

# QualityPath™ Elective Knee Replacement and Total Hip Replacement Maintenance of Designation (MoD)

## Introduction

### 1. Overview of The Alliance®

The Alliance moves health care forward by controlling costs, improving quality and engaging individuals in their health. An employer-owned, not-for-profit cooperative, our more than 240 members provide coverage to about 85,000 people in Wisconsin, Illinois and Iowa. Our robust network lets members choose from more than 120 hospitals, 20,000 professional service providers and 5,500 medical clinic sites in Wisconsin, Illinois, Iowa and Minnesota.

The Alliance continually pursues higher value on behalf of its members, including strategies such as measuring quality, negotiating pay-for-performance contracts, nurturing patient engagement and collaborating with stakeholders at every level of the health care system. The Alliance provides education and resources to help members design value-based benefit plans and implement employee wellness and prevention programs.

### 2. The Program

*QualityPath* identifies high-quality care; uses new ways to pay for care; and rewards patients who choose that care with lower out-of-pocket costs. We worked with providers to develop these programs.

We started this initiative at the request of some of our members who are interested in developing incentives for their employees and family members to choose high-value providers.

This program will use evidence-based standards to assess the quality of care provided. Those that meet or exceed thresholds will be publicly recognized for quality. All aspects of this process will be completely transparent.

### 3. Submission Instructions

These instructions are intended to provide guidance to respondents and to facilitate fair and objective evaluations of submissions. **Please follow these instructions carefully.**

#### a. Contact Point/Responses to Questions

Please direct all questions, clarifications and inquiries regarding this MoD to [QualityPathRFP@the-alliance.org](mailto:QualityPathRFP@the-alliance.org). We will provide a written response to all questions to all respondents to ensure that proposals are based on uniform information.

#### b. Responses Format

A separate response needs to be submitted for each individual facility applying, even if multiple facilities are part of the same system. The designation is for a facility and a surgeon practicing at that facility (facility and surgeon specific).

Each criterion has a number in front of it. Where possible, please reference the number in the supporting documentation to assist with cross-referencing criteria and documentation.

c. Response Submission

Please provide an electronic version of your response, signed by the authorized representative of your organization. Submissions should be sent to:

[QualityPathRFP@the-alliance.org](mailto:QualityPathRFP@the-alliance.org)

Final responses are due June 18, 2019, no later than 5 p.m. Central time. Any responses submitted after 5 p.m. may not be considered.

d. Key Dates

- Responses due: Tuesday, June 18, 2019
- Meetings to discuss evaluation results: Week of July 15, 2019

## QualityPath™ Elective Knee Replacement (KA) and Total Hip Replacement (THA) Criteria Overview

For easy reference, this section contains a list of criteria and supporting documentation. A more detailed version of the criteria is available immediately following this section. Each item below is linked to the more detailed version.

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## Summary of Changes from Previous Version

- Updated links and dates throughout the document

## Registry Participation

Rationale: Facilities and providers need timely, accurate and clinically relevant information to improve patient outcomes, determine appropriate care, engage patients in decision-making and be good stewards of scarce resources.

Resources: <http://www.ajrr.net/>

## Registry – Facility Criteria

### # 1 Facility must participate in the American Joint Replacement Registry.

Timing: Every twelve months (Spring Maintenance of Designation)

Fully Meets: Facility is submitting data to the full extent allowed by the registry.

Supporting Documentation: Dashboard report from the registry.

### # 2 Facility must use data from the registry to support quality improvement efforts.

Timing: Every twelve months (Spring Maintenance of Designation)

Fully Meets: Facility demonstrates existing use of registry data for quality improvement efforts **and** demonstrates surgeon involvement in these efforts.

Supporting Documentation: Provide a brief description of how your facility uses registry data to work together with surgeons to improve quality. Inclusion of a quality improvement project example is appreciated, but not required.

## Registry – Surgeon Criteria

### # 3 Surgeon must participate in the American Joint Replacement Registry.

Timing: Every twelve months (Spring Maintenance of Designation).

