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Executive Summary

Coercion and violation of human rights have marked the interaction of many minority groups with and within the medical system, especially with respect to reproductive and sexual health services. Reproductive and sexual health services are broad and include screening and treatment for sexually transmitted infections; screening and treatment for conditions of the genital organs including cancer as well as conditions that can impact quality of life such as fibroids and endometriosis; 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 healthcare system, helping to decrease disparities in access to care and potentially population health outcomes more broadly through access to primary and specialty care.

Health disparities, preventable differences in health outcomes, are due to a multitude of intersecting factors including but not limited to problematic (e.g., racist, ableist, etc.) interpersonal interactions and broader systematic inequality (e.g., health insurance access). Minority populations experience disproportionately high rates of unintended pregnancy and sexually-transmitted diseases and also experience lower rates of screening for common cancers. More drastic health disparities are seen in differences in material mortality.

These recommendations aim to improve quality, equity, and cultural appropriateness of reproductive and sexual healthcare services across the lifespan in Washington State. The workgroup has expanded on the populations identified in Senate Bill 5602 (2019) 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 specific best practices for these populations, the workgroup recognizes how intersectionality, membership in multiple demographic groups, informs an individual's identity, past experiences, access to resources, impact of both positive and negative historical events, and care needs and so focused on framing improvement areas around broad, yet tangible best practices. Autonomy, the hallmark of person-centered care, forms the foundation of these recommendations.

Differences in population disease burden, needs, and resilience necessitate different clinical services and care. The workgroup seeks to base changes in a targeted universalism approach, universal goals pursued by targeted interventions. These recommendations seek to reorient our existing healthcare system to meet the needs of our specific population groups and the population at large.

The four focus areas, cultural humility, access, patient-centeredness and appropriate care, and an outline of corresponding clinical steps are on page 5. Checklists specific to individual stakeholder groups are included for patients and family members, delivery systems, health plans, Washington State agencies, and for correctional facilities on pages 8 through 12. The four focus areas are further unpacked with supporting evidence for recommended changes on pages 13-17. Measurement, to be used for monitoring population health, clinical quality, and in paying for value, is discussed on page 19.

Dr. Robert Bree Collaborative Background

The Dr. Robert Bree Collaborative was established in 2011 by Washington State House Bill 1311 “...to provide a mechanism through which public and private healthcare stakeholders can work together to improve quality, health outcomes, and cost effectiveness of care in Washington State.” The Bree Collaborative was named in memory of Dr. Robert Bree, a leader in the imaging field and a key member of previous healthcare quality improvement collaborative projects.

Members are appointed by the Washington State Governor and include public healthcare purchasers for Washington State, private healthcare purchasers (employers and union trusts), health plans, physicians and other healthcare providers, hospitals, and quality improvement organizations. The Bree Collaborative is charged with identifying healthcare services annually with substantial variation in practice patterns, high utilization trends in Washington State, or patient safety issues. For each healthcare service, the Bree Collaborative identifies and recommends best-practice, evidence-based approaches that build upon existing efforts and quality improvement activities to decrease variation. In the bill, the legislature does not authorize agreements among competing healthcare providers or health carriers as to the price or specific level of reimbursement for healthcare services. Furthermore, it is not the intent of the legislature to mandate payment or coverage decisions by private healthcare purchasers or carriers.

See **Appendix A** for a list of current Bree Collaborative members.

Recommendations are sent to the Washington State Healthcare Authority for review and approval. The Healthcare Authority (HCA) oversees Washington State’s largest healthcare purchasers, Medicaid and the Public Employees Benefits Board Program, as well as other programs. The HCA uses the recommendations to guide state purchasing for these programs. The Bree Collaborative also strives to develop recommendations to improve patient health, healthcare service quality, and the affordability of healthcare for the private sector but does not have the authority to mandate implementation of recommendations.

For more information about the Bree Collaborative, please visit: www.breecollaborative.org.

The Bree Collaborative was asked through the 2019 Senate Bill 5602 to develop a workgroup to “identify, define, and endorse guidelines for the provision of high quality sexual and reproductive health services in clinical settings throughout Washington...include[ing] the development of specific clinical recommendations to improve sexual and reproductive healthcare 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 healthcare system that truly meetings the needs of a diverse population.

See **Appendix B** for the Colorectal Cancer Screening Workgroup Charter and a list of members.

See **Appendix C** for results of the guideline and systematic review search.

Background

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...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 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, and postpartum care. Further, reproductive and sexual health services can serve as an entry point into the healthcare 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 appropriateness of reproductive and sexual healthcare services across the lifespan in Washington State especially for those who are Black, indigenous, people of color, immigrants and refugees, those who have experienced violence including human trafficking, people with disabilities, and those who are Lesbian, Gay, Bisexual, Transgender, and/or Questioning or Queer (LGBTQ).

Intersectionality

This report acknowledges that a person often has multiple ways of identifying. This intersectionality between and within population groups informs how a person who is Black and has a disability, or a person who is indigenous and queer, might experience day-to-day life, racism, ableism, or homophobia, and have differential access to un-biased, quality healthcare differently than someone who is Black and queer. These intersecting identities inform a person’s past experience with health care, with reproductive and sexual health education, their access to health care coverage and care delivery including screening for cancer, their risk of exposure to sexually transmitted infections (STIs), how they think about their family planning goals, and their healthcare needs broadly.

Additionally, belonging to one of these groups can be associated with a higher likelihood of experiencing violence, such as for people with disabilities and also indigenous women.³ Just as belonging to a specific racial or ethnic group may not be a visibly identifiable characteristic, a person may have any number of visible or non-visible disabilities including difficulties with hearing, seeing, moving, thinking, learning, and/or communicating that may be temporary or last throughout a person’s life. These can inform the likelihood of a person having received of education about healthy relationships and sexual health due to bias within educational systems, and individual families.⁴ Across these intersecting identities, the

workgroup identifies autonomy as a hallmark of person-centered care that forms the foundation of these recommendations.

