

# STATE HEALTH POLICY

STATE HEALTH POLICY BRIEFING PROVIDES AN OVERVIEW AND ANALYSIS OF EMERGING ISSUES AND DEVELOPMENTS IN STATE HEALTH POLICY.

Many Federally Qualified Health Centers (FQHCs) have made significant strides to achieve the Healthy People 2020 goal to reduce the incidence of cervical cancer through more robust screening efforts. This *State Health Policy Briefing* features lessons and best practices from 14 FQHCs selected across seven states with leading rates for cervical cancer screening. Recognizing the link between adoption of enhanced primary care delivery models, including the Patient-Centered Medical Home (PCMH), and improved screening outcomes, best practices are outlined across the five attributes of a PCMH: patient-centered, comprehensive, coordinated, accessible, and safe high-quality care. This publication was made possible through the support of the Health Resources and Services Administration.

NATIONAL ACADEMY  
for STATE HEALTH POLICY

# Briefing

A PUBLICATION OF THE NATIONAL ACADEMY FOR STATE HEALTH POLICY

AUGUST 2013

## A Medical Home Framework for Increasing Cervical Cancer Screening Rates: Best Practices for FQHCs

*Christina Miller and Mary Takach*

Cervical cancer has affected nearly 250,000 women in the U.S since 1973.<sup>1</sup> While prevalence of the disease has declined in recent years—largely due to increased prevention efforts<sup>2</sup>—more than 12,300 women are expected to be diagnosed with this preventable condition this year.<sup>3</sup> The purpose of this brief is to share best practices and lessons from Federally Qualified Health Centers (FQHCs) in seven states that have made significant strides in screening for cervical cancer (see text box: FQHC selection). Their examples may inspire all health care organizations to make needed changes to improve quality of care and achieve *Healthy People 2020* goals to reduce the incidence of cervical cancer<sup>4</sup> as gauged through the Uniform Data System (UDS) cervical cancer screening measure.

The Patient-Centered Medical Home (PCMH) model provides a useful framework for quality and care delivery improvement to achieve higher cervical cancer screening rates. Recognizing the link between PCMH and improvements for screening, the Health Resources and Services Administration (HRSA) recently (FY2012)

opened a PCMH supplemental funding opportunity aimed specifically at improving outcomes related to cervical cancer screening.<sup>5</sup> Accordingly, the five functions and attributes of the PCMH model defined by the Agency for Healthcare Research and Quality (AHRQ) have been used as the framework for this brief.

- Patient-centered care;
- Comprehensive care;
- Coordinated care;
- Accessible services; and
- Quality and safety<sup>6</sup>

Appendix A offers a full breakdown of characteristics and PCMH activity at all interviewed FQHCs.

## USING THE MEDICAL HOME FRAMEWORK TO IMPROVE CERVICAL CANCER SCREENING

### PATIENT-CENTERED CARE

A key principle of the PCMH model is emphasis on patients managing their care with consideration of their personal networks, resources, and values. Interviewed health centers seek to improve patient-centeredness by educating new and existing patients specifically about the importance of Pap screenings by:

- Hosting community outreach days;
- Participating in local health fairs;

### FQHC Selection

Two FQHCs were selected and interviewed from states with high rates of FQHC cervical cancer screening (Colorado, Maine, Maryland, New York, Texas, Vermont, and Virginia) based upon percent of women with completed Pap tests as reported through Uniform Data System (UDS) data from 2009-2011. Interviewees were also selected to maintain a balance of large, small, urban, and rural FQHCs.

- Programming electronic medical records (EMR) to automatically generate appropriate educational resources for patients based on inputted data about their screening history or results; and
- Programming EMRs to automatically send alerts to staff to contact patients about whether they are due for a Pap test or to follow-up abnormal test results.

