Bree Collaborative Meeting
May 20th 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, MPH, 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, Family Care Network (to be confirmed)
Kristina Petsas, MD, UHC
Rodica Pop, PhD, RN, MultiCare (to be confirmed
Tao Kwan-Gett, MD, MPH, DOH (to be confirmed)

MEMBERS ABSENT

Colin Fields, MD Kaiser-Permanente
Susanne Quistgaard, MD, Premera Blue Cross
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
Brodie Dychinco, MSHA, Boeing
Sarah Rafton, MSW, Behavioral Health Catalyst

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 March Minutes
Outcome: Unanimously approved March Minutes

2026 WORKGROUP UPDATES

Dr. Transue transitioned the meeting to invite workgroup updates:

- **Alzheimer's and Other Dementias Revision –** Kris Rhoads, PhD, workgroup chair
    - **Guideline Updates: Detection & Diagnosis**
        - For persons with cognitive impairment and their caregivers
            - Support distinguishing between normal aging and cognitive impairment
            - How to keep your brain healthy (referring to recently created Dementia Action Collaborative resource)

                - Follow up with a provider if taking a cognitive assessment online or received a field memory test
            - For primary care
                - Staff AND clinicians trained in communication with those experiencing memory loss
                - Use a two-step diagnostic process similar to what was recommended in 2017, but the workgroup is supportive of exploring strategies to delegate cognitive testing to another health professional (e.g., trained MA)
                - Blood-based biomarkers (BBMs)
                    - They do not confirm or rule out a diagnosis of dementia or cognitive impairment – further cognitive evaluation is always needed to determine a diagnosis
                    - Best practice for BBMs is use in specialty settings for evaluation of appropriateness for amyloid-targeting therapies
                    - May be appropriate for people with a diagnosis of mild cognitive impairment or mild dementia, who are appropriate and interested in amyloid-targeting therapies, and have the ability to see a neurology specialist within 4 weeks
                    - Clinicians should understand who may and may not be a good candidate for BBMs
    - Discussion
        -

- **Perimenopause and Menopause –** Beth Bojkov, MPH, RN, Director of Research and Best Practice
    - Guideline Updates: Recognition & Assessment, Management
        - For primary care
            - Beginning at age 40, discuss perimenopause and menopause at regular visits
            - Diagnosis for those 45+ primarily clinical
            - Provide anticipatory guidance on midlife health protection
            - Discuss available treatments (MHT, non-hormonal therapies, etc.
            - MHT
                - Evaluate for contraindications for MHT
                - Engage in SDM about risks and benefits of MHT
                - Use of MHT should be symptom driven with period reassessments
                - Emphasize risks of using compounded bioidenticals
        - For behavioral health
            - Recognize perimenopause and menopause as a contributor to behavioral health

- Beginning at age 40, incorporate brief menopause-informed assessment for appropriate patients
- Coordinate with primary care
- MHT
    - When symptoms of depression co-occur with VMS in perimenopause, consider referral for trial of MHT

▪ Other
- Health Plans
    - Indicate menopause-certified providers in directory
    - Provide coverage for all routes of MHT
- Employers
    - In benefit design, ensure coverage of multiple routes of MHT
- Department of Health
    - Consider menopause care and midlife women's health needs in needs assessments
- Health Care Authority
    - Consider developing a SDM tool for MHT during menopause

o Discussion
▪ Appreciate incorporation of midlife health into the conversation
▪ Wondering if MHT includes conversation about testosterone therapy/androgen therapy/DHEA?
- Yes we will get to discussing that

▪ Have you explored how to think about certified menopause providers versus those who are versed in menopause care but maybe are not certified?
- Yes more to come, we do not want to pigeonhole providers into needing this certification to provide menopause care

- **Lung Cancer Screening –** Beth Bojkov, MPH, RN, Director of Research and Best Practice
    - **Implementation Roadmap**