See **Appendix D** for a crosswalk of disparities identified in the literature for these population groups relevant to sexual and reproductive health.

Historical Framework

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, along with pervasive racism, ableism, homophobia, transphobia, nationalism intersecting with anti-immigrant sentiment lead to and inform health disparities between white Americans those who are Black, indigenous, people of color, those with disabilities, LGBTQ+, and immigrants and refugees today.⁵ Institutionalized racism and other -isms, societal allocation of access to or failure to provide access to resources or services, is pervasive through social structures and impacts health and health needs.⁶

These historic experiences inform the trust and lack thereof that many different groups have in and with the medical system. Trust, another foundation of high-quality sexual and reproductive healthcare services, necessitates applying a historical lens across population groups, from the impact of genocide, forced separation of children from parents and community, and again forced sterilizations among the American Indian and Alaska Native population to the forced sterilization of people with disabilities.⁷ The classification of homosexuality as a mental disorder in the Diagnostic and Statistical Manual until 1973, current need in many healthcare systems for a person to be diagnosed with gender dysphoria prior to access to hormonal therapy or gender confirmation surgery, and current stigma to all the populations making up the LGBTQ+ community similarly inform have eroded trust in the medical system. The impact of shared social experiences such as genocide, slavery, segregation impact differences in health outcomes and access to resources (e.g., redlining) that in turn impact health outcomes. Being Black, indigenous, and/or a person of color can therefore inform a person's lifetime access to education and to healthcare. These themes of lack of autonomy and respect run through the minority experience from the start 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.

Measuring and Responding to Health Disparities

Health disparities, preventable differences in health outcomes, are due to a multitude of intersecting factors including but not limited to problematic (e.g., racist, ableist, etc.) interpersonal interactions and systematic inequality (e.g., insurance coverage). Within each of the populations of interest (e.g., Black, indigenous, people of color, immigrants and refugees, those who have experienced violence including human trafficking, people with disabilities, LGBTQ+), disparities can be seen within relevant reproductive and sexual health services (e.g., 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, and postpartum care.

The workgroup is sensitive to making broad, overly general statements about any of the priority populations, and acknowledges that an individual's sexual and reproductive health needs are be informed both by membership in a broader population group and by individual experiences. Differences

within these groups in terms of disease burden and clinical need may be greater than those between groups. The literature does show that multiple of these groups have shown disproportionately high rates of unintended pregnancy and sexually-transmitted diseases and also experience lower rates of screening for common cancers of the reproductive and sexual organs and therefore higher mortality from these cancers due to later diagnosis.^{8,9} Disparities in screening for common cancers such as breast and cervical cancer are seen geographically as well in Washington State with lower rates in rural areas.¹⁰ Therefore geography as well as class informs access to healthcare. Some disorders of the reproductive organs are more likely to be seen in and are more severe in people of particular ethnic and racial backgrounds as Black women being more likely to have fibroid tumors and being likely to have larger and more numerous tumors and Asian women in some studies having higher rates of endometriosis.¹¹ Drastic health disparities are seen in differences in material mortality. The United States has the highest maternal death rate among developed nations with more than 50,000 mothers having life-threatening complications annually.^{12,13} 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.¹⁴ 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 need rather than equality or providing the same service to all, has the potential to reduce this disparity.

The workgroup seeks to improve reproductive and sexual healthcare services across the variety of spaces through which people access care. Most people access reproductive and sexual healthcare through outpatient or inpatient healthcare facilities for the services discussed. However, people also access healthcare services through the criminal justice system. Those who are Black, Indigenous, and/or Hispanic are show disproportionately high rates of incarceration in Washington as well as in other states.¹⁵ Those who are incarcerated often face unique barriers to high-quality reproductive and sexual health services including but not limited to cancer screenings, prenatal care, and in some cases being shackled while giving birth. The American College of Obstetrics and Gynecologists outlines recommendations for this population in their [Reproductive Healthcare for Incarcerated Women and Adolescent Females](#) that are adapted later in this report.

Differences in population disease burden, needs, and resilience necessitate different clinical services and care. Building from an equity framework, the workgroup seeks to base changes in a targeted universalism approach, universal goals of high-quality, evidence-informed sexual and reproductive healthcare pursued by targeted interventions for populations more likely to experiences disparities.¹⁶ Identifying disparities by population group is therefore important to direct targeted interventions and monitor change and the workgroup urges better collection of data on an individual's race and ethnicity in order to find and intervene disparities more accurately.

Recommendation Framework

While these clinical steps below are directed to providers of clinical care, true change requires the coordinated efforts of all sectors within healthcare. The framework below is further elaborated on the following pages for health plans, employers, patients and families, state agencies, and correctional facilities. The workgroup aims to create a healthcare system in which access, appropriate care, patient-centeredness, and cultural humility underpin all interactions, especially those involving sexual and reproductive health, acknowledging 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 healthcare system. 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).

