
Bree Collaborative | Reproductive and Sexual Health Workgroup

March 4th, 2020 | 2:00 – 3:30

Foundation for Health Care Quality

705 2nd Avenue, Suite 410 | Seattle, WA 98104

MEMBERS PRESENT

Charissa Fotinos,* MD, (Chair) Deputy Chief Medical Officer, Washington State Health Care Authority
Colin Fields*, MD, Kaiser Permanente
Leo Gaeta,* Vice President of Programs, The Columbia Basin Health Association
Heather Maisen, MPH, MSW, Family Planning Program Manager, Seattle King County Public Health
Adrienne Moore,* Deputy Director of Quality Improvement, Upstream
Cynthia Harris,* Family Planning Program Manager, Washington Department of Health

Angela Chen,* MD, Obstetrics and Gynecology, EvergreenHealth
Mandy Weeks-Green,* Senior Health Policy Analyst, Officer of the Insurance Commissioner
Paul Dillon,* Latinx Outreach & Organizing Program, Planned Parenthood of Greater Washington and North Idaho
Catherine West,* JD, Staff Attorney, Legal Voice
Rita Hsu,* MD, FACOG, Obstetrics and Gynecology, Confluence Health

STAFF AND MEMBERS OF THE PUBLIC

Ginny Weir, MPH, Bree Collaborative
Alex Kushner, Bree Collaborative

Karina Silva,* Family Planning Coordinator, The Columbia Basin Health Association

* By phone/web conference

CHAIR REPORT AND APPROVAL OF MINUTES

Charissa Fotinos, MD, Washington State Health Care Authority, and Ginny Weir, MPH, Bree Collaborative welcomed members to the workgroup and those present introduced themselves.

Motion: Approval of February 5th minutes

Outcome: Approved unanimously

Heather Maisen, MPH, MSW, Family Planning Program Manager, Seattle King County Public Health, found the literature that was shared helpful for identifying some barriers to care for immigrant and refugee populations, but thought they left a lot of room for more research

PRESENTATION: SUPPORTING THE REPRODUCTIVE HEALTH NEEDS OF IMMIGRANT FAMILIES BY LEO GAETA AND KARINA SILVA OF THE COLUMBIA BASIN HEALTH ASSOCIATION

Leo Gaeta, Vice President of Programs, and Karina Silva, Family Planning Coordinator, took over to present to the workgroup on the practices of The Columbia Basin Health Association.

- Health centers located in the Columbia basin, an area known for agriculture with three locations in three different counties. Across all three locations, the organization saw 36,301 patients in 2019 of which 86 percent were low income, almost 80% identified as individuals of color. 47% agricultural workers. Majority of patients speak Spanish. They are seeing an increasing amount of indigenous people from Mexico.

- Model of care: patient centered reproductive health, medical care team, and support staff. Family care program has two components: clinical and outreach. Community outreach is a large component of their practice. They use EMR and client visit records (Ahlers) for documentation.
- Barriers: Patient knowledge and comfort level regarding contraception; cultural beliefs and myths; access and affordability; public charge (individuals are concerned about accessing services based on media around changes in policy—CBHA has to educate patients on the current laws to encourage them to get care); community; medical care team workflows; staff knowledge and comfort level regarding contraception counseling.
- Other group members added to the list of patient obstacles:
 - Dr. Fotinos added provider knowledge gaps that go unaddressed or unrecognized.
 - Heather Maisen mentioned partner support of contraception as a large influence and potential obstacle. Providers need to support mothers in making their own decisions—can even role play partner conversations with patients. Partners can often be coercive in decision making.
 - Mr. Gaeta has seen a shift in the level of support that partners are providing. He gave examples of women in heterosexual relationships mentioning that their partners would be open to vasectomies if they were covered. However, he has also seen plenty of examples of domestic abuse where one partner is not free to make their own decisions.
- Angela Chen, MD, Obstetrics and Gynecology, EvergreenHealth, brought up the problem of translation: patients come to her practice but do not speak English and rely on their partners to translate—this can lead to distortion or omission of information and precludes the partner who cannot speak English from giving full consent. The group agreed that this language barrier would be important to name.
 - Related to the above point, phone interpretation is not ideal. There are rarer languages and dialects in our population where it is hard to find an interpreter.
 - Dr. Fotinos suggested a hospital-wide policy to not use an interpreter. However, Dr. Chen responded that sometimes the patients themselves (along with their partners) do not trust interpreters; or the male in a heterosexual relationship will refuse to have an interpreter involved with his partner.
 - Other issues with phone interpreters: they are often busy. Also, interpreters often have a higher education level than some patients and so may use a different vocabulary (especially medical vocabulary) that makes them unable to coherently communicate with the patient.
 - Ms. Maisen added that her hospital has been creating a sheet of commonly used terms regarding reproductive health in Spanish and English to help with translation. **She will share this resource when it is complete.**
 - It is important to have services for non-verbal and non-hearing individuals as well.
 - Mr. Gaeta offered that CBHA have paraprofessionals who come from similar backgrounds to their patients to help with interpretation in the presence of a language barrier. However, for culturally sensitive issues, such as developmental disabilities, some families do not want an interpreter because the community is so small that the patient and interpreter might know each other and the family feels shame about the issue.

