Bree Collaborative Meeting

Meeting will begin at 1PM PST

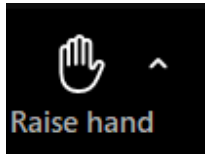
July 22nd 2026| Hybrid Meeting

Before We Begin…

- The meeting is hosted as a Zoom Webinar
- When you log on, you are automatically an “Attendee”
  - As an attendee, you are automatically muted and are unable to turn on your video or sound.
- Bree Staff will promote Bree Members to a “Panelist” so they are able to speak and share their video with the meeting group
- **Please notify Bree staff in the chat if you are attending the meeting on behalf of a Bree Member.** Bree staff will promote you to “Panelist”

Public Comment

- As a member of the public, you are an “Attendee” in the meeting and cannot unmute yourself or share your video.
- If you would like to provide a public comment, **please raise your hand by clicking the button at the bottom of your screen**.



- Bree staff will call on you to speak and promote you to a “Panelist.”
- As a “Panelist”, you will be able to unmute yourself and share your video to provide your comment.
- After you have commented, Bree staff will move you back to an “Attendee” for the meeting.

Agenda

Welcome

Action Item: Adopt May Minutes

2026 Workgroup Updates

Alzheimer's and Other Dementia's Revision

Lung Cancer Screening

Perimenopause and Menopause

2027 Topics

Survey Responses

Public Comment

Open Discussion

Voting

Closing and Next Steps

Meeting Minutes: May 2026

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)

2026 Workgroup Updates

1:05 – 1:50

First: Lung Cancer Screening

Lung Cancer Screening

Joelle Fathi, DNP, ARNP, (co-chair)

Kim Kummer, MS, MPH, Jamestown Family Health Clinic (co-chair)

1:05 – 1:20

The Problem: Adherence to Lung Cancer Screening

- **People 50-80** (CMS covers 50-77)[1], **with a history of 20 pack-years smoking, and within 15 years since quitting or currently smoking** are recommended for lung cancer screening by the USPSTF (Grade B) [2]
- **Uptake of lung cancer screening in Washington state for those eligible is below the national average** (15.8%of those eligible in 2025) and only slowly climbing
- **Nodules requiring further evaluation are detected by comparing annual LDCT to baseline**. Adherence to annual screening is critical for early-stage lung cancer detection. When implemented with fidelity, lung cancer screening can flip the stage of disease from 80% of people diagnosed at stage 4 to 80% of people being diagnosed at stage 1. [3]
- **Adherence across settings varies widely**, [4] but programs that provide centralized coordination demonstrate superior adherence rates.[5]
- **Completion of annual screening is different across various groups**, but studies show those who currently smoke or are from minoritized racial or ethnic backgrounds have lower adherence rates.[6]
- Barriers to annual screening that have been reported by patients in the Seattle area include **cost, uncertainty about insurance coverage, accessibility and transportation, and other medical conditions**.[7] Most cited key facilitator was provider recommendation.

1. Centers for Medicare & Medicaid Services. (2022, February 10). National coverage determination (NCD) for lung cancer screening with low dose computed tomography (LDCT) (210.14). https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=364
2. U.S. Preventive Services Task Force. (2021, March 9). Recommendation: Lung cancer: Screening. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/lung-cancer-screening
3. National Lung Screening Trial Research Team; Aberle DR, Adams AM, Berg CD, Black WC, Clapp JD, Fagerstrom RM, Gareen IF, Gatsonis C, Marcus PM, Sicks JD. Reduced lung-cancer mortality with low-dose computed tomographic screening. N Engl J Med. 2011 Aug 4;365(5):395-409. doi: 10.1056/NEJMoa1102873. Epub 2011 Jun 29. PMID: 21714641; PMCID: PMC4356534.
4. Sakoda LC, Rivera MP, Zhang J, et al. Patterns and Factors Associated With Adherence to Lung Cancer Screening in Diverse Practice Settings. *JAMA Netw Open.* 2021;4(4):e218559. doi:10.1001/jamanetworkopen.2021.8559
5. Ezenwankwo, E., Jones, C., Nguyen, D. T., & Eberth, J. M. (2025). Lung cancer screening adherence in centralized vs decentralized screening programs: A meta-analysis of U.S. cohort studies among individuals with negative baseline results. CHEST Pulmonary. Advance online publication. https://doi.org/10.1016/j.chpulm.2025.100236
6. Lopez-Olivo MA, Maki KG, Choi NJ, Hoffman RM, Shih YT, Lowenstein LM, Hicklen RS, Volk RJ. Patient Adherence to Screening for Lung Cancer in the US: A Systematic Review and Meta-analysis. JAMA Netw Open. 2020 Nov 2;3(11):e2025102. doi: 10.1001/jamanetworkopen.2020.25102. PMID: 33196807; PMCID: PMC7670313.
7. Holman, A., Kross, E., Crothers, K., Cole, A., Wernli, K., & Triplette, M. (2022). Patient perspectives on longitudinal adherence to lung cancer screening. Chest, 162(1), 230–241. https://doi.org/10.1016/j.chest.2022.01.054

Guidelines to increase adherence: Delivery Systems

- **Clarify roles and responsibilities within lung cancer screening.** Designate accountable groups for the following:
  - Screening for tobacco use and history, assessing readiness to quit, and documenting in the medical record
  - ordering LDCT for LCS
  - communicating results and scheduling necessary follow-up
  - tracking patients engaged in LCS
- **Offer lung navigation services across the continuum of lung cancer screening.**
- **Develop/adopt protocols for results notification** based on LungRADS criteria and timely follow-up for those needing further evaluation
- **Maintain access to directory of facilities recognized for quality in LDCT and meet technical capacity to deliver lowest dose of radiation** for clinician ordering and referral
- Develop or adopt in-house referral process or partnerships other systems to provide access to **multidisciplinary specialty teams and/or nodule/tumor boards for those needing specialty referral**

CMS National Coverage Determination: Lung Cancer Screening

Beneficiary Eligibility Criteria

Beneficiaries must meet all of the following eligibility criteria:

- Age 50 - 77 years;
- Asymptomatic (no signs or symptoms of lung cancer);
- Tobacco smoking history of at least 20 pack-years (one pack-year = smoking one pack per day for one year; 1 pack =20 cigarettes);
- Current smoker or one who has quit smoking within the last 15 years; and,
- Receive an order for lung cancer screening with LDCT.

Eligibility Criteria

Counseling and Shared Decision-Making Visit

Before the beneficiary's first lung cancer LDCT screening, the beneficiary must receive a counseling and shared decision-making visit that meets all of the following criteria, and is appropriately documented in the beneficiary's medical records:

- Determination of beneficiary eligibility;
- Shared decision-making, including the use of one or more decision aids;
- Counseling on the importance of adherence to annual lung cancer LDCT screening, impact of comorbidities and ability or willingness to undergo diagnosis and treatment; and,
- Counseling on the importance of maintaining cigarette smoking abstinence if former smoker; or the importance of smoking cessation if current smoker and, if appropriate, furnishing of information about tobacco cessation interventions.

Shared Decision-Making Counseling Criteria

Reading Radiologist Eligibility Criteria

The reading radiologist must have board certification or board eligibility with the American Board of Radiology or equivalent organization.

Radiology Imaging Facility Eligibility Criteria

Lung cancer screening with LDCT must be furnished in a radiology imaging facility that utilizes a standardized lung nodule identification, classification, and reporting system.