Table 1: Focus Areas and Outline of Clinical Steps

Focus Area	Outline of Clinical Steps (further details on following pages)
Cultural Humility	<ul style="list-style-type: none"> • Understand the historical and cultural background of your patient population • Provide culturally humble care
Access	<ul style="list-style-type: none"> • Ensure that care is physically accessible to those of all abilities • Understand the insurance barriers for your patient population including those that may exist due to immigration or residency status • Offer materials and services in languages appropriate to your population • Offer accessible materials that are easy to understand and available in a variety of accessible formats including braille, large print, audio • Assess the person’s understanding of topics discussed using the teach back or show me method (demonstrate what they have been told)
Person-centered Care	<ul style="list-style-type: none"> • Build a trauma-aware workforce of clinical and non-clinical staff • Offer trauma-informed care and work to build interpersonal trust • Examine and mitigate coercion or provider bias including implicit bias based on race, ethnicity, being indigenous, gender, sex, LGBTQ+, disability, immigration status, weight, or other patient-specific factors • Reaffirm the confidentiality of conversations and any test results • Involve family or friends if desired by the person • Understand a person’s individual needs
Appropriate care	<ul style="list-style-type: none"> • Educate on healthy relationships and intimate partner violence • Offer prevention, screening, and onsite treatment or referral for reproductive health conditions including cancer screenings as outlined in the USPSTF, STI screening and treatment, and behavioral health screening and brief intervention or referral to treatment • Ask about parenting intention in the next year annually • Offer family planning 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 • Offer or refer to accessible pre-conception care, prenatal care, labor and delivery, postpartum care, and abortion services

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).¹⁷ The United States as a whole is moving to a minority-majority population, which is estimated to occur around 2050.¹⁸ Approximately 14%, 1.06 million people, reside in Washington State and were born abroad in 2017.¹⁹ 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.^{20,21}

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.²² 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 additional healthcare services due to the trauma.²³ Further, more than half of women who have experienced contact physical violence report symptoms of post-traumatic stress disorder.⁶

Previous Bree Collaborative Recommendations

These recommendations seek to build on previous Bree Collaborative Recommendations, where relevant especially the following:

[Hysterectomy Report and Recommendations](#), adopted January 2018, discuss racial and ethnic differences in the rate, route, including whether hysterectomy is minimally invasive, and probability of complications from hysterectomy.²⁴ The Recommendations aim “to promote appropriate use of hysterectomy, including pre-surgical counseling, and evaluation, while recognizing individual variation based on clinical opinion and patient preference [through] three focus areas: 1. Assessment and medical management, by indication; 2. Uterine sparing procedures, by indication, 3. Surgical procedure including follow-up care, emphasizing the enhanced recovery after surgery protocol and use of a minimally invasive approach.”

[LGBTQ+ Report and Recommendations](#), adopted September 2018, aim build a healthcare system allowing everyone to have a fair opportunity to be healthier understanding that LGBTQ+ persons experience elevated rates of depression, sexual abuse, smoking, and other substance use and that; that lesbian women are less likely to undergo certain screening tests for cancer (e.g., mammography to test for breast cancer, papanicolaou (pap) test for cervical cancer) and both men and women in same sex relationships are less likely to report insurance coverage; and that gay and bisexual men made up 70% of new HIV infections in 2016, with higher rates among those aged 25-34 and black and Hispanic/Latino gay and bisexual men.^{25,26 27,28 29} Recommendations are based in a whole-person care framework, taking into consideration a person’s multiple individual factors that make up health, wellness, and experience

(e.g., behavioral health, past trauma, race/ethnicity) in such a way that is not identity or diagnosis-limiting. Focus areas include communication, language, and inclusive environments; screening and taking a social and sexual history; and areas requiring LGBTQ-specific standards and systems of care.

[The Maternity Bundled Payment Model](#), adopted January 2020, discusses opportunities for clinical improvement including reducing cesarean section rates, increasing provision of care through appropriate providers in appropriate settings, reducing pre-term birth rates, reducing mortality rates for the gestational parents and for infants, and reducing health disparities.^{30,31} Clinical improvements in proactive identification and treatment of cardiovascular disease, increasing the rate of physiologic birth, and provision of more personalized postpartum care with a higher number of and more frequent visits also serve as areas for improvement. The guideline presents a payment model that includes prenatal care, labor and delivery, and postpartum care along with clinical components for internal quality tracking and performance metrics.

[Prostate Cancer Screening](#), adopted November 2015, recommend that all men be evaluated by their provider for family history and factors that may elevate the risk of prostate cancer (e.g., sibling or parent with a prostate or breast cancer diagnosis, race). For average risk men under 55, over 70 years, who have significant co-morbid conditions, or who have a life expectancy less than 10 years, a PSA test is not recommend. Clinicians who believe there is overall benefit, should order this test for average risk men between 55-69 years old only after a formal and documented shared decision-making process. Clinicians who believe there is overall harm may initiate testing at the request of the patient after a formal and documented shared decision-making process.

Stakeholder Checklists

These recommendations are not intended to be used in lieu of medical advice

Patients and Family Members

- Find out what type of health insurance you have
 - If you are insured, talk to your health plan about what services are covered
 - If you are insured as a dependent on another person's health plan, talk to your health plan about any concerns about the confidentiality of the healthcare you receive
 - If you are uninsured, talk to your healthcare provider about access to insurance or see if you may be covered through [Apple Health](#) (Washington State Medicaid), **including the Family Planning Only program regardless of documentation status**, or are able to buy insurance on the [Health Benefit Exchange](#)
- Find a healthcare provider that you feel comfortable talking with about your healthcare needs, including your sexual and reproductive health
- During a clinical visit, talk to your provider or care team about:
 - Your past sexual history including the gender, sex of your sexual partners as well as types of sex and any history of sexually transmitted infections.
 - Whether you want or need screening for sexually transmitted infections, also called STIs
 - Whether you want to become a parent in the next year
 - Any concerns that you might have about being down or depressed, especially if you have had thoughts of hurting yourself or others
 - Your relationships with your partners including whether you have ever felt unsafe in the relationship(s) or experienced threats of harm or violence
 - Tobacco, alcohol, or drug use
 - How often to have regular cancer screenings
 - Community resources that are available in your area
 - How comfortable you feel in your provider's office including any feedback about access, and any other issues
 - Any concerns about the confidentiality of the care you are receiving, including any concerns about communications from your provider or health plan
- If you are pregnant, you may be eligible for Apple Health (Washington State Medicaid) – find more information [here](#) as income requirements are different than for those who are not pregnant
- For information about abortion services, see the Department of Health's webpage [here](#)

