Bundled Payment Implementation for Primary Total Joint Patients

2016 Combined Sections Meeting

Speaker(s):
- Gary Calabrese, PT, DPT
- Karen Green, PT, DPT
- Douglas Newlon, PT
- Steven Pamer, PT, MPA, GCS

Session Type: Educational Sessions
Session Level: Multiple

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February 17-20, 2016
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HPA The Catalyst
is the Section on Health Policy & Administration of the American Physical Therapy Association

www.aptahpa.org
Implementation of a Bundled Payment Initiative for Primary Total Joint Patients

February 19, 2016

Gary Calabrese PT, DPT
Karen Green PT, DPT

Doug Newlon, PT
Steve Pamer PT

Disclosure

The speakers of this presentation have no relevant financial or nonfinancial relationships to disclose.
Learning Objectives

• Participants will be able to verbalize understanding of the Bundled Payment Care Initiative and its impact on provision of care for total joint patients

• Participants will be able to discuss initiatives for implementation and continuation of a BPCI program

• Participants will be able to identify potential barriers to successful implementation of a BPCI program

Agenda

• Introduction & History of Bundled Payment Care Initiative (BPCI) – Gary Calabrese (30 min)

• The First Hospital, Successes & Lessons Learned – Doug Newlon (30 min)

• Partners in Care – Steve Pamer (20 min)

• Rolling Out the Rest, Successes & Lessons Learned – Karen Green (30 Min)

• Q & A (10 min)
Introduction & History of Bundled Payment Care Initiative (BPCI)

Two Paradigms in Health Care Reform

1. Managing population health, PCMH
2. Managing episodes of care, Bundled payments

Total Spend: Commercial & Government

Source: Ohio.gov, McKinsey
Affordable Care Act Charged CMS to Explore Innovative Payment Models

Center for Medicare & Medicaid Innovation (CMMI)

Bundled Payments for Care Improvement (BPCI)

Model 2: Retrospective Acute Care Hospital Stay & Post-Acute Care

BPCI Agreements with Medicare

| Bundle                  | MS DRGs 469 & 470  
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td></td>
<td>Primarily total hip/knee replacements</td>
</tr>
<tr>
<td>Episode Duration</td>
<td>7 days prior, 30 days post</td>
</tr>
<tr>
<td>Target Price</td>
<td>Determined by location</td>
</tr>
<tr>
<td>Contract</td>
<td>3 years (10/1/13 – 9/30/16)</td>
</tr>
</tbody>
</table>

Episode of care was defined by CMS and priced based on historic CMS spend. No patients or providers are excluded.
What are bundled payments?

Total Joint: Fee for Service

Total Joint: Bundled Payment

Creating Value Through Episode Management

Premise:

- When change in health status demands intervention, managing the entire episode is preferable to fragmented care delivery

Tactic:

- Care redesign focusing on improved care coordination and patient and provider engagement yields better care at lower cost

Strategic Imperative:

- Providers who master this approach will have a competitive advantage in the marketplace
Contracting Through BPCI, CC Retains Most of Value Created

CMS cost savings contracted at 3%

Opportunity

Care Improvement

What’s in/What’s Out

- Traditional Medicare
- Surgeon Participation (all; no exclusions)
- DRG 469 and 470
- Hip Fractures
- Opt Out Option
- 3 Year Lock on Medicare Spend
Key Provisions

Waivers
- 3-day hospital stay for Post Acute Care payment
- Homebound status for Home Care

Gainsharing
- Opportunity to share risk and reward among providers
- CMS allows gain sharing with participating providers, e.g. the Quality Alliance, home health, etc. *

* In process of developing shared savings model to be rolled out in 2015.

