Family Medicine Updates

From the Association of Family Medicine Residency Directors

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VALUABLE NEW AFMRD MEMBER-FOCUSED CHANGES

One of the most common reasons members give for joining a professional association is the opportunity to be a part of an exclusive community of peers.

This is certainly true of the Association of family Medicine Residency Directors (AFMRD), whose e-mail discussion list (commonly referred to as "the Listserv") is ranked as the most valuable membership benefit, year after year.

Former AFMRD Board President Perry Pugno, MD, MPH, described the reason this community is so vital to the program director: "Part clinician, part administrator, part teacher, these individuals had—and still have—a unique position within their medical communities. A director's job is a lonely one. Physician colleagues see the director as a representative of the administration; to management, he or she is a physician. There are few peers within the hospital with whom to talk."

Like others in the family of family medicine organizations, the AFMRD has made a commitment to improving family medicine education by providing a community where members can obtain the support and resources they need to achieve excellence. One way we have long accomplished this is through a members-only e-mail list. This older technology, however, had significant restrictions on its structure and search capabilities, and members' feedback included frustration with the limitations of the tool. In fact, one of the most common prequels to an e-mail posting on the AFMRD e-mail list was, "I know this was just on the Listserv, but…" Yet, it remained invaluable to our members for its capacity to connect those sharing the same struggles.

In late 2015, the AFMRD invested in a powerful online platform that preserves the camaraderie of the e-mail list—and eliminates many of the frustrations. The new technology enables members to maintain a broad sense of community, and delivers more personalized and improved searchable information than ever before.

This investment, which stemmed from ambitious communication and technology objectives outlined in our strategic plan, opens up exciting new opportunities for communication, collaboration, and innovation.

Among the features we have activated thus far are the following:

- A robust discussion forum with all the e-mail convenience of an e-mail list, plus the bonus of online access to discussion threads and searchable archives
- Calendars personalized to each member's involvement in the organization
- A member directory that can be searched by location and areas of special interest
- A structured toolbox, including a section where members can easily upload documents for sharing
- A central landing page, placing all resources within easy reach

With these new tools, the AFMRD aims to support a sense of common mission and purpose in training the primary care workforce that our country so desperately needs. We hope to meet the needs around a myriad of educational and administrative topics, from how to teach ultrasound to job descriptions to how to manage the problem resident.

In addition to bringing new technology to the community, the AFMRD is pleased to be welcoming a new group of members into the community.

In light of the new single accreditation system, the AFMRD has partnered with the American College of Osteopathic Family Physicians (ACOFP) to offer memberships to program directors of AOA family medicine residency programs, many of whom will be seeking ACGME accreditation.

The Association of Family Medicine Residency Directors envisions a vibrant community of residency directors engaged in excellence, mutual assistance, and innovation to meet the health care needs of the public. We believe these recent expansions are huge, strategic steps towards serving that vibrant community.

Stephen Schultz, MD; Lynn Pickerel

From the North American Primary Care Research Group

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MANIFIESTO CANCÚN

El apoyo efectivo de la atención primaria es un componente importante del proceso de cambio de los sistemas

de salud.[1] Con esta orientación, la North American Primary Care Research Group (NAPCRG), en el marco de su XLIII encuentro anual, organizó una pre-conferencia con el objetivo de apoyar al Colegio Mexicano de Medicina Familiar (CMMF) en la adquisición de capacidades para conducir el proceso de cambio del Sistema de Salud Mexicano (SSM). Para ello, el CMMF convocó a un grupo especial de trabajo, conformado por investigadores y líderes académicos del país quienes, reunidos el día 24 de octubre de 2015 en la ciudad de Cancún, Quintana Roo, México, desarrollaron esta propuesta con el propósito de fijar su postura frente a la reforma del SSM y proponer estrategias para su implementación.

