

Bree Collaborative Meeting

Meeting will begin at 11AM PST

September 23rd 2026 | In Person Retreat



Before We Begin...

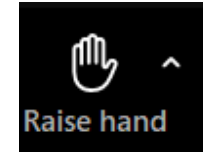


- The meeting is hosted as a Zoom Webinar
- When you log on, you are automatically an “Attendee”
 - As an attendee, you are automatically muted and are unable to turn on your video or sound.
- Bree Staff will promote Bree Members to a “Panelist” so they are able to speak and share their video with the 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

Mountain Climber Awards

Action Item: Adopt July Minutes

Perimenopause and Menopause

Action Item: Approve for public comment

Alzheimer's Disease and Other Dementias

Action Item: Approve for public comment

Lunch

Lung Cancer Screening

Action Item: Approve for public comment

2027 Topic Selection

Presentations

Initial Vote

Public Comment

Open Discussion

Voting

Closing and Next Steps



Meeting Minutes: July 2026



Bree Collaborative Meeting July 22nd 2026 | 1:00-3:00PM Hybrid

MEMBERS PRESENT

Emily Transue, MD, MHA, Comagine Health (in person)
Jake Berman, MD, MPH, University of Washington
Amy Laurent, MSPH, (Proxy) 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
Darcy Jaffe, ARNP, WSHA
Debbie Roessler, MD, Family Care Network (to be confirmed)
Kristina Petsas, MD, UHC
Rodica Pop, PhD, RN, MultiCare (to be confirmed)
Allen Christensen, DHEd, MBA, CHES, (Proxy) DOH (to be confirmed)

MEMBERS ABSENT

Colin Fields, MD Kaiser-Permanente
Susanne Quistgaard, MD, Premera Blue Cross
James Murray, MD, Confluence (to be confirmed)
Drew Oliveira, MD, WHA (to be confirmed)
Katina Rue, DO, WOMA (to be confirmed)

Congratulations and Welcome! (officially)



The following members have been officially appointed by the Governor:

- **Rodney Anderson, MD**, Family Care Network (*Debbie Roessler, MD, as proxy*)
- **Tao Kwan-Gett, MD, MPH**, Department of Health
- **Drew Oliveira, MD, MHA**, Washington Health Alliance
- **Katina Rue, DO, FAAFP, FACOFP**, Yakima Valley Farm Workers Clinic
- **Arooj Simmonds, MD**, Providence North Division

Mountain Climber Award for Excellence in Health Equity



Congratulations to our award winners!



Perimenopause and Menopause

Nicole Saint Clair, MD, FACOG, Regence, Workgroup Chair



Workgroup Members



Name	Title	Organization
Naomi Busch, MD, MSCP	Founder and Director	Seattle Menopause Medicine
Rizza Cea, DNP, CNM	Clinical Consultant Title X Medical Director Sexual and Reproductive Health Programs	Department of Health
Annelise Gaaserud, MD, MPH, MSCP	Family Medicine Physician	Kaiser Permanente
Carolyn Halley, MD	Medical Director	Healthpoint
Karin Inderbitzin, RN, BSN	Occupational Nurse Consultant Clinical Quality and Care Transformation Employee and Retiree Benefits Division	Washington Health Care Authority
Amy Laurent, MSPH	Global Health and Research Manager	Microsoft
Laura Marie MacPherson, MSN	Director of Maternity Programs	Molina

Name	Title	Organization
Drew Oliveira, MD, MHA	Medical Director	Washington Health Alliance
Kristina Petsas, MD, MBA, MLS	Chief Medical Officer - Commercial (Employer & Individual) - PNW, AK, HI	United Healthcare
Denise Rodriguez	Menopause Doula	Seattle Menopause Doula
Nicole Saint Clair, MD, FACOG (chair)	Executive Medical Director	Regence
Arooj Simmonds, MD	CMO North Division	Providence
Kris Somol, ND	Associate Professor School of Naturopathic Medicine	Bastyr University
Asher Strauss, PsyD	Director of Behavioral Health	Kinwell
Josephine Young, MD, MPH, MBA, FAAP	Medical Director, Commercial Markets	Premiera

Overview



- **Over 1.3 million people enter menopause annually;** Vasomotor symptoms, such as hot flashes/flushes and night sweats, affect up to 80% of individuals; more frequent and severe vasomotor symptoms are associated with multiple risk factors for cardiovascular disease, including hypertension and dyslipidemia.
- **Fewer than 20% are clinically identified before they fully transition into menopause,** missing an opportunity to control symptoms, improve quality of life, and protect long-term health. Evidence-based treatments to address symptoms include hormonal and nonhormonal options
- Individuals with moderate to severe menopausal symptoms report **higher likelihood of adverse work outcomes**, such as being forced to take leave or even quit/being laid off from positions.

***Aim:** To standardize high-quality care and best practices through perimenopause and menopause in Washington state in order to prevent disease, promote wellbeing, reduce cost, and increase productivity.*

Vision for Washington State



1. **Clinicians have a consistent baseline level of knowledge, skills, and resources** to recognize, counsel on, and manage perimenopause and menopause comprehensively
2. **Communities broadly view menopause as a normal life transition for which medical support is available, appropriate, and acceptable.**
3. Perimenopause and menopause care is grounded in **shared decision-making and patient-centered care.**
4. **Menopause is a timepoint in which patients and clinicians address midlife health comprehensively** (e.g., nutrition, risk management, chronic disease prevention, etc.)
5. Proactive communication across all settings **normalizes the menopause transition, reducing stigma by setting shared expectations about what to expect and when to seek support.**

Vision for Washington State



6. Employers support their employees and dependents during the menopause transition through benefit design, employee accommodations, etc. **Employer best practices with minimum standards, are clear.**
7. **Health plans and healthcare purchasers adopt reproductive health strategies that explicitly include perimenopause and menopause,** supported by recommendations that guide coverage, reimbursement, and care model investment to enable high-quality, longitudinal care
8. **Washingtonians are able to access perimenopause and menopause resources, care, and treatments equitably.** This includes explicitly addressing racial/ethnic and geographic health disparities in menopause experiences, access to care, and outcomes, as well as specific guidelines for special populations
9. **Education, training, and practice standards for menopause care are consistently integrated across the full spectrum of clinicians with trusted patient relationships** (physicians, NPs, midwives, NDs, PAs, etc.) with clear expectations for competency and accountability to address gaps in training.

Guidelines



Primary Care Clinicians

- Proactively recognize and assess symptoms of perimenopause and menopause
- Use validated tools to assess symptom severity, impact on quality of life, and response to treatments (e.g., MHT); provide anticipatory guidance on symptom variability and duration
- Identification w/o diagnostic testing for those aged 45+
- Co-create plan for symptom management, inclusive of hormonal and nonhormonal interventions
- If initiating MHT, consider starting with lowest dose, transdermal formulation for those with risk factors, and reassessing effectiveness after several months
- Address midlife health comprehensively, including cardiometabolic risk factors, musculoskeletal protection, and behavioral health
- Seek out accredited and evidence-based continuing education on perimenopause and menopause

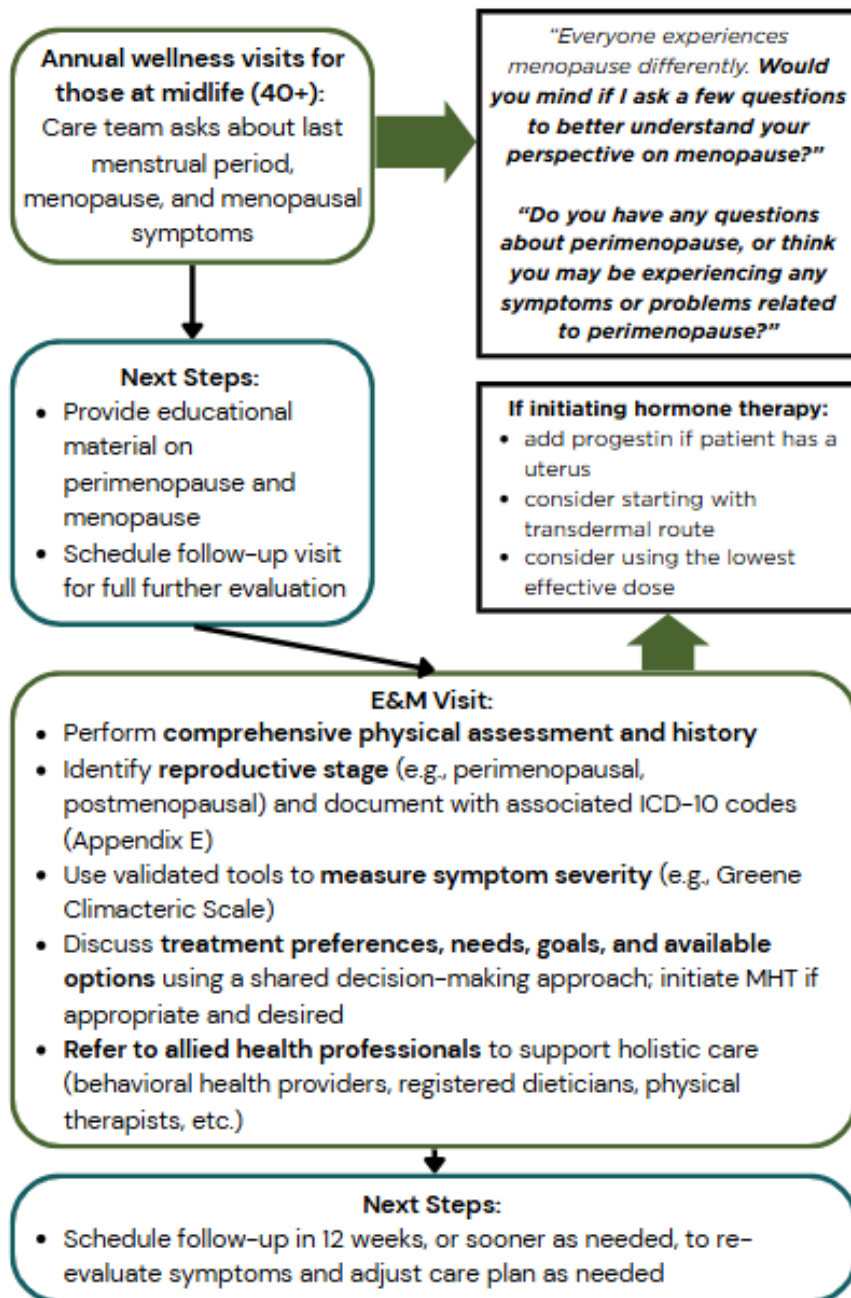
Primary Care and Women's Health Systems

- Integrate validated menopause symptom assessment tools into EHR
- Ensure referral capacity to specialty care (e.g., reproductive endocrinology) as needed
- Develop and implement protocols for proactive identification, recognition, assessment, and management of menopause across primary care settings
- Integrate patient education on menopause into midlife health materials (e.g., cardiovascular health, bone health, behavioral health)
- Provide access to/list of accredited trainings for healthcare professionals on perimenopause and menopause
- Audit medical education training provided at clinic or health system for evidence-based perimenopause/menopause care

Example Workflow

For Primary Care and Women's Health Clinics

Example Workflow for Primary Care



Guidelines



Behavioral Health

- Recognize perimenopause and menopause as major contributors to behavioral health; identity shift common as hormone levels and bodies change
- Beginning at age 40, incorporate brief menopause-informed assessment (ask about menopausal symptoms and impact on mood, sleep, etc.)
- Coordinate with primary care, whether integrated or not
- Consider the influence menopause may have on behavioral health concerns
- Menopausal hormone therapy (MHT) is not considered first line treatment for depression; however, may reduce depressive symptoms if they coincide with menopausal symptoms
- SSRIs/SNRIs not considered first line for vasomotor symptoms (e.g. hot flashes, night sweats)

Health Plans

- Send members communication about perimenopause/menopause and where to find evidence-based information
- Enforce transparency in coverage of range of interventions both hormonal and nonhormonal (e.g., behavioral health visits, nutrition, physical therapy, hormonal and nonhormonal medication)
- Ensure transdermal MHT with progestin is in lowest cost tier for members
- Review utilization management policies to reduce barriers to accessing generic estradiol and micronized progesterone (MHT)
- Initiate additional surveillance for those who initiate MHT over age of 65

Guidelines



Employer Purchasers

- Incorporate menopause into public awareness and wellbeing campaigns/initiatives
- Include in benefit design transparent coverage of MHT, review UM policies, make EAPs visible to employees
- Evaluate vendors providing women's health or family benefits to ensure access to clinicians specially trained in women's health, and align care protocols with national guidance
- Explicitly include menopause-related symptoms in accommodations
- Include peri/menopause in workplace wellbeing, leave, other policies
- Regular manager/supervisor training inclusive of menopause
- Outline and post accountability structure for menopause in workplace

Department of Health

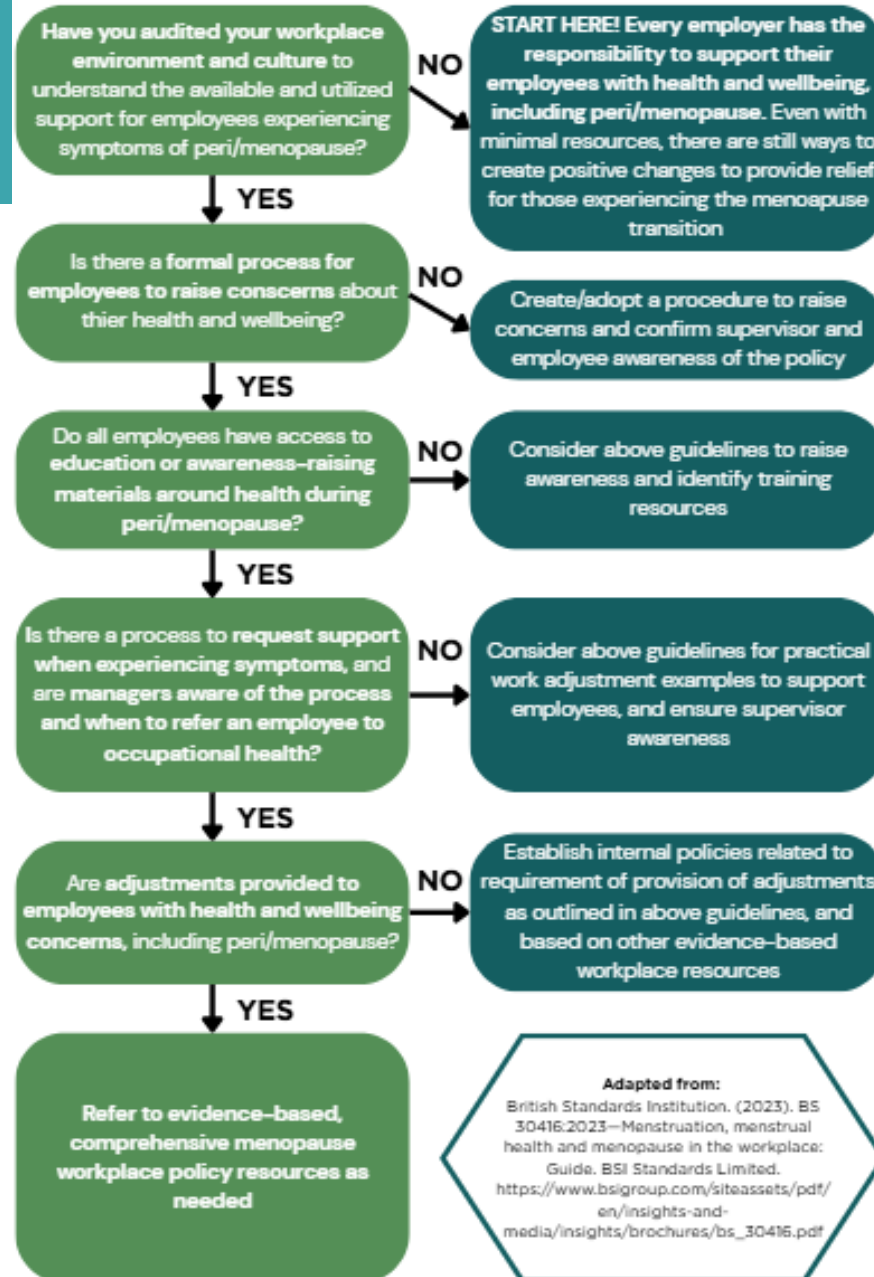
- Align with EO
- Ask about perimenopause/menopause care and midlife women's health needs in population health needs assessment
- Partner with/collaborate with professional associations to facilitate access to accredited educational training/events for clinicians
- Promote public awareness of perimenopause/menopause, including public-facing website with links to evidence-based information
- Partner with/collaborate with OSPI to encourage incorporate of education around menopause into state-mandated sexual and reproductive health education in schools (*with example statements*)

Health Care Authority

- Align with EO
- Require MCOs to provide transparent coverage of hormonal and nonhormonal interventions for menopause
- Adopt or adapt SDM tools to support PCPs in menopause care

Employer Workflow

Is Your Workplace Menopause-Inclusive?



