

Background

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...impl[ing] that people are able to have a 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.*”¹ Reproductive and sexual health services are broad and include screening and treatment for sexually transmitted infections, screening and treatment of cancers of the genital organs, and family planning including contraception, infertility treatment, pre-conception care, prenatal care, labor and delivery, and postpartum care. 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 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.”² These recommendations aim to improve quality, equity, and cultural appropriateness of reproductive and sexual health care services across the lifespan in Washington State especially for people of color, immigrants and refugees, victims and survivors of violence including of human trafficking, people with disabilities, American Indians/Alaska Natives, and those who are Lesbian, Gay, Bisexual, Transgender, and/or Questioning or Queer (LGBTQ). Patient autonomy is a hallmark of patient-centered care and forms the foundation of these recommendations.

Coercion and violation of human rights have marked the interaction of many minority groups with and within the medical system. The legacy of slavery, Jim Crow laws, non-consensual medical experiments including forced sterilizations and the Tuskegee Syphilis Study in which syphilis was left untreated by the United States Public Health Service among black men in Alabama until 1972, along with pervasive racism inform health disparities between black and white Americans today.³ This historical lens can and should be applied across population groups, from the impact of genocide and forced separation of children from parents and community among the American Indian and Alaska Native population on some of the poorest health outcomes of any racial group, to the forced sterilization of people with disabilities.⁴ These themes of lack of autonomy, respect, and individual value run through experiences from the inception of the United States to current day. Interventions aimed at improving health of any population must be informed by that people’s history and include the voice and perspective of those people and the community organizations they lead.

Washington State Demographics

Washington state is home to approximately 7.6 million people, of whom 78.9% identify as white; 4.3% as black or African American, alone; 1.9% as American Indian or Alaska Native, 0.8% as Native Hawaiian or other Pacific Islander, alone; 4.8% as two or more races; 12.9% as Hispanic or Latino; and 68% as white, alone (not Hispanic or Latino).⁵ The United States as a whole is moving to a minority-majority population, estimated to occur around 2050.⁶ Approximately 14%, 1.06 million people, reside in Washington State and were born abroad in 2017.⁷ Of that 1.06 million, 45% were born in Asia, 30% in Latin America, 15% in Europe, and 6% in Africa.⁴ Approximately 8.8% 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.³ Approximately 4.6% of Washingtonians identify as lesbian, gay, bisexual, transgender or queer or questioning (LGBTQ), 4.8% of people in the Seattle-Tacoma-Bellevue metro area.^{8,9}

Violence is common, but more difficult to report at a state level. Of those surveyed, 51.9% of women and 66.4% of men report being physically assaulted as a child by a caretaker or assaulted as an adult.¹⁰ Approximately 33% of women and 17% of men have experienced contact sexual violence from an intimate partner some point in their lifetime and 25% of women and 11% of men have experienced contact sexual violence from any source, resulting in injury, fear, concern for safety, and needing services.¹¹ More than half of women who have experienced contact physical violence report symptoms of post-traumatic stress disorder.⁶

Measuring Disparities

Minority populations experience disproportionately high rates of unintended pregnancy and sexually-transmitted diseases and also experience lower rates of screening for common cancers.^{12,13} Disparities in screening for common cancers such as breast and cervical cancer are seen geographically as well in Washington State.¹⁴ Foreign-born women are less likely to have health insurance when compared to those born in the United States and less likely to use sexual and reproductive health care services.¹⁵ Lack of coverage stems mainly from systemic policy barriers.¹⁶

2020 Workgroup

The Bree Collaborative was asked through the 2019 Senate Bill 5602 to develop form a workgroup 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.”

The workgroup met from January to October 2020 to recommend system- and individual-level changes to build a health care system that truly meetings the needs of a diverse population. Differences in population disease burden, needs, and resilience necessitate different clinical services and care. The workgroup also aspires to build a health care system that fits the needs of our diverse population and so developed the following focus areas

- Access to sexual and reproductive health care including through language and literacy level, physical access,
- Appropriate care
- Patient-centeredness including reducing stigma and confidentiality
- Cultural sensitivity and being humble

Recommendation Framework

Disparities in population disease burden (e.g., uterine fibroids, prostate cancer, outcomes such as higher material mortality for African American gestational parents, access to care such as through insurance barriers for the immigrant population, and individual and population-level resilience necessitate different interventions. Further, an individual has many intersecting identities, all of which contribute to overall health.