Key Success Factors and Principles
**Surgeon as Team leader**

- Manages the episode: clinical and financial impact
- Sets the expectations of patient and team
- Direct attention to entire care continuum of total joint replacement care
- Opportunity exists to enhance value through better care coordination

**Specialty Care Coordinator**

- Manages each patient through the episode
- Single point of patient contact
- Management starts when patient consents and is scheduled
- Education resource for patient, patient family and clinical team; monitors key activities (e.g., joint class participation); monitors LOS in hospital, Home Health and SNF; communication with clinical team: on plan/off plan
Episode-Based Complete Care Philosophy

- Care Path Utilization: Following best practices
- Care Coordination: Working seamlessly together
- Connected Care: Providing care in appropriate venue

Clinical Teams, Patient and Family Engagement

Managing Risk: Increased LOS; 30 Day All Cause Readmission

1. Diabetes: Hgb A1c if >7 delay and refer
2. Smoker: if YES then refer to smoking cessation
3. BMI: if >40---refer for counseling, metabolic consult
4. Anemia: if Hgb <12 in females and <13 in males, delay and refer - blood management*
5. Staph colonization: if in HC facility or HC worker or hx of MRSA, screen and decolonize
6. Narcotic dependence, manage upfront
7. Anticoagulation history or need preoperatively
Guiding Principles

- **Invest in the up front in process:** Preoperative identification, sufficient symptoms interfering with ADL, work or recreation, quality of life, inability of alternative treatment to resolve symptoms, objective evidence of joint disease amenable to surgical correction.

- **Engaged and educated patients and families are key:** Patients become drivers of their recovery, families and other care givers must be identified preoperatively, actively engaged and committed to helping the patient recover, inform patients of their risk factors.

- **Patients should expect to return to their home as soon as it is safe:** return of physiologic function, pain managed with oral medication, safe environment at home.

Guiding Principles

- **More is not better; less may be more:** volume of services does not drive value of care, increased number of interventions may increase risk, each intervention carries a risk that must be weighed against its intended.

- **Time in a facility should be limited:** Risk of hospital acquired conditions(e.g., infections, DVT’s), sleep deprivation, immobility, malnourishment.
The First Hospital, Successes & Lessons Learned

- Euclid Hospital
  - Rapid Recovery – Go Live
  - BPCI Go Live – at risk

Euclid Hospital Proposal

<table>
<thead>
<tr>
<th>Post Acute Period</th>
<th>30 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proposed Discount</td>
<td>3%</td>
</tr>
<tr>
<td>Bundle</td>
<td>Total hip/knee replacements (MS DRGs 469 &amp; 470)</td>
</tr>
<tr>
<td>Patient Population</td>
<td>Medicare FFS patients</td>
</tr>
<tr>
<td>Duration of program</td>
<td>3 years</td>
</tr>
</tbody>
</table>
BPCI Timeline - 2013

January 1, 2013
Phase I (No Risk) period begins

January 10, 2013
Submitted additional documentation to CMS finalizing our bundle and care redesign plan

January 31, 2013
CMS publicly announces participants

March & May 2013
Data sharing, target price setting, contracting process

July 1, 2013
Phase II (Risk) period begins

TKA and THA at Euclid: BPCI and Rapid Recovery

• Create an environment for success of program
• Define success for the program
• Establish team around shared goals
• Enhance communication among team members
• Establish principles that form the basis of care
• Help define accountability and responsibilities
Principles

• Patients should expect to return to their homes as soon as it is safe
• Shared expectation
• Time in an Institution should be minimized to reduce the risk of Hospital Acquired Condition
• Being in Hospital/SNF is not health promoting

Principles

• Patients need to be thoroughly educated and engaged in the process of their care and become drivers of their recovery
• Families and other support personnel must be identified preoperatively and actively engaged and committed to helping the patient recover
Principles

• Volume of services does not drive value of care
• Less intervention is sometimes better
• More pain meds or therapy or interventions do not inherently produce better outcomes

Principles of Value-Based Health Care Delivery

• The central goal in health care must be value for patients, not access, volume, convenience, or cost containment

\[
\text{Value} = \frac{\text{Health outcomes}}{\text{Costs of delivering the outcomes}}
\]

