Bree Collaborative | First Episode Psychosis
January 17th, 2025| 7-8:30AM
Hybrid

MEMBERS PRESENT VIRTUALLY

Carl Olden, MD, Central Washington Family Medicine
Vickie Kolios,
Nick Kassebaum, MD, SCOAP
Nawar Alkhamesi, MD, PhD, MBA, FRCS (GEN. SURG.), FRCS, FRCSEd, FRCSC, FACS, FASCRS
Timothy Barnwell, MD
Evan P. (Patch) Dellinger, MD
Eduardo Smith-Singares, MD, Kadlec-Providence
Andrea Allen, RN
Michael Bota, MD, MultiCare
Robert Rush, MD
Venu Nemani, MD, PhD, Virginia Mason
Rosemary Grant, RN, BSN, CHPQ, CPPS, Washington State Hospital Association
Thien Nguyen, MD, Overlake
Ty Jones, MD, Regence
Irl Hirsch, MD, UW Diabetes Institute

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)
Emilie Jones

WELCOME

Beth Bojkov, Bree Collaborative, welcomed everyone to the first Bree Collaborative Surgical Patient Optimization Workgroup. Those present introduced themselves, their organizations, and their current experience with surgery optimization, especially around anemia and glycemic control.

DISCUSS: BREE BACKGROUND AND WORKGROUP PROCESS

Beth introduced the Bree and the workgroup process. The Bree Collaborative is a program of the Foundation for Health Care Quality. The Bree was established by the state legislature in 2011 in response to health care services with high variation and utilization that do not produce better outcomes. Each year, Bree members (drawn from public and private healthcare stakeholders) choose three to four topics to develop recommendations. Surgical Patient Optimization is one of three topics for 2025.
The workgroup will meet monthly throughout 2025 to define the purpose and scope, identify focus areas, review existing guidelines. The report will include recommendations for specific health care stakeholders and will be sent to the WA Health Care Authority. The workgroup must follow Open Public Meetings Act regulations. This includes workgroup member training and conflict of interest disclosure. Following the presentation, Beth opened the floor for comments, but there were no questions.

PRESENT& DISCUSS: WORKGROUP MEMBERS

Beth opened the brainstorming conversation with a discussion on additional stakeholders to consider inviting to participate or speak:

- Some additional stakeholders to consider for participation or inviting to speak, including:
    - Patient advocacy
    - Nurse Practitioner/Physician Assistant Representation
    - Jehovah's Witness

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- Blood Management Society, Bloodworks Northwest

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Meeting notes:

- **Topic Overview:** Nick presented the topic of surgical patient optimization, focusing on the importance of addressing anemia and glycemic control to improve surgical outcomes.
- **Data and Evidence:** Nick shared data and evidence supporting the need for standardized protocols for preoperative optimization, highlighting the impact of anemia and glycemic control on surgical outcomes.
- **Workgroup Scope and Focus:** The workgroup discussed the scope and focus areas for the project, including the importance of collaboration between primary care and surgical care, and the potential impact of continuous glucose monitoring (CGM) on perioperative glycemic control.
- **Charter Approval:** The workgroup reviewed and approved the draft Charter, with edits to include considerations for CGM and different standards based on resource availability.

Follow-up tasks:

- **Patient Advocacy Representation:** Reach out to American Diabetes Association or Breakthrough T1D to get a patient representative on the Type 1 diabetes side. (Beth)
- **Nurse Practitioner Representation:** Contact the professional association in Washington to find a nurse practitioner or PA interested in joining the workgroup. (Beth)
- **Jehovah's Witness Involvement:** Engage with the Jehovah's Witness community to support the initiative and involve them in discussions about anemia management. (Beth)
- **Blood Management Society:** Reach out to Bloodworks Northwest to discuss the distributional aspects of blood availability and the cost of maintaining the blood supply. (Beth)
- **Preoperative Optimization Clinics:** Follow up with Rob to identify a nurse practitioner from his group who can join the workgroup. (Beth, Rob)
- **Claims Data Analysis:** Explore the possibility of pulling reports to look at demographics and other diagnoses of patients being readmitted with surgical complications. (Rosemary)
- **CGM in Perioperative Period:** Include the impact of continuous glucose monitoring (CGM) in the perioperative period as part of the best practices for optimization. (Beth)

PRESENT& DISCUSS: TOPIC OVERVIEW

Beth transitioned the meeting to allow Dr. Nick Kassebaum to provide an overview of the topic and potential scope.

