

Bree TJR Workgroup meeting: work sheet for June 4, 2021

We are nearing the end of our first draft for the clinical cycles 1-4. This work sheet includes **proposed edits to clinical content in red font**. Our goal on June 4 is to review content for cycles 1-4, and if possible, Quality Standards and Warranty. The working draft of the bundle also includes some nonclinical edits I have made to improve clarity and organization. These are proposed for your approval and are indicated in **green**.

Cycle I – Appropriateness: Impairment Due to Osteoarthritis Despite Non-Surgical Therapy

Item 1: Cycle I/A/1 – document impairment

The 2017 bundle document has no requirement that an initial history and physical exam is compatible with osteoarthritis. Citation 50 (Metcalf) identifies clinical findings most likely to predict osteoarthritis.

Suggest inserting the following to the working draft:

- 1. Document findings on the patient’s history and physical examination compatible with a diagnosis of osteoarthritis of the knee or hip.**

Cycle II – Fitness for surgery

Item 2: Cycle II/B/1

We have not specified that the personal care partner is physically, intellectually, or emotionally qualified for this demanding task. Adding “qualified” draws attention to credentialing the care partner according to judgement of the provider team.

Suggest specifying a qualified personal care partner

- 1. Patient should designate a physically and intellectually qualified personal care partner**

Item 3: Cycle II/C)/1 – Perform pre-operative history, physical and screening lab tests

Citation 56 (NICE Guideline NG45) is from the National Institute for Health and Care Excellence (NICE) from the English National Health Service. The guideline stratifies preop tests for a major surgery according to the patient’s underlying medical comorbidities (ASA grade).

<https://www.nice.org.uk/guidance/ng45>

As we have previously discussed, citations 15 and 16 relate low serum albumin to adverse outcomes. Low serum albumin appears a non-specific but important indicator of adverse prognosis and has multiple causes. Elevated CPK is associated with CAD and COPD but is not currently recommended as a preop test for elective surgery.

Suggest substituting the following for II/C)/1/b:

b. Order pre-op tests according to the NICE guideline for routine preoperative tests for elective surgery according to the American Society of Anesthesiologists (ASA) risk stratification. Tests may include full blood count, tests for hemostasis, test of kidney function, ECG, lung function/arterial blood gas and others. <https://www.nice.org.uk/guidance/ng45>
Serum albumin is a nonspecific test that may predict underlying disease and adverse outcomes.

Item 4: Cycle II/C)/1 -- Perform pre-operative history, physical and screening lab tests
Postop nausea and vomiting and constipation may complicate recovery from total joint replacement. Citations 59 (ERAS) and 67 (American Gastroenterological Association Institute) document risk and recommendations for management.

Suggest adding the following to this section:

- h. Screen for postoperative nausea and vomiting and manage as needed throughout perioperative period.
- i. Screen for constipation and manage as needed throughout perioperative period.

Cycle III – Safe Surgery: Repair of the osteoarthritic joint

Item 5: Cycle III/A) -- COVID-19 precautions

Citations 45, 46, and 47 related to safe practice regarding COVID-19

Suggest adding line 7:

1. All medical, administrative, support staff, and volunteers should be vaccinated or wear a mask on campus. Facilities, providers, support staff, volunteers and patients will all comply with current CDC guidelines.

Item 6: Cycle III/C) -- Selection of the surgical implant

The following text is proposed to replace the existing cycle III/C) in its entirety:

1. On a semiannual basis, provider groups will require contracted implant manufacturers to provide data from a national registry and their internal records concerning device failure and complications reported for patients receiving implants sold to the provider group. Implant failure rate should be \leq 1% per year for the first five years following introduction, then never $>$ 5% between years 6-10.
2. All hospitals and facilities must report level I data to the American Joint Replacement Registry.

Cycle IV– Return to function: Post-Operative Care

I see no obvious changes needed to this section. The WSHA discharge tool kit has not been changed since the 2017 version of the bundle.

Is there a need to reiterate the standard for avoiding constipation?

Quality Standards

These have been set by purchasers and have been use across several versions. Any changes needed?

Warranty

These standards are based on avoidable hospital readmissions as determined by CMS and other contributors as noted. Any changes needed?