GENERAL DISCUSSION

- Ms. Weir asked the group how to make best practice recommendations for language barriers.

- The recommendations should discuss interpreters and the limits of interpreters.
- What to do about partners who object to interpreters? If a partner who objects to an interpreter is present during translation, patients who want birth control will sometimes leave without it.
 - Mr. Gaeta said that they often use WIC appointments for sensitive issues. However contraceptive counseling is not covered by insurance.
 - Low-resource individuals can also access pregnancy supportive services which can be less intimidating than medical counseling. However, it is only available to women who are pregnant.
- Group's recommendations should state explicitly that women (or the birth parent) are always the ones who should be making decisions about their health and must maintain autonomy during decision making.
 - Could facilitate this by instituting policies and staff guidance to only bring back the patient during a visit. Potential downside: the partner may refuse to let the family come at all if this is the policy.
- The group discussed how changes in public charge have affected immigrant and refugee populations seeking reproductive and sexual health care.
 - More home visits—people are afraid to go into the doctor.
 - Pregnant women are foregoing prenatal care and hospital delivery due to concerns about ICE and public charge.
 - Immigrants moving from other states with more aggressive deportation and internment policies are afraid to access resources including WIC and other care networks.
 - Current public charge rules say that seeking pregnancy services does not impact immigration status.
 - Another member responded that while it may be useful to find ways of disseminating this information, the facts may not matter when immigration policy and ICE actions are changing so rapidly. Immigrant populations have to maintain a level of distrust to stay safe.

Action Item: Paul Dillon to share FAQ sheet on Public Charge with the group. Heather Maisen to share toolkits relating to public charge.

- Ms. Weir asked the group about the ACOG guidelines relating to immigrant detention. Group agreed that it is worth making recommendations for detention centers even if they do not have federal jurisdiction (there are some state holding facilities, as well).
 - Mr. Gaeta suggested that we recommend detention centers follow integrated care protocols to meet patient needs holistically.
- Best practices for cancer screening: Washington state cervical cancer screening has a large Spanish speaking population. Colin Fields, MD, Kaiser Permanente said that Kaiser created a dashboard looking at cervical and breast cancer screening disparities across the state.

Action Item: Colin Fields to share dashboard resources with the group.

- Dr. Hsu emphasized the importance of community outreach. Dr. Fotinos added it would be worth recommending that not all care has to be done by traditional medical providers.
 - Karina gave examples of successful community outreach events that CBHA has done. Events like Mother's Day dances can offer fun activities and screening while also addressing stigma. Having a family event can also help the mother prioritize her needs since her children will be being taken care of during the event.
- Ms. Weir asked about the four domains that the group discussed last time. Dr. Fotinos said that applying these domains to the various populations is a good start for the group, and new themes can be addressed as needed.

- The group discussed the OPRHAC tool that was reviewed. It has flaws in terms of equitable access and staff biases, but is a reasonable starting point. Ms. Weir would like the group to develop a similar tool with stated improvements.
- Dr. Fotinos asked that the group keep in mind that they will need to address which recommendations are reasonable for various different treatment environments. Do not want to overwhelm primary care with unreasonable asks.
- Should the group make recommendations for men?
 - Recommend asking all patients if they intend to become pregnant in the next 12 months—this determines frequency of screening.
 - One member mentioned that we need to make sure we aren't using copyrighted language from "One Key Question". There is also a risk in asking the above question if the provider cannot give follow up care.
- The group agreed to recommend the development of a billing code for high quality contraceptive counseling sessions.
- Mr. Gaeta closed by asking that the group recommend a broad approach that addresses the fears of the population in regards to seeking care.

GOOD OF THE ORDER

Dr. Fotinos thanked all for attending and adjourned the meeting.