Fully Meets: Surgeon submitting data (or having data submitted on their behalf) to the full extent allowed by the registry.

Supporting Documentation: Dashboard report from the registry.

## Transparency

Rationale: Consumers have a right to know about differences in cost and quality between health care facilities, physicians and other clinicians; and a responsibility to



educate themselves about these differences as part of making health care decisions. Providers should share this information via public reporting when they have an option to do so. As part of the *QualityPath* program, we will not publicly disclose the individual measure results provided in response to this portion of the RFP outside of the *QualityPath* project team. We will be publishing what results and measures were considered as part of the program and which hospital-provider pairs achieve the *QualityPath* quality designation.

## Transparency – Facility Criteria

### # 4 THA/TKA case volume for the past two calendar years

Timing: Every twelve months (Spring Maintenance of Designation).

Fully meets: Facility has a case volume of 30 cases over the past two calendar years AND sufficient case volume to allow CMS to calculate all CMS measures in this section. This requirement is intended to ensure enough cases to reliably measure quality. It is not being used as a proxy for quality.

Does not meet: Less than 30 cases over the past two calendar years OR if any measure indicates there were too few cases to calculate a meaningful result a facility is ineligible for the *QualityPath* quality designation.

Benchmark: Not applicable

Supporting Documentation: Case volume

### # 5 THA/TKA Complication rate (proportion of patients with one or more of the following eight complications: AMI, pneumonia, sepsis/septicemia during the index admission or within seven (7) days of admission; surgical site bleeding, pulmonary embolism, or death during the index admission or within 30 days of admission; or mechanical complication or periprosthetic joint infection/wound infection during the index admission or within 90 days of admission.)

Timing: Every twelve months (Spring Maintenance of Designation), as updated by CMS.

Fully meets: Performance “as expected” or “better than expected”

Does not meet: Performance “worse than expected” or “number of cases too small”

Supporting Documentation: None – results available on HospitalCompare

Resources:

- Measure methodology: <https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228772782693>
- HospitalCompare: <http://www.medicare.gov/hospitalcompare/search.html>

## # 6 THA/TKA 30-day Readmission rate

Timing: Every twelve months (Spring Maintenance of Designation), as updated by CMS.

Fully meets: Performance “as expected” or “better than expected”

Does not meet: Performance “worse than expected” or “number of cases too small”

Supporting Documentation: None – results available on HospitalCompare

Resources:

- Measure methodology:  
<https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1219069855841>
- HospitalCompare: <http://www.medicare.gov/hospitalcompare/search.html>

## # 7 5 year revision rates

Timing: Every twelve months (Spring Maintenance of Designation)

Fully meets: Results shared with *QualityPath*

Benchmark: None. We will not set a benchmark until results are available through a standardized, central source, such as the registry.

Supporting Documentation: For each procedure, provide percentages, # of patients in the numerator, and number of patients in the denominator. Preferred time frame 1/1/2014 – 12/31/2018. Indicate if a different time frame included.

Start with patients who received a joint replacement within the measurement time frame. Of those patients, how many have had to return for a joint revision within five years after the initial replacement.

Codes:

Knees:

- Replacement
  - ICD-9: 81.54
  - CPT: 27447 or 27446
  - ICD-10: 0SRC0xx (right) or 0SRD0xx (left)
- Revision
  - ICD-9: 00.80, 00.81, 00.82, 00.83, 00.84, or 81.55
  - CPT: 27486 or 27487
  - ICD-10:

▪ Right:

Code	With
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0SWC0xx	N/A
0SRC0xx	0SPC0JZ
0SRV0JZ	
0SUV09Z	0SPC09Z
0SRT0JZ	0SPC09Z and 0SPC0JZ
0SUC0JZ	
0SUT09Z	
0QRD0JZ	0QPD0JZ
0QUD0JZ	
0SUC09C	

▪ Left:

