



Are Physicians Providing Comprehensive Reproductive and Sexual Health Care Services to Women?

A Survey of New York City Physicians

Reproductive Health and Managed Care Policy Series

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Planned Parenthood
of New York City, Inc.

About PPNYC

Since 1916, Planned Parenthood of New York City (PPNYC) has been an advocate for and provider of reproductive health services and education for New Yorkers. Serving more than 30,000 clients annually, PPNYC's three health care centers in Manhattan, Brooklyn, and the Bronx offer reproductive health services, including gynecological care, contraception, pregnancy testing, abortion, testing and treatment for sexually transmitted infections, and HIV counseling and testing. As a voice for reproductive freedom, PPNYC supports legislation and policies to ensure that all New Yorkers—regardless of age or ability to pay—will have access to the full range of reproductive health care services and information. PPNYC's unique position as a safety-net provider, educator, and advocate gives us firsthand knowledge that often sparks research questions for further investigation. In turn, we use our findings not only to improve service delivery, but also to inform our advocacy and influence public policy.

About the Clinician Training Initiative

In 1993, PPNYC launched the Clinician Training Initiative (CTI) to help reverse a national trend of decreasing numbers of physicians with the skills and commitment to perform abortions. CTI conducts education and outreach to medical schools and residency programs encouraging new providers to add abortion to their scope of practice. CTI also provides hands-on clinical training in surgical and medical (non-surgical) abortion services primarily to OB/GYN and family practice residents and physicians, and to physician assistants as well. More recently, the program expanded to include hands-on training for family planning and colposcopy. In 2000, CTI hosted the first national training

on the new early option abortion pill, mifepristone (formerly known as RU-486), a meeting that was co-sponsored by the Planned Parenthood Federation of America's Consortium of Abortion Providers and the National Abortion Federation. Currently, CTI is joining forces with The Access Project to train primary care practitioners to provide mifepristone.

In addition to its training program, CTI generally educates, advocates, conducts research, and offers technical assistance to create a new generation of health professionals who are committed to comprehensive women's health care.

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Introduction

Reproductive and Sexual Health Care Is Primary Care

Basic services such as family planning, gynecological care, screening for sexually transmitted infection (STI), and sexual health assessment are fundamental to addressing the preventive health care needs of women. In a single year, 74% of women of reproductive age in the U.S. seek reproductive health services.¹ For many women, reproductive and sexual health care is essentially primary care and their entry into the health care system in general.

A resource prepared for physicians by the U.S. Preventive Services Task Force, the *Guide to Clinical Preventive Services*, explicitly sets forth that reproductive health care is primary and preventive care for women.² For both adolescents and adults, the guide recommends screening and/or counseling patients for chlamydia (with chlamydia testing recommended for all adolescents and for high-risk adults), cervical cancer (including Pap tests), STI prevention, high-risk behavior, unintended pregnancy, and contraception.

In response to the growing health care needs of adolescents, the American Medical Association (AMA) issued “Guidelines for Adolescent Preventive Services” (GAPS) to make recommendations about the optimal care of adolescent patients. The AMA stated that “primary care physicians and other health care providers must respond by making

preventive services a greater component of their clinical practice.”³ The GAPS recommendations include asking adolescents about their sexual orientation, sexual activity, and alcohol or drug use. GAPS also recommends STI screening and counseling about unintended pregnancy.

Furthermore, the National Committee for Quality Assurance (NCQA), which is responsible for accrediting managed care organizations (MCOs), established a set of measures of reproductive and sexual health care called the Health Plan Employer Data and Information Set (HEDIS).⁴ These benchmarks include the screening of MCO members for chlamydia, breast cancer, and cervical cancer. Taken together, the U.S. Preventive Services Task Force’s and NCQA’s recommendations outline a path for physicians to follow in providing basic primary and preventive reproductive and sexual health services.

