Total Hip & Total Knee Replacement
Advanced Disease Specific Care Certification

Standardized Performance Measures
Abstraction Training

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TJC Staff

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Training Objectives

- State the four standardized performance measures
- Describe the numerator and denominator for each measure
- Identify if a patient should be included/excluded from each measure
- Describe data submission requirements
Performance Measure Expectations for “Core” Certification Programs

- Non-standardized measures
- Programs collect and analyze data on 4 or more performance measures
- Two of the four should be clinical measures related to or identified in clinical practice guidelines for THKR population
- Non-prescriptive
THKR Advanced Certification
Performance Measure Expectations

- Standardized performance measures
- Precisely defined specifications
- Standardized data collection protocols
- Uniformly adopted for use
- Identified/specified by The Joint Commission and external expert members of Technical Advisory Panel
2 Types of Measures

- “Chart abstracted”
  - Manually abstracted
  - Required as of 1/1/2018

- “eCQMs” – Electronic Clinical Quality Measures
  - Specified in a standard electronic format
  - Designed to use structured, encoded data present in the electronic health record
  - Under development
Measure Calculation: Chart-Abstracted & eCQM

Chart-Abstracted Process

- Provide Care
- Interpret Care
- Calculate Rate

eCQM Process

- Provide Care
- Calculate Rate
Finalized Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>THKR-1</td>
<td>• Regional Anesthesia</td>
</tr>
<tr>
<td>THKR-2</td>
<td>• Postoperative Ambulation on Day of Surgery</td>
</tr>
<tr>
<td>THKR-3</td>
<td>• Discharged to Home</td>
</tr>
<tr>
<td>THKR-4</td>
<td>• Preoperative Functional/Health Status Assessment Using a Patient Reported (PRO) Tool</td>
</tr>
</tbody>
</table>
Measure Stratification

THKR-1

THKR-IP-1

THKR-IP-1a Hip & Knee Overall
THKR-IP-1b Hip
THKR-IP-1c Knee

THKR-OP-1

THKR-OP-1a Hip & Knee Overall
THKR-OP-1b Hip
THKR-OP-1c Knee
Note: This slide presentation highlights key points and abstraction guidelines only. Complete measure specifications are provided in the Inpatient and Outpatient Implementation Guides and should be used for medical record abstraction.

https://www.jointcommission.org/assets/1/6/THKRIIP_Manual2018January1.PDF

Using the Implementation Guides

- Initial Patient Population Algorithm
- Sample Size Requirements
- Measure Information Forms (MIFs)
  - Description
  - Clinical Rationale
  - Numerator, denominator statements
  - Data elements
  - References
  - Algorithms
Using the Implementation Guides (cont)

- Data Dictionary – for each data element:
  - Definition
  - Allowable values
  - Notes for abstraction
  - Suggested data sources
  - Inclusion/exclusion criteria

- Appendices
  - Code Tables
## Initial Patient Population

<table>
<thead>
<tr>
<th>INCLUDED</th>
<th>EXCLUDED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age ≥ 18 years</td>
<td>Partial hip &amp; partial knee replacements</td>
</tr>
<tr>
<td>Length of Stay ≤ 120 days</td>
<td>Revision &amp; resurfacing procedures</td>
</tr>
<tr>
<td>Principal Procedure = Total Hip or Total Knee Replacement</td>
<td>Removal of implanted devices/prostheses</td>
</tr>
<tr>
<td></td>
<td>Complication of internal fixation devices/prostheses diagnoses</td>
</tr>
<tr>
<td></td>
<td>Malignant neoplasm of the pelvis, sacrum, coccyx or lower limb diagnoses</td>
</tr>
</tbody>
</table>
## Initial Patient Population (ICD & CPT® Codes)

### INPATIENT INITIAL PATIENT POPULATION (Measure Set Level)

<table>
<thead>
<tr>
<th>Table (found in Appendix A)</th>
<th>CODING SCHEME</th>
<th>Data Element</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INCLUSIONS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1a Total Hip Replacements</td>
<td>ICD10PCS</td>
<td>ICD-10-PCS Principal Procedure</td>
</tr>
<tr>
<td>1b Total Knee Replacements</td>
<td>ICD10PCS</td>
<td>ICD-10-PCS Principal Procedure</td>
</tr>
<tr>
<td>2 Partial Hip &amp; Partial Knee Replacements</td>
<td>ICD10PCS</td>
<td>ICD-10-PCS Other Procedures</td>
</tr>
<tr>
<td>3 Revision &amp; Resurfacing Procedures</td>
<td>ICD10PCS</td>
<td>ICD-10-PCS Other Procedures</td>
</tr>
<tr>
<td>4 Removal of Implanted Devices/Prostheses</td>
<td>ICD10PCS</td>
<td>ICD-10-PCS Other Procedures</td>
</tr>
<tr>
<td>5 Complication of Internal Fixation Devices/Prostheses</td>
<td>ICD10CM</td>
<td>ICD-10-CM Principal or Other Diagnosis</td>
</tr>
<tr>
<td>6 Malignant Neoplasm of the Pelvis, Sacrum, Coccyx or Lower Limb</td>
<td>ICD10CM</td>
<td>ICD-10-CM Principal or Other Diagnosis</td>
</tr>
</tbody>
</table>

