Dr. Robert Bree Collaborative
Lumbar Fusion Bundled Payment Model Re-Review Workgroup Minutes
Tuesday, May 22nd, 2018 | 3:00-4:30
Foundation for Health Care Quality

Members Present

Robert Mecklenburg, MD, Virginia Mason (Co-Chair)
Kerry Schaefer, MS, King County (Co-Chair)
James Babington, MD, (for Sara Groves-Rupp), University of Washington Medicine
Arman Dagal, MD, Spine COAP
Sharon Eloranta, MD, CHI Franciscan
Gary Franklin,* MD, Labor and Industries
Andrew Friedman,* MD, Virginia Mason
Michael Hatzakis, MD, Physiatrist Overlake
Medical Center
Marcia Peterson,* Washington State Health Care Authority
Linda Radach,* Washington Advocates for Patient Safety
Mia Wise, DO, Medical Director, Premera Blue Cross
Farrokh Farrokhi,* MD, Neurosurgeon, Virginia Mason Medical Center

Staff/Guests

Vickie Kolios-Morris, MSHSA, Spine COAP
Dennis Hoover, PharmD, Virginia Mason Memorial
Alicia Parris, Bree Collaborative
Jason Thompson, MD, Proliance Surgeons
Ginny Weir, MPH, Bree Collaborative

* By phone/web conference

WELCOME, INTRODUCTIONS

Robert Mecklenburg, MD, Virginia Mason, opened the meeting. All those present introduced themselves. Ginny Weir, MPH, Bree Collaborative, announced the Washington Advocates for Patient Safety's screening of the Bleeding Edge.

Motion: Approve 4/24/18 minutes.
Outcome: Passed with unanimous support.

LUMBAR FUSION BUNDLE AND WARRANTY REWRITES

The group reviewed the Lumbar Fusion Bundle and Warranty including additions and rewrites from group members and discussed:

- Cycle I
    - Whether a physiatrist should truly be the leader of the collaborative care conference and verifier that elements of the bundle have been met.
    - Removing the work "appropriate" from spine surgeon.
    - Defining physical therapy as the previous definition was too generic.
        - Lumbar stabilization programs combined with hip stabilization programs do benefit patients.
        - How to best enforce appropriate physical therapy as chart notes are highly variable.
        - The bundles break from charge code-based validation. Many items cannot be line-itemized.
        - Whether the physiatrist should verify physical therapy appropriateness or whether this is a contractual issue requiring verification from the purchaser for a certain number of cases.

- Pain psychologists are hard to find and would serve as a significant barrier.
    - Whether a clinical psychologist would be necessary or an MSW would be sufficient.
    - Whether to include a pain specialist.
    - Decision to include "clinical psychologist or pain specialist."
- Discussing collaborative care conference as a second opinion.
    - Aetna requires a second opinion for spine surgery as does Costco.
    - Easier for some provider groups. Small groups in small communities would have difficulty.
    - Opinion: Participation in conferences can make us better surgeons.
    - Many of the cases discussed in the conference setting are in the grey zone of appropriateness.
- Worry about discouraging surgeons.
- Patient-reported outcomes.
    - Whether to require a minimally significant improvement or difference. This is not known for most of the patient reported outcomes.
    - Consensus to use "severe disability unresponsive to non-surgical care" rather than persistent disability.
    - Persistent disability is associated with worse outcomes – with a positive relationship between length of time of disability and poorer outcomes.

- Cycle II
    - This is optimizing the patient for surgery.
    - Inclusions are not ideal, but where we could gain consensus.
    - Determining nutritional status with albumin.
    - How to get a patient with a BMI over 40 to lose weight if they have pain and disability.
    - All these inclusions are on a continuum.
    - These are also "should" not "must" as the measures are not perfect and a patient may still be a good candidate with a slightly higher BMI.
    - Add "and assist patient in meeting goals."
    - Liver function.
        - Asking patients for self-report of having hepatitis or liver cirrhosis.
        - Adding "particularly for high-risk patients."
    - Smoking cessation
        - Should also be four months post surgery and will be added to Cycle IV.
        - Whether to require testing which can pick-up nicotine-replacement treatment.
        - Nicotine itself is bad for outcomes.

Action Item: Arman to send citation about nicotine replacement.

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.