Consumer Partnership for eHealth

June 27, 2016

Submitted Electronically

The Honorable Sylvia Matthews Burwell
Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, D.C. 20201

Mr. Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, D.C. 20201

Re: Medicare Program; Merit-Based Incentive Payment System and Alternative Payment Model Incentive Under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models (CMS-5517-P)

Dear Secretary Burwell and Administrator Slavitt:

The Consumer Partnership for eHealth (CPeH) and the undersigned 34 organizations and individuals submit these formal comments on the proposed requirements for Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) incentives through the Quality Payment Program, created under the Medicare Access and CHIP Reauthorization Act (MACRA).[1] CPeH is a coalition of more than 50 consumer, patient and labor organizations working at the national, state and local levels to advance private and secure health information technology (health IT) and health information exchange in ways that measurably improve the lives of individuals and their families. The combined membership of CPeH represents more than 127 million Americans.

We appreciate the opportunity to comment on these proposed requirements. Consumers are eager to work with the Centers for Medicare & Medicaid Services (CMS) to leverage health IT and health information exchange to improve the quality and value of care, and ensure that new models of care delivery and payment provide consumers and their family caregivers access to well-

[1] The 34 organizations and members of the Consumer Partnership for eHealth, joined by others, who sign this letter do so jointly in one letter rather than send 34 separate letters. If CMS counts responses for any particular purpose, please count them as 34 responses rather than a single response.

coordinated, patient- and family-centered care.[2] Our comments focus on provisions in the proposed rule related to the use of health IT in MIPS and Advanced APMs.

Health IT use in the Quality Payment Program

The robust use of health IT and health information exchange is fundamental to achieving the foundational goals of MIPS and Advanced APMs to incentivize high-quality, efficient practices, coordinated care and improved health outcomes.

For consumers, health IT can be used to engage individuals as equal members of their health care team by equipping them with the tools to work in partnership with professional care team members, better understand and manage their own health, and care for loved ones.[3] Specifically, health IT can help patients and their caregivers make more informed decisions; be better connected to their care team; generate and share important health information; and set, track and achieve personal health and wellness goals. MACRA must advance patients' and family caregivers' ability to access, contribute to, and use their own health information if we want to achieve high-value care and a healthier population.

With this in mind, the overall arc of the Quality Payment Program is directionally positive in driving advanced, person-centered uses of health IT. The Advancing Care Information (ACI) category of MIPS – particularly through the measures prioritized in the performance score – is clearly structured to encourage actions that promote the policy objectives of interoperability, care coordination and patient and family engagement. Furthermore, several activities in the Clinical Practice Improvement Activity (CPIA) category leverage the use of certified electronic health record technology (CEHRT) to manage chronic and preventive care, create linkages to community-based resources and support progress on patient-identified health goals.

However, the proposed requirements for health IT adoption and use for both MIPS and APMs are not sufficient to move towards substantial, person-centered uses of health IT that support health system transformation. **Future changes to the scoring methodology and more stringent measures of health IT use will be important to truly transform care and enhance the overall health of patients.**

We offer the following recommendations to strengthen the MIPS and APM requirements regarding health IT use:

- MIPS – ACI category: Improve the stringency of the category to drive more substantial uses of health IT:

[2] For brevity, we refer throughout our comments to "patient" and "care," given that many federal programs and initiatives are rooted in the medical model. To some, these terms could imply a focus on episodes of illness and exclusive dependency on professionals. Any effort to improve patient and family engagement must include the use of terminology that also resonates with the numerous consumer perspectives not adequately reflected by medical model terminology. For example, people with disabilities frequently refer to themselves as "consumers" or merely "persons" (rather than patients). Similarly, the health care community uses the terminology "caregivers" and "care plans," while the independent living movement may refer to "peer support" and "integrated person-centered planning."

[3] National Partnership for Women & Families, *Engaging Patients and Families: How Consumers Value and Use Health IT* (Dec. 2014), available at http://www.nationalpartnership.org/research-library/health-care/HIT/engaging-patients-and-families.pdf.