– Outcomes are the full set of patient health outcomes over the care cycle—NEED DATA ON OUTCOMES
– Quality is one outcome: absence of adverse events--Safety
– Costs are the total costs of care for a patient’s condition over the care cycle—NEED DATA ON COSTS

Courtesy of Professor Porter
Mary Witkowski
Dr. Caleb Stowell
Harvard Business School
Value = Quality/Cost

- Improve Quality of Care
- Reduce Cost of Care

Total Joint Care Path

- Standardization of Care
  - Staff Education
  - Patient Education
    - Multidisciplinary group designed
    - Creation of standardized patient education THA/TKA binders
    - Standardization of Pre-op Total Joint Classes
The Total Experience
Total Joint Replacement
and Complete Care

Patient Optimization

- BMI
- HgA1C
- Anemia management
- Smoking Cessation
Hospital Care

• Full time Care Advocate in place
• Completes data information on each patient having knee, hip or Birmingham joint before seeing patient.
• Rounds on patient daily
• Determines that stockings on, anticoagulation administered, antibiotics discontinued, pain level, foley removed, progress in therapy and discuss discharge plans
• Discusses with patient post op instructions

Hospital Care

• Follow up phone calls made on each patient 2-3 days after discharge from hospital, SNF or Rehab. Surgical follow up episode placed in Epic.
• Joint Class is being redesigned to meet rapid recovery specifications
• Additional joint class offerings to be provided.
• Documentation in EPIC of instructions given during joint class and that patient attended class.
• Restructuring shifts and therapy schedules with patients.
  - POD 0 Evaluations
  - BID Tx sessions
Post Acute Care

• Have met with intake office and taught rapid recovery
• Working with Market and Network services about extension of program to private payors and medicare programs
• Intake office in communication with Main Campus CM dept for back fill of single joints for SNF
• Coordination with Home Health
The single greatest impact to the cost of the bundle:

Discharged to home rate

469/470 at Euclid for 30-day PAC Period

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<thead>
<tr>
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<tbody>
<tr>
<td>Home-Going Population</td>
<td>12%</td>
<td>29%</td>
<td>46%</td>
</tr>
<tr>
<td>Rehab/SNF- Going Population</td>
<td>88%</td>
<td>71%</td>
<td>54%</td>
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<tr>
<td>Potential Gainshare/ Loss</td>
<td>$57,169</td>
<td>$239,418</td>
<td></td>
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<tr>
<td>Discount Achieved Over our 2009 Experience</td>
<td>4.3%</td>
<td>8.4%</td>
<td></td>
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</table>

Opportunity

Unsure of our target from CMS

Jan 2013 Going Home Rate: 59%

Orthopedics Advisory Council

- Surgical Core Measures
- PI Study Results
  - Nursing, Therapy, PAT, Pharmacy
- Surgical Site Infections
- VTE Reporting
- Report Card
## Euclid Hospital Complete Care Bundle Patients Report Card

<table>
<thead>
<tr>
<th></th>
<th>Q1 2013</th>
<th>Q4 2013</th>
<th>Q1 2014</th>
<th>Q2 2014</th>
<th>Q3 2014</th>
<th>Q4 2014</th>
<th>Q1 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Discharge Home</strong></td>
<td>39%</td>
<td>71%</td>
<td>75%</td>
<td>70%</td>
<td>68%</td>
<td>68%</td>
<td>55%</td>
</tr>
<tr>
<td><strong>SNF</strong></td>
<td>56%</td>
<td>28%</td>
<td>23%</td>
<td>27%</td>
<td>31%</td>
<td>31%</td>
<td>41%</td>
</tr>
<tr>
<td><strong>Readmissions</strong></td>
<td>5.00%</td>
<td>2.00%</td>
<td>1.60%</td>
<td>2.70%</td>
<td>2.00%</td>
<td>4.80%</td>
<td>1.9%</td>
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<tr>
<td><strong>LOS</strong></td>
<td>3.4</td>
<td>2.9</td>
<td>2.67</td>
<td>2.87</td>
<td>3.01</td>
<td>3.05</td>
<td>3.115</td>
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<tr>
<td><strong>HCAHPS Would Recommend</strong></td>
<td>81.2%</td>
<td>82.4%</td>
<td>84.4%</td>
<td>83.9%</td>
<td>81.8%</td>
<td>79.3%</td>
<td>82.4%</td>
</tr>
<tr>
<td><strong>HCAHPS Overall Rating</strong></td>
<td>73.3%</td>
<td>87.9%</td>
<td>78.1%</td>
<td>84.4%</td>
<td>84.8%</td>
<td>75.9%</td>
<td>82.4%</td>
</tr>
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### Euclid Results