### EXCLUSIONS

<table>
<thead>
<tr>
<th>Table (found in Appendix A)</th>
<th>CODING SCHEME</th>
<th>Data Element</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INCLUSIONS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1a Total Hip Replacements</td>
<td>CPT®</td>
<td>CPT® Code with Modifier</td>
</tr>
<tr>
<td>1b Total Knee Replacements</td>
<td>CPT®</td>
<td>CPT® Code with Modifier</td>
</tr>
<tr>
<td>1c Bilateral Hip Replacements</td>
<td>CPT®</td>
<td>CPT® Code with Modifier</td>
</tr>
<tr>
<td>1d Bilateral Knee Replacements</td>
<td>CPT®</td>
<td>CPT® Code with Modifier</td>
</tr>
<tr>
<td>2 Partial Hip &amp; Partial Knee Replacements</td>
<td>CPT®</td>
<td>CPT® Code with Modifier</td>
</tr>
<tr>
<td>3 Revision &amp; Resurfacing Procedures</td>
<td>CPT®</td>
<td>CPT® Code with Modifier</td>
</tr>
<tr>
<td>4 Removal of Implanted Devices/Prostheses</td>
<td>CPT®</td>
<td>CPT® Code with Modifier</td>
</tr>
<tr>
<td>5 Complication of Internal Fixation Devices/Prostheses</td>
<td>ICD10CM</td>
<td>ICD-10-CM Principal or Other Diagnosis</td>
</tr>
<tr>
<td>6 Malignant Neoplasm of the Pelvis, Sacrum, Coccyx or Lower Limb</td>
<td>ICD10CM</td>
<td>ICD-10-CM Principal or Other Diagnosis</td>
</tr>
</tbody>
</table>
# Additional Code Exclusions at the Measure Level

## INPATIENT: ADDITIONAL CODE EXCLUSIONS AT THE MEASURE LEVEL

<table>
<thead>
<tr>
<th>THKR-IP-1</th>
<th>THKR-IP-2</th>
<th>THKR-IP-3</th>
<th>THKR-IP-4</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>Femur, hip, pelvic fractures</td>
<td>Appendix A, Table 7</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bilateral procedures</td>
<td>Appendix A, Tables 1a, 1b</td>
<td></td>
</tr>
</tbody>
</table>

## OUTPATIENT: ADDITIONAL CODE EXCLUSIONS AT THE MEASURE LEVEL

<table>
<thead>
<tr>
<th>THKR-OP-1</th>
<th>THKR-OP-2</th>
<th>THKR-OP-3</th>
<th>THKR-OP-4</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>Femur, hip, pelvic fractures</td>
<td>Appendix B, Table 7</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bilateral procedures</td>
<td>Appendix B, Table 1c (Bilateral Hip), Table 1d (Bilateral Knee)</td>
<td></td>
</tr>
</tbody>
</table>
# Initial Patient Population - Data Elements

<table>
<thead>
<tr>
<th>INPATIENT</th>
<th>OUTPATIENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission Date</td>
<td>Outpatient Encounter Date</td>
</tr>
<tr>
<td>Birthdate</td>
<td>Birthdate</td>
</tr>
<tr>
<td>Discharge Date</td>
<td>Outpatient Departure Date</td>
</tr>
<tr>
<td>ICD-10-CM Principal Diagnosis Code</td>
<td>ICD-10-CM Principal Diagnosis Code</td>
</tr>
<tr>
<td>ICD-10-CM Other Diagnosis Codes</td>
<td>ICD-10-CM Other Diagnosis Codes</td>
</tr>
<tr>
<td>ICD-10-PCS Principal Procedure Code</td>
<td>CPT® Codes with Modifier*</td>
</tr>
<tr>
<td>ICD-10-PCS Other Procedure Codes</td>
<td></td>
</tr>
</tbody>
</table>

*End User Agreement Required*
Monthly Sampling

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Inpatient (minimum)</th>
<th>Outpatient (minimum)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>MONTHLY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hip</td>
<td>10</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>Knee</td>
<td>10</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>20</td>
<td>40</td>
</tr>
</tbody>
</table>

- For populations of 10 or less in any category above, abstract all cases.
- For populations of > 10, sampling is acceptable but not required.
- See page 6 of Implementation Guide for sampling details.
# Data Abstraction Tools

## Implementation Guide for Measure Information Forms, Algorithms, Data Element Definitions, And Notes for Abstraction

### Inpatient

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Unique Patient Identifier</th>
<th>Birth Date</th>
<th>Admission Date</th>
<th>Discharge Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-10 Principal DX Code</td>
<td>ICD-10 Other DX Code</td>
<td>ICD-10 Principal Procedure Code</td>
<td>ICD-10 Other Procedure Codes</td>
<td>ICD-10 Other Procedure Codes</td>
</tr>
</tbody>
</table>

