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Editor's Choice

Rethinking the Well Woman Visit: A Scoping Review to Identify Eight Priority Areas for Well Woman Care in the Era of the Affordable Care Act

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A B S T R A C T

Purpose: The annual pap smear for cervical cancer screening, once a mainstay of the well woman visit (WWV), is no longer recommended for most low-risk women. This change has led many women and their health care providers to wonder if they should abandon this annual preventive health visit altogether. Changing guidelines coinciding with expanded WWV coverage for millions of American women under the Patient Protection and Affordable Care Act have created confusion for health care consumers and care givers alike. Is there evidence to support continued routine preventive health visits for women and, if so, what would ideally constitute the WWV of today?
Methods: A scoping review of the literature was undertaken to appraise the current state of evidence regarding a wide range of possible elements to identify priority areas for the WWV.
Findings: A population health perspective taking into consideration the reproductive health needs of women as well as the preventable and modifiable leading causes of death and disability was used to identify eight domains for the WWV of today: 1) reproductive life planning and sexual health, 2) cardiovascular disease and stroke, 3) prevention, screening, and early detection of cancers, 4) unintended injury, 5) anxiety, depression, substance abuse, and suicidal intent, 6) intimate partner violence, assault, and homicide, 7) lower respiratory disease, and 8) arthritis and other musculoskeletal problems.
Conclusions: The WWV remains a very important opportunity for prevention, health education, screening, and early detection and should not be abandoned.

The Patient Protection and Affordable Care Act (ACA) of 2010 mandates that health plans cover a range of preventive services including an annual well woman visit (WWV) for free. Recent publications from the Institute of Medicine (IOM), including *Clinical Preventive Services for Women: Closing the Gaps* (IOM, 2011a) and the *Future of Nursing: Leading Change, Advancing Health* (IOM, 2011b) highlight a significant paradigm shift in U.S. health policy from treating illness to promoting health. In its *Future of Nursing* report, the IOM articulates a vision for the health care system to intentionally promote wellness and prevent disease, one in which "primary care and prevention are central drivers of the health care system" (IOM, 2011b, p. S-1). The IOM recommendations for women's preventive services (2011a) envision the WWV as a way to address cost barriers and other disparities associated with obtaining preventive services and to reduce a woman's risk of disease, disability, and illness. These recommendations made important strides to ensure broad and more universal access to certain preventive services for women without the associated costs (such as copays or deductibles) that have been shown to deter women from seeking such services (Olchanski, Cohen, & Neumann, 2013; Robertson & Collins, 2011).

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At the same time that health plans are implementing the ACA-mandated coverage for annual WWVs without cost sharing, certain key components of the traditional WWV, such as the annual Pap smear for cervical cancer screening and the bimanual pelvic examination, are being challenged. Specifically, joint 2012 guidelines from the American Cancer Society (ACS), the American Society for Colposcopy and Cervical Pathology, and the American Society for Clinical Pathology (Saslow et al., 2012) as well as by the American College of Obstetricians and Gynecologists (ACOG, 2012b) now advocate for cervical cancer screening with a Pap smear only every 3 to 5 years in low-risk women. In 2014, the American College of Physicians issued a new clinical guideline recommending against routine screening pelvic examinations in asymptomatic, nonpregnant adult women (Qaseem et al., 2014), although the ACOG continues to recommend yearly pelvic examinations (ACOG, 2014). These changing recommendations and other campaigns to reduce the use of low-value services in health care (ABIM Foundation, 2015) have led to popular press headlines and professional editorials questioning the need for any kind of preventive care at all.

Fortunately, the ACA guarantee for a yearly WWV as a covered benefit without cost sharing has helped to protect these visits from possible extinction. Women's health experts, advocates, and organizations have responded to questions about the value of these visits with guidance for policy makers, clinicians and health care consumers. A *Consumer Guide* to the WWV (National Women's Law Center, Brigham and Women's Hospital & Connors Center for Women's Health, 2014) a WWV software application ("app"; Nurse Practitioners in Women's Health, 2014), and a comprehensive list of age-based recommendations for *Components of the Well-Woman Visit* from the ACOG Well Woman Task Force (Conry & Brown, 2015) have been released in the past year. Nevertheless, more work needs to be done to solidify the value of this preventive health visit, to help clinicians prioritize among the many potential highest value WWV elements, and to educate and empower women to fully utilize their preventive health and screening benefits (Fitzgerald, Glynn, Davenport, Waxman & Johnson, 2015; Sawaya, 2015).