### COMPREHENSIVE CARE

The PCMH model takes a holistic approach to care, including prevention, wellness, and behavioral and specialty care. Although some interviewed health centers did not have the capacity to offer all services “in-house,” many have strategies in place to ensure the provision of comprehensive care such as:

### PATIENT-CENTERED CARE SPOTLIGHT—CARE FOR THE HOMELESS (NEW YORK, NY)

Care for the Homeless’s approach to delivering *patient-centered care* has been uniquely tailored to meet the needs of its primarily homeless and transient population. Care’s staff is split into care teams, including case managers, physicians, mid-levels, and others, who travel to 30 care sites across New York City situated in shelters or other areas where homeless individuals gather.

The average “tenure” for patients is only 6-12 months, and providers and staff strive to raise awareness, educate, and treat patients—particularly on the importance of primary care and prevention—during this brief period. Activities to engage new patients range from distributing mass transit passes or reimbursing for other costs of traveling to the clinic, to hosting community days such as “Paps for Pocketbooks,” in which staff hand out donated products to patients who receive a screening. To better serve this population, providers and staff attend cultural competency training for working with the homeless population. All educational materials created for patients are written at a third-grade reading level to accommodate issues with literacy.

Care’s high patient return rates, despite disadvantages that come with an inability to track patients by telephone or mail, are credited to consistency in care teams at the designated care delivery spots. When patients come in, providers are trained to reinforce the importance of screening, like that for cervical cancer. Staff schedule follow up appointments for patients to review results regardless of outcome, encouraging patients to take ownership of all results as a method of reinforcing the importance of the test and preventive care.

- Providing educational materials on prevention and screening early and often to patients, including community education efforts like collaboration with local schools to provide appropriate health education to adolescents;
- Training staff to regularly (ex. quarterly, bi-monthly) pull patient records and flag patients due for preventive services (including cervical cancer screening) and then contacting patients promptly to schedule an appointment to receive necessary services;
- Training nurse practitioners and medical assistants to recall and review patient records to ascertain if patients are up to date on all screening and preventive services prior to a patient's appointment;
- Flagging records for providers to offer any needed services to patients during the appointment, even if the patient is in for unrelated services;
- Adopting a team-based care model to collectively be responsible for a patient's care. Teams include a mix of practitioners, mid-levels, case managers, behavioral health specialists, and front desk staff;
- Including providers on the care team who can be designated to specifically serve women's health needs and are able to conduct well-woman exams and Pap tests;
- Delivering appropriate verbal and/or printed educational material to patients—often generated directly out of resource libraries embedded within health centers' EMRs—relevant to the care received and any necessary follow-up before patients leave appointments; and
- Developing protocols for nurses or medical assistants to schedule follow-up appointments or share any information needed for referrals prior to patients leaving an appointment.

### COMPREHENSIVE CARE SPOTLIGHT—CLINICA CAMPESENA FAMILY HEALTH SERVICES (BOULDER, CO)

Clinica has designed a workflow to ensure patients receive a *comprehensive care* experience from the moment they first step into their health center's doors. Clinica maintains a Pap test registry in its EMR to track screening information. Front desk staff review information from the registry monthly to identify and contact patients who are due for a test. Additionally, a reminder system was built into the EMR to alert providers and staff when patients, in for any appointment, are due for a Pap test.

Once patients are in for their appointment, care delivery centers around a "pod," or care team of primary care practitioners, medical assistants, a registered nurse, a case manager, a behavioral health professional, and front desk staff. The pod collaborates closely in delivering a patient's care. Pods are also regularly updated with performance data on the services they provide.

To meet women's health needs, Clinica employs four OB/GYNs and provides ongoing education to all providers on women's health issues. Recently, for example, medical assistants were educated on ASCCP guidelines for screening and have improved their practice in ensuring appropriate tools are available to providers prior to coming in for a patient's appointment.

### COORDINATED CARE

Care delivered to patients must also be coordinated, not only between providers within a health center, but throughout the broader health care system used by a patient, including specialty care and social services and supports. Interviewed health centers improve coordination through:

### COORDINATED CARE SPOTLIGHT—ST. CROIX REGIONAL FAMILY SERVICES (PRINCETON, ME)

In rural Maine, access to specialty care and social services can be particularly difficult for patients of St. Croix, who travel from as far as 50 miles to receive care. Led by a licensed nurse practitioner, a team of medical assistants and the office manager collaborate to *coordinate care* services and assistance delivered to patients across the area, including arranging for appointments and transportation to specialty care, oncological care, and pain management services up to 100 miles away from the health center. Through their work, the care coordination team has developed deep relationships with the health center's patients, resulting in patients engaged in their care.

