Bree Collaborative Meeting
March 25th 2026| 1:00-3:00PM
Hybrid

MEMBERS PRESENT VIRTUALLY

Emily Transue, MD, MHA, Comagine Health
Jake Berman, MD, MPH, University of Washington
Colleen Daly, PhD, Microsoft
Gary Franklin, MD, Washington State Department of Labor and Industries
Judy Zerzan-Thul, MD Washington HCA
Carl Olden, MD, Central Washington Family Medicine
Norifumi Kamo, MD, MPP, Virginia Mason
Drew Oliveira, MD, WHA (to be confirmed)
Darcy Jaffe, ARNP, WSHA
Rodney Anderson, MD, FCN (to be confirmed)
Nicole St. Clair, MD, Regence
Arooj Simmonds, MD, Providence (to be confirmed)
Katina Rue, DO, Team Health (to be confirmed)
Kristina Petsas, MD, UHC

MEMBERS ABSENT

Colin Fields, MD Kaiser-Permanente
Susanne Quistgaard, MD, Premera Blue Cross
Tao Kwan-Gett, MD, Department of Health (to be confirmed)
James Murray, MD, Confluence (to be confirmed)

STAFF AND MEMBERS OF THE PUBLIC

Beth Bojkov, MPH, RN, FHCQ
Karie Nicholas, MA, GC, FHCQ
Emily Nudelman, DNP, RN, FHCQ
Ginny Weir, MPH, FHCQ TVW Streaming
Susanna Waldman, WSMA

WELCOME

Dr. Transue welcomed everyone and opened the meeting. Dr. Transue then asked the Collaborative for a motion to approve the minutes from last meeting.

Motion: Approve January Minutes
Outcome: Unanimously approved January Minutes

2026 WORKGROUP UPDATES

Dr. Transue transitioned the meeting to invite workgroup updates:

Perimenopause and Menopause (Dr. Nicole Saint Clair)

- Focus areas detailed below:
    - Recognition & Assessment
        - Patient perspective: I understand what will happen to me and my body as I go through the menopause transition, as well as when to seek help with symptoms. My primary care provider has spoken to me about the transition, answered my questions, and we made a plan for if I experience bothersome symptoms
        - Components:

        - Provider education around normal and abnormal physical and behavioral health changes and symptoms during perimenopause and menopause from the patient perspective and how clinical decision-making can support patients
        - Inclusive of where experiences may differ, including for those receiving gender-affirming hormone therapy, those who arrive at menopause surgically, those with primary ovarian insufficiency, and others as identified.
        - Assessment of symptoms of perimenopause and menopause at home and in clinical settings
    - End users
        - Patients
        - Primary Care Systems (including PCP, OBGYN, Midwives, etc.)
        - Behavioral Health Systems and Providers
        - Health Plans
        - Department of Health
- Management
    - Patient perspective: I know what medical care is available and appropriate to support my symptoms. I've had an honest discussion with my provider about the risks and benefits of available treatments, and created a plan to provide relief from symptoms and protect my health as I age.
    - Components:
        - Symptom management grounded in shared decision-making, and non-hormonal treatments
        - Hormone therapy selection (type, route, dose, duration, etc.)
        - Use of evidence-based complementary and alternative medicines
        - Lifestyle, prevention and screening for whole-person midlife health, such as for:
        - cardiovascular disease
        - metabolic health
        - osteoporosis
        - mental health concerns
        - urogenital and sexual health concerns
        - etc.
    - End users:
        - Patients
        - Primary Care Systems (including PCP, OBGYN, Midwives, etc.)
        - Behavioral Health Systems and Providers
        - Health Plans
        - Department of Health
- Workplace Support & Quality Measurement
    - Patient perspective: I feel supported by my workplace to talk openly about menopause without stigma or negative impact to my career and can request flexibility and accommodation if needed to prioritize my health and wellbeing.
    - Components:
        - Employers offer a basic level of menopause-informed benefit design for hormone and nonhormone options for symptom management,

practices and accommodations during the menopause transition inclusive of formal accommodations, and opportunities to openly discuss my experience with others
                - Systems (delivery systems, health plans, employers, state agencies) monitor and report out quality measures for perimenopause and menopause care
                - Accessible and available peer support groups
            - End users:
                - Primary Care Systems (including PCP, OBGYN, Midwives, etc.)
                - Behavioral Health Systems and Providers
                - Health Plans
                - Employers
                - Health Care Authority
    - Education
        - Patient perspective: I learned about the full spectrum of sexual and reproductive health, including menopause, in school. Trusted adults in my life, including healthcare professionals, know how to answer my questions from puberty through menopause.
        - Components:
            - Integration of public education for menopause in school systems
            - Evidence-based and comprehensive curriculum on the menopausal transition in provider training and education
        - End users
            - Academic Medical Centers
            - Department of Health
- Discussion
    - Incorporate culturally appropriate lens especially when it comes to recognition and assessment of symptoms