### Inpatient: Data Abstraction Tools

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Unique Patient Identifier</th>
<th>Birth Date</th>
<th>Admission Date</th>
<th>Discharge Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-10 Principal Code</td>
<td>ICD-10 Other Codes</td>
<td>ICD-10 Principal Procedure Code</td>
<td>ICD-10 Other Procedure Codes</td>
<td>ICD-10 Other Procedure Codes</td>
</tr>
</tbody>
</table>

### Outpatient

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Unique Patient Identifier</th>
<th>Birth Date</th>
<th>Discharge Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-10 Principal DX Code</td>
<td>ICD-10 Other DX Code</td>
<td>ICD-10 Principal Procedure Code</td>
<td>ICD-10 Other Procedure Codes</td>
</tr>
</tbody>
</table>

### Outpatient: Data Abstraction Tools

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Unique Patient Identifier</th>
<th>Birth Date</th>
<th>Discharge Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-10 Principal Code</td>
<td>ICD-10 Other Codes</td>
<td>ICD-10 Principal Procedure Code</td>
<td>ICD-10 Other Procedure Codes</td>
</tr>
</tbody>
</table>

### Ambulance

- YES or NO
- Ambulance Date/Time

### Discharge Disposition

1. Home
2. Hospice-Home
3. Hospice/Health Care Facility
4. Acute Care Facility
5. Other Health Care Facility
6. Exploratory
7. Left AMA
8. Not Documented or UTD

### PACU Discharge Data/Time

<table>
<thead>
<tr>
<th>Postop ICU Admission/Transfer</th>
<th>YES or NO</th>
<th>Postop ICU Admission/Transfer Date/Time</th>
</tr>
</thead>
</table>

### Discharge Code

1. Home
2. Hospice-Home
3. Hospice/Health Care Facility
4. Acute Care Facility
5. Other Health Care Facility
6. Exploratory
7. Left AMA
8. Not Documented or UTD

### Regional Anesthesia

- Yes or No

- Reason for No Regional Anesthesia
- Reason for No Ambulating the Day of Surgery
- Reason for Not Discharging Patient to Home

- Resident of Other Health Care Facility

### Residency Information

- YES or NO

### Implementation Guide

- Refer to implementation guide for measure information forms, algorithms, data element definitions and notes for abstraction.
## General Data Elements

<table>
<thead>
<tr>
<th>INPATIENT</th>
<th>OUTPATIENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission Date</td>
<td>Outpatient Encounter Date</td>
</tr>
<tr>
<td>Birthdate</td>
<td>Birthdate</td>
</tr>
<tr>
<td>Discharge Date</td>
<td>Outpatient Departure Date</td>
</tr>
<tr>
<td>Hispanic Ethnicity</td>
<td>Hispanic Ethnicity</td>
</tr>
<tr>
<td>ICD-10-CM Principal Diagnosis Code</td>
<td>ICD-10-CM Principal Diagnosis Code</td>
</tr>
<tr>
<td>ICD-10-CM Other Diagnosis Codes</td>
<td>ICD-10-CM Other Diagnosis Codes</td>
</tr>
<tr>
<td>ICD-10-PCS Principal Procedure Code</td>
<td>CPT® Codes* with Modifier</td>
</tr>
<tr>
<td>ICD-10-PCS Other Procedure Codes</td>
<td></td>
</tr>
<tr>
<td>ICD-10-PCS Principal Procedure Date</td>
<td>CPT® Code* Procedure Date</td>
</tr>
<tr>
<td>Payment Source</td>
<td>Payment Source</td>
</tr>
<tr>
<td>Postal Code</td>
<td>Postal Code</td>
</tr>
<tr>
<td>Race</td>
<td>Race</td>
</tr>
<tr>
<td>Sex</td>
<td>Sex</td>
</tr>
</tbody>
</table>

Data elements in red font are listed in data dictionary, not required at this time
# THKR-1 Regional Anesthesia

Patients undergoing a total hip or total knee replacement with regional anesthesia attempted or administered

Total hip & total knee replacements

<table>
<thead>
<tr>
<th>Denominator Population</th>
<th>Numerator Population</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Included Populations:</strong></td>
<td><strong>Included Populations:</strong></td>
</tr>
<tr>
<td>• Total hip &amp; total knee replacements</td>
<td>• Patients with regional anesthesia administered or attempted</td>
</tr>
<tr>
<td></td>
<td>• Regional anesthesia includes neuraxial (spinal and epidural blocks) as well as peripheral nerve blocks</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Excluded Populations:</th>
<th>Excluded Populations:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medical Reason for No Regional Anesthesia</td>
<td>None</td>
</tr>
<tr>
<td>• Patient Refusal</td>
<td></td>
</tr>
<tr>
<td>• History of Spinal Fusion</td>
<td></td>
</tr>
</tbody>
</table>
Rationale

– Compared to general anesthesia, statistically significant decrease in 30-day mortality and in-hospital complications including pneumonia, kidney failure and the need for mechanical ventilation.

– Decrease in operative blood loss and need for blood transfusions.