Delivery Systems offering Reproductive and Sexual Health Services

Infrastructure

- Before or during a visit, people are asked to self-report their:
 - Race and ethnicity
 - Preferred language
 - Gender identity, chosen pronouns, and chosen name
 - Any immunization need relevant to sexual health such as for human papillomavirus (HPV) for those under 26 years old
- Forms and protocols (e.g., mission statement, employee materials) reflect that the delivery site has an open and affirming environment that includes non-discrimination in hiring practices
- Age-appropriate and culturally inclusive reading materials and audiovisual aids are available in the reception area and examination rooms
- Patient-facing forms and information:
 - Are readable at an 8th grade reading level
 - Are available in languages that reflect the patient population
 - Are available in accessible formats including braille, large print, audio
 - Use inclusive, non-stigmatizing language
 - Reaffirm the confidentiality of information
- The site is physically accessible to those with mobility issues including entering/exiting, moving within the facility, during the clinical encounter such as seating within an exam room
- Telehealth is available to augment in-person encounters where appropriate
Consideration is taken for differing needs such as for populations who may be staying home to avoid Immigrations and Customs Enforcement (ICE)
- Translation services for languages common among the patient population is available so that family or friends are **not** used to translate during a clinical encounter
- At least annually, use post-visit surveys to measure patient reported outcomes are sent to people who have accessed care including a validated measure of patient trust in the clinician (e.g., Wake Forest Physician Trust Scale)³²
- Site provides or has referral process in place for pregnant people including prenatal care, labor and delivery, postpartum care, and abortion services

Clinical Encounters

- Protocol on using non-stigmatizing language when interacting with patients is in place
- Site has trauma-informed care protocol in place
 - Staff training needs around being trauma aware are identified
 - Resources to train staff in trauma-informed care and/or empathetic interactions are identified
 - Training on trauma-informed care takes place that includes how to recognize the signs of trauma, that a person's current behavior can be

understood as a coping strategy in response to past trauma, how to respond using a universal trauma precautions approach, how to partner in creating supportive and stress-free clinical environments

- Family, friends, or other support people are included in the clinical encounter if desired by the person
- Where relevant, providers assess the person's understanding of topics discussed using the teach back or show me method in which the person is asked to demonstrate what they have been told
- The patient's comfort level is considered when taking a sexual history
- Sexual history as part of an initial new patient visit includes sex of sexual partners, type of sex (vaginal, anal, oral), history of previous sexually transmitted infections, and worry of having contracted an STI or other testing need
- All people are asked annually if they want to become a parent in the next year including LGBTQ+ persons and people with disabilities
 - If the person expresses ambivalence around parenting intention, initiate a discussion on comprehensive contraceptive methods, as appropriate to the person's individual needs
 - Data on contraceptive prescriptions is monitored by race to find disparities in rates and potential bias
 - All contraception methods are stocked
 - Workflow is set up to offer same-day access to contraception of person's choice
 - Provider prescribes 12 months of contraception if desired by patient
- If pregnant, the person is counseled on options including accessing maternity care services if available onsite and/or on abortion services if desired by the person
- Information on healthy relationships and intimate partner violence is provided or discussed rather than a universal screening approach
- Those with intellectual and developmental disabilities are offered the same shared-decision making approach as all people
- Sterilization is not brought up unless initiated by the person receiving care
- If appropriate, the provider discusses other reproductive health services including referrals around sperm or egg banking, fertility treatments and reproductive technology, counseling on all options including abortion, preconception counseling, adoption and surrogacy, depending on the person's individual needs
- The provider reiterates the use of confidentiality of what is discussed in a clinical visit, especially for adolescents and teens, except in cases of self-harm or physical or sexual abuse of minors
- People are screened at least annually using a validated instrument for:
 - Depression
 - Anxiety
 - Suicidality
 - Tobacco use

- Alcohol
- Other drug use
 - Any positive behavioral health screen follows an appropriate workflow that includes brief intervention, brief treatment, and/or referral to higher levels of care such as outlined in the Bree 2017 Behavioral Health Integration recommendations, the 2018 Suicide Care recommendations, the 2015 Addiction and Dependence Treatment recommendations, and/or the [USPSTF recommendations on tobacco](#)
- People are screened appropriately for relevant cancers of the sexual and reproductive health system including:
 - Cervical cancer screening for people with cervical tissue including transgender men following age and other risk categories as outlined by the [USPSTF on cervical cancer screening](#)
 - Breast cancer screening for people with breast tissue including transgender men following age and other risk categories as outlined by the [USPSTF breast cancer screening](#)
 - Colorectal cancer screening following age and other risk categories as outlined by the [USPSTF colorectal cancer screening](#)
 - Prostate cancer screening is discussed as an individual choice with those with prostate tissue including transgender women following age and other risk categories as outlined by the [USPSTF on prostate cancer screening](#)

