Bree Collaborative Meeting

Meeting will begin at 1PM PST

March 25th, 2026| Hybrid Meeting

DR. ROBERT
BREE
COLLABORATIVE

Before We Begin...

- The meeting is hosted as a Zoom Webinar
- When one logs on, they 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**.
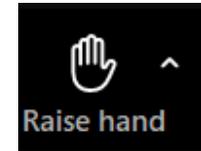
- Bree staff will call on you to speak and promote you to a "Panelist."

- 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.

Welcome

Welcome
   Action Item: Adopt January Minutes
2026 Workgroup Updates
   Lung Cancer Screening
   Peri/Menopause
   Alzheimer's and Other Dementias
   Revision
Report Management
   Primary Care
   Cardiovascular Care
Implementation & Evaluation Updates
2026 Legislative Session
Round Robin Updates
Next Steps and Close

WOMEN'S
HISTORY MONTH

Meeting Minutes: January 2026

Bree Collaborative Meeting
January 28th 2026| 1:00-3:00PM
Hybrid

MEMBERS PRESENT VIRTUALLY

Emily Transue, MD, MHA, Comagine Health

Jake Berman, MD, MPH, University of Washington

Colleen Daly, PhD, Microsoft

Gary Franklin, MD, Washington State Department of Labor and Industries

Judy Zerzan-Thul, MD Washington HCA

Carl Olden, MD, Central Washington Family Medicine

Norifumi Kamo, MD, MPP, Virginia Mason

Drew Oliveira, MD, WHA (to be confirmed)

Darcy Jaffe, ARNP, WSHA

Rodney Anderson, MD, FCN (to be confirmed)

Tao Kwan-Gett, MD, DOH (to be confirmed)

Nicole St. Clair, MD, Regence

Kristina Petsas, MD, UHC

MEMBERS ABSENT

Arooj Simmond, MD, Providence (to be confirmed)

Colin Fields, MD Kaiser-Permanente

Susanne Quistgaard, MD, Premera Blue Cross

Katina Rue, DO, Team Health (to be confirmed)

James Murray, MD, Confluence (to be confirmed)

STAFF AND MEMBERS OF THE PUBLIC

Beth Bojkov, MPH, RN, FHCQ

Karie Nicholas, MA, GC, FHCQ

Emily Nudelman, DNP, RN, FHCQ

Ginny Weir, MPH, FHCQ

TVW Streaming

2026 Workgroup Updates

Lung Cancer Screening

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

Focus Areas

Eligibility & Engagement

Stigma, Bias, & Equity

Screening with LDCT

Results Management

Focus Areas

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

Focus Areas

Focus Area	Components	End Users
Stigma, Bias & Equity	• Outreach to populations with historical or demonstrated inequities in screening rates, including by race and ethnicity, rural locations, those covered by Medicaid or uninsured, and minoritized LGBTQIA+ populations • Explore telehealth, mobile screening models, and other technological advances to engage underserved populations • Healthcare provider targeted education and training around stigma and bias in lung cancer screening • LCS Navigation support • Communication is understandable, person-centered, and consistent with guidelines with clear next steps for patients and families • Track outcomes and identify disapriteis in screeninga nd moratlity • Include lung cancer screening measures in value-based contracting	• Patients and Families • Clinicians • Delivery Systems • Health Plans • Employers • State Agencies

Focus Areas

Focus Area	Components	End Users
Screening with LDCT	• Integration of smoking cessation at all touchpoints of the LCS continuum • Designate ownership of LCS workflow and population-level management • Low-dose CT (LDCT) provided according to ACR technical standards • Identify and standardize reporting of lung nodules • EHR processes for screening documentation, clinical decision tools, and reminders • Track and clearly communicate the process and frequency of lung cancer screening (annual LDCT with potential for increased frequency to track abnormal findings)	• Patients & Families • Clinicians • Delivery Systems • Health Plans • Employers • State Agencies

Focus Areas

Focus Area	Components	End Users
Results Management	- Timely, guideline-aligned (e.g., Lung-RADS) results management and follow-up - Standardized processes and care coordination to ensure follow up with annual screening, follow-up and referral to specialty care after abnormal LDCT findings; Pathway to access multidisciplinary review for results management - Access to recommended care for completion of LCS - Designated process owner and reliable tracking systems for cancer screening registry follow-up and outreach to close care gaps and prevent missed follow-up	- Patients and Families - Clinicians - Delivery Systems - Health Plans - Employers - State Agencies - State Legislature?