Lung Cancer Screening (Beth Bojkov)

- Focus areas below:
    - Eligibility & Engagement
        - Components
            - Screening and documentation of tobacco history at all points of care
            - Identification of eligible individuals according to national evidence-based guidelines
            - Utilization of EHR tools, automated risk identification, registries/panels, and other strategies to streamline identification
            - Streamline access to shared decision-making about risks and benefits of LCS
            - Report screening engagement by race and ethnicity, by site and health plan
        - End users
            - Patients and Families
            - Clinicians
            - Delivery Systems
            - Health Plans

        - Employers
    - Stigma, Bias, & Equity
        - Components
            - Outreach to populations with historical or demonstrated inequities in screening rates, including by race and ethnicity, rural locations, those covered by Medicaid or uninsured, and minoritized LGBTQIA+ populations
            - Explore telehealth, mobile screening models, and other technological advances to engage underserved populations
            - Healthcare provider targeted education and training around stigma and bias in lung cancer screening
            - LCS Navigation support
            - Communication is understandable, person-centered, and consistent with guidelines with clear next steps for patients and families
            - Track outcomes and identify disparities in screening and mortality
            - Include lung cancer screening measures in value-based contracting
        - End users
            - Patients and Families
            - Clinicians
            - Delivery Systems
            - Health Plans
            - Employers
            - State Agencies
        - Screening with LDCT
            - Integration of smoking cessation at all touchpoints of the LCS continuum
            - Designate ownership of LCS workflow and population-level management
            - Low-dose CT (LDCT) provided according to ACR technical standards
            - Identify and standardize reporting of lung nodules
            - EHR processes for screening documentation, clinical decision tools, and reminders
            - Track and clearly communicate the process and frequency of lung cancer screening (annual LDCT with potential for increased frequency to track abnormal findings)
        - End users
            - Patients & Families
            - Clinicians
            - Delivery Systems
            - Health Plans
            - Employers
            - State Agencies
    - Results Management
        - Components
            - Timely, guideline-aligned (e.g., Lung-RADS) results management and follow-up

                - Standardized processes and care coordination to ensure follow up with annual screening, follow-up and referral to specialty care after abnormal LDCT findings; Pathway to access multidisciplinary review for results management
                - Access to recommended care for completion of LCS
                - Designated process owner and reliable tracking systems for cancer screening registry follow-up and outreach to close care gaps and prevent missed follow-up
            - End users:
                - Patients and Families
                - Clinicians
                - Delivery Systems
                - Health Plans
                - Employers
                - State Agencies
                - State Legislature?
- Discussion
    - The group will be discussing effective interventions for tobacco cessation as part of our integration of cessation across the continuum

Alzheimer's and Other Dementias Revision (Dr. Kris Rhoads - approximately 2:30 PM)

- Focus Areas (listing the updates to the focus areas only)
    - Risk Reduction
        - Multicomponent interventions to reduce risk
        - Aggressive treatment of hypertension, diabetes, and hyperlipidemia in midlife and beyond.
        - Routine screening and referral for hearing loss and visual impairment; Routine screening and treatment for depression and anxiety
        - Closed-loop referral to community programs (physical activity, nutrition, community building)
    - Early Detection & Diagnosis
        - Case detection & diagnostic workflow
        - Comprehensive Diagnostic Evaluation (e.g., blood based biomarkers, APOE genotyping, Anti-amyloid therapies)
    - Ongoing Care, Support & Management
        - Team-based care models
        - Integration of community support, caregiver support
    - Other Areas
        - Minor updates
- Discussion
    - How do we add unique value for risk reduction?
        - Tell patients what's good for your heart is good for your brain
        - Addition of screening for hearing loss
    - Super difficult to get folks engaged with discussion around mild cognitive impairment.
        - Not necessarily distrust but some holdouts with nihilism
        - When started years ago – strong propensity to be more aggressive managing risk factors when cognitive impairment is present

- Have we discussed case detection versus screening?
  - VMCS finally published
  - Leaning on case detection, circumvents USPSTF guidelines that need updating
  - Highlighting opportunities to case detection, what should you be looking for to raise the likelihood that you will notice it

2026 LEGISLATIVE SESSION UPDATES

Emily Transue, MD, MHA, transitioned the meeting to invite Dr. Judy Zerzan-Thul to provide brief updates after the 2026 legislative session.