Clinicians and Delivery Systems

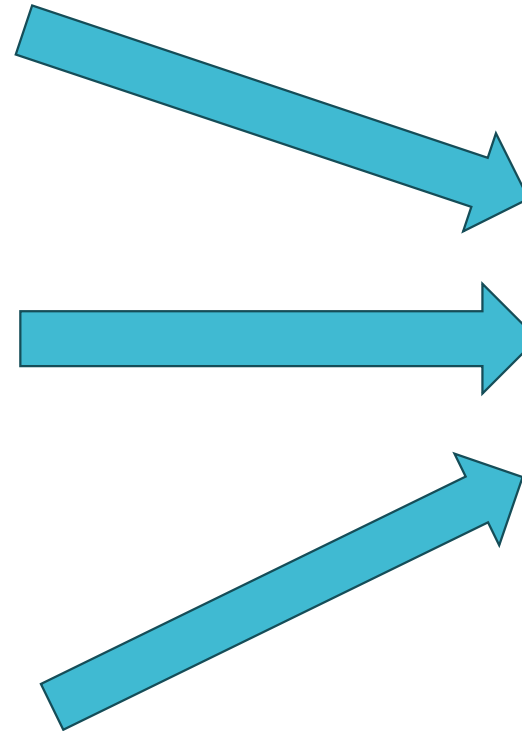
- Identifying and assessing menopause; normalizing the transition
- Access to hormonal and nonhormonal interventions
- Midlife health assessment and prevention
- Clinician education and training

Payors and Purchasers

- Lowering barriers to accessing evidence-based treatments
- Menopause-informed workplace accommodations and policies
- Member and employee education, awareness, and resources

State Agencies

- Clinician and public education and resources; validating accredited sources of information
- Enforcing lower barriers to MHT and nonhormonal treatment options



- **Symptom relief and improved quality of life**
- **Menopause as a timepoint to assess and address midlife health**
- **System of coordinated support across workplaces, clinical settings, schools, and public health**

The background of the slide is a light gray surface covered with numerous small, light-colored wooden blocks. Each block has a black question mark printed on its top face. The blocks are scattered across the entire frame, creating a pattern of question marks.

Questions

Next Up: Alzheimer's and Other Dementias Revision

Public Comment Approval



- Appointed Bree Collaborative members only



Alzheimer's and Other Dementias

Kris Rhoads, PhD, UW Memory and Brain Wellness Center, Revision Workgroup Chair



Workgroup Members

Name	Title	Organization
Richard Furlong, MD	Internal Medicine, Section Head Kirkland Medical Pavillion	Virginia Mason Franciscan Health
Barak Gaster, MD	Professor of Medicine	University of Washington Memory and Brain Wellness Center
Marci Getz, MPH	Director - Healthy Aging Initiatives	Washington State Department of Health
Michelle Graham, MD, MME, FAAFP	Chief Medical Officer, Pacific Northwest - WA, OR, HI, AK	UnitedHealthcare Medicare & Retirement
LuPita Guitierrez-Parker	Patient Advocate	
Michelle Hamilton, DO, MBA	Medical Director, Clinical Management & Policy	Molina
Carroll Haymon, MD	Physician Faculty Clinical Advisor and Consultant	Providence Swedish AC Haymon Consulting
Nancy Isenberg, MD, MPH	Medical Director Center for Healthy Aging, Co-Lead, Project ECHO Dementia	Swedish Neuroscience Institute
Lynne Korte, MPH	Dementia Care Policy and Program Analyst/Manager	Washington Department of Social and Health Services

Name	Title	Organization
Cathy McCaul	Advocacy Director	American Association of Retired Persons (AARP) Washington
Vicki McNealley, PhD, MN, RN	Director of Assisted Living	Washington Health Care Association
Kristoffer Rhoads, PhD (chair)	Professor of Neurology Neuropsychologist Co-Lead, Project ECHO Dementia	University of Washington Memory and Brain Wellness Center UW ADRC Clinical Core
Katina Rue, DO, FAAFP, FACOFP	Medical Director	Team Health
Nina Sanderson	Regional Manager	Midwest QIN-QIO
Maureen Schmitter-Edgemont, PhD	Regents Professor	Washington State University
Allyson Schrier	Caregiver Advocate	Zinnia TV
Lama Sibai, PsyD, MA	Chief Medical Officer	Nolia Health
Jamie Teuteberg, MS	Director of Healthy Aging Initiatives Health and Aging Policy Fellow	Washington State Health Care Authority

Name	Title	Organization
Emily Trittschuh, PhD	Associate Director of Education and Evaluation Geriatric Research Education and Clinical Center	VA Puget Sound HCS
Kyle Unland, MS, RDN	Community-Based Prevention Section Manager	Washington State Department of Health



Overview



- Alzheimer's disease and other dementias is a growing public health concern in Washington. The number of Washingtonians living with dementia is expected to double by 2045.
- Recent estimates show over 250,000 uncompensated caregivers in the state.
- Combined health and long-term care costs, unpaid caregiving, diminished quality of life, and lost wages add up to estimated \$818 billion in 2026 in the U.S.
- Since 2017: New advanced diagnostics and therapeutics, updates in risk reduction for dementia, and emerging wrap around care models

Aim: update and standardize evidence-based prevention, early detection, and treatment for those living with and at risk for Alzheimer's Disease and other dementias to prevent and delay progression of these conditions for our community.

Focus Areas



2017

Diagnosis
Ongoing Care, Support and Management
Advance Care Planning and Palliative Care
Need for Increased Support and/or Higher Levels of Care
Preparing for Potential Hospitalization
Screening for Delirium Risk



2026

Risk Reduction
Detection and Diagnosis
Ongoing Care, Support and Management • Advance care planning • Palliative care • Need for increased support/higher levels of care • Preparing for hospitalization • Screening for delirium

Guidelines



Primary Care Teams (including Clinicians)

- Identify and address **modifiable risk factors** across the life course
- **Assess cognition when** concerns are raised, when presenting completed assessment, after abnormal cognitive brief assessment, and when observing signs and symptoms
- **Further evaluation** (direct input from family/patient, assess cognitive function w/ tool, evaluate for addressable causes, order imaging as appropriate) -> **if uncertain, repeat in 6-12 months**
- **When diagnosis is made**, assess caregiver stress, capacity and support, discuss ways to improve safety and quality of life (e.g., driving, mitigating confusion, financial security, etc.), connect to resources, assess and address hearing/vision loss
- **Advanced diagnostics and therapeutics (next slide)**
- **Include patient/family as care team members**, identify goals of care, and maximize function
- **Incorporate diagnosis into other care** and identify conditions that may worsen symptoms
- **Provide education** (about diagnosis, available treatment, natural progression, neuropsych symptoms)
- **Advance care planning and palliative care** (discuss and document, introduce concept of palliative care)
- **Discuss preparing for hospitalization** or higher levels of care

Primary Care Settings

- **Provide brain health education**; incorporate brain health into chronic disease prevention programs
- Develop system **to identify adults at higher risk for cognitive impairment**, and flag
- Design clinic workflow to support **brief assessment of cognition and separate visit for further evaluation**
- Make **checklist for visit when a diagnosis is made**
- Train clinicians on **how to communicate diagnosis**; train staff **how to communicate with people who have cognitive impairment**
- Support early detection **through clinician and staff training**
- Offer **dementia care management services**
- Identify care team member's role **to assess caregiver distress, fatigue, capacity, knowledge, skills** as core component of each visit
- Provide **checklist on preparing for hospitalization**

Advanced Diagnostics and Therapeutics



- Blood based biomarkers (BBMs) do not definitively rule out or rule in a diagnosis of Alzheimer's disease. A comprehensive evaluation is needed to make an accurate diagnosis.
- 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 have the 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 BBMs is unclear and evolving. See the **Alzheimer's Association Clinical Practice Guidelines** [here](#).
- Amyloid targeting therapies have been FDA-approved for the treatment of Alzheimer's disease. The clinical benefit of these therapies is debated, and the risks, costs, and monitoring burdens are significant. Understand who might be a good candidate for amyloid-targeting therapies when discussing treatment options. The following is a noncomprehensive list of criteria for those that are most likely to benefit:
 - Mild cognitive impairment or the earliest stages of dementia (e.g., minimal interference with high-level IADLs)
 - Low comorbidity; long life expectancy
 - Primary etiology of cognitive impairment is Alzheimer's disease
 - Not on an anticoagulant
 - APOE phenotype is known (e.g., 4/4 is high risk)
 - Patient and family understand the benefits and risks of treatment, including cost and medical monitoring requirements (e.g., regular imaging)

Guidelines



Residential Care Facilities

- Make information about **brain health and risk reduction** available
- **Know signs and symptoms of cognitive impairment** – observe and note
- Ensure **family/caregiver participation in care planning** as appropriate
- Provide **psychosocial and emotional support**
- Connect to **community resources**
- Regular **dementia-specific training** including nonpharmacological interventions for neuropsych symptoms
- **Educate staff on symptoms of hearing loss/vision loss**, how to communicate, how to approach advance care planning conversations, and refer for ACP resources
- **Encourage care planning conversations**, and have documents on file
- Encourage to **discuss value of palliative care and hospice**
- **Facilitate information sharing and outreach**, especially during transition or times of crisis

Hospitals

- **Educate staff on MCI and dementias**
- Work towards accreditation as **geriatric emergency department**
- Clarify **decision-making capacity when admitted**, identify surrogate
- **Be cautious of diagnosing dementia in hospital setting**
- Integrate actions/programs that support **smooth transitions** (DAC Discharge/Transition toolkit)
- **Before DC:**
 - Assess family/caregiver support
 - Connect to resources
 - Support selection of appropriate facility
 - Proactively discuss length of stay, cost, etc.
- Regular education on the **difference between 3D's (dementia, delirium, and depression)** (Northwest Geriatric Workforce Enhancement Center)
- **Screen all at risk on admission for delirium using brief tool** (e.g., CAM)
- Track and monitor completion of delirium screening

Guidelines



Health Plans

- **Send educational material on brain health**; increase member awareness of age-related changes vs dementia, benefits of timely diagnosis
- **Cover hearing/vision aids no cost**
- **Chronic disease prevention programs at no/minimal OOP cost**
- Integrate coverage of **fruit and vegetable prescription programs**
- **When initial diagnosis identified in claims:**
 - Route automatically to internal care manager/coordinator/navigator team
 - Send resources including Dementia Roadmap, Alzheimer's Association, and contact information for local AAA
- Provide access to **palliative care without having to be eligible for hospice**
- Explore opportunities allow **billing for cognitive assessment delivered by non-physician**
- Access to **care management services**
- **Facilitate information sharing**, especially during transition or times of crisis

Employers

- **Increase employee awareness** of WA family caregiver support programs, brain health, difference between age-related changes vs dementia, benefits of timely diagnosis of MCI/Alz disease
- Explicitly include **cognitive sx as acceptable for accommodations**
- **Include in benefit design**
 - access to DPP and SMBP
 - medical respite for unpaid caregivers
 - WA Paid family medical leave as appropriate
- Host/refer employees to **support groups**
- Align **workplace policies with maintaining brain health** (e.g., nonsmoking, physical activity, healthy foods, EAPs for BH)
- Review and integrate employer resources (**Alzheimer's Association Brain Health at Work**)

Guidelines



Department of Health

- **Integrate brain health and dementia risk reduction** across programs through the life course
- **Sustain and strengthen partnerships with health systems, CBOs, private sector partners,** and advocate for policies that reduce dementia risk
- **Analyze/share data as available** (e.g., BRFSS) with partners to drive risk reduction
- Encourage **education/training on brain health and dementias** for public health staff, clinicians, CHWs, etc.
- **Send “Dear Colleague” letters to PCPs and tribal nations**

Health Care Authority

- Cover with minimal/no OOP cost **annual wellness visit for adults** across MCO and FFS apple health
- Integrate incentives for QI in care for older adults aligned with **Age-friendly health systems**
- Add **contract language to MCOs/DSNP/PEBB/SECC to address need for improved care coordination and support materials** triggered by dementia diagnosis
 - Route automatically to internal care manager/coordinator/navigator team
 - Send resources Dementia Roadmap, Alzheimer’s Association, contact information for local AAA
- **Test implementation of payment models for comprehensive dementia care** (e.g., GUIDE)

Detection & Diagnosis

"I or my family members have concerns about memory. My care team talks with me about my concerns and helps me understand the cause of any trouble with thinking ability. I know who to contact in case of urgent questions or situations and have thought about the type of care that I would want at different stages of the disease."



Current State

While some clinicians may routinely screen for or discuss cognitive issues with patients, in many cases issues with memory and cognition are only addressed if they are brought up by the patient or family member(s). Once brought up by the patient or family member, issues with memory or cognition may be adequately addressed by the clinician. In some cases there may be no clinical follow-up. The clinician may be unsure about screening tools, how to utilize the Medicare Annual Wellness Visit, or next steps and may not feel comfortable discussing cognitive issues. Specialty consultation may be unavailable if needed.

Intermediate Steps

Practices work to increase clinicians' level of comfort and expertise in diagnosing and discussing a dementia diagnosis. Clear guidelines are available on how to make the diagnosis using validated tools with the expectation that the clinician will truthfully discuss the diagnosis with the patient and family and record the diagnosis in the medical record. Practices may pilot screening programs with select populations before scaling implementation. Clinicians may involve a neurologist or other specialist as needed for consultation and support or for differential diagnosis.