Health Plans

- Data from care delivery sites is collected and aggregated to look for disparities in access or services provided within and across:
 - Race and ethnicity
 - Language
 - Sex
 - Screening for relevant cancers of the sexual and reproductive health system
 - Prenatal care utilization
 - Perinatal care outcomes reported for those who are Black, indigenous, and people of color
- Health plan records accurately reflect a person's gender, pronouns, and chosen name
If gathered at a health plan level such as upon enrollment, this is communicated to care delivery sites
- All people are assigned to a primary care provider or team and this is communicated to the person
- Utilize a bundled payment methodology for perinatal care as outlined in the 2019/2020 Obstetric care Bundled Payment Model
- Network includes adequate perinatal care including abortion services following Washington state law
- Performance and quality metrics are included in contracts with providers and other purchasing agreements that promote equity in reproductive and sexual health
- A simple process for individuals insured as dependents on another person's health plan (e.g., a minor using their parent's insurance) is developed to access care confidentially and pursuant with RCW 48.43.505
 - Information outlining this processes is clearly communicated
- If infertility coverage is offered, coverage is equitable for subscribers with same and opposite sex partners including not requiring 12 months if under 35 and 6 months if over 35 of non-covered clinically-supervised insemination prior to reimbursement if not in an opposite-sex relationship
- Develop value-based contracts with providers around reproductive and sexual health services including perinatal bundled payments
- Parenting intention screening is included in MCO, Rural, and APM4 contracts

Washington State Health Care Authority

- Extend Washington State Medicaid eligibility to 12 months (365 days) postpartum at the same income level as for those who are pregnant

Employers

- Health plan records accurately reflect a person's gender, pronouns, and chosen name
- All covered employees are assigned or attributed to a primary care provider or team
 - Assignment is communicated to the employee
- A bundled payment methodology for perinatal care as outlined in the 2019/2020 Obstetric care Bundled Payment Model is used
- Health plans report having an adequate perinatal care network
- Performance and quality metrics are included in contracts with providers and other purchasing agreements that promote equity in reproductive and sexual health such as cancer screening by race
- A simple process for individuals insured as dependents on another person's health plan (e.g., a minor using their parent's insurance) is developed to access care confidentially
 - Information outlining this processes is clearly communicated
- Consider benefits around infertility and improve language around leave for same sex couples who adopt or conceive through surrogacy
 - If infertility coverage is offered, coverage is equitable for subscribers with same and opposite sex partners including not requiring 12 months if under 35 and 6 months if over 35 of non-covered clinically-supervised insemination prior to reimbursement if not in an opposite-sex relationship

Criminal Justice System

Adapted from Reproductive healthcare for incarcerated women and adolescent females. Committee Opinion No. 535. American College of Obstetricians and Gynecologists. Obstet Gynecol 2012;120:425–9.

- A full continuum of care is provided including:
 - Appropriate cancer screenings based on age and other risk categories
 - Follow up to any positive screens is provided
 - In-house services or referrals for preventive and curative care
 - Health education
 - Adequate planning before release from correctional facility
 - Behavioral health screening, using a validated instrument, and brief intervention, brief treatment and/or higher levels of treatment are provided including for:
 - Depression
 - Anxiety
 - Suicidal ideation
 - Tobacco use
 - Alcohol
 - Other drug use
- Full continuum of care for those who are pregnant is provided including:
 - Training for providers on how to care for pregnant inmates
 - Access to prenatal care
 - Access to abortion services
 - Restraints are avoided during labor and delivery
 - Medications and comprehensive care coordination for opioid use disorder during pregnancy
 - Postpartum breastfeeding promotion
- Access to the full range of contraception services is available
- If hospitalization or other off-site healthcare occurs, prescribed treatments, such as medications, continue once the patient returns to the correctional facility
- Incarcerated women and adolescents are protected from sexual abuse
 - If sexual abuse occurs, the guilty party is punished to the full extent of the law

Culturally-Humble Care

A person is both an individual with distinct needs and has needs that are informed by cultural background. Our workgroup believes that understanding both is necessary to ensure high-quality care, starting with addressing bias present within individual healthcare providers and staff and bias that is systemic in our healthcare infrastructure.

Addressing Bias

Implicit bias, nonconscious assumptions based on incomplete information such as a person's appearance, along with stereotyping are pervasive among American society. These biases are present among healthcare providers as well, contributing in part to disparities in health.³³ Implicit bias impacts the healthcare experiences and outcomes of all of populations of interest within this report. Some aspects of implicit bias in medical care have been well-documented, such as white medical students and residents, as well as those outside of the medical profession, reporting a belief that Black people feel less pain than white people.³⁴

Within sexual and reproductive health services, what a provider recommends for type of contraception, especially long-acting reversible contraception, have been shown to vary depending on a patient's race/ethnicity and their socioeconomic status (i.e., that long-acting reversible contraception is more likely to be recommended for low socioeconomic status Black and Latina patients than low socioeconomic white patients.)³⁵ To support health equity, the American College of Obstetricians and Gynecologists (ACOG) recommends practitioners raise awareness of health disparities among colleagues within their organization, support organizational quality improvement initiatives to target identified disparities, educate colleagues about relevant community resources, work with community partners such as local public health to address the social determinants of health, and advocate for policy changes to improve health and reduce disparities.³⁶

Cultural Humility

Competence, implying the "detached mastery of a theoretically finite body of knowledge," is problematic in the delivery of healthcare due to a "false sense of security [from] stereotyping" and issues in which behaviors or symptoms are ascribed to the person's specific cultural background rather than their individual disease or disorder.³⁷ Cultural awareness trainings are critiqued for their inability to effect meaningful change due to being short and often infantilizing, being unable to make up for the empathy-burnout that time-scare providers experience, and not showing any meaningful effect on a person or a population's health outcomes.^{38,39,40} Cultural humility relies on a life-long learning process in which a provider is "flexible and humble enough to assess anew the cultural dimensions of the experiences of each [person]."³⁰ Rather than having a static endpoint, self-questioning and self-critique, and active listening become part of the process.⁴¹

Access to Care

Barriers to access inform many of the disparities seen across our priority populations. While some barriers to care are informed by state and national-level policy, others stem from physical barriers to the care delivery site or language and cognitive barriers that can hinder patient understanding of written or verbal material and therefore following recommendations or understanding diagnoses.