In addition to the services recommended by the national standards described above, comprehensive reproductive health care also includes access to emergency contraception and abortion services. Emergency contraception is post-coital contraception used up to 72 hours after unprotected sex to prevent pregnancy. It is 85% effective and has the potential to reduce the number of unintended pregnancies by more than

50%.⁵ For those women who do experience an unintended pregnancy, high-quality care requires that they receive options counseling, and, when appropriate, abortion services. With the number of unintended pregnancies each year in the U.S. approaching three million,⁶ it is essential that women have access to the health care services that can help them address this contingency.

The Training of Physicians in Reproductive and Sexual Health

In order to provide primary and preventive reproductive and sexual health care, physicians must be trained in these services. But the training they currently receive is far from ideal. A 1995 study of family medicine residency programs found that less than a quarter (24%) of residents had adequate training in providing contraceptive methods, other than oral contraceptives, and only 15% of chief residents had clinical experience in providing first-trimester abortions.⁷ A 1999 study found that family practice and OB/GYN residents in Maryland were completing their training with little or no experience with contraceptive methods or abortions.⁸

In addition to learning about specific methods and procedures, physicians must also be trained in discussing sexual orientation, domestic violence, and risk behaviors, which can uncover behavioral and environmental factors relevant to an individual's reproductive and sexual health. Screening and assessment

in these areas enhance the overall quality of care and are necessary to identify specific health concerns. One study, "Why Doctors Have Difficulty with Sex Histories," found that among the 93% of medical students who had been trained in taking sexual histories, 50% felt themselves to be poorly trained and 25% felt embarrassed to ask the necessary questions.⁹

The Managed Care Environment

Beyond the need for training, physicians must have a working environment conducive to the provision of primary and preventive women's health care services. That environment is increasingly proscribed by managed care. Unprecedented numbers of New Yorkers have enrolled in managed care plans, and nationwide 76% of insured women under age 65 are in managed care.¹⁰ In addition to the growing commercial managed care market, other New Yorkers too are finding themselves in managed care arrangements. Governments are increasingly relying on managed care to deliver health care to populations enrolled in Medicaid, Medicare, and the Child Health Insurance Program for uninsured children. In New York State, Family Health Plus for uninsured adults and HealthPass for employees of small businesses are also utilizing managed care packages.

MCOs promise primary and coordinated preventive care, which includes reproductive and sexual health care. In New York State, the state legislature attempted to make it easier for women to obtain such services by enacting the Direct Access law which mandates that MCOs shall not limit member access, within the MCO's network, to "... primary and preventive obstetric and gynecological services ... or to any care related to a pregnancy."¹¹ This means that members of an MCO may go directly to a provider in their network for reproductive and sexual health care services, without a referral from either the MCO or the primary care provider.

The purchasers of health insurance (employers, governments, and individuals) embraced managed care because it promised a means to control health care costs. Managed care also held out the promise of coordination of care on the expectation that primary care physicians would emphasize preventive care as the cornerstone of their practice. Costly acute care would be avoided by providing services such as cervical and breast cancer screening, family planning, and HIV testing. However, instead of creating the opportunity for physicians to provide a broad array of primary and preventive women's health care services, managed care has turned out differently. A Commonwealth Fund study found that many physicians employed by MCOs are spending less time with each patient and experiencing a high level

of patient turnover.¹² The juxtaposition of coordination of care with the need to contain costs presents a contradiction in priorities.

Purpose of PPNYC's Survey

Because PPNYC is concerned about the effects of managed care on health care delivery to women, we decided to conduct a survey in 1999 to assess its actual impact. The survey aimed to: 1) determine whether primary care and OB/GYN physicians practicing in New York City provided preventive women's health care to their female patients of childbearing age; 2) identify what training physicians had related to these services; and 3) measure physicians' perceptions of managed care's effect on the delivery of such services.