    - a) Replace the one-patient threshold for each measure in the base score with a five percent threshold beginning in 2019;
    - b) Reduce the weighting of the base score relative to the performance score in future years;
    - c) Award bonus points for improvement on the performance score; and
    - d) Adopt the main proposal for determining Meaningful EHR Users based on an ACI score of 75 points.
- MIPS – CPIA category: Strengthen activities promoting person-centered uses of health IT:
    - a) Consolidate similar activities;
    - b) Provide greater specificity regarding activity requirements; and
    - c) Add additional innovative health IT use activities to the inventory list.
- Advanced APMs: Adopt the proposal to increase the threshold for CEHRT use to 75 percent of clinicians in the second reporting year.
- MIPS and Advanced APMs: Incorporate innovative functionalities as required components of the MACRA regulations' definition of certified EHR technology.

MIPS – ACI performance category

Eligibility

We appreciate that, through their eligibility for MIPS, more types of clinicians will be using health IT (than were previously eligible for the Meaningful Use EHR Incentive Program). Widespread adoption facilitates greater health information exchange and interoperability across the care continuum, and supports care coordination. **We encourage CMS to invest resources to support clinicians new to using health IT in fulfilling the ACI performance category. Additionally, CMS should conduct oversight and provide timely feedback on how all clinicians are fulfilling measures of health IT use.** Providers serving vulnerable populations would especially benefit from additional support and technical assistance to address barriers to equal access to and use of health IT, as well as to implement patient-facing communication platforms and educational materials that are tailored to patients' language preferences, literacy levels, and accessibility needs. Additionally, as adoption and use of health IT increase among MIPS eligible clinicians, ACI measures will need to evolve to make continued progress on patient engagement, care coordination and interoperability objectives.

Structural requirements

We strongly support CMS's proposal to align measures in the ACI category with measures finalized for the Meaningful Use program, as a way to ease transition from participation in the Meaningful Use program to MIPS.

We also support full calendar year reporting for the ACI category to achieve alignment across MIPS categories (e.g., the Quality performance category). Requiring full-year reporting is more likely to prompt changes to provider workflows that are essential to realizing the full potential of health IT. Full-year reporting allows for sustained progress on prioritized ACI measures, particularly those that may be most challenging such as Care Coordination through Patient Engagement objectives. Limiting reporting on measures to 90 days also hinders progress on

interoperability and health information exchange. Patients and families should be able to experience the benefits of health IT – getting questions answered through secure email, or having summary of care records incorporated into new providers' health records – any day of the year, rather than a particular three-month period.

Additionally, we appreciate that there are clear interrelationships among MIPS program categories that leverage and use health IT, especially between the ACI and CPIA categories. These intersections help to further integrate health IT use and corresponding workflow and culture changes. For instance, CPIAs that leverage CEHRT to engage patients and their authorized family caregivers in the creation of care plans, documentation of patient goals or sharing of information through advanced portals would presumably facilitate clinician performance in the ACI category as well (secure messaging, patient-generated health data, educational materials, etc.) – and vice versa.

Base score

We understand that the ACI category's two-tiered scoring system (base and performance scores) simultaneously encourages adoption and use of health IT by new clinicians while rewarding performance on measures that have the greatest impact on patient and family engagement, care coordination and interoperability.

While we appreciate the intent of the base score – to create a proxy for basic health IT use that provides a foundation for all eligible clinicians (including new adopters of health IT) – we are dismayed that CMS again proposed the "one patient" threshold, this time for all measures in the base score.

Keeping the "one patient" threshold – and broadening its application to all measures (not just View/Download/Transmit and Secure Messaging) – undermine CMS's commitment to make patients and family caregivers true and equal partners in improving health through shared information and shared decision-making. It sends the wrong signal – to the nation's patients and families, and to clinicians.

Additionally, such a low threshold essentially creates check-the-box process measures for health IT rather than encourage effective use of health IT. Measuring performance for a single patient or encounter is hardly representative of whether providers are robustly using health IT to improve patient care and outcomes.