Insurance

Access to health insurance coverage determines access to healthcare delivery due to the high cost of medical care. Insurance coverage varies based on where people live and on their citizenship status. 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 healthcare services.⁴² Lack of coverage stems mainly from systemic policy barriers.⁴³

A primary barrier for those who are immigrants is the public charge rule, that denies legal residency status to those “likely to become a public charge” meaning one who “receives one or more public benefits (as defined in the final rule) for more than 12 months, in total, within any 36-month period.”⁴⁴ Technically those who are classified as refugees are except from this rule. Within Washington, Apple Health offers limited coverage for noncitizens, the Alien Emergency Medical (AEM) Program offers coverage “for individuals who do not meet citizenship or immigration status requirements, or for qualified individuals who have not met the 5-year immigration bar, and have a qualifying medical condition.”⁴⁵ More information [here](#).

The workgroup acknowledges that much of this is outside of the control of individual stakeholders and argues for understanding of how these barriers may impact a delivery system’s patient population and advocacy for more inclusive coverage as a next step.

Information

The majority of American adults read at an 8th grade reading level while medical texts including instructions are written at a 10th grade reading level.⁴⁶ This gap in understanding results in preventable poor health outcomes as people are unclear as to their next clinical steps or become disengaged from care because of a lack of understanding.

Lack of comprehensive of written and/or spoken English also serves as a barrier to a healthcare system that predominantly uses English. In some counties in Washington state, almost a third of households speak English less than very well.⁴⁷ Similarly, in some counties, more than half of households speak a language other than English, most frequently Spanish. Information by counties in Washington State on the prevalence of languages spoken in the home is available [here](#). More information is available from the Washington Coalition for language access [here](#) and from the Robert Wood Johnson Foundation [here](#).

Physical Space

Physical accessibility of healthcare spaces is one of the largest issues for people disabilities, especially in rural areas.^{48,49} This modifiable access issue should consider: parking spaces, entrances using ramps over stairs, doors, clear pathways internal and external, height of desks, restrooms with grab bars, and adjustable exam tables among other factors. CMS offers a resource on physical accessibility [here](#). Information for people with disabilities and for providers including a checklist is available from the American Disabilities Act National Network [here](#).

Aside from physical accessibility, the workgroup acknowledges that representation of a diverse population through images within the delivery site (e.g., posters, reading material in waiting rooms) can increase trust in the person-provider encounter.

Patient-centered care starts with the use of non-stigmatizing language in written materials and in personal encounters. The University of California San Francisco offers the resource for HIV #LanguageMatters: Addressing Stigma by Using Preferred Language available [here](#). Example: *Person living with HIV* rather than *HIV infected person*.⁵⁰

Abuse, violence, and other forms of trauma are widespread. The landmark 1998 study on adverse childhood experiences (ACEs) shows the high prevalence of ACEs across populations and links these experiences to a lifetime risk of poor health outcomes such as alcoholism, depression, heart disease, cancer, and obesity.⁵¹ While children are highly sensitive to trauma, as seen through these later health impacts, trauma is also impactful for adults. Trauma-informed care is built on understanding a person's individual life experiences (e.g., asking what has happened to you) and the need for a clinical encounter to empower rather than re-traumatize a person.⁵² The term was developed to integrate an understanding and strategies to mitigate trauma into delivery of behavioral health care and has since been adapted to physical health services and to delivery of integrated physical and behavioral health services.⁵³ Many of the individual elements have been regularly used in the delivery of care for decades including addressing a person's distress, providing emotional support, encourages positive coping, but practice is ahead of literature and no best-practice guideline or widely used metric to track practitioner adherence to trauma-informed care exists.⁵⁴

Integrating trauma-related issues into counseling has had positive effects for survivors of physical and sexual abuse and shown reductions in mental health symptoms.⁵⁵ In many cases, providers operate under the assumption that someone has experienced trauma without directly asking whether this is so, a universal precautions approach.⁵⁶ Key aspects include fostering a person's feeling of safety in the clinical encounter and developing a positive, trusting person-provider relationship. Trust is based in a one party being vulnerable, such as through having an illness or a lower level of knowledge and believing the other party will care for their interests.⁵⁷ Fidelity, competency, honesty, and confidentiality are also dimensions of trust.³⁹

Reproductive and sexual health questions and services can feel especially invasive for a person who has experienced trauma. Establishing or reaffirming a person-provider relationship rests on developing interpersonal skills including being non-judgmental, providing reassurance, reaffirming that the person can and should ask questions, and talking about the person's goals of care or treatment.⁵⁸ This workgroup does not endorse a single guideline for trauma-informed care as this care philosophy cannot be operationalized through a checklist, although checklists can serve as a starting point.

Many organizations have developed toolkits to support trauma-informed care. The Centers for Disease Control and Prevention lists six principles to a trauma-informed approach:⁵⁹

- **Safety:** Staff and people receiving care feel physically and psychologically safe
- **Trustworthiness and transparency**
- **Peer support:** Those with lived experience of trauma as allies in recovery or using stories
- **Collaboration and mutuality:** Decision making is shared, power differentials among staff or between providers and people receiving care is reduced

- **Choice:** Empowerment and self-advocacy
- **Cultural, historical and gender issues:** Recognizing and addressing historical trauma, removing provider bias, care that is responsive to cultural background

Moving to a trauma-informed approach in a clinical setting starts with being trauma-aware, as the Substance Abuse and Mental Health Services Association (SAMHSA) does through their four Rs:⁶⁰

- **Realization** that anyone may have experienced trauma and their behavior can be understood as a coping strategy to address past trauma
- **Recognize** the signs of trauma
- **Respond** to the above through using a universal precautions approach (e.g., all people are approached as though they have experienced trauma)
- **Resist Re-traumatization** by seeking to not create toxic or stressful environments

