

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)

STAFF AND MEMBERS OF THE PUBLIC

Shawna Altmiller, RN,
BSN, MHL, Regence
Laurel Avila, MBA, RN,
BSN, Greater Health
Now
Caleb Banta-Green,
PhD, MPH, UW, ADAI
Jessica Beach, MPH,
DrPHc, Molina
Abigal Berube, MPH,
CPHQ, CPCHE, WSHA
Beth Bojkov, MPH, RN,
FHCQ
Chuck Drescher, MD,
Swedish Cancer
Institute
Leslie Emerick, MPA,
Leslie Emerick
Consulting
Andrea Estes, MBA,
HCA
Joelle Fathi, ARNP, Go2
for Lung Cancer

Charissa Fotinos, MD
Adie Goldberg, PhD,
MSW, Providence
Ty Jones, MD, Regence
Nicholas Kassebaum,
MD, SCOAP
Vickie Kolios, MSHSA,
CHPQ, SCOAP
Kim Kummer, MS, MPH,
Jamestown Family
Health Clinic
Karie Nicholas, MA, GC,
FHCQ
Emily Nudelman, DNP,
RN, FHCQ
Maureen Oscadal, MPH,
RN, BSN, UW, ADAI
Taryn Robinson, MSW,
Kirkland Fire
Nini Shridhar, MPH,
DOH
Mandy Sladky, MSN,
RN, CARN, UW, ADAI

Tenaya Sunbury, PhD,
MS, HCA
TVW Streaming

Susanna Waldman,
WSMA
Ginny Weir, MPH, FHCQ
Kelly Youngberg, MHA,
UW, ADAI

WELCOME

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

Motion: Approve May Minutes

Outcome: Unanimously approved May Minutes

2026 WORKGROUP UPDATES

Dr. Transue transitioned the meeting to invite workgroup updates:

- **Lung Cancer Screening** – Joelle Fathi, ARNP, Go2 For Lung Cancer, Workgroup Chair
 - **The problem:**
 - Eligible adults need annual LDCT screening, but Washington uptake and adherence remain low, especially among people who currently smoke and minoritized communities.
 - Key barriers include cost, insurance uncertainty, transportation, and competing health needs; provider recommendation is a major facilitator.
 - **Guidelines to increase adherence:**
 - **Delivery Systems (summarized)**
 - Clarify accountable roles for tobacco history, LDCT ordering, results follow-up, and patient tracking.
 - Offer navigation across the lung cancer screening continuum.
 - Use Lung-RADS protocols for results notification and timely follow-up.
 - Maintain referral access to quality LDCT facilities.
 - Ensure referral pathways to specialty teams or nodule/tumor boards.
 - **Health Plans**
 - Cover annual LDCT lung cancer screening without cost sharing or prior authorization.
 - Do not count other CTs toward the annual screening benefit.
 - **Department of Health**
 - Promote lung cancer screening training for CHWs and primary care teams.
 - Encourage stigma and bias continuing education for clinicians.
 - Use person-first language in programs and materials.
 - Add screening education to tobacco prevention and cessation materials.
 - Create concise provider materials on eligibility, benefits, risks, and supports.
- **Alzheimer's and Other Dementias** – Beth Bojkov, MPH, RN, Director of Research and Best Practice
 - **Blood based biomarkers**

- Seeing an increase in patients with no cognitive symptoms and normal cognitive testing but with positive blood based biomarkers - **Need more guidance for primary care providers for how to counsel patients who show up with positive BBMs**
- **Primary care guidelines**
 - BBMs do not confirm or rule out Alzheimer's disease.
 - BBMs may be appropriate for MCI or mild dementia patients considering amyloid-targeting therapy with timely neurology access.
 - BBMs are best established in specialty settings for anti-amyloid-treatment eligibility; other uses remain unclear.
 - Discuss who may be a good candidate for amyloid-targeting therapy.
- **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)."*
 - **Primary care guidelines (summarized)**
 - Identify goals of care and maximize function.
 - Include patients and caregivers in care planning.
 - Assess and support caregiver capacity and distress.
 - Offer dementia care management services.
 - Address neuropsychiatric symptoms through shared decision-making.
 - **Hospital**
 - 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
 - **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](#)
 - **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
- **DOH (summarized)**
 - Integrate brain health into chronic disease prevention programs.
 - Raise public awareness of caregiving health impacts and resources.
 - Help health systems address chronic conditions linked to dementia risk.
 - Train community health workers in dementia.
 - Use provider and Tribal leader letters to promote brain health, risk reduction, and early diagnosis.
- **Perimenopause and Menopause** – Beth Bojkov, MPH, RN, Director of Research and Best Practice
 - **Guideline Updates**
 - Simplification of guidance around MHT
 - Example questions to ask at routine visits to open the door for further discussion
 - *“Everyone experiences menopause differently. Would you mind if I ask a few questions to better understand your perspective on menopause?”*
 - *Do you have any questions about menopause, or think you may be experiencing any symptoms or problems related to menopause?”*
 - Midlife health
 - Focus on conditions that go underrecognized or underdiagnosed
 - Cardiovascular health – symptoms of cardiac problems not always recognized
 - Obstructive sleep apnea – incidence increases with weight gain and decline in estrogen may impact muscle tone in airway
 - Behavioral health – increase in behavioral health concerns during this time period
 - Musculoskeletal – proactive osteoporosis prevention, dealing with joint pain/stiffness/muscle aches
 - Workplace supports
 - Framework for workplace supports
 - Physical aspects
 - Policies and processes
 - Workplace culture
 - Work redesign and role adjustments