Optimal Care

1. The patient has an identified primary care clinician.
2. Patient and family members receive coordinated care as part of an interdisciplinary team that has been trained in how to talk about cognitive impairment, including office staff, specialists and community partners.
3. Family members/other caregivers are included in conversations and feel supported and heard.
4. Primary care clinicians know the value of early detection and feel comfortable truthfully discussing cognitive issues. Early detection is routine
5. Primary care has established clinical protocols for the evaluation of cognitive impairment using standard tools. These protocols include both brief assessments performed during routine visits such as the annual wellness visit, and a more complete cognitive and functional assessment performed once a true clinical concern has been identified through screening or clinical history.
6. A positive finding is followed by additional evaluation and confirmation of the diagnosis, if needed. See Alzheimer's Association Medicare Annual Wellness Visit Algorithm [here](#).
7. The diagnosis conversation and any subsequent conversations follow the Alzheimer's Association principles for a dignified diagnosis, listed in Appendix E, and includes an advance care planning conversation. (CPT code 99483)

Impact



Clinicians and Delivery Systems

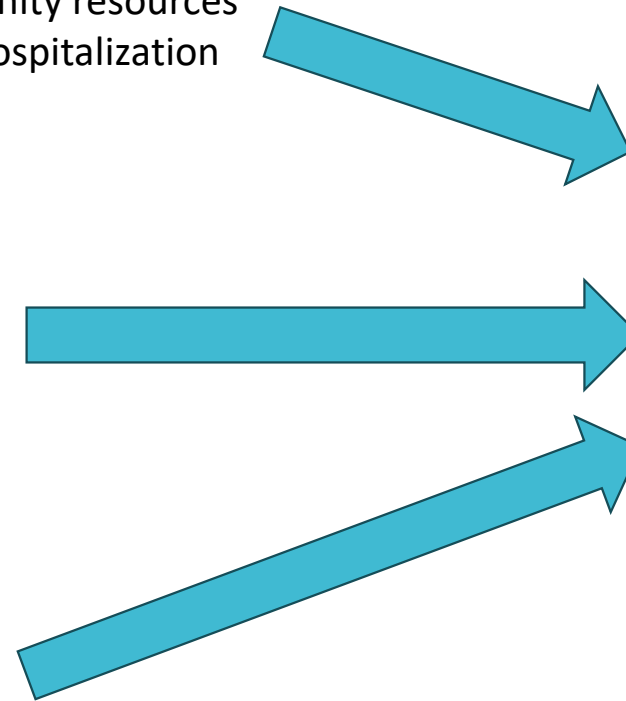
- Promoting brain health and risk reduction
- Proactive assessment of cognition and diagnosing with dignity; navigating novel diagnostics and therapeutics grounded in evidence
- Wrap around dementia care, facilitate access to community resources
- Support proactive advance care planning, prepare for hospitalization and higher care needs, and identify/mitigate delirium

Payors and Purchasers

- Promote brain health and risk reduction
- Payment structure that supports wrap-around dementia care
- Proactively support access to care management/coordination and further information on community resources

State Agencies

- Promote brain health and risk reduction; age-friendly health systems
- Collaborate and strengthen partnerships
- Integrate incentives in contracting
- Dementia professional training



Washingtonians are able to reduce their risk for dementia, receive evidence-based guidance from clinicians on cognitive changes, dignified diagnosis, and continual coordinated support through the disease process from the whole system



Questions

Next Up: Lunch

Public Comment Approval



- Appointed Bree Collaborative members only



Lunch

Meeting will resume at 12:45PM



Lung Cancer Screening

Joelle Fathi, DNP, ARNP, GO2 for Lung Cancer/UW, Lung Cancer Screening Workgroup Co-chair

Kim Kummer, MS, MPH, Jamestown Family Health Clinic, Lung Cancer Screening Workgroup Co-chair



Workgroup Members



Name	Title	Organization
Andrea Allen, RN, MHA	Nurse Consultant, Apple Health Fee For Service	Washington Health Care Authority
Jessica Beach, MPH, DrPHc	Health Equity Director	Molina
Kristin Bohreer, RN, BSN	Clinical Program Manager for LCS & ILN	Virginia Mason Medical Center
Maggie Chin, MD	Medical Director of Cancer Screening	Washington Permanente Medical Group
Elyse Dumont, RN	Lung Navigator Population Health	Mason Health
Joelle Fathi, DNP, RN, ARNP, ANP-BC, CTTS, FAANP, FAAN (co-chair)	Chief Healthcare Delivery Officer	GO2 for Lung Cancer
Ty Jones, MD, CPPS, CHPW, CAQSM	HCA Account Medical Director	Regence Blue Shield
Kim Kummer, MS, MPH, CIC (co-chair)	Quality Manager	Jamestown Family Health Clinic
Jennifer Kummerfeldt, ARNP	Director of Population Health	Mason Health
Saba Lodhi, MD	Pulmonologist/Critical Care Medicine	Confluence Health

Name	Title	Organization
Drew Oliveira, MD, MHA	Medical Director	Washington Health Alliance
Brandon Omernik, MS, CTTS	Tobacco Treatment Specialist	Fred Hutch Cancer Center
Susanne Quistgaard, MD	Medical Director, Provider Customer Engagement	Premiera Blue Cross
Matty Triplette, MD, MPH	Medical Director Lung Cancer Screening & Living Tobacco Free Services	Fred Hutch Cancer Center
Douglas E. Wood, MD, FACS, FRCSEd	Henry N Harkins Professor and Chair, Department of Surgery	University of Washington

Lung Cancer Screening



- Lung cancer kills more Washingtonians than breast, cervical, and colorectal cancer combined.
- Only 28% of cases of lung cancer in Washington state are diagnosed in early stage, despite national guidelines for lung cancer screening published initially in 2013.
- Washington ranks **37th out of 50 states** in screening those at high risk.
- Appreciate a **20%** lung cancer mortality reduction with lung cancer screening, and additional **7%** reduction in all-cause mortality
- Screening can flip the stage of disease from 80% of people diagnosed at stage 4 to **80% of people being diagnosed at stage 1.**
- 5-year survival rates for those diagnosed at early stage are estimated at **65%**, compared to 10% at late-stage diagnosis

***Aim:** Increase uptake and adherence to appropriate lung cancer screening in Washington State*

Roles and Responsibilities



Clinicians

- Screen for and accurately document tobacco history
- Ask about and advise to quit smoking; provide cessation support interventions.
- Schedule separate appointment to discuss LCS, shared decision-making (SDM) approach
- Order low-dose CT at accredited facility, and ensure timely communication of results
- Referral to specialty management for Lung-RADS Category 3 & 4 findings following American College of Radiology (ACR) standards

Delivery Systems

- Tracking and monitoring system for those potentially eligible
- Incorporate digital tools to support screening (e.g., SDM integration)
- Provide navigation support and cessation resources across the screening continuum
- Tracking and engagement to ensure annual follow-up scans at a minimum
- Establish partnerships to access multidisciplinary teams and/or tumor/nodule boards for
- Establish protocols for management of other clinically significant findings

All patient/member/employee-facing communication should use person-first language (e.g., people who smoke instead of smokers)

Roles and Responsibilities



Plans

- Identify members who may be eligible for screening, drive eligibility awareness, and incentivize screening; include covered under ACA (\$0 for initial scan)
- Incentivize screening for and documenting tobacco history (HEDIS measure)
- Track and monitor and annual adherence for those engaged in screening
- Discourage payor-initiated changes (steerage) in screening facility
- Ensure CTs for other concerns/conditions are not counted towards member's annual screening benefit

Employer Purchasers

- Assess population risk level for lung cancer (e.g., age, smoking)
- Incorporate screening into employee-facing health promotion; emphasize early detection saves lives
- Collect deidentified data to understand percent of employees potentially eligible for screening
- Account for screening in leave policy (allow for time off to get screened at accredited facility)

All patient/member/employee-facing communication should use person-first language
(e.g., people who smoke instead of smokers)

Roles and Responsibilities



Department of Health

- Encourage regular required CE for health professionals to reduce stigma and bias and improve health outcomes for people living with stigmatized conditions (*e.g., substance use disorders including smoking, psych/mental health conditions*)
- Integrate public-facing information/announcements about benefits of LCS (*early screening saves lives*) into health promotion activities and materials for tobacco prevention and cessation
- Identify lung cancer screening as a priority focus for CHWs and primary care teams (*e.g., proactively identify and refer eligible individuals*)
- As able, develop and host Lung Cancer Screening Task Force

Health Care Authority

- Review and approve shared decision-making aids for LCS
- Require MCOs to report on performance of tobacco cessation HEDIS measure; As able, require MCOs to report on lung cancer screening measures, stratified by race/ethnicity at a minimum.
- Consider use of effective strategies to incent screening for other cancers (*e.g., colorectal, cervical, breast*) and investigate if they could be applied to lung cancer screening.
- Encourage MCOs to establish automatic authorization/remove prior authorization for ACR guideline-concordant follow-up scans (*e.g., 3-, 6-month scans*)

All public/patient/member/employee-facing communication should use person-first language (*e.g., people who smoke instead of smokers*)

Measuring Screening and Impact



At minimum, organizations should monitor the following domains:

- **Eligibility Identification**

- *Purpose: Identify individuals who may benefit from lung cancer screening.*
- Percentage of individuals age 50–80 meeting USPSTF eligibility criteria

- **Screening Completion and Adherence**

- *Purpose: Ensure eligible individuals both initiate and continue annual LDCT screening.*
- Percentage of eligible individuals who complete an initial LDCT screening (of all eligible individuals not yet screened)
- Percentage of previously screened individuals who return for annual LDCT screening (of all previously screened individuals due for annual LDCT)

- **Tobacco Screening and Cessation**

- *Purpose: Reduce future lung cancer risk among populations at high risk*
- Tobacco screening rate
- Tobacco cessation intervention rate
- Percentage of screening-eligible people who formerly smoked

- **Follow-Up and Results Management**

- *Purpose: Ensure patients receive the full benefit of screening.*
- Follow-up completion rate after abnormal findings
- Time from abnormal result to diagnostic evaluation
- Lost-to-follow-up rate

- **Impact**

- *Purpose: Track improvement in lung cancer outcomes.*
- Percentage of cancers diagnosed at Stage I/II vs. Stage III/IV
- Reduction in disparities across population

Lung Cancer Screening Implementation Roadmap

Intermediate Steps

Organizations prioritize de-stigmatizing lung cancer and smoking, train clinicians to identify and refer those eligible for screening, and establish systems to support adherence to annual LDCT and appropriate results management

Current State

People who smoke may feel they “deserve” lung cancer; clinicians may unintentionally stigmatize or avoid discussing screening and offering smoking cessation support. People with early-stage lung cancer miss opportunities to engage in screening and go undetected, leading to worse outcomes and higher cost.

Future State

People eligible for lung cancer screening are reliably identified in clinical encounters, routed to opportunities to engage in shared decision-making, asked about and offered tobacco cessation support as appropriate, and supported through the continuum from initial engagement to potential diagnosis



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Questions

Next Up: Vote to approve for public comment

Public Comment Approval



- Appointed Bree Collaborative members only



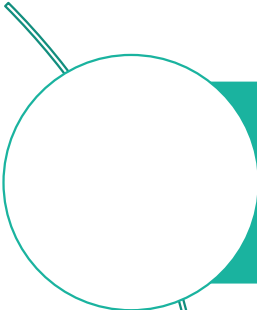
2027 Topic Selection



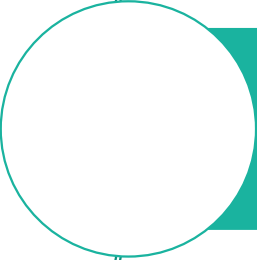
The Process



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

The Hidden Undernutrition Crisis in Surgical Patients

Preoperative Nutritional Risk & GLP-1-Associated Sarcopenic Malnutrition

Nick Kassebaum, MD, SCOAP

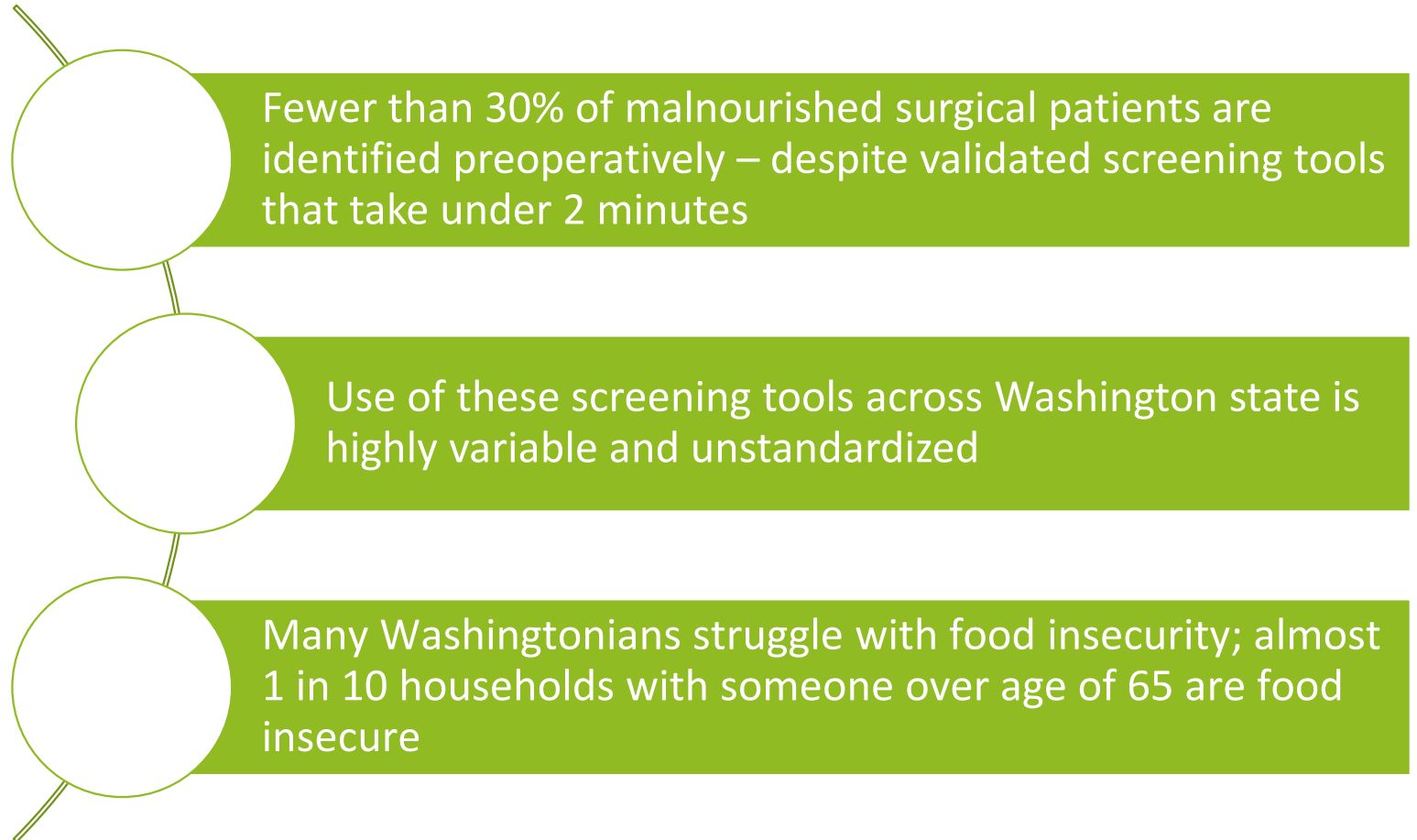


Baseline: High Malnutrition in Surgical Patients



20-50% of surgical patients suffer from preoperative malnutrition, independently predicting:

-  SSI
- Delayed wound healing
-  30-day mortality



Against the already high baseline rates of malnutrition, we have a new population of people at high risk of malnutrition:

GLP-1 associated sarcopenia

GLP-1 use in those without diabetes increased **700%** in past four years

GLP-1 RAs may cause lean muscle loss as high as **15-40%**

Sarcopenia is associated with poor surgical outcomes, including increased length of stay and mortality

Emerging evidence suggests GLP-1 use associated with poorer surgical outcomes

BMI alone cannot reliably detect sarcopenia in those with obesity – current screening is outdated

- Mahase E. (2024). GLP-1 agonists: US sees 700% increase over four years in number of patients without diabetes starting treatment. *BMJ (Clinical research ed.)*, 386, q1645. <https://doi.org/10.1136/bmj.q1645>
- Rossi, G., Bucciarelli, L., Mananguite, CL. et al. Muscle loss and GLP-1R agonists use. *Acta Diabetol* 63, 333–342 (2026). <https://doi.org/10.1007/s00592-025-02611-2>
- Knoedler, S., Schliermann, R., Knoedler, L., Wu, M., Hansen, F. J., Matar, D. Y., Obed, D., Vervoort, D., Haug, V., Hundeshagen, G., Paik, A., Kauke-Navarro, M., Kneser, U., Pomahac, B., Orgill, D. P., & Panayi, A. C. (2023). Impact of sarcopenia on outcomes in surgical patients: a systematic review and meta-analysis. *International journal of surgery (London, England)*, 109(12), 4238–4262. <https://doi.org/10.1097/JIS9.0000000000000688>
- Lewis JE, et al. "Semaglutide and Postoperative Outcomes Following Body Contouring Surgery." *Aesthetic Surgery Journal*, 2025. Available at: <https://doi.org/10.1093/asj/sjae241>

