

IMPROVING UTILIZATION OF BREAST AND CERVICAL CANCER SCREENING IN YOUR OFFICE PRACTICE

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It has been well documented that early detection and early intervention for breast and cervical cancer saves lives. However, the challenge is to ensure that physicians' practices are effective in implementing the standard guidelines for screening and that all women are screened and undergo appropriate follow-up. Early detection and intervention are imperative since African-American women are twice as likely as European-American women to die from breast cancer even though the incidence of breast cancer is lower. African-American women have fewer mammograms and are being diagnosed later after metastases have occurred. Studies also show that women are more likely to have mammograms if their physicians so advise. However, the most common reason women give for not obtaining mammograms is, "My doctor never recommended it." By using a simple critical path analysis tool to systematically evaluate an office practice and by implementing practical, simple principles, a physician can increase utilization of breast and cervical cancer screening. (*J Natl Med Assoc.* 1995;87:700-704.)

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BREAST CANCER

Breast cancer is the most common type of cancer among women in the United States, accounting for an estimated 182 000 new cases in 1994. The second leading cause of cancer death in women (after lung cancer), breast cancer was predicted to cause an estimated 46 000 deaths in 1994.¹

The average lifetime risk for a woman in the United States of developing breast cancer is approximately one in nine, and breast cancer mortality increases with age, with the first deaths occurring at approximately age 30. African-American women have lower incidence rates than white women but higher death rates at every stage of diagnosis.¹ Recently released results from a National Cancer Institute (NCI) study indicate that African-American women are more than twice as likely as white women to die from breast cancer. Much of this increase in mortality is attributed to the fact that breast cancer in African-American women more often reaches an advanced stage before it is diagnosed. One study suggested that breast tumors may be more aggressive in African-American women, but the most important conclusion of the study was that early screening for breast cancer is essential.²

More than half (nearly 16 million) of all African-Americans are female, and less than half of all non-white women have regular preventive tests such as Pap smears or mammograms.³ Data from the National Breast and Cervical Cancer Early Detection Program indicate that the percentage of screening mammograms

provided in 1993 was 48.4% for whites and 14.7% for African Americans.⁴ For poor and near-poor women, the rates are the lowest.

Despite efforts to increase awareness of the need for mammograms among middle-aged and older women, only half of all women from ages 50 to 64 reported receiving mammography within the past year. Screening for women age 65 and older was even lower than for women 50 to 64 years of age.⁵

CERVICAL CANCER

In 1994, it was predicted that approximately 15 000 cases of invasive cervical cancer would be diagnosed and 4600 women would die from it in the United States. Rates for carcinoma in situ reach a peak for both African-American and white women between 20 and 30 years of age. After the age of 25, however, the incidence of invasive cancer in African-American women increases dramatically, while in white women, the incidence rises more slowly.¹ The incidence of cervical cancer has been estimated to have been decreased 70% by screening. However, a large proportion of women, particularly elderly African-American women and middle-aged, poor women, do not have regular Pap tests. If women had Pap tests on a regular basis, death from cervical cancer could be prevented almost entirely.⁶

SCREENING GUIDELINES AND QUALITY ASSURANCE

Some standard screening guidelines from major authorities are excellent if they are followed consistently. These guidelines are established by the American Academy of Family Physicians, the American Cancer Society, and the American College of Obstetricians and Gynecologists.

The true challenge is implementing the standards and improving the utilization of breast and cervical cancer screening by patients in your practice. Research has shown that knowledge of preventive care guidelines is not enough. The real issue is making the recommendations a part of your routine practice. Clearly, daily practice habits and office personnel are powerful forces in determining the level and type of services. The importance of this factor is especially clear when efforts are made to improve the performance of preventive services such as mammography and Pap smears. Studies show that initially, performance rates improve. However, over time, performance returns to baseline levels.⁷ Why? The status quo is hard to change. The importance of this problem cannot be overemphasized.

IMPROVING SCREENING UTILIZATION The First Step

To break old practice patterns and improve utilization of screening, reinforce for yourself and your staff that as primary-care providers, you are where prevention, early detection, and early intervention make the difference. It is important to orient your entire practice to these three high-priority approaches. The attitude and perception of the physician and office staff are important variables that greatly affect preventive care.⁸

In addition, underline the fact that your practice serves as the "medical home" for the women in your communities. Your practice is where women go for medical information and advice to which they listen and trust. Therefore, it is disconcerting to learn from surveys that the two most common reasons women don't obtain mammograms are: "I didn't know the importance" and "My doctor never recommended it." This latter statement is the most frequently cited reason for a woman failing to receive a mammogram. Studies have shown that women are more likely to have mammograms if their physicians advise them to do so.⁹