	Access	Appropriate care	Patient-centeredness	Cultural sensitivity and being humble
People of Color			Trust	
Immigrants and Refugees	Insurance Language		Trust	
Victims and survivors of violence			Trust	
People with disabilities	Physical access		Trust	
American Indian/Alaska Native			Trust	
LGBTQ			Trust	

Examples from Shared Decision-Making Report

Patients and Family Members

- Think about your broad health and wellness-related goals (e.g., being able to attend an upcoming family wedding).
- Where different options are available, like the areas noted in this document, give your provider(s) information about your values and preferences and discuss options, tradeoffs, and implications of a decision together.
- Ask about whether a patient decision aid is available.
- Ask your care provider about the test or treatment options available, including the option of “doing nothing” or “watchful waiting.”

Health Care Delivery Organizations and Systems

Providers

- Participate in skills training. Shared decision making is a learned skill set that is supported by patient decision aids.

Health Plans and/or Professional Liability Carriers

- Incorporate shared decision-making requirements as standards for value-based models (e.g., Centers of Excellence).

Employers

- Incorporate shared decision-making requirements as standards for value-based contracting (e.g., Centers of Excellence, Accountable Care Organizations).
- Talk to your health plan about the importance of shared decision making and how to report on use of shared decision making including how to ensure appropriate reimbursement.

Washington State Health Care Authority

- Encourage the patient decision aid developer community to develop patient decision aids for the ten priority areas publicly available at no cost.

Examples from Shared Decision-Making Report

Options for tracking shared decision making are below including those aligning with value-based reimbursement models from the Bree Collaborative and Federal programs:

- **Shared Decision-Making Process**

Steward: Massachusetts General Hospital

NQF #2962

This measure assesses the extent to which health care providers actually involve patients in a decision-making process when there is more than one reasonable option. This proposal is to focus on patients who have undergone any one of seven common, important surgical procedures: total replacement of the knee or hip, lower back surgery for spinal stenosis of herniated disc, radical prostatectomy for prostate cancer, mastectomy for early stage breast cancer or percutaneous coronary intervention (PCI) for stable angina. Patients answer four questions (scored 0 to 4) about their interactions with providers about the decision to have the procedure, and the measure of the extent to which a provider or provider group is practicing shared decision making for a particular procedure is the average score from their responding patients who had the procedure.

- **Informed, Patient-Centered Hip and Knee Replacement Surgery**

NQF #2958

Steward: Massachusetts General Hospital

The measure is derived from patient responses to the Hip or Knee Decision Quality Instruments. Participants who have a passing knowledge score (60% or higher) and a clear preference for surgery are considered to have met the criteria for an informed, patient-centered decision. The target population is adult patients who had a primary hip or knee replacement surgery for treatment of hip or knee osteoarthritis.

Appendix C: Guideline and Systematic Review Search Results

	Year	Title	Summary
AHRQ: Research Findings and Reports	2019	Can Physical Activity Improve the Health of Wheelchair Users? A Systematic Review	In-progress
	2018	Achieving Health Equity in Preventive Services: Systematic Evidence Review	In populations adversely affected by disparities, evidence is strongest for patient navigation to increase colorectal, breast, and cervical cancer screening; telephone calls and prompts to increase colorectal cancer screening; and reminders including lay health workers encouraging breast cancer screening. Evidence is low or insufficient to determine effects of barriers or effectiveness of other interventions because of lack of studies and methodological limitations of existing studies.
	2012	Closing the Quality Gap Series: Quality Improvement Interventions To Address Health Disparities	The literature on QI interventions generally and their ability to improve health and health care is large. Whether those interventions are effective at reducing disparities remains unclear. This report should not be construed to assess the general effectiveness of QI in the health care setting; rather, QI has not been shown specifically to reduce known disparities in health care or health outcomes. In a few instances, some increased effect is seen in disadvantaged populations; these studies should be replicated and the interventions studied further as having potential to address disparities.
Cochrane Collection Reviews	2015	Advocacy interventions to reduce or eliminate violence and promote the physical and psychosocial well-being of women who experience intimate partner abuse	Intensive advocacy may improve everyday life for women in domestic violence shelters/refuges in the short term and reduce physical abuse one to two years after the intervention. There is no clear evidence that intensive advocacy reduces sexual, emotional, or overall abuse, or that it benefits women’s mental health. It is unclear whether brief advocacy (mostly given in healthcare settings) is effective, although it may provide short-term mental health benefits and reduce abuse, particularly in pregnant women and those suffering less severe abuse. We considered the results of several studies to be potentially biased because of weak study designs. There was little consistency between studies, with variations in the amount of advocacy given, the type of benefits measured, and the lengths of follow-up periods. As a result, it was hard to combine their results, and we cannot be certain of how much advocacy interventions benefit women or the impact of the type of advocacy, the place it was given, or the severity of the abuse experienced by the women receiving the intervention.
	2015	Screening women for intimate partner violence in healthcare settings	The evidence shows that screening increases the identification of women experiencing IPV in healthcare settings. Overall, however, rates were low relative to best estimates of prevalence of IPV in women seeking healthcare. Pregnant women in antenatal settings may be more likely to disclose IPV when screened, however, rigorous research is needed to confirm this. There was no evidence of an effect for other outcomes

(referral, re-exposure to violence, health measures, harm arising from screening). Thus, while screening increases identification, there is insufficient evidence to justify screening in healthcare settings. Furthermore, there remains a need for studies comparing universal screening to case-finding (with or without advocacy or therapeutic interventions) for women's long-term wellbeing in order to inform IPV identification policies in healthcare settings.