Future improvements: base score

We strongly urge CMS to increase the thresholds for the base score measures to five percent beginning with reporting year 2019. A minimum standard of five percent is well below or equal to all Meaningful Use thresholds for 2017, and signals a genuine expectation by CMS that organizations and providers make the process changes necessary to support electronically-enabled care. Additionally, CMS could consider increasing the weight of the performance score relative to the base score, to further emphasize performance on high-value and person-centered uses of health IT.

With respect to CMS's proposals for the base score, we prefer the primary proposal in which providers would report on 11 measures (as opposed to the alternate proposal that would require additional submission on Clinical Decision Support (CDS) and Computerized Provider Order Entry (CPOE)). Removing CDS and CPOE from the measure set will enable providers to direct their attention to measures that have the greatest potential for improvement and impact on care delivery, which often require more robust changes to workflow and corresponding organizational culture.

We also support CMS's proposed requirement to fulfill the objective to protect patient health information (perform a security risk analysis and implement security updates as necessary) in order to receive any base score, and ultimately any score in the ACI category. We appreciate the continued attention paid to protecting the privacy and security of consumers' electronic health information.

Performance score

With respect to the performance score, **we strongly support the prioritization of measures that promote interoperability, care coordination and patient and family engagement.** These measures have great potential to improve the quality, efficiency and experience of care.

Consumers need a comprehensive and accurate view of their health and health care, and they should be able to direct their health information based on personal preferences. We enthusiastically support the inclusion of measures that assess individuals' use of online access to their health information and secure email exchange with care team members. Additionally, we support the following ACI performance score measure requirements:

- **Family caregivers:** Allowing authorized family caregivers to access the health information of their loved ones and send secure messages on their behalf reinforces family caregivers' role as essential members of the care team.
- **Application Programming Interfaces (APIs):** By requiring providers to offer patients the ability to view, download and transmit their health information through both portals and APIs, CMS pursues the transition to APIs prudently.
- **Patient-generated health data and data from non-clinical settings:** Effective care planning and coordination require a comprehensive approach to health that is not exclusively focused on interactions with the health care system. Incorporation and use of both non-clinical and patient-generated health data are an effective approach for engaging patients and their families, ensuring that care results in better outcomes, and decreasing costs associated with unnecessary readmissions and difficulties with adherence.
- **Health information exchange:** Meaningful and effective coordination of care requires electronic sharing of information across all providers, as well as with patients and families. We support supplementing medication reconciliation for transitions of care with reconciliation of medication allergies and problems, as part of the health information exchange objective. These criteria will enhance safety as well as care coordination.

Future improvements: performance score

In response to CMS's request for comment on how to increase the impact of ACI performance

category measures in future years, we suggest that CMS reward clinicians for improvement through bonus points. Specifically, we recommend that clinicians who increase their total ACI performance score by five percentage points or more would receive two bonus points to be added to their total ACI performance score. This would give providers the flexibility to experiment with health IT functionalities (and specific measures) in the ways that are most relevant to their practices and patient populations.

Definition of Meaningful EHR User

The definition of Meaningful EHR User will have an important effect on health IT adoption and robust use. We are concerned that **prematurely reducing the ACI category's weight could have a chilling effect on progress towards robust, person-centered use of health IT.**

Therefore, we prefer the primary proposal to use a 75-point threshold (rather than the alternate proposal of 50 points) to determine Meaningful EHR Users, and urge CMS to consider a higher threshold in future years. We oppose the alternate proposal to lower the threshold to 50 points because it would mean that providers who only fulfill the base score (in which providers have to complete measures for just one patient/encounter) would be considered a meaningful EHR user. This is hardly a sufficient proxy for determining whether providers are robustly using health IT to improve patient care.

Information blocking

We strongly support CMS's inclusion of timely access by patients to their electronic health information in the required attestation regarding information blocking. Hindering individuals in timely accessing and using their health records is a prime example of information blocking.

MIPS – CPIA performance category

We appreciate that these proposed activities aim to drive health care system transformation, and strongly support the inclusion of new categories on health equity and behavioral/mental health integration. **We are heartened to see several proposed activities throughout the CPIA subcategories that encourage person-centered uses of health IT,** such as providing patients "access to an enhanced patient portal that provides up to date information . . . and includes interactive features allowing patients to enter health information and/or enables bidirectional communication."