Perimenopause & Menopause

Nicole Saint Clair, MD (chair)

Focus Areas

Recognition & Assessment

Management

Workplace Supports & Quality Measurement

Education

Focus Areas

Focus Area	Patient Perspective	Details	End Users
Recognition & Assessment	I understand what will happen to me and my body as I go through the menopause transition, as well as when to seek help with symptoms. My primary care provider has spoken to me about the transition, answered my questions, and we made a plan for if I experience bothersome symptoms.	• Provider education around normal and abnormal physical and behavioral health changes and symptoms during perimenopause and menopause from the patient perspective and how clinical decision-making can support patients ○ Inclusive of where experiences may differ, including for those receiving gender-affirming hormone therapy, those who arrive at menopause surgically, those with primary ovarian insufficiency, and others as identified. • Assessment of symptoms of perimenopause and menopause at home and in clinical settings	• Patients • Primary Care Systems (including PCP, OBGYN, Midwives, etc.) • Behavioral Health Systems and Providers • Health Plans • Department of Health

Focus Areas

Focus Area	Patient Perspective	Details	End Users

Management	I know what medical care is available and appropriate to support my symptoms. I've had an honest discussion with my provider about the risks and benefits of available treatments, and created a plan to provide relief from symptoms and protect my health as I age.	• Symptom management grounded in shared decision-making, and non-hormonal treatments
		• Hormone therapy selection (type, route, dose, duration, etc.)
		• Use of evidence-based complementary and alternative medicines
		• Lifestyle, prevention and screening for whole-person midlife health, such as for:
		  o cardiovascular disease
		  o metabolic health
		  o osteoporosis
		  o mental health concerns
		  o urogenital and sexual health concerns
		  o etc.
			• Patients
			• Primary Care Systems (including PCP, OBGYN, Midwives, etc.)
			• Behavioral Health Systems and Providers
			• Health Plans
			• Department of Health

Focus Areas

Focus Area	Patient Perspective	Details	End Users
Workplace Support and Quality Measurement	I feel supported by my workplace to talk openly about menopause without stigma or negative impact to my career and can request flexibility and accommodation if needed to prioritize my health and wellbeing.	• Employers offer a basic level of menopause-informed benefit design for hormone and nonhormone options for symptom management, practices and accommodations during the menopause transition inclusive of formal accommodations, and opportunities to openly discuss my experience with others • Systems (delivery systems, health plans, employers, state agencies) monitor and report out quality measures for perimenopause and menopause care • Accessible and available peer support groups	• Primary Care Systems (including PCP, OBGYN, Midwives, etc.) • Behavioral Health Systems and Providers • Health Plans • Employers • Health Care Authority

Focus Areas

Focus Area	Patient Perspective	Details	End Users
Education	I learned about the full spectrum of sexual and reproductive health, including menopause, in school. Trusted adults in my life, including healthcare professionals, know how to answer my questions from puberty through menopause.	• Integration of public education for menopause in school systems • Evidence-based and comprehensive curriculum on the menopausal transition in provider training and education	• Academic Medical Centers • Department of Health

Report Management

Emily Transue, MD, MHA

Proposed Action

- Status: **Inactive**

Approved Bree Collaborative Members vote

Cardiovascular (2012)

Collaborative Recommendations: Increase Measurement and Reporting of Appropriateness of PCI

Steps
1. An appropriate use insufficient information report (2012 data) by hospital will be posted on the COAP members-only section of the COAP website. Target date: August 1, 2012.
2. COAP will provide feedback to hospitals and tools for reducing the amount of insufficient information in their data. Target date: August – December 2012.

Collaborative Recommendations: Increase Measurement and Reporting of Appropriateness of PCI

Steps

3. An updated appropriate use insufficient information report (based on 4th Quarter 2012data only), by hospital, will be given to the Collaborative and hospitals to review. Hospitals will have the option to not be identified. Target date: April 15, 2013.