Relevant Coding and Billing Infrastructure

DR. ROBERT BREE COLLABORATIVE

Codes To Document Patient Eligibility*

ICD-10 Code	Description
Z87.891	Personal history of nicotine dependence/ history of active tobacco use
F17.210	Nicotine dependence, cigarettes, uncomplicated
F17.211	Nicotine dependence, cigarettes, in remission
F17.213	Nicotine dependence, cigarettes, with withdrawal
F17.218	Nicotine dependence, cigarettes, with other nicotine-induced disorders
F17.219	Nicotine dependence, cigarettes, with unspecified nicotine-induced disorders
Z12.2	Encounter for screening for malignant neoplasm of respiratory organs ***Not for use with fee-for-service Medicare beneficiaries; some commercial payors or Medicare Advantage plans may require**

*These are the ICD-10 codes required by CMS for Medicare beneficiaries. Some commercial payor coding requirements to document patient eligibility may differ.

Reimbursement Codes

CPT Code	Description
G0296	Provider shared decision-making discussion about lung cancer screening
71271	Annual lung cancer screening with Low-Dose CT (LDCT)
71250	3-6 months (Lung-RADS 3 & 4) Follow-up diagnostic imaging for lung finding **without** contrast
71270	3-6 months (Lung-RADS 3 & 4) Follow-up diagnostic imaging for lung finding **with and without** contrast

Guidelines to Increase Adherence: Health Plans

- **Cover LDCT for LCS without any cost sharing** (CPT 71271) per USPSTF Grade B recommendations
- **Remove restrictions to reimbursement for LDCT for LCS, like prior authorization**
- **CTs for other concerns or conditions should not be counted towards a member's annual screening benefit**. Cover annual LDCT without cost sharing regardless of other CT exams completed within the year that were not for or including evaluation of pulmonary nodule(s)
- **If able, make available insurance products that waive member cost-sharing** (not applicable to monitoring after a diagnosis has been made or to treatment) **for:**
  - All steps of lung cancer screening, including repeat LDCT scans within 3-6 months after an abnormal initial screening result
  - Access to annual comprehensive tobacco cessation interventions, including behavioral interventions and pharmacotherapy

Carelon Health Plan Guidelines

Lung cancer screening

For interval evaluation of Lung-RADS findings, see Chest Imaging guidelines ("Pulmonary nodule or mass")

Annual low-dose CT (LDCT) is indicated when **ALL** of the following criteria are met:

- Age equal to or greater than 50 and less than or equal to 80
- 20 or greater pack-year history* of cigarette smoking (current smoker, or quit date within the past 15 years), or established asbestosis-related lung disease
- No health problems that would substantially limit life expectancy or ability to undergo an intervention with curative intent
- At least 12 months since last LDCT or CT chest**

**One pack-year of smoking equals smoking 1 pack (20 cigarettes) per day for 1 year, or 7300 cigarettes annually.*

***CT chest done for/including evaluation of pulmonary nodule(s).*

Potential misinterpretation of guidelines -> Insurance denials for LDCT due to CT chest for other reasons or evaluation anecdotally in the community

Carelon Medical Benefits Management. (2026, April 4). Oncologic imaging 2026-04-04. Carelon Clinical Guidelines and Pathways. https://guidelines.carelonmedicalbenefitsmanagement.com/oncologic-imaging-2026-04-04/

Guidelines to Increase Uptake & Adherence: Department of Health

- **Promote of lung cancer screening training for community health workers and primary care teams.**
- **Encourage regular stigma and bias health professional continuing education** for providers to maintain licensure (e.g., MD, DO, APP) and other clinicians as able (e.g., RN)
- **Encourage use of person-first language** (e.g., “person who smokes” instead of “smoker”) across all programs and written materials
- **Integrate education about benefits of lung cancer screening in health promotion activities and materials for tobacco prevention and cessation.**
  - Develop and/or use healthcare professional facing and concise material communicating eligibility, benefits and risks to screening, and resources available to support screening.

Next Up: Results Management

- **Lung-RADS is gold standard** for classification of lung nodules and recommended follow-up
- **Clinically significant findings besides nodules is very prevalent** (33.8% in the National Lung Screening Trial)[1] -> delivery systems need protocols to navigate next steps for these findings
- **Best practices in management of abnormal findings** include engagement of multidisciplinary teams and/or tumor/nodule boards and access to specialty services in a timely manner
- **Take home message: no nodule left behind!**

1. Gareen IF, Gutman R, Sicks J, et al. Significant Incidental Findings in the National Lung Screening Trial. *JAMA Intern Med.* 2023;183(7):677–684. doi:10.1001/jamainternmed.2023.1116

Questions

Next Up: Alzheimer's and Other Dementias

Alzheimer's and Other Dementias Revision

Beth Bojkov, MPH, RN

1:20 – 1:35

Appropriate Use of Biomarkers

*"seeing an increase in referrals for people with a + biomarker test but no cognitive symptoms and normal testing…**[family medicine] have been advised to send for biomarkers in patients with family history of dementia and/or mild subjective cognitive symptoms**…and then in biomarker + have been to told to refer."*

From sample report

Your p-Tau 217 result is 0.26 ng/l

This is excellent! Congratulations! This is a normal p-Tau 217, indicating that not even the earliest stages of Alzheimer's-related pre-dementia (which occur over a decade before dementia) have begun. It's a good idea to repeat this p-Tau 217 test every two years, so you can avoid cognitive decline for your lifetime.

Routine cognitive testing is advised for individuals 30 and older, particularly if they have any of the following risk factors.

Family history of dementia | ApoE4 | Memory loss | Concussion or head trauma | Social isolation

Physical inactivity | Depression | Sleep apnea | Mold exposure | Smoking

Excessive alcohol consumption | Heart disease | High blood pressure | Obesity | Diabetes

Untreated vision loss | Hearing loss | Unhealthy diet | Poor sleep

From website

Draft Guidelines

Primary Care

- **Blood based biomarkers (BBM) do not definitively rule out or rule in a diagnosis of Alzheimer's disease.**
- BBMs may be appropriate for people with a diagnosis of mild cognitive impairment or mild dementia who are **otherwise appropriate for and interested in amyloid-targeting therapies, and ability to see a neurologist within 4 weeks.**
- **Best practice for use of BBMs is in specialty settings** to establish eligibility for amyloid-targeting therapy; **outside of those settings best practice for use of BBM is unclear and evolving**.
- **Understand who might be a good candidate for amyloid-targeting therapies when discussing treatment options.**

Health Plan

- **Require cognitive assessment evaluation as a prior authorization requirement for coverage of blood based biomarkers**, especially in primary care settings

Ongoing Care, Support, & Management

Patient Perspective: "Once I have a diagnosis, I and my family members feel hopeful that we/I can manage my cognitive diagnosis with my care team and family member(s)."

optimal care for those living with dementia and their family/caregiver(s) is

- Person-centered and goal concordant
- Relies on comprehensive assessment
- Interdisciplinary and team-based
- Provides dementia care navigation and care coordination
- Identifies and actively supports the caregiver, including frequent assessment of capacity and needs
- Longitudinally monitored and reassessed
- Inclusive of medication management as well as training to address behavioral and neuropsychological symptoms
- Integrated with community supports
- Ideally providing access to 24/7 support
- Able to guide patients and families through advance care planning decisions

Ongoing Care, Support, & Management

Primary Care

- **Identify the patient's goals of care and work to maximize function** that meets patient and family needs.
- **Include the patient and family or other caregivers as part of the care team**. This means proactively asking about, routinely reassessing, and centering care plans around their needs, preferences, and capacity.
- **Support caregivers and assess caregiver distress, fatigue, capacity, knowledge, and skills as a core component of each visit**.
- Offer dementia care management services either through your care team or a community service provider (e.g., home health, geriatric care managers, enhanced outpatient management) to all patients and families diagnosed with dementia
- **Ask about and discuss neuropsychiatric symptoms** (e.g., agitation, psychosis) **and management strategies using a shared-decision making approach** appropriate to the patient.