Brief Overview of Methodology

We drew the physician sample from the American Medical Association's Masterfile and included OB/GYNs and primary care physicians (PCPs) who indicated their specialty as General Practice, Internal Medicine, Adolescent Medicine, or Pediatrics. We included in the sampling frame only physicians with direct patient contact. PPNYC mailed surveys to a random sample of 668 physicians working in New York City in the fall of 1999.

The 20-question survey, pre-tested with PPNYC physicians, collected quantitative information about the reproductive and sexual health services that the physicians provided; the areas in which the physicians had been trained; and what they thought about man-

aged care's impact on their provision of such services. The survey also collected some qualitative data in the form of physicians' judgements about their training and general remarks on the managed care system. We sent the survey with an ink pen as an incentive, followed it with a reminder postal card, and finally mailed a second survey along with a dollar bill to those who had not yet responded.

Out of 668 surveys mailed, we received 156 responses. We determined 18 to be ineligible because the respondents had retired, did not see females of reproductive age, or had an expired mailing address. Our findings/analysis are based on the remaining 138 responses (a 21% response rate).

Findings/Analysis

Of the total number of respondents, 25% were OB/GYNs and 75% were primary care physicians with one of the specialties listed above. Sixty percent practiced in private or group practice, 26% in a hospital, and 14% in a health center. Additionally, 70% contracted with at least one MCO to provide health care services.

Services Provided

The survey asked physicians which women's health services they provided. Seventy percent reported providing HIV testing and 60% reported providing Pap smears. As for family planning services, 68% reported providing oral contraceptives, while

fewer provided emergency contraception (51%), Depo-Provera (46%), diaphragms (44% of non-pediatric physicians), and IUDs (28% of non-pediatric physicians). Abortion services were offered least often. As expected, OB/GYNs provided these services most often. Note that pediatricians are excluded in the percentages for methods not widely used by adolescents. (See Table 1.)

Recognizing that some physicians may refer out for services, we included this option in the survey. Many physicians who did not directly provide a service did refer out for it. Others did not. Five percent neither provided nor referred for HIV testing, 21% for emergency contraception, 17% for tubal ligations (for non-pediatric physicians), 18% for surgical abortion, and 27% for medical (non-surgical) abortion.

The survey also asked physicians whether they prescribed emergency contraception for immediate use—43% said yes—and for future use—9% said yes.

Counseling, Screening, and Assessment

Beyond the provision of discrete services, the survey asked respondents if they provided counseling, screening, and assessment for behavioral and environmental risk factors for their adult and adolescent female patients. For adults, 74% of the respondents reported always providing or offering to provide breast

Table 1 – Services Provided by Respondents

<i>Services</i>	<i>% Provide</i>	<i>% Refer</i>	<i>% Neither</i>
HIV Testing	70.1	24.6	5.2
Oral Contraception	67.9	23.1	9.0
Pap Smear	59.8	34.1	6.1
Emergency Contraception	50.8	28.5	20.8
Depo-Provera	46.2	35.4	18.5
Diaphragm *	44.1	44.9	11.0
IUD *	27.5	56.0	16.5
Tubal Ligation *	23.9	58.7	17.4
Surgical Abortion	16.5	65.4	18.1
Medical Abortion	8.7	64.6	26.8

* Pediatricians excluded for Diaphragm, IUD, and Tubal Ligation services because adolescents generally do not use these methods.

Table 2 – Counseling, Screening, and Assessment Provided by Respondents to Adult and Adolescent Patients

<i>Services</i>	<i>% Always Provide for Ages 20-45</i>	<i>% Always Provide for Ages 13-19</i>
Breast Self-Exam Instruction	73.6	57.5
Sexual History Screening	61.5	63.9
HIV Risk Behavior Counseling	59.7	61.8
STI Screening	59.0	59.3
Contraceptive Counseling	56.9	52.9
Substance Abuse Screening	45.5	53.6
Sexual Orientation Assessment	40.8	40.5
Family Violence Screening	36.9	43.1

self-exam instruction. Fewer respondents offered counseling about HIV risk behaviors (60%), STI screening (59%), contraceptive counseling (57%), and substance abuse screening (46%). Discussion of sexual orientation and family violence screening occurred least often (41% and 37%, respectively). The percentages were similar for adolescent patients. (See Table 2.)

