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## Bree Collaborative | Perimenopause and Menopause

March 11<sup>th</sup> 2026 | 2:30-4PM

Hybrid

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### MEMBERS PRESENT VIRTUALLY

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Nicole Saint Clair, MD, FACOG (chair), Regence  
Karin Inderbitzin, RN, BSN, WA HCA  
Laura Marie MacPherson, MSN, Molina  
Annelise Gaaserud, MD, Kaiser Permanente  
Carolyn Halley, MD, Healthpoint  
Asher Strauss, PsyD, Kinwell

Kris Somol, ND, Bastyr University  
Cyndi Tefft, Microsoft  
Josephine Young, MD, Premera  
Naomi Busch, MD, Seattle Menopause Medicine  
Janice Tufte, Hassanah Consulting

### STAFF AND MEMBERS OF THE PUBLIC

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Beth Bojkov, MPH, RN, Bree Collaborative  
Emily Nudelman, DNP, RN, Bree Collaborative  
Karie Nicholas, MA, GDip, Bree Collaborative  
Ginny Weir, MPH, CEO, Foundation for Health  
Care Quality

### WELCOME AND INTRODUCTIONS

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Beth reviewed the agenda for the day and asked for a motion to approve the minutes from January and February

- Action: Motion to approve January and February minutes
- Outcomes: January and February minutes approved

### PRESENT& DISCUSS: NICE GUIDELINE ON MENOPAUSE: IDENTIFICATION AND MANAGEMENT

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Beth transitioned the group to review the National Institute for Health and Care Excellence (NICE) guidelines for [Menopause: Identification & Management](#). Beth summarized the following:

- Overview:
  - Covers **identification, assessment, and management** of menopause
  - Applies to **women, trans men, and non-binary people registered female at birth**
  - Emphasizes:
    - Individualized, patient-centered care
    - Shared decision-making
    - Appropriate use of hormone and non-hormone therapies
  - Updated evidence through **2024**
- Core Principles of Care: **Individualized Care & Information Support**
  - Tailor care to the individual over time as symptoms evolve
  - Normalize menopause as a **life transition**, not a disease; can happen earlier than midlife in specific circumstances
  - Provide clear, accessible information on:
    - Symptom variability (type, severity, duration)
    - Contraception needs; fertility
    - Bone, muscle, cardiovascular, and overall midlife health
  - Offer **psychological support** for early menopause (ages 40–44)
- Identifying Perimenopause & Menopause: Clinical Diagnosis First
  - Diagnose without lab testing in most people  $\geq 45$  years with sx

- Use clinical criteria
  - Perimenopause: new vasomotor symptoms (VMS) + cycle changes
  - Menopause: 12 months without menses (if not on hormone therapy)
- Be aware:
  - Hormonal contraception complicates the diagnosis
  - Some groups experience menopause earlier
- FSH testing only in special circumstances (ages 40-45, <40)
- Discussing Management Options: Shared Decision-Making
  - Discuss benefits, risks, routes, dose, and duration of treatments
  - Hormone therapy conversations should include Estrogen-only vs combined
  - Revisit decisions regularly; symptoms may reoccur when stopping hormone therapy
- Nonhormonal and Complementary Options
  - Menopause-specific CBT for:
    - VMS
    - Sleep disturbance
    - Mood symptoms (HRT can be offered if sx are not meeting clinical criteria and occurring at the same time as other menopause sx)
  - Counsel patients that:
    - Safety and efficacy of unregulated hormones are unknown
    - Supplements (e.g., isoflavones, black cohosh, St. John's wort, etc.) have:
      - Variable quality
      - Some gaps in evidence
      - Potential drug interactions (e.g., tamoxifen, anticoagulants, anticonvulsants)
- Managing VMS & Genitourinary Syndrome of Menopause (GSM)
  - VMS
    - Offer HRT
    - CBT is effective alternative or adjunct
    - SSRIs/SNRIs/clonidine NOT first-line therapy
  - GSM
    - Offer vaginal estrogen (local, has low systemic absorption)
    - Non-hormonal moisturizers/lubricants as alternatives or adjuncts
    - Ospemifene if first line options fail
  - Do not offer vaginal laser therapy outside clinical trials
- Special populations and safety considerations
  - Those with hx of breast cancer
    - Start with non-hormonal GSM treatments
    - Vaginal estrogen may be considered with specialist input
    - For people on aromatase inhibitors -> get specialist input
  - CV disease
    - Do not use HRT for primary or secondary prevention
  - Dementia
    - HRT does not prevent dementia
  - Menopause through surgery
    - Proactively discuss fertility options and expectations for menopause before, during and after surgery course
  - High risk VTE