Se desarrollaron cuatro sesiones de trabajo, a través de mesas de discusión, coordinadas por representantes de NAPCRG y bajo la dirección del doctor Chris Van Weel. En la primera se analizaron las necesidades, fortalezas y debilidades del SSM. En la segunda sesión, el doctor Jon Salsberg nos permitió reflexionar sobre el sustento filosófico de la investigación participatoria, cuyo fundamento es la evidencia basada en la práctica (a diferencia de la concepción de que la práctica se debe basar en la evidencia), y el reconocimiento de la capacidad de autodeterminación de los miembros de un grupo para facilitar la identificación de sus necesidades, así como la interpretación y aplicación de los resultados de un proceso de investigación.[2]

En un tercer momento, los doctores Rick Glazier y Andrew Bazemore nos compartieron dos estrategias de cambio en los sistemas de salud de Canadá y Honduras, que mostraron cómo un diagnóstico adecuado de la demanda de servicios de una población, al ser mostrado a los tomadores de decisiones, permitió reconocer la necesidad de proponer estrategias alternativas al modelo vigente de atención que, al ser voluntariamente aceptadas por los proveedores de servicios, mejoraron las condiciones de su desempeño profesional y sobre todo, permitieron impactar de manera favorable en las condiciones de salud de la población.

En otro escenario, el trabajo desarrollado por el grupo del Robert Graham Center[3] fue un ejemplo de beneficios derivados de la interacción entre integrantes del equipo de salud y la comunidad.

Este trabajo evidenció la complejidad de los determinantes de la salud propuestos por la OMS.[4] Fue inevitable contrastar estas experiencias con nuestro sistema de salud que, si bien ha mostrado logros importantes como la vacunación universal, aumento en la esperanza de vida y disminución de la mortalidad materna,[5] también se ha caracterizado por una baja capacidad resolutiva en el primer nivel de atención, heterogeneidad en su implementación, ineficiencia y fragmentación, alto costo-beneficio e incapacidad para lograr una cobertura universal.

Tras reconocer los diferentes factores que determinan la salud de la población y el insuficiente cumplimiento de nuestra responsabilidad social, consideramos que el primer paso a seguir es la definición de cuáles determinantes son susceptibles de ser abordados; como consecuencia, emitimos el siguiente manifiesto:

1. El propósito que oriente nuestras acciones debe ser mejorar la salud de la población.
2. El modelo a seguir es el de Atención Primaria a la Salud (APS).
3. Nuestra participación en la futura implementación de la Reforma del Sistema de Salud Mexicano (RSSM) debe ser activa.
4. Todas las instituciones de salud involucradas en la RSSM deben establecer un convenio para su participación.
5. Se debe convocar a todos los actores involucrados en la atención del proceso de salud y enfermedad.
6. En el plazo inmediato, se requiere:

1.1 Realizar un diagnóstico situacional de los proveedores y los usuarios del sistema de salud.

1.2 Discutir y homogeneizar entre los actores el concepto de APS.

1.3 Evaluar la organización de los cuidados de salud, la educación médica y la investigación bajo el marco conceptual de la ecología de la atención médica.[6]

1.4 Hacer evidente la percepción de los pacientes sobre los beneficios de la atención primaria y la medicina familiar.

1.5 Desarrollar investigación participatoria con los prestadores de los servicios de salud; el primer actor a considerar debe ser el médico familiar.

1.6 Evaluar todas las acciones realizadas y abordar con rigor científico los procesos involucrados en los diferentes escenarios de ejercicio de la medicina familiar.

1.7 Concretar la conformación del Colegio Mexicano de Medicina Familiar como colegio de profesionistas para tener un sólido sustento legal y jurídico y, como consecuencia, mayor representatividad.

1.8 Convocar a encuentros y foros de discusión acerca de la función de los médicos familiares en el contexto mexicano, con la participación de otros posibles actores y tomadores de decisiones, interesados en apoyar el proceso de consolidación de la medicina familiar y la implementación de la APS en el país.