Code	With
0SWD0xx	N/A
0SRD0xx	0SPD0JZ
0SRW0JZ	
0SUW09Z	0SPD09Z
0SRU0JZ	0SPD09Z and 0SPD0JZ
0SUD0JZ	
0SUU09Z	
0QRF0JZ	0QPF0JZ
0QUF0JZ	
0SUD09C	

Hips:

- Replacement
  - ICD-9: 81.51
  - CPT: 27130
  - ICD-10: 0SR90xx (right) or 0SRB0xx (left)
- Revision
  - ICD-9: 00.70, 00.71, 00.72, or 00.73
  - CPT: 27134, 27137, or 27138
  - ICD-10:

▪ Right:

Code	With
0SR90xx	0SP90JZ
0SRA0xx	
0SRR0xx	
0SU90xx	0SP909Z or 0SP90JZ
0SUA0xx	
0SUR0xx	

▪ Left:

Code	With
0SRB0xx	0SPB0JZ

0SRE0xx	0SPB09Z or 0SPB0JZ
0SRS0xx	
0SUB0xx	
0SUE0xx	
0SUS0xx	

Explanation: 5-year revision rates are an important outcome to measure for these procedures. We recognize that the lack of a national registry has hindered precise measurement, but we expect that facilities are tracking this to the best of their ability today.

**# 8 Patient experience scores (HCAHPS) specific to orthopedic unit(s)**

Timing: Every twelve months (Spring Maintenance of Designation)

Fully meets: Results shared with *QualityPath*

Benchmark: None, however, we will be looking at these results within the context of the facility's overall scores, state facility averages, and national facility averages as downloaded from data.medicare.gov.

Supporting Documentation: For the unit(s) in your facility that most often care for THA/KA patients, results for the following questions. Results can be given in percentages (vs. patient counts), but please include the number of patient responses represented in the survey to help us gauge reliability. Results should include the most recent calendar year of inpatient data you have received from your survey vendor. Include the timeframe in your submission.

- How often did nurses communicate well with patients?
- How often did doctors communicate well with patients?
- How often did patients receive help quickly from hospital staff?
- How often was patients' pain well controlled?
- How often did the staff explain about medications before giving them to patients?
- Were patients given information about what to do during their recovery at home?
- How do patients rate the hospital overall?
- Would patients recommend the hospital to friends and family?

**Transparency – Surgeon Criteria**

**# 9 THA/KA case volume for each of the past two calendar years**

Timing: Every twelve months (Spring Maintenance of Designation)

Fully meets: Surgeon has a case volume of 30 cases over the past two calendar years AND 30 or more denominator-qualifying (not excluded) cases in each of the CMS measure discharge-level data files. This requirement is intended to ensure enough cases to reliably measure quality. It is not being used as a proxy for quality.

Does not meet: Surgeon has a case volume of less than 30 cases over the past two calendar years OR less than 30 denominator-qualifying (not excluded) cases in either CMS measure discharge-level data files.

Benchmark: Not applicable

Explanation: We are not using this as a proxy for quality nor as a benchmarked measure. The intent is to ensure a physician has enough cases to generate the reliable quality measure results.

Supporting Documentation: Case volume

**# 10 THA/TKA Complication rate (proportion of patients with one or more of the following eight complications: AMI, pneumonia, sepsis/septicemia during the index admission or within seven (7) days of admission; surgical site bleeding, pulmonary embolism, or death during the index admission or within 30 days of admission; or mechanical complication or periprosthetic joint infection/wound infection during the index admission or within 90 days of admission.)**

Timing: Every twelve months (Spring Maintenance of Designation), as updated by CMS

Fully meets: Complication rate not statistically worse (95% confidence interval) than the mean complication rate of all applying and participating surgeons

Does not meet: Surgeon has less than 30 denominator-qualifying (not excluded) cases in the discharge-level data file

Supporting Documentation: *QualityPath* will be using the CMS methodology and calculations for this measure. Surgeons will need to coordinate with the submitting facility to submit a surgeon-identified, patient-de-identified, copy of the facility's "Discharge-Level Data and Risk Factor Excel Files" that accompany the facility's Hospital-Specific Report from CMS. Please see Appendix A for instructions on formatting the report to remove patient identifiable information.