However, the CPIA category currently lacks sufficient structure and detail to ensure that these activities have a positive impact on patients' experience and health outcomes. For instance, the currently proposed 90-day reporting period does not provide sufficient time to document sustained practice engagement in these activities; accordingly, we recommend a full-year reporting period for CPIAs. Moreover, there is no assessment of how well the activity was accomplished, or if the activity resulted in any improvement in outcomes or patient experience.

Therefore, in the final rule, we recommend that CMS strengthen the inventory of CPIAs, particularly Care Coordination and Beneficiary Engagement activities, in the following ways:

1. Add greater specificity to existing activities;
2. Consolidate similar activities; and

3. Include additional activities encouraging innovative health IT uses on the inventory list.

By employing these three strategies, CMS could create more detailed and meaningful activities that have a greater impact on improving patient experience and health outcomes, and drive clinicians toward practice activities required for participation in Advanced APMs.

Firstly, greater specificity of the activities and related documentation and reporting requirements would move the activities beyond low-impact "check-the-box" process activities toward investments that truly move a practice towards transformed care delivery. We note that certain CPIAs – particularly for chronic disease management – already include this kind of specificity; we encourage CMS to refine Beneficiary Engagement and Care Coordination measures to be similarly explicit and robust.[4]

Secondly, we also recommend consolidation of similar activities to create CPIAs that more comprehensively address clinical areas of focus. For example, as proposed, there are multiple activities that engage patients and their family caregivers in the creation and use of care plans. While we greatly support the focus on shared care plans, we suggest a single, more robust care planning CPIA that leverages the information and activities we know patients and families want and need (see example below). Such consolidation not only will provide greater simplicity, but also will allow practices to focus on high-impact activities.

Thirdly, we recommend the inclusion of new activities that leverage health IT in innovative ways. These activities could allow clinicians to explore innovative health IT functions that warrant inclusion in the definition of CEHRT, as well as newly introduced certified capabilities that are not yet required of all eligible clinicians (e.g., a CPIA that leverages the optional 2015 CEHRT criterion related to integrating and using social, psychological and behavioral data).

We offer the following example to illustrate how we envision improving the inventory of CPIAs, specifically with regard to health and care planning. This example encapsulates our recommendations to add more specificity, consolidate related activities, and incentivize innovative uses of technology:

> "Engage patients and authorized family caregivers in developing individualized plans of care that prioritizes patients' goals for action. These plans of care should be appropriate to age and health status and may include health risk appraisal; gender, age and condition-specific preventive care services; plan of care for chronic conditions; and advance care planning. These plans of care should be documented in the certified EHR technology, and clinicians should provide patients annually with an opportunity for development and/or adjustment of their plan of care.
>
> Specific information documented in CEHRT should include some or all of the following:

[4] For instance, one proposed CPIA for the Population Management subcategory entails "participation in a systematic anticoagulation program (coagulation clinic, patient self-reporting program, patient self-management program) for 60 percent of practice patients in year 1 and 75 percent of practice patients in year 2 who receive anti-coagulation medications (warfarin or other coagulation cascade inhibitors)."

- Caregiver name/role/status;
- Assessment and plan of treatment (including referrals to community-based services and supports);
- Health concerns;
- Goals (both patient and provider); and
- Advance directive content."[5]

This example is informed by the Consumer Partnership's principles for health and care planning.[6] Consumers envision moving beyond the concept of a care plan as a document fixed in time, to a multidimensional, person-centered health and care planning process built on a dynamic, electronic platform. This next generation of care plans connects individuals, their family and other personal caregivers, and health care and social service providers, as appropriate, and provides actionable information to identify and achieve individuals' health and wellness goals. We subsequently developed several use cases to illustrate how this kind of robust, electronically-enabled health and care planning could look for individuals of different ages, health conditions and socioeconomic backgrounds. We encourage CMS to draw upon these principles and related use cases as resources as they consider how to develop CPIAs that move us towards this vision (see Appendix).