Gap

– 52% of knee replacements and 60% of hip replacements were performed under general anesthesia. (Source: NSQIP 2005-2011)
THKR-IP-1 & THKR-OP-1

Data Elements:

- ICD-10-PCS Principal/Other Procedure Code/CPT® Codes with Modifier
- ICD-10-CM Principal/Other Diagnosis Codes
- Reason for No Regional Anesthesia
Key Data Element:  *ICD-10-PCS Principal Procedure Code (Inpatients Only)*

- **Definition:** The principal procedure is the procedure performed for definitive treatment rather than diagnostic or exploratory purposes, or which is necessary to take care of a complication.

- **Listed as the first coded procedure in the medical record**
Key Data Element: *ICD-10-PCS Other Procedure Codes (Inpatients Only)*

- **Definition:** The other or secondary (ICD-10-PCS) codes identifying all significant procedures other than the principal procedure.
- **Listed after the principal procedure in the medical record**
- **Note:** Only concerned with procedure codes listed in Appendix A, Tables 1a, 1b, 2, 3, 4
Key Data Element: CPT® Codes with Modifier (Outpatients Only)

- The Current Procedural Terminology (CPT®) code(s) and modifier(s) associated with this outpatient encounter.

- Note: CPT does not distinguish between “principal” and “other” or “secondary” diagnoses as ICD does.

- “First listed” procedure should be primary surgery
Key Data Element:  *CPT® Codes with Modifier (Outpatients Only)*

- Modifiers are optional
  - 50 = bilateral
  - LT = left
  - RT = right
Key Data Element: *ICD-10-CM Principal Diagnosis Code*

- **Definition:** The ICD-10-CM diagnosis code that is primarily responsible for the admission of the patient to the hospital for care during this hospitalization.

- **Listed as the first coded diagnosis in the medical record.**
Key Data Element: *ICD-10-CM Other Diagnosis Codes*

- **Definition:** The other or secondary (ICD-10-CM) codes associated with the diagnosis for this hospitalization
- **Listed after the principal diagnosis in the medical record**
- **Note:** Only concerned with diagnoses codes listed in Appendix A or B, Tables 5, 6, 7
Key Data Element: *Reason for No Regional Anesthesia*

**Definition:** Reasons why regional anesthesia was not used or attempted for the procedure:
- Documentation of previous spinal fusion
- Documentation of patient/family refusal of regional anesthesia
- Other reasons why regional anesthesia was not used or attempted documented by physician/APN/PA

**Allowable Values**
- **Y (Yes)** There is physician/APN/PA documentation why regional anesthesia was not used or attempted.
- **N (No)** There is no physician/APN/PA documentation why regional anesthesia was not used or attempted or unable to determine from medical record documentation.
Key Data Element: *Reason for No Regional Anesthesia*

**Note for Abstraction:**

- To select “Yes”, documentation of a reason must be dated prior to or on the PACU Discharge Date (or prior to or on the day of surgery if patient did not go to the PACU)
- If reasons are not mentioned in the context of anesthesia, do not make inferences
- Reasons must be documented by a physician/APN/PA
  - Exceptions:
    - Patient/family refusal may be documented by RN
    - Historical documentation indicating previous spinal fusion
THKR-IP-1 & THKR-OP-1

Numerator Statement:
- Patients undergoing a total hip or total knee replacement with regional anesthesia attempted or performed.

Data Element:
- Regional Anesthesia
Key Data Element: *Regional Anesthesia*

- **Definition:** Documentation that the procedure was performed using regional anesthesia or that regional anesthesia was attempted.

- **Allowable Values:**
  - 1. There is documentation that the procedure was performed using regional anesthesia.
  - 2. There is documentation that regional anesthesia was attempted but unsuccessful.
  - 3. There is no documentation that the procedure was performed using regional anesthesia and there is no documentation that regional anesthesia was attempted but unsuccessful or unable to determine from the medical record documentation.
Key Data Element: Regional Anesthesia

Notes for Abstraction:
- If regional anesthesia was attempted but unsuccessful, select “2”.
- If regional anesthesia was performed/attempted in combination with a modality listed in the Exclusion Guidelines, select “1”.
- Inclusion/Exclusion Terms:

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>This list is not all-inclusive:</td>
<td></td>
</tr>
<tr>
<td>• Adductor canal block</td>
<td></td>
</tr>
<tr>
<td>• Epidural block</td>
<td></td>
</tr>
<tr>
<td>• Fascia iliaca block</td>
<td></td>
</tr>
<tr>
<td>• Femoral block</td>
<td></td>
</tr>
<tr>
<td>• Obturator block</td>
<td></td>
</tr>
<tr>
<td>• Paravertebral blocks</td>
<td></td>
</tr>
<tr>
<td>• Peripheral Nerve blocks (single injection or continuous infusion)</td>
<td></td>
</tr>
<tr>
<td>• Psoas block</td>
<td></td>
</tr>
<tr>
<td>• Saddle block</td>
<td></td>
</tr>
<tr>
<td>• Sciatic</td>
<td></td>
</tr>
<tr>
<td>• Spinal block</td>
<td></td>
</tr>
<tr>
<td>• Subarachnoid blocks</td>
<td></td>
</tr>
<tr>
<td>• General Anesthesia</td>
<td></td>
</tr>
<tr>
<td>○ Endotracheal</td>
<td></td>
</tr>
<tr>
<td>○ Inhaled gases</td>
<td></td>
</tr>
<tr>
<td>○ Intravenous</td>
<td></td>
</tr>
<tr>
<td>○ Laryngeal mask airway or anesthesia (LMA)</td>
<td></td>
</tr>
<tr>
<td>○ Total Intravenous Anesthesia (TIVA)</td>
<td></td>
</tr>
<tr>
<td>• Conscious sedation</td>
<td></td>
</tr>
<tr>
<td>• Deep sedation</td>
<td></td>
</tr>
<tr>
<td>• Local with sedation</td>
<td></td>
</tr>
<tr>
<td>• Local with stand-by</td>
<td></td>
</tr>
<tr>
<td>• Monitored anesthesia care (MAC)</td>
<td></td>
</tr>
</tbody>
</table>
THKR-IP-1: Inpatient Regional Anesthesia