Ongoing Care, Support, & Management

Hospitals

- **Utilize DAC Discharge/Transitions Tool**
- **Assess family and caregiver support early in hospital stay, and feasibility of providing care at home** (e.g., activities of daily living)
- **Connect to any available community supports** (e.g., in-home services). **Tailor to locally available resources, but always include:**
  - Area Agency on Aging

Ongoing Care, Support, & Management

Employers

- Incorporate **family/caregiver supports** for employees into employee assistance programs, including medical respite models.
- **Make employees aware of**
  - Washington's Family Caregiver Support Programs. Learn more: Caregiver Resources | DSHS
  - Washington's Paid Family Medical Leave benefit. Learn more: Washington's Paid Family Medical Leave

Ongoing Care, Support, & Management

HCA

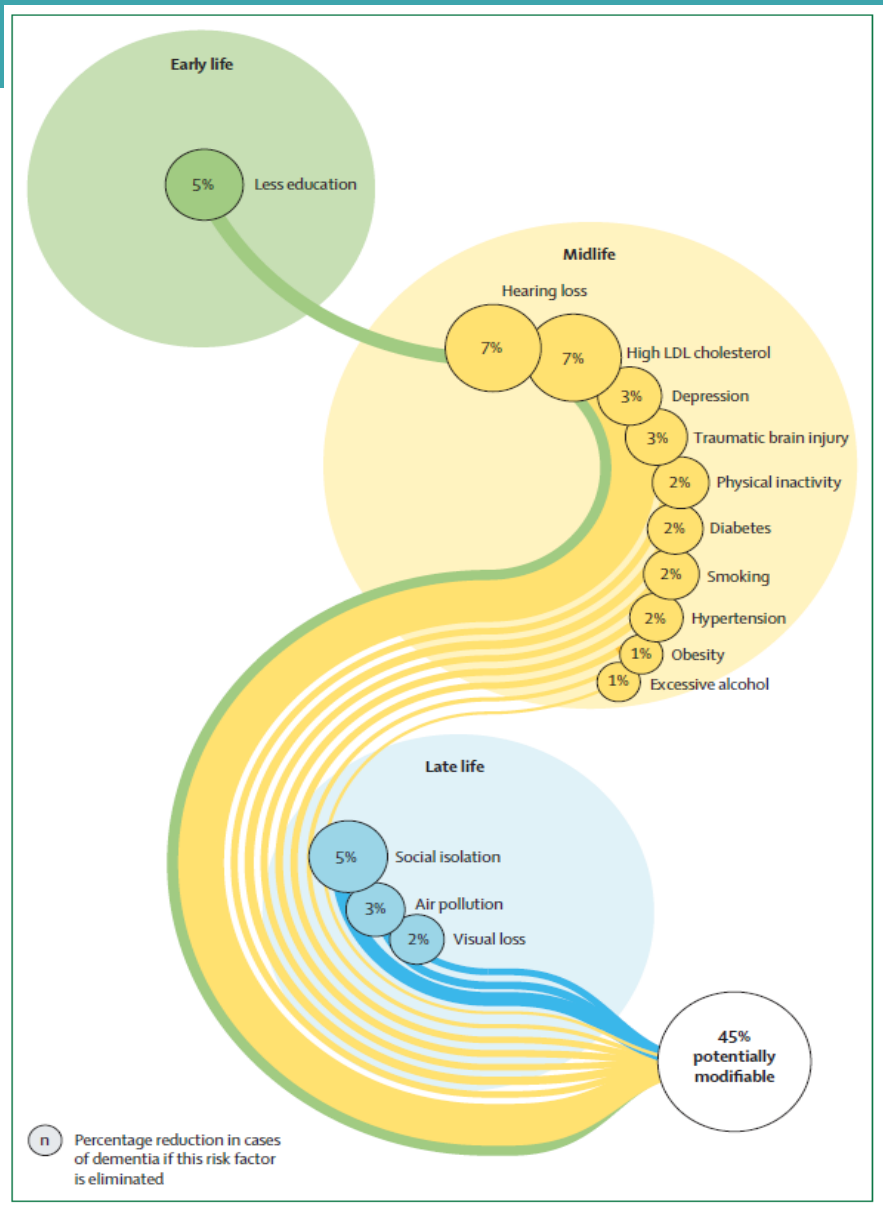
- **Add contract language to carrier contracts** (MCO, DSNP, PEBB, SEBB) **that address the need for improved care coordination and support materials triggered by a dementia diagnosis**. Required outreach material may include but is not limited to:
  - Contact information for local Area Agency on Aging
  - 24/7 helpline for the Alzheimer's Association
  - A copy of the Dementia Roadmap
- **Test implementation of payment models for comprehensive dementia care**, especially for underserved communities

Ongoing Care, Support, & Management

DOH

- **Integrate brain health education across chronic disease prevention and management programs** at the state, local, and tribal level; ensure they are aware of the connections between brain health and chronic disease
- **Bring knowledge, awareness, and education regarding health impacts of caregiving to the general public.** Promote resources for caregivers to the general population.
- Support health systems in **understanding the connection between chronic conditions and dementia risk** (e.g., hypertension, diabetes, smoking cessation)
- **Train community health workers in dementia** (e.g., ASTHO training)
- **Consider sending "Dear Colleague/Tribal Leader" letters** to primary care providers and tribal nations to promote brain health, dementia risk reduction, and the importance of early detection and diagnosis (example: Utah Department of Health)

Cognitive Resilience and Risk Reduction



Patient Perspective: "I and my family have spoken to our healthcare team(s) about how to maintain our brain health as we age. We have the knowledge and ability to improve our risk factors like blood pressure, diabetes, high cholesterol, hearing, and vision, and feel supported to ask for help from our care team and our community"

Identify risk factors that are **actionable in the clinical space**, and for which there is **strong available evidence** that they are associated with increased risk for developing dementia

- Use Lancet Commission framework to talk about modifiable risk factors
- Focus on **mid-life** (Lancet Commission: 18-65) and **later life** (Lancet Commission: >65) risk factors

Coming Up

- Dementia Summit: Primary Care at the Forefront | Washington State Health Care Authority

Dementia Summit: Primary Care at the Forefront

Thu, 06/25/2026

Primary care providers play a crucial role in early detection, diagnosis, and management for people living with dementia. Earn 6.5 CMEs while spending the day sharpening your skills, connecting with peers, and diving into impactful discussions.

- View the agenda PDF.
- View the flyer. PDF

Summit details

- **Date:** Friday, October 23, 2026
- **Time**: 8 a.m. – 5 p.m.
- **Location:** Pacific Northwest University of Health Sciences, Yakima, WA 98901.
- **Cost**: $100
- **Continuing medical education (CME):** 6.5