- Employing care coordinators, case managers, or patient managers tasked with assisting with referrals and tracking follow-up care even when not completed in-house;
- Providing translation services to patients, including interpreters able to travel with health center patients to outside follow-up appointments; and
- Establishing concrete processes for receipt of screening results by appropriate providers and staff and arrangement for follow-up care for any patients that receive abnormal screens.

### ACCESSIBLE SERVICES

Access to providers and staff to serve patients' needs is a critical attribute of PCMH-based care that interviewed health centers seek to improve by:

- Partnering with local community organizations or transportation providers to offer free or discounted transportation options to patients;
- Offering extended hours on weekends or evenings;
- Reserving appointments specifically for preventive care or building time for preventive care

#### ACCESSIBLE SERVICES SPOTLIGHT— ALEXANDRIA NEIGHBORHOOD HEALTH SERVICES (ALEXANDRIA, VA)

Taking proactive measures to increase *access* to care, Alexandria makes every effort to increase the number of staff available to conduct screening. These efforts have included incorporating time in every appointment to dedicate to women's health issues and to conduct screens if needed. In addition to the clinic's part-time gynecologists, family practitioners at the center have increasingly become more involved in conducting the screening. This is supported by dedicated training on women's issues, including performance of colposcopies. Alexandria also employs a family nurse practitioner that conducts a walk-in clinic specifically dedicated to performing exams and screens for women. Next year, Alexandria plans to expand these services further by offering "women's health days" one Saturday per quarter during which it will offer breast exams and Pap tests.

into existing time slots to avoid the need for a follow-up visit;

- Training providers and designing workflows so that providers and staff will step in as necessary to fill-in for occupied providers; and
- Enabling nurse practitioners, physician assistants, and general internists to conduct Pap tests to increase health center capacity to conduct screenings.

### QUALITY AND SAFETY

Using evidence-based guidelines not only enables health centers to provide consistent care across providers and sites, but also guarantees that the most efficient and effective care is delivered. Guidelines governing appropriate delivery of Pap tests have varied over recent years with the American College of Obstetricians and Gynecologists (ACOG) in 2012 recommending that most women between the ages of 21 -29 be screened for cervical cancer no more than once every three years and between the ages of 30-65 every three to five years. Engaging providers and staff to follow the new guidelines is challenging and to mitigate these effects, interviewed health centers are:

- Developing more robust resource libraries for providers and staff accessible directly through EMRs;

#### ROLE OF HIT IN MEETING QUALITY AND SAFETY GOALS

Interviewees almost universally acknowledged the importance of electronic infrastructure, specifically EMR systems, as a key component to advancing their ability to provide comprehensive services. Beyond using information culled from EMRs to generate patient reports, data is used to assess patterns in care delivered by physicians, staff, and/or the health center overall, including identifying providers who may need additional training or assistance on delivering Pap tests in accordance with current guidelines. Furthermore, many FQHCs are building or connecting with systems across the health sector to better access data and coordinate care when patients receive services outside of the FQHC.

- Providing opportunities for providers and staff to participate in formal trainings within or outside of the health center;
- Establishing systems either in-house or with regional partners to share information learned from outside training or educational events or to collaborate on hosting regional events; and
- Designating leaders or “staff champions” ranging from Medical Directors and Chief Medical Officers to physicians and staff empowered to proactively promote organizational change by arranging for training opportunities for health center providers and staff or exploring other methods for improving screening rates at the health center.

## FINANCING EFFORTS TO IMPROVE CERVICAL CANCER SCREENING

Many health centers also participate in state and national programs specifically dedicated to supporting cervical cancer screening. Three Lower Counties in Maryland, for example, uses funds available through Maryland’s Breast and Cervical Cancer Screening Program, sponsored through the Centers for Disease Control and Prevention, to increase the number of staff available to perform screening tests.