**Numerator:** Patients undergoing a total hip or total knee replacement with regional anesthesia attempted or performed.

**Denominator:** Patients undergoing a total hip or total knee replacement.

### To calculate measure:

\[
\frac{E}{E + D}
\]
# THKR-2 Postoperative Ambulation on Day of Surgery

Patients who ambulated on the day of surgery

| Total hip & total knee replacements |

## Denominator Population

<table>
<thead>
<tr>
<th>Included Populations:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Total hip &amp; total knee replacements</td>
</tr>
</tbody>
</table>

## Numerator Population

<table>
<thead>
<tr>
<th>Included Populations: Postoperative ambulation (walking)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Day of surgery</td>
</tr>
<tr>
<td>• Any location including PACU</td>
</tr>
<tr>
<td>• To account for late cases where early ambulation takes place but not on day of surgery (i.e. crosses midnight), if patient ambulates less than or equal to 4 hours of dc from PACU, numerator is met</td>
</tr>
</tbody>
</table>

## Excluded Populations

<table>
<thead>
<tr>
<th>Excluded Populations:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Postoperative patients who are admitted to ICU the day of surgery</td>
</tr>
<tr>
<td>• Documented contraindication for not ambulating on day of surgery</td>
</tr>
<tr>
<td>• Femur, hip, pelvic fractures (ICD-10-CM Principal or Other Diagnosis Code listed in Appendix A or B, Table 7)</td>
</tr>
<tr>
<td>• Patient expired/left AMA the day of surgery</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Excluded Populations: None</th>
</tr>
</thead>
</table>
Rationale

– Early ambulation reduces the risk of complications associated with bed rest such as deep vein thrombosis, pulmonary embolism, atelectasis, pneumonia and urinary retention.
– Decreased length of stay, lowering the patient’s risk for hospital acquired infections and other complications.
– Improvement in outcomes (range of motion, gait, balance, muscle strength and pain) without an increase in adverse events.
THKR-IP-2 & THKR-OP-2

Data Elements:

- CPT® Code Procedure Date
- Discharge Date (inpatients only)
- Discharge Code (outpatients only)
- Discharge Disposition (inpatients only)
- ICD-10-PCS Principal Procedure Date (inpatients only)
- Outpatient Departure Date (outpatients only)
- Postoperative ICU Admit or Transfer
- Reason for Not Ambulating the Day of Surgery
- PACU Discharge Date
Key Data Element: *CPT® Code Procedure Date* (Outpatients Only)

Definition: The month, day, and year when the total hip or total knee replacement procedure was performed.
Key Data Element: **Discharge Code** (Outpatients Only)

**Definition:** The final place or setting to which the patient was discharged from the outpatient setting.

**Allowable Values:**
- 1 Home
- 2 Hospice - Home
- 3 Hospice - Health Care Facility
- 4a Acute Care Facility - General Inpatient Care
- 4b Acute Care Facility - Critical Access Hospital
- 4c Acute Care Facility - Cancer Hospital or Children's Hospital
- 4d Acute Care Facility - Department of Defense or Veteran's Administration
- 5 Other Health Care Facility
- 6 Expired
- 7 Left Against Medical Advice/AMA
- 8 Not Documented or Unable to Determine (UTD)
Key Data Element: Discharge Code (Outpatients Only)

Notes for Abstraction:

- If the medical record states only that the patient is being discharged to another hospital and does not reflect the level of care that the patient will be receiving, select 4a.
- See Inclusion Guidelines (Data Dictionary) for detailed descriptions for each allowable value.
Key Data Element: *Discharge Disposition* (Inpatients Only)

**Definition:** The final place or setting to which the patient was discharged on the day of discharge

**Allowable Values:**
- 1 Home
- 2 Hospice - Home
- 3 Hospice Health Care Facility
- 4 Acute Care Facility
- 5 Other Health Care Facility
- 6 Expired
- 7 Left Against Medical Advice/AMA
- 8 Not Documented or Unable to Determine (UTD)
Key Data Element: *Discharge Disposition* (Inpatients Only)

Notes for Abstraction:

- Only use documentation written on the day prior to discharge through 30 days after discharge when abstracting this data element.
- If the medical record identifies the facility the patients is being discharged to by name only (e.g., Park Meadows), and does not reflect the type of facility or level of care, select value “5” (Other Health Care Facility).
- See Inclusion Guidelines for detailed descriptions for each allowable value.
Key Data Element: **PACU Discharge Date**

Definition: The month, day and year the patient was discharged from the PACU following THKR procedure.

