

Bree Collaborative | Total Knee and Total Hip Replacement Bundle Workgroup

June 4, 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
Sarah Darveau Foster, RN, (for Michael Chen),
Premera
Andrew Friedman, MD, Virginia Mason

Michael Griffin, Providence St. Joseph Health
Kevin McDonald, MD, Virginia Mason
Cat Mazzawy, WSHA
Linda Radach, Washington Advocates for
Patient Safety
Steve Overman, MD
Emily Transue, MD, MHA, Health Care Authority

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

Matt Albright, Providence
Kathy Torrey, Premera
Joshua Drumm, Providence

WELCOME

Robert Mecklenburg, MD, retired, Virginia Mason, welcomed members to the workgroup. Nick Locke, MPH, introduced himself as the project manager lead for this workgroup.

Movement: Adopt April and May minutes.

Action: Unanimous adoption.

CYCLE III: SURGERY

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

- I-Adding term “appropriateness” to Cycle I.
- 1-A-1: Added “document findings on the patient’s history and physical examination which is compatible with the diagnosis of osteoarthritis.”
 - Agreement with adding this.
 - How much can be done in person vs. virtually. Sequencing of these as someone might be coming from far away. We have not specified how this should be done.
- Scope does not include osteonecrosis.
- I-B-1: Should *designate a physically and intellectually qualified care personal care partner...*
 - How this should be screened.
 - All surgeons have postponed surgeries when they have a caregiver who cannot physically help them.
 - CHANGE: Use **capable** not qualified.
- II-C-1-b: Screening lab test item.
 - Review NICE guidelines on major or complex surgery.
 - American Society of Anesthesiologists says that patients who are healthy do not need as many screening studies. Grades the testing with the severity of underlying disease.
 - Also the American College for Surgery that has strong for surgery.
 - Consensus this is a good model.
 - Most common tests are listed (e.g., arterial blood gas)

- National shortage of some items – such as tubes for blood draw.
- Not meant to be restrictive meant to be basic quality standards. Not meant to supersede clinical judgment.
- Different labs for different patients adds confusion and makes audit more difficult.
- Whether to call out the controversial of not doing unnecessary labs.
- ADD: Cite Strong for Surgery.
- ADD: may include test for hemostasis and others based on comorbidities
- CHANGE: Complete blood count
- Albumin and C-reactive protein. Non-specific. Like to include in bundle but not sure if should be for all patients.
 - Should be de-coupled.
 - Interest in wanting to check for inflammation. CRP checks for occult inflammation.
 - Was originally added because it is in Strong for Surgery.
 - Often times patients will have an elevated CRP and are sent to rheumatologist but they cannot see why. This can be a barrier. Not enough rheumatologists.
 - Compromise could be advisory.
- ADD: CRP may be considered for three reasons: 1) to establish a baseline for post-op comparison when ordered as marker of post-op infection; 2) to screen for undiagnosed conditions non-specific elevations*: infection or non-infectious inflammatory conditions; obesity associated. *CRP elevations may correlate with increased DVT risk, post-op pain, and failed TJR.
- II-C-1-G-H: Nausea and constipation.
- III- Added “safe surgery”
- III-A-7: COVID infection control.
 - Vaccine was emergency approval. What will this look like in two years? We don’t say COVID.
 - Volunteers and patients
 - How to talk about COVID. Airborne respiratory illnesses?
 - ADD: Vaccination or wear a mask as appropriate for circulating illnesses as per current CDC guidelines.
 - Delete last sentence.
- III-C: Selection of surgical implant.
 - How to define acceptable failure rate in three years or five years. AOS standard is less than 5% in ten years.
 - Aseptic loosening or osteolysis is what registries say. There is not a source of information. We want patients to get good implants.
 - Everyone likes 90 day complication rates but what we want to know is the five year complication rate. Within five years it is probably the surgeon that causes failure not the device.
 - Do we have a consistent and shared understanding of what implant failure means? Industry does not know either.
 - The way that patients get a bad implant is through early adoption of new technology with no evidence.

Action Item: Kevin to draft language on selection for surgical implant.

GOOD OF THE ORDER

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