4. Once hospitals have been given a chance to employ methods for improvement, and any corrections they might have made have been incorporated, an updated report (based on 4thQuarter 2012 data only) will be posted on the public section of the COAP website. The Collaborative will also ask the Puget Sound Health Alliance to post COAP data on its Community Checkup website, which compares data on health care services across the Puget Sound region, on a quarterly basis. Hospitals will have the option not to be identified. Target date: May 1, 2013. (See Appendix D for a sample report of how the un-blinded data will be presented; note: "Hospital 1..2..3", etc, will be replaced with the hospital name once the report is finalized and prior to posting on the website. Hospitals that choose not to participate in the report will have their names listed with no data).

Proposed Action

- Status: **Reaffirmed, archive Background**

- *Approved Bree Collaborative Members vote*

Primary Care (2020)

- **Primary care, widely identified as the cornerstone of the health care system,** is the usual source of health promotion, disease prevention, and care for a population's acute and chronic health problems.

Focus Area	Definition
Defining Primary Care	Team-based care led by an accountable provider that serves as a person's source of first contact with the larger healthcare system and coordinator of services that the person receives. Primary care includes a comprehensive array of appropriate, evidence-informed services to foster a continuous relationship over time. This array of services is coordinated by the accountable primary care provider but may exist in multiple care settings or be delivered in a variety of modes.
Components of Primary Care with Large Impact	- Care coordination - Integrated behavioral health - Disease prevention and screening - Chronic condition management - Medication management - Health promotion - Person-centered care that considers physical, emotional, and social needs
Measuring Primary Care	Based in claims, care delivered in an ambulatory setting by a predefined group of providers and team members as a proportion of total cost of care

Primary Care
Reaffirmed 2026

Primary care is the cornerstone of the healthcare system, acting as a usual source of health promotion, disease prevention, and care for acute and chronic health conditions. In Washington state, access to regular, high-quality primary care is a challenge for many. In 2020, the Bree Collaborative elected to develop standards for a state-wide definition for primary care to support multi-payor payment reform, with a focus on defining primary care, the components of primary care with large impact, and measuring primary care. In 2026, the Bree Collaborative reaffirms our Primary Care Guidelines.

PRIMARY CARE IS team-based care led by an accountable provider that serves as a person's source of first contact with the larger healthcare system and coordinator of services that the person receives. Primary care includes a comprehensive array of appropriate, evidence-informed services to foster a continuous relationship over time. This array of services is coordinated by the accountable primary care provider but may exist in multiple care settings or be delivered in a variety of modes.

PRIMARY CARE INCLUDES:
- Care coordination
- Chronic condition management
- Disease prevention and screening
- Health promotion
- Integrated behavioral health
- Medication management
- Person-centered care that considers physical, emotional, and social needs

PRIMARY CARE IS MEASURED through claims data: care delivered in an ambulatory setting by a predefined group of providers and team members as a proportion of total cost of care

Access the full report here (published in 2020)

For Clinicians and Clinics

Primary Care Site MUST HAVE Elements

- **Team-based care strategies** (*e.g., huddles, care management meetings, high-risk patient panel review*) **are consistently used** through co-located or integrated models.

- **Behavioral health provider(s) are part of the care team** through co-located or integrated models

- **Active patients are assigned or attributed to a primary care provider or team for advanced clinical judgment**
  - the primary care team may/may not reside in the same physical setting and does not need to have the same organizational affiliation to act as a team

- Care is **evidence-based and/or evidence informed**

- **Services that address the whole person (multiple organ systems) are regularly offered including:**
  - Active management of chronic diseases
  - Acute care for minor illnesses and injuries
  - Office-based procedures and diagnostic tests
  - Preventive services including USPSTF recommended cancer screenings
  - Vaccinations
  - Patient education
  - Self-management support
  - Medication management
  - Chronic condition management
  - Behavioral health support

- **Convenient and flexible care options** allow easy access to the right care in the right setting when needed.