Resources:

- Measure methodology:  
<https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1228772782693>

**# 11 THA/TKA 30-day Readmission rate**

Timing: Every twelve months (Spring Maintenance of Designation), as updated by CMS

Fully meets: Readmission rate not statistically worse (95% confidence interval) than the mean readmission rate of all applying surgeons

Does not meet: Surgeon has less than 30 denominator-qualifying (not excluded) cases in the discharge-level data file

Supporting Documentation: *QualityPath* will be using the CMS methodology and calculations for this measure. Surgeons will need to coordinate with the submitting facility to submit a surgeon-identified, patient-de-identified, copy of the facility's "Discharge-Level Data and Risk Factor Excel Files" that accompany the facility's Hospital-Specific Report from CMS. Please see Appendix A for instructions on formatting the report to remove patient identifiable information.

Resources:

- Measure methodology:  
<https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1219069855841>

### **# 12 5 year revision rates**

Timing: Every twelve months (Spring Maintenance of Designation)

Fully meets: Results shared with *QualityPath*

Benchmark: None. We will not set a benchmark until results are available through a standardized, central source, such as the registry.

Supporting Documentation: For each procedure, provide percentages, # of patients in the numerator, and number of patients in the denominator. Preferred time frame 1/1/2014 – 12/31/2018. Indicate if a different time frame included.

Specification:

- Knee
  - Denominator: Patients with a knee arthroplasty (27447, 27446)
  - Numerator: Patients in denominator who had a revision (27486 or 27487) within five years of original surgery date
- Total Hip
  - Denominator: Patients with a total hip arthroplasty (27130)
  - Numerator: Patients in denominator who had a revision (27134, 27137, 27138)

Explanation: 5-year revision rates are an important outcome to measure for these procedures. We recognize that the lack of a national registry has hindered precise measurement, but we expect that surgeons are tracking this to the best of their ability today.

### **# 13 Patient experience scores**

Timing: Every twelve months (Spring Maintenance of Designation)

Fully meets: Surgeon-level Clinician Group (CG)-CAHPS Adult Visit Survey results shared with *QualityPath*.

Preferred: Surgeon-level (S)-CAHPS Surgical Care Survey results shared with *QualityPath*

Benchmark: None

Supporting Documentation:

- From CG-CAHPS, provide results for the following items. Results can be given in percentages (vs. patient counts), but please include the number of patient responses represented in the survey to help us gauge reliability. Results should include the most recent year of data you have received from your survey vendor. Include the timeframe in your submission.
  - How well did providers (of Doctors) communicate with patients? (Composite)
  - Patients' rating of provider (or Doctor)
- From S-CAHPS, provide results for the following items. Results can be given in percentages (vs. patient counts), but please include the number of patient responses represented in the survey to help us gauge reliability. Results should include the most recent year of data you have received from your survey vendor. Include the timeframe in your submission.
  - Information to help you prepare for surgery
  - How well surgeon communicates with patients before surgery
  - Surgeon's attentiveness on day of surgery
  - Information to help you recover from surgery
  - How well surgeon communicates with patients after surgery
  - Patients' rating of surgeon

Explanation: The S-CAHPS provides information on aspects of patient surgical experience that are not available through any of the other CAHPS instruments. However, we recognize that CG-CAHPS is more widely used. As the Surgical Care Survey becomes more widely adopted, it is very likely that we will shift this requirement in future versions of this program.

Resources: Surgical Care Survey: <https://www.facs.org/advocacy/quality/cahps>

## **Standardized Clinical Processes**

We do not have separate criteria for facility and physician use of standardized clinical processes. We recognize that different workflows will work for different organizations and it is not our intent to be prescriptive. Wherever these processes fit in the physician-hospital workflow, they need to be well defined, repeatable, and reliable.

