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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-

based care to improve the chances of obtaining a healthy family. It truly represents delivery of preventive and chronic disease health care to patients of childbearing ages."

For example, said O'Gurek, a family physician might see a young woman with a history of hypertension coming into the office as a new patient, and she may have been started on an ACE inhibitor by another practice or even an ER or urgent care center.

"Given the family physician mindset, he or she is immediately attuned to asking the patient about birth control and family planning," he said. "Knowing the woman's reproductive plan is important to delivering chronic disease care for her hypertension and therefore, this conversation must take place.

"Implementation of preconception care is not a new addition to delivered care; rather, it is synonymous with delivering evidence-based men's and women's health care during the reproductive years."

Simply put, said O'Gurek, "Preconception care is primary care."

Chris Crawford
AAFP News

From the American Board of Family Medicine

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A MESSAGE FROM THE ABFM PRESIDENT

As the American Board of Family Medicine (ABFM) transitioned into Maintenance of Certification for Family Physicians (MC-FP) from our old recertification paradigm, I made several promises to our Diplomates. I assured them that: (1) we wanted to develop meaningful, continuous, long-term relationships with them as we worked together to help them deliver the highest quality of care to their patients; (2) we would listen carefully to the feedback that they provided to us and act on it accordingly to make completion of their requirements as efficient as possible; and (3) we would endeavor to evolve MC-FP in keeping with the best evidence of assessment, measurement, and quality improvement science.

In keeping with these promises, the ABFM has several important improvements in MC-FP to announce. These include no longer requiring completion of the clinical simulation component of the Self-Assessment Modules (SAMs) for MC-FP Part II credit, transitioning everyone to the MC-FP point system, adding a new Continuous Knowledge Self-Assessment process to the Part II menu, and instituting a major discount in fees for Diplomates aged over 70 years. We would also like to announce new initiatives for this year in practice transformation and physician burnout.

Unlinking the Clinical Simulation From the Knowledge Assessment in the SAMs

We have just completed an exhaustive review of all of the evaluations that our Diplomates provided after completion of their Performance in Practice Modules (PPMs) for Part IV and the SAMs for Part II. We shared with our Diplomates the preliminary results from the very positive feedback that was provided with respect to the PPMs last winter. This data has now been fully analyzed and a peer-reviewed manuscript has been accepted for publication this year. More importantly, our research staff has just finished a thorough analysis of the SAM data. Unlike the PPM data, however, this data was somewhat more concerning.

While very positive feedback on the knowledge assessment portion of the SAMs was apparent, the assessment of the utility of the clinical simulation component was less favorable. Not only were the quantitative evaluations significantly lower, the qualitative analysis of over 5 million open-ended feedback comments from 325,000 completed SAMs also revealed several important concerns about technical and navigation issues in the simulations. In an effort to determine whether Diplomate familiarity and periodic technical improvements had affected the ratings over time, we analyzed a second data set from almost 100,000 SAMs completed more recently in 2013 and 2014.

The findings were essentially unchanged. Diplomates consistently rated the knowledge assessments more favorably than the clinical simulations. The majority of the negative comments about the clinical simulations revolved around 4 major issues: difficulty in ordering or scheduling tasks; inadequate recognition of questions or language by the simulator; limited medication, treatment, and diagnostic options; and the lack of "realness" in the simulation environment. We provided this data to our Board of Directors for their review at their April 2015 and October 2015 meetings. Between those 2 meetings, our Clinical Simulation Team, led by Senior Vice President Michael Hagen, undertook the task of making several technical improvements to the clinical simulation interface.

While these changes resulted in improvement in the clinical simulation evaluations during this brief period of time, our Directors endorsed unlinking the clinical simulation and knowledge assessment com-