
Bree Collaborative | Total Knee and Total Hip Replacement Bundle Workgroup

May 7, 2021 | 2:00 – 3:30pm

Virtual

MEMBERS PRESENT

Robert Mecklenburg, MD (Chair), Retired,
Virginia Mason Medical

LuAnn Chen, MD, MHA, FAAFP, Community
Health Plan of Washington

Emily Transue, MD, MHA, Health Care Authority

Michael Griffin, Providence St. Joseph Health

Kevin McDonald, MD, Virginia Mason

Alyssa Beene (for Dayna Weatherly-Wilson, RN)
Proliance Surgeons

Steve Overman, MD, MPH, University of
Washington

Joshua Drumm, DO, Providence

Michael Chen, Premera

STAFF AND MEMBERS OF THE PUBLIC

Mary Beth McAteer, Virginia Mason

Katie Sypher, 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. Minutes will wait as there is not a quorum.

CYCLE III: SURGERY

Dr. Mecklenburg began the discussion talking through the worksheet starting with Cycle III. The workgroup discussed:

- Higher volume places have better quality. This is consistently seen. Does not mean that lower volume surgeons and institutions cannot do great work.
 - Tends to shunt patients to high-volume centers so language is flexible.
 - No change will be made to the number
- III-A – Adding COVID-19 precautions. Citations 45, 46, 47 all relate to COVID-19. Based on previous experience requiring a flu shot. Won suit that if you don't get a flu vaccine then you wear a mask so now is the policy that you get a vaccine or you wear a mask.

Institutional policy that:

- "all medical, administrative, support staff, and volunteers will be vaccinated.
- Facilities, providers, support staff, volunteers and patients will all comply with current CDC guidelines."
- Now COVID is primary reason we have this but might there be an opportunity to generalize this.
- "should be vaccinated" or that they wear a mask
- Staff at Group Health was also challenged by mandating staff get vaccinated and said they had to wear a mask.
- Whether to call our patients or family members.
- Adding patients and family members.
- Short stay surgery
 - How long the person stays in the facility may not be an item that we want to get into. Market forces pushing toward a shorter stay.
- Cycle III-B – Elements of the optimal surgical process
 - Early recovery after surgery.

- 9 – more explicit about use of urinary catheters. “The routine use of urinary catheters is not recommended and when used they should be removed as soon as the patient is able to void, ideally within 24 hours after completion of surgery. “
- Avoid bleeding and low blood pressure “ a. Tranexamic acid is recommended to reduce perioperative blood loss and the requirement for postoperative allogenic blood transfusion, unless contraindicated”
 - No known contraindications for topical application, only for IV.
 - Support for this.
- Avoid deep venous thrombosis and embolism. Goes back to Medicare SCIP standards. Employ pharmacologic and/or mechanical prophylaxis according to estimation of patient’s risk.
 - Almost cult followings of certain medications
 - Consider stratifying patients by DVT risk.
- Other ERAS standards. Fasting, nausea and vomiting, normothermia. Surgeons do not have control over anesthesia.
 - ADD: Fasting: clear fluids should be allowed up to 2 hours and solids up to 6 hours
 - ADD: Nausea and Vomiting. Screen for nausea and vomiting as in the ERAS protocol.
 - SILENT: Maintaining normothermia. Normal body temperature. Not sure how measurable this is.
- ERAS does not talk about post-operative constipation. This can happen prior to surgery and after a person has gone home.
- Selection of the surgical implant.
 - Between manufacturers and the provider is the accountability for ensuring that the implant that is offered is safe.
 - Seeing institutional regulation of implants through contracts and preferred vendors.
 - AJARR is not easy to navigate.
 - Implant failures are required to be reported to purchasing facilities, which are required to track implants for just this reason.
 - Suggest that hospitals need provide comparative data on implant manufacturers with which they contract compared to other leading manufactures - dislocation, revision and other implant failure data?
- Revisiting COVID vaccine at the next meeting.

GOOD OF THE ORDER

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