The majority of health centers interviewed participate in federal, state, or payer-based coordinated care, including Meaningful Use<sup>7</sup>, or PCMH initiatives, including HRSA’s PCMH initiative to encourage health centers to gain PCMH recognition,<sup>8</sup> enabling them to qualify for incentive payments for delivering enhanced primary care. As a participant in Vermont’s Blueprint for Health Advanced Primary Care Practice Demonstration, Springfield Medical Care Systems, Inc. receives per-member per-month payments from all major carriers in the state. Pines Health Services in Maine receives a six percent payment incentive from Blue Cross Blue Shield for meeting designated thresholds for OB/GYN care. Qualifying for added payments required both FQHCs to achieve PCMH recognition through NCQA.

## CONCLUSION

Improving cervical cancer screening practices is an important way for health centers to advance national prevention goals. Health centers can look toward aligning prevention strategies with comprehensive quality improvement strategies, such as the PCMH model. Such a comprehensive strategy will likely serve not only to achieve desired gains in improved prevention, but also build lasting, systematic improvements of care delivery and quality improvement. For more information on this topic, including specific examples from three of the featured FQHCs, please refer to the National Academy State Health Policy June 20, 2013 Webinar, *What You Can Do Today (and Tomorrow!) to Improve Cervical Cancer Screening* available at: <http://www.nashp.org/webinar/what-you-can-do-today-and-tomorrow-improve-cervical-cancer-screening>.

---

## ENDNOTES

1 National Cancer Institute. Surveillance Epidemiology End Results (SEER) Program Research Data (1973-2010). Released April 2013, based on November 2012 submission.

2 The Centers for Disease Control and Prevention, Cervical Cancer Statistics. <http://www.cdc.gov/cancer/cervical/statistics/>. Accessed on June 11, 2013

3 National Cancer Institute SEER Stat Fact Sheets: Cervix Uteri. <http://seer.cancer.gov/statfacts/html/cervix.html#prevalence>. Accessed on June 11, 2013

4 HealthyPeople.gov. 2020 Topics & Objectives—Objectives A-Z. <http://www.healthypeople.gov/2020/topicsobjectives2020/default.aspx> Accessed on June 11, 2013

5 More information about the HRSA FY 2012 Supplemental Funding for Quality Improvement in Health Centers opportunity can be accessed here: <http://www.hrsa.gov/grants/apply/assistance/pcmh/>

6 The Agency for Healthcare Research and Quality. Patient Centered Medical Home Resource Center. [http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh\\_home/1483/pcmh\\_defining\\_the\\_pcmh\\_v2](http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh_home/1483/pcmh_defining_the_pcmh_v2) Accessed on June 11, 2013

7 Centers for Medicare & Medicaid Services: Meaningful Use. [http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Meaningful\\_Use.html](http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Meaningful_Use.html). Accessed on August 13, 2013

8 More information about this initiative can be accessed here: <http://bphc.hrsa.gov/policiesregulations/policies/pal201101.html>

**NATIONAL ACADEMY**  
*for* STATE HEALTH POLICY

**About the National Academy for State Health Policy:**

The National Academy for State Health Policy (NASHP) is an independent academy of state health policy makers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice. As a non-profit, non-partisan organization dedicated to helping states achieve excellence in health policy and practice, NASHP provides a forum on critical health issues across branches and agencies of state government. NASHP resources are available at: [www.nashp.org](http://www.nashp.org).

**Acknowledgments**

The authors wish to thank the Health Resources and Services Administration (HRSA) advisory committee, specifically the Bureau of Primary Health Care and Office of Women's Health, and our HRSA Project Officer Lynnette Araki for their continued support and guidance on this project. We also wish to acknowledge the contributions of our NASHP team members, Carrie Hanlon and Rachel Yalowich throughout the development of this work. Finally, the authors wish to thank key informants and federally qualified health center staff who helped inform this project through interviews, email correspondence, and/or thoughtful review of this report. Informants and staff represent: Alexandria Neighborhood Health Services; American Academy of Physicians; American Cancer Society; Care for the Homeless; Centers for Disease Control and Prevention; Charles B. Wang Community Health Center; Chase Brexton Community Services, Inc.; Clinica Family Health Services; El Centro de Corazón; HealthWorks for Northern Virginia; High Plains

Community Health Center; Migrant Clinicians Network; NE Washington County Health Center; North Texas Area Community Health Centers, Inc.; Pines Health Services; Springfield Medical Care Systems, Inc.; St. Croix Regional Family Health Care Center; and Three Lower Counties Community Services, Inc.

