

# The Unique Role of Family Physicians in Caring for Women Across the Reproductive Age Span

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**W**omen of reproductive age receive their usual health care from a variety of providers, including family physicians, general internists, obstetricians/gynecologists, and nurse midwives at private practices, health departments, community health centers, and hospitals. Nationally, 27.3% of all office visits for women ages 18-44 were to family physicians' offices, compared with 31.2% to obstetricians/gynecologists and 10.3% to general internists, with the remaining 31.2% of visits to subspecialty care physicians.<sup>1</sup> While many women consider their obstetrician/gynecologist their primary care physician, a significant number of women consider family physicians to be their primary physician for all of their health care needs.

After medical school, family physicians complete three years of residency training during which they focus on the care of the whole person, irrespective of age and/or gender. The residency requirements for family medicine include training in gynecologic care and maternity care, as well as structured experiences in non-obstetrical, non-gynecologic care of women that deal with the study of gender differences and the diversity of women's health needs throughout the life cycle.<sup>2</sup> Family physicians are also trained to care for children and adolescents and often begin care for a woman during her childhood. In addition to providing preventive, gynecologic, and contraceptive care to women, family physicians routinely diagnose and treat common acute and chronic medical conditions such as diabetes, hypertension, obesity, mental health disorders, and tobacco abuse. Many perform gynecologic procedures such as endometrial biopsies, colposcopy, and insertion of intrauterine devices (IUDs) and other implantable contraceptives. Family physicians can also facilitate contraception by performing vasectomies on male partners. Because of the breadth and depth of their training, family

physicians are capable and well-suited to fill the role of primary care provider for women of reproductive age.

Family physicians play a critical role in access to care for women of North Carolina. As of 2007, there were 2,612 licensed family physicians practicing in all but two of the 100 counties in the state.<sup>3</sup> In contrast, there were 1,009 obstetricians/gynecologists practicing in only 71 of the 100 counties. Figure 1 shows the Health Profession Shortage Areas (HPSA) in North Carolina with all providers included; 41 counties are designated partial or full HPSAs. Figure 2 shows how the same HPSA map would look without family physicians; 64 counties would be designated as HPSAs. Figure 3 shows how the map would look without general internists; 49 counties would be designated as HPSAs. Figure 4 shows how the map would look without obstetrician/gynecologists; 42 counties would be designated as HPSAs. Finally, Figure 5 shows how the map would look without pediatricians; 42 counties would be designated as HPSAs. Family physicians also play a large role in supervising mid-level providers (nurse practitioners and

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physician assistants) either in private offices or public health department settings, thereby expanding the number of primary care providers in a given community. The impact of family physicians on access to health care in North Carolina, especially in the rural areas of the state, is readily apparent.

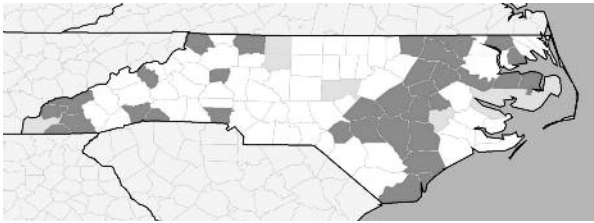
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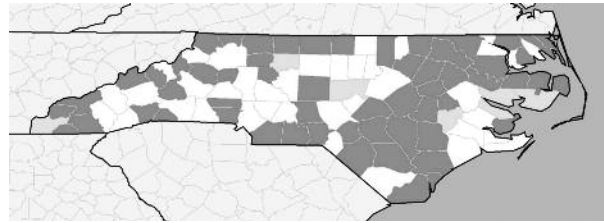
**Figure 1.**  
Health Professional Shortage Area (HPSA)



Legend:  
HPSA Wizard -- 2006 Federal HPSA Designations  
 ■ Full HPSA  
 ■ Partial HPSA  
 □ Not a HPSA

Source: Data derived from the *HealthLandscape* website.  
<http://www.healthlandscape.org/>. Accessed August 20, 2009.

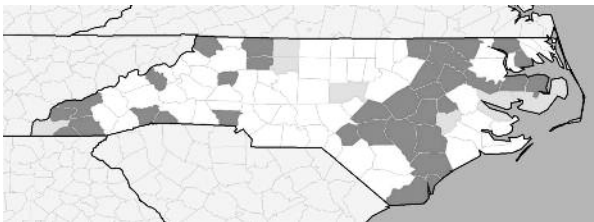
**Figure 2.**  
Health Professional Shortage Area (HPSA) without FP



Legend:  
HPSA Wizard -- 2006 Federal HPSA Designations  
 ■ Full HPSA  
 ■ Partial HPSA  
 □ Not a HPSA

Source: Data derived from the *HealthLandscape* website.  
<http://www.healthlandscape.org/>. Accessed August 20, 2009.