Emily Transue, MD, MHA, transitioned the meeting to begin discussing potential 2027 topics. The process was to review all nominations, engage in public comment, open discussion, and identify top 6 topics to explore in September as potential work for 2027.

- Barriers and Facilitators to Topic Success
 - 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
 - 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*
- **2027 Topic Nominations**
 - 28 submissions
 - 15: healthcare facilities
 - 7: state agencies
 - 3: patient or CBO
 - 0: insurance/payor
 - 0: post-acute facility
 - Nominations
 - Prioritized by the Steering Committee
 - REVISION: Addiction & Dependence Treatment Report & Guidelines
 - Anal cancer screening
 - Artificial Intelligence (AI) governance and clinical implementation
 - Mobile Integrated Health (2)
 - Nutritional Risk and Malnutrition
 - Obstructive Sleep Apnea
 - Opportunistic salpingectomy (OS) for ovarian cancer prevention
 - Pediatric pain management, including commendations for multimodal and nonopioid pain management
 - Peripheral Artery Disease
 - Polycystic Metabolic Ovarian Syndrome (formerly PCOS)
 - All Others
 - ARNPs in Primary Care; transition-to-practice pathways (2)
 - Autoimmune diseases delayed diagnoses
 - Bidirectional Behavioral Health Integration (BHI) from the patient perspective
 - Community-based palliative care access
 - Community-based sepsis recognition and treatment
 - Continuity of Care, Interinstitutional Transfers (2)
 - Language Interpretive Services
 - Obstetrics Care (2012) Revision
 - Oral Health Access for people with intellectual disability

- Peer Review
- Polypharmacy
- Sexual and Reproductive Health Report & Guidelines Revision
- Tele-curbside (access to specialty care in rural communities)
- Tobacco: Commercial tobacco and smoking cessation treatment, SBIRT (ACT for under 18)
- Women's Health services access
- Youth behavioral health and substance prevention in rural communities (early identification, prevention, SBIRT)
- How patients have changed
- 'acceptable' unprofessionalism of trial lawyers
- Revision: Addiction & Dependence Treatment (2014)
 - 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
 - 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 (PMOS, 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, 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.
 - 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.
- 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.)
 - 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 (AI)
 - 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
 - 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 (**supported by Colin Fields, Katina Rue, and WSMA**)
 - 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

