Body System: Women's Health		
Session Topic: Well Woman Exam		
Educational Format		**Faculty Expertise Required**
REQUIRED	Interactive Lecture	Expertise in the field of study. Experience teaching in the field of study is desired. Preferred experience with audience response systems (ARS). Utilizing polling questions and engaging the learners in Q&A during the final 15 minutes of the session are required.
OPTIONAL	Problem-Based Learning (PBL)	Expertise teaching highly interactive, small group learning environments. Case-based, with experience developing and teaching case scenarios for simulation labs preferred. Other workshop-oriented designs may be accommodated. A typical PBL room is set for 50-100 participants, with 7-8 each per round table. Please describe your interest and plan for teaching a PBL on your proposal form.

Professional Practice Gap	**Learning Objective(s) that will close the gap and meet the need**	**Outcome Being Measured**
• Physicians are often nonadherent to ACOG cervical cancer screening guidelines • Women with symptoms suggestive of breast cancer diagnosis, often delay presentation to their family physician • Less than 50% of women receive two consecutive screening mammograms at recommended intervals • Women, particularly those without access to health care, who rely on current breast cancer mobile apps may be misinformed about breast self-examination • In the primary care setting, assessing and addressing knowledge and distress barriers may improve adherence to follow-up recommendations for low-income, inner-city women who are frequently non-adherent to follow-up	1. Conduct age appropriate screening of female patients according to current evidence-based recommendations. 2. Assess patient's health risks and counsel patients on necessary lifestyle modifications to maintain health. 3. Differentiate specific issues, disease processes, and treatments based on ethnicity, gender, and genetics. 4. Develop a protocol for well-woman screening that encompasses the eight priority areas for well-woman care.	Learners will submit written commitment to change statements on the session evaluation, indicating how they plan to implement presented practice recommendations.

recommendations after an abnormal cervical cytology • Screening for retinopathy is suboptimal • Ethnic disparities exist in breast, cervical and colorectal cancer incidence, stage at diagnosis and survival rates • Screening guidelines from multiple national organizations frequently contradict one another.		

ACGME Core Competencies Addressed (select all that apply)

X	Medical Knowledge	X	Patient Care
X	Interpersonal and Communication Skills		Practice-Based Learning and Improvement
	Professionalism		Systems-Based Practice

Faculty Instructional Goals

Faculty play a vital role in assisting the AAFP to achieve its mission by providing high-quality, innovative education for physicians, residents and medical students that will encompass the art, science, evidence and socio-economics of family medicine and to support the pursuit of lifelong learning. By achieving the instructional goals provided, faculty will facilitate the application of new knowledge and skills gained by learners to practice, so that they may optimize care provided to their patients.

- Provide up to 3 evidence-based recommended practice changes that can be immediately implemented, at the conclusion of the session; including SORT taxonomy & reference citations
- Facilitate learner engagement during the session
- Address related practice barriers to foster optimal patient management
- Provide recommended journal resources and tools, during the session, from the American Family Physician (AFP), Family Practice Management (FPM), and Familydoctor.org patient resources; those listed in the References section below are a good place to start
    - Visit http://www.aafp.org/journals for additional resources
    - Visit http://familydoctor.org for patient education and resources
- Provide recommendations for conducting age appropriate screening of female patients according to current evidence-based recommendations.
- Provide recommendations for assessing patient's health risks and counsel patients on necessary lifestyle modifications to maintain health.
- Provide recommendations for differentiating specific issues, disease processes, and treatments based on ethnicity, gender, and genetics.
- Provide recommendations for developing a protocol for well-woman screening that encompasses the eight priority areas for well-woman care.

Needs Assessment

There are more than 150 million women of all ages in the United States and they comprise nearly 60% of all office visits to physicians. Of that number, 87% make preventive care visits to primary care physicians, a significant portion of whom are family physicians. In fact, family physicians see female patients in 119 million office visits per year; more than 43 million of whom are between the ages of 18-44. Nearly 22% of these visits occur in rural areas, where family physicians often serve as the only healthcare provider.[1] According to the Centers for Disease Control and Prevention (CDC), 13.3% of women 18 years and over, are in fair or poor health.[2] The CDC goes on to report that 38.5% of women 20 years and over are obese; 33.4% of women 20 years and over have hypertension; and that heart disease is the leading cause of death. Additionally, breast cancer continues to be the most commonly diagnosed cancer and the second leading cause of cancer deaths among U.S. women. Compared with white women, black women historically have had lower rates of breast cancer incidence and, beginning in the 1980s, higher death rates. Despite improvements in early detection and treatment for breast cancer, black women continue to have the highest breast cancer mortality rate. Since 1975, black women have had lower breast cancer incidence compared to white women, but rates have recently converged, in part because of increasing breast cancer incidence in black women.[3]

