

# Dr. Robert Bree Collaborative reproductive and sexual health report

Second Substitute Senate Bill 5602; Section 6; Chapter 399; Laws of 2019  
December 15, 2020



# Dr. Robert Bree Collaborative reproductive and sexual health report

## Acknowledgments

Thank you to our Sexual and Reproductive Health Workgroup chair, Dr. Charissa Fotinos, and our Bree Collaborative chair, Dr. Hugh Straley.



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# Table of contents

Executive summary .....	1
Background.....	2
Defining reproductive health.....	3
Washington State demographics.....	5
Recommendation framework .....	6
References .....	8
Appendix A: Bree Collaborative background.....	9
Appendix B: Bree Collaborative members .....	11
Appendix C: Reproductive and Sexual Health Workgroup members .....	13



# Executive summary

*Stakeholders working together to improve health care quality, outcomes, affordability, and equity in Washington State.*

This report describes the work of the Bree Collaborative to develop recommendations for sexual and reproductive health. It is submitted by the Health Care Authority (HCA) on behalf of the Dr. Robert Bree Collaborative (Bree Collaborative or Collaborative) to the Washington State Legislature, as directed in Substitute Senate Bill 5602 (SSB 5602), Section 6, and enacted as Chapter 399, Laws of 2019.

HCA is the sponsoring agency of the Bree Collaborative, a public/private group created to give health care stakeholders the opportunity to improve health care quality, patient outcomes, affordability, and equity in Washington State through recommendations regarding specific health care services.

Since its 2011 formation, the Bree Collaborative has successfully pursued its mission. In 2020, the Collaborative convened a workgroup to improve quality, equity, and cultural appropriateness of reproductive and sexual health care services across the lifespan in Washington State. The workgroup expanded on the populations identified in SSB 5602 to focus on improvement of clinical services for those who are Black; indigenous; people of color; immigrants or refugees; have experienced violence including human trafficking; people with disabilities; and Lesbian, Gay, Bisexual, Transgender, and/or Questioning or Queer (LGBTQ+).

Rather than develop best practices specific to these population groups, which could further stigmatize already underserved populations, the workgroup recognizes the impact of intersectionality (i.e. membership in multiple demographic groups) on an individual's identity. In addition, past experiences, access to resources, and impact of both positive and negative historical events impact individual identity, health, and care needs. In response to this, the workgroup focused on framing improvement areas around broad, yet tangible best practices. Autonomy, the hallmark of person-centered care, and equity form the foundation of these recommendations.

The four focus areas are:

- Cultural humility
- Access to care
- Care that is person-centered
- Appropriate care

Within the report, the focus areas are outlined through clinical steps and checklists specific to individual stakeholder groups including: patients and family members, delivery systems, health plans, Washington State agencies, and correctional facilities. The report further unpacks the four focus areas with supporting evidence for recommended changes and recommendations on how to measure and monitor population health, clinical quality, and pay for value. This legislative report summarizes the guidelines in the full set of recommendations that will be available on the [Bree Collaborative website](#).



# Background

A person's sexual and reproductive health needs are informed both by membership in broader population groups and by their own individual and unique experiences. Underserved groups may share specific exposures, such as lack of access to health insurance coverage or cultural/linguistic obstacles. These exposures contribute to disproportionately high rates of unintended pregnancy and sexually-transmitted diseases, and also lower rates of screening for common cancers of the reproductive and sexual organs and therefore higher morbidity and mortality from these cancers due to delayed diagnosis.<sup>1,2</sup> Disparities in screening for common cancers such as breast and cervical cancer are seen geographically in Washington State with lower rates in rural areas.<sup>3</sup> Therefore geography as well as class contributes to access to and lack of health care.

Some disorders of the reproductive organs are more prevalent and more severe in people of particular ethnic and racial backgrounds. For example, Black women are more likely to have fibroid tumors and are more likely to have larger and more numerous tumors, while Asian women in some studies have higher rates of endometriosis.<sup>4</sup> Stress from racism, also known as weathering, especially for those who are Black, can cause systemic inflammation leading to poor health outcomes and contributing to overall disparities in health and mortality.<sup>5</sup>

Drastic health disparities are seen in the variability in maternal mortality. The United States has the highest maternal death rate among developed nations with more than 50,000 mothers having life-threatening complications annually.<sup>6,7</sup> Mortality differs greatly based on race and ethnicity, with Black mothers being three to four times as likely to die in childbirth than white mothers and more likely to suffer complications that lead to maternal death and injury.<sup>8</sup> Black newborns similarly have higher mortality rates than white newborns, a rate that is dramatically reduced when they are cared for by Black clinicians.<sup>9</sup> Similarly, indigenous gestational parents are disproportionately likely to die during and after childbirth. Equity in provision of reproductive and sexual health services, truly meeting an individual's needs rather than equality or providing the same service to all, has the potential to reduce this disparity.