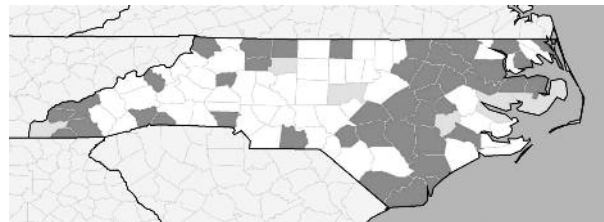
**Figure 3.**  
Health Professional Shortage Area (HPSA) without OB/GYN



Legend:  
HPSA Wizard -- 2006 Federal HPSA Designations  
 ■ Full HPSA  
 ■ Partial HPSA  
 □ Not a HPSA

Source: Data derived from the *HealthLandscape* website.  
<http://www.healthlandscape.org/>. Accessed August 20, 2009.

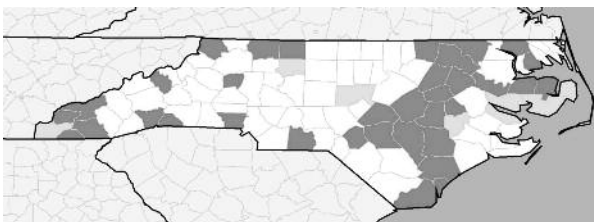
**Figure 4.**  
Health Professional Shortage Area (HPSA) without GIM



Legend:  
HPSA Wizard -- 2006 Federal HPSA Designations  
 ■ Full HPSA  
 ■ Partial HPSA  
 □ Not a HPSA

Source: Data derived from the *HealthLandscape* website.  
<http://www.healthlandscape.org/>. Accessed August 20, 2009.

**Figure 5.**  
Health Professional Shortage Area (HPSA) without Pediatricians



Legend:  
HPSA Wizard -- 2006 Federal HPSA Designations  
 ■ Full HPSA  
 ■ Partial HPSA  
 □ Not a HPSA

Source: Data derived from the *HealthLandscape* website.  
<http://www.healthlandscape.org/>. Accessed August 20, 2009.

Family physicians who provide primary care in North Carolina are essential to improving the overall health of the community. One emerging model in medicine is the patient-centered medical home (PCMH). The importance of the PCMH and its vital role in providing care for patients' needs has been widely published.<sup>4</sup> Family medicine is uniquely positioned to answer the growing need for PCMHs in North Carolina. In 2007, the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association issued a joint declaration of principles to describe a PCMH. In it, the patient-centered medical home is described as having the following components: (1) *a personal physician* with an ongoing relationship with the patient to provide continuous and comprehensive care; (2) *physician directed medical care* by personally leading a team responsible for the ongoing care of the patients; (3) *whole person care*, for example, care for all stages of life, acute and chronic illnesses, preventive services,

# The Role of North Carolina Medicaid in Women's Health and Wellness

Patti Forest, MD, MBA, FFAFP

There are numerous opportunities for public policy to improve women's health care. Programs that promote access to comprehensive health care and support services deliver long-term cost benefits and enhance quality of life. North Carolina Medicaid collaborates with several partners across the state to address the physical, mental, and perinatal health care needs of eligible women. According to the Henry J. Kaiser Family Foundation, three-quarters of the adult Medicaid population are women. Medicaid finances 41% of all births in the US and accounts for 71% of all publicly-funded family planning services. However, in their words: "childless women without disabilities typically are never eligible no matter how poor."<sup>1</sup> Over the years, North Carolina Medicaid has been proactive in seeking ways to expand eligibility to low-income women while delivering cost benefits to the state.

In October 2005, North Carolina Medicaid implemented the Be Smart Program, a five-year demonstration waiver project for family planning services to reduce unintended pregnancies and improve the well-being of children and families. Though only in its fourth year, this Family Planning Waiver has provided services to thousands of women across the state. During its first year, 9,819 women received services, 15,858 the second year, and the number of women receiving services continues to increase annually. The program has drastically reduced Medicaid-covered costs

associated with unintended pregnancies. According to the January 2009 Interim Annual Report for the program, 1,139 pregnancies were averted by pregnancy prevention during the second year of the waiver due to the existence of the program. This resulted in a Medicaid cost savings of \$11,735,000. Preliminary findings show that the subsequent waiver year resulted in an even greater Medicaid cost savings of between \$13,862,000 and \$14,219,000.<sup>2</sup>

North Carolina has taken advantage of federal options to expand Medicaid eligibility criteria to allow greater coverage for pregnant women. The Baby Love Program was launched in 1987 as a joint effort between the Division of Medical Assistance and the Division of Public Health. This Medicaid-funded program was designed to offer pregnant women and their infants early, continuous, and comprehensive health care and other needed support services with the goals of improving health and reducing infant mortality. Services include case management, childbirth education classes, in-home nursing care for high-risk pregnancies, medical nutrition therapy, and health and behavioral interventions.<sup>3</sup> Since the beginning of this program, the infant mortality rate has decreased from 14.9 deaths per 1,000 live births (1987) to 8.2 infant deaths per 1,000 (2008).