Practice Gaps

Data from a 2012 American Academy of Family Physicians (AAFP) CME Needs Assessment Survey indicates that family physicians have statistically significant and meaningful gaps in the medical skill necessary to provide optimal well-woman examinations.[4] More specifically, CME outcomes data from 2013 AAFP FMX (formerly Assembly) *Well-woman Care* sessions, suggest that physicians have knowledge and practice gaps regarding awareness of and compliance with current evidence-based screening recommendations and guidelines, particularly with regard to alcohol, smoking, STIs, cancer, immunizations, depression, bone density, and heart health.[5]

A review of the literature identifies the following knowledge and/or practice gaps:

- Physicians are often nonadherent to ACOG cervical cancer screening guidelines[6]
- Women with symptoms suggestive of breast cancer diagnosis, often delay presentation to their family physician[7]
- Less than 50% of women receive two consecutive screening mammograms at recommended intervals[8]
- Women, particularly those without access to health care, who rely on current breast cancer mobile apps may be misinformed about breast self-examination[9]
- In the primary care setting, assessing and addressing knowledge and distress barriers may improve adherence to follow-up recommendations for low-income, inner-city women who are frequently non-adherent to follow-up recommendations after an abnormal cervical cytology[10,11]
- Screening for retinopathy is suboptimal[12]
- Ethnic disparities exist in breast, cervical and colorectal cancer incidence, stage at diagnosis and survival rates[13]
- USPTSF mammography and cervical cancer screening guidelines contradict screening guidelines from other major national organizations[14,15]

Changing guidelines revolving around preventive care for women along with the expanded Well Woman Visit coverage under the Patient Protection and Affordable Care Act have resulted in

confusion for health care consumers and providers. In 2013, the American College of Obstetricians and Gynecologists (ACOG) convened a task force to develop age-specific well-woman health care guidelines in order to improve health outcomes. Evidence-based guidelines, evidence-informed guidelines, and uniform expert agreement formed the foundation for the final recommendations.[16,17]

Eight priority areas for well-woman care have been identified under the provision of the Patient Protection and Affordable Care Act. These eight domains for the well woman visit include: 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.[17]

The well woman visit is a very important opportunity for prevention, health education, screening, and early detection. Family physicians require updates of the changing guidelines and recommendations, and an understanding of the identified priorities in order to achieve optimal primary and secondary preventive care to promote health and well-being for women.

Physicians may improve their care of adult female patients by engaging in continuing medical education that provides practical integration of current evidence-based guidelines and recommendations into their standards of care, including, but not limited to the following:

- AAFP Breast Cancer Clinical Preventive Service Recommendations[18]
- AAFP Cervical Cancer Clinical Preventive Service Recommendations[19]
- AAFP Chlamydia Clinical Preventive Service Recommendation[20]
- AAFP Colorectal Cancer Clinical Preventive Service Recommendation[21]
- AAFP Coronary Heart Disease Clinical Preventive Service Recommendation[22]
- AAFP Depression Clinical Preventive Service Recommendation[23]
- AAFP Diabetes Clinical Preventive Service Recommendations[24]
- AAFP Genital Herpes Simplex Virus Infection Clinical Preventive Service Recommendation[25]
- AAFP Glaucoma Clinical Preventive Service Recommendation[26]
- AAFP Gonorrhea Clinical Preventive Service Recommendation[27]
- AAFP Healthful Diet and Physical Activity to Prevent Cardiovascular Disease (CVD) Clinical Preventive Service Recommendation[28]
- AAFP Hepatitis Clinical Preventive Service Recommendation[29]
- AAFP Human Immunodeficiency Virus (HIV) Clinical Preventive Service Recommendation[30]
- AAFP Hypertension Clinical Preventive Service Recommendation[31]
- AAFP Adult Immunization Schedules[32]
- AAFP Lipid Disorders[33]
- AAFP Obesity Clinical Preventive Service Recommendation[34]
- AAFP Osteoporosis Clinical Preventive Service Recommendation[35]
- AAFP Ovarian Cancer/BRCA Mutation Testing Clinical Preventive Service Recommendation[36]
- AAFP Physical Activity, Counseling Clinical Preventive Service Recommendation[37]