Focus Area	Current State	Intermediate Step	Best Practice
Eligibility & Engagement	Eligibility for LCS and utilization of SDM are inconsistent, largely visit-based, and not routinely tracked to ensure completion	• Make tobacco history of vital sign • Adopt standard decision aid or template/workflow for SDM in primary care	• Patients are automatically flagged as potentially eligible in the EHR • Patient-centered SDM is accessible and integrated seamlessly
Stigma, Bias, & Equity	Stigma, bias, inequitable access to screening, and inconsistent navigation	• Stigma and bias training for patient-facing HCPs • Expand use of telehealth and mobile CT	• Stigma-free communication is the norm • Navigation support is matched to individual-level risk

	contribute to low engagement		
Screening with LDCT	Smoking cessation integration, workflow ownership, and tracking LDCT and follow-up are inconsistent	• Assess readiness for smoking cessation and be prepared to provide cessation counseling at every touchpoint • Designate clear owner of LCS follow-up	• Reliable access to guideline driven follow-up • Dedicated lung cancer screening navigator responsible for tracking and monitoring • Payment reinforces the full screening pathway
Results Management	Follow-up after abnormal LDCT findings is variable, sometimes incomplete; incidental findings lack clear and consistent follow0-up	• Require radiology utilize Lung-RADS reporting; align nodule management protocols • Assign clear process owner for abnormal result follow-up	• Timely, reliable follow-up for all abnormal findings • Multidisciplinary review of concerning findings universally accessible • Incidental findings are addressed with appropriate referral

- **Guideline Updates: Stigma, Bias, & Equity**
    - For clinicians & delivery systems
        - Training on stigma-free conversations about smoking history and benefits of LCS
        - Ask those 50+ and with a history of smoking about LCS eligibility at annual wellness visits
        - Implement bias-aware policies and person-first language across systems
        - Make tobacco cessation programs highly visible
    - For plans & employers
        - Emphasize that early detection saves lives; incorporate LCS into other cancer screening awareness efforts
        - Require training on reducing stigma/bias for member-facing staff (plans) and managerial staff (employers)
        - Utilize person-first language
        - Access to robust tobacco cessation interventions as a standard benefit (aligned with Apple Health coverage)
        - Discourage use of punitive incentives for people who smoke
    - For others
        - Public Health (Local and DOH)

        - Encourage person-first language
        - Require training on reducing stigma/bias
        - Partner with CBOs, tribes, community leaders, to amplify LCS benefit messaging
    - WA State Leg
        - Require regular stigma and bias training for health professionals (CE's)

PRESENTATION: COMMUNITY INFORMATION EXCHANGE (CIE)

Emily Transue, MD, MHA, transitioned the meeting to invite Michael McKee, M.Ed., Comagine Health, to provide an update on the progress of the state-wide CIE initiative

- Michael reviewed the reasoning behind implementing a CIE (providing streamlined care coordination, integrated data sharing, closed-loop referrals with longitudinal record, and interoperable technologies connecting systems), the purpose and goals, the timeline, governance structure, and statewide vision for the CIE
- CIE will be inclusive of:
    - Technology and legal infrastructure that enables community-based workers to coordinate health-related social needs (HRSN) services with cross-sector partners who collaborate to deliver integrated care ensuring better access to social care supports to improve health and well-being.
    - This may include:
        - Technology and legal infrastructure that enables community-based workers to coordinate health-related social needs (HRSN) services with cross-sector partners who collaborate to deliver integrated care ensuring better access to social care supports to improve health and well-being.
        - This may include:
        - Resource directory
        - Client management system including shared client information
        - Needs assessment screening
        - Intake management
        - Shared care planning & care team info
        - Closed-loop referral
        - Referral history and a community record of social supports provided
        - Event notification
    - CIE goals
        - Provides legal and technical infrastructure to enable cross-sector care coordination
        - Makes it easier for care coordinators to find and get help for social care needs like food, housing, and transportation for Washingtonians
        - Connects partners to work together and share information for faster and more coordinated support

- Starting with an interim advisory committee and interim data and technical advisory workgroup (IDATA)

PRESENTATION: RURAL HEALTH TRANSFORMATION PROGRAM (RHTP)

Dr. Transue transitioned the meeting to invite Dr. Judy Zerzan-Thul, HCA, to provide an update on the RHTP:

- Judy provided a program overview of the RHTP, what the funds must support, the initiatives contained within the RHTP, and the funding restrictions and caps as set out by CMS
    - Initiatives include:
        - **Rural hospital innovation ($60 million)**
          Support rural hospitals in adopting new technologies, coordinating services, and developing sustainable payment models.
        - **Community prevention and care coordination ($18 million)**
          Strengthen community-based programs and workforce to help manage care outside traditional clinical settings.
        - **Tribal health investments ($19 million)**
          Invest in the health and wellbeing of members of sovereign Tribal Nations, including workforce development and care coordination.
        - **Technology and data solutions ($19 million)**
          Expand technology and data tools that improve access, care coordination, and system efficiency.
        - **Rural workforce development ($32 million)**
          Support training and recruitment for key rural health roles including nurses, primary care providers, and community health workers.
        - **Behavioral health system expansion ($25 million)**
          Strengthen rural behavioral health services through workforce development, crisis response, and telehealth support.
    - Funding caps/restrictions
        - Pre-award costs
        - Federal or local fund matching
        - Services/equipment/support that is the legal responsibility of another party
        - Goods/services not allocable to the project
        - Supplanting state, local, Tribal, or private funding
        - Construction or building expansion
        - Independent research and development
        - Covered telecommunications and video surveillance equipment
        - Meals, unless in limited circumstances
        - Lobbying
        - Duplicated payments
        - Clinician salaries or wage supports for non-compete limitations
        - Social Security Act 2105(c) paragraphs 1, 7, and 9
        - EMR funding—No more than 5% can be used to support a replacement of a previous HITECH certified EMR system in place as of 1 September 2025

        - Clinician funding—Provider payments can't exceed 15% of total award.
        - Rural Tech Catalyst Fund—No more than 10% can be used to fund the development of innovative and patient focused chronic diseases prevention and management technologies.
        - Renovation—Renovations and alterations can't exceed 20% of total award.
        - Administrative overhead—Can't exceed 10%, most activities are limited to 7.1%.

PRESENTATION: HEALTH & WELLEBING BENEFITS STRATEGY

Dr. Transue transitioned the meeting to invite Brodie Dychinco, MHSA, Boeing, to introduce himself and share more about Boeing's health and wellbeing strategy.

- Brodie covered an overview of Boeing as a company, the current market challenges, outlined their approach and factors that impact decisions, how they prioritize their efforts, and provided a case study example of direct contracting.
    - Market challenges
        - Rising costs
        - Provider dynamics
        - Utilization and disease burden
        - Administrative complexity
        - Workforce impact
    - Efforts prioritized
        - **Accountability and Ownership:** transparent access to data and reporting, partner with the right organizations, and innovation
        - **Experience and Simplification:** benefit design with incentives that actually drive improvement, easy access to help, integration, personalized care
        - **Sustainability, Affordability, and Quality:** evidence-based clinical innovation, reduce cost/fraud/waste, access to high quality primary care

PRESENTATION: WASHINGTON THRIVING

Dr. Transue transitioned the meeting to invite Sarah Rafton, MSW, Behavioral Health Catalyst, to introduce herself and share more about the Washington Thriving Strategic Plan for prenatal through age 25 behavioral health.

- Sarah reviewed the WA Thriving plan goals, guiding principles, first initiatives and highlights from the 2026 legislative session
    - Goals:
        - Serve Washington Equitably: ensure reach and quality across the state; extra attention and resources directed toward people who face the greatest barriers
        - Focus on what matters to youth, families, & workforce: services, supports, and policies attuned to strengths, desires, & needs of each young person, family, and workforce member
        - Expand upstream: build strong wellness foundations, prevention, and early supports

        - Make help easy to find and get: ensure coordinated, accessible, effective services and supports across the full continuum
        - Strengthen the structures: ensure a coordinated, collaborative, informed, adaptive, and sustainable behavioral health ecosystem
    - First initiatives
        - Infrastructure
            - Establish infrastructure to deploy existing resources while building the foundation for future coordination and care.
                - HB 2429 – Establishing WA Thriving
        - Perinatal mental health and substance use
            - Advance culturally responsive, non-stigmatizing perinatal mental health and substance use screening and overcome barriers to family-centered substance use care for pregnant and parenting people.
                - Investments in perinatal supports workgroup to address SUD access for parents
        - K-12 student behavioral health
            - Clarify schools' role in students' behavioral health and provide all schools with access to tools and resources they may choose to apply for students' well-being and readiness to learn.
                - HB 1634 – develop technical assistance and training network for all schools
        - Treatment services expansion
            - Improve crisis and stabilization services for young people, while also expanding services to prevent escalation to crisis. Increase capacity for young people with complex conditions.
                - Intersection with DSHS strategic planning 1580 work ongoing

2027 TOPIC SELECTION DISCUSSION

Dr Transue opened the floor for discussion and questions about our presentation, then transitioned the group to reviewing the topic selection process. The following was discussed:

- DOH priorities are access to healthcare and BH, good to keep in mind as we think about topics
- USPSTF leadership change
- AI governance and use in healthcare could be a useful topic – several members expressed interest in this topic

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: **July 22nd, 2026, 1PM-3PM PST**