Washington State has prioritized increasing quality, affordability, and equity of health care through innovation work such as the [Health Technology Assessment program](#), the [Prescription Drug Program](#), [Healthier Washington](#), and the [Dr. Robert Bree Collaborative](#). The Bree Collaborative's work is a key component of [Healthier Washington](#), outlining evidence-based standards of care and purchasing guidelines for high-variation, high-cost health care services. The Bree Collaborative is structured after the work of the Advanced Imaging Management (AIM) project and named in memory of Dr. Robert Bree. Dr. Bree was a leader in the imaging field and a key member of the AIM project working to reduce inappropriate use of advanced imaging (e.g., CT, PET, and MRI scans) in Washington State. See Appendix A: Bree Collaborative Background for more information and Appendix B for the list of Bree Collaborative members.

The Washington State Legislature established the Bree Collaborative in 2011 to provide a process for public health care purchasers for Washington State, private health care purchasers (self-funded employers and union trusts), health plans, physicians and other health care providers, hospitals, and quality improvement organizations to work together to identify and recommend evidence-based strategies to improve health care quality, outcomes, and affordability. Engrossed Substitute House Bill 1311 (ESHB 1311) amended RCW 70.250.010 (Advanced Diagnostic Imaging Workgroup Dr. Robert Bree Collaborative reproductive and sexual health report December 15, 2020



definition) and 70.250.030 (Implementation of Evidence-Based Practice Guidelines or Protocols); added a new section to Chapter 70.250 RCW; created a new section; and repealed RCW 70.250.020. All Collaborative meetings are open to the public and follow [the Open Public Meetings Act](#).

Substitute Senate Bill 5602 added a new section to Chapter 70.250 RCW to read as follows:

(1) No later than January 1, 2020, the collaborative shall begin a review to identify, define, and endorse guidelines for the provision of high quality sexual and reproductive health services in clinical settings throughout Washington. This shall include the development of specific clinical recommendations to improve sexual and reproductive health care for:

- (a) People of color;
- (b) Immigrants and refugees;
- (c) Victims and survivors of violence; and
- (d) People with disabilities.

(2) The collaborative shall conduct its review consistent with the activities, processes, and reporting standards specified in RCW 70.250.050. In conducting its review, the collaborative shall apply a whole-person framework to develop evidence-based, culturally sensitive recommendations to improve standards of care and health equity.

(3) By December 15, 2020, the collaborative, through the authority, shall provide a status report to the committees of the legislature with jurisdiction over matters related to health care and to the governor.

The Collaborative convened a workgroup to address SSB 5602 in January 2020 that has met monthly to develop evidence-informed best practices (See Appendix C for the list of workgroup members.). The workgroup expanded on the populations identified in SSB 5602 to focus on improvement of clinical services for those who are Black, indigenous, people of color, immigrants or refugees, have experienced violence including human trafficking, people with disabilities, and Lesbian, Gay, Bisexual, Transgender, and/or Questioning or Queer (LGBTQ+).

Differences in population disease burden, needs, and resilience necessitate tailored clinical services and care. Building from an equity framework, the workgroup sought to ground changes in a targeted universalism approach, universal goals of high-quality, evidence-informed sexual and reproductive health care pursued by targeted interventions for populations more likely to experience disparities.<sup>10</sup> Identifying disparities by population group is important to direct targeted interventions and monitor change. The workgroup urges better collection of data on an individual's race and ethnicity to identify and intervene in areas where there are documented disparities.

**Learn more about the workgroup and see all past meeting materials:**

[www.breecollaborative.org/topic-areas/current-topics/reproductive-health/](http://www.breecollaborative.org/topic-areas/current-topics/reproductive-health/)

## Defining reproductive health

The World Health Organization defines reproductive health as *“a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes...imply[ing] that people are able to have a*

Dr. Robert Bree Collaborative reproductive and sexual health report  
December 15, 2020



*satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.”<sup>11</sup>*

Reproductive and sexual health services are broad and include screening and treatment for sexually transmitted infections, screening and treatment of disorders of the genital organs (e.g., cancer, fibroids, endometriosis), and family planning including contraception, infertility treatment, pre-conception care, prenatal care, labor and delivery, postpartum care, and pregnancy termination. Further, reproductive and sexual health services can serve as an entry point into the health care system, helping to decrease disparities in access to care and potentially outcomes broadly. The workgroup did not review clinical best practice guidelines for the multitude of clinical services encompassing reproductive and sexual health (e.g., for adolescents, for older adults) and rather focused on a framework to address the disparities in access to or content of care for the priority populations.