Evidence-Based Strategies



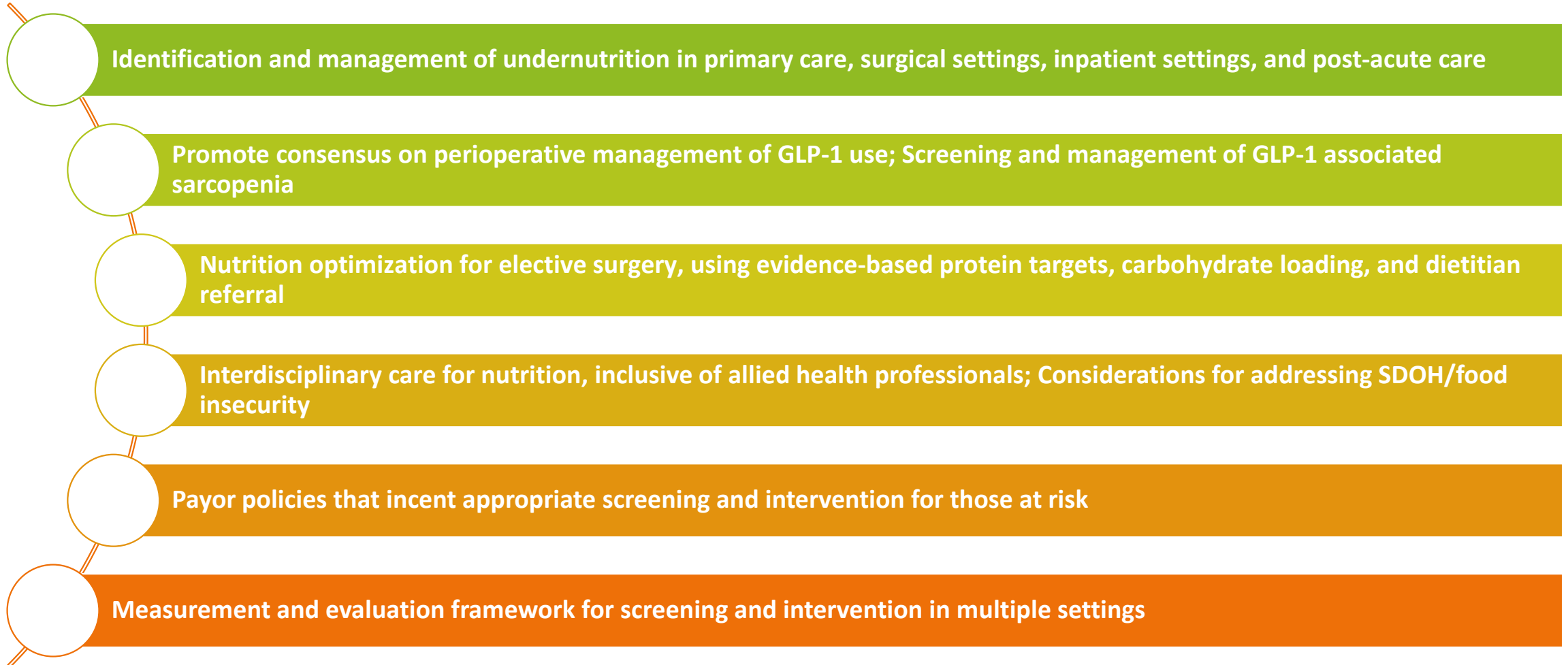
Low-cost interventions can deliver high returns for patients, clinicians, and the system

Short-term oral protein supplementation (1.2–1.5 g/kg/day for 7–14 days pre-surgery) and carbohydrate loading have demonstrated measurable positive impacts on postoperative outcomes.

Dietitian referral pathways and EHR-embedded screening tools are already in place at most Washington health systems.

Oral nutrition intervention is extremely low cost – estimate under \$100 per patient for 2 weeks

Proposed Scope



The Window to Act is Narrow and Closing



6 months

GLP-1 surgical volume accelerates. Without guidance, day-of-surgery cancellations (aspiration risk) and unrecognized sarcopenia drive rising SSI rates.

3 years

Long-term GLP-1-induced lean mass loss manifests as postoperative frailty and functional decline in the aging surgical population

12 months

Health systems absorb the financial impact of increased readmissions and prolonged length of stay (LOS) in the GLP-1 population.

10 years

Nutritional optimization becomes integral to precision medicine. Systems building infrastructure now will lead; others will trail in quality and equity.

Bree's Unique Impact



- **Build consensus around practical, evidence-based approaches to identifying and managing undernutrition and perioperative risk across health care settings**, with special attention to emerging risk of GLP-1 associated sarcopenia
- **Align quality measures and incentives** around early and consistent identification and intervention
- **Reduce avoidable surgical complications and hospitalizations** and support healthier aging for Washingtonians



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Questions

Next Up: Anal Cancer Screening

Anal Cancer Screening

Colin Fields, MD, Kaiser Permanente



Overview of Topic



Anal cancer is an equity issue, disproportionately impacting:

People living with
HIV

Men who have sex
with men

Transgender
women

Solid organ
transplant
recipients

Individuals with a
history of vulvar
pre-cancer or
cancer

Most anal cancers are caused by HPV
and are preceded by **high grade
squamous intraepithelial lesion (HSIL)**.
Treatment of HSIL reduces progression
to anal cancer by

57%

- Care is mainly localized in urban areas; no standardized structure across health systems
- New guidelines recommend targeted screening for higher-risk populations; USPSTF is **NOT** reviewing anal cancer screening
- Lack of screening means increased risk of cancer; delays in access to HRA means potential for more advanced disease, need for chemoradiation/surgical interventions, and higher cost to patient/systems

Historical Context



In the 1960s: as cervical cancer screening became standard of care, the rate of cervical cancer was $\sim 40/100,000$ person years

State/National Policies



Corresponds with WSMA & AMA Policy

WSMA Policy: Health Care: Expanding Access to High Resolution Anoscopy

The WSMA advocate for the development of further access to high resolution anoscopy in Washington state. (Res C-3, A-25)

“The WSMA advocate for the development of further access to high resolution anoscopy in Washington state.”



This Bree topic is endorsed by WSMA.

Cancer

Expanding Access to High Resolution Anoscopy H-55.962

Topic: Cancer

Meeting Type: Annual

Action: NA

Council & Committees: NA

Policy Subtopic: NA

Year Last Modified: 2026

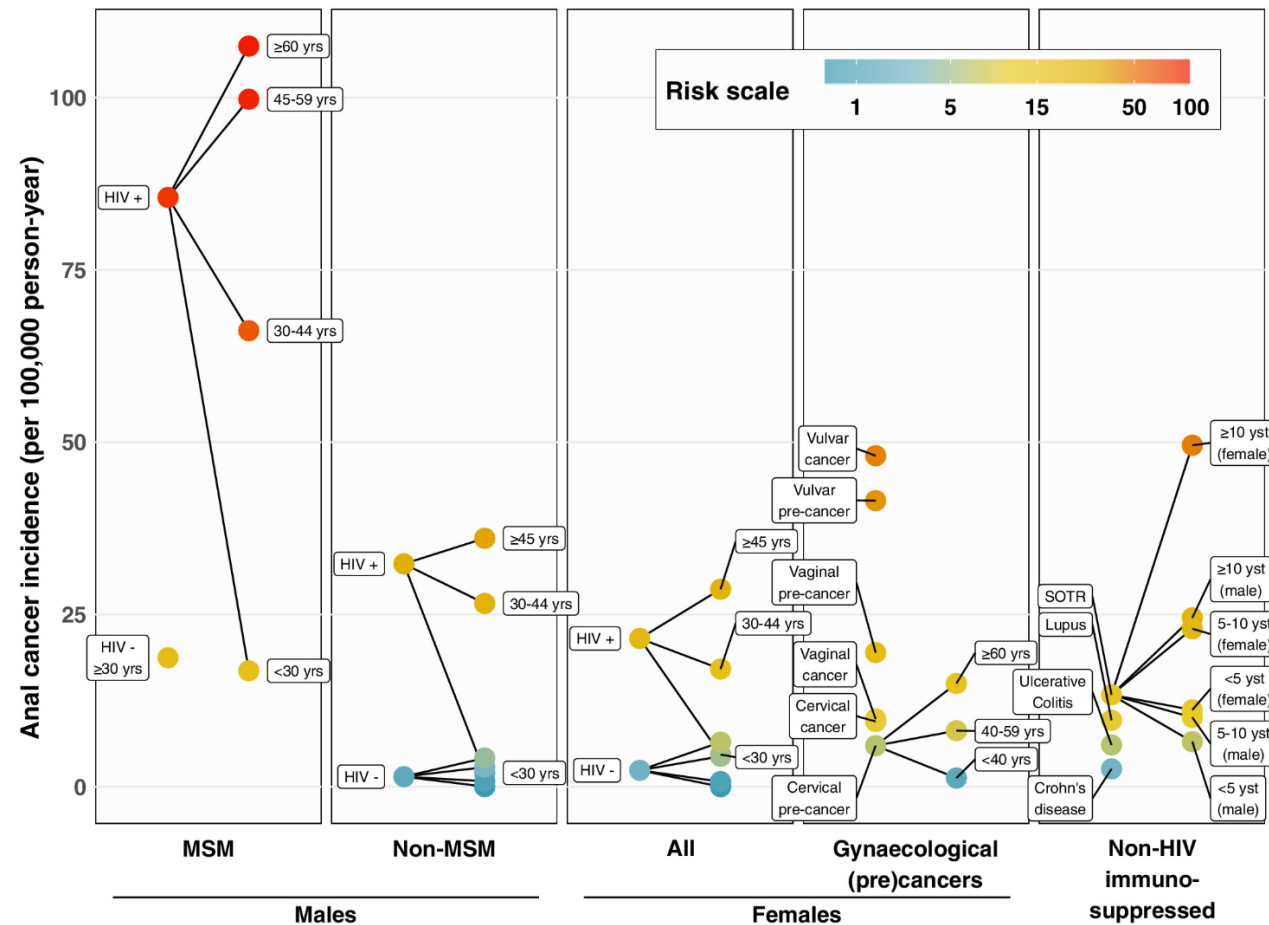
Type: Health Policies



1. Our American Medical Association will collaborate with relevant national medical specialty societies to promote development and dissemination of evidence-based and practical guidance, referral pathways, and implementation strategies to integrate **anal** cancer screening and HRA access into routine care for high-risk populations.
2. Our AMA encourages and promotes educational resources, training opportunities, and competency guidance related to high-resolution anoscopy developed by relevant medical specialty societies and other expert organizations in order to support expansion of patient access and an appropriately trained workforce.
3. Our AMA will advocate at the federal and state levels for policies that expand equitable access to high-resolution anoscopy (HRA) for high-risk populations, including ensuring adequate reimbursement, reducing geographic disparities, and supporting workforce development.
4. Our AMA encourages federal agencies, including the Health Resources and Services Administration (HRSA) and Centers for Medicare and Medicaid Services (CMS), to support funding mechanisms and demonstration programs that expand HRA capacity in HIV care settings, federally qualified health centers, and underserved communities.

Current Data: Risk groups

Anal cancer risk scale



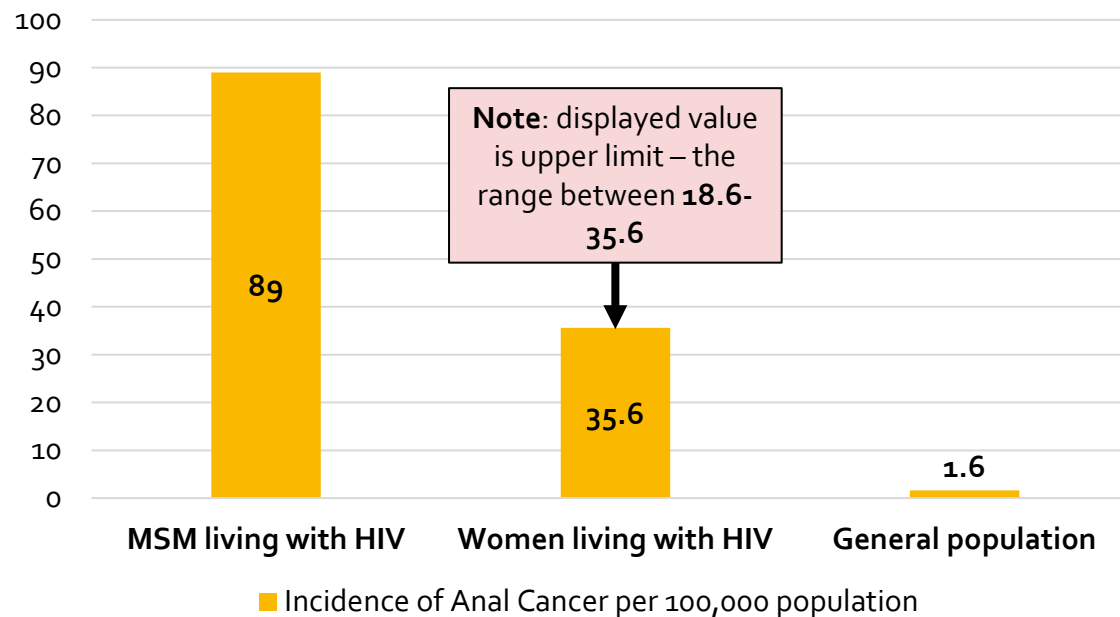
Clifford et al. Int. J. Cancer. 2020;1–11. <https://doi.org/10.1002/ijc.33185>

Current Data: PLWH



Although anal cancer is relatively rare in the general population, it is the **fourth most common cancer among people living with HIV**.

Incidence of Anal Cancer



- The incidence of anal cancer is estimated to be **89 per 100,000** among men living with HIV who have sex with men and **between 18.6 and 35.6 per 100,000** among women living with HIV.
- In comparison, the incidence of anal cancer in the general population is **1.6 per 100,000**.
- **In 2024, there were ~13,505 PLWH in WA state within the age groups where anal cancer screening should be discussed.**

• National Institutes of Health. *In people with HIV, treating precancerous anal lesions cuts risk of anal cancer by more than half*. Published June 15, 2022. Accessed September 14, 2026. <https://www.nih.gov/news-events/news-releases/people-hiv-treating-precancerous-anal-lesions-cuts-risk-anal-cancer-more-half>

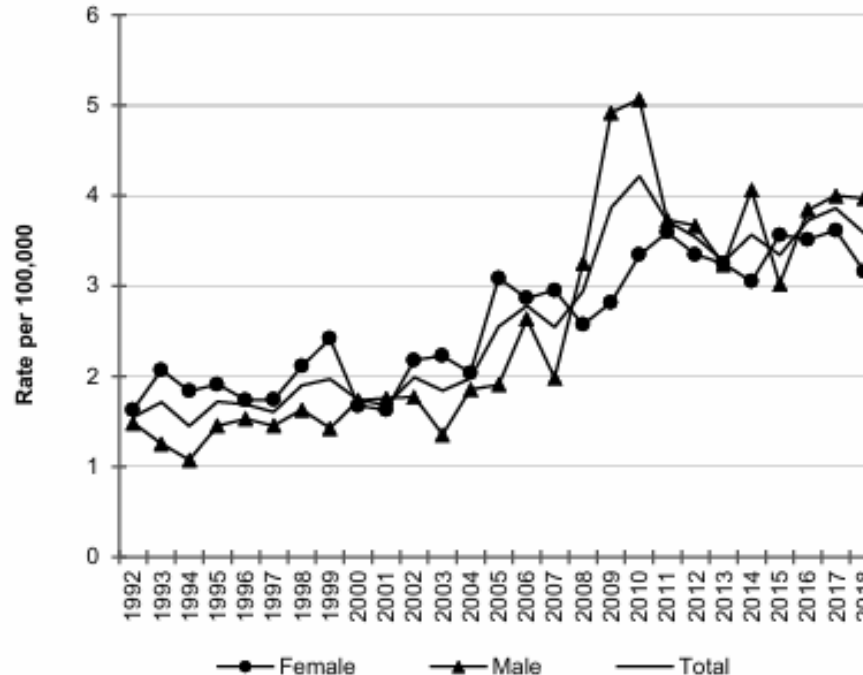
• Infectious Disease Assessment Unit, Washington State Department of Health. Washington State HIV Surveillance Report, 2025 Edition.

Current Data: Anus, Anal Cancer and Anorectum



Anus, Anal Cancer and Anorectum

Washington State Residents by Gender
Incidence Rate Trends
Age-adjusted to 2000 US standard population



For anus, anal canal and anorectum age-adjusted incidence rates have changed as follows.

Both sexes combined: Rates remained level from 1992 to 2003; increased sharply by 11.6% per year from 2003 to 2010; remained level from 2010 to 2013; remained level since 2013.

Men: Rates remained level from 1992 to 2005; increased sharply by 24.3% per year from 2005 to 2009; remained level since 2009.

Women: Rates increased steadily by 3.1% per year from 1992 to 2018.

