Bree Collaborative | Surgical Patient Optimization
Wednesday September 9th, 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
Tiffany Levia, Proliance
Irl Hirsch, MD, UW Medicine
Andrea Allen, RN, HCA
Christina Stafie, MD, KP
Ty Jones, MD, Regence
Vickie Kolios, MSHSA, CPHQ, SCOAP

STAFF AND MEMBERS OF THE PUBLIC

Beth Bojkov, MPH, RN, Bree Collaborative
Karie Nicholas, MA, GDip, Bree Collaborative
Emily Nudelman, DNP, Bree Collaborative

WELCOME

Carl Olden, MD, workgroup chair, welcomed everyone to the Bree Collaborative Surgical Patient Optimization September Workgroup. Quorum was reached.

- **Objective**: September minutes approved
- **Action**: September minutes approved

HEALTH PLAN LEVERS: SURG OPTIMIZATION

Dr. Olden transitioned the meeting to allow Ty Jones, MD, Regence, to present on health plan

- Not aware of all individual patient factors, aware of what surgery the patient will ultimately have
    - Whether or not patient was admitted
- What they can't do
    - Preop physical notes
    - See surg H+Ps reliably
    - Manually review clinical documentation
- Prior authorizations are typically automatic, not really manually reviewed
- Don't require documentation from surgery that occurred
- What health plans can do
    - See dates, CPTs and ICD10s of labs, IV meds, surgeries, admissions and transfusions
    - Remove barriers – drop prior auth for labs, oral and IV iron
    - Clarify coverage, make anemia screening/treatment explicitly covered
    - Pay modest incentives – small bonuses for preop screening, completion of specific procedures
    - Contracting requirements – use specific guidelines
    - Engage members – reminders and nudges to complete labs for surgeries they are aware of
- What advanced plans can do

    - Data sharing – provide feedback reports on provider screening rates and transfusions outcomes
    - Quality incentives – ties screening rates to bonus pools/P4P
    - Bundled payments – one payment covers surgery + 90 days; provider bears risk for transfusion
    - Shared savings – plans and providers split savings if episode costs drop, transfusions drop (or screening quality measures are met if savings are created elsewhere)
- What Bree guidelines could look like:
    - All plans should: remove PA for preop anemia screening labs, and IV iron treatments, clarify coverage, offer modest incentive and engage members
    - Where feasible plans should integrate preop screening into quality programs, share data with providers
    - Plans with advanced payment models should embed preop screening and/or transfusions into bundles and shared savings contracts

Discussion

- Actual execution of preoperative screening and response to lab results must occur within the hospital or provider system – they have real-time knowledge to enact changes
- Large employers have resources to support quality initiatives – smaller ones expect appropriate care without needing to oversee clinical details
- Claims data can be ambiguous, and diagnosis codes may not always reflect clinical findings – manual reporting or audits may be necessary for quality programs
- ASCs have specific set of challenges compared to hospitals
- Helpful to identify high risk procedures for anemia and transfusion (elective spine, colorectal)
- Actionable quality measures for employers and health plans to monitor are important
- Don't want to be too specific on ICD10 and CPT codes because it could rule out others that should be included in these recommendations
- While A1c can be inaccurate,

DRAFT GUIDELINES REVIEW

Beth transitioned the group to reviewing the draft guidelines for feedback.

- While A1c can be an inaccurate management, a super high A1c is still indicative of higher risk
- Admissions are recommended for patients requiring intravenous insulin to treat hyperglycemia
- There are still problems with access of outpatient diabetes management especially in rural areas – some of the recommendations may not be feasible in all communities

Action Steps

- Beth requested everyone review the draft guidelines and report to provide feedback and she would take votes to pass for public comment over email

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 **Tuesday, November 4th from 7-8:30AM**, where we will review combined draft report and guidelines.