Sin duda, estas acciones fortalecerán nuestro sistema de salud y deberán enlazarse con acciones posteriores, todas ellas sustentadas en la autocrítica permanente y el ejercicio reflexivo.

Propuesta formulada como resultado de trabajos previos y el desarrollado durante la pre-conferencia de la XLIII Reunión Anual de la North American Primary Care Research Group, Cancún, México, 24 de octubre de 2015

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Referencias

1. North American Primary Care Research Group. New York, NY: The Association. Disponible en: http://www.napcrg.org/Resources/CancunManifesto.
2. Jagosh J, Bush PL, Salsberg J, et al. A realist evaluation of community-based participatory research: partnership synergy, trust building and related ripple effects. *BMC Public Health*. 2015;15:725.
3. The Robert Graham Center [website]. http://www.graham-center.org.
4. Organización Mundial de la Salud. Informe sobre la salud en el mundo 2008: La atención primaria de salud, más necesaria que nunca. Ginebra: OMS; 2008.
5. Juan M. Hacia un sistema nacional de salud universal. [Towards a national universal health system]. *Cir Cir*. 2014;82(1):98-108.
6. Green LA, Fryer GE Jr, Yawn BP, Lanier D, Dovey SM. The ecology of medical care revisited. *N Engl J Med*. 2001;344(26):2021-2025.

AAFP **From the American Academy of Family Physicians**

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AAFP URGES FAMILY PHYSICIANS TO INTEGRATE PRECONCEPTION CARE INTO PATIENT VISITS

The concept of preconception care dates back to the 1980s, when the US Department of Health and Human Services' inaugural Healthy People initiative (http://www.healthypeople.gov) included a focus on reducing unintended pregnancies. Numerous reports and initiatives have promoted the implementation and integration of the initiative into primary care ever since. Preconception care remains a strategic objective of Healthy People 2020.

And even though data show that rates of family physicians who provide prenatal and obstetrical care are declining, all family physicians and health care professionals who provide care to women of childbearing age need to provide preconception care.

To better promote preconception care concepts to its members, the American Academy of Family Physicians (AAFP) recently developed and released a comprehensive preconception care position paper.

David O'Gurek, MD, of Philadelphia, Pennsylvania is a member of the AAFP Commission on Health of the Public and Science and chaired the workgroup that created the paper.

"With the United States ranking poorly on infant mortality and preterm birth rates, and preconception care having an impact on improving the health of the population, the AAFP stands strongly for integrating these concepts more fully into care delivery," he told *AAFP News*.

The Academy created the preconception care paper to ensure members had access to quality, evidence-based information to support and direct their efforts in key areas, O'Gurek explained.

The paper presents current benefits of and barriers to preconception care and issues a call to action for family physicians to incorporate preconception care counseling and screening into all visits for women of childbearing age and into all well visits for men of reproductive age. Additionally, the paper offers recommendations and support for preconception care and includes summary information to facilitate implementation.

What the Paper Offers Family Physicians

Specific interventions for both men and women are outlined in the paper, along with easy-to-read summary tables for each group.

For example, for women of reproductive age, topics include reproductive planning, the use of folic acid, contraception, family and genetic history, chronic disease management, immunizations, and sexually transmitted infections.

Preconception counseling also includes addressing lifestyle risks—including alcohol, tobacco, and substance use—and providing resources and support for lifestyle modifications.

For men of reproductive age, topics are similar and include social and behavioral history, as well as physical, sexual, and emotional abuse.

The paper also cites research on various substances, anatomical variations, behaviors, and environmental issues that may affect a man's ability to contribute to a successful conception. Body weight, for example, may affect reproductive success; according to some studies, every 20 pounds added to a man's ideal body weight can lead to a 10% increase in his risk of infertility.

Why Preconception Care Should be Incorporated

O'Gurek said he understands firsthand why family physicians might be hesitant to add preconception care to their already busy schedules.

"However, it's important to note that preconception care and its elements should really not be new to family physicians," he said. "It's a genuine example of family-centered health care that provides evidence-