2014 [Interventions for preventing or reducing domestic violence against pregnant women](#)
 There is insufficient evidence to assess the effectiveness of interventions for domestic violence on pregnancy outcomes. There is a need for high-quality, RCTs with adequate statistical power to determine whether intervention programs prevent or reduce domestic violence episodes during pregnancy, or have any effect on maternal and neonatal mortality and morbidity outcomes.

None

<https://www.cdc.gov/sexualhealth/>

None

2013 [Intimate Partner Violence: Prevalence Among U.S. Military Veterans and Active Duty Servicemembers and a Review of Intervention Approaches](#)
 We also identified six SRs that evaluated interventions aimed at decreasing exposure to IPV. None of these SRs assessed primary IPV prevention strategies; all summarized literature on secondary prevention strategies such as screening for IPV. Overall, screening in health care settings increases identification of IPV victimization and appears to be feasible and acceptable. Screening alone, however, does not decrease rates of IPV victimization. Other secondary prevention strategies (behavioral interventions, advocacy interventions) provide insufficient evidence to demonstrate significant changes in IPV or IPV-related mental or physical harms.

Health Technology Assessment Program
 Centers for Disease Control and Prevention

Institute for Clinical and Economic Review
 Veterans Administration
 Evidence-based Synthesis Program

<p><u>2015</u></p>	<p><u>Racial and Ethnic Disparities in Obstetrics and Gynecology</u></p>	<p>Reducing racial and ethnic disparities in health and health care should be a priority for all obstetrician–gynecologists and other women’s health care providers. Obstetrician–gynecologists can help to meet this objective by</p> <ul style="list-style-type: none"> • raising awareness among colleagues, residents, staff, and hospital administrators about the prevalence of racial and ethnic disparities and the effect on health outcomes • understanding the role that practitioner bias can play in health outcomes and health care • strongly encouraging the adoption of federal standards for collection of race and ethnicity information in clinical and administrative data to better identify disparities • promoting research that not only identifies structural and cultural barriers to care but also tests the effectiveness of interventions to address such barriers • educating patients in a culturally sensitive manner about steps they can take to prevent disease conditions that are prevalent in their racial and ethnic groups • supporting and assisting in the recruitment of obstetrician–gynecologists and other health care providers from racial and ethnic minorities into academic and community health care fields
<p><u>2012 (reaffirmed 2019)</u></p>	<p><u>Intimate Partner Violence</u></p>	<p>Obstetrician–gynecologists are in a unique position to assess and provide support for women who experience IPV because of the nature of the patient–physician relationship and the many opportunities for intervention that occur during the course of pregnancy, family planning, annual examinations, and other women’s health visits. The U.S. Department of Health and Human Services has recommended that IPV screening and counseling should be a core part of women’s preventive health visits. Physicians should screen all women for IPV at periodic intervals, including during obstetric care (at the first prenatal visit, at least once per trimester, and at the postpartum checkup), offer ongoing support, and review available prevention and referral options. Resources are available in many communities to assist women who experience IPV.</p>
<p><u>2017</u> <u>2014</u></p>	<p><u>Domestic Violence</u> <u>Interactive site for clinicians serving women with disabilities</u></p>	<p>FAQs</p> <ul style="list-style-type: none"> • Part 1 includes an overview of the program, The Scope of Disability in Women, and Psychosocial Issues. • Part 2 includes The GYN Examination, GYN Health Screening, Sexually Transmitted Disease and Skin Examination • Part 3 encompasses Medical and Reproductive Considerations. Modules include: Contraception; Menses and Abnormal Uterine Bleeding; Pregnancy and Parenting; Urinary and Bowel Considerations; Diet, Physical Activity and Weight; Adolescent Health; and Aging and Osteoporosis. • Part 4 encompasses Reproductive Health Specific to Disability. Modules include: Spinal Cord Injury, Spina Bifida, Multiple Sclerosis, Cerebral Palsy, Intellectual and Developmental Disabilities, and Sensory Disabilities. • Part 5 encompasses Access to Health Care. Modules include: ADA Requirements and Incentives, Disability Culture, and Universal Design/Office Practice Solutions

- Part 6 is the Resources Section with links to resources for providers, patients and those who care for them.