### **# 14 Decision Support for Ordering High-Tech Diagnostic Imaging Tests (HTDI) (CT, MRI)**

Rationale: Decision support provides immediate help determining the best diagnostic imaging test based on a patient's indication and available evidence and best practice. It helps physicians order the right test the first time, saving the cost of unnecessary or low utility tests. We are looking for a process that provides up-to-date, evidence-based information to providers at the point of order. The process needs to allow for data gathering to evaluate how the process is working and to provide feedback to ordering providers on their ordering patterns. The scope of the process should include affiliated/referring primary care practice.

Definition of Affiliated/Referring: These are all examples of practices that would be considered affiliated/referring:

- Practices that are part of the same integrated delivery system as the facility applying for the quality designation
- Practices that are part of the same integrated delivery system as the physician applying for the quality designation
- Practices that have a formal agreement or arrangement to refer to either the facility or physician applying for the quality designation
- Practices that participate in a vehicle that allows for joint managed-care contracting with applicant (e.g. IPAs, ACOs, etc.) and refer primarily to applicant.

Timing: Every six months (Spring and Fall Maintenance of Designation)

Fully meets: Fully implemented for the full patient population and reports are being generated and shared.

Supporting Documentation: A feedback report, demonstrating the ability to provide feedback results at an aggregate facility level and allow for drill-down by practice and clinician. The intent is not for these to be different reports, but one report that can be rolled-up and down to help evaluate and improve both the process and individual provider ordering utility. The report should cover all high-tech diagnostic imaging and all "appropriateness levels" assigned in the decision support system. At a minimum, it should include the rates for the facility, affiliated/referring clinics, and surgeons applying.

## **# 15 Shared Decision Making**

Rationale: Shared decision making using a standard, high-quality decision aid ensures that patients are informed of all options for treating their condition prior to the procedure, that they understand the risks and benefits of each option, and that they want to proceed with a joint replacement. We are looking for a process that engages all patients considering elective joint replacement in shared decision making using a high-quality decision aid.

Timing: Every six months (Spring and Fall Maintenance of Designation)

Fully meets: Process fully implemented for all patients undergoing elective joint replacement.



Preferred: Shared decision making happens prior to the patient meeting with the surgeon.

Supporting Documentation:

- Provide a description of the shared decision making process.
- Provide a copy of the decision aid. The decision aid must include a non-surgical treatment option.
- For each procedure, provide percentages, numerators, and denominators of patients participating in shared decision making broken out by physician, practice, and by facility. Denominator is all patients receiving elective knee replacement or elective hip replacement. We are looking for reporting capability and evidence of process implementation. There is no comparison benchmark. See example report in Decision Making Quality below.

### # 16 Decision Quality Assessment

Rationale: Assessing the quality of shared decision making prior to elective joint replacement helps identify gaps in the patient's understanding and the extent to which the patient was actively engaged in deciding to have elective joint replacement. Performing this assessment prior to the elective joint replacement provides the opportunity to resolve gaps in understanding.

Timing: Every six months (Spring and Fall Maintenance of Designation)

Fully meets: Process fully implemented for all patients participating in the shared decision making process.

Supporting Documentation:

- Provide a description of the process for assessing the quality of shared decision making. This process needs to use the decision quality assessment tool available at: <https://mqhdecisionsscience.org/tools-training/decision-quality-instruments/>
- For each procedure, provide percentages, numerators, and denominators of patients participating in an assessment of shared decision making broken out by physician, practice, and by facility. Denominator is all patients undergoing elective joint replacement. We are looking for reporting capability and evidence of process implementation. There is no comparison benchmark.

