



# **Value-Based Elective Total Knee Replacement Quick Reference Guide**

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## VALUE-BASED ELECTIVE TOTAL KNEE REPLACEMENT

**Total knee replacement (TKR)** can provide substantial pain relief and functional improvement for **carefully selected patients** with advanced symptomatic knee disease.<sup>1,2</sup> But elective TKR should not be the default response to knee osteoarthritis.<sup>3</sup> **Conservative care is the default treatment pathway**, and surgery becomes appropriate only when reasonable nonoperative care has not produced acceptable relief, the patient's goals favor definitive treatment, and the patient has sufficient capacity to benefit from surgery and rehabilitation.<sup>1,4</sup>

Elective treatment creates an opportunity to **improve function before deciding that surgery is necessary**.<sup>4</sup> Exercise and physical therapy, weight and activity strategies, appropriate medications or injections, supportive devices, self-management, and management of contributing conditions can **reduce symptoms, preserve function**, and in some patients **defer or eliminate the need for TKR**.<sup>4,5</sup> Conservative care should be **individualized** and **goal-directed** rather than treated as a checklist or authorization requirement.<sup>6</sup>



### AAVBC PERSPECTIVE

*Value-based TKR begins with the right treatment, not the procedure. For most patients with knee osteoarthritis, start with a **reasonable, individualized trial of conservative care** (physical therapy, activity and weight optimization, appropriate analgesia, and selective intra-articular steroid injection) and use the response to determine whether surgery remains necessary. Many patients continue to improve on structured nonoperative programs and roughly a quarter proceed to arthroplasty within two years, so **surgery should not be treated as the default endpoint**.<sup>1,5</sup> When symptoms remain substantially limiting despite an adequate trial and radiographic disease is moderate-to-severe, evaluate through shared decision-making whether TKR is the right intervention for the right patient.<sup>2,7</sup>*

*If TKR is indicated, match the surgery itself to the **lowest acuity site of care the patient can safely use**. In appropriately selected patients, outpatient TKR performed at a hospital outpatient department or a stand-alone ambulatory surgery center (ASC) yields 90-day complication, reoperation, revision, readmission, and ED-visit rates **comparable to inpatient surgery**, and large matched analyses show lower adverse-event rates with no increase in 30-day readmission.<sup>8,9</sup>*

*ASC's are a preferable option vs. Outpatient hospital to **lower the risk of nosocomial infections** and reduce out-of-pocket costs for patients.*

***Site-of-care selection is itself part of the value-based decision:** the goal is the least intensive setting that safely meets the individual patient's needs, escalating to inpatient admission only when comorbidity, reserve, or home support require it.*

*For patients who do proceed to surgery, the goal of prehabilitation is not simply to make the patient "fit for surgery." It is to **build the strength, mobility, nutrition, confidence**, and **practical home support** needed to recover safely and return home. Prehabilitation improves preoperative function and quadriceps strength and function at 6 weeks postoperatively with **reduced length of stay**, and should **begin before surgery** linked to specific functional and home-readiness goals.<sup>10,11</sup> Because home-based rehabilitation is at least as effective as clinic- or facility-based rehabilitation after uncomplicated TKA in patients with adequate social*

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