Notes for Abstraction:
- The intent is to capture the date the patient physically left the PACU.
- If a patient is discharged from a PACU level of care, however, remains in the PACU, do not abstract this time.
- EXCEPTION: In the outpatient setting, if a patient is discharged to home from the PACU setting, use the date anesthesia cleared the patient to the next level of care.
Key Data Element: *Postoperative ICU Admit or Transfer*

- **Definition:** Documentation that the patient was admitted or transferred to the intensive care unit (ICU) at this facility postoperatively on the day of surgery or the day of discharge from the PACU (if different from the day of surgery).

- **Allowable Values:**
  - Y (Yes) The patient was admitted or transferred to the ICU postoperatively on the day of surgery or the day of discharge from the PACU (if different from the day of surgery).
  - N (No) The patient was not admitted or transferred to an ICU postoperatively on the day of surgery or the day of discharge from the PACU (if different from the day of surgery), or unable to determine from medical record documentation.
Key Data Element: Postoperative ICU Admit or Transfer

Notes for Abstraction:

- In order to select “Yes” for this data element there must be a Physician/APN/PA order for admit or transfer to an ICU.
- If the patient was transferred to the ICU immediately after surgery without going to the PACU, select "Yes".
- If the patient is transferred to an ICU unit at another facility postoperatively on the day of surgery or the day of discharge from the PACU (if different from the day of surgery), select "Yes".
Key Data Element: *Reason for Not Ambulating the Day of Surgery*

- **Definition:** Reasons for not ambulating the patient on the day of surgery

- **Allowable Values:**
  - Y (Yes) There is documentation of a reason for not ambulating the patient on the day of surgery.
  - N (No) There is no documentation of a reason for not ambulating the patient on the day of surgery or unable to determine from medical record documentation.
Key Data Element: Reason for Not Ambulating the Day of Surgery

Notes for Abstraction:

- To select “Yes”, documentation of a reason for not ambulating the patient on the day of surgery must be dated on or prior to the PACU Discharge Date or on or prior to the day of surgery if the patient did not go to the PACU.
- Must be documented by a physician/APN/PA/nurse/physical therapist/occupational therapist.
- If reasons are not mentioned in the context of ambulation, do not make inferences.
- If the data element “Postoperative ICU Admit or Transfer” was abstracted as “Yes”, select “Yes”.
- In the absence of a medical reason, patient/family/caregiver refusal is not an acceptable stand alone reason for not ambulating on the day of surgery.
THKR-IP-2 & THKR-OP-2

Numerator Statement:
- Patients undergoing total hip or total knee replacement who mobilized postoperatively the day of surgery or mobilized in the PACU or within 4 hours of discharge from the PACU.
  - To account for late cases where early ambulation takes place but not on day of surgery (i.e. crosses midnight), if patient ambulates less than or equal to 4 hours of dc from PACU, numerator is met

Data Elements:
- Ambulation
- Ambulation Date
- Ambulation Time
- PACU Discharge Date
- PACU Discharge Time
Key Data Element: *Ambulation*

- **Definition:** Documentation that the patient ambulated at any time during the postoperative period.

- **Allowable Values:**
  - Y (Yes) There is documentation the patient ambulated during the postoperative period.
  - N (No) There is no documentation the patient ambulated during the postoperative period or unable to determine from medical record documentation.
Key Data Element: *Ambulation*

**Notes for Abstraction:**

- There is no minimum distance requirement.
- Ambulation with assistive devices (e.g., walker, cane) and/or physical assist (e.g., therapist, nurse) is acceptable.
- Documentation that the patient actually ambulated must be present. Do not assume the patient ambulated based solely on documentation that PT/OT saw the patient.
- Ambulation can be documented by any member of the healthcare team including but not limited to physician, advanced practice nurse, physician assistant, nurse, nurse assistant, clinical technician, physical therapist, occupational therapist, kinesiotherapist.
- **Inclusion/Exclusion Terms:**

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulate</td>
<td>Bedside commode usage</td>
</tr>
<tr>
<td>Step</td>
<td>Dangle</td>
</tr>
<tr>
<td>Walk</td>
<td>Out of bed order</td>
</tr>
<tr>
<td></td>
<td>Sit in bed</td>
</tr>
<tr>
<td></td>
<td>Sit out of bed</td>
</tr>
<tr>
<td></td>
<td>Sit to Stand</td>
</tr>
<tr>
<td></td>
<td>Stand</td>
</tr>
<tr>
<td></td>
<td>Transfer from bed to chair</td>
</tr>
<tr>
<td></td>
<td>Up to chair</td>
</tr>
</tbody>
</table>
Key Data Element: *Ambulation Date/Time*