- SB 5915 WASHINGTON STATE LEGISLATURE
  - Adjustments to the Health Technology Assessment program process
    - Review Medicare guidelines and coverage and consider
    - Evidence consideration for reviews
    - Life-threatening rare disease, consider input from clinical experts
    - New timeframes for determinations
    - Re-reviews have to include all available clinical evidence not just evidence since last dtermination
- HB 1706 Washington State Legislature
  - Speaks to requirements for use of AI in prior authorization process for commercial, PEBB, SEBB – AI cannot be sole means to delay, deny or modify services
- Changes to 340B
  - Transparency and understanding around some o the manufacturing restrictions
- Immigrant worker protection – notification of employees ahead of time
- HB2242
  - Preventative services access – authorizes DOH to issue recommendations and guidance
- Received smaller budget cuts than expected, but DOH received some large cuts
  - Funded
    - Doula Hub and referral system for Medicaid – hub that will help doulas bill Medicaid, TA, support, etc.
    - Health homes program
    - Cuts to PT/OT/SLP in Medicaid did not pass
    - Apple health expansion program – have had that program for a couple years, move to FFS
  - Federal directives
    - Prior authorization work around APIs - make it more seamless and electronic
    - Managed care access rules – will have secret shoppers for Medicaid
  - Work requirements for Medicaid
    - Working internally to figure out who is medically frail, determine from claims data to automatically exempt some people
  - Rural health transformation project hiring a manager
  - Tribal opioid summit funded this year
  - HCMACS
    - EHR services for state hospitals and DOC to better enable transfer of information
- Questions
  - How does the HTA offer value to HCA in combination with other guideline-providing organizations

        - It is helpful especially on topics or services for which there's a lot of controversy on whether or not to cover services, devices, etc.
        - Worthwhile task to follow the evidence, also saving a fair bit of money
        - Nobody is regulating or overseeing what providers do at all, nipped some things in the bud in the past (e.g., upright MRIs)
        - Need to have a mechanism to review emerging and controversial
        - HTCC is about coverage criteria for very specific services, Bree is about systems issues and how different people in the system interact around optimizing care. Complementary but distinct organizations and purposes.
        - HTCC also transparent, really helpful when doing the Diabetes Bree topic to look at CGM coverage criteria
    -

REPORT MANAGEMENT

Dr. Transue transitioned the meeting to invite Beth Bojkov, MPH, RN, to review updated reports and guidelines

- Review of categories
    - Active: all reports under 5 years old
    - Needs Review: all reports 5 years old and over
    - Inactive: Bree Collaborative has voted to make inactive – guidelines no longer reflect current evidence-based practice OR are not longer relevant to the current healthcare landscape in Washington. Accessible for historical purposes.
- Cardiovascular Care (2012)
    - Original report written in 2012 with the intent to improve data capture for the purposes of comparing against appropriate use criteria to drive improved use of appropriate PCI. Cardiac COAP remains the implementation mechanism for this quality improvement work, and we are not actively supporting implementation or evaluation of this report and set of guidelines currently.
    - Discussion:
        - Are we seeing any reports on variable use rates of cardiac stenting in Medicare population? Not sure if COAP is addressing that themselves.
            - Not entirely sure, concerns of overuse of stenting are out there, should pass that back to COAP for their consideration and explore collaboration as needed

Motion: Archive Cardiovascular Care Report as Inactive
Outcome: Cardiovascular Care Report is archived

- Primary Care (2020)
    - Concentrated the report to 6 pages simply focusing on the focus areas and guidelines for clinicians, clinics, health plans and purchasers
    - Discussion
        - Seeing more micro-primary care, but want to make sure that when the team is called out, that we don't require offices to employ all team members (can work across organizations and sites)
        - NCQA is developing an updated model, would be worth it to review in a few years as well

- Might be some conversation about universal primary care – universal health commission
    - Fee across everyone to fund the majority of primary care as a benefit to everyone
    - Large employers are doing this already (e.g., Boeing, King County, etc.)

