Preconception Care in Primary Care

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Purpose

The purpose of this research project was to explore how family practice practitioners provide preconception healthcare (PCC) and their experiences using preconception care language. Education and a template for PCC was provided to a local practitioner, to use during all well women exams (WWE) for reproductive age women.

Much of the Women's Health field is spent on avoiding pregnancy, but there are important considerations for women who wish to become pregnant or are at risk for unintended pregnancy.

Significance of the Problem

45% of pregnancies in the US are unintended, and maternal and fetal health concerns often are not addressed for 2-3 months after development begins (Kost et al., 2018).
Health risks that may not be addressed due to delayed preconception and prenatal care include low folic acid levels; underweight, overweight, and obesity concerns; uncontrolled diabetes, hypertension and other chronic conditions; exposure to alcohol, smoking, and other environmental toxins; mental health concerns and intimate partner violence (IPV); and delayed immunization status (ACOG, 2019; CDC, 2006).

- Maternal mortality rates in the United States are currently about 17.4 per 100,000 live births, with 37.3 deaths per 100,000 in the African American population (Driscoll & Ely, 2020).
- 70% of women with pregnancy complications were not instructed to improve their health prior to pregnancy (Stanhope & Kramer, 2021).
- Pre-pregnancy obesity is the largest risk factor for pregnancy induced hypertension and gestation diabetes (Stanhope & Kramer, 2021; Goodfellow et al., 2017).
- Only 40% of women report taking folic acid prior to pregnancy (Goodfellow et al., 2017).
- 20% of women of reproductive age smoke, and 16% continue through pregnancy (Fuehrer et al., 2015).

Barriers to PCC

Practitioner Barriers

- Lack of time and reimbursement (Goodfellow et al., 2017; Hampton et al., 2015)
- Struggles with the intimate nature of PCC, especially in context of gender, language, cultural, or religious barriers (Goodfellow et al., 20170
- Practitioners' own ambivalence and expectations of their patients' ambivalence of these topics (Fuehrer et al., 2015)

Patient Barriers

- Lack of patient awareness of need for PCC & No pressing health needs to discuss (Goodfellow et al., 2017)
- Patients may already believe that they have sufficient PCC knowledge, they may not believe that they are at risk for unintended pregnancies or poor pregnancy outcomes, and they may not understand the goals (Fuehrer et al., 2015)
- Perceived psychological stress from PCC, including pregnancy fears and superstition about admitting to early attempts (Bortolus et al. 2017; Hussein et al. (2016)
- Social barriers: Hispanic, African American, and Native American were all found to have the lowest rates of insurance and pre-pregnancy physical assessments; highest rates of unintended pregnancies, pregnancy induced hypertension, and gestational diabetes (Stanhope & Kramer 2021)

Nursing Theoretical Framework

Betty Neuman's nursing theoretical framework encompasses a holistic view of nursing to optimize health. A patient's resources are defined by physiological, psychological, socio-cultural, spiritual, and developmental variables. (Petiprin, 2020; Ahmadi & Sadeghi, 2017).
It provides a framework for providers to assess stress response systems and coping mechanism

- Primary prevention includes folic acid supplementation, up to date immunization status, and engagement in regular exercise.
- Secondary prevention interventions include smoking cessation and screening for depression and IPV.
- Tertiary prevention includes management and optimization of chronic health conditions, moving patients back towards a state of health.

Methods/Project Description

ACOG (2019), CDC (2006), and AAFP (2019) recommend that PCC occur within routine primary care appointments

Do you intend to become pregnant in the next year?

An electronic medical record (EMR) template was created with the guidelines from ACOG, CDC, and AAFP. Key points were taken to make the template streamline for a WWE

Three local providers were approached with the project proposal, but only one took on the project.
She implemented the HPI and A&P template for 2 months and then was interviewed with her experiences.

PCC Template

HPI

Birth control method: ***
Folic Acid Supplementation: ***yes, no
Desire for conception in the next year? ***yes, no
Medical History: Asthma, Cancer, Diabetes, HTN, HIV, IBD, Renal Disease, Seizure disorder, SLE or RA, Thromboembolic disease (history of clotting disorder), Thyroid disease
***are these conditions controlled?
Medication List: Anti-coagulants, isotretinoins (acne medication), anti-epileptic agents, ACE or ARB, statins, lithium, methotrexate ***adjust/stop/alternate therapy needed?
Depression Screening: ***
Immunizations, alcohol, and tobacco addressed elsewhere in HPI
Screening for IPV: Do you ever feel unsafe at home? Need for STI screening: ***yes, declined
Regular Exercise: ***yes, no
BMI: ***underweight, healthy, overweight, obese

A&P

Preconception health was discussed with the patient as recommended by ACOG. Screenings for Depression, alcohol and tobacco use, IPV, STI screening and health life styles were discussed. Folic Acid supplementation was discussed, as USPTF Recommends all women who are capable of pregnancy take 0.4-0.8mg of Folic Acid prior to conception. This recommendation extends to women on birth control, as 45% of all pregnancies in the US are unplanned.
At this time, conception is***not planned for this patient, and ***no changes to their health care plan were made.

Outcomes/Evaluation

Successes:

- One provider took on the project for two months
- Broke down some barriers with her patients, including some of the provider's own expectations of who would be trying for children vs patients who were not interested at all in reproduction.
- Increased folic acid supplementation
- Conversations with otherwise healthy women

Barriers:

- Did not use the template with every WWE
  - Very busy days and complicated patients
  - Patients the provider knew well
- Time constraints was the biggest reason the two providers did not take on the project
- One provider also struggled with ambivalence towards the project need, preferring such topics to be OB/GYN

Changes for the future:

- Larger study sample size with more providers
- Time study with before/after implementation of PCC
- Formal surveys or providers and patient experiences

Implication for APRN/Conclusion

PCC provides as great foundation for holistic primary care for women, with thorough assessments of stressors and risk factors

PCC allows providers the chance to ask patients about their future plans and goals, something that is not always done in time constricted visits

Healthy patients are given more to talk about with their providers and patients with chronic conditions are given more opportunities to improve their health

Though time constraints and lack of awareness were two of the biggest barriers to PCC, but ones that can be overcome

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