The 2018 Guttmacher–Lancet Commission on sexual and reproductive health and rights argues for *“removing barriers that hinder...individuals’ [being] able to make decisions about their own sexual and reproductive lives, and exercise their sexual and reproductive rights...at policy, system, community, and societal levels.”<sup>12</sup>* Reproductive justice, complementary to the above, is the, *“human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities.”<sup>13</sup>* Both of these frameworks informed the structure and content of the recommendations.



## Washington State demographics

The United States as a whole is moving to a minority-majority population, which is estimated to occur around 2050.<sup>14</sup> Approximately 14 percent, or 1.06 million people, reside in Washington State who were born abroad.<sup>15</sup> Of that 1.06 million, 45 percent were born in Asia, 30 percent in Latin America, 15 percent in Europe, and 6 percent in Africa.<sup>4</sup> Washington state is home to approximately 7.6 million people, of whom:

- 78.9 percent identify as white
- 4.3 percent as Black or African American, alone
- 1.9 percent as American Indian or Alaska Native
- 9.6 percent as Asian, alone
- 0.8 percent as Native Hawaiian or other Pacific Islander, alone
- 4.8 percent as two or more races
- 12.9 percent as Hispanic or Latino
- 68 percent as white, alone (not Hispanic or Latino)<sup>16</sup>

Approximately 8.8 percent of Washingtonians under 65 report having a disability, defined as serious difficulty with one or more basic areas of functioning including hearing, vision, cognition, and ambulation.<sup>3</sup>

Approximately 4.6 percent of Washingtonians identify as lesbian, gay, bisexual, transgender or queer or questioning (LGBTQ), 4.8 percent of people in the Seattle-Tacoma-Bellevue metro area.<sup>17,18</sup> Of people who are transgender in Washington State, 14 percent report being unemployed, 28 percent report living in poverty, 38 percent report serious psychological distress, and 38 percent report at least one negative health care-related experience due to being transgender.<sup>19</sup>

Violence occurs in multiple contexts, including interpersonal violence as well as violence caused by the state. Due to stigma, fear, and other factors, accurate reporting is difficult. According to national surveys, 51.9 percent of women and 66.4 percent of men report being physically assaulted as a child by a caretaker or assaulted as an adult.<sup>20</sup> Approximately 33 percent of women and 17 percent of men have experienced contact sexual violence from an intimate partner at some point in their lifetime. Additionally, 25 percent of women and 11 percent of men have experienced contact sexual violence from any source, resulting in injury, fear, concern for safety, and needing additional health care services due to the trauma.<sup>21</sup> Further, more than half of women who have experienced contact physical violence report symptoms of post-traumatic stress disorder.<sup>6</sup>





# Recommendation framework

While the clinical steps our workgroup developed are directed to providers of clinical care, true change requires the coordinated efforts of all sectors within health care. The framework below is further elaborated in the report for health plans, employers, patients and families, state agencies, and correctional facilities. The workgroup aims to create a health care system in which cultural humility, increased access, and care that is both person-centered and appropriate underpin all interactions, especially those involving sexual and reproductive health. This frame acknowledges that an individual has many intersecting identities, all of which contribute to overall health, and that may not be apparent or be documented within a person’s health record.