While a universal trauma precautions approach negates the need for explicit trauma screening, some practices, such as pediatric practices, have found screening to be helpful. The American Academy of Pediatrics offers clinical assessment tools for people who have been exposed to violence [here](#), including adverse childhood experiences. The signs of trauma are diverse, varying from person to person, include emotional, physical, cognitive, and behavioral signs, and may change over time.⁶¹ A non-exhaustive list includes:

- Emotional: Emotional dysregulation anger, anxiety, sadness, and shame, numbing or detachment
- Physical: sleep disturbances; gastrointestinal, cardiovascular, neurological, musculoskeletal, respiratory, and dermatological disorders; urological problems; and substance use disorders
Somatization
- Cognitive: Cognitive errors, misinterpreting situations dangerous, excessive or inappropriate guilt, idealization, rationalization, delusions, intrusive thoughts or memories
- Behavioral: reenactments, self-harm or self-destructive behaviors

Appropriate Care

The scope of services provided in a reproductive health visit depends on an individual's unique medical history, risk factors, age, and provision of other care. A full review of the number of services encompassing reproductive and sexual health is not within the scope of this workgroup and so these recommendations focus on areas that have been identified as key disparities for the populations of interest including family planning, education and screening, and sexually transmitted infections.

The American College of Obstetricians and Gynecologists recommends adolescents receive an initial visit focused on screening and reproductive preventive health between ages 13-15.⁶² The American Academy of Pediatrics offers information specific to adolescents and teens [here](#) including on pregnancy prevention/family planning.

Reproductive healthcare for people with disabilities should be focused on dignity, respect, confidentiality, autonomy, avoidance of harm and incorporation of an individual's knowledge of puberty, consent, menstruation (if applicable), sexuality, and safety. The American College of Obstetrics and Gynecologists recommends against menstrual suppression before menarche and endometrial ablation.⁶³

Family Planning

Minority women who report perceiving discrimination are less likely to use effective contraception.⁶⁴ The *pregnancy intention* screening question, here changed to use the term *parenting intention* to be inclusive of those who cannot or may not intend to become pregnant, has been found by patients to be helpful in starting a conversation about family planning and related to contraceptive use.^{65,66} This question is typically well-received by patients and clinicians report felt the question should be included in routine reproductive healthcare.^{67,68} Patient centered contraceptive counseling allows the patient and provider to work together in talking about needs and preferences, is more likely to allow a person's preferences to be part of the eventual decision, and more likely to result in adherence to the chosen contraceptive method.^{69,70}

The Family Planning National Training Center provides four best practice recommendations to increase contraceptive access: stock a broad range of contraceptive methods, discuss pregnancy intention and provide patient-centered counseling, develop systems for same-visit provision of all contraceptive methods, and utilize diverse payment options to reduce cost as a barrier.⁷¹ Patients switching from no method of contraception to any method results in a greater reduction in pregnancy than switching from to a moderately effective to most effective method. Women's decisions about which methods to use are less impactful than their decisions about whether to use contraception at all.⁷² Information on birth control across the gender spectrum is available [here](#).

Education and Screening

Screening for diseases and disorders impacting reproductive health organs should follow guidelines of the US Preventive Services Task Force (USPSTF) and relevant specialty societies, except for intimate partner violence. Universal education about healthy relationships and intimate partner violence are recommended over screening. Non-structured discussions on parenting or healthy relationships are

more likely than structured screening tools to result in a person's disclosure of having experienced intimate partner violence.⁷³ Other practitioners recommend case finding, offering services to those showing signs or symptoms of violence over universal screening.⁷⁴

Cervical, breast, and prostate cancer screening should follow the age-specific guidance of the USPSTF and be individualized based on risk factors (e.g., family history). People with cervical tissue should be screened if age 21-29 every three years, if 30-65 every three years with cervical cytology alone or every five years with high-risk human papillomavirus alone or in combination with cervical cytology alone, if over 65 screening is not recommended if previous screening has been adequate.⁷⁵ People with breast tissue should be screened for breast cancer with a mammography every other year if aged 50-74, base a decision to screen 40-49 on the risks and benefits of screening.⁷⁶

For people who have receptive anal sex, clinicians should follow the 2015, the Washington State Department of Health and Public Health Seattle and King County PrEP Implementation Guidelines⁷⁷ with more specific definitions that allow for easier adoption. The workgroup endorses these guidelines and recommends their use across Washington State. The guidelines are available [here](#). For HIV treatment, follow the United States Department of Health and Human Services Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV, available [here](#) (updated March 2018).

Sexually Transmitted Infections

All people starting at age 13, regardless of cultural background, gender identity, sexual orientation, disability status, should be screened for sexual transmitted infections with self-report. People with disabilities should be screened for STIs and counseled on safer sexual practices as STIs are often undiagnosed or underdiagnosed among those with disabilities.⁷⁸ Older adults should also be screened for and counseled on STIs for the same reason. Men who have sex with men (MSM) and transgender persons who have sex with men are at elevated risk for human immunodeficiency virus (HIV) and other sexually transmitted infections (STIs). However, many who identify as LGBTQ+ may not be comfortable or may have difficulty disclosing sexual and gender orientation to their healthcare providers.⁷⁹

Measurement

The workgroup acknowledges the potential for measurement to perversely incentivize non-patient-centered or coercive care. Additionally, the workgroup seeks to reduce administrative burden and so lists only measures that have been validated and are owned by the National Quality Forum (NQF).

0033 Chlamydia Screening in Women (CHL)

Description: The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.

Numerator: Females who were tested for chlamydia during the measurement year.

Denominator: Females 16-24 years who had a claim or encounter indicating sexual activity.

More information [here](#)

2903 Contraceptive Care – Most & Moderately Effective Methods

Description: The percentage of women aged 15-44 years at risk of unintended pregnancy provided a most effective (i.e., sterilization, implants, intrauterine devices or systems (IUD/IUS)) or moderately effective (i.e., injectables, oral pills, patch, ring, or diaphragm) FDA-approved methods of contraception.

