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Identifying Strategies to Increase Cervical Cancer Screening Rates in a Federally Qualified Health Center

Elysia Chin[1], Andrew Brougher[2], Ecler E. Jaqua[2], Van Nguyen[2], Mary Hanna[2], Jhanelle Dawes[2], Kelly Morton[2]

[1]Loma Linda University School of Medicine, Loma Linda, CA, United States
[2]Department of Family Medicine, Loma Linda University School of Medicine, Loma Linda, CA, United States

INTRODUCTION AND OBJECTIVES: Interval colorectal cancer (ICC) is defined as Though cervical cancer-related deaths have significantly decreased since the implementation of cervical cancer screening (CCS) via the Papanicolaou (Pap) smear, it remains a leading cause of death in low-income and racial/ethnic minority women, possibly attributed to access to screening. Federally Qualified Health Centers (FQHC) typically serve low-income women and, on average, have a 53% CCS rate compared to the 80+% national screening rate.[1] Cervical cancer is also diagnosed at more advanced stages at FQHCs. Factors that affect screening rates include electronic medical record (EMR) support, staff ratios, and the primary care physician's availability to screen. Our FQHC family medicine residency aimed to increase CCS to greater than 60% with multiple quality improvement cycles over two years.

METHODS: Quality improvement (QI) projects on CCS were executed via "plan-do-study-act" (PDSA), 4 month cycles from June 2018 to September 2020, focusing on utilizing EMR support, improving staff ratios, and increasing physician availability to screen. Cycle #1 used the EMR for patient education via a templated after-visit summary (AVS). Cycles #2 and 3 encouraged staff to review the patients' chart for documented CCS and encourage same-day CCS if applicable. Cycle #4 aimed to improve clinician and staff communication prior to the start of each clinic to prepare for CCS. Cycle #5, the current cycle, will aim to offer CCS to any eligible patient if none are documented in the EMR, have attending physicians encourage CCS if patient declines with the resident physician, and have a female physician, resident and attendings, available at all times to complete CCS if the patient prefers. A pre- and post-test questionnaire and CCS rates were reviewed with each cycle.

RESULTS: Cycle #1 had a slight increase in screening rate from 57.9% to 59.5%. Cycle #2 and #3 saw decreases in CCS to 57 and 49%, respectively. Cycle #4, however, saw an increase in CCS from 49 to 55% by increasing communication between physicians and staff via huddling before each clinic. The current cycle's results are not yet available.

CONCLUSIONS: These findings suggest that the strategies used to increase CCS likely requires a multifaceted approach that includes more patient education, interdisciplinary collaboration, better utilization of the EHR, and continuation of mandatory huddles. Future interventions should continue to focus on patient education, improving CCS health literacy,

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Send correspondence to: ehchin@llu.edu

with the goal of improving health disparities in communities similar to that represented by an FQHC.

REFERENCES:

1. Swan J, Breen N, Coates RJ, Rimer BK, Lee NC. Progress in cancer screening practices in the United States: results from the 2000 National Health Interview Survey. Cancer. 2003;97:1528-40.