**Table 1: Focus Areas and Outline of Clinical Steps**

Focus Area	Outline of Clinical Steps
<b>Cultural Humility</b>	<ul style="list-style-type: none"> <li>• Understand the historical and cultural background of a patient population including the role of the state or the medical establishment in causing harm or oppression and self-awareness of implicit bias</li> <li>• Engage with the community</li> <li>• Provide culturally humble care</li> </ul>
<b>Access</b>	<ul style="list-style-type: none"> <li>• Offer enhanced access to care (e.g., same-day access, after hours, telehealth)</li> <li>• Ensure that care is physically accessible to those of all abilities including accessible transportation</li> <li>• Understand the financial barriers (including insurance) for your patient population including those that may exist due to immigration or residency status</li> <li>• Offer materials and services in languages appropriate to your population</li> <li>• Offer accessible materials that are easy to understand and available in a variety of accessible formats including braille, large print, audio, at an 8<sup>th</sup> grade reading level</li> <li>• Assess the person’s understanding of topics discussed using the teach back or show me method (demonstrate what they have been told)</li> </ul>
<b>Person-Centered Care</b>	<ul style="list-style-type: none"> <li>• Understand a person’s individual needs</li> <li>• Build interpersonal trust within the clinical visit</li> <li>• Build a trauma-aware workforce of clinical and non-clinical staff</li> <li>• Examine and mitigate coercion or provider bias including implicit bias based on race, ethnicity, being indigenous, gender, sex, LGBTQ+, age, disability, immigration status, weight, or other patient-specific factors</li> <li>• Reaffirm the confidentiality of care including test results, medications, appointments, and communications</li> <li>• Involve family or friends if desired by the person</li> </ul>
<b>Appropriate care</b>	<ul style="list-style-type: none"> <li>• Educate the person about healthy relationships and intimate partner violence</li> <li>• Offer prevention, screening, and onsite treatment or referral for reproductive health conditions including cancer screenings as outlined in the United States Preventive Services Task Force, sexually transmitted infection screening and</li> </ul>

Dr. Robert Bree Collaborative reproductive and sexual health report  
December 15, 2020



**Table 1: Focus Areas and Outline of Clinical Steps**

Focus Area	Outline of Clinical Steps
	<p>treatment, and behavioral health screening and brief intervention or referral to treatment</p> <ul style="list-style-type: none"><li>• Ask all people about parenting intention in the next year annually, at least</li><li>• Offer contraceptive counseling including a full range of contraceptive choices during same-day appointments and infertility treatment (or referral). Use a shared-decision making approach for all people</li><li>• Offer or refer to accessible pre-conception care, prenatal care, labor and delivery, postpartum care, and pregnancy termination services</li></ul>



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# Appendix A: Bree Collaborative background

The Bree Collaborative has had great success working with many Washington State organizations to solicit nominations of experienced and engaged community leaders as Bree Collaborative members. In August 2011, the WSHA, the Washington State Medical Association (WSMA), the Association of Washington Healthcare Plans (AWHP), large employers, and other community stakeholders nominated health care experts who served as the Bree Collaborative's first 23 members after appointment by former Governor Chris Gregoire.

Steve Hill served as the Bree Collaborative's first Chair. Mr. Hill is the former director of the Washington State Department of Retirement Systems and former director of the HCA. In November 2014 Mr. Hill announced his retirement as Chair of the Bree Collaborative, and in March 2015 Governor Jay Inslee appointed Dr. Hugh Straley as chair. Dr. Straley is board certified in both internal medicine and medical oncology and served in many leadership roles at Group Health Cooperative. He retired as medical director and president of Group Health Physicians in 2008. He has also served as chief medical officer for Soundpath Health and as interim medical director and consultant to Amerigroup Washington.

A steering committee advises the chair. The committee is comprised of Bree Collaborative members representing a health care purchaser, health plan, health care system, and quality improvement organization. See **Appendix C** for a current list of steering committee members.

The Bree Collaborative is housed in the Foundation for Health Care Quality. The Foundation provides project management and is responsible for employing staff. Funding from the HCA is secure through June 2020 as part of the state's budget process through a four-year grant.

The Bree Collaborative has held meetings since 2011. Find agendas and materials for all Collaborative meetings on the Bree Collaborative website: [www.breecollaborative.org](http://www.breecollaborative.org). All Collaborative meetings are open to the public and follow the Open Public Meetings Act.

At the November 2012 meeting, the Bree Collaborative adopted bylaws setting policies and procedures governing the Bree Collaborative beyond the mandates established by the legislation (ESHB 1311). The Collaborative revised bylaws in September 2014.

**Find current bylaws at:** [www.breecollaborative.org/wp-content/uploads/bylaws-final.pdf](http://www.breecollaborative.org/wp-content/uploads/bylaws-final.pdf)

After the Bree Collaborative identifies a focus area, it must identify and analyze evidence-based best practices to improve quality and reduce variation in practice patterns. The Bree Collaborative must also identify data collection and reporting sources and methods to establish baseline utilization rates and measure the impact of strategies reviewed by the Collaborative. To the extent possible, the Bree Collaborative must minimize cost and administrative burden of reporting and use existing data resources.



