Bree Collaborative | Surgical Patient Optimization
Tuesday June 3rd, 2025| 7-8:30AM
Hybrid

MEMBERS PRESENT VIRTUALLY

Carl Olden, MD, Central Washington Family Medicine
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
Edie Shen, MD, UW Medicine/Harborview
Cristina Stafie, MD, Kaiser Permanente
Irl Hirsch, MD, UW Medicine
Judy Chen, MD, UW Montlake
Tony Roche, MD, Harborview

STAFF AND MEMBERS OF THE PUBLIC

Beth Bojkov, MPH, RN, Bree Collaborative
Karie Nicholas, MA, GDip, Bree Collaborative

WELCOME

Carl Olden, MD, workgroup chair, welcomed everyone to the Bree Collaborative Surgical Patient Optimization June Workgroup.

Action: motion to approve May minutes
Outcome: May minutes unanimously approved

POSTOPERATIVE PLANNING

Dr. Olden transitioned the meeting to our postoperative planning scenarios from the end of last meeting.

First Scenario:

- Friday OP D and C for diagnosis of endometrial adenocarcinoma in a 65-year old woman with BMI of 45, hx hypertension but without known DM, has a pre-operative glucose of 180 and gets a single dose of short-acting insulin in OR for a 45 min start to finish procedure. BG is 165 in recovery, and she is ready to go home by noon.
- Does she need follow-up in next 2 days or can she wait until early next week? Does Anesthesia send her home on a daily dose of long-acting insulin? This is a procedure that is low risk for infection so maybe not.
    - Suggestion: Send her home with meds but diet information and scheduled follow-up with Primary Care next week.

Second scenario:

- same patient but getting OP total knee replacement, 10AM start time, recovered from anesthesia and ready to go home by 4pm, Does she get home glucose monitor, lancets, strips, control solution and insulin to take at home until she can be seen next week? Who does this, Surgeon or Anesthesia?
- This would be the perfect patient to use CGM intraoperatively and have her wear the sensor home, teach patient or family member how to set up smartphone app to sync with the sensor and capture data until seen the next week. Much less costly approach than admitting for glucose monitoring and treatment.

Discussion

- Close monitoring and follow up with primary care provider is ideal to manage hyperglycemia and reduce risk of complications
- CGMs might be ideal in the second scenario involving knee replacement, but challenges include:
    - Difficulty of prescribing glucose monitoring equipment and insulin – uncommon for surgeons to do this for postop patients, lack of existing administrative infrastructure
    - Dietary education needs – realistic and practical dietary advice like avoiding simple sugars and low-carb diets
    - Realistic infrastructure for follow up care and CGMs – cost, coverage, need for proper training
- Care management services provided by health plans could assist in ensuring high-risk patients receive the necessary follow up to prevent readmission and manage condition effectively
    - Internal algorithms could support determination of which patients are at high risk for readmission – require additional follow up care

PREOPERATIVE ANEMIA OPTIMIZATION

Beth transitioned the group to introduce the topic of anemia optimization. Beth reviewed the prevalence of anemia, impact on surgical outcomes, and provided a birds-eye view of existing guidelines for screening and treatment.

- Anemia is more common among young adult females and older adults, and prevalence varies depending on surgical population (e.g., higher in vascular surgery, gynecological surgery, colorectal surgery)
- Preoperative anemia increases morbidity and mortality, hospital length of stay, rate of complications (acute kidney injury, stroke, MI) among other outcomes
- Existing guideline emphasize screening for preop anemia in “major surgery” (e.g., expected blood loss >/= 500mL), evaluating and identifying underlying cause of anemia preoperatively, treating preoperative iron deficiency anemia with iron supplementation (IV most effective preoperatively) and checking hemoglobin concentrations before surgery.
- **Barriers**:
    - Implementation of anemia management in colorectal patients – need to investigate causes of anemia, and need adequate time to do so. Many patients needing colorectal surgery present with anemia as their first symptom, leading to short time frame for treatment before surgery. Time between treatment and surgery may not be enough to be effective at raising Hb
    - Prior authorization blocks access to certain formulations which can delay treatment
    - Nonchalance towards mild anemia and impact on outcomes
    - Costs for annual screening for A1c and Hb
- Needed solutions:
    - Improved access to high quality iron formulations, and their prior authorization requirements
    - Clear standardized pathways and messaging to surgical teams to indicate need to optimize anemia before surgery.
    - Effective messaging about benefits of preop optimization, and clear communication for patients to understand the importance of optimization of anemia to adhere to recommended interventions

PUBLIC COMMENT AND GOOD OF THE ORDER

Carl invited final comments or public comments, then thanked all for attending and their effort. The workgroup's next meeting will be on Wednesday, July 9th from 7-8:30AM.