Questions

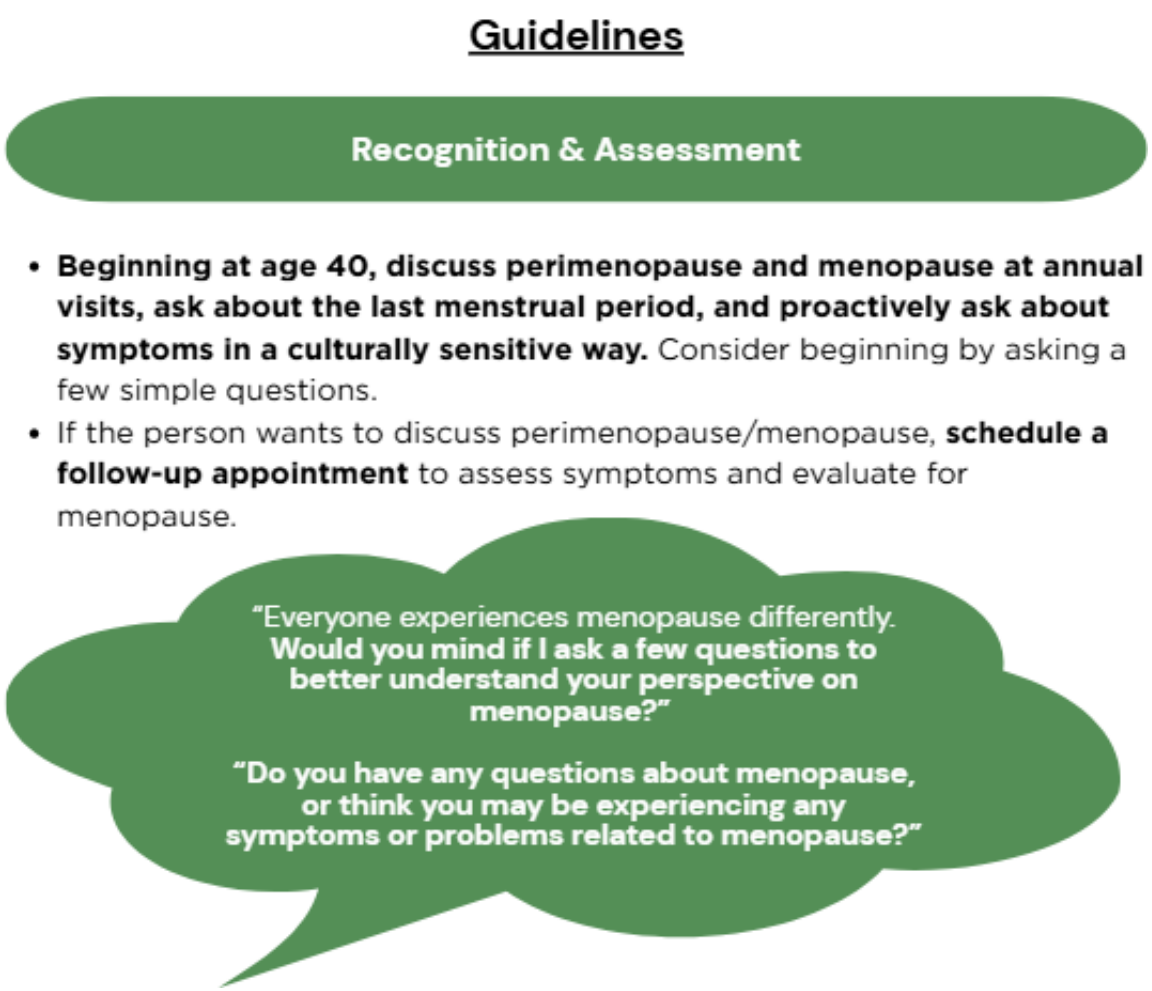
Next Up: Lung Cancer Screening

Perimenopause & Menopause

Nicole Saint Clair, MD (chair)

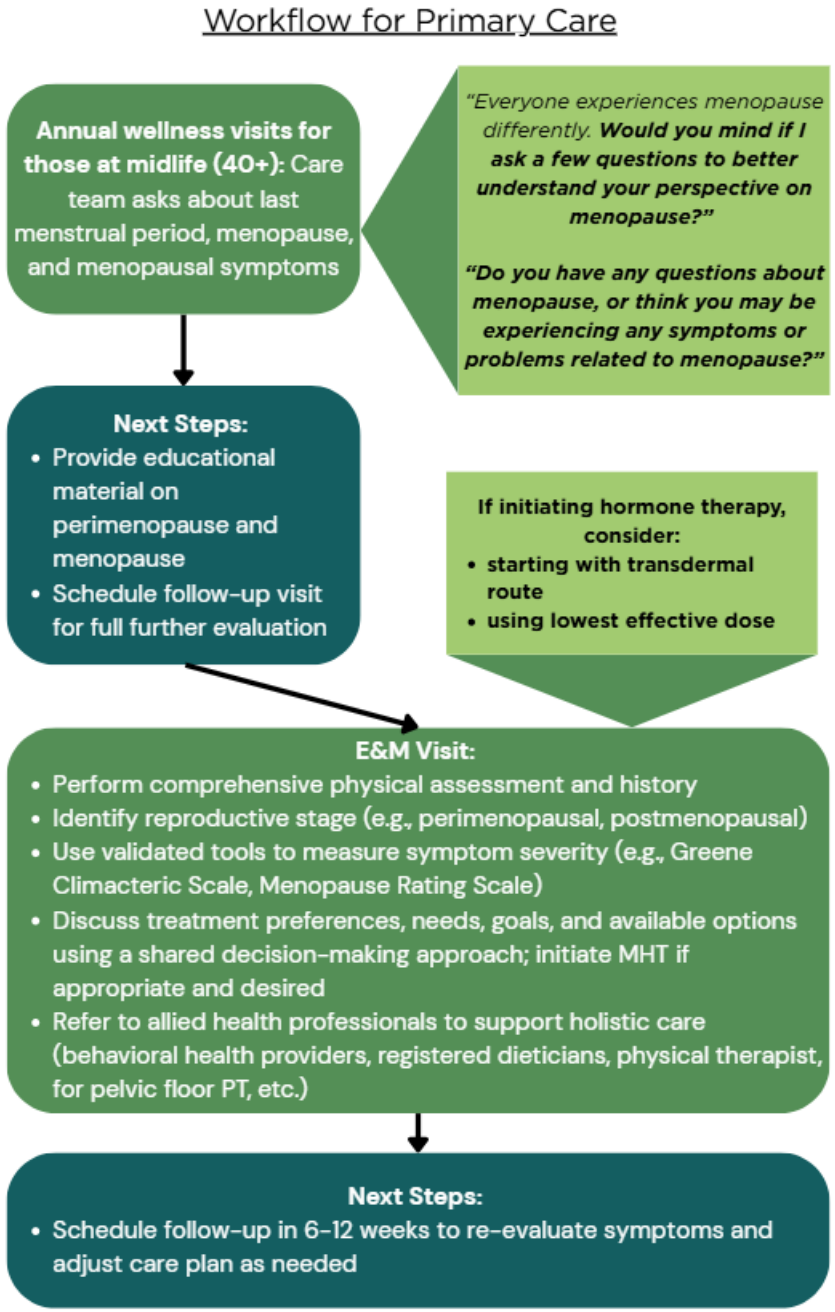
1:35 – 1:50

Recognition and Assessment



- Simplifying guidance around MHT – avoid unnecessary barriers to access
  - Discuss the small, absolute increases in risk of complications (less compared to OC)
- Example questions to ask at routine visits to open the door for further discussion
  - Schedule separate evaluation and management visit for full assessment, discussion of treatment options, and midlife health promotion and prevention

Primary Care Workflow



Menopause as a Midlife Health Opportunity

- Opportunity to focus on **midlife health** conditions that often go underrecognized or underdiagnosed
  - Cardiovascular health – heart disease is the leading cause of death for women in the U.S.
  - OSA – decline in estrogen may impact muscle tone in the airway, menopause also associated with weight gain -> risk for OSA
  - Behavioral health – perimenopause and menopause are associated with an increase in behavioral health concerns, and many are juggling responsibilities at both work and home
  - Musculoskeletal – proactively address osteoporosis prevention as well as joint pain, stiffness, muscle aches

Minimum Competency for Clinicians

- Primary care clinicians should be equipped to manage perimenopause and menopause – when should it constitute a referral?