**Definition:** The date/time the patient first ambulated following the surgical procedure.

**Notes for Abstraction:**
- Review the record to determine the earliest date/time the patient ambulated following the surgical procedure. There is no minimum distance requirement.
- Ambulation in the PACU is acceptable
- Same guidelines as *Ambulation* data element
Key Data Element:  *PACU Discharge Time*

- **Definition:** The time the patient was discharged from the PACU following THKR procedure
- **Notes for Abstraction:**
  - The intent is to capture the time the patient physically left the PACU.
  - If a patient is discharged from a PACU level of care, however, remains in the PACU, do not abstract this time.
  - EXCEPTION: In the outpatient setting, if a patient is discharged to home from the PACU setting, use the time anesthesia cleared the patient to the next level of care.
THKR-IP-2: Inpatient Postoperative Ambulation on Day of Surgery

Numerator: Patients undergoing total hip or total knee replacement who ambulated postoperatively the day of surgery or in the PACU or within 4 hours of discharge from the PACU.

Denominator: Patients undergoing a total hip or total knee replacement.

To calculate measure: E + D
THKR-3 Discharged to Home

Patients discharged to home

Total hip & total knee replacements

<table>
<thead>
<tr>
<th>Denominator Population</th>
<th>Numerator Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Included Populations:</td>
<td>Included Populations: Patients discharged to home</td>
</tr>
<tr>
<td>• Total hip &amp; total knee replacements</td>
<td></td>
</tr>
<tr>
<td>Excluded Populations:</td>
<td>Excluded Populations: None</td>
</tr>
<tr>
<td>• Bilateral/concurrent procedures</td>
<td></td>
</tr>
<tr>
<td>• Femur, hip, pelvic fractures (ICD-10-CM</td>
<td></td>
</tr>
<tr>
<td>Principal or Other Diagnosis Code listed in</td>
<td></td>
</tr>
<tr>
<td>Appendix A or B, Table 7)</td>
<td></td>
</tr>
<tr>
<td>• Expired or left AMA</td>
<td></td>
</tr>
<tr>
<td>• Resident of nursing home or “other health</td>
<td></td>
</tr>
<tr>
<td>care facility”</td>
<td></td>
</tr>
<tr>
<td>• Medical/social reason for not discharging</td>
<td></td>
</tr>
<tr>
<td>patient to home</td>
<td></td>
</tr>
</tbody>
</table>
Rationale

- No difference in pain, functional outcomes, or patient satisfaction between groups that received home-based rehabilitation versus inpatient rehabilitation.
- Cost effective

Gap

- 49% discharged to inpatient rehabilitation facility (IRF) or skilled nursing facility (SNF) for rehabilitation. (Source: 2012 Medicare claims data)
- Hence, only 51% of patients were discharged to home.
THKR-IP-3 & THKR-OP-3

Key Data Elements:
- Reason for Not Discharging Patient to Home
- Resident of Other Health Care Facility
Key Data Element: *Reason for Not Discharging Patient to Home*

**Definition:** Reasons for not discharging the patient to home.

**Allowable Values:**
- **Y (Yes)** There is documentation of a medical/social reason for not discharging the patient to home.
- **N (No)** There is no documentation of a medical/social reason for not discharging the patient to home or unable to determine from medical record documentation.
Key Data Element: *Reason for Not Discharging Patient to Home*

**Notes for Abstraction:**

- Must be documented by a physician/APN/PA/nurse/social worker/care manager/discharge planner/physical therapist/occupational therapist.
- Reasons do NOT need to be documented at discharge or otherwise linked to the discharge timeframe: Documentation of reasons anytime during the encounter are acceptable.
  - If reasons are not mentioned in the context of discharge to home, do not make inferences.
  - In the absence of a medical/social reason, patient/family/caregiver refusal is not an acceptable stand alone reason for not discharging the patient to home.
Key Data Element: Resident of Other Health Care Facility

Definition: The patient is currently a resident of an Other Health Care Facility prior to this encounter.

Allowable Values:
- Y (Yes) The patient is currently a resident of an Other Health Care Facility prior to this encounter.
- N (No) The patient is not currently a resident of an other health care facility prior to this encounter or unable to determine from medical record documentation if the patient is a resident of an other health care facility.
Key Data Element: *Resident of Other Health Care Facility*

Notes for Abstraction:

- To select “Yes” the patient must currently be a resident of a facility listed in the Inclusion List prior to this encounter.
- If the patient is a resident of an assisted living facility (ALF) or assisted living care at a nursing home, intermediate care, or skilled nursing facility, select “No”.
- If the patient is a resident of a retirement community, select “No”.
- Inferences should not be made based on internal knowledge. If the medical record identifies the facility where the patient resides by name only (e.g., “Park Meadows”), and does not reflect the type of facility or level of care, select “No”.

