Bree Collaborative | Perimenopause and Menopause
May 13th 2026| 2:30-4PM
Hybrid

MEMBERS PRESENT VIRTUALLY

Nicole Saint Clair, MD, FACOG (chair), Regence
Karin Inderbitzin, RN, BSN, WA HCA
Annelise Gaaserud, MD, Kaiser Permanente
Carolyn Halley, MD, Healthpoint
Asher Strauss, PsyD, Kinwell
Jamie Kowatch, RD, CDCES
Laura MacPherson, MSN, Molina
Amy Laurent, MSPH, Microsoft

STAFF AND MEMBERS OF THE PUBLIC

Beth Bojkov, MPH, RN, Bree Collaborative
Karie Nicholas, MA, GDip, Bree Collaborative
Emily Nudelman, DNP, RN, Bree Collaborative

WELCOME AND INTRODUCTIONS

Beth reviewed the agenda for the day and asked for a motion to approve the minutes from the previous meeting

- Action: Motion to approve April minutes
- Outcomes: April minutes approved

REVIEW WORKPLAN & DESIRED OUTCOMES

Dr. Saint Clair transitioned the group to revisiting our workplan and desired outcomes. Key points to keep in mind include:

- To not reinvent the wheel
- Use the available guidelines, research and clinical expertise/judgment to simplify perimenopause and menopause management for all audiences
- Today's goal is to complete first draft of recognition and assessment guidelines and begin reviewing the management guidelines for menopausal hormone therapy

REVIEW & REVISE: RECOGNITION & ASSESSMENT GUIDELINES

Beth transitioned the meeting to review and edit the draft guidelines. Edits were made to the following in green text.

Primary Care

- Beginning at age 40, counsel and discuss perimenopause and menopause at routine visits ~~annual visits~~
- Assess and document symptoms, FMP, quality of life
- More difficult to diagnose for those on hormonal prescriptions and those post-hysterectomy
- Use validated tools for symptom assessment - incorporate validated tool into EHR
- Diagnosis for those 45+ should primarily be based on history and symptoms without lab testing
- Provide anticipatory guidance on symptom severity, duration, expected changes
- Discuss available treatments (hormonal, nonhormonal)
- Ask about and evaluate post-menopausal bleeding If unsure if symptoms are related to perimenopause or menopause, or suspect primary ovarian insufficiency, consider specialty referral

- Special populations

Behavioral Health

- Recognize perimenopause and menopause as a contributor to behavioral health
- Beginning at age 40, incorporate a brief menopause-informed assessment for all appropriate patients
- Coordinate with primary care (specifics for integrated and nonintegrated)
- Special considerations (early menopause or POI, gender-affirming care)

Health Plan

- Indicate menopause-certified providers in an accessible provider directory.
- Promote evidence-based menopause support resources for all members beginning at age 40+
- Continue to support behavioral health integration and co-location with primary care.
- Incorporate assessment/ counseling for perimenopause/menopause under routine preventive visit coverage ($0 copay)

DOH

- Consider perimenopause and menopause care and midlife women's health needs when performing population health needs assessments

OIC

- Require all insurance to cover menopause symptom assessment and management as preventive care

Discussion

- Include chronic UTI and yeast infection as actively listed issues under Genitourinary
- May want to add something under weight changes – menopause-related adiposity changes are frequently resistant to change through this period
- Oral contraceptives are covered explicitly under the ACA – is there flexibility to cover MHT in a similar sense? Need more information from OIC/health plans

REVIEW: BRIEF MHT EVIDENCE REVIEW

Beth transitioned the meeting to a brief evidence review of menopausal hormone therapy to prepare for discussing management guidelines. The following was covered:

- Why MHT matters: prevalence of symptoms, impact on workplace and productivity, MHT as the most effective treatment for VMS and GSM, miscommunication from early WHI findings and impact on practice
- Findings from WHI trial on risk of adverse events using CEE +/- MPA; when looking at younger ages, only statistically significant risk was VTE – observational data suggest lower risk with transdermal routes; WHI subgroup analysis for those 50-59 had 40% lower MI risk, lower all-cause mortality -> supports timing hypothesis
- NICE shared decision-making tool for MHT using visualizations to communicate absolute risk
- Guideline comparison on approach to MHT (NICE, NAMS, CMS, Endocrine Society, IMS)
    - All emphasize individualized patient-centered decision-making, periodice risk-benefit evaluation
    - "critical window" is a unifying theme – starting MHT during or near menopause yields best benefits
    - More recent guidelines emphasize no uppoer age limit, extended use aceptabale for those having ongoing symptoms or high risk of fracture
    - Oral estrogen has highest risk of VTE compared to other methods; micronized progesterone highlighted by some as having better safety profile than other progestins

REVIEW: MANAGEMENT (MHT) GUIDELINES

Beth transitioned the group to review guidelines for management related to menopausal hormone therapy. Changes below written in green.

- Patients
  - MHT is highly effective for vasomotor and genitourinary symptoms
  - Most appropriate if <60 or within 10 years of FMP
  - Review personal risks with clinician
  - Engage in informed discussion about benefits, risks, and preferences
- Primary Care
  - Evaluate contraindications before prescribing
  - Use shared decision-making—greatest benefit in <60 / early menopause
  - When presenting with VMS, GSM, (top 5) in age range/<10 years since menopause consider MHT first line along with other therapies
  - ~~Initiate MHT for bothersome VMS/GSM symptoms;~~ MHT is first line of treatment unless contraindicated or not preferred; use lowest effective dose; periodically reassess
  - Prefer transdermal routes to reduce VTE risk when appropriate
  - Counsel on risks: small ↑ breast cancer (EPT), ↑ VTE/stroke (lower with non-oral)
  - Offer alternatives when needed (SSRIs/SNRIs, gabapentin, clonidine, NK3 antagonists)
  - Use vaginal estrogen for GSM (generally safe)
  - Avoid compounded bioidentical HT due to safety concerns
  - Incorporate decision aids into workflow
  - Do not initiate MHT at 65+ (BEERs criteria)
- Behavioral Health
  - MHT is not first-line for primary mood disorders
  - Screen for menopause-related contribution to symptoms
  - Review strategies and lifestyle changes for managing symptoms
  - Consider referral for MHT if vasomotor symptoms coexist and antidepressants and BH strategies are ineffective

Discussion

- Need further guidance on sequencing of MHT
- Consider the whole symptom profile together – joint pain, insomnia, VMS, GSM, sleep, mood, etc. – encourage providers to ask about other symptoms not just VMS and GSM

PUBLIC COMMENT AND GOOD OF THE ORDER

Dr. Saint Clair invited final comments or public comments, then thanked all for attending. The workgroup's next meeting will be on **Wednesday, June 10th from 2:30-4PM PST.**