Training and Education

The survey asked physicians about their training in women's health care. While most respondents in this study reported receiving training in specific services such as pelvic exams, Pap smears, and STI screening, respondents were less likely to be trained to do health screenings and assessments. Fifty-nine percent of respondents received training in family violence screening, 56% in adolescent risk assessment, and 54% in sexual orientation assessment. Half of the respondents reported receiving training in counseling skills, and, as expected, more than two-thirds had no training in abortion services. (See Table 3.)

A comparison of the percentages of those who were trained to provide a service (Table 3) and those who do provide a service (Tables 1 and 2) reveals that receiving training in a service does not necessarily lead a physician to provide that service. For example, while 86% of respondents reported receiving training in Pap smears, only 60%

Table 3 – Training Received by Respondents

<i>Services</i>	<i>% Received Training</i>	<i>% Did Not Receive Training</i>
Pelvic Exam	90.1	9.9
STI Screening	86.7	13.3
Pap Smear	85.6	14.4
HIV Risk Behavior Assessment	82.9	17.1
Sexual History Screening	81.4	18.6
Substance Abuse Screening	70.1	29.9
Family Violence Screening	58.9	41.1
Adolescent Risk Assessment	56.4	43.6
Sexual Orientation Assessment	54.4	45.6
Counseling Skills	50.8	49.2
Surgical Abortion	31.1	68.9
Medical Abortion	20.7	79.3

Table 4 – Respondents’ Perceptions of the Effects of Managed Care

<i>Has managed care affected...</i>	<i>% Decrease</i>	<i>% No Effect</i>	<i>% Increase</i>
The amount of time you spend with each patient?	49.5	41.9	8.7
The total volume of patients in your care?	18.3	29.0	52.7
Your ability to coordinate your patients' care?	43.6	51.1	5.3
The turnover of patients in your care?	6.5	37.6	55.9
The number of patients seen in a typical day?	12.9	34.4	52.7
The number of women's health services you provide?	22.8	60.9	16.3

of respondents reported actually providing Pap smears.

Managed Care

The final section of the survey focused on how physicians viewed the impact of managed care on their ability to provide reproductive and sexual health care services. Seventy percent of respondents contracted to provide services with at least one MCO. Of these, half reported that managed care decreased the amount of time spent with each patient, 53% found that managed care increased the number of patients seen in a typical day, and 44% felt that managed care decreased their ability to coordinate patient care. Respondents also reported a loss in continuity of care—56% said that managed care increased the turnover of patients in their care.

In addition, to test their knowledge of New York State's Direct Access law, the survey asked physicians whether referrals were needed for certain services. They reported that referrals were needed for abortions (46%), gynecological care (43%), and family planning (24%). But, in fact, under the Direct Access law, referrals are not required for any of these services.

Discussion

Women need and deserve preventive and comprehensive health care, which includes a wide array of reproductive and sexual health services. Each year, the vast majority of women seek such services, thus highlighting the need for providers to offer such care.

PPNYC's survey revealed that many primary care and OB/GYN physicians fail to provide—or even refer patients for—basic reproductive and sexual health care and that many do not assess behavior and environmental risk factors. The results of the survey showed that 6% of the respondents neither provided nor referred their female patients for Pap smears. Additionally, the results showed that nearly half failed to provide emergency contraception and many neither provided nor referred for this service. Considering that women have only 72 hours after unprotected sex in which to take emergency contraception, we find this to be inadequate care.