Current Data: Cancer rate/HIV prevalence by county

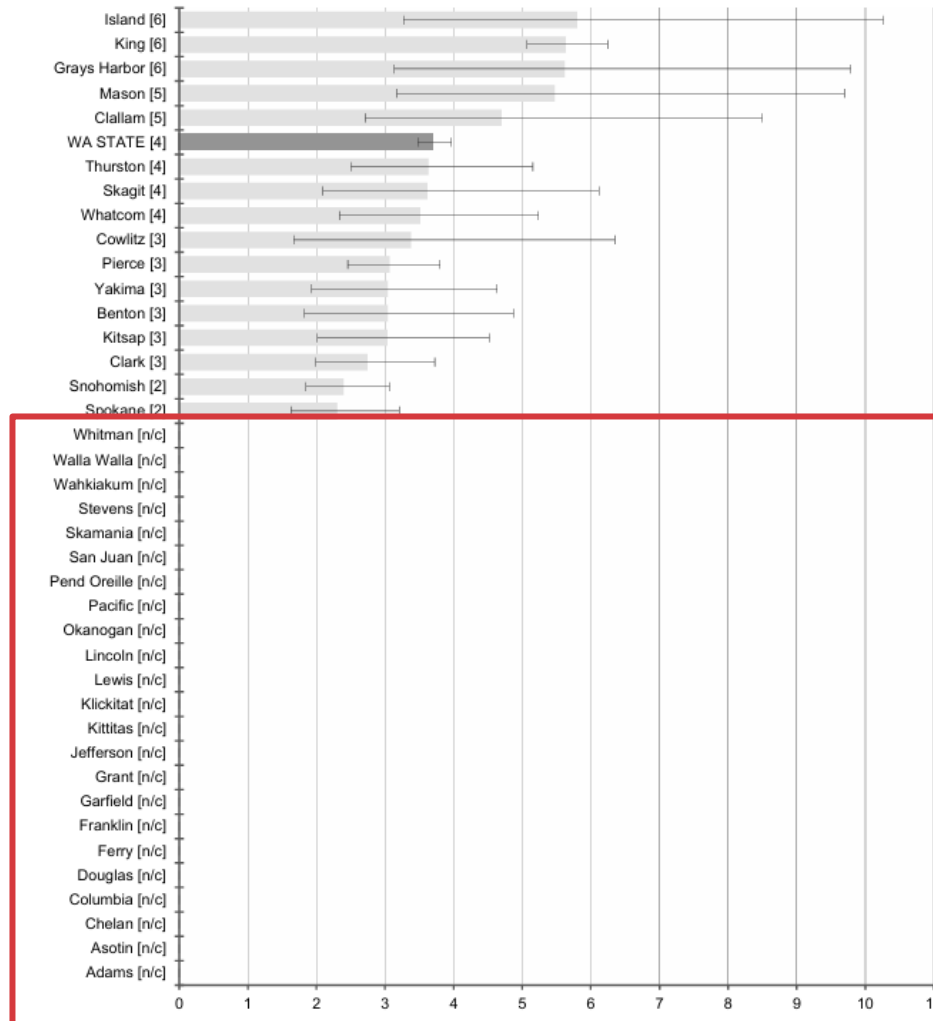


Anus, Anal Cancer and Anorectum

2016-2018 Washington State Residents

Average Annual Incidence Rates by County with rates in [] and 95% CI's

Age-adjusted to 2000 US standard population



Do we really think that these smaller counties have no incidence of anal cancer OR are we not looking for it?



Washington State Department of Health.
Cancer by Site, 2018. Washington State
Cancer Registry; 2022. Accessed September
14, 2026.
<https://fortress.wa.gov/doh/wscr/PDF/18Report/CancerBySite18.pdf>

Age-adjusted rate per 100,000
NOTE: Rates and confidence intervals are not calculated if there are fewer than 10 cases for the combined data from 2016-2018.

Evidence Based Strategies



- Identify high-risk individuals and document risk factors
- Annual symptom assessment and DARE when indicated
- Referral of abnormal results for HRA
- Develop workforce training for HRA capacity
- Standardize screening pathways and follow-up
- Align coverage for screening, biopsy and HSIL treatment
- Monitor disparities in access and outcomes

Proposed Scope



Scope: the Bree Collaborative can address knowledge and capacity gaps by

- Identifying a network of subject matter experts across WA state
- Reviewing International Anal Neoplasia Society (IANS) and other established anal cancer screening guidelines and identifying deficiencies that exist within WA state
- Promoting standardized screening pathways
- Developing workforce, coverage recommendations, and equitable access to prevention services
- HRA access & capacity building

Out of Scope

- HPV vaccination implementation outside screening guidelines
- Diagnosis and treatment of anal cancer
- Detailed management of symptomatic anal disease.

Proposed Scope By Audience



Clinicians

- Identify and assess high risk patients
- Document risk factors and symptoms
- Perform DARE and anal cytology
- Refer abnormal results for HRA
- Provide patient/clinician education and support retention

Delivery Systems

- Implement clinical pathways
- Train clinicians in HRA
- Ensure timely follow-up and treatment of HSIL
- Use patient navigation and recall systems for monitoring

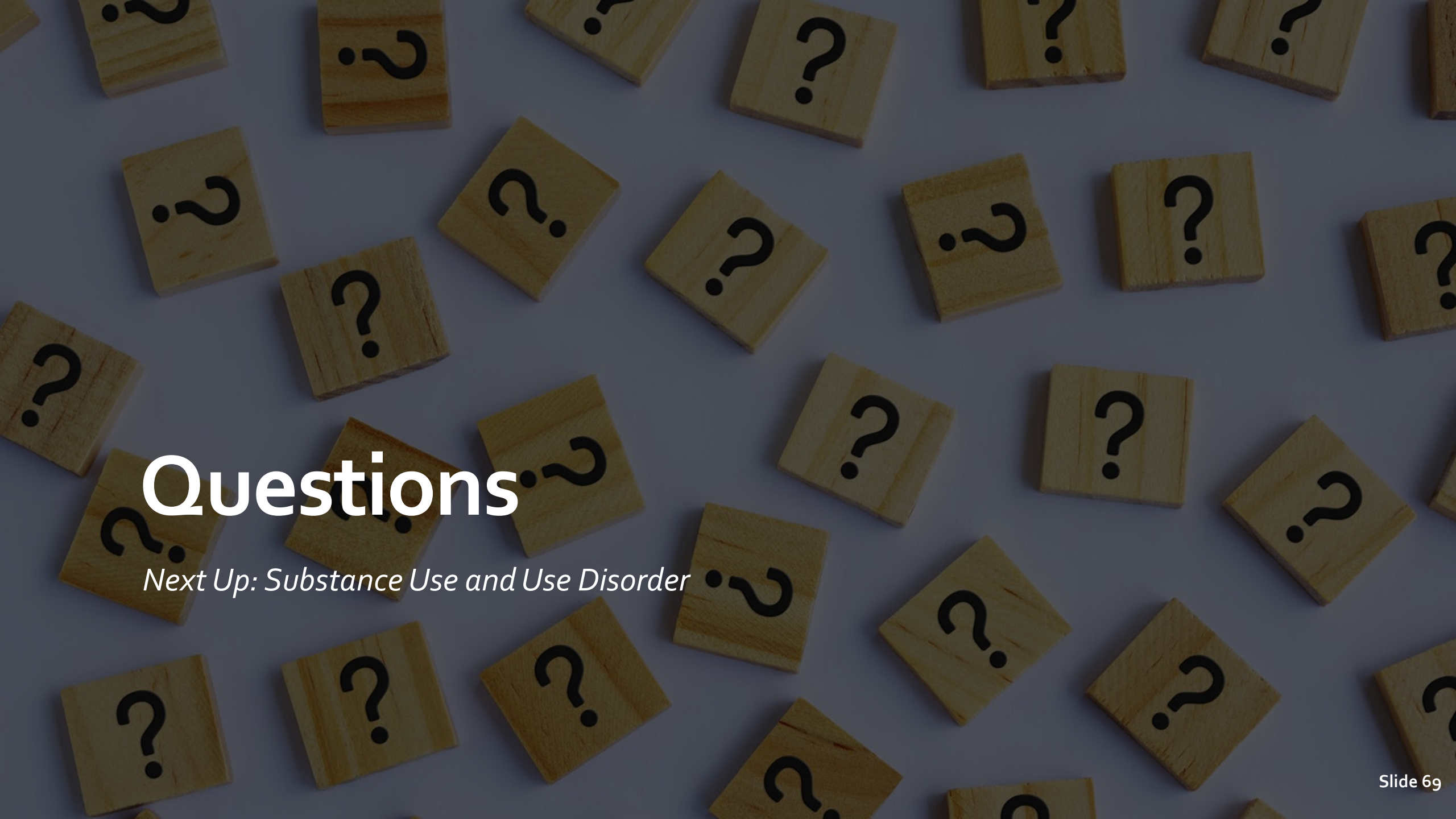
Plans & Purchasers

- Align benefits structures
- Ensure network adequacy for HRA
- Monitor access
- Innovate access in rural areas
- Remove financial barriers

Bree's Unique Impact



- Fill a knowledge and capacity gap in guideline-aligned care for those at higher risk for anal cancer
- Promote standardized screening pathways, identification of eligible individuals, and standards for timely follow-up of abnormal screening results
- Identify and address coverage and workforce barriers to access
- **Champion equitable access to cancer prevention** in populations that experience compounding health inequities.

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Questions

Next Up: Substance Use and Use Disorder

Substance Use & Use Disorder

A paradigm shift to health, safety, quality, and cost approaches



Overview of Topic

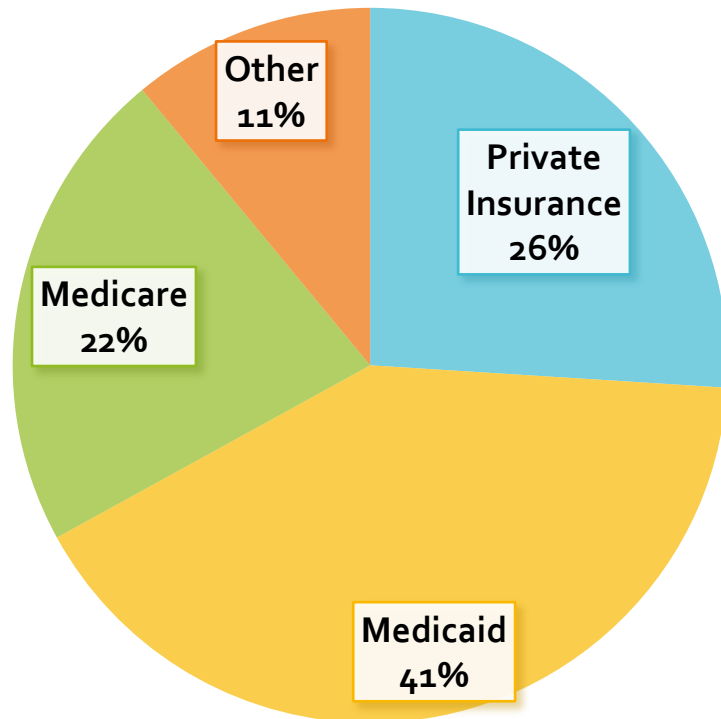


- **Substance use, impacts >>50% of adults, & substance use disorder (SUD), >16% of adults, both associated with significant morbidity, mortality, & \$\$\$.**
- Person-centered and evidence-based approaches for engagement, health care, and use disorder treatment exist; **availability is highly variable** based on the type & legality of substance, care settings, & provider types.
- **Broad proper guidance for clinicians, health systems plans, and interest holders would improve care and outcomes,** reducing cost as well as stigma while increasing care engagement
- **The previous Bree Report on Addiction & Dependence (2014) needs to be updated and broadened to substance use** to encompass a broader array of the current and changing use patterns impacting health

Costs from 2023



Who Pays for BH Admissions?



For Commercial Payers

- 5% of admits for SUD
- Mean cost/payment \$15,500
- 74% of admissions are alcohol related, 14% opioid
- Residential SUD admissions average \$21,900/admission

Paradigm shift, moving upstream



- Motivations are the questions...
- Ongoing engagement is the tool...
- Improving health and safety is the goal...

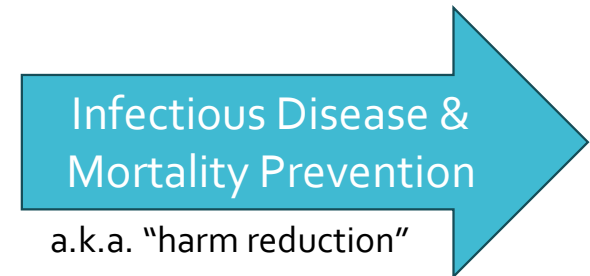
ADDICTION
FRAMING



Primary prevention



Secondary prevention



Tertiary prevention

PUBLIC
HEALTH
FRAMING

Substance Use Occurs along a spectrum

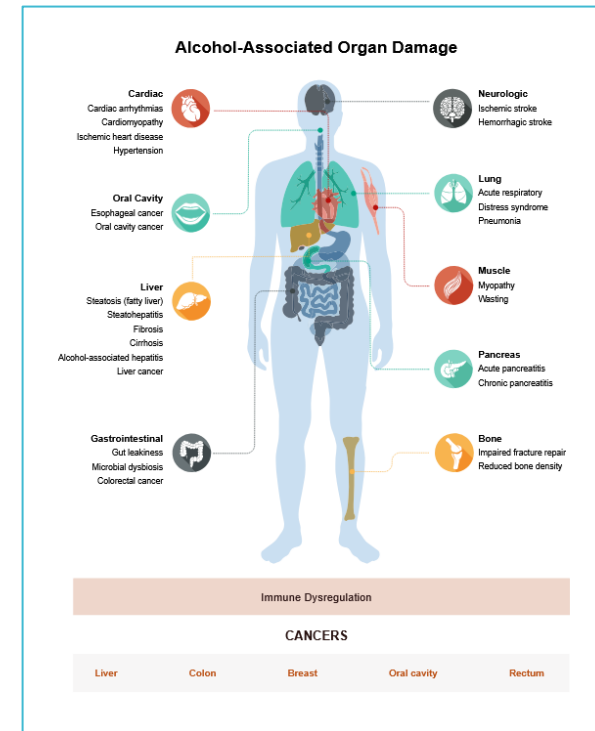


- Currently substance use is treated in a mostly binary fashion-
non-harmful and harmful.
 - Diagnose and treatment (referral) if SUD, otherwise no response.
- Motivations and reasons for use are rarely explored.
- Most people with problematic use **do** want to stop/reduce their use
- Paradigm shift from +/- SUD to a pre-diabetes type model is needed.

Alcohol as an example



- **Sleep, pain, and mood concerns are common**
 - Alcohol and other substance use are common self-management and/or causes
- **Current screening focused on diagnosis of AUD**
- Use reduction is a worthy goal and conversation whether a person has use disorder or not. **Research shows significant improvements in a multiple health domains with reducing alcohol use.**



JAMA Psychiatry

Home Issues Multimedia For Authors

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Review

Reductions in World Health Organization Risk Drinking Levels as a Primary Efficacy End Point for Alcohol Clinical Trials
A Review

Katie Witkiewitz, PhD^{1,2}; Raymond F. Anton, MD³; Stephanie S. O'Malley, PhD⁴; et al.

Cite Permissions Metrics Comments

JAMA Psychiatry
Published Online: September 17, 2025
doi: 10.1001/jamapsychiatry.2025.2508

Significant improvements with reductions in WHO RDLs

Biomarkers (n=5 of 5 studies)

Neural function (n=3 of 3 studies)

Alcohol-related consequences (n=6 of 7 studies)

AUD symptoms/diagnosis (n=3 of 3 studies)

Psychiatric symptoms/diagnosis (n=5 of 7 studies)

Functioning and quality of life (n=12 of 13 studies)

- Health care costs
- Sleep
- Craving
- Mortality
- Motivation to change

This article provides a narrative review of 34 articles that have examined WHO RDLs as a surrogate marker of how people with AUD feel and function.

Both substance use disorder and diabetes are chronic *health* conditions – they are treated very differently



Domain	Type 2 Diabetes	Substance Use Disorder
Burden	29 M people over 18 years w/diagnosis 115 M have pre-DM	49 M (>12 years old) 71 M heavy or binge alcohol use in last month AND ~70M w/ illicit drug use
Lead time for health risks to present	10-20 years	Shorter esp. after opioid OD, risk of death highest in 1 st few days
Getting care	92% had their BP, cholesterol, and A1c checked w/in the last yr	10-20% received any treatment in the last year
Spend on treatment	~ \$307 B in 2022	~ \$13.1B 2021
Care models	System and community wide	Specialty care and some primary care
Approach to compliance	- Keep at it - Expend more resources	Inability to comply is a diagnostic criteria - Frustration, abandonment - Referral to non-EB treatment

Proposed Scope



Within Scope

- Substance use and use disorder (SU(D)) involving alcohol, cannabis, pharmaceuticals, Kratom/7-OH, and illicit drugs such as methamphetamine and non-Rx fentanyl.
- Consensus of best practices for patient, family member, care team, and provider education, identification, engagement strategies, health supports/safety planning/harm reduction, and evidence-based treatment.
- Identification and implementation of quality measures and employer policies that are supportive in addressing SU(D).