Physicians and their office staff should be aware that surveys indicate the majority of patients are interested in disease prevention.^{10,11} Patients will comply with most recommended services if appropriately offered by a physician.¹²

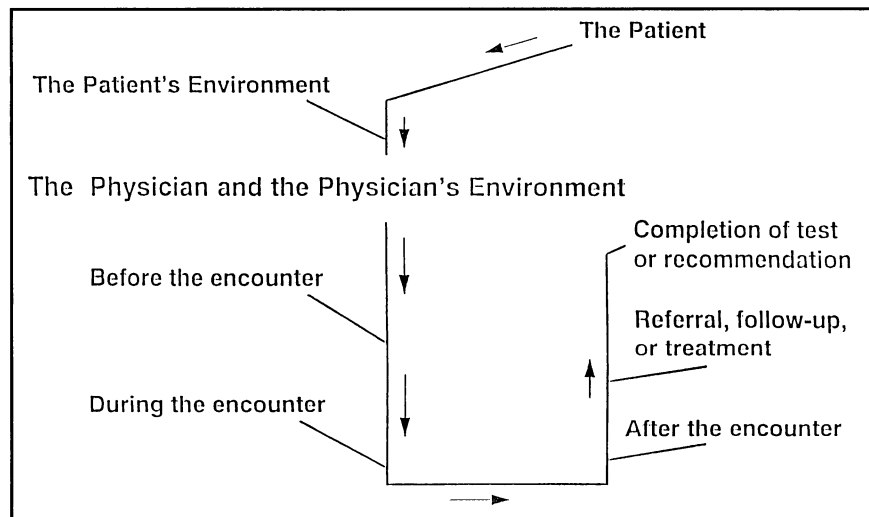
The Second Step

A thorough review of what you are doing currently must be conducted. Are you educating the women in your practice? If so, how, when, who, and how often? Are you teaching breast self-examination? Are you recommending mammography; are you performing or assuring Pap smears? What are your baseline performance rates? This must be done accurately to distinguish actual performance from estimated performance. Pommerenke and Dietrich¹³ reported that a primary-care physician estimated that 90% to 95% of adult female patients had received a Pap smear in the previous 2 years. After a review of 100 randomly selected charts, the physician was surprised to learn that only 50% of the women over the age of 50 had been screened in the past 2 years. Of the remaining women, many had never had a Pap test.

THE PATIENT PATH MODEL

The Patient Path Model⁷ can provide a framework for systematic practice evaluation. It is a tool for self-audits in a practice environment. The model is based on a critical path analysis process that is used in

Figure. The Patient Path Model. (Reprinted with permission from Pommerenke FA, Dietrich A. Improving and maintaining preventive services, part 1. *J Fam Pract.* 1992;34:86-91. Copyright ©1992, Appleton & Lange Inc.)



many nonmedical fields to analyze potential problem areas in a process and correct them.

The Patient Path Model starts with the patient and proceeds through the physician-patient encounter. Intersecting the path are opportunities for and barriers to providing preventive care (Figure). There are four spheres of influence that affect patient care: the patient, the patient's environment, the physician, and the physician's environment.

The Patient

The patient, who may not have knowledge of the benefits of screening, may:

- present barriers of cultural beliefs, eg, will not touch breasts (Freeman,¹⁴ with the Women in Touch group in South Bend, Indiana, speaks of the "taboo" held by many African-American females against touching or examining their bodies, which is inculcated at an early age),
- lack knowledge about the benefits of mammography,
- have access barriers such as lack of money for a mammogram or lack of transportation (mobile vans often can help in this instance),
- be fearful (often a serious deterrent), and
- experience language or educational barriers.

The Patient's Environment

This environment may not provide the facilities or encouragement for screening and includes elements such as public health policy, insurance regulations, lack of incentives, fragmentation of health care, and lack of consensus. Physicians have little control over this sphere of influence.

The Physician

The physician may not be aware of the patient's family history or may not recommend the procedure. The skills, perceptions, and attitudes of the physician and office staff are important in preventive care.

The Practice Environment

Primary care research has shown that utilization of preventive services can be improved by modifications in the physician's practice environment.⁷ The practice environment includes practice characteristics, office design, patient care systems, protocols, and personnel. Patient compliance with clinical breast examinations are improved with private dressing areas, gowns, and other arrangements for patient comfort.⁷ Posters and educational messages in waiting areas help motivate patients to initiate discussions with their physicians regarding screening.

Medical records, reminder systems (such as patient postal cards), and staff skills are all important before the actual encounter so that a discussion of screening services will not be overlooked, avoided, or postponed.

