Bree Collaborative | Surgical Patient Optimization
Tuesday March 4th, 2025| 7-8:30AM
Hybrid

MEMBERS PRESENT VIRTUALLY

Carl Olden, MD, Central Washington Family Medicine
Vickie Kolios, CHPQ, SCOAP
Nick Kassebaum, MD, SCOAP
Nawar Alkhamesi, MD, PhD, MBA, FRCS (GEN. SURG.), FRCS, FRCSEd, FRCSC, FACS, FASCRS
Evan P. (Patch) Dellinger, MD
Andrea Allen, RN, Washington HCA
Rosemary Grant, RN, BSN, CHPQ, CPPS, Washington State Hospital Association
Thien Nguyen, MD, Overlake
Tiffany Leiva, RN, Proliance
Edie Shen, MD, UW Medicine
Cristina Stafie, MD, Kaiser Permanente
Scott Helton, MD, Virginia Mason
Eduardo Smith-Singares, MD, Kadlec Medical Center

STAFF AND MEMBERS OF THE PUBLIC

Beth Bojkov, MPH, RN, Bree Collaborative
Emily Nudelman, DNP, RN, Bree Collaborative
Karie Nicholas, MA, GDip, Bree Collaborative
Cora Espina, ARNP, Foundation for Health Care Quality (Intern)

WELCOME

Beth Bojkov, Bree Collaborative, welcomed everyone to the Bree Collaborative Surgical Patient Optimization March Workgroup. Those new to the group introduced themselves, their role, and their reason for interest in this group.

Action: February minutes unanimously approved

PERIOPERATIVE HYPERGLYCEMIA IS DANGEROUS TO NONDIABETICS (AND DIABETICS)

Beth turned the meeting over to Dr. E Patchen Dellinger (UW, retired) to present on perioperative hyperglycemia risk for people with and without diabetes, and an example of the protocol from UWMC developed to address hyperglycemia in all patients. Slides available here: Perioperative Hyperglycemia is Dangerous to Nondiabetics and Diabetics

Main points included:

- Regardless of the diagnosis of diabetes, hyperglycemia increases morbidity, mortality and length of stay
- People without diabetes are at elevated level of risk for surgical site infection
- Exact “best” level of glucose control in the perioperative period is not known, but tight glucose control is tricky and hypoglycemia increases the risk of morbidity and mortality
- A1c does not affect risk if hyperglycemia is prevented in the perioperative period
- The higher your blood sugar levels, the higher your risk for complications and risk continues to POD2
- Nondiabetics and diabetics should be treated the same for perioperative glycemic control

Question & Discussion:

- Still getting difficulty with buy in for ambulatory council to check and aggressively treat hyperglycemia for nondiabetics
- Staffing and educational support for modification of order sets supported successful implementation at UW – staff ratios are critical

- Software programs support doing this in an easier fashion, nonacademic spaces do not have the same resources
- Focus on tools currently in hospitals and primary care – identify patients who are most at risk for hyperglycemia preop and postop which is done by medical history and taking an A1C
- At one example hospital, they do not check a BG on surgeries that go home the same day. Consider feasibility of checking BG preop for most if not all patients through some thresholds
    - In preop setting, can we standardize everyone getting a BG check whether outpatient or planned inpatient
    - If inpatient, can you monitor based on the staff that you have (including for insulin gtt)
- Challenges
    - Buy in
    - Logistics – glucometers in every preop holding/OR, QI for monitors
    - Staffing capabilities
    -
- CGMs are not reliable enough to replace POC glucometers at this point especially in OR
- If we can narrow down who do we check and when do we check in Preop (e.g., risk factors like age, BMI, risk of ischemic disease)
- Consider how to incentivize PCPs to check an A1c in preop evaluation for more people. Especially for ambulatory surgery, it is better to catch things up front because it's difficult to turn someone away for an A1c just barely over the line (e.g., 7.5%)

POSITION STATEMENT SUMMARY

Beth Bojkov invited Cora Espina, ARNP, to describe several relevant resources,

- Reviewed the 2024 society for ambulatory anesthesia updated consensus statement
    - Do not recommend postponing ambulatory surgery based on A1C
    - Proceed with planned procedures if hyperglycemic but without symptoms of DKA/HHNS
    - When CGM is used, verify with finger stick BG
    - Do talk about using home infusion pumps (insulin infusion) significant perioperative >250mg/dL patients should be treated with insulin
    - Preference for subq insulin in OR for ambulatory
- Commonalities between ADA/ Endo Society/UpToDate
    - Goal A1c <8%
    - Aim to optimize BG before surgery, different in optimizing during surgical procedure

Discussion

- Caution against setting recommendations for using subq versus IV insulin give the variation in complexity and procedures – one reference suggesting hypoglycemia with subq insulin instead of IV in bariatric procedures
- No randomized trial currently that shows if you treat patients who are not diabetic who are hyperglycemic that they have better outcomes than without treatment
- Would be perioperative physician's job to manage A1c if there is not a periop clinic to do that themselves

PUBLIC COMMENT AND GOOD OF THE ORDER

Beth invited final comments or public comments, then thanked all for attending. At the next workgroup meeting, the team will review protocols from organizations in the community to begin drafting our guidelines. The workgroup's next meeting will be on Tuesday, April 1st from 7-8:30AM.