Out of Scope

- Tobacco
- Process addictions e.g. gambling, sex, internet

Current Data Sources and Examples

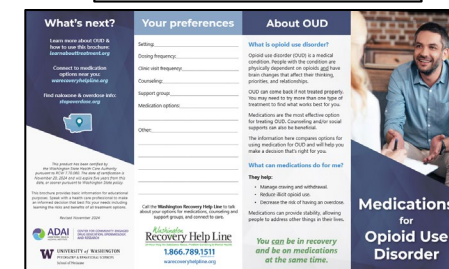
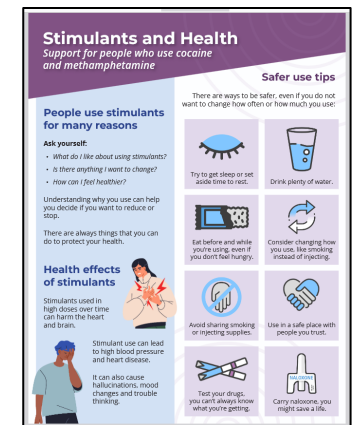
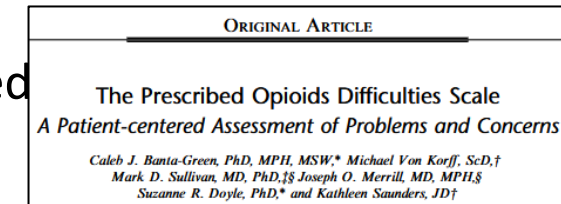


- Substance use and use disorder rates, Rates of treatment receipt, + new questions (Survey- BRFSS)
- Morbidity and mortality related to substance use (poisoning/OD and all cause) (Utilization-DOH vital stats, WEMSYS, HCA/Medicaid, State BH Data, All payors claims database)
- Substance related health and SUD treatment care utilization (HCA/Medicaid, State BH Data, All payors claims database)
- Needed healthcare and not obtained it for people using illicit substances (Survey- WA State Syringe Services Program UW ADAI)

Evidence Based Strategies



- Clinicians/Care Teams: Appropriate screening based on substances used & symptoms; client self-identification of benefits, problems and concerns; SUD diagnoses and shared decision making about health, safety, and treatment options
- Shared decision making/Motivational Enhancement: (e.g., Meds for OUD State Certified PDA,
- Delivery Systems: Workforce Training and structured wraparound care approaches
- Payors: Coverage of engagement/monitoring of SU, services inclusive of multidisciplinary care team members (e.g., nurses, peer/care navigators); benefit redesign to incent accessible care and engagement of sub-acute patients



Partners & Opportunities



Department of Health, Health Care Authority, UW SOM/ADAI, WSU Medicine, patient advocacy organizations, MCO's, WSHA, WA Liquor and Cannabis Board, Washington Health Alliance, WA Society of Addiction Medicine...

Local initiatives this leverages:

- **Substance Use Recovery Services Advisory Committee** sunsets this year, recommended holistic, integrative, lower barrier approach to care, law enforcement diversion, recovery navigation
- **State Opioid Response** clinical funding from HCA/SAMHA and implementation support UW/ADAI
- **American Society of Addiction Medicine** Criteria 4th Edition takes effect January 2028 ASAM New Dimension → Person-Centered Considerations, which integrates social determinants of health, patient preferences, and motivational enhancement into treatment planning
- **WA Treatment & Policy Research Workgroup** (UW ADAI and WSU Medicine) Health care payors, State agencies, Policy makers, Providers, Researchers
- **WA Liquor and Cannabis Board** Goal #1 “highest level of public health and public safety”

Impact of Bree Collaborative Report



1. Standardized care pathways to support care teams

- Providing tools to help understand a person's use
- Give tools to providers to have a productive conversation about substance use
- Leverage existing supports and resources for patients who need treatment

2. Policy recommendations

- Care pathways that are tied to reimbursement and payment
- Standardize measurement for substance use care
- Care pathways for engagement around substance use
- Support and champion efforts to build primary care in terms of time and payment reform

Appendix



Questions

Next Up: PMOS

Polyendocrine Metabolic Ovarian Syndrome (PMOS)

Emily Transue, MD, MHA



Overview



- **Polyendocrine Metabolic Ovarian Syndrome (PMOS) is the most common endocrine disorder affecting women, with approximately 1 in 10 reproductive-age women globally experiencing the condition**
- Black women and those covered with Medicaid have been found to be less likely to receive a diagnosis, and features of PMOS vary between racial and ethnic groups
- PMOS is associated with higher risk of cardiovascular disease, stroke, diabetes, hypertension, anxiety and depression, adverse outcomes in pregnancy, and small increase in absolute risk for premenopausal endometrial cancer
- Recent expert consensus (2026) changed the name from PCOS to PMOS to reflect the constellation of signs and symptoms associated with PMOS, beyond ovarian symptoms

- Neven, A. C. H., Forslund, M., Ranasinha, S., Sethi, P., Dhungana, R. R., Mousa, A., Tay, C. T., Teede, H., & Boyle, J. A. (2026). Prevalence of polycystic ovary syndrome: a global and regional systematic review and meta-analysis. *Human reproduction update*, 32(3), 277–312. <https://doi.org/10.1093/humupd/dmaf030>
- Iris Lee, Julia Vresilovic, Maryam Irfan, Robert Gallop, Anuja Dokras, Higher Incidence of Metabolic Syndrome in Black Women With Polycystic Ovary Syndrome: A Longitudinal Study, *The Journal of Clinical Endocrinology & Metabolism*, Volume 107, Issue 4, April 2022, Pages e1558–e1567, <https://doi.org/10.1210/clinem/dgab840>
- Teede, H. J., Tay, C. T., Laven, J. J. E., Dokras, A., Moran, L. J., Piltonen, T. T., et al. (2023). Recommendations from the 2023 International Evidence-based Guideline for the Assessment and Management of Polyendocrine Metabolic Ovarian Syndrome. *Fertility and Sterility*, 120(6), 1147–1165. <https://doi.org/10.1016/j.fertnstert.2023.08.011>
- Teede, H. J., Tay, C. T., Laven, J., Dokras, A., Moran, L. J., Piltonen, T. T., Costello, M. F., Boivin, J., Redman, L. M., Boyle, J. A., Norman, R. J., Mousa, A., Joham, A. E., & International PCOS Network (2023). Recommendations from the 2023 International Evidence-based Guideline for the Assessment and Management of Polycystic Ovary Syndrome†. *Human reproduction (Oxford, England)*, 38(9), 1655–1679. <https://doi.org/10.1093/humrep/dead156>
- Tay, C. T., Mousa, A., Vyas, A., Pattuwage, L., Tehrani, F. R., & Teede, H. (2024). 2023 International Evidence-Based Polycystic Ovary Syndrome Guideline Update: Insights From a Systematic Review and Meta-Analysis on Elevated Clinical Cardiovascular Disease in Polycystic Ovary Syndrome. *Journal of the American Heart Association*, 13(16), e033572. <https://doi.org/10.1161/JAHA.123.033572>

Current Data



Washington Kaiser Permanente cohort study found PMOS was underdiagnosed by about 50%; Hawaiian and Pacific Islander, American Indian/Alaska Native, and Hispanic groups were more likely to be diagnosed.

PMOS is a multisystem condition, associated with a range of other health conditions

- Higher odds of experiencing impaired glucose tolerance (OR 3.26; 95% CI 2.17-4.90) and type 2 diabetes (OR 2.87; 95% CI 1.44-5.72)
- Higher odds of cardiovascular disease (OR 1.68; 95% CI 1.26-2.23) and stroke (OR 1.71; 95% CI 1.2-2.44)
- Higher odds of experiencing moderate/severe depression (OR 4.18; 95% CI 2.68-6.52)

Economic costs are high to patients and the system: estimated \$4.3 billion annually in 2020 USD from pregnancy-related and long-term morbidities alone

Almost 50% of people with PMOS see ≥ 3 healthcare professionals before diagnosis

Evidence-based Strategies



2023 International Guidelines call for a coordinated, longitudinal approach to care for people living with PMOS, expanding beyond episodic reproductive care

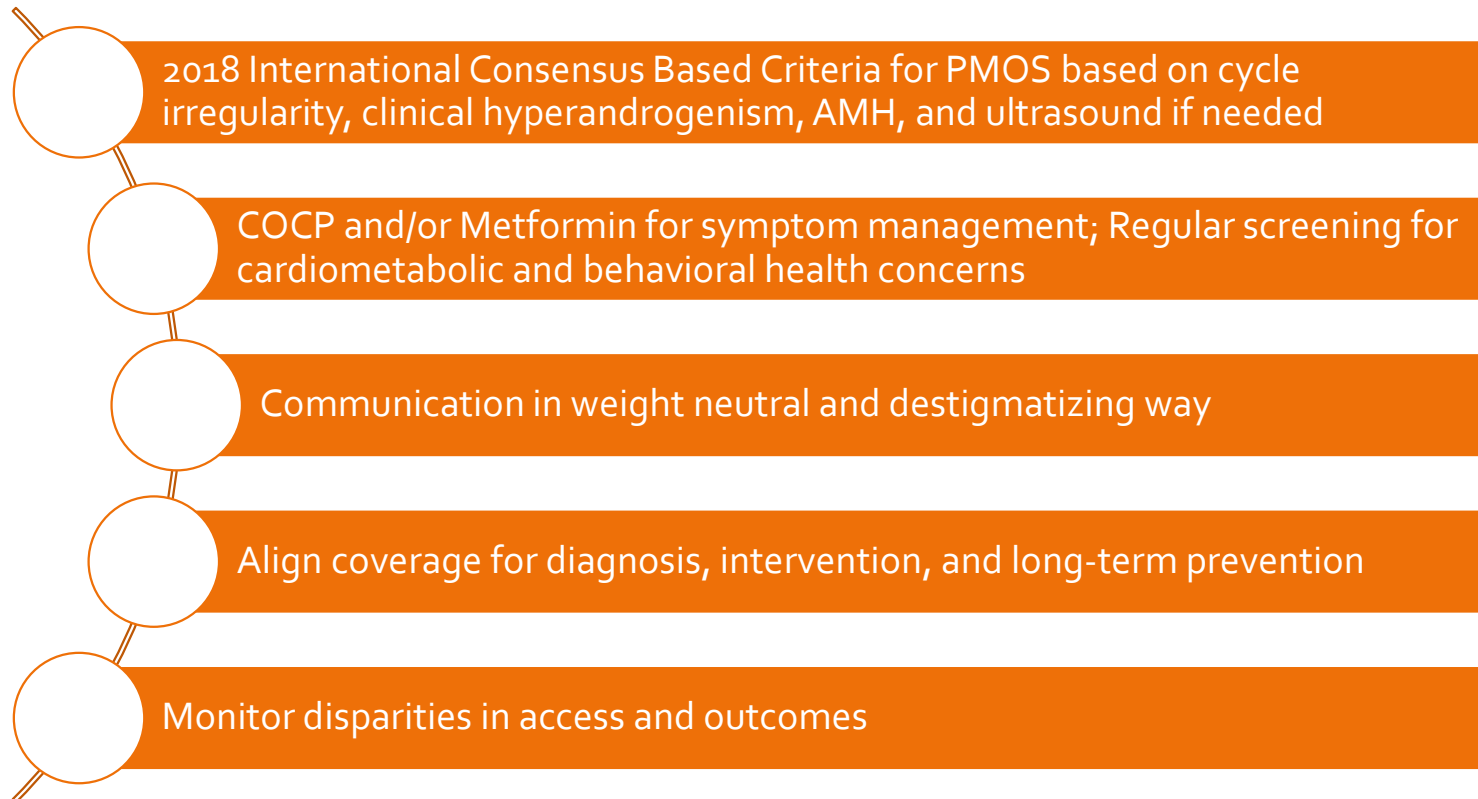
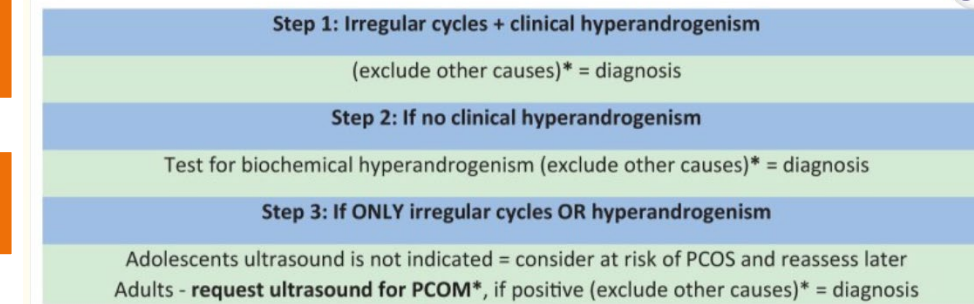


Figure 1.

Algorithm 1: Diagnostic algorithm for polycystic ovary syndrome (PCOS)



* Exclusion of other causes = TSH, prolactin, 17-OH progesterone, FSH or if clinically indicated exclude other causes (e.g. Cushing's Syndrome, adrenal tumours). For hypogonadotrophic hypogonadism, usually due to low body fat or intensive exercise, exclude clinically and with LH/ FSH. PCOM = polycystic ovarian morphology on ultrasound

Proposed Scope



In Scope

- Consensus best practices for education, recognition, and diagnosis across the lifespan, including appropriate use of diagnostic testing
- Individualized assessment and metabolic, reproductive, behavioral health, dermatologic and other symptoms
- Risk reduction and monitoring for long-term cardiometabolic and endometrial health
- Considerations for family planning
- Benefit design and workplace support for those experiencing symptoms related to PMOS
- Development of measurement framework for PMOS care

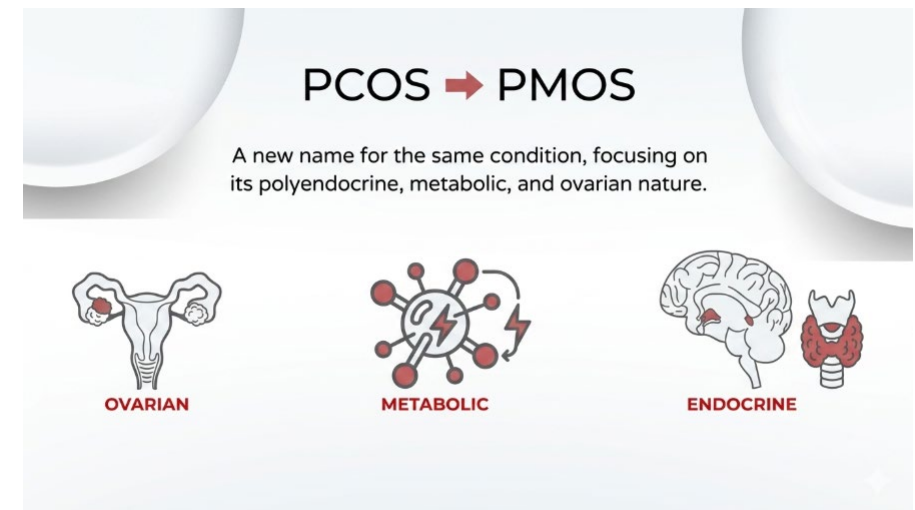
Out of Scope

- Detailed management of infertility
- Management of related chronic conditions
- Other endocrine/gynecologic conditions

Bree's Unique Impact



- Address a **knowledge gap and variation** in diagnosis, delayed diagnosis, and improved whole-person care
- Promote strategies to **reduce productivity loss** and **improved workplace supports**
- Align the healthcare ecosystem around **comprehensive care across the lifespan instead of episodic reproductive health care**
- Improved **prevention and care experience** for people living with a **very common metabolic-endocrine-reproductive condition**





Questions

Next Up: AI Governance

Health Care AI Governance

Darcy Jaffe, ARNP, WSHA



AI is not coming - it is already here. Adoption can outpace the safeguards needed to protect patients and safeguard trust in the healthcare system.