For example:

	Patients having a procedure	Participated in Shared Decision Making	Participated in Decision Quality Assessment
Physician A	1000	900 / 1000 = 90%	450 / 1000 = 45%
Clinic A	2000	1800 / 2000 = 90%	900 / 2000 = 45%
Hospital A	4000	3600 / 4000 = 90%	1800 / 4000 = 45%

### # 17 Joint School Participation

Rationale: Patients should understand the surgical and recovery process

Timing: Every six months (Spring and Fall Maintenance of Designation)

Fully meets: Pre-procedure “Joint School” is available.

Supporting Documentation:

- Describe “Joint School” process
- For each procedure, provide percentages, numerators, and denominators of patients participating in joint school broken out by physician, practice, and by facility. Denominator is all patients undergoing elective joint replacement. We are looking for reporting capability and evidence of process implementation. There is no comparison benchmark. See example report in Decision Making Quality above.

### **# 18 Patient Reported Outcome Measures (PROMs)**

Rationale: Patient Reported Outcome Measures (PROM) document the level of severity of pain and functional impairment as reported by the patient. Severity of symptoms could help assess procedural appropriateness and effectiveness.

Timing: Every six months (Spring and Fall Maintenance of Designation)

Fully meets: A process is in place to assess patient reported pain and function before and after surgery using any standardized instruments. Process goal should be a minimum of a pre-op assessment and one post-op assessment completed at 6 or 12 months.

Supporting Documentation:

- Provide a description of the process to obtain PROMs.
- Provide information on PROMs used.
- For each procedure, at each point in time (pre-op, post-op, etc.) provide percentages, numerators, and denominators of patients completing each PROM broken out by physician, practice, and by facility. Denominator is all patients undergoing each type of elective joint replacement. We are looking for reporting capability and evidence of process implementation. There is no comparison benchmark.

### **# 19 Conversation About Future Care Needs**

Rationale: Spelling out what kind of medical care we want if we are too ill or hurt to express our wishes is a way of telling our wishes to family, friends, and health care professionals to avoid confusion later on.

Timing: Every six months (Spring and Fall Maintenance of Designation)

Fully meets:

- Process in place to ensure a conversation about future care needs is documented.

- For elective joint replacement, proportion of patients with a conversation documented is tracked and shared with *QualityPath*. Denominator is all patients undergoing each type of elective joint replacement.

Benchmark: None.

Supporting Documentation:

- A description of the process for ensuring a conversation about future care needs.
- Provide percentage of patients with conversation documented. We are looking for evidence of process implementation.

## Disclose Potential Conflicts of Interest

Rationale: Full disclosure of potential conflicts of interest helps ensure treatment decisions are not influenced by commercial interests.

Definitions:

- Direct industry payments: Payments or items of value given directly to a health care provider by a manufacturer of drugs, medical devices, biologicals, or other medical supplies when made directly to a health care provider for purposes other than payment for providing medical treatment.
  - Examples (for clarification, not intended to be all-inclusive)
    - Payment from a drug manufacturer to a physician to fund research.
    - Royalties from a device manufacturer to a physician.
- Indirect industry payments: Payments or items of value given to a health care provider by a third-party, where the third-party has received the funds from a manufacturer of drugs, medical devices, biologicals, or other medical supplies with the direction to provide payment to the health care provider.
  - Example (for clarification, not intended to be all-inclusive)
    - Payment from a drug manufacturer to a non-profit to fund a provider speaking at an industry event.

### # 20 Disclose Potential Conflicts of Interest – Facility

Timing: Every twelve months (Spring Maintenance of Designation)

Fully Meets:

- Facility has a policy in place that includes full disclosure of industry conflict of interest to patients.
- Facility must track all direct and indirect payment.

Supporting Documentation

- Disclosure of conflict policy
- An example of how disclosure of conflict information is provided to patients

- Provide total direct and indirect payments, broken out by payer, to *QualityPath*

## **# 21 Disclose Potential Conflicts of Interest – Surgeon**

Timing: Every twelve months (Spring Maintenance of Designation)

Fully Meets:

- Surgery practice has a policy in place that includes full disclosure of industry conflict of interest to patients.
- Surgery practice must track all direct and indirect payment.