- **At least one alternative to traditional physical and behavioral health office visits is offered** (*e.g., e-visits, phone visits, group visits, home visits, alternate location visits*)

- **Site also offers expanded hours** (e.g., early mornings, evenings, weekends)

- **Health information technology is in place** that supports **management of the patient panel at a population health level** while also supporting **optimal care at the individual patient level.**
  - To be effective, the primary care provider must be "connected" to the broader healthcare ecosystem through some mechanism that supports interoperability, such as a Health Information Exchange (HIE) that supports a longitudinal patient-centric record and near/real time alerts to support

STRONGLY RECOMMENDED for High Quality Primary Care

- **Infrastructure**
  - Forms/protocols reflect **open and affirming environment**
  - **Age-appropriate and culturally inclusive reading/audiovisual material** and aids available

- **Access**
  - **Physically accessible** to those with mobility issues
  - **Translation services available** for languages common among the patient population (providers, certified interpreters) **Do NOT rely on family or friends**
  - Patient-facing forms and information are **readable at a 4-6ᵗʰ grade level**, available in **relevant languages and accessible formats**, use **inclusive and nonstigmatizing language**, and reaffirm **confidentiality**

- **Information**
  - **Health records for each active patient contain at least the following:**
    - problem list
    - medication list
    - surgical history
    - allergies
    - race and ethnicity (if disclosed)
    - preferred language
    - sexual orientation
    - gender identity
    - chosen pronouns and name
    - BMI/growth chart, immunization
    - parenting intention in the next year (if applicable)
    - advance directive or other advance care planning
    - other care needs (e.g., oral, dental)
  - **Care plan is coordinated, documented and accessible** to all primary care team members
  - **Risk stratification process in place** that includes medical need, behavioral health diagnoses, and health-related social needs
  - At least every 2 years, site **post-visit surveys conducted** to measure patient-reported outcomes
  - **Whole-person needs are identified and met at a population level**
  - Quality and effectiveness **improve over time**
  - Patient visits with assigned clinician/team are **tracked and reported to health plans**
  - Capacity to **query and use data** to support clinical and business decisions

STRONGLY RECOMMENDED for High Quality Primary Care

- **Referrals**
  - **Agreements or contracts among providers, plans and other organizations to coordinate transitions are in place**, including:
    - Emergency department and inpatient visits
    - Residential and partial treatment facility stays
    - Stays at substance use disorder treatment facilities
    - Community resources to support non-medical social needs that impede health improvement
  - **Referrals to offsite services are tracked,** and **overdue referrals prompt outreach** to the patient
  - **Referral patterns are identified and adjusted** to improve patient outcomes and reduce cost and unnecessary care
  - **Hospitals and EDs responsible for most patients' hospitalizations and ED visits are identified;** timeliness of notification and information transfer is assessed.
  - **Opportunities to work with accountable communities of health (ACHs) to improve community supports are identified.**

- **Content of Care**
  - **People are screened at least annually using a validated instrument for:**
    - Depression
    - Anxiety
    - Suicidality
    - Tobacco Use
    - Alcohol
    - Other drug use
  - **A process for follow-up, brief intervention, brief treatment and/or referral to treatment is documented**
  - **Coordination of care** and meeting care needs
  - During a clinical visit, **patients and providers engage in:**
    - Self-management support
    - Shared decision-making as appropriate
    - Motivational interviewing for behavior change

Both Health Plans and Purchasers

- Members/Employees receive information about the **value of primary care, how to access primary care within the network**, and are **asked/encouraged to select a primary care provider/team** at enrollments

Health Plans

- Members **select or are paneled to a primary care provider/team** through a process **transparent to the purchaser and the individual member.**

- Members are **notified when a primary care provider is held accountable for their care. Members can change their preferred provider** by notifying the health plan.