Advanced APMs

If designed and implemented correctly, Advanced APMs have the potential to provide comprehensive, coordinated, patient- and family-centered care and to help drive down costs and increase value. This promise rests on the ability of APMs to meet the needs of the patients they serve and to improve how care is delivered, which includes engaging beneficiaries in the integration and effective use of health IT and health information exchange.

Advanced APMs will only be as strong as the underlying models that qualify, particularly the models' requirements regarding the use of health IT. Additional requirements may be necessary to ensure that these new models of care leverage health IT in innovative ways to improve patient care, experience and outcomes. It will be important to monitor the health IT-related requirements that are incorporated into Advanced APMs (such as Medicare Shared Savings Tracks 2 & 3) to ensure continued progress in the use of health IT. **Therefore, we urge CMS to consider how to increase transparency and public input into these models.**

Since qualifying Advanced APMs receive a substantial lump sum bonus of five percent, it is reasonable to expect a strong commitment by the APMs to widely adopt health IT. With respect to the threshold for CEHRT use, although we appreciate that some clinicians included in potential Advanced APMs have not previously used CEHRT, we urge that the proposed 50 percent

[5] This example includes elements from multiple proposed CPIAs related to care planning, including: Population Management – "Proactively manage chronic and preventative care . . ."; Population Management – "Provide longitudinal care management . . ."; Care Coordination – "Implementation of practices/processes to develop regularly updated individual care plans . . ."; Care Coordination – "Develop pathways to neighborhood/community-based resources"; and Beneficiary Engagement – "Engage patients, family and caregivers in developing a plan of care . . .".

[6] *Care Plans 2.0: Consumer Principles for Health and /Care Planning in an Electronic Environment* (Nov. 2013), available at http://www.nationalpartnership.org/research-library/health-care/HIT/consumer-principles-for-1.pdf.

threshold to qualify as an Advanced APM should be reassessed in future years of the program. W**e support CMS's proposal to increase the threshold for CEHRT use to 75 percent of clinicians in the second performance period.**

Use of Certified EHR Technology

We support the use of CEHRT because it leverages existing technological functionality to facilitate high-value care and supports movement towards patient-centered care through capture of critical information about individuals' health and care outside the clinical setting.

In order to successfully engage in activities that lead to health care system transformation, providers would also benefit from functionalities available in but not yet required by the 2015 Edition of CEHRT. Some features currently deemed "optional" are critical for the level of performance expected in certain ACI measures and clinical practice improvement activities include Social, Psychological, and Behavioral Data; Care Plans; Clinical Quality Measures – Filter; and Accessibility-Centered Design. These functionalities are instrumental to engaging patients, and coordinating and evaluating care (including many specified CPIAs in the Beneficiary Engagement and Coordinating Behavioral and Mental Health subcategories). Moving forward, these features should be included as required components of the MACRA regulations' definition of certified EHR technology, and integrated into corresponding policy requirements on how providers must use certified health IT.

Looking Ahead

In order to manage forthcoming changes to payment and delivery under MACRA, providers may select quality and ACI measures and clinical practice improvement activities that are most closely aligned with their current quality measurement and reporting and clinical improvement efforts – regardless of whether these activities work together to advance better care and improved health outcomes.

Moving forward, providers should be encouraged to select quality measures, clinical practice improvement activities and relevant ACI measures that complement one another. Taking a more holistic, comprehensive approach could strengthen overall efforts to achieve high-quality, well-coordinated, patient- and family-centered care. For example, a provider focused on managing chronic conditions within the patient population would choose care plan-related CPIAs, quality measures that focus on patient experience and improved outcomes, and ACI measures that leverage patient-centered communication (soliciting goals for PGHD, encouraging patients to access lab results through a patient portal, etc.). We also recommend identifying specific, established quality measures to align with each improvement activity to measure impact on outcomes and patient experience. This holistic approach to care delivery would benefit the nation's patients and maximize the effect of new models of care delivery and payment.

