New York State Primary Care Physician Practices and Perspectives on Offering Reproductive Health Services

J Gen Intern Med 36(6):1805–7
DOI: 10.1007/s11606-020-06162-w
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INTRODUCTION

Primary care provides an important opportunity for patients to access comprehensive reproductive health (RH) services, particularly as reductions to family planning programs continue.¹ There is a lack of data on the specific RH services provided by primary care physicians (PCPs) and their perceptions of offering these services.² Such information can aid in successfully expanding RH services in primary care. Our objectives were to determine the RH services New York State (NYS) PCPs report providing, their perception of the benefits and disadvantages to providing such services, and which RH services they felt were most important to offer.

METHODS

We recruited a convenience sample of NYS PCPs through the American Medical Association (AMA) Master File, attendance at two NYS primary care conferences, and staff meetings at two NYS federally qualified health center (FQHC) networks. We describe the recruitment, data collection, and study instrument details, as well as report other findings elsewhere.^{3, 4} Our sample was more likely to be female, younger, and specialize in family medicine than the AMA sampling frame.

We conducted chi-squared and one-way ANOVA tests to assess significant differences by specialty in providing any RH or contraceptive services in the last year, and the mean number of perceived benefits and disadvantages (including barriers) to providing RH services, respectively.

RESULTS

Half of the physicians in our sample were female. The largest proportion of respondents was aged 42–59 (38%), followed by 36% aged 24–41. The majority of respondents provided at least one RH service in the last year (88%), with HIV/STI testing and counseling (74%) being the most common,

followed by contraceptive counseling (67%) and cervical cancer screening (63%; Table 1). The least reported service provided was induced abortion (9%). The majority of respondents provided at least one contraceptive method/service (74%), most notably the pill (71%). Eighty-eight percent of family medicine physicians reported providing the pill, compared with 58% internal medicine providers. However, less than 40% of PCPs provided any of the other contraceptive services. A significantly larger proportion of family medicine physicians reported providing any RH (97% vs. 82%) and contraceptive service (91% vs. 61%) in the last year, compared with internal medicine respondents ($p < 0.0001$).

Respondents endorsed an average of 8.4 benefits, from a list of 14 (standard deviation (SD) 4.3, range 0–14; Table 2) associated with providing RH services in primary care settings, with increased access to RH services (82%) and patient convenience (82%) cited as the most common benefits. On average, respondents endorsed 1.5 disadvantages, from a list of 10 (SD 1.5, range 0–9). The most frequently held perceived disadvantage was not being sufficiently trained (51%), cited more often by internal medicine providers (66%) compared with family medicine respondents (38%). This was followed by additional time that may detract from other primary care services (32%); over a third reported no disadvantages (36%). Family medicine physicians had significantly higher average perceived benefits (9.8 vs. 6.7, 9.5) and fewer disadvantages (1.1 vs. 2.0, 1.8), compared with internal medicine and other PCPs ($p < 0.0001$). However, the majority of internal medicine providers noted many benefits.

Respondents felt the most important RH services to add to their clinic were contraceptive counseling (29%) and cervical cancer screening (29%), followed by HIV/STI testing and counseling (27%), all endorsed by more internal medicine respondents.

DISCUSSION

Although PCPs in our sample offer some RH services, there is room for expansion of comprehensive services. Our findings may reflect differences in RH training by specialty. As compared with internal medicine physician respondents, family medicine physician respondents are already providing more RH services and may be more comfortable with the prospect of further expanding such services, given recommendations from the American Academy of Family Physicians to integrate such services.⁵ Recognizing the differences in experiences,

Received March 18, 2020
Accepted August 14, 2020
Published online September 1, 2020

Table 1 Reproductive Health Practices of New York State Primary Care Physician Respondents, 2017