- Data from care delivery sites is **collected and aggregated to understand variation in care and look for disparities in access or services provided** within and across:
  - Race and ethnicity
  - Language
  - Sex
  - Screening for relevant cancers of the sexual and reproductive health system
  - Prenatal and postpartum;
  - Perinatal care outcomes reported for those who are Black, Indigenous, and people of color

- Health plan records **accurately reflect a person's gender, pronouns, and chosen name**

- **A payment mechanism supports primary care features that are not reimbursed through traditional fee-for-service payments,** including value-based reimbursement (e.g., FFS enhancements, prospective PMPM) that could incent transformation, performance-based incentives, or more expansive capitation.
  - **Multipayor models** are prioritized
  - **Share relevant information including cost** with providers/practices
  - Payment mechanisms are **clearly articulated to employers**

Purchasers

- **Benefit designs are structured to encourage the use of primary care** including Value-Based Insurance Design (VBID) mechanisms tied to primary care, such as:
  - **$0 cost for specified in-person or virtual care services** delivered by the individual's named primary care provider
  - **Lower out-of-pocket cost for specialty care** accessed after seeing one's primary care provider/team
  - When qualified high deductible health plans with Health Savings Accounts (HSA's) are in place, **rules allowing for first dollar coverage under expanded "preventive services"** are applied

- Agree to **support non-fee-for-service payment mechanisms for primary care** in partnership with other purchasers

- **Non-fee-for-service forms of primary care payment are clearly articulated by plans and supported by employers;** qualifications for payment eligibility and success measures clearly understood and openly shared.

- **Contracts with health plans and/or directly with delivery systems require:**
  - Measurement of primary care spend
  - Total cost of care
  - Measurement of quality of care
  - Measurement of disparities in care outcomes by race/ethnicity;
  - Reporting of primary care spend
  - Targets for primary care spend
  - Requirement that consumers select or be paneled to a primary care provider or team
  - When individual selection is not in place, the primary care provider/team to whom the individual is assigned is clearly communicated and the individual has the ability to change that assignment
  - Penalties for indicators of not-managed and not-coordinated care, like avoidable hospital readmissions or avoidable ED

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Implementation and Outreach

Emily Nudelman, DNP, RN

Quarter 1

- Bree 2025 Report Spotlights (3)

- Surgical Patient Optimization Webinar
  - Cutting Surgical Risk – Early Detection of Hidden Hyperglycemia and Anemia
  - Beyond Transfusion: Anemia Optimization for Culturally Informed Bloodless Surgery

- Community Webinars and Events
  - Catalyst for Change – Energizing Innovation for a Resilient Behavioral Health System
  - Navigating New Terrain: Keeping Up to Date with Evolving Vaccine Guidance
  - Mar. 10-12th: NW Rural Health Conference [Spokane]
  - Mar 12th: UW Climate Change & Clinical Practice Symposium [Seattle]
  - Mar 19th: Washington State Immunization Summit [Tacoma/Virtual]

Quarter 2

- Looking into opportunities to strengthen relationships and alignment across the systems

- Surgical Patient Optimization
  - Webinar: Beyond Transfusion: Anemia Optimization for Culturally Informed Bloodless Surgery on Thursday, March 26th 12:00-1:00PM
  - Facilitating a Panel discussion at SCOAP Annual meeting in May

- Implementation Support
  - Extreme Heat and Wildfire Smoke
  - First Episode Psychosis
  - Behavioral Health [Youth, Perinatal, Adult]
  - Oncology

- Health in Action Collaborative

Health Action Collaborative

About the Action Collaborative

Join Bree Collaborative Staff as a participant in the Health Action Collaborative! participants will receive support in taking their chosen health project from an idea to developing an implementation plan that can be enacted within their organization.

Open to individuals working within the healthcare ecosystem (clinicians, delivery sites, QI teams, purchasers, plans, etc.)

Join Us!

Contact bree@qualityhealth.org for more information and to sign-up to participate.

The Committment

- May-December 2026 bi-weekly meetings
- 1-hour "Learn" Meeting
- 1-hour "Lab" Meeting (Optional)
- Chosen health topic aligns with a Bree Report topic

The Benefits of Participating

Development of a health project plan & implementation skills

Population Health at the forefront of the design

Networking with peers in WA State

Share our events and offerings with your networks

Connect us with ongoing work

Implement a guideline

How you can help Implementation and Outreach

Evaluation

Karie Nicholas, MA, GDip

Evaluations

Purposes

1. To demonstrate spread, outcomes and impacts of Bree guidelines
2. To inform report revisions and future report topic selections

End-of-Life Care	Risk of Violence Towards Others
• Hospital policies (Estimated completion April 2026) - Cohort analysis of hospital policies • Legislative actions (Estimated completion April 2026) – assessment of legislation • Patient services (in development – retrospective cohort study, outcomes over time	• Legislative actions – (in development) assessment of legislation • Behavioral Health System implementation (in development)– Case study