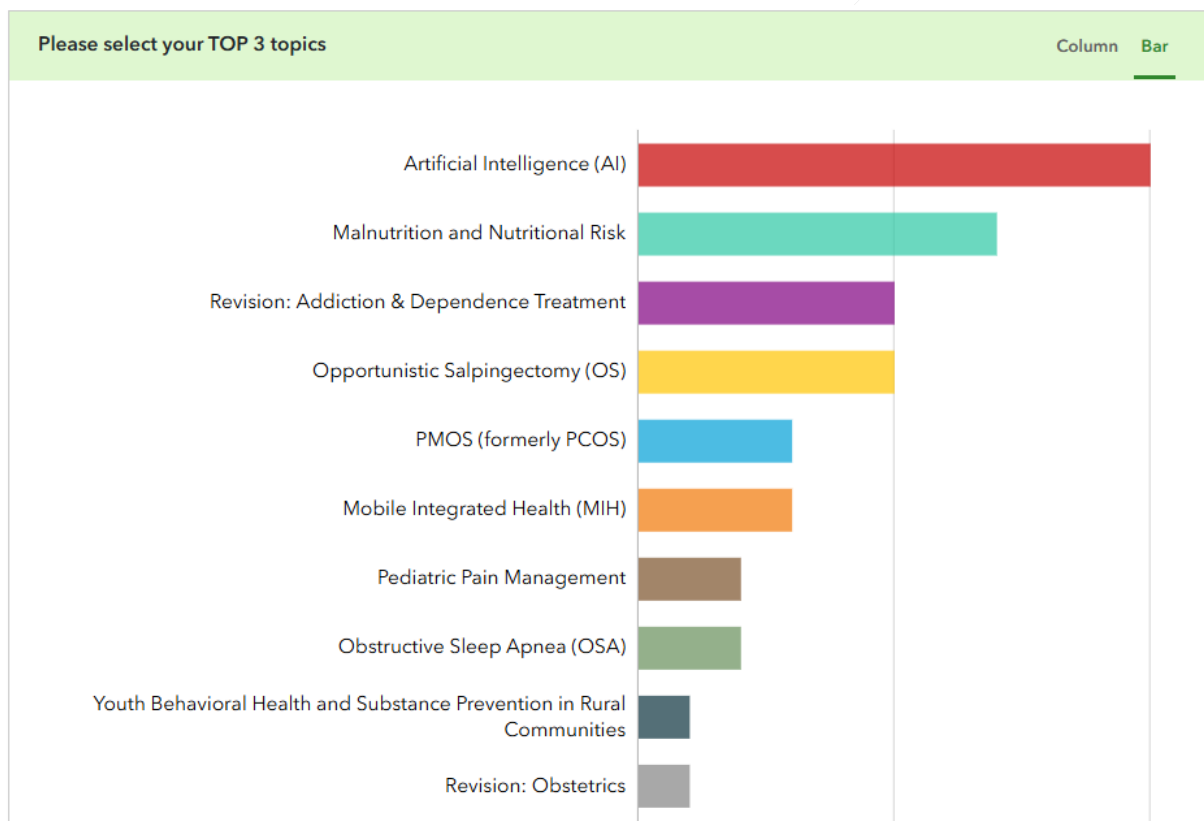
recipients, and people with a history of vulvar cancer or precancer. Best practice guidelines recommend routine screening for high-risk groups, as treatment of HSIL can prevent development of cancer.

- 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).
 - 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 (MIH)
 - 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
 - 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.
 - 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 (OSA)
 - 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
 - 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
- Bree Member Questions/Discussion
 - Rodica Pop (MultiCare): voiced support for pediatric pain management and artificial intelligence topics
 - Nicole Saint Clair (Regence): voiced support opportunistic salpingectomy (not many good options for screening and treatment for ovarian cancer) and malnutrition and nutritional risk (considering GLP-1 RAs, intersecting reduction of SNAP benefits, lower access to food)
 - Arooj Simmonds (Providence): voiced support for artificial intelligence (everyone is trying govern it themselves) and mobile integrated health (social drivers of health are super hard to follow, access is not there, would be a good idea)
- Public Comment
 - Leslie: public policy director for Washington state hospice and palliative care, what can we do in the future to make it more palatable for the committee in the future
 - Laurel Avila: submitted mobile integrated health, as an RN and former clinic director, wanted to add a couple comments about what MIH is. The people involved in MIH are in the homes, MIH can address those who have been discharged or post-ER visits to decrease hospital readmissions; MIH also able to help with polypharmacy/multiple medications that they are on, helping patients understand their medications and how to take them.
 - Caleb Banta-Green: research professor in school of medicine at UW, submitted the revision of Addiction and Dependence Treatment report and guidelines. Sat on the 2017 OUD guidelines and very familiar with Bree, need is very high around substance use disorder, majority of people use a substance; also at an inflection point with the state opioid response with lots of federal support has 1 year left of funding Substance use recovery services advisory committee is winding down, and opioid settlement dollars are already beginning to decrease; Other collaborative spaces where payors and health systems are coming forward to show how they can do good and prevent harm.
 - Chuck Dresher: gynecologic oncologist, submitted OS topic, first time attending Bree meeting and really amazing, really now have an evidence-based intervention to change the landscape for ovarian cancer care in Washington state. Large population-based

study showed salpingectomy at time of gynecologic surgery reduces ovarian cancer risk by 80%. High uptake and interest in gynecologic procedures. Talking with general surgeons, there has been positive response. Bree could bring all the stakeholders together to support implementation.

- Nini Shridhar: state genetics coordinator at DOH, first Bree meeting, amazing to see the proposals and collaborative in action – do not have a proposal in any listed. Two conditions that align with Bree’s work: hereditary breast and ovarian cancers, and LYNCH syndrome – strong impact from early identification, detection, and intervention to prevent negative impacts. Hope to consider these for future years topics.
- Nick Kassebaum: Anesthesiologist at Harborview, Medical Director for SCOAP, submitted 3 proposals and advocating for 2: AI and malnutrition/nutritional risk. Timeliness of these both are crucial. If we don’t come out and make statements about expectations for AI governance, go-no-go thresholds for new tools, post-deployment monitoring expectations, expectations for equity and bias screening, mandate human in the loop; GLP-1 RAs – so many people are on these, sarcopenic malnutrition means those with huge amounts of weight loss are indistinguishable for malnourishment. We need improved screening for this, to avoid surgical implications.
- Straw Poll:

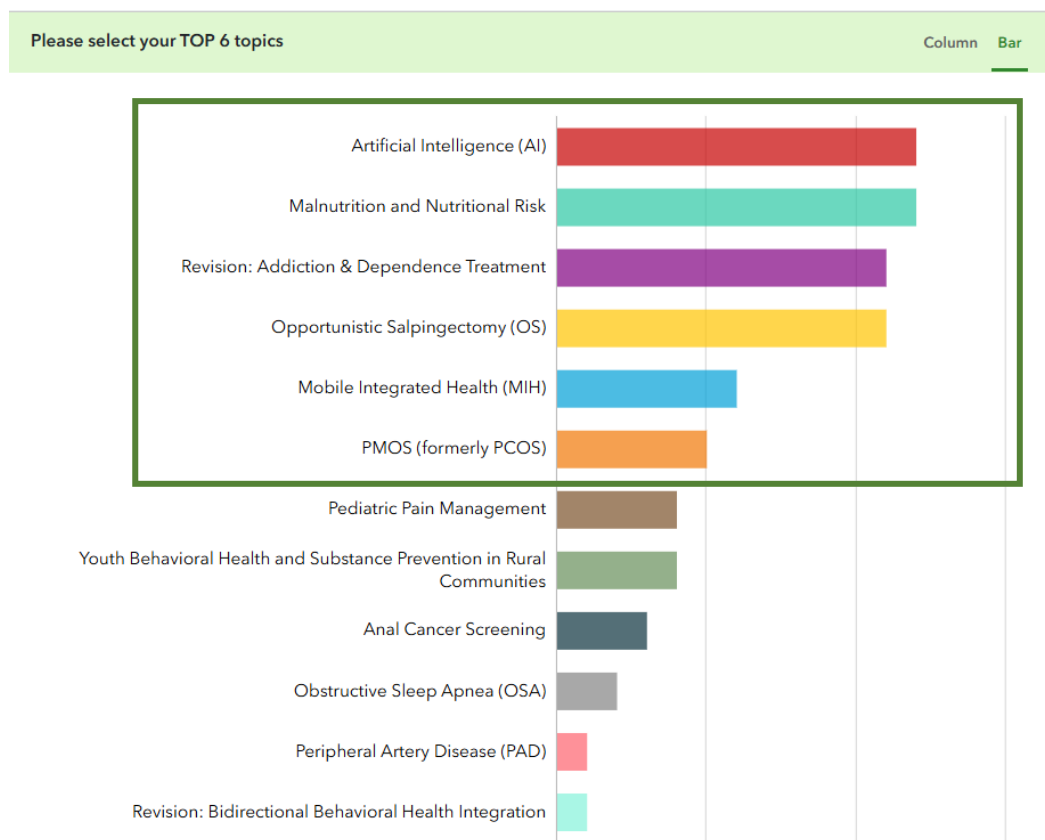


- Discussion
 - We will have a total of 3 topics for 2027
 - Rodica: Advocacy for opportunistic salpingectomy (OS), not able to do much for ovarian cancer
 - Judy: Like the idea of OS, wondering what the evidence is for it? Time where we don’t have a lot of money, and have to think about that carefully. Might be an expansion of

what we do now, want to make sure the evidence for it is strong

- Chuck: foundational evidence based on population based cohort in BC with 85,000 women, half underwent salpingectomy procedure, other half did not have salpingectomy – they were followed for 10 years, hazard ratio was 0.22 for high grade serous cancer (most common and lethal) with the OS procedure. Cost wise, there's not been a formal cost effectiveness analysis in this particular setting, but looking at it from risk, risk of ovarian cancer 3-4% lifetime risk, its cost effective for these people. Increase in cost is marginal so far – including professional and instrument fees, in the range of a few hundred dollars on average (using back of the napkin math); compares very favorably compared against colonoscopy, NNT is favorable.

- Final Vote



Commercial Tobacco and Smoking Cessation Treatment, SBIRT				
Community-based Palliative Care				
Access to Women's Health Services				
Oral Health Access for People with Intellectual Disabilities				
Polypharmacy				
Revision: Obstetrics				
Revision: Sexual and Reproductive Health				
Care Coordination				
Delayed Diagnoses for Autoimmune Disorders				
ARNPs in Primary Care				
Language Interpretive Services				
Peer Review				
Tele-curbside (Specialty Care in Rural Communities)				

- Archive some of these for future reference!

CLOSING AND PUBLIC COMMENT

Dr. Transue thanked those who attended, reviewed upcoming events and closed the meeting. Next Bree Collaborative Meeting: **September 23rd, 2026, 11AM-3PM PST**