2001	Abuse Assessment Screen	<p>Many women with disabilities are at risk for abuse, however standard screening tools may not unveil abuse common to women with disabilities such as with holding assistance or treatment.</p> <p>McFarlane, J, et al. Abuse Assessment Screen-Disability (AAS-D): Measuring frequency, type, and perpetrator of abuse toward women with physical disabilities. J of Women's Health and Gender-Based Medicine 2001;10(9):861-866.</p>
2015	Health Care for Unauthorized Immigrants	<p>Unauthorized (undocumented) immigrants are less likely than other residents of the United States to have health insurance. The American College of Obstetricians and Gynecologists has long supported a basic health care package for all women living within the United States without regard to their country of origin or documentation. Providing access to quality health care for unauthorized immigrants and their children, who often were born in the United States and have U.S. citizenship, is essential to improving the nation's public health.</p>
2018	Importance of Social Determinants of Health and Cultural Awareness in the Delivery of Reproductive Health Care	<p>The American College of Obstetricians and Gynecologists makes the following recommendations for obstetrician–gynecologists and other health care providers to improve patient-centered care and decrease inequities in reproductive health care:</p> <ul style="list-style-type: none"> • Inquire about and document social and structural determinants of health that may influence a patient's health and use of health care such as access to stable housing, access to food and safe drinking water, utility needs, safety in the home and community, immigration status, and employment conditions. • Maximize referrals to social services to help improve patients' abilities to fulfill these needs. • Provide access to interpreter services for all patient interactions when patient language is not the clinician's language. • Acknowledge that race, institutionalized racism, and other forms of discrimination serve as social determinants of health. • Recognize that stereotyping patients based on presumed cultural beliefs can negatively affect patient interactions, especially when patients' behaviors are attributed solely to individual choices without recognizing the role of social and structural factors. • Advocate for policy changes that promote safe and healthy living environments.

References

- ¹ World Health Organization. Reproductive Health. Available: <https://www.who.int/westernpacific/health-topics/reproductive-health>
- ² Starrs AM, Ezeh AC, Barker G, Basu A, Bertrand JT, Blum R, et al. Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher-Lancet Commission. *Lancet*. 2018 Jun 30;391(10140):2642-2692.
- ³ Prather C, Fuller TR, Jeffries WL 4th, et al. Racism, African American Women, and Their Sexual and Reproductive Health: A Review of Historical and Contemporary Evidence and Implications for Health Equity. *Health Equity*. 2018;2(1):249–259. Published 2018 Sep 24. doi:10.1089/hec.2017.0045
- ⁴ Blue Bird Jernigan V, Peercy M, Branam D, et al. Beyond health equity: achieving wellness within American Indian and Alaska Native communities. *Am J Public Health*. 2015;105 Suppl 3(Suppl 3):S376–S379. doi:10.2105/AJPH.2014.302447
- ⁵ <https://www.census.gov/quickfacts/WA>
- ⁶ <https://www.pewsocialtrends.org/2012/11/07/a-milestone-en-route-to-a-majority-minority-nation/#>
- ⁷ <https://www.migrationpolicy.org/data/state-profiles/state/demographics/WA>
- ⁸ <https://news.gallup.com/poll/203513/vermont-leads-states-lgbt-identification.aspx>
- ⁹ https://news.gallup.com/poll/182051/san-francisco-metro-area-ranks-highest-lgbt-percentage.aspx?utm_source=Social%20Issues&utm_medium=newsfeed&utm_campaign=tiles
- ¹⁰ <https://www.ncjrs.gov/pdffiles1/nij/183781.pdf>
- ¹¹ <https://www.cdc.gov/violenceprevention/pdf/NISVS-StateReportBook.pdf>
- ¹² Haider S, Stoffel C, Donenberg G, Geller S. Reproductive health disparities: a focus on family planning and prevention among minority women and adolescents. *Glob Adv Health Med*. 2013;2(5):94–99. doi:10.7453/gahmj.2013.056
- ¹³ Centers for Disease Control and Prevention. STDs in Racial and Ethnic Minorities. Accessed: <https://www.cdc.gov/std/stats17/minorities.htm#ref1>
- ¹⁴ Washington Health Alliance. Community Checkup. <https://www.wacomunitycheckup.org/compare-scores/measure-detail/?Measure%20Name=Breast%20cancer%20screening>
- ¹⁵ Tapales A, Douglas-Hall A, Whitehead H. The sexual and reproductive health of foreign-born women in the United States. *Contraception*. 2018;98(1):47–51.
- ¹⁶ Hasstedt K, Desai S, Ansari-Thomas Z. Immigrant Women’s Access to Sexual and Reproductive Health Coverage and Care in the United States. November 20, 2018. The Commonwealth Fund. Available: <https://www.commonwealthfund.org/publications/issue-briefs/2018/nov/immigrant-womens-access-sexual-reproductive-health-coverage>