Dr. Robert Bree Collaborative
Lumbar Fusion Bundled Payment Model Re-Review Workgroup Minutes
Tuesday, March 27, 2018 | 3:00-4:30
Foundation for Health Care Quality

Members Present

Lydia Bartholomew,* MD, Aetna
Arman Dagal, MD, Spine SCOAP
Gary Franklin,* MD, MPH, Labor and Industries
Andrew Friedman,* MD, Virginia Mason
Sara Groves-Rupp,* Harborview Medical Center
Michael Hatzakis,* MD, Overlake Hospital
Robert Mecklenburg, MD, Virginia Mason (Co-Chair)
Marcia Peterson,* Washington State Health Care Authority
Linda Radach,* Washington Advocates for Patient Safety
Kerry Schaefer, King County (Co-Chair)
Mia Wise, DO, Premera Blue Cross

Staff/Guests

James Babbington,* MD, Swedish Medical
Carlo Bellabarba,* MD, UW Medicine
Alicia Parris, Bree Collaborative
Jason Thompson, MD, Proliance Surgeons
Dayna Weatherly, Proliance
Ginny Weir, MPH, Bree Collaborative
Vicki Kolios, MHA, Spine SCOAP

* By phone/web conference

WELCOME, INTRODUCTIONS

Robert Mecklenburg, MD, Virginia Mason, opened the meeting. All those present introduced themselves. Dr. Mecklenburg asked for additions or corrections to the minutes.

Motion: Approval of minutes
Outcome: Passed

Dr. Mecklenburg asked for additions to agenda. No additions to agenda.

LUMBAR FUSION BUNDLE AND WARRANTY

The group reviewed **Cycle I: Disability Despite Non-Surgical Therapy** of the 2014 Bundle section A and discussed alternative/additional language that would address gaps in the previous bundle:

- Requiring Promis-10 and ODI standard may be redundant
- Grouping patients based on presence of neurologic signs and those with functional impairment
  - Neurologic signs i.e. progressive motor loss, bowel or bladder dysfunction would warrant immediate surgery
- Challenge defining “functional impairment” and ‘meaningful improvement”
- Measuring function using both PROMIS-10 with pain interference score
  - Would give objective measures for positive impact in patients’ lives
- Allowance of other validated patient reported measures
- Dr. Mecklenburg inquired about number of clicks/time required to complete surveys
  - Computer adapted testing can keep clicks low with high precision
- Room for error in patient reported outcome measures
  - Variation of reporting between individuals

- Gary Franklin, MD, MPH, Labor and Industries pointed out merits of having both a specific testing (ODI) and general (PROMIS-10) tool for determining disability
    - If functionality tests inquire about duration of disability
    - Correlation between length of disability and prognosis
- Group determined that none of the tools ask that question
- Whether to include neurological signs/dysfunction
- Inquired about the necessity of listing Roland Morris, EQ-5D, SF 36 are they frequently used
    - Jason Thompson, MD, Proliance Surgeons confirmed SF-36 used frequently at UW
    - Inclusion was for flexibility at various institutions
- Use of the word “or” between A.1 and A.2
    - James Babbington, MD, Swedish Medical explained “or” was included to allow for bypassing patient reported outcome tool with presence of objective neurological signs when there is an urgent need for surgery
    - Group agreed “or” is necessary
- Prioritized preferred patient outcome tools in A.2
- 1.A Phrase “due to” was changed to “associated with” for clarity
- Group tentatively agreed to a proposal of including additions made by Dr. Babbington

Group viewed Cycle 1 Section B with alternative language and discussed:

- Dr. Thompson presented opinions on alternative imaging that will accurately gauge instability
    - Patients may have radicular pain not due to instability in the sagittal plane (forward and backward)
    - Less instability on volitional flexion and extension films due to pain and resistance by patient
    - Slippage will show on upright radiograph but supine MRI will allow back to relax and t2 weighted images will show no evidence of spondylolisthesis
        - Results in inaccurate radiology report
    - Combination of standing flexion and extension films and supine lateral film may show instability that may not show in just standing films
    - MRIs may show effusions and gaps in facets
- Should MRI be ordered if not already done
    - Keeping tests to minimum necessary
    - Price of an MRI vs. value
- Most patients who fall under the bundle will have already had an MRI

Action Item: Andrew Friedman, MD, Virginia Mason to write and send language to the group about supine imaging

Action Item: Dr. Thompson to provide reference for addition to 1.B regarding spinal lesions

Group viewed Cycle 1.C: non-surgical therapy 1 compared to NICE and ACP recommendations and discussed:

- Bundle scope is bundle just for chronic back pain
    - NICE did not distinguish
    - ACP based on longevity of pain
- Dr. Babbington suggested that the bundle’s requirement of an imaging finding would imply that back pain does not fall under “non-specific”

Behavioral intervention recommendations common to both the NICE and ACP recommendations and the group discussed:

- Would high index of catastrophizing or low self-efficacy be a fitness issue to prevent surgery
    - Group will discuss at a later meeting
- NICE recommendations to “consider manual therapy”
    - Group decided not to include in bundle
- C. 1, 2 “and” was added to clarify that both are required
- Arman Dagal, MD, Spine SCOAP proposed combining a-d of C.2 since some of the medications listed cannot be used in the context of 3 month treatment
    - Acetaminophen removed from C.2
    - 2 changed to “if not contraindicated”
- Use of the word trial in C.2 changed to “time-limited trial”
- Changes made to 2.C pharmacological interventions based on NICE and ACP
    - Skeletal muscle relaxants added
    - Removed tricyclic antidepressants
- Should a physiatrist be required part of collaborative team
    - Challenges in assembling teams in less integrated smaller medical centers
    - Marcia Peterson, Washington State Health Care Authority suggested if evidence of a better outcome is present, it should be required
- Dr. Dagal pointed out challenges in trying to group together patients with neurologic symptoms and patients low back pain and no neurologic symptoms
    - Majority of patients are low back pain without neurologic symptoms
- Dr. Franklin suggested a pain psychologist on the team since pain is the main symptom
- Group will discuss later should/must and pain psychologist inclusion
- Dr. Mecklenburg asked for suggestions to improve the meeting
    - Mia Wise, DO, Premera Blue Cross more clarification on population being discussed

      Action Item: Michael Hatzakis, MD, Virginia Mason to develop examples to add specificity to “active physical therapy”

GOOD OF THE ORDER/OPPORTUNITY FOR PUBLIC COMMENT

Dr. Mecklenburg thanked those who brought language contributions and all who attended and asked for public comments and final comments. The meeting was adjourned.