The Bree Collaborative must also identify strategies to increase the use of evidence-based practices. Strategies may include:

- Goals for appropriate utilization rates
- Peer-to-peer consultation
- Provider feedback reports
- Use of patient decision aids
- Incentives for the appropriate use of health services
- Centers of Excellence or other provider qualification standards
- Quality improvement systems
- Service utilization or outcome reporting

The Governor must appoint the Collaborative chair, and the HCA must convene the Collaborative. The Bree Collaborative must add members or establish clinical committees, as needed, to acquire clinical expertise in specific health care service areas under review. Each clinical committee shall include at least two members of the specialty or subspecialty society most experienced with the health service identified for review.

ESHB 1311, Section 3 calls for the Bree Collaborative to:

“... report to the administrator of the authority regarding the health services areas it has chosen and strategies proposed. The administrator shall review the strategies recommended in the report, giving strong consideration to the direction provided in section 1, chapter 313, Laws of 2011 and this section. The administrator's review shall describe the outcomes of the review and any decisions related to adoption of the recommended strategies by state purchased health care programs. Following the administrator's review, the Bree Collaborative shall report to the legislature and the governor regarding chosen health services, proposed strategies, the results of the administrator's review, and available information related to the impact of strategies adopted in the previous three years on the cost and quality of care provided in Washington State.”



## Appendix B: Bree Collaborative members

Member	Title	Organization
1. Gary Franklin, MD, MPH	Medical Director	Washington State Department of Labor and Industries
2. Stuart Freed, MD	Chief Medical Officer	Confluence Health
3. Richard Goss, MD	Medical Director	Harborview Medical Center, University of Washington
4. Wm. Richard Ludwig, MD	Chief Medical Officer, Accountable Care Organization	Providence Health and Services
5. Greg Marchand	Director, Benefits & Policy and Strategy	The Boeing Company
6. Robert Mecklenburg, MD	Medical Director, Center for Health Care Solutions	Virginia Mason Medical Center
7. Kimberly Moore, MD	Associate Chief Medical Officer	Franciscan Health System
8. Carl Olden, MD	Family Physician	Pacific Crest Family Medicine, Yakima
9. Drew Oliveira, MD	Executive Medical Director	Regence BlueShield
10. Mary Kay O'Neill, MD, MBA	Partner	Mercer
11. John Robinson, MD, SM	Chief Medical Officer	First Choice Health
12. Jeanne Rupert, DO, PhD	Provider	One Medical
13. Angela Sparks, MD	Medical Director Clinical Knowledge Development and Support	Kaiser Permanente Washington
14. Hugh Straley, MD (Chair)	Retired	Medical Director, Group Health Cooperative; President, Group Health Physicians
15. Shawn West, MD	Medical Director	Embrite
16. Laura Kate Zaichkin, MPH	Director of Health Plan Performance and Strategy	SEIU 775 Benefits Group

Dr. Robert Bree Collaborative reproductive and sexual health report  
December 15, 2020



Member	Title	Organization
17. Judy Zerzan, MD, MPH	Chief Medical Officer	Washington State Health Care Authority



# Appendix C: Reproductive and Sexual Health Workgroup members

Member	Title	Organization
1. Trish Anderson, MBA	Senior Director, Safety and Quality	Washington State Hospital Association
2. Janet Cady, ARNP	Medical Director, School Based Program	Neighborcare
3. Angela Chien, MD	Obstetrics and Gynecology	EvergreenHealth
4. Paul Dillon/Lili Navarrete	Latinx Outreach & Organizing Program	Planned Parenthood of Greater Washington and North Idaho
5. Colin D. Fields, MD	Chief, Gender Health Program	Kaiser Permanente Washington
6. Charissa Fotinos, MD (Chair)	Deputy Chief Medical Officer	Washington State Health Care Authority
7. Leo Gaeta	Vice President of Programs	The Columbia Basin Health Association
8. Cynthia Harris, PhD	Family Planning Program Manager	Department of Health
9. Leigh Hofheimer	Program Coordinator	Washington State Coalition Against Domestic Violence
10. Rita Hsu, MD, FACOG	Obstetrics and Gynecology	Confluence Health
11. Heather Maisen, MPH, MSW	Family Planning Program Manager	Public Health – Seattle & King County
12. Adrienne Moore	Deputy Director of Quality Improvement	Upstream
13. Ivanova Smith	Patient Advocate	UW LEND Faculty

Dr. Robert Bree Collaborative reproductive and sexual health report  
December 15, 2020





Member	Title	Organization
14.	Mandy Weeks-Green	Senior Health Policy Analyst
15.	Catherine West, JD	Legal Voice (formerly Northwest Women's Law Center)
16.	Giselle Zapata-García	Co-Director
		Latinos Promoting Good Health (also Latinx Health Board, Executive Committee Co-Chair)

