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Cervical Cancer Screening at Community Health Centers of Burlington

ADRIENNE JARVIS

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Problem Identification and Description of Need

In 2013, 69.4% of U.S. women 18 and older had a Pap test within the prior 3 years.¹

In December 2016, of female patients at CHCB aged 24-64, 51.3% had EHR documentation of Pap tests within current guidelines (<30 within 3 years, 30 or older Pap + HPV within 5 years or Pap alone every 3 years).

To increase the number of women being screened according to guidelines, essential to identify the root of the problem and possible barriers.

- Is this an EHR documentation issue? Are these women receiving Pap tests from another provider, such as UVM MC or Planned Parenthood?
- Given CHCB's unique population, are there other barriers such as patient refusal, language, or education?

Public Health Costs

Cervical cancer incidence and mortality rates in Vermont do not differ from the rest of the U.S. In Vermont, cervical cancer is the 14th most common cancer in women and 16th leading cause of cancer death.² Cervical cancer is the leading cause of cancer death in women in developing countries.³

5-year relative survival rates for cervical cancer detected at different stages are 91% for early, 57% for regional and 16% for distant.⁴

The cost of a gynecological exam with a Pap test is approximately \$200. The cost for cervical cancer treatment in the first six months for in situ, local, regional, and distant is \$3,807, \$23,187, \$35,853, and \$45,028 respectively.²

Most invasive cervical cancers are found in women who have never been screened or have not been screened within the last 5 years.⁴

Community Perspective

Possible barriers to Pap tracking and testing according to interviews with CHCB physician providers, Director of Quality Management, and Pap Manager:

- Lack of insurance
- Managing multiple comorbidities – patients may attend frequent visits for chronic conditions such as diabetes, hypertension, or chronic pain, but may not be seen for specific preventive physical exams
- Knowledge of and comfort with exam, especially with New American populations
- Refusal due to trauma history
- Difficult for patients to remember or keep track of their own Pap tests. Many patients are not aware of the difference between receiving a gynecological exam for other reasons or a Pap test.
- Difficulty coordinating records with providers who use labs other than UVM MC
- Pap tracking is not automatic. Pap manager receives results and manually tracks abnormal results.

Intervention and Methodology

- CHCB supplied list of 3215 women aged 24-64 who did not have documentation of a Pap test within the guidelines.
- List was randomized and 50 charts were reviewed. An IRB/HIPAA protected excel document was created for in-office use for panel management and patient follow up. Chart notes in the CHCB EHR (Next Gen) were reviewed and compared with UVM MC (Prism) lab results.
- This panel management document, including patient and provider information, was grouped by root cause of missing Paps with additional notes specific to each patient's situation. This was provided to the Director of Quality Management and Pap Manager for patient follow up.
- Director of Quality Management also plans to present results of analysis to providers to improve preventive patient care coordination.

Results/Data

Of 50 randomized patients without Pap tests within current guidelines:

- 56% (28 patients) appear overdue for Pap tests.
- 28% (14) had record or indication of Pap tests done by providers outside CHCB either in a SOAP note or in PRISM.
- 6% (3) had been seen at CHCB for an acute visit only.
- 4% (2) did not have Pap tests indicated due to total hysterectomies.
- 4% (2) did not appear to be active patients – had no visit notes in chart.
- 2% (1) refused Pap test offered by provider.

If these results hold consistent for the overall population, the number of primary care CHCB patients missing Pap tests is closer to 27.5% rather than 48.7%, with 72.5% of CHCB patients having received Pap tests within guidelines.

Evaluation/limitations

50 patient charts reviewed is only 1.6% of the total 3,215. This is a major limitation to this project. Continuing this project with more patients would greatly strengthen the results.

Chart reviewing with cross-referencing is a very time intensive process. It is sometimes difficult to categorize root cause due to lack of specificity in notes – for example, it may be indicated that a patient is transferring care from an outside provider but prior Pap tests are not mentioned and no external records are available.

The largest challenge to accurate documentation appears to be care coordination and receipt and integration of external records from outside providers.

Another barrier appears to be patients seen consistently for management of multiple chronic comorbidities or acute visits without documentation of Pap tests or preventive visits.

Few patients were documented refusing a Pap test, though perhaps more patients are deferring the exam than noted or avoiding preventive visits.

Recommendations for Future projects

Expanding the number of charts reviewed would strengthen the root cause analysis.

Using the information gathered to reach out to patients would improve the rate of cervical cancer screening at CHCB.

Presenting the data to CHCB providers will support further analysis of improving preventive care measures for those patients falling through the cracks, especially those only seeking acute care or those managing complex medical issues.

More automatic EHR systems to integrate results from outside labs/providers into CHCB's EHR would greatly streamline care, minimize reliance on self-report and scanned faxes, and simplify preventive care.

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