Primary Care Guidelines - Referral

- **Identification of perimenopause or menopause for those 45 or older should primarily be based on history and symptoms.** Routine labs or other diagnostic testing is not recommended.
  - When reproductive stage is unclear, consider referring to the **STRAW + 10 criteria** or most updated guidance and consider specialty referral (e.g., reproductive endocrinology)

Behavioral Health in Menopause Care

- **Recognize perimenopause and menopause as a contributor to behavioral health**
- **Beginning at age 40, incorporate a brief menopause-informed assessment for all appropriate patients, focusing on common symptom domains:**
- **Coordinate with primary care**
  - In integrated settings: communicate regularly with the other members of the primary care team regarding monitoring and treatment of behavioral health symptoms
  - In non-integrated settings: establish referral network and pathways for medical evaluation when menopause is suspected
- **Special considerations**
  - **Early menopause or POI may be distressing** – offer psychological support and referral to community resources
  - **Those utilizing gender-affirming care:** Do not assume gender identity based on symptoms; coordinate hormone-related concerns with the gender-affirming hormone therapy (GAHT) prescriber when applicable.
- Menopausal hormone therapy (MHT) is **not considered a first-line treatment for major depressive disorder or anxiety disorders.**
- Many people experiencing perimenopause or menopause **experience mood symptoms**.
- SSRIs and SNRIs have shown **some effectiveness** at reducing vasomotor symptoms of menopause, **but are not considered first line therapy.**

Health Plan

- **Promote evidence-based menopause support resources for all members beginning at age 40+**
  - Send member-facing culturally sensitive communications about importance of discussing perimenopause and menopause symptoms with your provider, and the existence of effective treatments for symptoms
- **Provide coverage for all routes of menopausal hormone therapy (MHT) (e.g., oral, vaginal, transdermal) across all stages of the menopause transition.** Ensure transdermal MHT is in the lowest cost tier for all members and consider prioritizes and first-line option.
  - Remove administrative restrictions for vaginal hormone therapy
- **If applicable, remove step therapy requirements for MHT** (e.g., requiring nonhormonal therapy trial before approval, requiring oral estrogen before transdermal)
- **Ensure coverage of evidence-based nonhormonal management options for vasomotor and genitourinary symptoms,** including selected prescription therapies, behavioral treatments, and over-the-counter symptom supports when feasible.
- **Require review/prior auth of new MHT prescriptions for people above age of 65**

Next Up: Workplace Supports

Four domains: physical aspects, policies and processes, workplace culture, and work redesign/role adjustment *(BSI – UK's National Standards Body)*

- **Physical aspects of work:** changes in the physical environment at work can improve the experience of menopausal symptoms and workplace environment for all. Examples include:
  - quiet spaces for those experiencing hypersensitivity to noise or light
  - discreet places to change clothes, comfortable size uniforms in breathable fabrics
  - Individually adjustable temperature controls (e.g., opening windows, localized fans or heaters, etc.)

Next Up: Workplace Supports

- **Policies and processes:** policies and processes that include peri/menopause accommodations and information can ensure fairness and consistency, and should fit within overall organizational health and wellbeing approach. Examples include:
  - Reviewing existing policies to identify where to integrate peri/menopause
  - Communicate policies to everyone in the organization, and provide a pathway for managers to ensure awareness and understanding of resources and obligations
  - Verify that absence or attendance management processes (e.g., sick time, medical leave, etc.) allow for peri/menopause symptoms and experience

Next Up: Workplace Supports

- **Workplace culture:** Establishing policies on their own is not enough to counteract societal and workplace stigma against peri/menopause. Workplaces need to hold leadership accountable to a no tolerance policy towards shaming, bullying, dismissing, and otherwise minimizing the experiences of those experiencing peri/menopause in the workplace. Consider the following:
  - Clearly define how leadership is accountable and responsible for implementing organizational approach to supporting employees through the menopause transition
  - Require regular training on peri/menopause, including relevant organizational policies, for supervisors who serve as the first point of contact for discussing medical needs at work
  - Encourage or provide informal support groups for those experiencing peri/menopause

Next Up: Workplace Supports

- **Work design and role adjustments:** How work is done and the ability to adjust roles to meet individual needs have a major influence on the experience of menopause in the workplace. Consider the following:
  - Provide flexibility in work location, scheduling, and duration, such as allowing splitting breaks into shorter intervals, or working longer hours some days and shorter hours other days. Consult employees to determine their preferences
  - If requested, allow temporary adjustments to be made to duties without repercussions (e.g., enable job sharing or contingency planning for temporary, lighter roles)

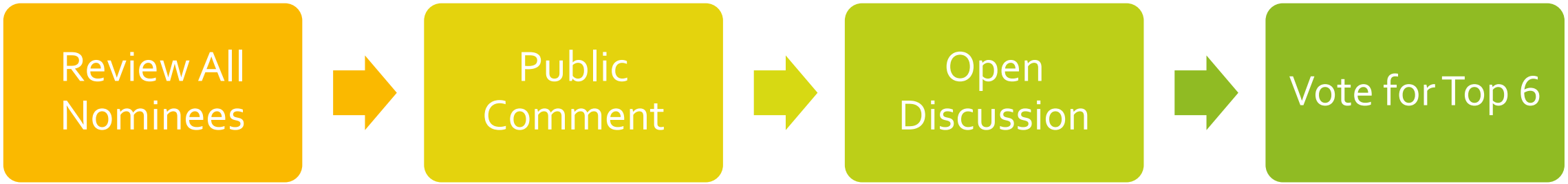
Questions

Next Up: 2027 Topics

2027 Topic Selection

1:50 – 2:55

The Process


Review All Nominees
Public Comment
Open Discussion
Vote for Top 6

Keep in Mind

- Who will use this report and guidelines? Are they asking for it?
- Is there shared interest in this topic among delivery systems, health plans, employers, state agencies, and public health?
- Are there barriers to high quality care we are able to influence or address?