- Consider transdermal HRT
  - Trans men & non-binary people
    - Ensure access to clinicians experienced in menopause and patient-centered care
- Hormone therapy & health outcomes
  - For people  $\geq 45$ , HRT is unlikely to affect life expectancy overall
  - Early menopause (40-44): risks and benefits of HT fall between those with premature ovarian insufficiency (POI) and those that arrive at menopause later
  - Route and formulation matter:
    - Lower doses carry less risk
    - Transdermal/vaginal route preferred when other risk factors are present
  - Use decision aids to support informed choice
  - Review tables for:
    - [Combined HRT versus no HRT: effect on specific health outcomes](#)
    - [Oestrogen-only HRT versus no HRT: effect on specific health outcomes](#)
- Premature Ovarian Insufficiency (POI): Under age 40
  - Diagnose based on symptoms plus elevated FSH on two tests 4-6 weeks apart
  - Do NOT rely on anti-mullerian hormone (AMH) testing alone
  - Offer hormone replacement (HRT or combined contraception) unless contraindicated (both offer bone protection)
  - Recommend continuing treatment until at least the average age of natural menopause
  - Baseline population risk of breast cancer/cardiovascular disease is very low in people 40 years old
  - Offer referral for psychosocial support
- Starting, stopping & reviewing treatment
  - Starting HRT
    - Use lowest effective dose
    - Combined HRT if uterus intact; estrogen-only if not
    - Those with intact uterus -> if experience bleeding after 3 months of treatment, seek care
  - Stopping HRT
    - Gradual or abrupt stop – no long-term difference in symptoms
  - Review treatment at 3 months then annually
  - Refer to menopause specialist when symptoms persist or if contraindications or complex histories exist

#### Discussion

- NICE consistent with NAMS regarding HRT for depressive sx: if symptoms are not diagnostic for clinical anxiety or depression, it may respond favorably to MHT
- Not mentioned but for some, progestogen may be offered without estrogen
- Is there menopause specific CBT?
  - <https://www.womens-health-concern.org/wp-content/uploads/2026/02/02-NEW-WHC-FACTSHEET-CBT-for-menopausal-symptoms-FEB2026-B.pdf>
  - [01-NEW-BMS-TfC-CBT-NOV2025-C.pdf](#)

#### **REVIEW & DISCUSS: DESIRED OUTCOMES & WORKPLAN**

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Beth transitioned the meeting to review edits to the list of desired outcomes, and review the focus areas. Changes are written in green.

1. Clinicians have a consistent baseline level of knowledge, skills, and resources to recognize, counsel on, and manage perimenopause and menopause phase of life 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, assessment, and treatment
4. Menopause is a timepoint in which patients and clinicians address midlife health comprehensively (e.g., nutrition, hydration, risk management, chronic disease prevention, etc.)
5. Proactive communication across home, clinical, workplace, and public health settings normalizes the menopause transition, reducing stigma and surprise by setting shared expectations about what to expect and when to seek support.
6. Employers support their employees and dependents through menopause transition through benefit design, employee accommodations, workplace management, manager training, providing opportunities to openly and safely discuss menopause, 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 include explicitly addressing racial/ethnic and geographic health disparities in menopause experiences, access to care, and health outcomes, as well as specific guidelines for populations for which general recommendations might not apply have guidance where able, including those with primary ovarian insufficiency, those using hormone therapy for gender affirming care or other reasons, those arriving at menopause surgically or early for other reasons, and other groups as identified.
9. Education, training, and practice standards for perimenopause through menopause care are consistently integrated across the full spectrum of clinicians with trusted patient relationships (physicians, NPs, midwives, NDs, BHPs, PA's, etc.) with clear expectations for competency and accountability to address longstanding gaps in training and inconsistency
10. Menopause care includes access to structured peer support such as group care models that normalize the transition, reduce isolation, and augment clinical management.