Numerator: Women aged 15-44 years of age at risk of unintended pregnancy who are provided a most (sterilization, intrauterine device, implant) or moderately (pill, patch, ring, injectable, diaphragm) effective method of contraception.

Denominator: Women aged 15-44 years of age who are at risk of unintended pregnancy.

More information [here](#)

2904 (Contraceptive Care – Access to LARC) specifically measures access to a single form of contraception. LARC should not be incentivized over other measures and should never be used in a pay for performance design. Instead, NQF 2903 (Contraceptive Care – Most & Moderately Effective Methods), should be used.

Patient-reported post visit surveys: At least annually, use post-visit surveys to measure patient reported outcomes including a validated measure of patient trust in the clinician (e.g., Wake Forest Physician Trust Scale

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 healthcare 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 healthcare setting; rather, QI has not been shown specifically to reduce known disparities in healthcare 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	2019	Interventions for sexual dysfunction following stroke	Use of sertraline to treat premature ejaculation needs to be tested in further RCTs. The lack of benefit with structured sexual rehabilitation and pelvic floor physiotherapy should not be interpreted as proof of ineffectiveness. Well-designed, randomised, double-blinded, placebo-controlled trials of long-term duration are needed to determine the effectiveness of various types of interventions for sexual dysfunction. It should be noted, however, that it may not be possible to double-blind trials of complex interventions.
	2015	Advocacy interventions to reduce or eliminate violence and promote the physical and psychosocial well-being of women who experience	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

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<p>Health Technology Assessment Program Centers for Disease Control and Prevention</p>	<p>intimate partner abuse</p>	<p>type of advocacy, the place it was given, or the severity of the abuse experienced by the women receiving the intervention.</p>
	<p>2015 Screening women for intimate partner violence in healthcare settings</p>	<p>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.</p>
	<p>2014 Interventions for preventing or reducing domestic violence against pregnant women</p>	<p>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.</p>
	<p>None</p>	
	<p>https://www.cdc.gov/sexualhealth/</p>	
<p>Institute for Clinical and Economic Review Veterans Administration Evidence-based Synthesis Program</p>	<p>None</p>	
	<p><u>2013</u> Intimate Partner Violence: Prevalence Among U.S. Military Veterans and Active Duty Servicemembers</p>	<p>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 healthcare 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.</p>

The American
College of
Obstetricians
and
Gynecologists

<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 healthcare should be a priority for all obstetrician–gynecologists and other women’s healthcare 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 healthcare • 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 healthcare providers from racial and ethnic minorities into academic and community healthcare 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 Healthcare. 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.

<u>2001</u>	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>
<u>2015</u>	Healthcare 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 healthcare package for all women living within the United States without regard to their country of origin or documentation. Providing access to quality healthcare 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>
<u>2018</u>	Importance of Social Determinants of Health and Cultural Awareness in the Delivery of Reproductive Healthcare	<p>The American College of Obstetricians and Gynecologists makes the following recommendations for obstetrician–gynecologists and other healthcare providers to improve patient-centered care and decrease inequities in reproductive healthcare:</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 healthcare 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.

Appendix D: Priority Population Reproductive and Sexual Health Exposures

A non-exhaustive crosswalk of the priority populations, relevant historical and current exposures, and unique needs for family planning, reproductive health conditions, and sexually transmitted infections is below^{80,81,82,83,84,85}

	Exposures	Family Planning	Reproductive Health Conditions	Sexual Transmitted Infections
Black Americans	Historical slavery, sterilization, Jim Crow Laws, violence, medical experimentation without consent Higher likelihood of incarceration Explicit and implicit racism/bias Lower likelihood of insurance coverage	Higher maternal mortality Higher infant mortality Discrimination in what contraceptives are offered	Higher likelihood of fibroids, hysterectomies Lower up to date cancer screenings Cancer typically diagnosed at later stage leading to higher mortality	Higher STI incidence including HIV, Gonorrhea, Chlamydia, Syphilis
People of Color	Explicit and implicit racism/bias Lower likelihood of insurance coverage	More frequent unplanned pregnancies Discrimination in what contraceptives are offered	Some populations have differential incidences of reproductive disorders including endometriosis	Some populations have higher STI incidence including HIV, Gonorrhea, Chlamydia, Syphilis
People who are Indigenous	Historical genocide, sterilization, violence, cultural destruction family destruction, medical experimentation without consent Higher likelihood of incarceration Explicit and implicit racism/bias More likely to experience violence	Higher maternal mortality Discrimination in what contraceptives are offered	Lower up to date cancer screenings Cancer typically diagnosed at later stage leading to higher mortality	Higher STI incidence including HIV, Gonorrhea, Chlamydia
Immigrants and Refugees	Explicit and implicit racism/bias Nationalism, anti-immigrant sentiment Lower likelihood of insurance coverage	Higher maternal mortality for some groups	Lower up to date cancer screenings Cancer typically diagnosed at later stage leading to higher mortality	Some populations have higher STI incidence including HIV, Gonorrhea, Chlamydia, Syphilis
People with Disabilities	Historical sterilization More likely to experience violence Lower likelihood of insurance coverage	Less likely to have received education on family planning Discrimination in what contraceptives are offered	Lower up to date cancer screenings Cancer typically diagnosed at later stage leading to higher mortality	Higher STI incidence Lower STI screening
LGBTQ+	Historical and current homophobia and transphobia Lower likelihood of insurance coverage	Less likely to be asked about parenting intention Higher family planning expense	Lower up to date cancer screenings including for trans-people and women who have sex with women	Men who have sex with men more at risk for HIV, Hep C

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