During the Encounter

Nurse-initiated reminder systems can alert the physician to the need for screening. Colored chart stickers or removable, self-sticking notes can be placed by a nurse on a patient chart to alert the physician to a patient's need for mammography and a clinical breast examination.^{7,13,15}

The US Public Health Service has created a *Put Prevention Into Practice Education and Action Kit* that

contains a clinician's handbook, personal health guides for patients and physicians, flow sheets, chart alert stickers, reminder postcards (to be mailed to patients), posters, and other resources to enable clinicians to provide optimal preventive care for their patients. The kit is available from the Superintendent of Documents in the US Government Printing Office.

As part of prevention, a nurse can explain to a patient breast self-examination, mammography, and the location of low-cost screening facilities. Educational materials should be available in the examination room.

After the Encounter

This is an essential part of the health promotion and disease prevention process. The office visit can be great, but after the visit, everything can collapse. For referral mammograms, written protocols will assist your office staff in making the appointment and providing the patient with instructions and directions to the facility.

Follow-up protocols will ensure that patients comply and obtain the screening procedure and that the results of the test are reviewed by the physician and discussed with the patient. This time may be used to identify problems and opportunities to improve utilization of screening services.

IMPROVING AND MAINTAINING PREVENTIVE SERVICES: PRACTICAL PRINCIPLES FOR PRIMARY CARE

Pommerenke and Dietrich¹³ have summarized accepted concepts for implementation of preventive services into practical principles. Each of the principles has been derived from the attributes of successful programs to improve the provision of preventive services in primary-care practices:

1. *Identify baseline performance rates.* This is essential to identify problem areas and help set realistic goals.
2. *Set reasonable and measurable goals for preventive activity and periodically review progress.* Even small improvements are important, especially if maintained over time. Periodic review of progress is essential or old habits will return or inefficient patterns will become established.
3. *Develop a comprehensive plan to achieve and maintain practice goals.* Have written protocols for referrals, follow-up, and recall. Have written job descriptions.
4. *Give a high priority to staff training and participation.* Participation of office staff is crucial to any plan to change existing practice patterns. By

nature, preventive services and screening for breast and cervical cancer must be repeated. Patients need to be recalled and examined periodically. Therefore, you need protocols and responsibilities assigned to certain office staff.

5. *Be sure that office systems, design, and organization facilitate preventive care.* Make this a standard. These practices must be institutionalized. Every opportunity to maximize prevention should be seized. For example, a great deal of talking occurs while vital signs are being taken. This is a good time to update preventive screening status. It is useful to include this aspect in job descriptions.
6. *Use every opportunity to perform preventive procedures.* Implement preventive procedures each time the patient is seen, for whatever reason. Do not wait for a routine periodic visit to practice prevention.
7. *Use reminder systems to ensure that patients at risk are identified, screened, and monitored.* Reminder systems overcome two of the most important barriers to clinical preventive care in primary care practice: lack of time and forgetfulness. Use flow charts, chart stickers, and computerized reminders.
8. *Consider continuing medical education (CME) programs that emphasize skills that can be applied in clinical practice.* Physicians should search for CME programs that can facilitate the implementation of preventive practices into daily routines, not merely programs that increase knowledge.
9. *Develop state-of-the-art counseling and communication skills.* Highly developed communication skills are vital for educating patients about early detection procedures and other aspects of health promotion and disease prevention.
10. *Keep cost issues in perspective and minimize economic barriers for patients.* The use of flexible payment schedules, low-cost facilities, and other economical procedures can facilitate the prevention process. Refer to free mammography screening programs.

FINAL SUGGESTIONS

- *Make screening procedures standard practice to be implemented by the entire staff at every opportunity.* There are many tools to do this, eg, African-American breast models to teach breast self-examination. On-site Pap smears and mammography greatly enhance the utilization of these procedures. Have a mammography van periodically visit your practice site if possible to improve access to mammography for your patients.

- *Maintain a tracking system.* There are tools to assist, but the most effective is a computerized tracking system.
- *Use available questionnaires and also survey your patients on how to improve screening approaches.*
- *Participate in educational activities outside the office where African-American women congregate (eg, churches, sororities, and workplaces) to enhance awareness, knowledge, and motivation.* This also provides visibility for your practice in the community.
- *Help empower women to take charge of their own health.* Have them help track their own screening needs and schedule. An innovative approach is to help form focus groups and support groups on prevention for patients in your practice. Support groups are common after diagnosis and treatment. This approach also should be used on the front end of the continuum to improve awareness, education, and utilization of preventive screening approaches to improve health.

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