Supporting Documentation

- Disclosure of conflict policy
- An example of how disclosure of conflict information is provided to patients
- Provide total direct and indirect payments, broken out by payer, to *QualityPath* for each surgeon applying for *QualityPath* quality designation.

## Appendix A – Formatting the Hospital Specific Report Excel Files for *QualityPath* submission.

### Resources:

Readmission measure overview page on QualityNet:

<https://www.qualitynet.org/dcs/ContentServer?cid=1219069855273&pagename=QnetPublic%2FPage%2FQnetTier3&c=Page>

Complications measure overview page on QualityNet:

<https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228772780555>

The Hospital-Specific Reports (HSRs) that CMS provides to hospitals provide detailed measure results for the readmissions and THA/TKA complications measures, including the Medicare Health Insurance Claim (HIC) that uniquely identifies a Medicare patient. These reports are available through the QualityNet Secure Portal.

### Formatting the THA/TKA Complication Measure Hospital Specific Report Excel File

- 1) You will be working in the tab labelled “IV.4 THA-TKA C Discharges.”
- 2) Using the patient information in the file, identify the primary surgeon for the THA or TKA. Insert surgeon’s National Provider Identifier (NPI) and name into the rows for that surgeon’s patients. Do this for all patients in the file.
- 3) Convert the HICNO into a unique non-patient-identifiable number. Please note some patients appear in more than one row. The ability to tell these rows are the same patient must be preserved to ensure accurate complication rate calculations. Notice in screen shot below, de-identified patient #123456A (rows 7 and 8) and patient # 123456B (rows 9 and 10) each appear twice because each had two separate types of complication.

	ID Number	Provider ID	Measure	HICNO	Medical Record Number	Beneficiary DOB	Admission Date of Index Stay	Discharge Date of Index Stay	Inclusion/Exclusion Indicator	Number of TKAs Performed (0, 1, or 2)	Number of THAs Performed (0, 1, or 2)	Patient Had a Complication (Yes/No)	Complication
7	1	999999	THA/TKA	123456A	999999	99/99/9999	99/99/9999	99/99/9999	0	1	0	Yes	AMI
8	2	999999	THA/TKA	123456A	999999	99/99/9999	99/99/9999	99/99/9999	0	1	0	Yes	Death
9	3	999999	THA/TKA	123456B	999999	99/99/9999	99/99/9999	99/99/9999	0	0	1	Yes	Infection
10	4	999999	THA/TKA	123456B	999999	99/99/9999	99/99/9999	99/99/9999	0	0	1	Yes	Mechanical complication
11	5	999999	THA/TKA	123456C	999999	99/99/9999	99/99/9999	99/99/9999	0	0	1	No	N/A
12	6	999999	THA/TKA	999999999A	999999	99/99/9999	99/99/9999	99/99/9999	0	0	1	No	N/A
13	7	999999	THA/TKA	999999999A	999999	99/99/9999	99/99/9999	99/99/9999	0	1	0	No	N/A

- 4) After converting the HICNO, delete the HICNO column.
- 5) Convert Beneficiary DOB to age at the time of Admit date of index stay.
- 6) Delete the following columns: Medical Record Number, Admission Date of Index Stay, Discharge Date of Index Stay, Admit Date for Complication, Death Date, and Provider ID of Readmitting Hospital.
- 7) The following columns should remain: ID Number, Provider ID, Measure, Surgeon NPI, Surgeon Name, De-identified Patient ID, Beneficiary Age, Inclusion/Exclusion Indicator, Number of TKAs Performed, Number of THAs Performed, Patient Had a Complication, Complication, Complication Occurred During Index Stay, Readmission to Same Hospital.
- 8) Leave all remaining tabs as is.
- 9) File is now ready to submission to *QualityPath*. When submitting, please include the date range covered by the file (for example: 2008 –2010 data). Do not convert the file to a format other than Excel. We will be calculating the rates directly in the file itself.