The provision of reproductive and sexual health care is dependent upon provider training in these areas. Without appropriate training, physicians have difficulty providing services and counseling women about their health care. Almost a fifth of the respondents did not receive training in conducting a sexual history screening, which may explain why nearly 40% did not always screen their patients of reproductive age. The same can

be said about family violence screening: almost half of the respondents received no training and even fewer always screened their female patients.

Moreover, our findings indicate that even with training, many physicians still do not provide essential reproductive and sexual health services. While more than 80% received training in HIV risk assessment, a considerably smaller proportion (about 60%) always provided this screening to their female patients of reproductive age. Further research is needed to determine why physicians did not provide services in which they were trained. The study of medical students cited above suggested that most of those trained in taking sexual histories were either too poorly trained or too embarrassed to take comprehensive sexual histories.¹³

The results of the survey also expose physicians' lack of understanding regarding the New York State Direct Access law. In spite of the fact that this law stipulates that members of MCOs have the right to *self-refer* to any provider in their plan for gynecological services, many physicians believed that referrals *from physicians* are required. Direct Access services covered by the survey should always be available to women in MCOs without the burden of obtaining a referral from a physician.

The rapid growth of managed care raises other concerns about the provision of

reproductive and sexual health care, as well as health care in general. This survey found that providers perceive that managed care is often at odds with its own prescribed objectives. Physicians spend less time with patients and experience more patient turnover, which leads to less continuity of care and less time to counsel and assess patient needs. The survey was not intended to evaluate the managed care system overall; nor did it attempt to compare the provision of reproductive health care in managed care versus a fee-for-service delivery system. Our findings do make clear, however, that in the area of reproductive health, managed care has not yet delivered the promised shift of resources and priorities to ensure that members will receive high-quality preventive services. The MCO environment may foster conditions that, in fact, make it difficult for providers to offer comprehensive services and screenings for reproductive and sexual health.

Conclusion

While this study should not be viewed as a definitive assessment of the delivery of reproductive health care in the dynamic New York City health care environment, it does highlight areas in which attention is needed to improve reproductive and sexual health care services. Physicians need additional training in providing reproductive and sexual health care procedures, as well as counseling, screening, and assessment, and they should be strongly encouraged

to offer these services to *all* women of reproductive age. If managed care is to fulfill the promise of coordinated care, MCOs and state and federal oversight agencies should monitor the provision of these services and cultivate clinical environments in which they can be provided. Prevention is the key to good health, and comprehensive reproductive health care services, screenings, and assessments are crucial to meeting women's health needs.

PPNYC's Next Steps

PPNYC is working to improve training for physicians, including those in MCOs. Our CTI program provides hands-on training to physicians and advanced practice clinicians in abortion care, colposcopy, and family planning. All training includes a strong counseling component. At PPNYC health centers, we screen patients for domestic violence, HIV risk behaviors, STIs, and unplanned pregnancies.

To address adolescent underutilization of health care services, the CTI program is engaged in an exciting collaboration with two Medicaid MCOs in New York City, New York Presbyterian Hospital, and other community organizations to develop a training curriculum to help physicians meet the reproductive and sexual health care needs of adolescents. The curriculum will be used to train primary care physicians under contract with the two Medicaid MCOs involved in the project. The New York State Department of Health, which is funding this project, may adopt the curriculum statewide.

As in the past, PPNYC intends to use the results of this survey to advocate for better care, training, and monitoring. In 1997, PPNYC conducted two studies that found that 49% of representatives of Medicaid managed care plans could not accurately answer questions about the Direct Access law,¹⁴ and that many women had not received preventive reproductive health care

services, education, or counseling from their primary care provider.¹⁵ These results prompted the New York State Department of Health to take steps to inform members of Medicaid managed care plans about the Direct Access law as well as another law, known as Free Access, that allows Medicaid managed care members to seek reproductive and sexual health care from a Medicaid provider in or out of their network. We hope that our new survey will similarly inspire steps in the right direction by professional associations, residency programs, reproductive and sexual health care organizations, MCOs, and government agencies. PPNYC recommends that:

- ▶ *Professional organizations, such as the American Medical Association and the American College of Obstetricians and Gynecologists, in collaboration with MCOs, should periodically review, update, and reissue clear guidelines about the specific reproductive and sexual health care services that physicians are expected to provide.*
- ▶ *Professional organizations and experienced health care providers should work together to develop health assessment screening tools, disseminate these tools widely to physicians, and provide training on the importance and use of such tools.*

- ▶ *Residency programs and other training facilities should train residents to provide comprehensive reproductive and sexual health care, counseling, and risk assessment.*
- ▶ *Reproductive and sexual health care organizations and foundations should conduct further research to determine how the training of providers affects their provision of, or referral for, reproductive and sexual health care.*
- ▶ *MCOs must offer continuous training to physicians in the provision of reproductive and sexual health care services (including emergency contraception), counseling, and risk assessment.*
- ▶ *MCOs must devise quality assurance measures for reproductive and sexual health care services, counseling, and risk assessment, and closely monitor providers to ensure that the care provided meets patients' needs.*
- ▶ *MCOs and local and state health departments must provide clear, ongoing education to providers about laws like New York State's Direct Access law, which allows individuals to seek reproductive and sexual health care services without a referral.*
- ▶ *Appropriate government agencies should monitor the delivery of reproductive and sexual health care services in MCOs and require corrective action when deficiencies are found.*

Endnotes

- ¹ Frost, J., Public or Private Providers? U.S. Women's Use of Reproductive Health Services, *Family Planning Perspectives*, 33(1):8, January/February 2001.
- ² U.S. Preventive Services Task Force, *Guide to Clinical Preventive Services*, 2nd edition, Washington, D.C., 1996.
- ³ American Medical Association, "Guidelines for Adolescent Preventive Services," <http://www.ama-assn.org/ama/pub/category/1980.html>.
- ⁴ National Committee for Quality Assurance, "The Health Plan Employer Data and Information Set (HEDIS)," <http://www.ncqa.org/pages/programs/hedis>.
- ⁵ Trussel, J., et al., Emergency Contraceptive Pills: A Simple Proposal to Reduce Unintended Pregnancies, *Family Planning Perspectives*, 24(6):269-273, 1992.
- ⁶ Fact sheet, *Contraception Counts: New York Information*, The Alan Guttmacher Institute, New York, 1999.
- ⁷ Steinauer, J., et al., Training Family Practice Residents in Abortion and Other Reproductive Health Care: A Nationwide Survey, *Family Planning Perspectives*, 29(5):222-227, August/September 1997.
- ⁸ Cheng, D., Family Planning Training in Maryland Family Practice and Obstetrics/Gynecology Residency Programs, *Journal of the American Medical Women's Association*, 54:208-210, Fall 1999.
- ⁹ Merrill, J., Laux, L., and Hornby, J., Why Doctors Have Difficulties with Sex Histories, *Southern Medical Journal*, 83(6):613-617, June 1990.
- ¹⁰ Collins, K., et al., *Health Concerns across a Woman's Lifespan: 1998 Survey of Women's Health*, The Commonwealth Fund, New York, May 1999.
- ¹¹ N.Y. Public Health Law § 4406-b(1) (McKinney 2001) (effective January 1, 1995).
- ¹² Collins, K., Schoen, C., and Sandman, D., *The Commonwealth Fund Survey of Physician Experiences with Managed Care*, The Commonwealth Fund, New York, February 1997.
- ¹³ See source cited in Note 9 above.
- ¹⁴ Lewis, V. and Lawler, K., *Do Managed Care Organizations Inform Members about the Free Access and Direct Access Laws? Planned Parenthood of New York City*, New York, April 1997.
- ¹⁵ Lewis, V., and Lawler, K., *The Transition to Managed Care: Experiences of Planned Parenthood Patients*, Planned Parenthood of New York City, New York, April 1997.

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