- **Topic Overview**: Nick presented the topic of surgical patient optimization, focusing on the importance of addressing anemia and glycemic control to improve surgical outcomes.
    - Suboptimal preparation before surgery lead to increased risk of infection, bleeding, transfusion, ICU stay, 30-day mortality and other post-operative complications
    - Anemia and glycemic control are modifiable risk factors that have significant impact on post-surgical outcomes
    - Using standardized protocols for optimization prior to procedures and unifying use of enhanced recovery process scores
- **Data and Evidence:** Nick shared data and evidence supporting the need for standardized protocols for preoperative optimization, highlighting the impact of anemia and glycemic control on surgical outcomes.

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- Black patients have higher rates of anemia preoperatively**,** Black, Hispanic, AI/AN patients more likely to experience uncontrolled diabetes/serum glucose leading to inequitable outcomes
    - Anemia present in up to 30% of patients coming for surgery (vs <15% in general population)
    - Nearly 20% of general surgery patients have diabetes, 23-60% have prediabetes or undiagnosed diabetes. High variation in HbA1c optimization prior to surgery, and inconsistent glucose control around time of surgery for people with hyperglycemia
    - Anemia associated with higher blood loss and most transfusions are given to anemic patients; preoperative anemia and poor A1c/serum glucose optimization are associated with: surgical infections, readmission, cardiovascular/kidney events, increase LOS, increase 30-day mortality and increased cost
- **Evidence-based strategies:** goal is to adopt and refine in the context of our state,
    - **Outpatient Delivery Systems:** preoperative anemia management and glycemic status ahead of elective or planned procedures, coordination between primary care and surgical teams, appropriateness for surgery, scheduling procedures in least restrictive settings
    - **Inpatient/Surgery Centers:** integration of anemia and glycemic status in protocols for surgical optimization
    - **Plans/Purchasers:** Consider anemia and glycemic control in their quality measures, criteria for reimbursement, minimize cost barriers to services that support preoperative optimization

Beth transitioned the group into discussing further the outcomes the group wishes to see from this work:

- Question: thought of anemia as a symptom not a disease itself, are we going to focus on the underlying chronic condition causing it
    - There are ways to evaluate and treat anemia in the short term, that's what we're trying to get at, and those interventions reduce risk of surgical complications
- Part of this group's work will be deciding roles of primary care/surgical teams for preoperative optimization of anemia and glycemic status
- EtOH, nicotine and opioids preoperatively are out of scope for this report and guidelines
- Extensive literature showing that in terms of perioperative complications and risk, controlling in the perioperative period and immediate postoperative period is better
- Risk of perioperative hyperglycemia is not limited to diabetes and prediabetic patients
- Mixed evidence of preoperative management of anemia –
- Potentially can look into claims data – potentially option for pulling reports for which patients are being readmitted with surgical complications
- Some studies that show improved outcomes for patients in ICU without aggressive treatment of serum glucose
- Want to keep CGM in-hospital use on our radar, HEDIS accepts CGM as a glucose control
- Considerations for health systems with different resource levels (are there different criteria for which A1c does matter for perioperative complications)
- Need to emphasize glucose control in patients who are NOT diabetic; there are a lot more nondiabetic patients than diabetic patients going to the OR

PRESENT & DISCUSS: CHARTER & ROSTER

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Beth then transitioned to reviewing the charter and roster. The following changes were made to the charter's purpose (changes/additions are in red)

- Improve collaborative management of surgical patients between primary care and surgical care
- Recommend strategies to integrate optimization of anemia and glycemic status (patients with and without diabetes) into perioperative protocols
- Recommend reimbursement structures and employer strategies to incent improved optimization of anemia, glycemic control and use of enhanced recovery after surgery protocols
- Identify best practices for anemia and glycemic status optimization around surgery, including innovative strategies (CGM monitoring)
- Out of Scope: Added EtOH/nicotine/opioids

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 comments made from the Bree member meeting on January 24th and continue the brainstorming discussion around potential focus areas for the report. The workgroup's next meeting will be on Wednesday, February 14th from 3-4:30PM.

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