Division of Health Care Finance & Administration

Health Care Innovation Initiative

Executive Summary

Total Joint Replacement Episode

Corresponds with DBR and Configuration V2.2

Updated January 11, 2017

OVERVIEW OF A TOTAL JOINT REPLACEMENT (HIP & KNEE) EPISODE

The total joint replacement episode revolves around an individual undergoing an elective hip or knee replacement. This episode is triggered by the joint replacement procedure, the primary purpose of which is to treat chronic arthritis of the hip or knee. The start date of the episode is 45 days prior to admission, and includes only claims related to the total joint replacement. Following discharge from the hospital, care associated with the joint replacement such as physical therapy and certain medications are included in the episode, as are complications related to the procedure like infections, blood clots, and readmissions for up to 90 days after discharge.

CAPTURING SOURCES OF VALUE

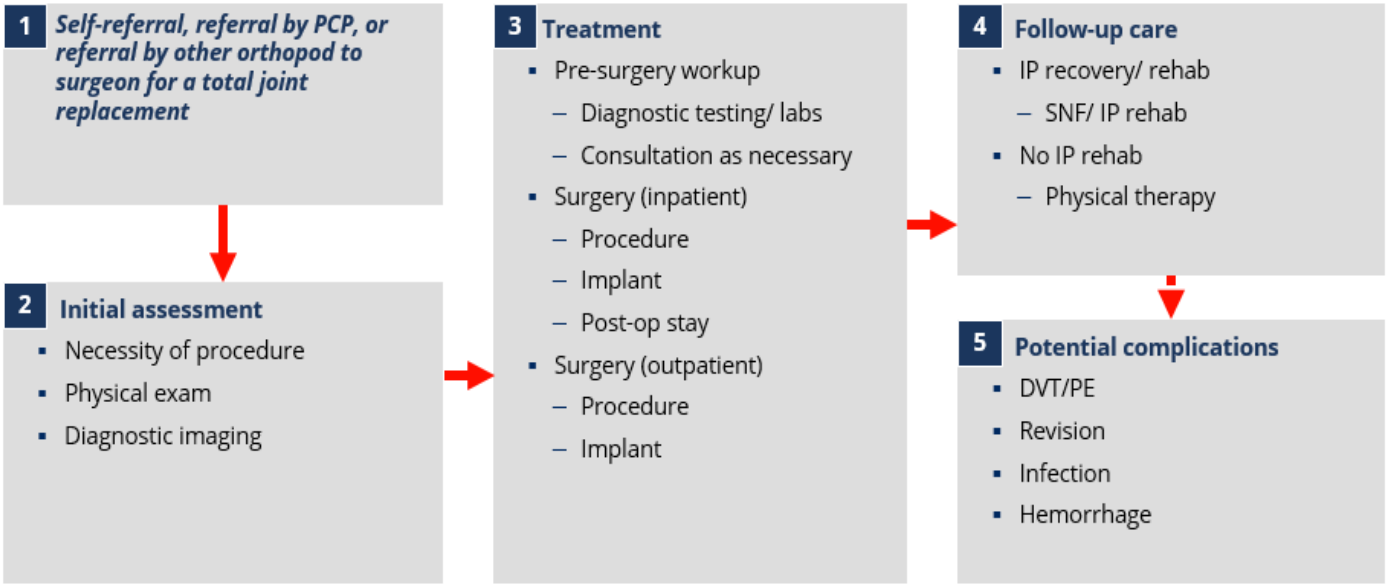
In treating total joint replacement patients, providers have multiple opportunities to improve the quality and cost of care. They can, for example, try to reduce the number of unnecessary services such as duplicates of diagnostic imaging during the initial assessment of the patient. The provider can also influence the use of more cost efficient facilities for the surgery and the length of a potential inpatient stay. Further, the provider can minimize the likelihood of complications and readmissions by safeguarding appropriate recovery and rehabilitation practices.

To learn more about the episode's design, please reference the following documents on our website at www.tn.gov/hcfa/topic/episodes-of-care:

