**Bree Collaborative | Total Knee and Total Hip Replacement Bundle Workgroup**
March 5th, 2021 | 2:00 – 3:30pm
**Virtual**

## MEMBERS PRESENT

Robert Mecklenburg, MD (Chair), Medical Director, Center for Health Care Solutions, Virginia Mason Medical
Linda Radach, Patient Advocate
LuAnn Chen, MD, MHA, FAAFP, Senior Medical Director, Community Health Plan of Washington
Andrew Friedman, MD, Physical Medicine & Rehabilitation Specialist, Virginia Mason
Cat Mazzawy, RN, Senior Director, Safety and Quality, Washington State Hospital
Association
Emily Transue, MD, MHA, Associate Medical Director, Health Care Authority
Michael Griffin, Associate Vice President, Orthopedics & Sports Medicine Institute, Providence St. Joseph Health
Jeff Stepanian, PA-C, EvergreenHealth
Dayna Weatherly-Wilson, RN, Manager, Value Based Healthcare, Proliance Surgeons
Steve Overman, MD, MPH, Clinical Professor of Medicine, University of Washington

## STAFF AND MEMBERS OF THE PUBLIC

Matthew Albright, Regional Director, Orthopedics & Sports Medicine, Providence St. Joseph Health
Melissa Moran-Hodge, MHA, CPHQ, Clinical Outcomes Analyst, Providence Surgeons
Katie Sypher, Program Manager, Orthopedics & Sports Medicine Institute, Providence St. Joseph Health
Nick Locke, MPH, Bree Collaborative
Ginny Weir, MPH, Bree Collaborative

## WELCOME

Robert Mecklenburg, MD, retired, Virginia Mason, welcomed members to the workgroup.

*Motion*: Approval of February 5th, 2021 minutes
*Outcome:* Passed with unanimous support

## GROUP DISCUSSION: CYCLE 1

Dr. Mecklenburg began the discussion talking through the worksheet. The workgroup discussed:

- Shared decision making (risk/benefits of approaches) (1-c) How to work into the conversation how many procedures an individual surgeon has completed. This may be awkward unless the patient brings it up.
    - Complication rates could be easily addressed with the risks and benefits – this is how often I have seen the complications happen. Patients may not know they need to ask that question.
    - This is also important to purchasers. Awkward until it is done with everybody.
    - Should this be kept at the system level to incent system change?
    - This also gives the patient the opportunity to have another surgeon.
    - However, surgeons can select on whom they operate and have artificially low complication rates through only choosing young, healthy people.
    - Pushback against documentation, prioritize must vs. should (administrative burden). Easier to have a website to point patients to.
    - What is the source for data? Not available via Google.
    - Providers will make available an information source that outlines volume.
    - Andrew Friedman to draft C-1-c.

- Implant. Whether a national registry should be consulted.
    - Does a national registry exist? AJRR does not have this information and is not accessible to patients.
    - A one-pager of complication information – consensus from group.
    - The goal is for the surgeon and the practice to be doing a good job. Are there institutional methods for monitoring?
    - The conversation with the surgeon must include written information regarding the surgical implant.
- Platelet rich plasma (PRP). Small RCT with problematic control group. Used with mild to moderate musculoskeletal information. Too early in the evolution of this data to make a statement.

**CYCLE II: FITNESS FOR SURGERY**

- Body Mass Index. Three good citations. Do not suggest need for change. People have benefit from surgeon, but the complication rate is higher.
- Hemoglobin A1c. New citations do not suggest need for edits.
- Tobacco. Citations 42 and 43. Indicate smoking leads to adverse outcomes. Is more than smoking, is nicotine use generally.
    - Whether to recommend testing the patient to see if they have stopped. The bundle generally says what the standard is but not how to achieve it.
- Opioids. No changes.
- Alcohol. New citation 24. Substance abuse disorder (alcohol and/or opioids) increases complication rates. No change needed.
- Depression. Two new citations, 24 and 25. Different perspectives on depression, whether it helps. Workgroup discussed and made no change.
- Peripheral circulation. Will be left in.
- Nutritional status. No change.
- CHANGE: Low Serum Albumen. 2-c-1 adds measure serum albumen. May be a measure of inflammatory activity. What if an abnormality is detected?
    - Action Item: Research next steps for therapy with low serum albumen.
- Adequate liver function. No change.
    - Baseline c-reactive protein?
- CHANGE: Absence of severe disability unrelated to osteoarthritis. Way this reads now means you can't have the surgery. Change to management of disability. II-1-k
    - Management and consideration.
    - This is fitness for surgery – what would make you change your approach.
    - Be as specific as we can about what outcome we are managing. What about a person with MS who will have pain improved but not function?
    - Language: Any disability can be managed such that the surgery can benefit the patient.
    - CHANGE: Remove the work disability throughout.
    - Add: immunosuppressive drugs
- Dementia. CHANGE: contract to contact.
- Care partner. Discussion of the importance of having a care partner.

**Action item:** Meck and Kevin to look into screening for osteoporosis.

**GOOD OF THE ORDER**

Dr. Mecklenburg thanked all for attending and adjourned the meeting.