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Women's Preferred Sources for Primary and Mental Health Care: Implications for Reproductive Health Providers

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A B S T R A C T

Purpose: To describe women's preferences for reproductive health providers as sources of primary and mental health care.

Methods: This is secondary data analysis of the Women's Health Care Experiences and Preferences Study, an Internet survey conducted in September 2013 of 1,078 women aged 18 to 55 randomly sampled from a U.S. national probability panel. We estimated women's preferred and usual sources of care (reproductive health providers, generalists, other) for various primary care and mental health care services using weighted statistics and multiple logistic regression.

Main Findings: Among women using health care in the past 5 years ($n = 981$), 88% received primary and/or mental health care, including a routine medical checkup (78%), urgent/acute (48%), chronic disease (27%), depression/anxiety (21%), stress (16%), and intimate partner violence (2%) visits. Of those, reproductive health providers were the source of checkup (14%), urgent/acute (3%), chronic disease (6%), depression/anxiety (6%), stress (11%), and intimate partner violence (3%) services. Preference for specific reproductive health-provided primary/mental health care services ranged from 7% to 20%. Among women having used primary/mental health care services ($N = 894$), more women (1%–17%) preferred than had received primary/mental health care from reproductive health providers. Nearly one-quarter (22%) identified reproductive health providers as their single most preferred source of care. Contraceptive use was the strongest predictor of preference for reproductive health-provided primary/mental health care (odds ratios range, 2.11–3.30).

Conclusions: Reproductive health providers are the sole source of health care for a substantial proportion of reproductive-aged women—the same groups at risk for unmet primary and mental health care needs. Findings have implications for reproductive health providers' role in comprehensive women's health care provision and potentially for informing patient-centered, integrated models of care in current health systems.

Prevalence rates of chronic disease and mental health conditions are rising among reproductive-aged women in the United States (Centers for Disease Control and Prevention [CDC], 2016b; Farr, Hayes, Bitsko, Bansil, & Dietz, 2011; Hayes, Fan, Smith, & Bombard, 2011; Kaiser Family Foundation, 2005, 2014; Ko, Farr, Dietz, & Robbins, 2012; National Institute of Mental Health [NIMH], 2016). One in 10 women ages 18 to 44 report having a chronic disease, including hypertension, high cholesterol, asthma, other respiratory diseases, or arthritis, among others (CDC, 2016b). One in 10 women also report symptoms of major depression or anxiety disorders in the past year (Ko et al., 2012; NIMH, 2016). Rates of chronic disease and mental health conditions are even higher among poor and racial/ethnic minority women (CDC, 2016b; Kaiser Family Foundation, 2005, 2014; Farr

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et al., 2011; Hayes et al., 2011; Ko et al., 2012; NIMH, 2016). Although common chronic disease and mental health conditions are recognized as leading causes of morbidity and mortality, their implications for women's reproductive health and family planning have been given less attention. A growing number of research studies have shown that chronic diseases, depression, anxiety, and stress are linked with decreased fertility, perinatal and infant morbidity, "risky" sexual and contraceptive behaviors, and increased rates of unintended pregnancy and sexually transmitted infections (Alder et al., 2007; Chor, Rankin, Harwood, & Handler, 2011; Davis, Beyer, Brown, & Connell, 2008; Denobles et al., 2014; Grote et al., 2010; Hall, Kusunoki, Gatny, & Barber, 2014; Hall, Moreau, Trussell, & Barber, 2013; Holing, Beyer, Brown, & Connell, 1998; Williams, Marsh, & Rasgon, 2007). Within current public health systems and policies, however, women's general and mental health and health care needs have been largely marginalized from their reproductive health and family planning issues.

Service use rates for primary care and mental health care are low among reproductive-aged women compared with their older counterparts and rates are disproportionate across sociodemographic groups (Farr, Bitsko, Hayes, & Dietz, 2010; Kaiser Family Foundation, 2005, 2014; Ko et al., 2012; Lee, Casanueva, & Martin, 2005). Younger, poor, and racial/ethnic minority women are less likely to have a primary care provider for diagnosis and treatment of acute or chronic conditions (non–reproductive-related issues) or receive evidence-based preventive care services (i.e., routine health promotion, maintenance, counseling, education) compared with their older and socially advantaged counterparts (Kaiser Family Foundation, 2005, 2014). Fewer than one-half of all nonpregnant reproductive-aged U.S. women with a major depressive episode are diagnosed or treated; detection and treatment rates are even lower among Black, Hispanic, and poor women (Farr et al., 2010; Kaiser Family Foundation, 2005, 2014; Ko et al., 2012; Lee et al., 2005). Some existing collaborative care models have sought to increase access to primary and mental health care by providing chronic disease or depression screening in obstetrical settings or by integrating mental health care treatment into generalist practices (Katon et al., 2010; Robbins et al., 2011; Miller, Kessler, & Peek, 2011; Tovar, Chasan Taber, Eggleston, & Oken, 2011; Zera, McGirr, & Oken, 2011). Yet, collaborative care models have not been widely implemented and, even when they are, do not reach all women equally (Kaiser Family Foundation, 2005, 2014).