Barriers and Facilitators to Success

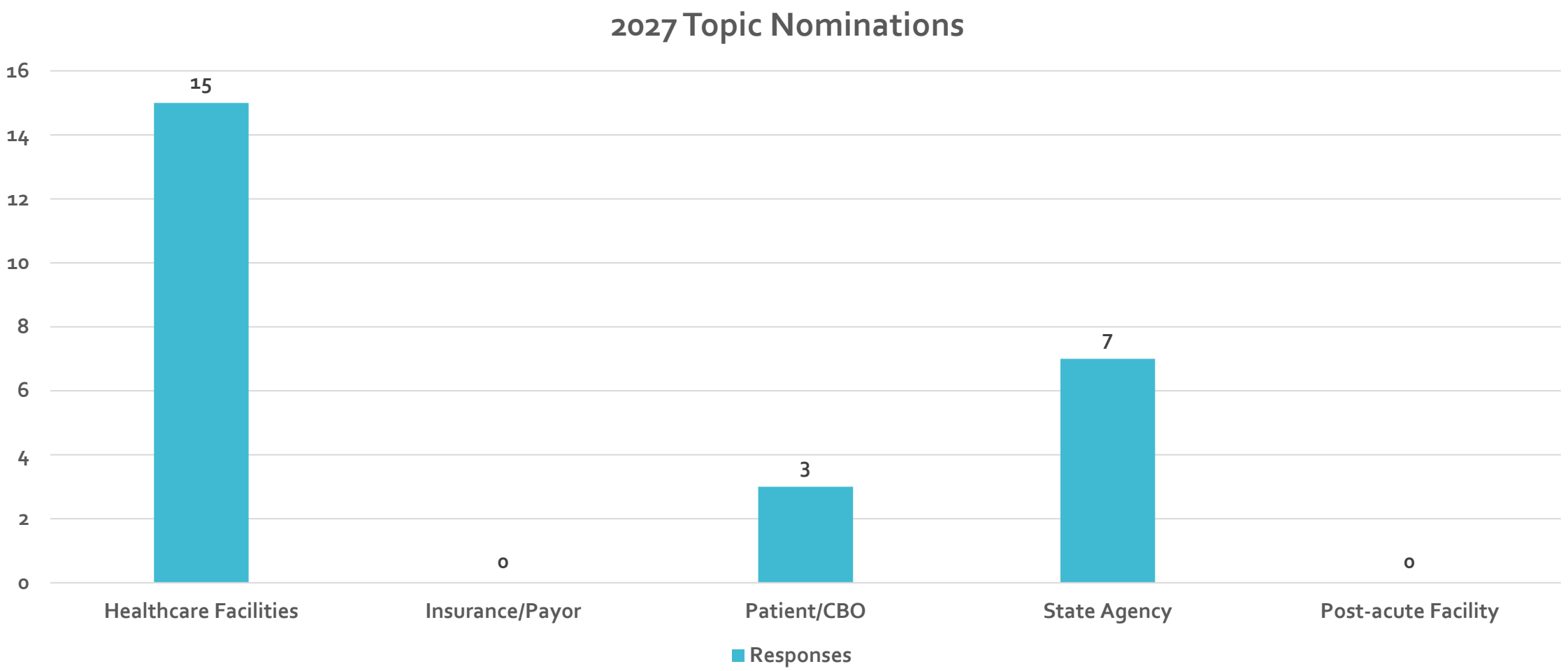
Facilitators

- Interest from most if not all partners, important to the public; **clear implementation partner(s)**
- Available levers to address the problem are **within our control** (state level)
- **Collaboration between payors and clinicians is necessary** to address the problem(s)
- *Examples: Menopause, Behavioral Health Integration*

Barriers

- Low interest, or interest from only a few partners
- Oversaturation
- Unclear or only emerging best practices to improve outcomes
- Barriers at the national level prevent quality improvement; solutions are otherwise out of our control

Demographics (N = 28)



Topic Nominees

Behavioral Health
Revision: Addiction & Dependence Treatment Report & Guidelines (2014)
Bidirectional BHI, from the patient perspective
Commercial tobacco and smoking cessation treatment, SBIRT
Youth behavioral health and substance prevention in rural communities (early identification, prevention, SBIRT)

Care Transitions
Care Coordination (2)

Chronic Disease Management
Screening for and treatment of peripheral artery disease
Polyendocrine Metabolic Ovarian Syndrome (PMOS)
Delayed Diagnosis for Autoimmune Diseases

Topic Nominees

General
AI governance
ARNPs in Primary Care (2)
Language Interpretive Services
Malnutrition
Mobile Integrated Health
Oral Health Access for People with Intellectual Disabilities
Obstructive Sleep Apnea
Peer Review
Polypharmacy
Tele-curbside (Access to Specialty Care in Rural Communities)

Topic Nominees

Infectious Disease

Community-based sepsis recognition and treatment

Oncology

Opportunistic Salpingectomy

Anal Cancer Screening

Surgery

Revision: Obstetrics (2012)

Managing Pain

Pediatric Pain Management

Revision: Palliative Care - Community-based Access for Rural and Underserved Communities (2019)

Reproductive Health

Revision: Sexual and Reproductive Health (2020)

Access to Women's Health Services

Worksheet Overview

- REVISION: Addiction & Dependence Treatment Report
- Polycystic Metabolic Ovarian Syndrome (formerly PCOS)
- Opportunistic salpingectomy (OS) for ovarian cancer prevention
- Pediatric pain management
- Artificial Intelligence (AI) governance and clinical implementation
- Anal cancer screening
- Peripheral Artery Disease
- Mobile Integrated Health
- Malnutrition and Nutritional Risk
- Obstructive Sleep Apnea

Topic	Overview	Proposed Scope	Potential Partners	Unique Bree Impact
REVISION: Addiction & Dependence Treatment	About 48 million people in the U.S. have a substance use disorder, but only 3.6% received treatment.[1] and More than 1 in 10 of Apple Health enrollees in 2022 had a substance use disorder diagnosis, with highest rates in American Indian/Alaska Native, Non-Hispanic White, and Black or African American populations.[2] SUD's are associated with a range of negative health risks and outcomes, including increased risk of contracting infections like HIV and Hepatitis C, developing cancer, cardiovascular disease, or stroke, and impacts both gestational parent and child when used during pregnancy.[3] Strategies exist to identify those experiencing substance use, provide a range of effective treatment options, reduce harm, and support them through recovery. Integrating these across settings with an aligned approach will support better access to and quality of care for those with SUDs.	SUD care integration across settings: crisis care, physical healthcare, housing, community-based agencies, and behavioral healthcare. Identifying current and emerging best practices for SUD care across these settings, recommended payor benefit design and reimbursement, employer policies, and defining state agency level recommendations for measurement of utilization and outcomes. Develop a unified approach to SUD care as a chronic condition across systems and settings.	UW Addiction, Drugs, and Alcohol Institute HCA DOH Washington Society of Addiction Medicine	The Bree could identify evidence-based and emerging best practices for substance use disorder care, align payment structures, and develop recommendations for measuring statewide utilization and outcomes.

Revision: Addiction & Dependence Treatment Report

Over 45 million people in the U.S. have a substance use disorder (SUD), and less than 1 in 20 receive appropriate treatment. SUD's are associated with a range of negative health risks and outcomes, including increased risk of contracting infections like HIV and Hepatitis C, developing cancer, cardiovascular disease, or stroke, and impacts to both gestational parent and child when used during pregnancy. Substance use and use disorder is highly stigmatized and leads to variation in care and persistent use of care models with low/no evidence base

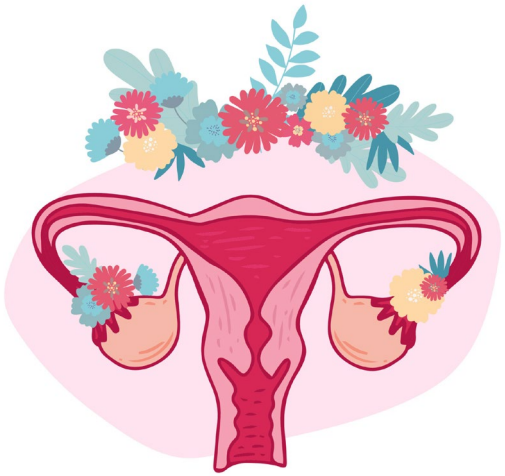
Bree's Unique Impact

The Bree Collaborative could:

- Update the state of the science on evidence-based and emerging best practices for substance use disorder care
- Promote low-barriers treatment access to reach highly stigmatized and underserved group
- Support alignment of statewide efforts to address substance use and measurement of utilization and outcomes

Polyendocrine Metabolic Ovarian Syndrome (formerly PCOS)

Polyendocrine metabolic ovarian syndrome (PMOS, formerly known as PCOS) affects 1 in 8 women. Living with PMOS is associated with increased risk for diabetes, hypertension, depression, and infertility; those impacted report dissatisfaction with care, delayed diagnosis, a and missed work due to symptoms. Healthcare-related economic burden from pregnancy-related and long-term morbidities alone is estimated to be over $4 billion annually.



Bree's Unique Impact

The Bree Collaborative could:

- Address broad variation in care associated with an under-researched condition
- Build consensus on best practices, address knowledge/education gap, and promote comprehensive care planning including chronic condition risk reduction and fertility planning
- Address roles and impacts across the spectrum (provider, employer, etc.)