<table>
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<tr>
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<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>Q1 2013</th>
<th>Q4 2013</th>
<th>Q1 2014</th>
<th>Q2 2014</th>
<th>Q3 2014</th>
<th>Q4 2014</th>
<th>Q1 2015</th>
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<tbody>
<tr>
<td><strong>Count</strong></td>
<td>272</td>
<td>26</td>
<td>14</td>
<td>14</td>
<td>52</td>
<td>17</td>
<td>69</td>
<td>69</td>
<td>69</td>
<td>69</td>
<td>69</td>
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<tr>
<td><strong>Bundle</strong></td>
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<td></td>
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<td></td>
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</tr>
<tr>
<td><strong>Patients</strong></td>
<td>272</td>
<td>26</td>
<td>14</td>
<td>14</td>
<td>52</td>
<td>17</td>
<td>69</td>
<td>69</td>
<td>69</td>
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<tr>
<td><strong>Average Length of Stay</strong></td>
<td>2.9</td>
<td>3.7144</td>
<td>2.63</td>
<td>3.115384615</td>
<td>2.765</td>
<td>3.03</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>BMI &gt;40</strong></td>
<td>6%</td>
<td>4%</td>
<td>21%</td>
<td>18%</td>
<td>12%</td>
<td>14%</td>
<td>12%</td>
<td>14%</td>
<td>12%</td>
<td>14%</td>
<td>12%</td>
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<tr>
<td><strong>BMI &gt;40 Treated/Referred</strong></td>
<td>10%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
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<td>0%</td>
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</tr>
<tr>
<td><strong>BMI &gt;40 Referral</strong></td>
<td>25%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Joint Class Participation</strong></td>
<td>29%</td>
<td>14%</td>
<td>72%</td>
<td>81%</td>
<td>25%</td>
<td>42%</td>
<td>25%</td>
<td>42%</td>
<td>25%</td>
<td>42%</td>
<td>25%</td>
</tr>
<tr>
<td><strong>Medication Reconciliation Complete</strong></td>
<td>-</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Medication Reconciliation Total pts over 65</strong></td>
<td>-</td>
<td>25</td>
<td>14</td>
<td>12</td>
<td>52</td>
<td>69</td>
<td>69</td>
<td>69</td>
<td>69</td>
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<tr>
<td><strong>SSI</strong></td>
<td>0.0037</td>
<td>0</td>
<td>0</td>
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<td>0.60</td>
<td>1.00</td>
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<td>1.00</td>
<td>1.00</td>
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<tr>
<td><strong>Falls w/ Injury</strong></td>
<td>0.54</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.80</td>
<td>0.30</td>
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<td>0.30</td>
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<tr>
<td><strong>Labs Acute/Post Acute</strong></td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td><strong>Readmission Rate (all data)</strong></td>
<td>3.3%</td>
<td>3.07%</td>
<td>2.74%</td>
<td>3.07%</td>
<td>3.07%</td>
<td>3.07%</td>
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<tr>
<td><strong>Readmission Count (all data)</strong></td>
<td>90</td>
<td>0</td>
<td>5</td>
<td>0</td>
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<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td><strong>Postop VTE/PE (Data reported is from previous month)</strong></td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td><strong>Postop Resp Failure (Data reported is from previous month)</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td><strong>Pt Complaints w/ Bundle</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td><strong>Discharge Disposition</strong></td>
<td>18%</td>
<td>55%</td>
<td>7%</td>
<td>0%</td>
<td>18%</td>
<td>0%</td>
<td>0%</td>
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<td>0%</td>
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<tr>
<td><strong>Home</strong></td>
<td>18%</td>
<td>55%</td>
<td>7%</td>
<td>0%</td>
<td>18%</td>
<td>0%</td>
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<td>0%</td>
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</tr>
<tr>
<td><strong>HHC</strong></td>
<td>51%</td>
<td>31%</td>
<td>37%</td>
<td>37%</td>
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<td>37%</td>
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<td>37%</td>
<td>37%</td>
<td>37%</td>
<td>37%</td>
</tr>
<tr>
<td><strong>SNF</strong></td>
<td>29%</td>
<td>35%</td>
<td>37%</td>
<td>37%</td>
<td>37%</td>
<td>37%</td>
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</tr>
<tr>
<td><strong>Total</strong></td>
<td>22%</td>
<td>35%</td>
<td>37%</td>
<td>37%</td>
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<td>37%</td>
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### HCAHPS