Focus Area	Patient Perspective	Details	End Users
Detection & Preparation Recognition & Assessment	<i>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</i>	<ul style="list-style-type: none"> <li>• 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 <ul style="list-style-type: none"> <li>○ Inclusive of where experiences may differ, including for those receiving gender-affirming hormone therapy,</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Patients</li> <li>• Primary Care Systems (including PCP, OBGYN, Midwives, etc.)</li> <li>• Behavioral Health Systems</li> </ul>

	<p><i>bothersome symptoms. as to how to detect if I am experiencing perimenopause.</i></p>	<p>those who arrive at menopause surgically, those with primary ovarian insufficiency, and others as identified.</p> <ul style="list-style-type: none"> <li>• Assessment of symptoms of perimenopause and menopause at home and in clinical settings <del>Accurate and early detection of perimenopause and menopause at home and in clinical settings</del></li> </ul>	<p>and Providers</p> <ul style="list-style-type: none"> <li>• Health Plans</li> <li>• Department of Health</li> </ul>
Management	<p><i>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.</i></p>	<ul style="list-style-type: none"> <li>• Symptom management grounded in shared decision-making, <del>including offer of menopausal hormone therapy (MHT) for those under 60 or within 10 years of their last menstrual period (LMP),</del> and non-hormonal treatments</li> <li>• Hormone therapy selection (type, route, dose, duration, etc.)</li> <li>• Use of evidence-based complementary and alternative medicines</li> <li>• <del>Risks and benefits of bioidentical hormone therapies and supplements</del></li> <li>• Lifestyle, prevention and screening for whole-person midlife health, such as for: <ul style="list-style-type: none"> <li>○ cardiovascular disease</li> <li>○ metabolic health</li> <li>○ osteoporosis</li> <li>○ mental health concerns</li> <li>○ urogenital and sexual health concerns</li> <li>○ etc.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Patients</li> <li>• Primary Care Systems (including PCP, OBGYN, Midwives, etc.)</li> <li>• Behavioral Health Systems and Providers</li> <li>• Health Plans</li> <li>• Department of Health</li> </ul>
Workplace Support and	<p><i>I feel supported by my workplace to talk openly about</i></p>	<ul style="list-style-type: none"> <li>• Employers offer a basic level of menopause-informed benefit design for hormone</li> </ul>	<ul style="list-style-type: none"> <li>• Primary Care Systems</li> </ul>

<p>Quality Measurement</p>	<p><i>menopause without stigma or negative impact to my career and can request flexibility and accommodation if needed to prioritize my health and wellbeing.</i></p>	<p>and nonhormone options for symptom management, practices and accommodations during the menopause transition inclusive of formal accommodations <del>paid leave</del>, and opportunities to openly discuss my experience with others</p> <ul style="list-style-type: none"> <li>• Systems (delivery systems, health plans, employers, state agencies) monitor and report out quality measures for perimenopause and menopause care</li> <li>• Accessible and available peer support groups</li> </ul>	<p>(including PCP, OBGYN, Midwives, etc.)</p> <ul style="list-style-type: none"> <li>• Behavioral Health Systems and Providers</li> <li>• Health Plans</li> <li>• Employers</li> <li>• Health Care Authority</li> </ul>
<p>Education</p>	<p><i>I learned about the full spectrum of sexual and reproductive health, including menopause, in school. before puberty. Trusted adults in my life, including healthcare professionals, know how to answer my questions from puberty through menopause.</i></p>	<ul style="list-style-type: none"> <li>• Integration of public education for menopause in school systems</li> <li>• Evidence-based and comprehensive curriculum on the menopausal transition in provider training and education</li> </ul>	<ul style="list-style-type: none"> <li>• Academic Medical Centers</li> <li>• Department of Health</li> </ul>

Discussion

- Plan for symptom management should have neutral language, so as not to assume the experience will be negative
- Remove the language of “detection” – it emphasizes diagnosis of a problem, which menopause is not
- How are we defining menopause?
  - STRAW criteria
- Positive response to incorporation of menopause in sexual and reproductive health education in grade schools (e.g., FLASH in King County)
- Changed compounded/bioidentical specific statement to a more vague statement about hormone selection that is all encompassing

- Still need to find a better term for “covered” under workplace supports – term covered means different things to employers and employees – employees will say its not covered if there’s a cost share component
- Consideration for state-level support of estradiol formulations give med supply chain shortage – often FDA allows for compounding to address the shortage in this situation

Links shared during meeting:

- [Menopause and Midlife Support Group for Women - Support Group in Seattle, WA, 98104 | Katherine May](#)
- <https://www.peps.org/programs>
- [Creating an action plan: guidance for employers - GOV.UK](#)
- <https://www.womens-health-concern.org/wp-content/uploads/2026/02/02-NEW-WHC-FACTSHEET-CBT-for-menop...>
- [01-NEW-BMS-TfC-CBT-NOV2025-C.pdf](#)

#### **PUBLIC COMMENT AND GOOD OF THE ORDER**

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Beth invited final comments or public comments, then thanked all for attending. At the next workgroup meeting, we will begin reviewing evidence for our first focus area: Recognition & Assessment. The workgroup’s next meeting will be on Wednesday, April 8th from 2:30-4PM, priority IN PERSON.