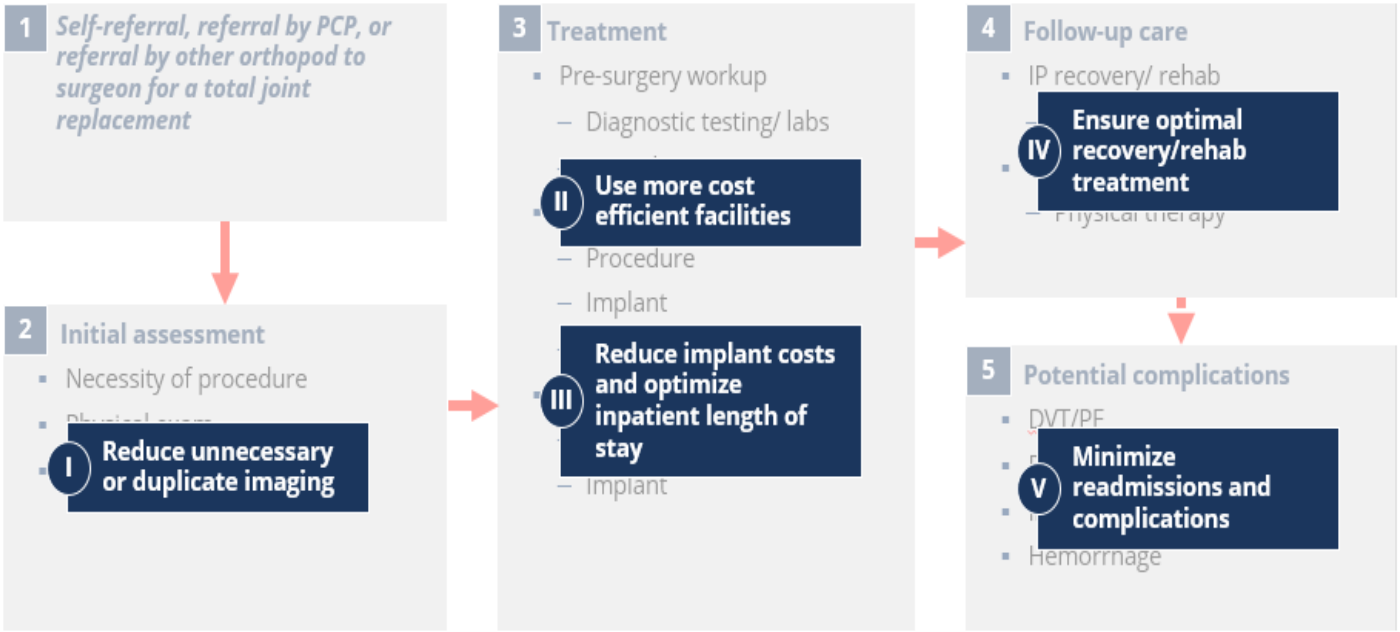
- *Detailed Business Requirements: Complete technical description of the episode*
  http://www.tn.gov/assets/entities/hcfa/attachments/tjrSummaries.pdf

- *Configuration File: Complete list of codes used to implement the episode*
  http://www.tn.gov/assets/entities/hcfa/attachments/TJRConfiguration.xlsx

Illustrative Patient Journey



Potential Sources of Value



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ASSIGNING ACCOUNTABILITY

The Principal Accountable Provider (also referred to as the quarterback) of the episode is the specific health care provider deemed to have the greatest accountability for the quality and cost of care for the patient. To state it differently, the quarterback is the provider who has the greatest ability to influence all of the health care delivered in a given episode. For the total joint replacement episode, the quarterback is the orthopedic surgeon who performs the procedure. All quarterbacks will receive reports according to their contracting entity or tax identification number.

MAKING FAIR COMPARISONS

The episode model is designed to be fair to providers and incentivize best practices without penalizing providers who care for sicker patients. As such, important aspects of the model are:

- Exclusion of episodes when clinical circumstances create the likelihood that the case will deviate substantially from the typical care path or when claims data is likely to be incomplete, and
- Risk adjusting to account for the cost of more complicated patients.

Some exclusions apply to any type of episode, i.e., are not specific to a joint replacement episode. For example, an episode would be excluded if more than one payer was involved in a single episode of care, the patient was not continuously insured by the payer between the day of the earliest claim included in the episode and the end of the episode, or if the patient had a discharge status of “left against medical advice”. Other examples of exclusion criteria specific to the total joint episode include a patient who undergoes a traumatic injury, organ transplant or has an unrelated medical event such as a malignant cancer.

For the purposes of determining a quarterback’s cost for each episode of care, the actual reimbursement for the episode will be adjusted to reflect risk factors captured in recent claims data in order to be fair to providers caring for more complicated patients. Over time, a payer may add or subtract risk factors in line with new research and/or empirical evidence. Furthermore, there may be some factors with a low prevalence or significance that would make accurate risk

adjustment difficult and may be used to exclude patients completely instead of adjusting their costs. The final risk adjustment methodology decisions will be made at the discretion of the payer after analyzing the data.

MEASURING QUALITY

The episode reimbursement model is designed to reward providers who deliver cost effective care AND who meet certain quality thresholds. A quarterback must meet or exceed all established benchmarks for any quality metric tied to gain sharing in order to be eligible to receive monetary rewards from the episode model. Quality metrics tied to gain sharing are referred to as threshold metrics. Other quality metrics may be tracked and reported for quality improvement purposes but may not be tied directly to gain sharing.

There are **no quality metrics** linked to gain sharing for the total joint replacement episode.

The quality metrics that will be tracked and reported to providers but that are not directly tied to gain sharing are:

- **Admission within post-trigger window 1:** Percent of valid episodes with a relevant admission or relevant observation care within post-trigger window 1 (lower rate indicative of better performance).

- **Post-operative deep vein thrombosis (DVT)/pulmonary embolism (PE) within post-trigger window 1:** Percent of valid episodes with deep vein thrombosis (DVT)/pulmonary embolism (PE) within post-trigger window 1 (i.e. 30 days after discharge) (lower rate indicative of better performance).

- **Post-operative wound infections:** Percent of valid episodes with post-operative wound infections within the post-trigger window (lower rate indicative of better performance).

- **Dislocations or fractures:** Percent of valid episodes with dislocations or fractures within the post-trigger window (lower rate indicative of better performance).

- **Average length of stay:** Average length of stay based on Medicaid covered days for episodes (lower rate indicative of better performance).

It is important to note that quality metrics are calculated by each payer on a per quarterback basis across all of a quarterback's episodes covered by that payer. Failure to meet all quality benchmarks tied to gain sharing will render a quarterback ineligible for gain sharing with that payer for the performance period under review.

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