Bree Collaborative | Lung Cancer Screening
April 1st, 2026| 3-4:30PM
Hybrid

MEMBERS PRESENT VIRTUALLY

Joelle Fathi, DNP, ANP-BC, UW (cochair)
Kim Kummer, MS, MPH, Jamestown Family Clinic (cochair)
Kristin Bohreer, RN, Virginia Mason
Susanne Quistgaard, MD, Premera
Brandon Omernik, MS, CTTS, Fred Hutch
Maggie Chin, MD, Kaiser Permanente
Douglas E. Wood, MD, UW
Saba Lodhi, MD, Confluence
Elyse Dumont, RN, Mason Health
Andrea Allen, RN, MHA, HCA
Christina Vanzuela, Caregiver Advocate
Matty Triplette, MD, Fred Hutch
Jessica Beach, MPH, Molina
Ty Jones, MD, Regence

STAFF AND MEMBERS OF THE PUBLIC

Beth Bojkov, MPH, RN, Bree Collaborative
Karie Nicholas, MA, GC, Bree Collaborative
Lisa Carter-Bawa, PhD, APRN, ANP-C, FAAN, FSBM-HMH CDI, Center for Discovery & Innovation

WELCOME

Dr. Joelle Fathi and Kim Kummer welcomed members to the April workgroup meeting. Joelle introduced our speaker – **Dr. Lisa Carter-Bawa:** Director of the Cancer Prevention Precision Control Institute and the Center for Discovery & Innovation, Co-leader of the Cancer Prevention & Control Program, and Deputy Associate Director of the Community Outreach & Engagement for Georgetown Lombardi Comprehensive Cancer Center consortium. She is a behavioral scientist with almost 2 decades of clinical experience as an adult nurse practitioner.

Action: Motion to approve March minutes
Outcome: March minutes approved

PRESENTATION: LUNG CANCER POLICY NETWORK RESOURCES

The group transitioned to invite Dr. Lisa Carter-Bawa to share a presentation on Stigma in Lung Cancer Screening:

- **Lung Cancer Stigma and Its Impact on Screening:** Dr. Lisa Carter Bawa led an in-depth discussion on the pervasive stigma surrounding lung cancer, highlighting how blame, shame, and silence affect patients' willingness to seek screening and care
    - **Definition and Mechanisms of Stigma:** Dr. Carter Bawa explained that lung cancer stigma is rooted in the assumption of personal responsibility for smoking, affecting both those who have smoked and those who have never smoked. She outlined three mechanisms: blame (cultural narrative of self-infliction), shame (internalized guilt reducing care-seeking), and silence (lack of advocacy and discussion), all of which reduce screening uptake and funding.
    - **Multi-Level Effects of Stigma:** Stigma operates at individual, clinician, and system levels. Individuals may avoid screening due to fear of judgment. Clinicians may unintentionally

communicate blame, and system-level requirements for smoking history disclosure can feel punitive. Public health messaging often unintentionally reinforces blame, leading to less investment in lung cancer screening compared to other cancers.
    - **Person-First Language and Communication:** The group emphasized the importance of using person-first language (e.g., 'person who smokes' instead of 'smoker') to reduce stigma, noting that even diagnostic codes and forms can perpetuate stigma. Language choices in clinical notes, public health messaging, and policy documents have measurable impacts on empathy and care.
    - **Stigma in Clinical Encounters and Community Outreach:** Leading with questions about smoking history can disengage patients. Changing language to focus on screening and risk factors, rather than labeling, can increase engagement. Patients often avoid or rush through conversations about smoking due to anticipated blame, which can result in missed screenings.
- **Strategies for Reducing Stigma in Lung Cancer Screening:** Dr. Carter Bawa presented evidence-based strategies for reducing stigma in lung cancer screening, with the group discussion on practical applications for Washington state guidelines:
    - **Reframing Messaging:** Shifting from fear-based or behavior-focused messaging to empowerment messaging, such as emphasizing early detection and health benefits rather than smoking history.
    - **Clinician Training and Person-First Language:** Need for stigma reduction training for clinicians, navigators, and outreach workers, focusing on person-first language and shared decision-making that avoids judgment. Training can address implicit biases and nihilism among clinicians, improving referral rates and patient trust.
    - **Community Engagement and Culturally Tailored Outreach:** Engaging trusted community organizations, health workers, and patient navigators—especially from priority populations—was highlighted as essential for effective outreach. Culturally tailored programs are necessary to address the unique needs of underserved communities.
    - **Stigma-Aware Program Design:** Designing programs to simplify screening processes, reduce disclosure burdens, and integrate screening into routine care can help normalize lung cancer screening and reduce stigma. Materials should reflect the diversity of the population served.
    - **Measuring Stigma-Related Outcomes:** Using baseline stigma measures in community outreach programs to assess changes over time and tailor interventions. Simple surveys can identify individuals with high stigma, allowing for targeted educational outreach.

PRESENT & DISCUSS: STIGMA, BIAS, & EQUITY DRAFT GUIDELINES

Beth transitioned the group to reviewing the draft guidelines for stigma, bias, & equity. The group discussed the following changes:

- Beth summarized key findings from recent publications including multi-level stigma barriers, the impact of racism and discrimination, and best practices for clinician-patient communication.
    - Ensure incorporation of **patient-centered language**, normalizing tobacco use, and highlighting available support and benefits
    - **Tobacco use should not bar access to needed procedural care,** but sometimes preparing for a procedure can be a motivation to quit. There needs to be nuanced consistent policies to emphasize clinicians not making assumptions about patients' willingness to attempt cessation or engage in care.

- **There is value in separating lung cancer screening discussions from smoking cessation counseling** to avoid overwhelming patients and build trust. Ongoing, relationship based approaches are needed

PUBLIC COMMENT AND GOOD OF THE ORDER

Joelle and Kim invited final comments or public comments, then thanked all for attending.
The workgroup's next meeting will be on **Wednesday, May 6th 2026 from 3-4:30PM**.