Thank you once again for the opportunity to provide input into the transformative Quality Payment Program and new payment and delivery models under MIPS and Advanced APMs. Robust advancement of health IT criteria that focus on improvement of outcomes in these new models is critical to ensure that delivery system reform efforts result in better care, better value

and healthier people. We look forward to working with CMS, providers and consumers across the nation to leverage technology to enhance the quality of care, foster trust with patients, bolster meaningful engagement and improve health outcomes. If you have any thoughts or questions about these comments, please contact Mark Savage at (202) 986-2600 or msavage@nationalpartnership.org.

Sincerely,

AIDS Alabama
American Association on Health and Disability
American Federation of State, County and Municipal Employees
Asian & Pacific Islander American Health Forum
Association of Asian Pacific Community Health Organizations
California Pan-Ethnic Health Network
Caregiver Action Network
Caring From a Distance
Center for Independence of the Disabled, NY
Center for Medical Consumers
Consumers' Checkbook/Center for the Study of Services
Consumers for Affordable Health Care Foundation
Consumers Union
Disability Rights Education and Defense Fund (DREDF)
Families USA
Family Caregiver Advocacy
Fenway Health
Genetic Alliance
Healthwise
Informed Medical Decisions Foundation
NAACP
National Consumers League
National Health IT Collaborative for the Underserved
National Health Law Program
National LGBTQ Task Force
National Partnership for Women & Families
New Yorkers for Accessible Health Coverage
Pacific Business Group on Health
PXE International
Summit Health Institute for Research and Education
The Children's Partnership

Mary Anne Sterling, Family Caregiver Advocate
Lucy Johns, member of the Board of Directors and Co-Chairs, Patient and Consumer Participation in Direct Work Group, DirectTrust

Renee Smith, member of the Board of Directors and Co-Chairs,
Patient and Consumer Participation in Direct Work
Group, DirectTrust

attachments

CARE PLANS 2.0

Pamela's Care Plan: Heart Health

AUGUST 2014

About Pamela

Pamela is a 67-year old woman with Coronary Artery Disease, or the build-up of plaque in her artery walls, which caused her to have a heart attack three months ago. At her most recent annual wellness visit, tests revealed that Pamela's condition has progressed into heart failure. Her heart struggles to adequately pump blood throughout her body, causing her to experience symptoms like shortness of breath and fatigue.

Pamela is a widow who has been living alone for the past four years. She is deeply involved with her church, where she teaches Sunday school classes. Pamela is slightly overweight and knows she should be more active, but does not have time or transportation to the recreational center to exercise.

Pamela's Care Team

Pamela now sees a **cardiologist** in addition to her **primary care physician** to monitor her heart function after the heart attack. Because she must have follow-up appointments with her providers frequently, she communicates most often with the **nurse practitioner** who consulted with Pamela at her discharge from the hospital. Pamela receives significant support from the **women in her church** who call to check in each day and make sure that Pamela is taking her medicine.

Clinical Goals

- **Medication.** Pamela must follow a regimen that includes four drugs and supplements to control her heart failure and prevent another serious event.
- **Routine follow-up care.** In order to monitor her heart failure and the side effects of her medications, Pamela needs follow-up appointments and

routine blood tests every three to six months.

- **Monitor weight gain.** Pamela needs to carefully and consistently monitor her weight because weight gain could indicate that she is building up excess fluid and having more serious heart failure.
- **Make lifestyle changes.** Pamela should limit the amount of salt, cholesterol, and fat in her diet in order to reduce her blood pressure. She also should exercise regularly and safely (resting after activity) so as to not put too much stress on her heart.

Care Team

- Pamela
- Cardiologist
- Primary care provider
- Nurse practitioner
- Nutritionist
- Physical therapist
- Women in church

Personal Goals

- **Avoid surgery.** Pamela's surgeon notifies her that surgery may be necessary if her heart function continues to deteriorate. Pamela wants to prevent surgery because she worries that the recovery time in the hospital would prevent her from participating in her church's activities.
- **Keep cooking her famous dishes.** Pamela also wants to maintain her reputation as the neighborhood's best cook. She takes pride in being known for her flavorful Southern food, and she is worried that friends and family will no longer like her cooking if she changes the recipes.