Opportunistic Salpingectomy (OS) for Ovarian Cancer Prevention

Ovarian cancer is the most lethal gynecologic malignancy, and the 5th leading cause of cancer death in women in the U.S. 70-80% are diagnosed at late stage, with only 35% 5-year survival rate. 70% of ovarian cancers originate in the fallopian tubes (FT) and surgical removal (salpingectomy) is a safe and effective strategy for ovarian cancer prevention. Opportunistic salpingectomy (OS) during non-gynecologic abdominal/pelvic procedures is recommended internationally for any person with ovaries and FTs who has completed childbearing.

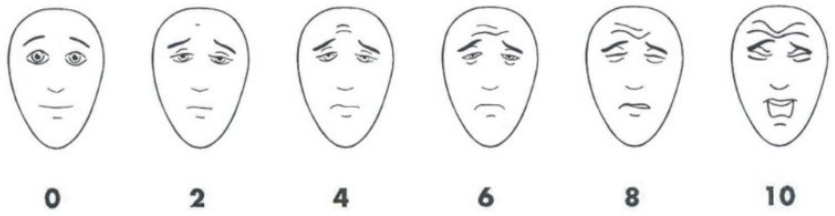
Bree's Unique Impact

The Bree Collaborative could:

- Adopt appropriate eligibility criteria for application of OS across Washington state, including for groups at higher risk of ovarian cancer
- Build consensus on consent conversations
- Clarify pathways for reimbursement of OS
- Address a knowledge/credentialing gap for surgery teams
- Potentially partner with SCOAP for ongoing implementation

Pediatric Pain Management

Pain is one of the most common reasons for children and adolescents to seek medical care. Opioid prescriptions for those <19 have declined in recent decades, but dentists and surgical subspecialists continuing to account for the highest proportion of prescribing and variation exists between settings and facilities in Washington to approaches to pain management. Multimodal pain management combining non-opioid approaches and opioid medications as needed is considered best practice. In recent years, specialty associations have developed new pediatric-specific guidelines for pain management (e.g., AAP, American Society for Pediatric Surgery, ADA, etc.)



Bree's Unique Impact

The Bree Collaborative could:

- Update the state of the science on pain management for pediatric patients, clarifying the impact of developmental stage on best practices
- Reduce variation in use of multimodal approaches to control pain in a population vulnerable to the long-term impacts of both uncontrolled pain and inappropriate opioid use
- Support alignment in measurement in utilization and outcomes specific to the pediatric population

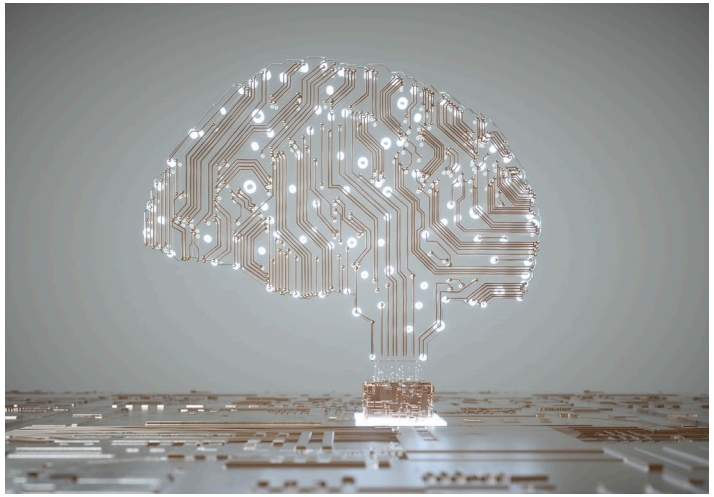
Artificial Intelligence

Artificial Intelligence (AI) is rapidly entering the healthcare ecosystem through documentation, triage, decision support, prior authorization, imaging, patient communication, administrative workflows, and many more applications. In 2024, 2 of 3 physicians report using healthcare AI in their practice. Fragmented approaches to AI in healthcare lead to concerns over data privacy and governance, algorithmic bias, model interpretability, strength and role of regulatory oversight, and maintenance of clinician control of care

Bree's Unique Impact

The Bree Collaborative could:

- Provide a framework for healthcare AI governance for delivery systems, payors, and employers relying on recently published consensus recommendations
- Recommend strategies for vendor contracting standards, prior authorization, and others that align with ethical AI use
- Facilitate transparency and collaboration between health systems, payors, and employers on standards for AI implementation in healthcare



Anal Cancer Screening

Anal cancer is most often caused by the human papillomavirus (HPV) and is preceded by high-grade squamous intraepithelial lesions (HSIL). While rare in the general population, certain groups are at higher risk of anal cancer, such as those living with HIV, men who have sex with men, solid organ transplant recipients, and people with a history of vulvar cancer or precancer. Best practice guidelines recommend routine screening for high-risk groups, as treatment of HSIL can prevent development of cancer.

Bree's Unique Impact

The Bree Collaborative could:

- Close a clinician education/knowledge gap around standardized screening of people at high risk for anal cancer
- Promote strategies to detect cancer early across settings
- Address variation in coverage of HRA to support access across the state
- Reduce inequities in cancer outcomes for underserved and marginalized groups

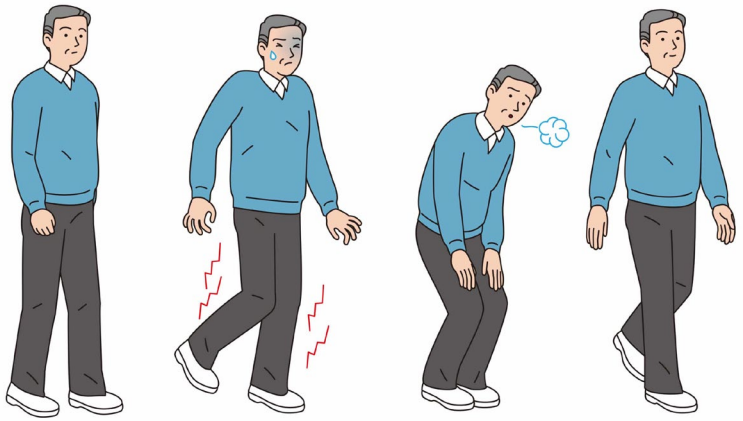
Peripheral Artery Disease (PAD)

PAD affects 8-10 million Americans each year, and is experienced disproportionately by minoritized populations. From 2009-2015, there has been a 50% increase in nontraumatic lower extremity amputation. Those diagnosed with PAD are less likely to be treated with guideline-directed medical therapy as those diagnosed for coronary artery disease (CAD).

Bree's Unique Impact

The Bree Collaborative could:

- Promote early detection and diagnosis of PAD, and reduce variation through guideline-directed medical therapy
- Develop a framework for evaluation of outcomes related to PAD care
- Align and support ongoing efforts in chronic disease prevention to prevent adverse outcomes such as lower-limb amputation



Mobile Integrated Health

Mobile integrated health (MIH) programs, most commonly housed in Fire Departments across Washington, offer essential, non-emergency services to residents of their county or jurisdiction such as care coordination, chronic disease management, medication administration and reconciliation, and others. MIH programs have been reported as cost effective through prevention of emergency visits, hospitalizations, and expensive medical transport. Many of these programs are solely grant funded, limiting sustainability and potential impact.

Bree's Unique Impact

The Bree Collaborative could:

- Leverage partnerships to bridge the gap in coverage between payors and providers practicing in MIH programs for designated, initial use care (e.g., crisis care)
- Identify next steps to expand this approach for other MIH programs
- Provide a framework for statewide and organizational evaluation

Malnutrition and Nutritional Risk

Studies estimate around 30% of hospitalized adult patients are at risk for malnutrition. Malnutrition is associated with high morbidity and mortality, but under-identified in the healthcare system. In addition, given the high utilization of GLP-1 RAs in the U.S., concerns have emerged around the development of sarcopenia in those at higher risk.