Variation: Different organizations apply different review, validation and monitoring practices.

Safety: Performance can fall when models are adopted but not validated for specific settings, workforce, or populations

Equity: Bias embedded within data sets translates to disparities in guidance and outcomes

Accountability: Opaque tools and unclear ownership weaken review, override and appeal.

Cost: potential for large cost savings, but require significant investment across the healthcare system

Gaps in Governance



Biased proxies lead to inequitable access to care

- Using an AI risk prediction model, Black patients were less likely than White patients to be recommended for a high-risk care management program.
- Remedying the disparity increased the percentage of Black patients receiving assistance from **17 -> 46.5%**

Lack of internal validation leads to safety and performance concerns

- In a cohort study of 27,697 patients, a widely integrated sepsis prediction model was found to only identify **7% of patients with sepsis who were missed by a clinician**
- The model also **missed 67% of patients with sepsis**, despite generating **alerts for 18% of all hospitalized patients**

Humans out of the loop leads to inappropriate care denials

- Prior authorization denials have grown sharply in recent years, from **5.6-5.8% in 2019** to **7.4% in 2022** coinciding with implementation of AI-driven automated processes
- Transparency on use of AI in care decisions, as well as how those decisions are made, is lacking

Current Landscape



Existing policies provide foundational principles and regulatory requirements, and taken together could define a common operational playbook for Washington's healthcare ecosystem

Washington

- Health Care Authority AI Ethics Framework: Public-sector principles for responsible use
- Washington's AI Task Force: Statewide recommendations and coordination for AI

Institutions/Systems

- Harvard AI in Medicine (AIM)
- Stanford FURM Framework

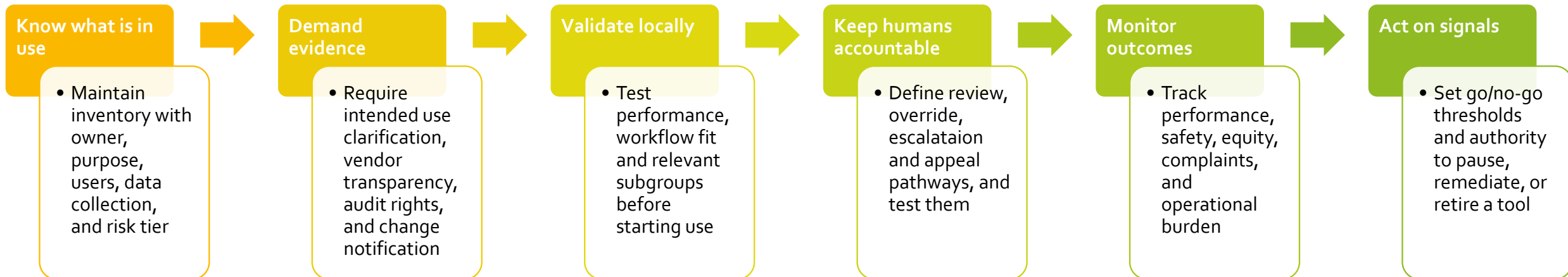
United States

- ASTP/ONC HTI-1: algorithmic transparency requirements for certified health IT
- FDA lifecycle: provides guidance on risk management across the total product lifecycle

International

- IMDRF Good Machine Learning Practices: international consensus best practices for machine learning through the lifecycle
- WHO Ethics and governance of artificial intelligence for health: ethics, human rights, and accountability principles

Strategies to safeguard AI



Proposed Scope



In Scope

- Consensus-based practices for AI inventory and accountability
- Procurement and vendor transparency recommendations
- Local and subgroup validation
- Human oversight recommendations, including override and appeal pathways
- Privacy and data stewardship guarantees
- Performance monitoring with go/no-go thresholds for deployment, including specific monitoring for impacts to health equity
- End user engagement in governance including front line staff, patients and community members
- Patient-clinician communication about personal and systems-level AI use in health

Out of Scope

- Governance for specific kinds of AI implementation,
- AI uses unrelated to patient care delivery (e.g., internal finances, operations, etc.)

Bree's Unique Impact



- Convene Washington clinicians, delivery system representatives, plans, purchasers, and state agencies to align expectations and priorities for AI governance in healthcare
- Synthesize and adapt local and national recommendations into a framework applicable across the healthcare ecosystem
- Develop a roadmap for governance framework implementation at the organizational level
- Promote safer, more transparent, and equitable AI use for Washingtonians

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Questions

Next Up: Community Paramedicine

Improving (Behavioral) Health Outcomes Through Community Medicine

Kim Hendrickson, BHCore at the University of Washington
Taryn Robinson, Kirkland Fire Mobile Integrated Health Program



Background: EMS= FRONTLINE OF HEALTH CARE ACCESS



- Approximately 450 licensed Emergency Medical Services (EMS) agencies/services in Washington-and more than 70% of Washington's operated by fire departments.
- **EMS is the door that is always open: providers addressing healthcare needs not addressed in other parts of the system.**
- Primary care unavailable → urgent care unavailable → 911 → EMS
- Discharged from hospital → no adequate follow-up → condition worsens → 911 → EMS

EMS= FRONTLINE OF HEALTH CARE ACCESS



EMS routinely responds to people experiencing:

- **Chronic illness**
- **Medication problems**
- **Psychiatric crises**
- **Suicidal ideation**
- **Intoxication**
- **Overdose**
- **Behavioral disturbances associated with cognitive decline**

Complex calls involving medical needs, behavioral health needs, and the social drivers of health.

Mobile Integrated Health (MIH)-Community Medicine



***Mobile Integrated Health** is a healthcare model that brings care to people where they live—often through EMS—while connecting medical, behavioral health, and social services to address needs before they become emergencies.*



International trend within EMS to expand community based care



Legacy 'Treat & Transport' model replaced by a model that treats non-emergency needs in place, addressing social and health factors



In WA: grass roots efforts among Fire Departments to reduce avoidable 911 and ED use



MIH, community medicine, co-response
=
different names, same objectives



What's new:
increasing focus on **behavioral health** and innovative responses

Current Data



- **Washington State estimates suggest that 40% of emergency department claims are primary care sensitive**
 - Approximately 18% of ED claims are behavioral health sensitive



- **Evidence-based practice supports integrated, multidisciplinary care models** that combine care coordination, patient education, and systematic follow-up to improve outcomes



MIH evidence-based practice includes:

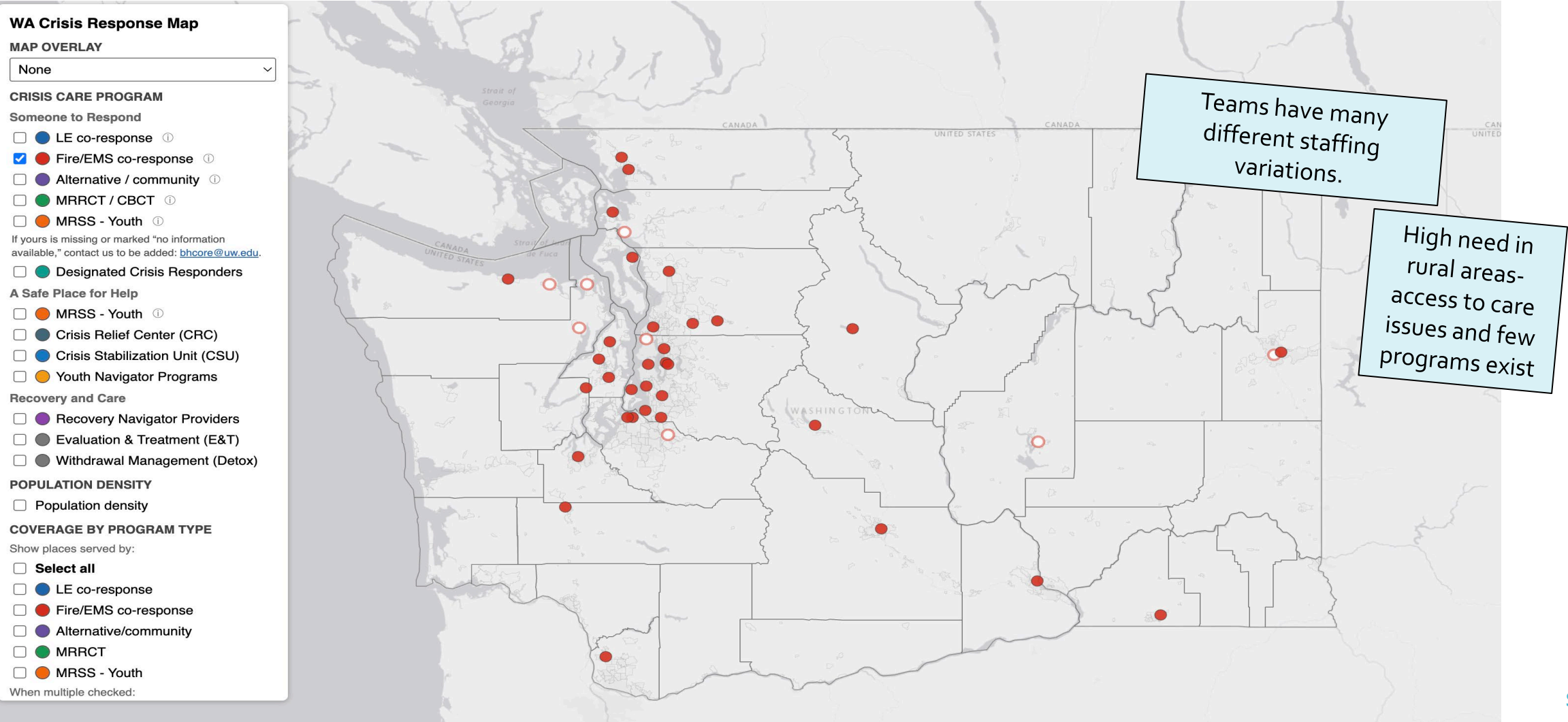
- Patient-Centered Medical Home (PCMH)
- Population Health Management
- Collaborative Care Models



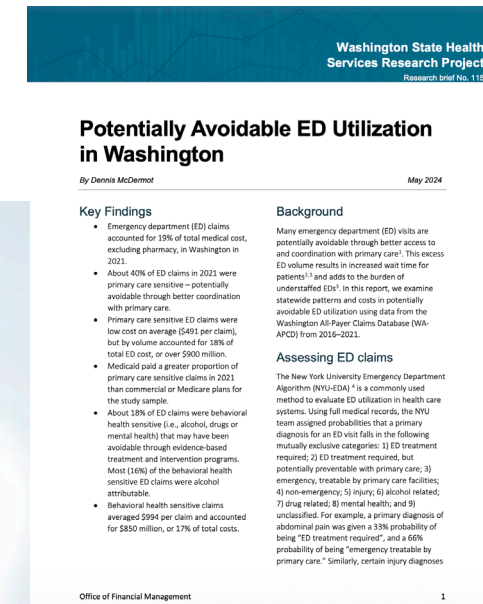
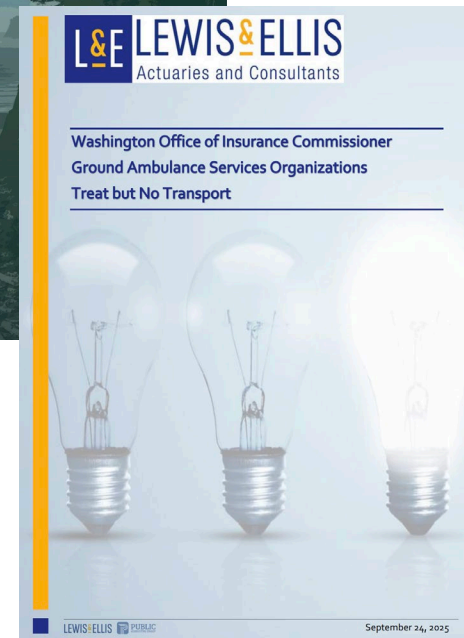
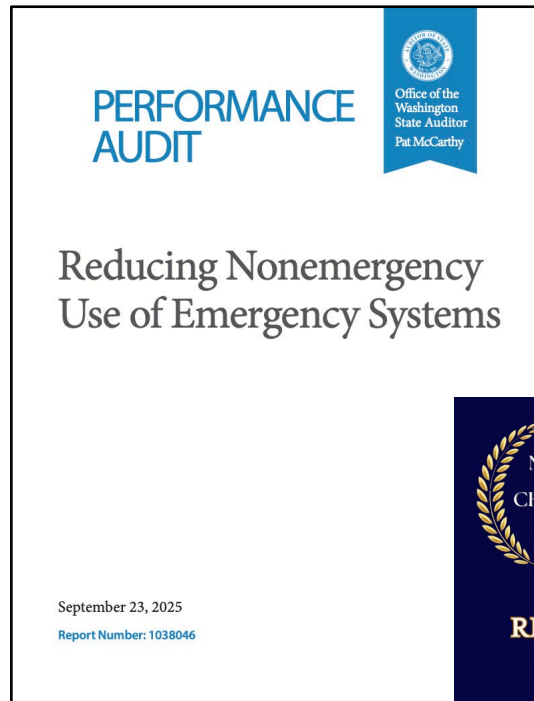
While incorporating:

- Principles of the Quadruple Aim
- Social Determinants of Health

MIH PROGRAMS IN WASHINGTON (2026)



Growing Interest in MIH – and Consensus to Support



PROBLEM = COMPENSATION/SUSTAINABILITY



EMS is a **mileage-based fee-for-transport-model**. Billing relates to **AMBULANCE** services.

The conflict:

- MIH programs are explicitly designed to do the opposite of traditional EMS by resolving calls on-scene, connecting patients to social services, or navigating to an alternative destination.

The impact:

- When an EMT or Paramedic spends several hours, over multiple weeks, providing in-home assessments, connections to social service supports, and transportation to alternative destinations, commercial and public plans typically pay \$0 because a transport to a hospital ED did not occur.

Reimbursement models have not caught up to operational realities and community needs, leaving Washington programs to rely on patchworks of alternative funding.

PROBLEM = UNCLEAR SKILLS AND STANDARDS



Local innovation has been a strength in MIH Development.

The bottom-up development of MIH has enabled communities to design programs around local needs.

But local variation has limits.

MIH lacks consistent standards for:

- **Workforce skills and competencies**
- **Scope of practice and services**
- **Program quality and outcomes**

Reimbursement should be tied to **minimum standards, measurable outcomes, and demonstrated value.**

Bree Collaborative Report



Possible Objectives:

- Create a statewide framework for MIH
- Recommendations to integrate MIH into medical and behavioral health systems
- Develop evidence-based standards for services, workforce, and outcomes
- Recommendations to build the community medicine workforce
- Inform training and competency standards
- Inform reimbursement and sustainability
- Establish measurable quality and outcome indicators
- Provide a framework for value-based reimbursement
- Give payers and policymakers evidence to inform coverage and payment decisions

From local innovation → statewide standards → sustainable reimbursement

Potential Partners



WORKFORCE & TRAINING

BHCore — University of Washington

Developing behavioral-health and (potentially) community-medicine training for EMS providers.

NATIONAL MIH EXPERTISE

National Association of Mobile Integrated Healthcare Providers (NAMIHP)

Brings national MIH/Community Medicine experience in education, best practices, research, standardization and policy.

REGULATION & REIMBURSEMENT

Washington State Office of the Insurance Commissioner

Provides the insurance-regulatory perspective needed to explore how MIH services could fit within Washington's healthcare financing system. The OIC is already represented in Bree Collaborative participation.

HEALTHCARE SYSTEM INTEGRATION

Greater Health Now

Connects MIH to healthcare-system transformation, regional partnerships and community-based care.

EMS & STATE STANDARDS

Washington Department of Health — EMS & Trauma Care Division

Brings statewide EMS regulatory, workforce and system expertise, including work focused on rural EMS sustainability, education and best practices.

RURAL HEALTH TRANSFORMATION

HCA + DOH Rural Health Transformation Program staff

An important opportunity to align MIH with Washington's current investment in community-based care, rural workforce development and behavioral health.