This publication was made possible by grant number UD3OA22891 from HRSA. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of HRSA

**Citation:**

Christina Miller and Mary Takach, *A Medical Home Framework For Increasing Cervical Cancer Screening Rates: Best Practices For FQHCs*, 2013 (Portland, ME: National Academy for State Health Policy).

**Portland, Maine Office:**  
10 Free Street, 2<sup>nd</sup> Floor, Portland, ME 04101  
Phone: [207] 874-6524

**Washington, DC Office:**  
1233 20th Street NW, Suite 303, Washington, DC 20036  
Phone: [202] 903-0101

## Appendix A. Applications of Medical Home Framework to Improve Cervical Cancer Screening Across Interviewed FQHCs

Location: Health centers self-report their urban/rural status yearly to HRSA based on the geographic location of the majority of their patient population.  
 Size: Small <10,000 patients;  
 Large >10,000 patients per year

CO: Clinica Campesina Family Health Services Location: Urban Size: Large	CO: High Plains Community Health Center Location: Rural Size: Small	ME: Pines Health Services Location: Rural Size: Large	ME: St. Croix Regional Family Services Location: Rural Size: Small	MD: Chase Brexton Health Services Location: Urban Size: Large	MD: Three Lower Counties Community Services, Inc. Location: Rural Size: Large	NY: Charles B. Wang Community Health Center Location: Urban Size: Large	NY: Care for the Homeless Location: Urban Size: Large	TX: El Centro De Corazon Location: Urban Size: Small	TX: North Texas Community Health Center, Inc. Location: Urban Size: Small	VT: Northeast Washington County Location: Rural Size: Small	VT: Springfield Medical Care Systems, Inc Location: Rural Size: Small	VA: Alexandria Neighborhood Health Services Location: Urban Size: Large	VA: HealthWorks for Northern Virginia Location: Urban Size: Small
<b>Quality and Safety</b>													
Review of performance data		•		•		•		•		•		•	
Peer review		•		•		•		•		•		•	
Resource Libraries				•									
Training for providers & staff		•		•		•		•		•		•	
Designated leader		•		•		•		•		•		•	
<b>Accessible Services</b>													
Multiple provider types enabled to conduct screenings		•		•		•		•		•		•	
Workflows to enable staff/provider trade off		•		•		•		•		•		•	
Reserved appointment time for prevention													
Extended hours on weekends or evenings				•		•		•		•		•	
Free or discount Pap tests				•		•		•		•		•	
Free or discount transportation services				•		•		•		•		•	
<b>Coordinated Care</b>													
Systems to facilitate record sharing outside of FQHC		•		•		•		•		•		•	
Assist patients with transportation and translation services				•		•		•		•		•	
Follow up on referral appointments				•		•		•		•		•	
Care coordinators/ case managers		•		•		•		•		•		•	
<b>Comprehensive Care</b>													
Incorporation of preventive care into all appointments		•		•		•		•		•		•	
Staff designated to serve women's health needs		•		•		•		•		•		•	
Connecting with navigators or care coordinators				•		•		•		•		•	
Schedule next appointment prior to patient leaving				•		•		•		•		•	
Team-based care		•		•		•		•		•		•	
Systematic review and contact of all patients in need of preventive services		•		•		•		•		•		•	
Review of records prior to appointments		•		•		•		•		•		•	
Built-in patient registry/ or report generation capacity		•		•		•		•		•		•	
<b>Patient-Centered Care</b>													
Cultural competency training		•		•		•		•		•		•	
Patient alerts		•		•		•		•		•		•	
Patient education		•		•		•		•		•		•	
EMR generated educational resources				•		•		•		•		•	
Community outreach		•		•		•		•		•		•	