Bree Collaborative | Reproductive and Sexual Health Workgroup
June 3rd, 2020 | 2:00 – 3:30
Held Remotely

MEMBERS PRESENT

Charissa Fotinos, MD, (Chair) Deputy Chief Medical Officer, Washington State Health Care Authority
Leo Gaeta, Vice President of Programs, The Columbia Basin Health Association
Heather Maisen, MPH, MSW, Family Planning Program Manager, Seattle King County Public Health
Cynthia Harris, Family Planning Program Manager, Washington Department of Health
Angela Chen, MD, Obstetrics and Gynecology, EvergreenHealth
Catherine West, JD, Staff Attorney, Legal Voice
Giselle Zapata-Garcia, Co-Director, Latinos Promoting Good Health; Executive Committee Co-Chair, Latinx Health Board
Mandy Weeks-Green, Senior Health Policy Analyst, Officer of the Insurance Commissioner
Janet Cady, ARNP, Medical Director of School Based Program, NeighborCare
Leigh Hofheimer, Program Coordinator, Washington State Coalition Against Domestic Violence
Adrianne Moore, Deputy Director of Quality Improvement, Upstream

STAFF AND MEMBERS OF THE PUBLIC

Terri Stewart, BSN, RN, SANE-A, SANE-P, Health Program Operations Manager, SANE Program/Medical Training Program, Harborview Abuse and Trauma Center
Ginny Weir, MPH, Bree Collaborative
Alex Kushner, Bree Collaborative
Amy Etzel, Bree Collaborative
Cara Bilodeau, Public Policy Manager, Upstream
Trish Anderson, MBA, Senior Director, Safety and Quality, Washington State Hospital Association
Beth Tinker, PhD, MPH, MN, RN, Washington State Health Care Authority
Natalie Bell, Kaiser Permanente Washington

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 May 6th minutes
Outcome: Approved unanimously

PRESENTATION: HEALTH CARE DELIVERY FOR VICTIMS OF VIOLENCE BY TERRI STEWART

Terri Stewart, BSN, RN, Health Program Operations Manager, SANE Program/Medical Training Program, Harborview Abuse and Trauma Center presented to the workgroup.

- Ms. Stewart reviewed SANE programs across the state. There are a variety of programs: 24/7, ED based SANEs, ED nurses.
    - However, access is more limited in rural areas.
- Some programs expect that all nurses can provide sexual assault services—this is not ideal. Gathering evidence is only one piece of providing care; how to properly care for and support patients takes real training.
- Ms. Stewart reviewed the pros and cons of statewide SANE care. Some of the current problems include:
    - Inconsistent funding for training; disparities in access; CVC reimbursement does not meet program costs; 24/7 programs are expensive so not all hospitals can have them;

hospitals do not always prioritize SANE services—nurses end up being under trained; most forensic nurses are not able to provide domestic violence (or other kinds of abuse) services.
    - Some victims are underrepresented in services, overrepresented in crimes. American Indian populations have higher rates of being sexual assault victims but do not have more services available to them as a result.
- She reviewed the state's domestic violence services, noting that most care is provided through emergency department visits, but there is inconsistent training in trauma informed, victim centered services.
    - There is inconsistent access to social workers in EDs and limited resources as well.
- The gold standard for DV care: forensic nurse evaluations for all DV victims. Training in strangulation, stalking and DV dynamics for ED providers. Reimbursement for forensic nurse DV evaluations through CVC.
- Ms. Stewart reviewed challenges facing the state and provided a wish list for the state that the workgroup would like to use.
    - Three broad categories for the wish list: consistent funding for forensic nurse training, CVC reimbursement, and mandatory hospital support for forensic nursing services.
- Ms. Weir asked what recommendations Ms. Stewart make for teaching providers about trauma-informed care. Ms. Stewart: teach providers that trauma-informed care means understanding that any person who comes in for care has experienced something difficult; these difficult challenges impact how patients interact with the medical system. Provider bias also needs to be addressed, especially when victims are stigmatized.
- A member asked for recommendations for people who experience sexual assault but do not make it to SANE care.
    - PCPs need to know how to prescribe medications and provide resources for these types of events, as some patients will prefer to talk to them first.
- The group discussed whether the location of care for these services could be moved from emergency rooms. This would be difficult: it takes a lot of space and resources to properly follow chain of custody rules for evidence. Nurses need oversight, and the board of pharmacy rules make it hard to prescribe important medication.

PRESENTATION: WHAT CAN REPRODUCTIVE HEALTH CARE FOR SURVIVORS LOOK LIKE? BY LEIGH HOFHEIMER

Leigh Hofheimer, Program Coordinator, Washington State Coalition Against Domestic Violence, presented to the group and explained that she would be sharing what her organization has learned from survivors.

- Ms. Hofheimer reviewed some of the traits of sexual coercion, including how the person causing harm in a relationship can use their partner's vulnerability against them.
- She reviewed some of the challenges facing survivors and their health.
    - Survivors are judged for not solving the problem of domestic and sexual abuse—in other words, they are blamed for not leaving the relationship.
    - There is elevated vulnerability and isolation during COVID, and inequities for families of color and immigrants that existed before COVID are still present.
    - There are systemic limits and restrictions on resources for survivors who stay in an abusive relationship.
- She shared some survivor experiences: survivors often fear that disclosing information will result in CPS or someone taking their kids. Providers often are visibly uncomfortable with screening question or will not make eye contact with patients during screening.

- Screening is not the answer—screening does not promote disclosure or in-depth conversation about a person's abuse. The solution is to be proactive— replace screening with Universal Education messages about healthy relationships and IPV resources.
- Ms. Hofheimer concluded by explaining how to offer proactive information and emphasized the value that comes from being proactive instead of reactive. Providing information about healthy relationships proactively means that health care providers are not gatekeeping information.
    - Building relationships is more productive outside of a crisis situation. The medical community and healthcare professionals could also do better at providing economic supports for stable housing and meeting other basic needs.
- She concluded on the message that "connection is the antidote to isolation and domestic and sexual violence".
- A member asked Ms. Hofheimer what one recommendation she would make for care providers. Her answer was to offer information proactively—do not wait to be asked.
    - Information does not have to be framed as being about assault; everyone needs information about healthy relationships and sexuality. This helps to reduce stigma around relationship difficulties.
- Ms. Stewart and Ms. Hofheimer both reiterated the importance of ceasing to ask the question, "Do you feel safe in your home?" This is not an effective screening question.
- Ms. Hofheimer's overall hope is for a move away from screening towards providing universal information proactively. Instead of checking off boxes, teach providers to have conversations.
- A member of the workgroup recommended including information in the final recommendation that helps prevent the perpetration of sexual violence—this may be a topic of future discussion.

GOOD OF THE ORDER

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