<table>
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<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>Q1 2013</th>
<th>Q4 2013</th>
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<th>Q1 2015</th>
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<tbody>
<tr>
<td><strong>Would Recommend</strong></td>
<td>81.2%</td>
<td>82.4%</td>
<td>84.4%</td>
<td>83.9%</td>
<td>81.8%</td>
<td>79.3%</td>
<td>82.4%</td>
<td></td>
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<tr>
<td><strong>Overall Rating</strong></td>
<td>73.3%</td>
<td>87.9%</td>
<td>78.1%</td>
<td>84.4%</td>
<td>84.8%</td>
<td>75.9%</td>
<td>82.4%</td>
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Partners in Care

- Cleveland Clinic Center for Connected Care
  - Cleveland Clinic Connected Care Skilled Nursing Units
  - Cleveland Clinic at Home

Historical Data

% of diagnosis 469 and 470 who typically went to SNU, OP or HHC

<table>
<thead>
<tr>
<th></th>
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<th>2015</th>
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<tbody>
<tr>
<td>SNU</td>
<td>58</td>
<td>39</td>
</tr>
<tr>
<td>OP</td>
<td>17</td>
<td>21</td>
</tr>
<tr>
<td>HHC</td>
<td>20</td>
<td>39</td>
</tr>
</tbody>
</table>
Impact

• Staffing, staffing, staffing!
  - Added 2 weekenders and 4 case managers
  - Currently 9 open positions

Impact

• Utilization: historical
  - Dates Jan – Aug 2014
  - Range 5 – 11 visits
  - Mode 8 visits
  - Mean: 7.57 visits
Visit 1

- **Visit 1 Expectations:**
- Schedule the first visit of OP PT visit.
- Establish visit frequency of 5 visits, plus one PRN visit.
- Assessment tools expected to be completed on the first visit:
  - Vital signs: BP, HR and temperature
  - ROM (please include position of testing and PROM and/or AROM)
  - EBT
  - Edema (objectively measured)
  - Medication compliance
Visit 1

- Teaching to be completed on the first visit:
  - Complete instruction and review of performance of HEP.
  - Edema management
  - Pain management/Medication compliance
  - Home safety instruction

Visit 1

- Review of the MD protocol.
- Review anti coagulation therapy education
- Review anti constipation instruction
- Wound instruction and nutrition counseling.
- Patient/family education
Visit 2

- Removal of dressing, if applicable, wound healing instruction including nutrition and smoking cessation.
- Review of goals
- Teaching to be completed on the second visit:
  - HEP progression of TKA HEP and open chain exercises

Visit 2

- Edema management
- Pain management/Medication compliance
- Review anti coagulation therapy education
- Review anti constipation instruction
- Patient/family education
- Stair instruction
Visit 3

• Removal of dressing, wound healing instruction including nutrition and smoking cessation.
• Review of goals
• Review of EBT
• Teaching to be completed on the third visit:
  