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and end of life care; (4) *coordination and integration of care* across all elements of the health system (e.g., hospital, subspecialty care, skilled nursing care) and the patient's community (family and community-based services); (5) *optimal quality and safety of care* through evidence-based medicine and continuous quality improvement techniques and with patient participation; (6) *enhanced access* to care; and (7) *just and appropriate payment structures* that support the provision of the above services and values improved outcomes.<sup>5</sup> There is growing evidence to support this model of care as a viable system to improve quality outcomes.<sup>4</sup> Many aspects of the PCMH focus on improving access, communication, and integration of care. Women's health, including prenatal care, family planning, and chronic disease management, provide excellent opportunities for collaboration among family physicians and other specialists.

The World Health Organization's key indicators for overall community health are infant mortality and birth weight.<sup>6</sup> Unfortunately, North Carolina is currently 43rd in the nation with regards to infant mortality.<sup>7</sup> In 2007, there were 1.8 million women of childbearing age in North Carolina with 130,886 births, of which 12,100 were classified as low birth weight

(< 2,500 grams).<sup>8</sup> There were 1,568 perinatal deaths (< one month of age) and 1,107 infant deaths (> one month but < one year of age).<sup>8</sup> Communities with an increased supply of primary care practitioners (family physicians, general internists, and pediatricians) per capita have lower infant mortality rates and higher birth weights, especially in areas with high levels of disparities.<sup>9</sup> Although there are a small but significant portion of family physicians who provide prenatal care (in North Carolina, 5% of family physicians provide both maternity care and deliveries and 11% provide prenatal care only, though in some counties family physicians are the only maternity care provider),<sup>10</sup> the improvements in infant birth weight and lower infant mortality rates are not necessarily the result of the care patients receive during the narrow prenatal timeframe. Evidence suggests these improvements are more the result of a continuity of health care provided across the reproductive lifespan, beginning with preconception family planning, chronic disease management, and risk reduction aimed at improving overall maternal and neonatal health.<sup>9</sup>

North Carolina Pregnancy Risk Assessment Monitoring System (PRAMS)<sup>11</sup> data showed that approximately 45% of all

In spite of this improvement, North Carolina continues to have an infant mortality rate higher than the national average. In an effort to improve neonatal outcomes in the state, the Division of Medical Assistance was awarded a grant by the US Centers for Medicare and Medicaid Services to address this challenge. The project is in partnership with the Perinatal Quality Collaborative of North Carolina and builds upon the collaborative success that North Carolina has demonstrated in primary care. In the recent legislative session, the General Assembly directed the Division of Medical Assistance to research and report on the feasibility and efficacy of a Medicaid waiver allowing two years of interconceptional coverage to low-income women who have given birth to high-risk infants. The report will address whether estimated cost savings from improved birth outcomes will offset the cost of providing Medicaid coverage to additional eligible women.<sup>4</sup>

Aside from family planning and reproductive health issues, North Carolina also covers mammograms and preventive

care to eligible women. Chronic disease management through the Community Care of North Carolina network provides valuable services to recipients while delivering cost savings to the state. Low-income adults with disabilities may be eligible for a broad array of services under the Community Alternatives Program for Adults. Medicaid coverage is extended to uninsured women under the age of 65 with breast or cervical cancer that has been detected through North Carolina's Breast and Cervical Cancer Control Program. The common theme in all of these programs is the partnership and collaboration between Medicaid and other entities across the state. In moving forward with health care reform, these partnerships will be vital in improving access to quality health care for all North Carolina citizens.

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pregnancies in North Carolina were unintended. Mothers with unintended pregnancies are more likely to have low birth weight infants and infants who die before their first birthday.<sup>11</sup> The causes of unintended pregnancy are multifactorial, including, but not limited to, the availability of birth control, the timing of postpartum follow-up, and the messages given to patients regarding health priorities and life choices. Because of the associated risks with unintentional pregnancies, Healthy People 2010 has set a goal of achieving 70% of pregnancies as intentional.<sup>12</sup> Family physicians, because they are the primary care practitioner for so many women in North Carolina are vital to the success of reducing unintended pregnancies.