Variable	Total (N = 443) n (%)	Family medicine (n = 216) n (%)	Internal medicine (n = 183) n (%)	Other (n = 25) n (%)
Provided <i>any</i> reproductive health services in the last year ^{*,†}	381 (88)	209 (97)	148 (82)	17 (68)
Reproductive health services provided in the last year ^{†,‡}				
HIV/STI testing and counseling	318 (74)	185 (86)	115 (64)	14 (56)
Contraceptive counseling	289 (67)	185 (86)	88 (49)	11 (44)
Cervical cancer screening	270 (63)	183 (85)	74 (41)	11 (44)
Sexual dysfunction counseling	217 (50)	139 (64)	66 (37)	8 (32)
Routine pregnancy intentions screening	208 (48)	147 (68)	51 (28)	9 (36)
Preconception care and counseling	191 (44)	143 (66)	37 (20)	10 (40)
Postpartum care	111 (26)	94 (44)	12 (7)	5 (20)
Prenatal care	110 (26)	89 (41)	17 (9)	4 (16)
Infertility evaluation	109 (25)	84 (39)	19 (11)	5 (20)
Transgender services	94 (22)	70 (32)	18 (10)	5 (20)
Spontaneous abortion management	72 (17)	63 (29)	3 (2)	6 (24)
Induced abortion	40 (9)	38 (18)	1 (1)	1 (4)
None	51 (12)	7 (3)	33 (18)	8 (32)
Provided <i>any</i> contraceptive services in the last year ^{*,§}	317 (74)	195 (91)	108 (61)	11 (46)
Contraceptive services provided in the last year ^{†,§}				
Birth control pill	305 (71)	190 (88)	103 (58)	10 (42)
DMPA/Depo-Provera injection	168 (39)	140 (65)	20 (11)	8 (33)
Emergency contraception	166 (39)	129 (60)	29 (16)	7 (29)
Distribute male condoms	159 (37)	110 (51)	41 (23)	7 (29)
Vaginal ring	120 (28)	98 (46)	14 (8)	7 (29)
IUD removal	104 (24)	93 (43)	5 (3)	6 (25)
IUD insertion	92 (22)	77 (36)	9 (5)	6 (25)
Implant insertion	71 (17)	67 (31)	2 (1)	2 (8)
Implant removal	67 (16)	63 (29)	1 (1)	3 (13)
Distribute female condoms	58 (14)	42 (20)	11 (6)	5 (21)
Diaphragm	31 (7)	25 (12)	5 (3)	1 (4)
Female sterilization/tubal ligation	20 (5)	14 (7)	4 (2)	2 (8)
Vasectomy	19 (5)	14 (7)	5 (3)	0 (0)
None	110 (26)	20 (9)	70 (39)	13 (54)

* $p < 0.0001$ † $n = 11$ missing

‡Percentages sum to greater than 100 as respondents were able to choose more than 1 response

§ $n = 16$ missing

Table 2 New York State Primary Care Physician Respondent Perceptions of Reproductive Health Services, 2017

Variable	Total (N = 443) n (%)	Family medicine (n = 216) n (%)	Internal medicine (n = 183) n (%)	Other (n = 25) n (%)
Perceived benefits (mean, (SD)) ^{*,†}	8.4 (4.3, range 0–14)	9.8 (3.8, range 0–14)	6.7 (4.3, range 0–13)	9.5 (3.6, range 0–13)
Perceived benefits of providing reproductive health services ^{†,‡}				
Increases access to reproductive health services	353 (82)	192 (89)	134 (74)	22 (92)
Patient convenience	352 (82)	188 (87)	137 (75)	21 (88)
Continuity of care	317 (73)	186 (86)	107 (59)	19 (79)
Avoids missed opportunity for contraception	308 (71)	172 (80)	112 (62)	19 (79)
Increases contraceptive use	291 (67)	169 (78)	100 (55)	18 (75)
Normalizes sexual and reproductive health	284 (66)	165 (76)	96 (53)	19 (79)
Patient preference	262 (61)	156 (72)	85 (47)	16 (67)
Improves preconception health	259 (60)	160 (74)	75 (41)	21 (88)
Ensures appropriate counseling when prescribing medications	258 (60)	156 (72)	83 (46)	17 (71)
contraindicated for pregnancy				
Holistic approach to health	257 (60)	149 (69)	89 (49)	14 (58)
Management of chronic conditions for women who become pregnant	237 (55)	140 (65)	74 (41)	18 (75)
All information in electronic health record	226 (52)	137 (63)	73 (40)	13 (54)
Increases folic acid use	205 (48)	132 (61)	59 (32)	12 (50)
None	8 (2)	0 (0)	6 (3)	0 (0)
Perceived disadvantages/barriers (mean, (SD)) ^{*,†}	1.5 (1.5, range 0–9)	1.1 (1.3, range 0–8)	2.0 (1.5, range 0–6)	1.8 (1.8, range 0–7)
Perceived disadvantages/barriers to providing reproductive health services ^{†,‡}				