### Formatting the Readmission Measure Hospital Specific Report Excel File

- 1) Remove data related to non-THA/TKA readmissions:
  - a. On the “I.1 30-Day R Perf” tab, remove AMI, COPD, HF, Pneumonia, Stroke, and CABG columns.
  - b. On the “I.2 Distrib of 30-Day R Perf” tab, remove AMI, COPD, HF, Pneumonia, Stroke, and CABG columns.
  - c. On the “I.3 30-Day R Discharges” tab, remove all lines of data where the value in the Measure column is AMI, CABG, COPD, HF, Pneumonia, or Stroke (i.e. not THA/TKA).
  - d. Delete the “I.4 Cond R Mix Comp” tab.
  - e. On the “I.5 Proc R Case Mix Comp” tab, delete the CABG columns.
- 2) All of the remaining steps are to be performed in the “I.3 30-Day R Discharges” tab.

- 3) Using the patient information in the file, identify the primary surgeon for the THA or TKA. Insert surgeon's National Provider Identifier (NPI) and name into the rows for that surgeon's patients. Do this for all patients in the file.
- 4) Convert the HICNO into a unique non-patient-identifiable number. Each row can have its own number. Patients will not have multiple rows in this report as they do in the complications report.
- 5) After converting the HICNO, delete the HICNO column.
- 6) Convert Beneficiary DOB to age at the time of Admit date of index stay.
- 7) Delete the following columns: Medical Record Number, Admission Date of Index Stay, Discharge Date of Index Stay, Readmission Date, Discharge Date of Readmission, Provider ID of Readmitting Hospital.
- 8) The following columns should remain: ID Number, Provider ID, Measure, Surgeon NPI, Surgeon Name, De-identified Patient ID, Beneficiary Age, Inclusion/Exclusion Indicator, Principle Diagnosis of Index Stay, Unplanned Readmission within 30 Days, Planned Readmission, Principle Discharge Diagnosis of Readmission, Readmission to Same Hospital.
- 9) File is now ready to submission to *QualityPath*. When submitting, please include the date range covered by the file (for example: 2008 –2010 data). Do not convert the file to a format other than Excel. We will be calculating the rates directly in the file itself.

## Appendix B – Summary Table of Timing for Maintenance of Designation Elements

Criterion	Inclusion in Maintenance of Designation Cycles	
	Spring	Fall
# 1 Facility must participate in the American Joint Replacement Registry.	Yes	No
# 2 Facility must use data to support quality improvement efforts.	Yes	No
# 3 Surgeon must participate in the American Joint Replacement Registry.	Yes	No
# 4 THA/TKA case volume for the past two calendar years (facility)	Yes	No
# 5 THA/TKA Complication rate (facility)	Yes	No
# 6 THA/TKA 30-day Readmission rate (facility)	Yes	No
# 7 5 year revision rates (facility)	Yes	No
# 8 Patient experience scores (HCAHPS) specific to orthopedic unit(s)	Yes	No
# 9 THA/KA case volume for the past two calendar years (surgeon)	Yes	No
# 10 THA/TKA Complication rate (surgeon)	Yes	No
# 11 THA/TKA 30-day Readmission rate (surgeon)	Yes	No
# 12 5 year revision rates (surgeon)	Yes	No
# 13 Patient experience scores (surgeon)	Yes	No
# 14 Decision Support for Ordering High-Tech Diagnostic Imaging Tests (HTDI) (CT, MRI, PET)	Yes	Yes
# 15 Shared Decision Making	Yes	Yes
# 16 Decision Quality Assessment	Yes	Yes
# 17 Joint School Participation	Yes	Yes
# 18 Patient Reported Outcome Measures (PROMs)	Yes	Yes
# 19 Conversation About Future Care Needs	Yes	Yes
# 20 Disclose Potential Conflicts of Interest – Facility	Yes	No
# 21 Disclose Potential Conflicts of Interest – Surgeon	Yes	No