Methods

The goal of this scoping review of the literature was to answer the question: What is the state of the literature, evidence for, and current policy recommendations regarding what should be included as components of the WWV? This review followed the five steps outlined by Arksey and O'Malley (2005) and further refined by Levac, Colquhoun, and O'Brien (2010) and Daudt, van Mossel, and Scott (2013). Because the WWV is generally composed of a package of many different possible services (which may include cancer screenings, behavioral health screenings and interventions, health education and counseling, and reproductive life planning [RLP]), the scoping review method was chosen because it lends itself to rapidly mapping relevant literature covering broader and more complex research or policy-related questions, to assimilating a broad and diverse range of interdisciplinary research and nonresearch sources, and to summarizing and prioritizing among important sources and types of evidence available (Anderson, Allen, Peckham & Goodwin, 2008; Davis, Drey, & Gould, 2009; Mays, Roberts, & Popay, 2001).

Relevant literature was identified using Medline/Ovid, CINAHL, and Google Scholar to also identify white papers and grey literature. In addition, hand searching of the U.S. Preventive Services Task Force (USPSTF), National Guideline Clearinghouse, and Cochrane databases, as well as the web sites of relevant professional organizations was undertaken to ensure inclusion of all possible practice guidelines or recommendations. Because of the breadth of this review, resources were limited to meta-analysis and clinical guidelines based on such analyses and focused on primary care settings, primary prevention, and preventive health guidelines, unless such resources were not available. References were generally limited to the year 2009 or later unless classic, often cited, or not yet revised/updated resources from earlier years were considered critical to the topic area. All applicable references were collected and organized by topic area in Mendeley (version 1.12, Mendeley Ltd, New York, NY).

Because this scoping literature review did not include human subjects, no institutional review board approval was required for this project.

Results

An initial search explored mortality and morbidity data and the general reproductive health needs of U.S. women to identify priority areas for the WWV. This initial iterative process is consistent with the experiences described by other researchers who used the scoping review methodology (Arksey & O'Malley, 2005; Daudt et al., 2013; Levac et al., 2010). In addition to addressing reproductive health issues for women, the WWV of today is an important opportunity to address the prevention and modification of risk factors for and/or early detection of the current leading causes of morbidity and mortality. Table 1 presents the most recent data available regarding leading causes of death in women and Table 2 summarizes the leading self-reported sources of disability in women. Modifiable risk factors including smoking, overweight/obesity, high blood pressure, physical inactivity, and high glucose account for more than two of every five deaths in U.S. women (Danaei et al., 2009), primarily from cardiovascular disease (CVD), lung cancer, stroke, and chronic obstructive pulmonary disease (COPD). As much as one quarter of direct medical costs of the U.S. health system have been attributed to modifiable risk factors (Grunfeld et al., 2013).

Although life expectancy at birth has improved in total for U.S. women over the past two decades, morbidity and related rates of disability have increased, with the same modifiable risk factors and alcohol use contributing to the increasing years lived with disability (Fineberg & U.S. Burden of Disease Collaborators, 2013). Some recent statistical modeling predicts more disease and earlier mortality ahead for younger Americans because of the high incidence of obesity and other factors (Reither, Olshansky, & Yang, 2011). Despite the high costs of the U.S. health system, the US ranks 36th in the world in life expectancy for women (World Health Organization, 2013), and 48th in maternal mortality indicating that much more can and should be done to ensure the health and longevity of women in this country.

In this first phase of the scoping review, the morbidity and mortality data discussed were used to identify a framework of eight priority areas for the WWV. Next, separate scoping reviews were conducted for each of the eight priority areas, resulting in a total of 169 references that were collated and extracted. Figure 1 details the overall flow of the scoping review search and selection (Davis et al., 2009). To ensure methodological rigor, the detailed search strategies and terms for each of the eight priority areas were documented in detail and are available upon request (Arksey & O'Malley, 2005; Daudt et al., 2013; Havill et al., 2014).