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Table 2. (continued)

Variable	Total (N = 443) n (%)	Family medicine (n = 216) n (%)	Internal medicine (n = 183) n (%)	Other (n = 25) n (%)
Not well trained	218 (51)	81 (38)	120 (66)	13 (54)
Additional time (detracts from other primary care services)	138 (32)	47 (22)	78 (43)	9 (38)
Unclear reimbursement/billing	98 (23)	45 (21)	46 (25)	5 (21)
May not be patient preference	69 (16)	21 (10)	40 (22)	6 (25)
Discomfort with reproductive health discussions	37 (9)	12 (6)	20 (11)	4 (17)
Not within the primary care scope of practice	32 (7)	1 (1)	28 (15)	2 (8)
Reduces support for stand-alone reproductive health clinics	20 (5)	6 (3)	11 (6)	2 (8)
Stigma	18 (4)	8 (4)	7 (4)	2 (8)
Detracts from patient-centered care	6 (1)	1 (1)	4 (2)	0 (0)
None	154 (36)	98 (45)	43 (24)	8 (33)
Most important reproductive health service to add ^{‡,§}				
Contraceptive counseling	120 (29)	43 (21)	71 (40)	5 (20)
Cervical cancer screening	119 (29)	43 (21)	69 (39)	6 (24)
HIV/STI testing and counseling	113 (27)	34 (16)	72 (41)	6 (24)
Transgender services	79 (19)	47 (22)	28 (16)	3 (12)
All services already provided	78 (19)	57 (27)	14 (8)	7 (28)
Sexual dysfunction counseling	76 (18)	28 (13)	41 (23)	6 (24)
Routine pregnancy intentions screening	72 (17)	26 (12)	44 (25)	2 (8)
Preconception care and counseling	67 (16)	27 (13)	38 (21)	2 (8)
Prenatal care	50 (12)	23 (11)	23 (13)	3 (12)
Infertility evaluation	39 (9)	20 (10)	15 (8)	4 (16)
Postpartum care	32 (8)	15 (7)	14 (8)	2 (8)
Induced abortion	27 (7)	17 (8)	6 (3)	4 (16)
Spontaneous abortion management	26 (6)	20 (10)	5 (3)	1 (4)
None	57 (14)	32 (15)	18 (10)	5 (20)

* $p < 0.0001$ [†] $n = 11$ missing[‡]Percentages sum to greater than 100 as respondents were able to choose more than 1 response[§] $n = 27$ missing

perspectives, and current scope of practice by PCP training is important when considering changes in practice protocols. Training on RH service delivery, particularly for internal medicine physicians, may be needed prior to implementation. As this is a convenience sample, our findings cannot be generalized to PCPs in NYS or elsewhere. Some respondents recruited at conferences may have been sub-specialists. Nonetheless, given the receptivity to providing RH care across sub-specialties, this study can inform administrators, clinicians, and educators considering expansion of RH services in primary care.

Funding This research was funded by the Society for Family Planning Research Fund (#SFPRF10-112-5). The funding source was not involved in the study design; in the collection, analysis, and interpretation of data; in the writing of the report; or in the decision to submit the article for publication. The views and opinions expressed are those of the authors and do not necessarily represent the views and opinions of SFPRF.

Compliance with Ethical Standards:

Conflict of Interest: The authors declare that they do not have no a conflict of interest.

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