Bree's Unique Impact

The Bree Collaborative could:

- Address implementation barriers to malnutrition screening and interventions across healthcare settings, including considerations for those using GLP-1 RAs
- Reduce variation in management, both short-term in preparation for procedures and long-term management based in primary care
- Reduction of unnecessary surgical delays and promotion of coordinated approach to malnutrition in clinical and workplace settings

Obstructive Sleep Apnea

Obstructive sleep apnea (OSA) affects 1 billion adults globally, often underrecognized and undertreated. As many as 40-80% of people living with chronic conditions experience sleep apnea. OSA is also associated with increased risks of post-operative complications and increased likelihood of ICU admission

Bree's Unique Impact

The Bree Collaborative could:

- Reduce variation in screening practices for OSA in primary care and surgical settings and increase uptake of management strategies
- Align payor incentives to screen for and address OSA in primary care and before surgery, and facilitate access to positive airway pressure devices
- Integrate OSA screening and management as part of the pre-surgical optimization pathway
- Reduce risk of surgical complications and chronic conditions

Previous Topics

Previous Revision Nominations

- Revision: THR/TKR
- Revision: Pediatric Psychotropics
- Revision: Collaborative Care for Chronic Pain
- Revision: Oncology Care – Early Stage Testing

Previous New Nominations

- Kidney Health
- Gestational Diabetes
- Vaccinations
- Weight Management
- Pediatric Autism Spectrum Disorder

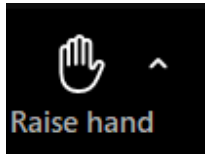
Next Up: Bree Member Questions & Discussion

Questions & Discussion

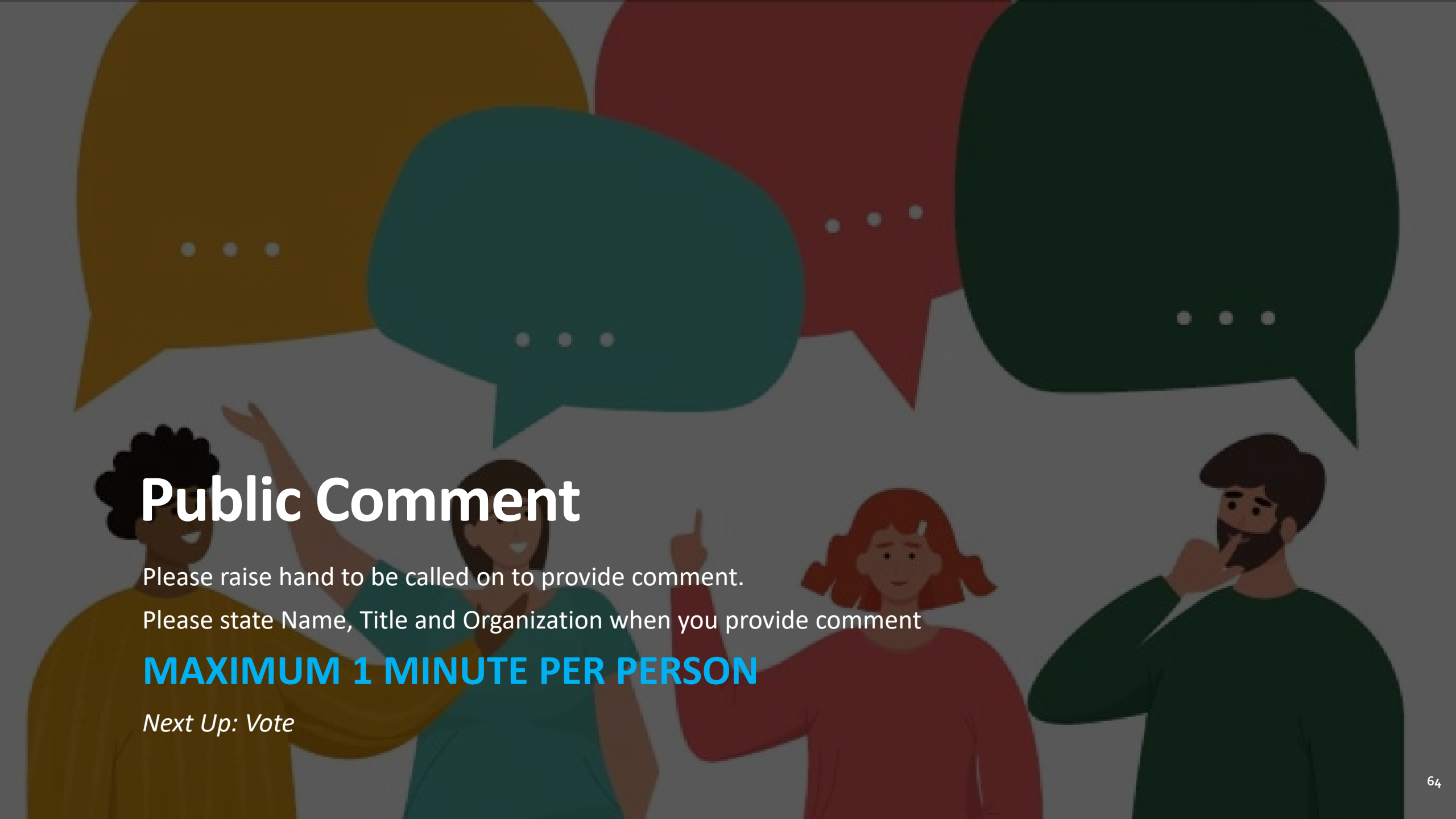
Next Up: Public Comment

Public Comment

- As a member of the public, you are an “Attendee” in the meeting and cannot unmute yourself or share your video.
- If you would like to provide a public comment, **please raise your hand by clicking the button at the bottom of your screen**.



- Bree staff will call on you to speak and promote you to a “Panelist.”
- As a “Panelist”, you will be able to unmute yourself and share your video to provide your comment.
- After you have commented, Bree staff will move you back to an “Attendee” for the meeting.



Public Comment

Please raise hand to be called on to provide comment.

Please state Name, Title and Organization when you provide comment

MAXIMUM 1 MINUTE PER PERSON

Next Up: Vote

Vote

- **ALL present members (officially appointed or not) should participate in voting**
- Pick your **TOP 3 TOPICS**
- The order does not matter
- Results will be displayed for further discussion

Link to the survey in the chat for hosts and panelists

Final Vote (as needed)

- **ALL present members (officially appointed or not) should participate in voting**
- Pick your **TOP 6 TOPICS**
- The order does not matter
- Results will be displayed for further discussion

Link to the survey in the chat for hosts and panelists

Closing

2:55 – 3:00

Next Time

Next meeting: **Wednesday, September 23rd 11AM-3PM IN PERSON**

(Virtual Available)

Held at Industrious Office:

Upcoming Events

- **Sept 2nd:** Equity in Optimization: The Intersection of Surgical Readiness and Social Drivers of Health
- **Sept. 16th:** Leading Successful Root Cause Analyses (Seattle, WA)
- **Sept. 17th:** Catalyst for Change: Harnessing Rural Ingenuity to Transform Health (Virtual)
- **Oct. 13-15th:** WA State Public Health Association Annual Meeting (Wenatchee, WA)
- **Oct. 15-16th:** NW Patient Safety Conference (Virtual)
- **Oct. 23rd**: Dementia Summit: Primary Care at the Forefront (Yakima)
- **Oct. 27th:** HICOR Value in Cancer Care Summit (Seattle)
- **Dec. 4th:** State of Diabetes: Puget Sound (Seattle)

Thank You!

Please email bree@qualityhealth.org with follow up questions or comments

See you in SEPTEMBER