Motion: Reaffirm Primary Care Report
Outcome: Primary Care Report reaffirmed

IMPLEMENTATION AND EVALUATION UPDATES

Dr. Transue transitioned the meeting to allow Dr. Emily Nudelman, Director of Implementation and Outreach, and Karie Nicholas, Evaluation and Measurement Manager, to provide updates to the Collaborative's implementation and evaluation work:

- Implementation
    - Quarter 1
        - 3 Bree Spotlight webinars on 2025 reports
        - Surgical Patient Optimization webinar series
            - Cutting surgical risk – early detection of hidden hyperglycemia and anemia
            - Beyond Transfusion – anemia optimization for culturally informed bloodless surgery
        - Community webinars and events
            - Catalyst for change – energizing innovation for a resilient behavioral health system
            - Navigating new terrain: keeping up to date with evolving vaccine guidance
    - Quarter 2
        - Surgical patient optimization work: facilitating panel discussion at SCOAP annual meeting
        - Implementation support:
            - Extreme heat and wildfire smoke
                - Case study on wildfire smoke and asthma utilized at the national level!
            - First episode psychosis
            - Behavioral health (youth, perinatal, adult)
            - Oncology
        - Health in action collaborative beginning in May – **reach out if interested!**
    - Discussion:
        - Link to example of wildfire smoke and asthma case study: Case-study-onepager-Asthma_wildfire-smoke.pptx

- Evaluation
    - End of life care
        - Hospital policies – cohort analysis
        - Legislative actions – assessment of legislation
        - Patient services – retrospective cohort
    - Risk of violence towards others
        - Legislative actions – assessment of legislation

        - Behavioral health system implementation – case study
    - Surgery Optimization
        - Working session to create data dictionary for surgical optimization measures
        - June-December 2026: continuing workgroup to define measures for audiences other than clinicians
    - Depression Remission
        - Learning community for improving measurement of depression remission
        - On common measure set
    - Discussion
        - Internal dashboards will be able to tell us how many people are engaging with our website, clicking on links to reports, and contact information of those interested.

ROUND ROBIN UPDATES

Emily Transue, MD, MHA, transitioned the meeting to invite Bree members to share announcements and updates from their organizations with the Bree Collaborative member communities.

- HCA – Dr. Zerzan-Thul
    - Trinity Wilson named new Medicaid Director at HCA
- Comagine – Dr. Transue
    - CMS conference attendance
        - Lots of conversation around prevention, in the midst of pulling back coverage for people on Medicaid
        - Improved agency coordination – HHS, CMS, FDA, etc. to bring new research into practice faster
        - Lots of focus on AI, expectation to make things less expensive
        - Still all in on value-based care
- L&I – Dr. Franklin
    - Working with medical commission on petition to make opioid rules somewhat more permissive especially for those on chronic opioids
    - Going to release interim rules over next few months – AMDG sent a letter about problems with that effort
- UW – Dr. Berman
    - Momentum around cross-system hypertension quality and value improvement
        - Coalescing to develop systematic and standardized approach
        - Bree workgroup and report help to roadmap some of that
    - Tracking and evaluating flurry of CMS/CMI programs
- Virginia Mason – Dr. Kamo
    - Moving to EPIC!
    - Trying to influence direction on the build of the EPIC, can attempt to integrate Bree work as we move along
- UW Family Medicine Residency Network – Dr. Olden
    - Looking at opportunities for residencies in RHTP – opportunities in rural and tribal health
    - Potential for developing a residency track focused on native health
- UnitedHealth – Dr. Petsas
    - HEDIS quality over the past year

        - Immunization measures are a concern – federal level guidance change, variety of state level guidance, definitely pockets where we're seeing a drop in vaccinations
- MultiCare – Dr. Pop
    - Lung cancer screening work – some use of AI to support incidental findings
        - Pathways to go straight to lung nodule clinics, tracking those measures
    - concerned with immunizations as others voiced

CLOSING AND PUBLIC COMMENT

Dr. Transue thanked those who attended, provided opportunity for public comment, reviewed upcoming events and closed the meeting. Next Bree Collaborative Meeting: **May 20th, 2026, 1PM-3PM PST**