Measurement

Surgery Optimization

- May 2026: Working session at the SCOAP conference to create a "data dictionary" for surgery optimization measures
- June-December 2026: Continuing workgroup to define measures for audiences other than clinicians

Depression Remission

- June – December 2026 – learning community for improving measurement of depression remission
- This measure is on the common measure set and references in many Bree behavioral health reports, including Early Interventions for Youth, but measurement is still difficult

Evaluation Subcommittees

Purpose:

- To help align report specific evaluation work across all audiences

Products:

- Theory of Change
- Evaluation Framework
- Measurement identification

When:

- June-December 2026

Student projects – dashboard development

WSU

- School of Electrical Engineering and Computer Science
- Built the "pipes" for data capture from multiple platforms and services
  - For internal dashboards
  - For external dashboards

UW

- School of Public Health - Health Informatics and Health Information Management Program
  - User experience and internal dashboard improvement

2026 Legislative Session Update

Judy Zerzan-Thul, MD, MPH

Washington HCA

Alzheimer's and Other Dementias Revision

Kris Rhoads, PhD (chair)

Focus Areas

Risk Reduction

Early Detection & Diagnosis

Ongoing Care, Support, & Management

Need for Increased Support and/or Higher Levels of Care

Preparing for Possible Hospitalization

Focus Areas

Focus Area	Details
Risk Reduction	• Aggressive treatment of hypertension, diabetes, and hyperlipidemia in midlife and beyond. • Routine screening and referral for hearing loss and visual impairment; Routine screening and treatment for depression and anxiety • Closed-loop referral to community programs (physical activity, nutrition, community building) • Existing measures/metrics used in VBP in Washington state
Early Detection & Diagnosis	• Case detection & diagnostic workflow • Comprehensive Diagnostic Evaluation (e.g., blood based biomarkers, APOE genotyping, Anti-amyloid

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Education	I learned about the full spectrum of sexual and reproductive health, including menopause, in school. Trusted adults in my life, including healthcare professionals, know how to answer my questions from puberty through menopause.	• Integration of public education for menopause in school systems • Evidence-based and comprehensive curriculum on the menopausal transition in provider training and education	• Academic Medical Centers • Department of Health

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Round Robin Updates

Facilitator: Emily Transue, MD, MHA

Public Comment

Please raise hand to be called on to provide comment.

Please state Name, Title and Organization when you provide comment

Closing

Next Time

- Next meeting: **Wednesday, May 20th 1-3PM Hybrid**
  - Held at Industrious FHCQ Office

Upcoming Events

- Mar. 26th 12-1:00 PM PST: **Beyond Transfusion: Anemia Optimization for Culturally Informed Bloodless Surgery**

- **Annual Meetings** [The Conference Center at Sea Tac]
  - May 27th, 2026: **COAP**
  - May 28th, 2026: **OBCOAP**
  - May 29th, 2026: **Spine and Surgical COAP**

Good of the Order

Expanding Access to High Resolution Anoscopy
- Speaker: Bob Geise, MD, Section Chief of infectious disease and travel medicine at VM Franciscan
- When: April 3 from 12-1 pm on Zoom (link provided at registration)

Expanding access to High Resolution Anoscopy (HRA) is critical to preventing anal cancer, as HRA is the gold-standard method for detecting and treating precancerous lesions before they become invasive disease. Anal cancer disproportionately affects people living with HIV, men who have sex with men, transgender women, and communities of color—groups that already face significant barriers to care. When access to HRA is limited, those at highest risk are least likely to receive timely screening and treatment, leading to avoidable late-stage diagnoses and worse outcomes.

In 2025, the WSMA House of Delegates adopted Resolution C-3 - Expanding Access to High Resolution Anoscopy. Bob Geise, a resolution author and section chief of infection disease and travel medicine at Virginia Mason Franciscan Health, will give an overview of how and when patients should be screened. Free for WSMA members, $30 for nonmembers. Register here.

This activity is approved for *AMA PRA Category 1 Credit*™

Thank You!

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

See you in MAY