Reproductive health providers, including family planning clinics, are often the main source of health care for many women—notably the very same groups of women at risk for unmet primary and mental health care needs (Cheng & Patel, 2011; Frost, Gold, & Bucek, 2012; Kaiser Family Foundation, 2014). Among women in their reproductive years, one-half (47%) see a reproductive health specialist as their regular health care provider (Kaiser Family Foundation, 2005). Although many reproductive health and family planning settings have the capacity to provide more comprehensive women's health services, efforts to address primary and mental health care have focused narrowly on perinatal and postpartum depression or basic obstetrics screening for diabetes, hypertension, and high cholesterol (Dennis, Ross, & Grigoriadis, 2007; Farr et al., 2010; LaRocca-Cockburn, Melville, Bell, & Katon, 2003; Robbins et al., 2011; Scholle & Kelleher, 2003; Schmidt, Greenberg, Holzman, & Schulkin, 1997; Tovar et al., 2011; Yonkers & Chantilis, 1995; Zera et al., 2011). Less is known about the extent to which nonpregnant women across the reproductive life span, especially those not pregnant or intending pregnancy, receive a broader range of primary and mental health care services from reproductive health providers. Moreover, few, if any, studies have considered women's preferences for reproductive health providers in their primary and mental health care—information that is important for more effective, patient-centered, integrated models of care (Katon et al., 2010; Miller et al., 2011).

Such information can also inform efforts to define the role of reproductive health providers within current health care systems and health policy climates. Women's insurance coverage for preventive and primary care services has expanded in recent years as a result of the Affordable Care Act and Medicaid expansion programs in many states (Kaiser Family Foundation, 2014). These benefits reach many women through family planning clinics, including Title X centers, other community-based safety net facilities, and obstetricians/gynecologists in private practice (Frost, Sonfield, Zolna, & Finer, 2014; Kaiser Family Foundation, 2014). At the same time, a variety of state-level reproductive health policies introduced over the last 5 years have restricted women's access to comprehensive services that are or could be offered in these settings (Frost et al., 2014). Because reproductive health providers are an important source of care within this changing landscape, a baseline assessment of women's preferences for and use of reproductive health providers for a broader range of their health care needs is warranted.

We estimated the preferred and usual sources of primary care and mental health care for a variety of specific services among a national random probability sample of women in the United States. We further identified factors associated with women's preference for reproductive health-provided primary and mental health care.

Materials and Methods

Study Design and Sample

We have described our study design and sample in detail elsewhere (Hall, Patton, Crissman, Zochowski, & Dalton, 2015). In brief, data were drawn from our cross-sectional, population-based, Women's Health Care Experiences and Preferences Study, an Internet-based survey of 1,078 U S. women aged 18 to 55 years conducted in September 2013. GfK (formerly Knowledge Networks, Menlo Park, CA) fielded the survey among their national household random probability panel. GfK is an existing Internet-based panel composed of 50,000 U.S. residents aged 13 and older representative of all 50 states. The GfK panel is sampled via random digit dialing telephone and probability-based address mailing methods. Individuals solicited to participate in the GfK panel but who do not have Internet access are provided with a laptop and Internet access at no cost. Each member of the panel has a unique login to allow them to access online surveys and survey invitations are sent by email. Modest incentives are used to encourage panel participation (e.g., $4 monthly gift card). All panelists routinely update demographic data, which allows for complex, stratified sampling designs. Additional detailed information about the GfK panel and methods is online (GfK, 2013).

Among GfK panelists eligible for inclusion in our study (English-speaking women ages 18–55), a random sample of 2,520 women were emailed an invitation to participate. Of these, 1,078 completed our study (43%). Compared with respondents, nonrespondents were more likely to be aged less than 30 years, identify as Black or Hispanic ethnicity, have less than a high school education, and annual incomes of less than $25,000 (all p