Bree Report Impact



- Clarify and align defined service categories to facilitate sustainable reimbursement for CP programs
- Identify minimum data and quality expectations as well as statewide evaluation plan to track implementation and demonstrate value
- **Support access to critical behavioral health care needs for rural Washingtonians and across the state**



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Questions

Next Up: Opportunistic Salpingectomy

Opportunistic Salpingectomy (OS)

Charles Drescher, MD
Providence-Swedish Cancer Institute
Paul G Allen Research Center



Overview of Topic



- **Ovarian cancer (OC) is the most lethal gynecologic malignancy**
75% of patients are diagnosed with advanced-stage disease, when 5-year survival is ~35%.
- Most OC are high-grade serous and originate in the fallopian tubes
- Opportunistic Salpingectomy (OS), or *surgical removal of the fallopian tubes*, is a practical prevention strategy
- OS is routinely recommended and offered during gynecologic procedures as standard of care
Associated with a 78% reduction in serous ovarian cancer risk*
- **Expanding OS to other abdominal or pelvic operations could increase access and save lives**
 - National and international guidelines are supportive
- An implementation roadmap for OS is needed for Washington State

In the news....



The New York Times

To Prevent Cancer, More Women Should Consider Removing Fallopian Tubes, Experts Say

A top research group is urging even women without genetic risks to have their fallopian tubes removed under certain circumstances.

A New Way to Prevent Ovarian Cancer Is Emerging. But It's Often Out of Reach.

— How do we turn opportunistic salpingectomy into something patients can actually choose?

by Diego Schaps, MD, MPH

September 18, 2026 · 4 min read [Add MedPage Today on Google](#)

ACS / AMERICAN COLLEGE OF SURGEONS

it...

One Surgery Could Prevent Most Ovarian Cancers, Surgeons Say

Expanding access to fallopian tube removal during planned abdominal surgeries in post-reproductive women could save thousands of lives every year

November 17, 2025

News Releases | Aug 20, 2026

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ACOG Strengthens Recommendations Supporting Salpingectomy for Ovarian Cancer Prevention

“...should support other surgical specialists in offering OS at the time of non-gynecologic surgery”

Ovarian Cancer Takes a Heavy Toll in Washington State



INCIDENCE*

9.5

per 100,000 females
95% CI: 9.1–9.9

2,189 new cases

National rank: 3rd quartile

MORTALITY*

6.4

per 100,000 females
95% CI: 6.1–6.7

1,637 deaths

National rank: TOP quartile

*Age-adjusted rates, females of all races and ethnicities. Incidence: 2019–2023; Mortality: 2020–2024. Source: CDC, U.S. Cancer Statistics. <https://www.cdc.gov/united-states-cancer-statistics/>

Current evidence supporting the effectiveness of OS



Salpingectomy prevents high-grade serous ovarian cancer in British Columbia.

British Columbia Population Study • 2008–2020 • N = 85,823

85,823

Patients studied

40,527 with OS | 45,296 comparison

HR 0.22

78% reduction in HGSC risk
(95% CI: 0.05–0.95)

HGSC	Person-Years	Cancer Events
OS Group	189,101	2
Comparison	370,133	21



Negative control: No difference in breast cancer (HR 0.99, CI: 0.84–1.17)

JAMA Netw Open

Published Online: February 2, 2026

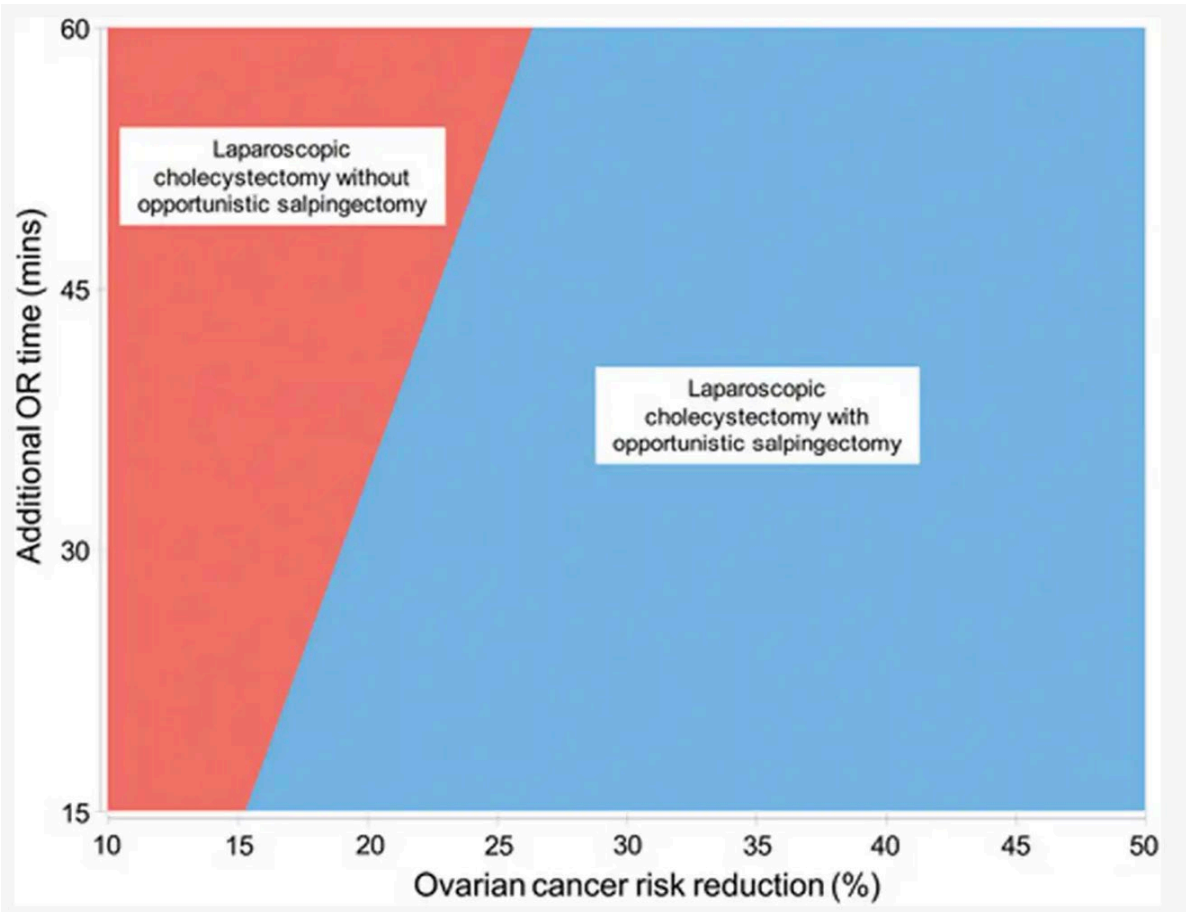
2026;9;(2):e2557267. doi:10.1001/jamanet-workopen.2025.57267

Modeling suggests OS is cost-effective

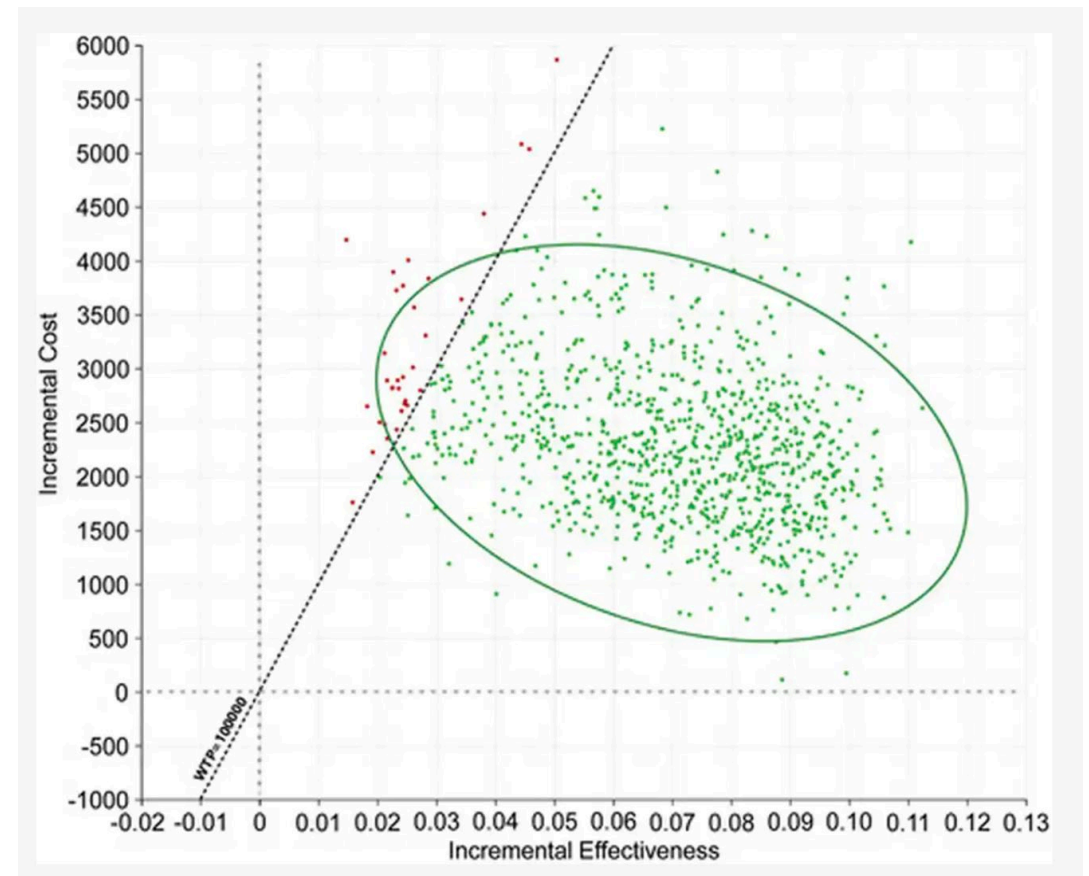
Matuso et al. 2022, Decision analysis of OS at Lap Cholecystectomy*



Two-way Sensitivity Analysis



Probabilistic Sensitivity Analysis



*PMID: 35129467.

OS was CE in 96.7% of 1000 simulations [Slide 118](#)

Evidence Based Strategies



Clinicians/Care Teams

- **Raise OS awareness** among clinicians and patients
- Develop training and **credentialing for non-gyn surgeons**
- Establish consensus **eligibility criteria**
- Standardize counseling and **informed consent**

Delivery Systems

- Build care pathways **linking gyn and non-gyn** surgical teams
- **Implement data collection** and outcomes monitoring

Plans

- Clarify coding, coverage, and reimbursement pathways for OS.

Purchasers

- **Advocate for OS coverage** and reimbursement
- **Educate employees** on ovarian cancer risk reduction

Proposed Scope



In Scope

- Clarify **statewide eligibility criteria** for OS during non-gynecologic abdominal and pelvic surgery
- **Develop guidelines and an implementation roadmap** for patient education, consent, and shared decision-making
- Clarify **reimbursement pathways** and address financial barriers
- **Address OS knowledge gaps** and build collaboration across surgical specialties
- **Develop a framework** for data collection, outcomes monitoring, and **evaluation** of cost, safety, and effectiveness
- **Identify barriers to implementation:** clinical, operational, financial, regulatory, policy

Out of Scope

OS during gynecologic procedures (e.g., hysterectomy, in lieu of tubal ligation)

We have engaged multiple partners



Washington State

- Hutchinson Institute for Cancer Outcomes Research (HICOR)
- Providence Swedish Cancer Institute
- Surgical Care and Outcomes Assessment Program (SCOAP)
- American Cancer Society

Additional partners to be engaged

National

- OutSmart Ovarian Cancer Initiative
- Michigan Multi-Specialty Action for Gynecologic Innovation & Care (MI-MAGIC)
- Ovarian Cancer Research Alliance



Impact of Bree Collaborative Report on this topic



- Close knowledge gaps and build statewide recommendations to ***accelerate OS adoption*** where appropriate
- Make OS a ***consistent, equitable option for every eligible patient*** undergoing surgery
- ***Reduce ovarian cancer deaths*** in Washington.



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Questions

Next Up: Initial Vote

Vote

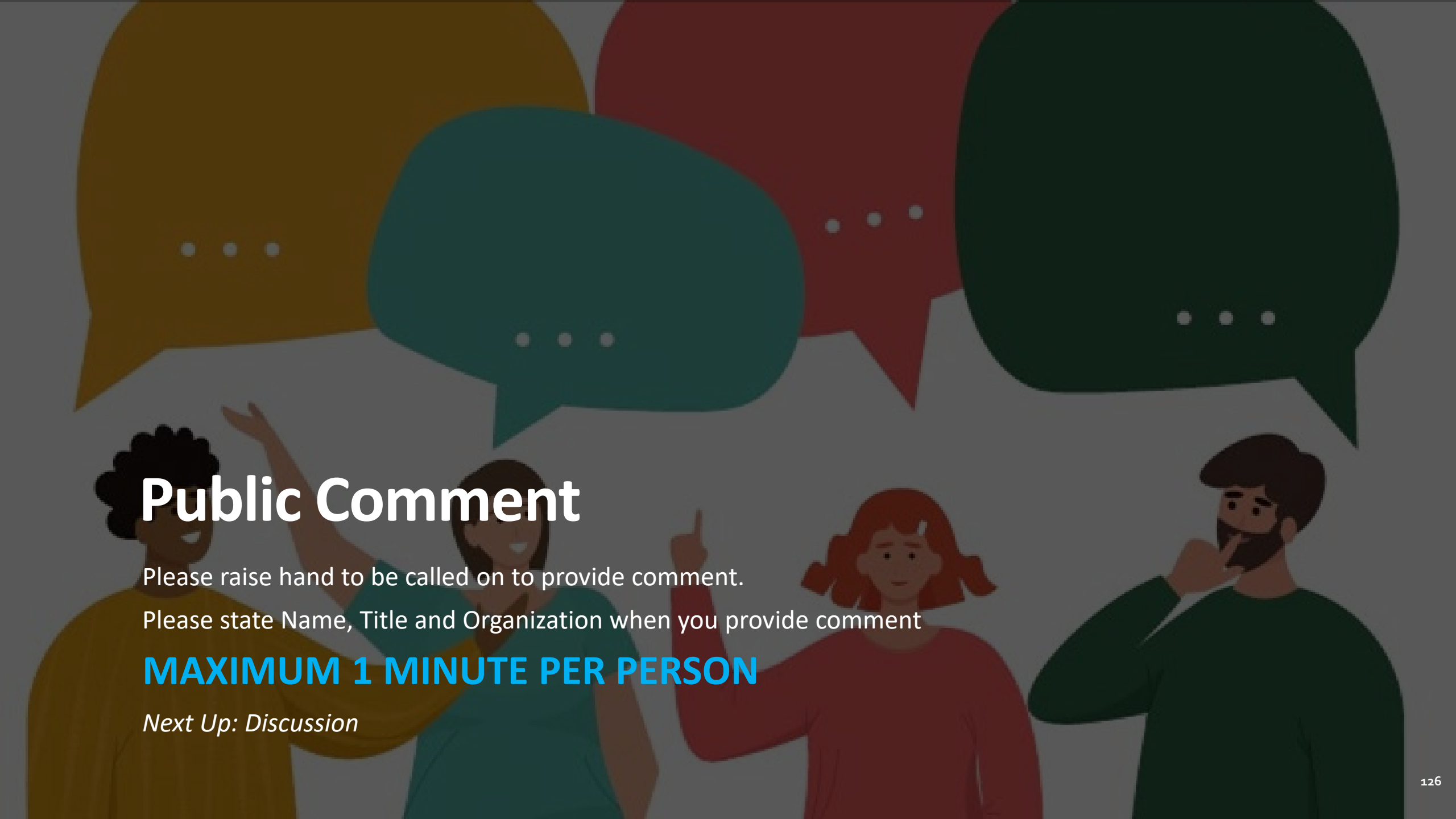


- **ALL present members (officially appointed or not) should participate in voting**
- Pick your **TOP 3 TOPICS**
- The order does not matter
- Results will be displayed for further discussion

Link to the survey in the chat for hosts and panelists

Public Comment





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: Discussion

Final Vote (as needed)



- All present members (**APPOINTED ONLY**) 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

Closing

2:55 – 3:00



Next Time



Next meeting: **Wednesday, November 18th 1PM-3PM**

(Hybrid)

Held at Industrious Office 400U @ Rainier Square



Upcoming Event-Nov. 3rd virtually



SUMMIT

Health in Action: Perseverance, Partnership, and Possibility

Hosted by Foundation for Health Care Quality &
Bree Collaborative





Thank You!

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

See you in NOVEMBER