Action Steps to Achieve Goals

- **Pamela** uses a "smart scale," which wirelessly transmits her weight to her cardiologist for monitoring. She notifies her doctor immediately if she gains three pounds in a day or five pounds in a week.
- Her **nurse practitioner** answers Pamela's questions about her recent blood tests through secure email and explains how Pamela's heart is functioning.
- Her **nutritionist** works with Pamela to identify healthy substitutes for her recipes so she can cook her favorite food for herself and her family and friends. Pamela has begun to compile a new cookbook of these recipes.
- Her **physical therapist** demonstrates safe exercises and provides a facility where Pamela can perform these exercises, such as riding a stationary bike, under supervision. Pamela's appointments are structured to include adequate time to rest after activity.
- The **women from church** create a schedule to drive Pamela to the clinic for her blood tests, as well as the exercise facility for her PT appointments.

CARE PLANS 2.0

Ted's Care Plan: **Knee Replacement**

AUGUST 2014

About Ted

Ted is a 72 year-old man who suffers from chronic knee pain. He has always been active and is an avid tennis player, but his arthritis has become so painful that he now has trouble walking up the stairs. Medicine, including prescription medicine and steroid injections, no longer works to manage his pain, so he has consulted with his doctor about knee replacement surgery. Ted's doctor supports surgery as an effective treatment option, and Ted's family agrees that now is an appropriate time for the procedure.

Ted's Care Team

After his surgery, Ted will follow-up with his **surgeon**, who will monitor how the wound is healing. Ted will work with a **physical therapist** to strengthen his knee muscles and improve his mobility to return to performing his normal household activities. His **daughter** has invited Ted to live at her house for the first few weeks after his surgery. Her house has a bedroom on the first floor, which is crucial because Ted won't be able to climb stairs for many weeks. When he does return home, Ted worries about his wife being able to help him around. The family has discussed hiring a **home health aide** for a few weeks.

Clinical Goals

- **Preventing infection**. While Ted is recovering in the hospital, a big concern is preventing infection, which can threaten Ted's health, require the removal the artificial joint, and increase his length of stay in the hospital.
- **Avoid falls.** Once Ted is out of the hospital, it is important to avoid falls, which could damage the artificial knee and cause the need for further surgery.

- **Prevent wear-and-tear.** Over the long-term, his surgeon wants to prevent Ted from wearing out the artificial joint because doing so can cause pain and the loosening or dislocation of the joint, which would necessitate further surgery. She recommends that Ted refrain from engaging in high-impact activity, and suggests low-impact activities like walking, swimming, or golfing instead.

Personal Goals

- **Regain normal activity levels ASAP.** Ted takes a family vacation every summer at their lake house, and he is determined to be able to get around without a walker or cane.
- **Exercise with his wife.** Ted would really like to play tennis again because it is an activity that he and his wife do together. He is struggling with the reality that he can no longer do high-impact activities.
- **Continue driving.** Ted does not want to be a burden to his family, and he also hopes to maintain his independence. His surgeon mentioned that he might be able drive in four to six weeks, depending on his range of motion.

Care Team

- Ted
- Primary care physician
- Surgeon
- Family members (wife and daughter)
- Physical therapist
- Home health aide

Action Steps to Achieve Goals

- **Ted** and his **surgeon** choose to implant a type of artificial joint that does not wear with activity as easily as a typical prosthetic so Ted can be more active. His surgeon also prescribes antibiotics to prevent infection while Ted is in the hospital.
- His **physical therapist** develops an exercise plan that gradually increases Ted's activity level, beginning with chair exercises and short walks around the house and progressing into normal household activities. Ted keeps a daily log of his activity and his resulting fatigue and pain.
- The local **Red Cross** provides free transportation service, so Ted's family plans to use this service to take him to his physical therapy appointments (until Ted is driving again).
- Ted's **daughter** organizes the installation of appropriate safety features in Ted's home, including handrails on the stairs and a shower bench for bathing, to help Ted avoid falls when he moves back home.
- **Ted** and his **wife** register for ballroom dancing classes, a low-impact activity that they can do together rather than tennis.