- AAFP Screening Pelvic Exam Clinical Preventive Service Recommendation[38]
- AAFP Sexually Transmitted Infections Clinical Preventive Service Recommendation[39]
- AAFP Skin Cancer Clinical Preventive Service Recommendation[40]
- AAFP Tobacco Use Clinical Preventive Service Recommendation[41]
- AAFP Clinical Practice Guidelines[42]

Patient-Centered Communication[43]

- Physicians should avoid interrupting the patient early in the interview.
- Observational studies
- Physicians should elicit the patient's agenda early in the interview until all concerns have been expressed. The phrase “Is there something else?” is preferred over “Is there anything else?”
- Training programs, even those of short duration (less than 10 hours), generally improve physicians' patient-centered communication skills.
- Training on patient-centered communication combined with disease-specific materials may improve patient outcomes.
- Patient-centered care is an intrinsically desirable health care priority regardless of its effect on clinical outcomes.

Health Maintenance in Women[44,45]

- Physicians should ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products.
- Physicians should screen all adults for alcohol misuse and provide behavioral counseling interventions to reduce alcohol misuse in individuals who engage in risky or hazardous drinking.
- Physicians should screen women of childbearing age for intimate partner violence, and those who screen positive should be provided with or referred to intervention services.
- Physicians should screen adults for depression when staff-assisted depression care supports are in place to ensure accurate diagnosis, effective treatment, and follow-up.
- All women planning or capable of pregnancy should take a daily folic acid supplement of 400 to 800 mcg.
- High-risk sexually active adults should be counseled on risk reduction for sexually transmitted infections.
- High-risk women should be screened for: Chlamydia (including all sexually active women 24 years and younger);Gonorrhea; &Syphilis
- All adults 65 years and younger should be screened for human immunodeficiency virus.
- Adults should be screened for elevated body mass index. Patients with obesity should be offered intensive counseling and behavioral interventions to promote sustained weight loss.
- Adults should be screened for high blood pressure.
- Women 45 years and older should be screened for dyslipidemia if at increased risk of CHD.
- Women 20 to 45 years of age should be screened for dyslipidemia if at increased risk of CHD.

- Asymptomatic adults with sustained blood pressure greater than 135/80 mm Hg (treated or untreated) should be screened for type 2 diabetes mellitus.
- Women 55 to 79 years of age should take approximately 75 mg of aspirin per day when the net benefit of ischemic stroke reduction outweighs the increased risk of gastrointestinal hemorrhage.
- Women should be screened for cervical cancer with Pap tests beginning at 21 years of age. Low-risk women should receive Pap testing every three years. Co-testing for human papillomavirus is an option beginning at 30 years of age, and can extend the screening interval to five years. Cervical cancer screening should be discontinued at 65 years of age or after total hysterectomy if the woman has a benign gynecologic history.
- Women 50 to 74 years of age should be screened for breast cancer with mammography biennially.
- Mammography should be considered in women 40 to 49 years of age based on each patient's values and the potential benefits and harms.
- Adults 50 to 75 years of age should be screened for colorectal cancer with an FOBT annually, sigmoidoscopy every five years with an FOBT every three years, or colonoscopy every 10 years.
- Routine screening for ovarian cancer with bimanual examination, transvaginal ultrasonography, or cancer antigen 125 testing is not recommended.
- Women 65 years and older should be screened for osteoporosis. Women younger than 65 years should be screened if the risk of fracture is greater than or equal to that of a 65-year-old white woman without additional risk factors.

Faculty should help physician-learners become familiar with the Choosing Wisely® campaign recommendations, and offer recommendations for integration into practice.[46]

These recommendations are provided only as assistance for physicians making clinical decisions regarding the care of their patients. As such, they cannot substitute for the individual judgment brought to each clinical situation by the patient's family physician. As with all clinical reference resources, they reflect the best understanding of the science of medicine at the time of publication, but they should be used with the clear understanding that continued research may result in new knowledge and recommendations. These recommendations are only one element in the complex process of improving the health of America. To be effective, the recommendations must be implemented. As such, physicians require continuing medical education to assist them with making decisions about specific clinical considerations.

References

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