When women interact with multiple providers in our fragmented health care system, the historical details of their total health care "picture" can easily become disconnected. Family physicians in a PCMH can reconnect those disparate fragments. They have the ability to affect family planning and pregnancy intendedness for these women as they seek care with their family physician for preconception care or, if now pregnant, for their immediate pregnancy. They may also affect pregnancy intendedness after patients return from receiving

care from their obstetricians, midwives, or maternal-fetal medicine specialists. Also, by providing care for children, family physicians have the opportunity to interact with mothers during well-child checkups and vaccinations and can partner with pediatrician colleagues to encourage all health care providers to take an active role in family planning.<sup>13</sup>

The 2007 PRAMS report also states that mothers with unintended pregnancies are less likely to adopt healthy behaviors during pregnancy, such as avoiding tobacco, illegal drugs, or alcohol.<sup>11</sup> In 2006, the Center for Disease Control and Prevention's (CDC) Preconception Care Work Group and Panel on Preconception Care recommended that elements of preconception care be integrated into every primary care visit, including screening for risks, identifying and treating chronic diseases, and reviewing reproductive health during the interconception period.<sup>14</sup> The North Carolina Department of Public Health's Preconception Health Strategic Plan mirrors the CDC Preconception Care Work Group with six priority areas: (1) pregnancy intendedness, (2) obesity and related conditions, (3) substance abuse, (4) mental health, (5) collaborative research and policy development, and (6) access to care.

Family physicians are ideally suited to meet all of these recommendations as they routinely care for acute and chronic diseases of women as well as provide care for their children.

Two examples illustrate how family physicians are best suited to help North Carolina achieve these goals. Thirty-six percent of North Carolina women ages 18-44 reported poor mental health.<sup>15</sup> Yet nearly 50% of individuals with a mental health disorder never see a mental health care professional.<sup>16</sup> At least once a year, however, 80% of these individuals visit their primary care provider.<sup>16</sup> Fifty percent of all mental health care in the US is delivered solely by a primary care physician; furthermore, non-psychiatric physicians prescribe approximately 70% of all psychotropic agents in the US.<sup>16</sup> Additionally, depression is an illness that responds best when treated via the care of a personal physician focused on the whole person in an integrated system (i.e., one that includes behavioral health and other partners of the health care team).<sup>16</sup>

As another example, the treatment of obesity is complex and requires the consistent care of a personal physician integrated with a care management team over an extended period of time, in conjunction with behavioral and societal changes. Twenty-nine percent of North Carolina women between ages 18-44 are obese, and 24% are considered overweight.<sup>17</sup> Family physicians have the ability to provide consistent messages, interface with the care management team, and activate resources—not just on behalf of the woman but for the whole family and community.

Family physicians have the potential to participate in partnerships across multiple disciplines. In the May/June 2009 issue of the *North Carolina Medical Journal*, the integrative and successful efforts of Community Care of North Carolina were highlighted.<sup>18</sup> Why not continue to expand this model into the area of women's health, including maternity care, by bringing together family physicians, pediatricians, obstetricians/gynecologists, midwives, maternal care coordinators, behavioral health providers, and home nurses to have a more coordinated system of continuity care? Collaboration around improving maternal and neonatal outcomes has already begun through increasing family physicians' awareness and involvement in the Perinatal Quality Collaborative of North Carolina (PQCNC). Multi-specialty cooperation in creating and implementing evidence-based guidelines and best practices for obstetrics could be enhanced through programs such as

the Institute for Healthcare Improvement (IHI) Idealized Design of Perinatal Care<sup>19</sup> and the Interventions to Minimize Preterm and Low Birth Weight Infants through Continuous Improvement Techniques (IMPLICIT) Network.<sup>20</sup> "Enhancing obstetric skills through partnerships of both family medicine and obstetricians/gynecologist residencies with the American Academy of Family Physician Advanced Life Support in Obstetrics (ALSO) course has been successful in several locations in providing an evidence-based simulation workshop used in over 47 countries to train all levels of maternity care providers (medical students and residents, labor and delivery and neonatal nurses, midwives, family physicians, and obstetricians).<sup>21</sup> These are the types of creative collaborations that will be necessary to successfully improve overall outcomes.

The health needs of women in North Carolina are indeed diverse and can be viewed as an overall indicator of our community's health. The unique role of family physicians in caring for this population cannot be overstated. Family physicians are located in HPSA areas throughout the state and are often the only medical provider caring for or supervising care for women in a given community. Their scope of training and practice is broad and comprehensive, covering women at all life stages, from infancy throughout adulthood. Family physicians can fulfill the role of a PCMH providing continuity and coordination of care, and collaboration. Family physicians can impact preconception, prenatal, and postpartum care and are experienced in caring for the chronic conditions which the women in our community face. They also have the unique opportunity to provide "well- family care" by incorporating well-woman care into well-child visits. Family physicians have played, and will continue to play, a vital and unique role in improving the health of this population by providing increased access to services and through ongoing collaboration with other medical specialties and health organizations. **NCMJ**

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