  • Gait instruction: assess gait and begin instruction with a cane
  • HEP :closed chain instruction HEP progression of TKA HEP and open chain exercises
  • Pain management/Medication compliance
  • Review anti constipation instruction
  • Patient/family education
Visit 4

- Review of goals
- Teaching to be completed on the fourth visit:
  - HEP review and instruction as needed
  - Gait instruction: progression to SC and outdoor ambulation

Visit 4

- Car transfer instruction HEP progression of TKA HEP and open chain exercises
- Pain management/Medication compliance
- Patient/family education
Visit 5

- Gait instruction: assess proficiency of ambulation on level surfaces and stairs with SC
- ROM: assessment
- EBT review
- Goal reevaluation and DC
- Oasis gathering point
- Progression of patient to OP PT.

Visits

- These five visits should occur between post op days 2 and 15, visits should be spaced two to three days apart.
Rolling out the Rest

- 8 Hospitals
  - 7 Regional Hospitals
  - 1 Main Campus (Pseudo PBCI)

The Hospitals
Keys To Success

• Early Engagement of Home Team
  - Key stakeholders from each hospital took ownership of local workflows

• Consistent Messaging
  - Both hard and soft messaging

• Visibility
  - All hospital metrics shared monthly = Healthy competition
Keys To Success

- Don’t Wait to Start
  - Many hospitals were working to support the initiative prior to Go-Live.

Lessons Learned

- Physician Messaging is Key
- Measure to be Sure – Turn perceptions into reality

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<tr>
<th>Week of</th>
<th>3-Aug</th>
<th>10-Aug</th>
<th>17-Aug</th>
<th>24-Aug</th>
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<th>7-Sep</th>
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<td>37%</td>
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Comments:
Lessons Learned

• Communicate
  - Early & Often
• Variance Happens
• Don’t assume Ortho Nurses know how to mobilize patients

Lessons Learned

• Culture of Mobility

Creating a “Culture of Mobility”

Orthopedic Nurse/PCNA Training

Debunking the Myths

1. The patient must be evaluated by therapy before they can get out of bed.
2. The 2-3 times that the patient is up with therapy is enough for them to get stronger and more mobile.
3. The patient will always be seen twice a day by therapy.
Lessons Learned

• Culture of Mobility

Femoral Nerve Catheter vs. Saphenous Block

Femoral Nerve Catheter
- Continuous infusion to proximal femoral nerve
- Affects sensory & motor aspects of L2,3,4 dermatomes/myotomes
- Precautions: Pt. needs a knee immobilizer when up until motor components resolve
- Resolution usually does not occur until after infusion is stopped
- Significant fall risk due to knee buckling

Saphenous Block
- One time injection into the adductor canal
- Affects sensory at L2,3,4 dermatomes/motor aspects
- No additional precautions
- Should last 24-36 hours
- Requires more skill administration and free of a "learning curve" placement

Weight-bearing Status....What does it mean

- WBAT – Weight Bearing as Tolerated
  - Patient should bear as much weight as they can tolerate up to full weight-bearing
- PWB – Partial Weight Bearing
  - Should be tolerated by a percentage of 20%, 50%, 75% of body weight
  - This is the percentage of the patient’s body weight
  - Example: A patient with 50% weight-bearing status could stand with weight equally distributed or both feet but should not shift more weight to the operative side without off-weighting to an assistive device
- FWB – Full Weight-bearing
- TDWB – Touch Down Weight Bearing
  - Can place foot on floor during transfers/ambulation but should not put weight through the entire foot
  - Sometimes documented as TTWB ( Toe Touch Weight Bearing)
- NWB – Non Weight Bearing
  - Extremely should be held up and not transfer any weight

Where are we Now?

• Standardized patient tools
  - Online Patient Guide
  - Online Exercise Video
  - Standardized Pre-Op Class

Are you planning to have total joint replacement surgery? Do you know someone who is?
Where are we Now?

- Metrics improving across all hospitals
- **Proposed** Comprehensive Care for Joint Replacement Payment Model