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THKR-IP-3 & THKR-OP-3

Numerator Statement:
- Patients who were discharged to home following total hip or total knee replacement

Data Elements:
- Discharge Code (outpatients only)
- Discharge Disposition (inpatients only)
THKR-4 Preoperative Functional/Health Status Assessment

Patients who completed the general health (VR-12 or PROMIS-Global) AND joint specific functional status assessments (HOOS Jr/subscales or KOOS Jr/subscales) within 90 days prior to surgery

Total hip & total knee replacements

<table>
<thead>
<tr>
<th>Denominator Population</th>
<th>Numerator Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Included Populations:</td>
<td>Included Populations:</td>
</tr>
<tr>
<td>• Total hip &amp; total knee replacements</td>
<td>Patients who completed the general health (VR-12 or PROMIS-Global) AND</td>
</tr>
<tr>
<td></td>
<td>Hips: HOOS Jr. (6 questions) or HOOS Pain, Function Daily Living Subscales (27 questions)</td>
</tr>
<tr>
<td></td>
<td>Knees: KOOS Jr. (7 questions) or KOOS stiffness, Pain, Function Daily Living Subscales (28 questions)</td>
</tr>
<tr>
<td></td>
<td>Within 90 days prior to surgery</td>
</tr>
<tr>
<td>Excluded Populations:</td>
<td>Excluded Populations: None</td>
</tr>
<tr>
<td>• Femur, hip, pelvic fractures (ICD-10-CM Principal or Other Diagnosis Code listed in Appendix A or B, Table 7)</td>
<td></td>
</tr>
</tbody>
</table>
Rationale

- Good orthopedic care requires knowledge of the patient’s history of musculoskeletal pain and associated limitations in daily function.
- Standardized measures of patient-reported outcomes (PROs) can provide this information.
- Integrating PROs into routine orthopedic patient visits can provide key information to monitor changes in symptom severity over time, support shared clinical care decisions, and assess treatment effectiveness.
THKR-IP-4 & THKR-OP-4

Data Elements:
- No new denominator data elements for this measure that we haven’t already covered.
THKR-IP-4 & THKR-OP-4

Numerator Statement:
- Percentage of patients who completed the general health (VR-12 or PROMIS-Global) AND joint specific functional status assessments:
  - HOOS JR (hip patients only)
  - KOOS JR (knee patients only)

Data Elements:
- Preoperative Assessments Completed
- Preoperative Assessments Completion Date
Key Data Element: *Preoperative Assessments Completed*

Definition: Documentation that the patient completed the general health and joint specific functional status assessments as specified below:

Allowable Values:
- **Y (Yes)** The general health and joint specific functional status assessments were completed.
- **N (No)** Both the general health and joint specific functional status assessments were not completed.

<table>
<thead>
<tr>
<th>Hips</th>
<th>Knees</th>
</tr>
</thead>
<tbody>
<tr>
<td>VR-12 or PROMIS-Global AND HOOS Jr.</td>
<td>VR-12 or PROMIS-Global AND KOOS Jr.</td>
</tr>
<tr>
<td>Or HOOS Pain, Functional Daily Living Subscales</td>
<td>Or KOOS Stiffness, Pain, Functional Daily Living Subscales</td>
</tr>
</tbody>
</table>

Hips

- VR-12 or PROMIS-Global
- AND
- HOOS Jr.
- Or HOOS Pain, Functional Daily Living Subscales

Knees

- VR-12 or PROMIS-Global
- AND
- KOOS Jr.
- Or KOOS Stiffness, Pain, Functional Daily Living Subscales
Key Data Element: Preoperative Assessments Completed

Notes for Abstraction:

- When determining if the preoperative general health and joint specific functional status assessments were completed, documentation must be present in the current medical record.
- Information can be retrieved from the actual assessment tools or a copy of the assessment tools in the current medical record or references to the tools present in the current medical record.
Key Data Element: *Preoperative Assessments Completion Date*

- **Definition:** The date the patient completed the general health and joint specific functional status assessments.

- **Notes for Abstraction:**
  - Information can be retrieved from the actual assessment tools or a copy of the assessment tools in the current medical record or references to the tools present in the current medical record.
  - If the general health and joint specific functional status assessments were completed on 2 different dates, select the earliest completion date.
To calculate measure:

\[ E \quad \frac{E + D}{E + D} \]
Data Submission

- Via CMIP (Certification Measure Information Process)
- Same as core certification data submission process
- Data due quarterly
- Contact account executive for more information
Need help?

Abstraction questions can be submitted to the Q&A portal at https://manual.jointcommission.org/. New users must first complete a brief registration prior to submitting a question.
Q&A

Due to the large number of participants listening to this presentation, we ask that you limit yourself to one question.

To ask a question please type your name, organization and your question in the chat box provided on the far right hand side of the screen.

The webinar replay and slide presentation will be recorded and posted here following the webinar date.
Additional Learning Opportunity

https://www.jointcommission.org/certification/dsc_orthopedic.aspx
www.jointcommission.org Under the topics tab in the upper navigation bar, click on the Certification tab, then click on Disease-Specific Care Certification, then Orthopedic and finally Total Hip and Total Knee Replacement.

https://manual.jointcommission.org/ Submit abstraction questions to this Q&A portal. New users must first complete a brief registration prior to submitting a question.

Inpatient Implementation Guide

Outpatient Implementation Guide
THANK YOU VERY MUCH FOR YOUR PARTICIPATION!