the bundle extends to 90-days post-operatively. Pre-operatively, the time window should include sufficient time to deliver the care necessary to meet the appropriateness standards.

Retrospective and prospective payment models can both be effective in different situations. A retrospective model may be most suitable when a number of providers or provider groups are contributing to the delivery of the bundle. A prospective model may be most suitable for situations in which 1) a budget is determined for a single provider entity delivering the entire bundle or specified components and 2) benefit design issues can be addressed.

Many entities will need to come together to operationalize TKR/THR bundle services, including the hospital, surgeon, anesthesia, and other supporting services. The Bree Collaborative is not specifying any particular process for distributing the bundle payment across those parties, but encourages the adoption of cost and reimbursement strategies that equitably allocate resources and payments.
QUALITY STANDARDS FOR TOTAL KNEE OR TOTAL HIP REPLACEMENT SURGERY

The provider group performing surgery must maintain or participate in a registry of all patients having first-time, single-joint total knee or total hip replacement surgery for osteoarthritis (TKR/THR patients), excluding patients with joint replacement for fracture, cancer, or inflammatory arthritis. This registry will be updated quarterly and be available for reporting to current or prospective purchasers and their health plan. It will be made available to quality organizations such as the Washington Health Alliance and the Foundation for Health Care Quality.

During the first year of the bundled contract, providers will be expected to install methods to measure appropriateness, evidence-based surgery, return to function, and the patient care experience according to the standards noted below. Reporting of results will be expected to begin the second year of the contract. The only exception to this reporting requirement is that the measures of patient safety and affordability noted in section 5 below will begin the first year of the contract.

See Appendix for more detailed information on quality standard numerators and denominators.

1. Standards for appropriateness
These standards are intended to document patient engagement in medical decision-making and measurement of impairment prior to surgery. Report:
   a. Proportion of TKR/THR patients (as defined above) receiving formal shared decision-making decision aids pre-operatively
   b. Proportion of TKR/THR patients with documented musculoskeletal function prior to surgery – the Knee Injury and Osteoarthritis Outcome Score (KOOS) Jr. or Hip Dysfunction and Osteoarthritis Outcome Score (HOOS) Jr.
   c. Proportion of TKR/THR patients with documented patient-reported measures of quality of life – the PROMIS-10 Global Health.
   d. Results of measures from 1b, specifically including responses to Quality of Life (Q1-Q4) and Pain (P1 and P4-5) scores for KOOS Jr. and HOOS Jr. and questions regarding everyday physical activities (Question 7) and pain (Question 10) on the PROMIS-10 survey

2. Standards for evidence-based surgery
These standards are intended to document adherence to evidence-based best practices related to the peri-operative process. Report the proportion of TKR/THR patients that have received all of the following in the peri-operative period:
   a. Measures to manage pain using multimodal anesthesia
   b. Measures to reduce risk of venous thromboembolism and pulmonary embolism
   c. Measures to reduce blood loss such as administration of tranexamic acid
   d. Measures to reduce infection such as administration of prophylactic antibiotics
   e. Measures to maintain optimal blood sugar control
3. Standards for ensuring rapid return to function
These standards are intended to optimize mobilization following surgery and measure patient recovery. Report:
   a. Proportion of TKR/THR patients with documented physical therapy within 24 hours of surgery
   b. Proportion of TKR/THR patients for which there are documented patient-reported measures of quality of life and musculoskeletal function nine to twelve months following surgery – the same measures should be used as in standard 1b
   c. Results of measures from 2b, specifically including responses to the questions identified in standard 1c

4. Standards for the patient care experience
These standards are intended to measure patient-centered care. Report:
   a. Proportion of total hospital or practice patients surveyed using HCAHPS
   b. Results of measures from 4a, specifically including responses to Q6 and Q22 if HCAHPS is used

5. Standards for patient safety and affordability
These standards are intended to measure success in avoiding complications and reducing readmissions. Report:
   a. 30-day all-cause readmission rate for TKR/THR patients
   b. 30-day readmission rate for TKR/THR patients with any of the nine complications included under the terms of the warranty
# APPENDIX C: DETAILED QUALITY STANDARDS

For all of the following, THR/TKR patients refers to first-time, single-joint total knee or total hip replacement surgery for osteoarthritis, excluding patients with joint replacement for fracture, cancer, or inflammatory arthritis.

Please note that three of the quality measures refer to specific results or scores and therefore have no numerator or denominator.

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Denominator</th>
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<tbody>
<tr>
<td><strong>1: Standards for appropriateness</strong></td>
<td></td>
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<tr>
<td>a</td>
<td>Number of TKR/THR patients receiving formal shared decision-making decision aids pre-operatively</td>
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<tr>
<td>b</td>
<td>Number of TKR/THR patients with documented patient-reported measures of quality of life and musculoskeletal function prior to surgery (Knee Injury and Osteoarthritis Outcome Score (KOOS) Jr. or Hip Dysfunction and Osteoarthritis Outcome Score (HOOS) Jr.</td>
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<tr>
<td>c</td>
<td>Proportion of TKR/THR patients with documented patient-reported measures of quality of life – the PROMIS-10 Global Health</td>
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<tr>
<td>d</td>
<td>Results of measures from 1b, specifically including responses Quality of Life (Q2 and Q4) and Pain (P1, and P4-5) scores for KOOS and HOOS and questions regarding everyday physical activities (Question 7) and pain (Question 10) on the PROMIS-10 survey</td>
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<tr>
<td><strong>2: Standards for evidence-based surgery</strong></td>
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<tr>
<td>a</td>
<td>Number of TKR/THR patients receiving measures to manage pain while speeding recovery in a multimodal format in the peri-operative period</td>
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<tr>
<td>b</td>
<td>Number of TKR/THR patients receiving measures to reduce risk of venous thromboembolism and pulmonary embolism in the peri-operative period</td>
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<td><strong>3: Standards for ensuring rapid return to function</strong></td>
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<tr>
<td>a</td>
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<td>b</td>
<td>Number of TKR/THR patients with documented patient-reported measures of quality of life and musculoskeletal function six months following surgery (same as used as in standard 1b)</td>
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<td>c</td>
<td>Results of measures from 2b, specifically including responses to the questions identified in standard 1c (Quality of Life (Q2 and Q4) and Pain (P1, and P4-5) scores for KOOS and HOOS and questions regarding everyday physical activities (Question 7) and pain (Question 10) on the PROMIS-10 survey)</td>
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<td><strong>4: Standards for the patient care experience</strong></td>
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<tr>
<td>a</td>
<td>Number of TKR/THR patients surveyed using HCAHPS</td>
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<tr>
<td>b</td>
<td>Results of measures from 4a, specifically responses to Q6 and Q22 if HCAHPS is used</td>
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<tr>
<td><strong>5: Standards for patient safety and affordability</strong></td>
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<tr>
<td>a</td>
<td>Number of TKR/THR patients readmitted to the hospital within 30 days of discharge, all causes</td>
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<tr>
<td>b</td>
<td>Number of TKR/THR patients readmitted to the hospital within 30 days of discharge for any of the nine complications included under the terms of the warranty</td>
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